DUAL PERSPECTIVE ON PTSD IN WAR VETERANS

An In-Depth Dual Perspective On

PTSD in War Veterans

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Frank Scott-Fall 2005

OM 6 Research Paper

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Western Etiology:

PTSD is a psychological response to the experience of intense traumatic events, principally those that jeopardize life. It can affect people of any age, culture or gender. While the public has become increasingly aware of this disorder in recent years, the condition has been known to exist since the times of ancient Greece and has been identified by many different names. During the American Civil War it was referred to as "soldier's heart", in the First World War it was called "shell shock", and in the Second World War it was known as "war neurosis."[1] Many soldiers were characterized as having "combat fatigue" while encountering symptoms associated with PTSD during warfare. In the Vietnam War, this became known as a "combat stress reaction." Some of these soldiers continued on to develop what became labeled in 1980 as Post Traumatic Stress Disorder.[2] The following will attempt to explore and analyze the etiological progression of PTSD, as documented throughout the United States history of war, starting with World War I to the current situation in Iraq. Additionally, the etiology, diagnosis, and treatment methods will be examined from both a Western/Biomedical perspective as well as an Eastern/Traditional Chinese Medicine perspective.

According to A.J. Glass, it was during World War I that the correlation between

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[1] Wolfe J, Erickson DJ, Sharkansky EJ, et al. Course and predictors of posttraumatic stress disorder among Gulf War veterans: a prospective analysis. *Journal of Consulting and Clinical Psychology*, 1999; 67(4): 520-8.

[2] Ibid, Wolfe J, Erickson DJ, Sharkansky EJ, et al.

clinically specific symptom patterns and combat duty were recognized.[3] Consequent to the prolonged exposure to artillery bombardment, it was believed that the high air pressure from the exploding shells generated physiological injuries giving rise to the set of symptoms categorized as "shell shock." Progression of these symptoms by the end of World War I altered the classification of this syndrome to "war neurosis"[4] Next, WWII presented with a 300% increase in sufferers of psychiatric distress in comparison to WWI, resulting in the number of soldiers being discharged from duty on the grounds of psychiatric disturbance exceeding the number of those being enlisted at one point.[5] Moving forward, Glass notes it was during the Korean War when the methodology of treatment to 'combat stress' advanced into a situational approach. Clinicians supplied immediate treatment to the afflicted soldier in expectancy of them to return to duty without delay post treatment.[6] This approach revealed a noteworthy outcome. Only 6% of the Korean War soldiers departed on the basis of psychiatric impairment in comparison to the 23% of WWII combatant departures. This statistic identified "situational stressors" of the soldiers as the chief source contributing to psychological damage.[7]

However, it was America's participation in the Vietnam War which exposed soldiers to a new level of terrorizing psychological warfare that produced a particularly devastating blow to the psyche of combatants. Lessons learned during the previous wars, insight gained from the Korean War, coupled with further plans for improvement would lead to no additional enrichment

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[3] Glass, A.J. Introduction. In P.G. Bourne (Ed.), THE PSYCHOLOGY AND PHYSIOLOGY OF STRESS. New York: Academic Press, 1969, xiv- xxx.

[4] Ibid, Glass, A.J. (1969)
[5] Tiffany, W.J. & Allerton, W.S. Army psychiatry in the mid-60s. AMERICAN JOURNAL OF PSYCHIATRY, 1967, 123: 810-821
[6] Glass, A.J. Psychotherapy in the combat zone. AMERICAN JOURNAL OF PSYCHIATRY, 1954, 110:725-731
[7] Bourne, P.G. MEN, STRESS AND VIETNAM. Boston: Little, Brown, 1970

of and preparation for the management of the soldiers' psychological ruin during the Vietnam War.[8]

An important trend was noted between soldiers post WWII and soldiers post Vietnam. After WWII, combatants began to complain of similar signs and symptoms. These included severe anxiety, dreams about combat, depression, uncontrollable anger and aggression, difficulties developing and maintaining interpersonal relationships as noted in a 5 year follow up study[9] and in a 20 year follow up study.[10]

Similarly, Vietnam Veterans complained of similar symptoms after their duties in war had ended. However, the uncommon feature was in the prevalence of soldiers afflicted. The numbers reported for Vietnam Veterans was significantly higher than those recorded for any of the previous wars. Furthermore, in both WWII and the Korean War, there was a linear relationship between psychological distress and intensity of war and vice versa. Conversely, this was not the case in Vietnam. Despite the heightened intensity of battle during Vietnam, no significant increase in psychological casualties was noted. In fact, it was the end of direct American combat involvement in the war in 1973 that posed a dramatic increase in psychological casualties.[11]

With this in mind, the military instated a new policy of DEROS or "date of expected return from overseas," rotating each soldier out of war after serving a 12 month contract in order

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[8] Ibid, Bourne, P.G.
[9] Futterman, S. & Pumpian-Mindlin, E. Traumatic war neuroses five years later. AMERICAN JOURNAL OF PSYCHIATRY, 1951, 108(6): 401-408.
[10] Archibald, H.E. & Tuddenham, R.D. Persistent stress reaction after combat: A twenty-year follow-up. ARCHIVES OF GENERAL PSYCHIATRY, 1965, 12: 475-481
[11] PRESIDENT'S COMMISSION ON MENTAL HEALTH. Report of the special working group: Mental health problems of Vietnam era veterans. Washington: Feb. 15, 1978.

to cut down on prolonged exposure to battle and development of psychological distress.[12] However, the shortcomings of this policy weren't recognized until later under the implementation of this new system. The negative side effects of DEROS included a newly forced isolation of soldiers from one another. Since DEROS was dependant on enlistment dates, each date of return was unique per soldier leading to a breakdown in platoon cohesion. With the breakdown of unit solidarity, many cliques were formed on basis of race, rank, and level of experience rather than by platoon, unit, or infantry. Furthermore, as experienced soldiers rotated out and new, inexperienced soldiers were sent in as replacements, resentment manifested against the 'new guys'. The notion that the new soldier's inexperience would lead to an increased chance of error resulting in the death of a soldier close to ending his time served in Vietnam fueled the isolation of these replacement soldiers from the already present ones.[13]

Additionally, a new syndrome dubbed "short timers syndrome" was introduced. This involved a soldier who was two months shy of returning home becoming increasingly withdrawn from battlefronts in attempts to safeguard oneself from injury or death. This furthered the isolation of the individual from the group compounded by mixed emotions of happiness on going home and guilt and shame for abandonment, disloyalty and selfishness. The above listed issues were further complicated by the novel war tactics implemented in Vietnam, witnessing death and desecration of fellow soldiers and civilians, and the turmoil and unrest upon coming home from the war in the form of political unrest and anti-war demonstrations, advancing the psychological trauma of the soldier. Vietnam undoubtedly cemented the pattern of modern day PTSD in

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[12] Kormos, H.R. The nature of combat stress. In C.R. Figley (Ed.), STRESS DISORDERS AMONG VIETNAM VETERANS: THEORY, TREATMENT AND RESEARCH. New York: Brunner/Mazel, 1978

[13] Ibid, Kormos, H.R.

veterans.

Likewise, the wars in Afghanistan and Iraq will likely yield a new generation of veterans at risk for the chronic mental health difficulties that result, in part, from exposure to the stress, adversity, and trauma of war-time experiences. These wars are the most sustained combat operations since the Vietnam War. A plethora of research has persuasively indicated that the rate and intensity of exposure to combat encounters is strongly linked with the risk of chronic posttraumatic stress disorder and related impairment.[14]

Since the formal "termination" of combat operations in the Iraq War, soldiers have been exposed to traumatizing circumstances that will likely affect their coping capacities and ability to adapt. The conflict in Iraq has been saturated with the hazards that arise from guerilla warfare (e.g., roadside bombs, IED, etc) arranged from indefinite civilian threats. In Iraq, soldiers are obliged to maintain an exceptional degree of alertness and to react cautiously to threats. There is much concern that soldiers will erroneously mistake harmless civilians for combatants. Soldiers must be cautious in regards to causing collateral damage to civilians in urban settings. The latter can cause chronic anxiety and strain. Polls indicate that 62% of soldiers reported being in threatening situations in which they were unable to respond assertively as a result of the guarded rules of engagement. There is already much evidence supporting that veterans of this new war are likely to have a considerably high incidence of PTSD; there is much need and concern for improved and effective diagnosis and treatment of this disorder.[15]

Diagnosis:

[14] Hoge C. W., Castro C. A., Messer S. C., McGurk, D. Cotting, D. I. & Koffman, R. L. (2004). Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. *New England Journal of Medicine, 351*, 13-22.
[15] Ibid, Hode, et. al

Traumatic stress can be viewed as a normal human reaction to intense incidents. Majority of people experience a considerable reduction or disappearance of symptoms over the first few months, particularly with the help of a strong support system such as caring family members and friends. For a significant minority, however, the symptoms do not appear to resolve quickly and, in some cases, persist to cause problems for the rest of that person's life. It is also common for symptoms to vary in intensity over time. Some people endure long intervals without any significant problems, only to relapse upon encountering a major life stress. In rare cases, the symptoms may not appear for months, or even years, after the trauma.[16]

What traumatizes one person can be less significant and detrimental to another. This variation in peoples' reactions occurs because of their individual personality, beliefs, personal values, and prior experiences (especially of other traumatic events in their life). Moreover, it occurs given that each person's understanding of the incident is unique. However, in all cases, the individual has experienced a threatening event causing them to respond with intense fear, helplessness, or distress.[17]

For military veterans, the trauma correlates to direct combat duties, presence in a dangerous war zone, or participating in peacekeeping missions under grim and stressful circumstances. Additionally, memories, images, smells, sounds, and feelings of the traumatic event can impinge the lives of those individuals afflicted with PTSD. Sufferers may remain utterly imprisoned by the memory of the previous trepidation causing them an inability to focus on their present situation. Those with PTSD report frequent, distressing memories of the event that they wish

[16] Davidson JR. Trauma: the impact of post-traumatic stress disorder. *Journal of Psychopharmacology*, 2000; 14(2 Suppl 1): S5-S12.
[17] Ibid, Davidson JR

they did not have. They may have nightmares of the event or other distressing matters. Movement, excessive sweating, and on occasion, acting out the dream while still asleep may accompany these nightmares. Patients report feeling as though the events were happening again; this is referred to as "flashbacks", or "reliving" the event. Commonly, patients may become disturbed, or experience physical signs such as sweating, heart racing, and muscle tension when factors/events occur reminding them of the incident. Overall, these disturbing symptoms trigger severe torment and can produce other emotions such as grief, guilt, fear and/or anger.[18]

Six DSM-IV criterion are essential and must be encountered in order for the diagnosis of PTSD to be fulfilled. These conditions are listed below:

1. exposure to a traumatic event
2. persistent re-experiencing of the event
3. persistent avoidance of stimuli associated with the trauma and reduced responsiveness to the environment
4. persistent symptoms of increased arousal not present before the trauma
5. these symptoms must be present for at least 1 month
6. symptoms must cause significant impairment in social, occupational, or other areas of function.

If a veteran presents with some but not all of these symptoms, do not discount a diagnosis of PTSD since other symptoms might have existed previously. A comprehensive history (including military history) will often disclose a full range of symptoms that transpired some time proceeding exposure.[19]

Treatment:

[18] Ibid, Davidson, JR

[19] American Psychiatric Association. Diagnostic and statistical manual of mental disorders, fourth edition, text revision. Washington, D.C.: American Psychiatric Association, 2000:467-8.

It is preferable to refer a patient to a Veterans Affairs (VA) hospital. More than 80 groups exist to identify and treat veterans suffering from combat-related PTSD. VA hospitals have mental health clinics in which clinicians that are knowledgeable and experienced in the treatment of PTSD patients are available. Also, referrals can be made to veterans centers that have substantial know-how in intervening and caring for veterans suffering from the malady. Assorted methods available for treatment include psychotherapy, drug therapy, or a merger of both tactics. Most facilities additionally offer family education, family therapy, PTSD education groups, stress management, spiritual groups, and recreational therapy.

Psychotherapy is implemented with moderate outcomes. Open dialogue with veterans about their experience, principally among veterans who have recently formed distressing symptoms, helps to assist in expression and improvement of symptoms; thereby facilitating additional therapeutic tactics. Special attention needs to be executed provided the prospect of suicide, specifically senior veterans with preparation for intervention upon isolation, hopelessness, or mood shifts.

Commonly, cognitive-behavioral therapy (CBT) is utilized in an attempt to work with the patient's cognition to alter emotions, thoughts, and behaviors. One branch of CBT that expressly addresses treatment of trauma is called exposure therapy. Exposure therapy requires carefully and cautiously exposing the patient to repeated detailed imaging of the trauma while in a safe and regulated atmosphere. The object of this is to aid the patient to confront the fear and learn to regain control of the dread and anguish that existed at the time of the initial trauma. Dependant on the patient's coping ability, traumatic memories can be confronted by either a "flooding"

mechanism or a "desensitization" process. Tackling all traumas and distressing memories simultaneously is classified as flooding, while patients who must deal with each stressor/trauma independently while gradually approaching the most difficult devastation is coined "desensitization."[20]

Pharmacotherapy also exhibits a significant role in treatment. Even though there is no specific medical treatment for PTSD, drug therapy may assist in the reduction of specific symptoms. Medication can aid in the reduction of the intensity of depression, insomnia and anxiety which are commonly experienced by the afflicted veterans. Though pharmacotherapy offers no remedy for PTSD, it provides enough relief for the patient to seek psychotherapy. [21]

Moreover, a fairly new treatment called Eye Movement Desensitization and Reprocessing (EMDR), involves constituents of both cognitive and exposure therapy coupled with techniques such as hand tapping, eye movement, and sounds to induce a modification of patients' attention back and forth across their midline. Though this procedure is still being researched, evidence has surfaced indicating the exclusive practice of attention alteration provides the patient an ability to recruit and sort through their mental vault of trauma.[22]

Traditional Chinese Medicine

[20] Stein MB, McQuaid JR, Pedrelli P, Lenox R, McCahill ME. Posttraumatic stress disorder in the primary care medical setting. Gen Hosp Psychiatry 2000;22: 261-9.
[21] Ibid, Stein MB, McQuaid JR, Pedrelli P, Lenox R, McCahill ME.
[22] http://www.emdr.com, Retrieved November 21, 2005.

These are a few modes in Western treatments commonly chosen by patients to help them begin to deal with the issue at hand. However, there are an assortment of therapies and treatments researched, presented, and available for patients to evaluate and explore. One promising approach is Traditional Chinese Medicine (TCM), a modality that employs acupuncture and herbology in an attempt to improve and possibly resolve the signs and symptoms associated with PTSD.

Traditional Chinese Medicine's approach to diagnosing and treating a patient is unlike that of Biomedicine. The patient is evaluated in a holistic manner with an understanding that the mind, body, and soul are interconnected and unified, hence an imbalance in one will lead to the disturbance of the other. This is not like Western medicine's approach of treating signs and symptoms individually and independent of other body systems, maintaining a divider between physical, emotional, and mental.

According to TCM, upon exposure to extreme stress or traumatic events with immoderate fluctuations in emotions or chronic states of emotional upset, the body's vital energy, qi, becomes stagnated within organs, channels and meridians running through our bodies. This stagnation of qi leads to disruption of the flow of qi thereby generating an imbalance in the body's harmony resulting in illness and pathology. Dissimilar from the Western modality, TCM does not specifically have a diagnosis and treatment strategy listed for the Western diagnosed disorder of PTSD. Instead, TCM evaluates each patient individually recording each specific complaint, sign and symptom, in addition to noting the quality of their tongue and pulse. The patient is then diagnosed based off of their responses to the TCM intake and a treatment is

devised that is unique and custom tailored to their specific complaints addressing the chief complaint first as reported by the patient.

Nevertheless, TCM does recognize stress as one of its categories. Ross states that anxiety is associated with the Heart and Kidney systems. Moreover, he reveals that Heart anxiety is rooted in kidney fear, manifested via sentiments of apprehension and fear while anticipating something bad about to occur. Should anger be a factor along with high tension, then a Liver-Gallbladder system is considered to be involved with further potential symptoms such as indecision, irritability, heightened sensitivity, pain, headaches, stiffness and/or spasms of the facial, neck, shoulder, and/or back muscles. Furthermore, Ross separated anxiety based off of the nature of the disturbance, its presentation being stagnant, excess, or deficient.[23]

Likewise, Flaws asserts that fright and fear will internally injure the three organ systems of heart, liver, and spleen. This disharmony primarily affects the flow and qi and blood. Additionally, Flaw maintains that there is an intimate relationship relating not only the spleen, liver, heart and kidneys, but qi, blood, phlegm and heat as well. Hence, these mechanisms further complicate one another upon their own imbalances.[24]

Diagnosis will be reliant upon how veterans presents. Generally, the veteran's signs and symptoms will coincide with either a particular disease category or a combination of disease patterns that best fit their signs and symptoms. The following will catalog some of the most

[23] Ross J. Acupuncture Point Combinations: The Key to Clinical Success. Philadelphia, Pa: Churchill Livingstone; 1995.
[24] Flaws, Bob. Lake, James. Chinese Medical Psychiatry. Boulder, CO:Blue Poppy Press; 2004.

common disease patterns listed for anxiety partnered with their acupuncture point prescription as reported by Flaws, Wiseman and Ellis, and McDonald and Penner.

Heart Qi deficiency

Signs & symptoms: palpitations, mild physical activity causes shortness of breath and/or feelings of oppression in the chest, spontaneous sweating, fatigue, listless, pale complexion, lack warmth to connect with people, trouble making conversation, trouble communicating one's meaning or intentions (slow), absence of joy

Tongue: normal or pale color with a white coating, may have midline crack

Pulse: may be empty, feeble, knotted, or intermittent

This pattern may be seen after blood loss from emotional problems

Treatment Principle: Tonify Heart Qi

Ht 5 → Tonifies Heart Qi
Pc 6 →Tonifies Heart Qi, pacifies Mind (good if sadness is causing the problem)
B1 15 →Back Shu point of Heart: tonifies Ht Qi. Moxa OK
Ren 17 →Influential Point of Qi. Tonifies Qi of Upper Burner and therefore affects Ht Qi. Good if sadness is the cause
Ren 6→Tonifies Qi of whole body. Exp. good if condition comes from a chronic illness and general Qi Deficiency

Heart Yang deficiency (& collapse)

Signs & symptoms: palpitations, mild physical activity causes shortness of breath and/or feelings of oppression in the chest, spontaneous sweating, fatigue, listless, bright-pale complexion, intolerance to cold (not relieved by clothing or blankets), cold limbs, limb edema, cyanotic lips, lack warmth to connect with people, trouble making conversation, trouble communicating one's meaning or intentions (slow), absence of joy, chest pain with cold limbs & sweat (heart attack)

Collapse: key symptoms are cyanotic lips, cold limbs and sweats, and a hidden minute pulse.

Tongue: pale swollen with a white moist coating

Pulse: deep weak, thin feeble, or knotted pulse

This pattern may be seen indirectly from Kidney Yang deficiency (chronic illness, excess sexual activity especially if exposed to cold after intercourse, chronic retention of Dampness, old age), after blood loss, from emotional problems, various physical heart diseases, heart failure, or circulatory failure caused by various acute or chronic diseases.

Treatment Principle: Tonify and warm Heart Yang

Ht 5→tonifies Heart Qi
Pc 6→ Heart Qi, pacifies Mind (good if sadness is cause)
Bl 15→Moxa to tonify Heart Yang
Ren 17 →Moxa to tonify Heart Yang
Ren 6→ Moxa to tonify all Yang energy of body. Esp. good if Heart Yang Deficiency results from Kidney Yang Deficiency
Du 14→Direct moxa to tonify Heart Yang

<u>Heart Blood deficiency</u>

Signs & symptoms: palpitations, dizziness, insomnia (trouble falling asleep), vivid dreams that can make one feel like their sleep was not quality, poor memory, numbness in the limbs, easily forget the words they wish to use and simple routine things in life (i.e. keys), anxiety, easily startled, easily fatigued, pale dull complexion, pale lips, may have dry &/or itchy skin, shyness, sense of vulnerability, withdrawn, amenorrhea, scanty periods, late menses.

This pattern could also lead to Kidney and Heart disharmony (Kidney and Heart Yin deficiency leading to Kidney Yin not nourishing the Heart Yin, hence, deficient Heart Fire)

Tongue: pale thin, may be dry

Pulse: thin, may be weak or choppy

Treatment Principle: Tonify the Blood and Heart, calm the Shen

Ht 7→tonifies Heart Blood and pacifies the Shen
Pc6→tonifies Heart Qi and pacifies Shen
Ren 14→tonifies Heart Blood and pacifies Shen - excellent where there is marked anxiety/restlessness
Ren 15→tonifies Heart Blood and pacifies Shen
Ren 4→tonifies Blood

Bl 17→influential point of Blood
Bl 20→back Shu point of Spleen, tonify to increase Spleen energy to produce more Blood

Heart Yin deficiency

Signs & symptoms: palpitations, irritability, dream disturbed sleep, easily startled, insomnia (falls asleep with only slight difficulty but sleeps shallow or wake often during the night), vivid dreams sometimes to the point of disturbing the sleep, five center heat sensation, anxiety, jumpy, chatty, fidgety, restless, flighty, malar flush, night sweats, tidal fevers, dry mouth, throat, and lips, cankers of the tongue, trouble with public speaking, tendency to quick and hasty words, poor memory for people or place names, amenorrhea, scanty periods.

Tongue: red with dry scanty or dry with no coating (peeled), red tip with redder spots, midline crack that may reach the tip and be quite deep depending on the severity of disease and constitutional weakness

Pulse: thin or thready and rapid, if severe may be floating and empty.

This pattern is often seen with chronic anxiety and a very busy or hectic lifestyle like that of the West. May also be seen in more in hot climates, tachycardia, arrhythmia, anemia, neurasthenia, hypertension, hyperthyroidism, and generalized anxiety disorders

Ht 7→tonifies Heart Blood and Heart Yin and pacifies Shen
Pc 6→calms Shen
Ren 14→tonify the Shen esp. good with marked anxiety
Ren 15→tonify the Shen esp. good where marked anxiety
Ren 4→tonifies Yin and "settles" the Shen
Ht 6→tonifies Heart Yin and stops night sweating
SP 6→tonifies Yin and calms the Shen
Ki 7→tonifies Kidneys and with Ht 6 stops night sweats
Ki 6→tonifies Kidney Yin and promotes sleep

Heart Fire

Signs & symptoms: palpitations, thirst, irritability, insomnia and dream disturbed sleep (dreams of fire are common), cankers of the tongue (more red and painful), agitation, anxiety, mental restlessness, impulsive, whole face red, dark urine that may contain blood and/or be painful constipation with dry stool (possible hematemesis), epistaxis, delerium, manic episodes, bitter taste.

Tongue: deep red with red tip and red spots, yellow coating, midline crack that may reach the tip and be quite deep depending on the severity of disease and constitutional weakness

Pulse: full rapid, may be intermittent.

This pattern is seen in emotional disturbances (chronic generalized anxiety, anger, worry, most notably depression)

Treatment Principle: Clear the Heart and Soothe the Shen

Ht 9→Clear Heart Fire
Ht 8→Clear Heart Fire
Ht 7→Pacify the Mind
Ren 15→Pacifies Shen and clears Heat
SP 6→Nourish Yin and cool Fire
Ki 6→Nourish Yin and cool Fire

Heart Blood Stasis

Signs & symptoms: palpitations, stabbing pain, constriction, or oppression in the heart region that may radiate to the left shoulder, medial (inner) aspect of left arm, or through to the back, this pain becomes more severe at night, shortness of breath, fatigue, cyanotic lips and nails, cold hands (lack of circulation to the limbs), feeling of impending doom. This may be caused by or complicated with Phlegm (overweight, expectoration of sputum, greasy tongue coating, nausea), or Yin type Cold obstruction (Heart Yang deficiency can't move the blood in the chest which shows sudden attacks of severe pain, cold limbs, intolerance to cold.

Tongue: purple (may show purple spots)

Pulse: uneven, knotted, or intermittent

This pattern is seen in patients suffering Yang deficiency, cold weather, Phlegm, and emotional problems (grief, anxiety, and anger not properly dealt with will stagnate in the chest impeding circulation of Qi and Blood. Smooth flow of Qi and Blood is needed for the proper functioning of the mind, and a smoothly functioning mind is needed for proper circulation of Qi and Blood).

Treatment Principle: Regulate Blood, remove stasis, tonify and warm Heart Yang (or sedate Ht Fire or tonify Ht Blood) pacify Shen

Pc 6→Regulates Heart Blood. Opens chest
PE 4→Xi Cleft Point: particularly useful to stop Heart pain during acute attack

Ht 7→pacifies Shen
Ren 17→Regulates Qi and Blood in the chest and stimulates the Zong Qi. If Heart Yang is Deficient, moxa can be used.
Bl 14→Regulates Heart Blood
Bl 17→Regulates Blood when needled. Tonifies Blood if moxa used
SP 10→Regulates Blood

Phlegm covering the Heart-Mind orifices

Signs & symptoms: mental confusion, palpitations, dementia, unconsciousness, fatigue (heavy feeling), cloudy thinking, apathy, haziness, abnormal behavior, soliloquy, nausea, fullness in the chest and epigastrium, Phlegm rattling sound in the throat, aphasia, dull complexion, copious expectoration of sputum, mental diseases (depression, bipolar, mentally handicapped, introverted, talking to oneself, delusional, blackouts, staring), these people are usually not dangerous to others (possibly to themselves), coldness, passive, 'slacker' behavior, not logical thinking. When combined with Wind, this pattern can manifest post-stroke (coma, paralysis, aphasia).

Tongue: swollen with thick sticky slippery whitish coating, may have midline crack with prickles in it

Pulse: slippery

It can be seen in adults who eat too much greasy-cold-raw (Phlegm forming) foods and have or are currently experiencing severe emotional difficulties. Epilepsy, hysteria, depression, neurosis, after effects of Wind-stroke, and coma, all may also show this pattern.

Phlegm-Fire disturbing the Heart-Mind

Signs & symptoms: mental restlessness, palpitations, manic episodes, fidgety, insomnia, vivid dreams that disturb sleep, easily frightened, bitter taste, delerium, strange speech, confusion, harsh behavior, violent, aggressive, uncontrollable laughter, singing, shouting, or crying, talking to oneself, depression, aphasia, flushed red face, dark urine (may see blood), constipation with dry stool, hallucinations, if severe enough patient may fall into a coma. This is a major pattern of Kuang Zheng.

- Kuang Zheng is a Fire (Yang) pattern that is usually complicated with Phlegm covering the Heart, mind, spirit, Hun (ethereal) and Po (physical) soul (Dian Zheng). This manifests as blockage accumulating and causing Heat until the point of bursting resulting in Fire surging upwards.

Tongue: red with greasy yellow coating, tip may be deep red and swollen with red spots, may

have midline crack with prickles in it

Pulse: full, slippery or wiry, and rapid.

This pattern is often seen in Schizophrenia, Bipolar manic-depression, neurosis, hysteria, menopausal syndrome, gram-negative sepsis, encephalitits, apoplexy, or epilepsy. It may be caused by severe emotional problems that cause stagnation and turn to Fire, a diet of rich spicy hot and greasy foods, and external pathogenic invasion (epidemic febrile diseases).

LV 3 → harmonize LV
PC 5 →expel phlegm
ST 40 → resolve phlegm
CV 12 → ST Mu
CV 17 → PC Mu
HT 7 → calm spirit

Aside from just acupuncture, patients will find that complementing their treatment with herbal formulas will yield better results for successful alleviation for their symptoms. Herbal formulas are effective in addressing internal disharmonies and deficiency and excesses, helping to restore the body back into balance. Furthermore, herbs provide an excellent way to "continue" treatment outside of the practitioner's office. This provides and continuity and consistency in rebuilding the body's loss. The majority of success that occurs with herbal compliance is in the practitioner's ability to custom make formulas centered around the disease pattern, symptoms, and chief complaints as reported by the patients. The practitioner is able to modify formulas with herbs which target specific matters unique to each patient, this facilitates direct targeting of disharmonies needing to be addressed and resolved. There are a vast amount of formulas available that are modified to the unique needs of each patient.

Accordingly, TCM's ability to customize its treatments both herbally and with needling to tackle the specific patterns unique to each patients'needs is clearly the foundation for the

strength and success of this modality's ability to treat PTSD. However, awareness of and access to this modality may serve as an obstacle for those veterans who are unfamiliar with this approach. Fortunately, acupuncture is gaining much recognition and exposure to the general public subsequent to various factors. These include increased funding for research, widely released studies asserting the use and success of acupuncture, frustration with unproductive or one-dimensional approach of Western medicine, and a noteworthy amount of publicity subsequent to celebrity endorsement of acupuncture.

The strength of Western medicine's role in successfully treating PTSD relies on it's availability as well as its multifaceted branches of treatment to effect relief. Pharmacotherapy's immediate drug effect of temporarily alleviating patient symptoms and psychotherapy's aspect of affecting cognition and behavior provides means of stabilizing the patients' state. Additionally, group therapy sessions in which veterans are able to speak with other veterans who have suffered similar symptoms with comparable backgrounds and unique comprehension of combat provides a footstep towards removing veterans from their isolation.

Conversely, the weakness of each modality lies in its inability to achieve what the other excels at. For example, in cases of extreme anxiety, depression, and mental disturbance, the usage of Western anti-psychotics and anti-depressants is necessary to relieve the immediate threat. TCM has no jurisdiction to prescribe such medication. Equally inadequate is Western medicine's inability to address the patient holistically and treat the patients' unique pattern of syndromes pertinent to them. Western medicine often must place each patient under imprecise category headings with broad treatment principles. This is evidenced by the cluster of patients

assembled under the umbrella diagnosis of PTSD with no specific differentiation in treatment in regards to the range of chief complaints expressed.

Obviously, the most beneficial approach for a combatant veteran suffering from PTSD to undertake would be that of an integrative one. In part, it seems that Western medicine is able to effectively administer to surface or external symptoms and complaints and attend to the disorder in its acute phase. Additionally, it is an excellent system to assist the veteran to assimilate into public aspects of life and socially acceptable behaviors by imparting adjustment in the patients' cognition. One can then maintain that TCM may be viewed as a mode of treatment most effective in focusing change on an internal level addressing the root causes of disharmonies impeding the quality of systemic functioning physically, mentally, and emotionally for the patient. This system may be more adequate in addressing the chronic pathologies present and necessitating the direct and personalized attention to symptoms as presented by the patient. Concisely, combining both modalities in treating PTSD in war veterans will surely enhance each one's strengths while simultaneously modifying the other's weaknesses.

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