

# Post Traumatic Stress Disorder in Veterans

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The symptoms of Post Traumatic Stress Disorder, or PTSD, are not new. Only the name of the disorder and the understanding of the causal factors are. Observation of these symptoms has occurred for centuries. The Greek poet Homer's Iliad was about war, betrayal, and PTSD (Shay, 1994). In 1597, Shakespeare, in Henry IV, described PTSD as reported by a spouse detailing the effects of war on her husband (Kulka, et. al., 1990). The belief is that the writer/poet Walt Whitman, who was a medic in the Civil War and wrote about the impact of the war on men, suffered severe depression as a result of PTSD (Porterfield, 1996). Nostalgia was the term used during the Civil War (Jay, 1991). Sigmund Freud observed the symptoms in sexually abused women and attributed it to the trauma. Later he revised his theory, under peer pressure, and referred to it as Hysterical Neurosis, saying the source was their vivid imagination and fantasies. In World War I, it was War Neurosis and Shell Shock, an internal character defect causing the former affliction and suspected brain damage from constant bombardment causing the latter. During World War II, it was called Acute Combat Reaction or Battle Fatigue (Porterfield, 1996). No matter what name they gave it, the symptoms were the same. Researchers began asking questions like: 1) What causes this reaction in people? 2) How do we treat it? 3) How long does it last? 4) What is the long-term outlook? 5) Can we learn how to prevent it? Although this paper will mainly focus on the veterans and combat environments, keep in mind that the effects of trauma will be very similar, regardless of the source of trauma. Some sections of this paper will be more specific in nature about what the veterans experience than others will.

## What is PTSD?

As the name implies, PTSD is a stress reaction to trauma occurring after the trauma. The trauma can be natural or man-made. Sometimes the symptoms appear almost immediately after the trauma, and sometimes the symptoms do not surface for years. The DSM-III-R defines the criteria for PTSD as exposure to one or more traumatic, psychologically stressful events outside the realm of usual human experience (Kulka, et. al., 1990). The event is intense, emotionally shocking, and leaves deep emotional and psychological scars (Porterfield, 1996).

A person with PTSD experiences feelings of marked terror or helplessness along with other symptoms. The symptoms fall into three classes: 1) Intrusive symptoms that cause the person to relive or re-experience the event; 2) Avoidance symptoms, avoiding anything that will remind them of the event; 3) Increased arousal or a state of heightened, constant readiness with an exaggerated startle response (Porterfield, 1996). **TABLE 1** details more symptoms.



As with many of the DSM-III-R categories, there are many who feel that the description of PTSD is very limiting. Due to these limitations of description, many combat veterans experiencing PTSD may be diagnosed as having borderline, antisocial, or other personality disorders instead of PTSD. Indeed, some actually do have these disorders in addition to or because of PTSD. Sometimes they are also misdiagnosed as having schizophrenia or bipolar disorder.

The World Health Organization has its own classification that offers a more accurate picture. They define PTSD as "Enduring personality change after catastrophic experience." They note that the following personality traits did not exist before exposure to the traumatic event or war: 1) A hostile or mistrustful attitude toward the world, 2) Social withdrawal, 3) Feelings of emptiness or hopelessness, 4) A chronic feeling of being "on the edge," as if constantly threatened, 5) Estrangement (Shay, 1994).

A significant percentage of our society suffers from PTSD, does not even realize it, and therefore, remain undiagnosed. 10% of the undiagnosed suffering have sufficient symptomology to meet the DSM-III-R criteria. More women than men suffer from PTSD because of domestic violence, and rape. Rape is the number one cause of PTSD among women (Porterfield, 1996). I believe that war is the leading cause of PTSD and suicide among men. More surviving Vietnam veterans with PTSD committed suicide than the total number of men killed in Vietnam (Butler, 1993).

There is also an old belief that children do not suffer from traumatic experiences and therefore do not suffer from PTSD. Experts thought this to be true especially if the parents did not speak of the traumatic incident. Some children do not forget the event or get over it as everyone once thought and they can, and do suffer from PTSD at very early ages. They experience personality changes and their play becomes grim and serious. They may cling to adults, experience phobias, or fears persistently, experience physical problems that have no cause, or experience regression. They may withdraw or have a preoccupation with the event and may even re-enact the event during play. Nightmares, bed-wetting, sleepwalking, and screaming during sleep are also symptomatic of childhood PTSD (Porterfield, 1996).

## SYMPTOMS OF PTSD

<u>INTRUSIVE</u>	<u>AVOIDANCE</u>	<u>INCREASED AROUSAL</u>	<u>ASSOCIATED FEATURES</u>
FLASHBACKS	SILENT ABOUT EXPERIENCES	HYPERVIGILANCE	IMPULSIVE
NIGHTMARES	MEMORY SUPPRESSION	POOR CONCENTRATION	FEEL OUT OF CONTROL
UNWANTED MEMORIES DURING AWAKE TIME	FEARS RETRIGGERING MEMORIES W/TREATMENT	EXPERIENCES INTERRUPTED SLEEP	SELF MEDICATE WITH DRUGS OR ALCOHOL
PSYCHOSOMATIC SYMPTOMS	CAN'T MAKE PLANS FOR THE FUTURE	EXAGGERATED STARTLE RESPONSE	25% HIGHER SUICIDE RATES *
FEELS EMOTIONS WITHOUT MEMORIES	LOSS OF INTEREST IN ENJOYABLE ACTIVITIES	DIFFICULTY FALLING ASLEEP	DIVORCE RATE IS TWICE AS HIGH *

**TABLE 1**

(Adapted from Porterfield except \* from Harrington et. al.)

### Traumatic Events

**TABLE 2** lists some examples of traumatic events. The column labeled "either/or" are events that could occur naturally or be man-made. This is only a sampling of events and the author acknowledges there are numerous more. The question to ask is

"What is it about traumatic events that causes these reactions and disrupts the lives and personalities of those affected?" The answer is a betrayal of a core belief or beliefs of what is right.

The traumatic event challenges, and may even violate thoughts and ideas of what is morally correct and how we perceive the world (Shay, 1994). There is a disruption of the basic sense of control and security that causes us to acknowledge our own powerlessness. Our illusion of safety and order is gone, disposed of (Markowitz, 1991). The victim gets charged with a "terrible truth" or unacceptable knowledge, that the world is a randomly cruel and dangerous place. Understanding and making sense of the event and accounting for the terror obsess the victim. The person endures personal pain and has a sense of being unbearable if they should choose to tell their story and that others will find the truth unbearable (Jay, 1991).

In fact, most of the public does not want to hear the truth because it is so unbearable. Therefore, the victim experiences violent rage and social withdrawal (Shay, 1994).

When the trauma involves rape or domestic violence, the terrible truth that the women will not speak of and that society does not want to believe, is that men perpetrate these acts of violence. In war, also perpetrated by men, veterans live with the terrible truth of betrayal of what is right at many levels, in some cases from the government and military, right on down to the family and personal level.

## EXAMPLES OF TRAUMATIC EVENTS

NATURAL EVENTS	MAN-MADE EVENTS	EITHER/OR EVENTS
HURRICANES	WAR	DEATH
FLOODS	PHYSICAL/SEXUAL ABUSE	PROPERTY LOSSES
TORNADOS	TERRORISM/BOMBINGS	THREATS OF PROPERTY LOSS
EARTHQUAKES	VEHICLE ACCIDENTS	THREATS OF DISASTER

**TABLE 2**

(Adapted from Porterfield)

### Duration of Symptoms

There is no specific answer to the question of how long do the symptoms last. Some traumatized victims never experience problems while other do. The reason for this is unclear, however, there are circumstances that can predispose someone. Sometimes the symptoms go away without treatment or intervention and sometimes they last for decades. Some individual's only experience partial PTSD exhibiting a few of the symptoms some of the time and others get a full blown case of the disorder. Others develop PTSD from extended exposure to those who have the disorder or from exposure to events associated with the traumatizing event. Some of those who served in or around Vietnam and did not actually see combat, like me, developed the symptoms, as did some of those who handled mutilated or dead comrades (Porterfield, 1996). An unexplainable correlation between race and likelihood of developing symptoms also exists (Kulka, et. al, 1990).

Some of the data and numbers are grim and staggering. For example, 85% of the survivors of the Nazi Concentration Camps of WWII had PTSD. Forty years later, 65% still have the disorder. At this point, the medical community was just beginning to understand the causal elements and how to treat the symptoms. 210,000 WWII veterans still have PTSD and are not connecting their symptoms with their problems. Therefore, they have not reached out for help (Porterfield, 1996).

Data from the National Vietnam Veterans Readjustment Study can give us another view of the intensity and duration of this phenomenon. 3.14 million men and 7,166 women served in Vietnam. 30.6% of the men

and 26.9 % of the women experienced full-blown PTSD. As of 1990, 15.2% (479,000) of the men and 8.5% (610) of the women still had the full-blown disorder. Roughly, one-half of the men and one-third of the women are still having problems 23 years after the end of the war. That amount is 228% higher than the number of WWII veterans. By comparison, only 2.5% of the men and 1.1% of the women who served during the Vietnam Era and were not in Vietnam had full-blown PTSD. The data also shows that 11.1% of the men and 7.8% of the women, about 350,000 veterans, who served in country had or have partial PTSD. The breakdown according to race showed that 27.9% of the sufferers were Hispanic, 20.6% were Black, and 13.7% classified as White/other (Kulka, et. al, 1990).

## **Contributing Factors**

Why were the numbers so staggeringly high in Vietnam compared to WWII, which was 300% higher than WWI? Again, no clear-cut answers exist, only numerous contributing factors. The average age of the soldier going to Vietnam was 17-19 years old. On an average that is eight years younger than those entering WWII are. These soldiers were not men, they were still innocent and naive boys who had not had a chance to complete developmental separation from family and create their own identity (Harrington & Jay, 1982). The circumstances and tactics used by the enemy were bizarre and unusual. The men received insufficient training for this type of warfare and there was betrayal of significant proportions in the ranks of the leaders. Men rotated in and out of Vietnam on an individual basis instead of with a unit. Most of the men experiencing PTSD were from the Army or Marines and served in I-Corps area and were from the lower ranks (E1-E3). Those who were wounded injured or lost a body part experience PTSD. Many men also did extended tours of duty that were greater than 13 months duration (Kulka, et. al, 1990). Public acceptance and support of the war was very low and homecomings were a joke.

## **Interventions**

The intervention of choice is individual or group therapy, or both, using medications when necessary. The earlier the intervention occurs, the better. After the bombing of the Federal Building in Oklahoma City last year, requests went out for teams of trauma intervention specialists to be at the scene to support and treat individuals who were in the building during the blast, those who lost someone special and the rescue workers.

An individual suffering from PTSD must experience normalization of the condition early on in treatment. This means reassuring the client that what they are experiencing and feeling is common to the disorder and that they are not going crazy (Markowitz, 1991). The therapist must also encourage the client to indulge in self-care, create safety, and get sober, if necessary. Without establishing these steps, without the preparation, it is possible to re-traumatize the client (Shay, 1994). The client must sense a caring, non-judgmental, supportive, understanding and validating attitude from the therapist and group members, otherwise he will not share.

Personal narrative or communalization is the process used in individual or group therapy. This means taking the risk to openly and honestly share your story with others and may involve very deep grief work. Jeffery Jay, author of "Terrible Truth," found this so powerful that he began taking willing clients out to



share their stories with the public. By sharing their stories, with every detail and feeling possible, veterans start to discover the meaning in their experience, and begin reconnecting with others. This process is paramount to healing.

Another aspect of healing and recovery that I feel authors overlooked in everything I have read is anger work. Victims of trauma have a right to feel and express their anger, even their rage, about the betrayal of what is right. Vietnam Combat Veterans got betrayed by their "leaders" often. Robert McNamara's lack of integrity and guts to withdraw his support for the war betrayed all of us at the highest level. We got betrayed by the politicians and the government. They went forward with the war even when they knew it was useless.

John P. Wilson, in his book "Trauma, Transformation, and Healing," writes of a particularly interesting, integrated, multidisciplinary, multitherapeutic approach. This involved a wilderness setting in the state of Washington, chosen for its resemblance to Vietnam. The program was one week long and utilized Native American Rituals along with traditional therapeutic approaches such as one-on-one counseling, group sessions, and group activities. Some of the rituals involved family, friends, and feasting. Everyone shared in the day-to-day tasks of cooking, cleaning up, etc. The results of a survey taken at the end of the weeklong program showed that both participants and staff had a positive experience. There was a significant reduction in symptoms at the end of the session and at one and three month follow-ups.

One other relatively new mode of therapy, Eye Movement Desensitization Reprocessing (EMDR) is worth mentioning here. Although nobody understands why or how the process works, it has been very effective on stubborn cases of PTSD among veterans and other trauma survivors (Butler, 1993, 1994; Markowitz, 1992). A three-year study at the V.A. Medical Center in Augusta, Georgia, showed it was more effective than the traditional group therapy used in a V.A. control group (Butler, 1994). Another veteran who had not been able to sleep through the night for 20 years was able to do so after one session (Butler, 1993). Trained therapists from other V.A. centers and independent practices report equally good results for treatment of PTSD. Howard Lipke, director of the North Chicago VA Hospital inpatient PTSD program has this to say:

"For 20 years, I've worked with Vietnam War veterans and never has any technique created so much significant change in my clients."

The technique, accidentally discovered by Francine Shapiro, involves asking the client to focus on the disturbing thoughts or memories and having the client follow the therapists rapid, lateral finger movement with his eyes simultaneously. This causes images, memories, emotions, associations, and thoughts to flow in the client's mind at a quick pace. The client not only becomes desensitized, less anxious, their thinking has changed, and they have learned something new. The memories lose their power. The treatment is the length of a normal session and there is an observation of immediate improvement or change. Shapiro's theory is that the neural stimulation that occurs allows long delayed learning and rapid processing of survival data to take place (Butler, 1993).

## Outlook for Recovery

The outlook for recovery varies with individuals. Most individuals are able to adapt and adjust to some extent, however this is not healing. The effects of war traumatized some veterans so severely that they cannot function in our society. They live in total isolation in remote areas of the country. Some of them are still living as if they are in the war, in a state of constant hyper arousal, constant paranoia, untrusting, and armed for protection. Some others are homeless or jobless, or both.

Many people do not seek help for any number of reasons. Some just do not want to talk about the traumatic event and others believe that if they do not talk about the event, the memories and symptoms will just go away. Although that may be true in a small percentage of cases, the majority of cases of PTSD would benefit from professional help. One of the stigmas that keep many, especially men, from seeking help is the idea of "being tough enough to handle this myself." Nothing is further from the truth (Porterfield, 1996).

Openly sharing the truth about the darkneses of life is one avenue of hope that makes some level of healing and recovery possible. Grief work to grieve the loss of innocence and other values is important. This helps the sufferer come to terms with the guilt, shame, and pain and begins the process of reconnection to self and the outside world. Much of the depression that PTSD sufferers experience is the result of repressed or denied anger. The betrayed victims have a right to their anger and rage and must receive encouragement to explore and express this in a safe manner.

Return to a completely normal, innocent, pre-trauma state, is not possible. The trauma betrays a person's trust and this brings about lasting changes in a person, some on a neurophysiological and biological level. On this basis, it is difficult to determine how much recovery is possible, for how long, or if a person will ever be entirely symptom free. We do know that some level of recovery is possible. Some victims recover to a very high degree and take their place in the community. They lead active, fulfilling, and satisfying lives (Shay, 1990).

## Prevention and Lessons

Can we prevent PTSD? Sure, if we eliminate war and other forms of man-made trauma. We cannot control the natural sources of trauma, only our own behaviors. We all know that this is a dream and will never happen in our time. There are, however, ways to **reduce** the effects of PTSD from combat.

1. The men must receive adequate training and equipment to function properly under the expected conditions.
2. Provide accountable and integral Leadership. Managing combat stress is a command responsibility.
  - 2.1 Leadership consists of intelligence, trustworthiness, humaneness, courage, and sternness.
3. Provide unquestionable support from the home front regardless of any ethical or political disagreement.

4. Provide unit rotation rather than individual rotation. This improves trust and unit bonding.
5. Encourage, support and educate the troops in doing grief work.
6. Do not encourage going berserk. This basically means do not encourage troops to vent their anger in out-of-control rage on the enemy.
7. Eliminate intentional motivation of troops by using humiliation and belittling to instill rage.
8. Respect the enemy as being human.
9. Acknowledge there will be psychiatric casualties.
10. Limit tours of duty to 1 year with no "reups" or extended tours.
11. Use older, mature men, not boys.
12. Encourage safe expression of anger and rage over the losses and betrayals
13. Provide alternatives for conscientious objectors.

(Shay, 1990, Items 1-9; Porpiglia, 1996, Items 10-12).

The level of mental health care must be significant. In WWII there was none and those who "broke down" got sent home. This led to the one-year tour of duty in Korea. None of the literature mentions PTSD cases connected with the Korean War. In Vietnam, there were only 16 psychiatrists in-country at any given time. By contrast, during the Gulf War, there were 3 teams of mental health workers always available. Each team consisted of 40 members with a variety of treatment modalities (Jay, 1991). Have we learned our lessons? The Gulf War certainly lends credence to the fact that we may have. Only time, and another war will tell, and I hope this never happens in my lifetime.

## **My Personal Experience with PTSD**

I was 20 years old, graduated from a 2-year technical college, and got drafted. I was between the proverbial rock and the hard place. My choices were: 1) Go to Canada, 2) Go to jail (do not collect \$200), 3) Enlist in some branch of the service. I enlisted in the Army for several reasons: 1) The Marines were definitely out, 2) The Navy was out because I get sea-sick, 3) Neither the Air Force, the Army Reserves or the Army National Guard had any electronic technician openings. For an extra year of service, I was guaranteed technical training and work in my MOS (Military Occupational Specialty). I figured if I had to go I might as well do something that I wanted to do and minimize the risk of the Army sending me into combat. I ended up with a critical MOS and went to "Nam" along with all of my classmates. Before entering the service, I had never been away from home for more than five days at a time. Nobody ever told me what it was going to be like. Nobody prepared me for what I was going to see and experience. I was



in country from August of 1970 to August 1971, working at several different locations, Long Binh, Than San Nhut, and Gia Dinh. I worked in a very high stress, behind the "lines" communications position.

I had some predispositioning factors, unbeknownst to me at the time, for some level of PTSD due to my poor emotional state. Life with my parents for the last two or three years had not been good and I was already angry and stressed. I had got out of one lousy relationship with a woman and into another one with a different woman and now the war. I got married to this woman before shipping out, which only added to the stressfulness of the situation. While I was overseas, she betrayed me.

When I returned home, my welcome was less than pleasant. My wife was cold and distant. I was numb. I had shut down to survive. A part of me died because of my experience, however, I did not know that. When I did feel, the only emotion I could feel was anger. I did not want to talk about my experience and I made that clear to my family and wife (avoidance symptom). My marriage failed as I settled into a good job. I went in and out of various relationships with women. Life was reasonable and I was not aware that I had any real problems or issues about "Nam." I just knew I did not want to talk about it.

Christmas of 1978 was the first time I experienced any difficulties concerning my experience. I was watching a movie on TV, alone, about a man who returned to Vietnam to find his son. I found myself crying without understanding what I was crying about (intrusive symptom). There were no memories attached to it. Now I realize the symbolism. I saw me looking for me, that young, innocent, naive part of me that had shut down, split off or died, and I was grieving. I still am. I never spoke about it to anyone, not even my girlfriend. She just would not understand and I went on with life (more avoidance). I saw movies like *Apocalypse Now*, *Good Morning Vietnam*, *Platoon*, watched TV programs *China Beach* and *Tour of Duty*, and had no reactions to them. Life went on and in the mid 1980's depression started to set in. I entered therapy in 1987 still without a clue. During a personal growth process in March, 1990 "Nam" came up again (re-stimulation/intrusive). This time I knew I had some issues going on.

What came up for me was guilt. Not survivor's guilt, guilt by association. Guilt that my participation in the war, a war I did not believe in, caused people to die. This was against everything taught to me in school, church, and family. Killing was not nice or appropriate. I realized war is nothing more than murder legalized (the terrible truth about what's right). I may as well have pulled the trigger. That is the way I felt and even though I never did, I felt like a murderer. At one point I even asked a friend to tell me I was not a bad person for being in the war, which she did.

Less than a year later, the Gulf War was taking shape. On Christmas Day, 1990 I saw TV reports showing troops in the desert and something happened. I experienced an intense flashback and suddenly, I filled with terror (intrusive again). A few weeks later the war broke out and I went numb for a while (avoidance, again). My involvement in a therapy group provided me with plenty of support for processing this. One of the facilitator was a retired veteran. He too, had been there. I made a statement that I had it mild compared to others and did not understand why I was having problems. The answer came back as denial and minimization of my experience. A bad experience forced me to do something I did not believe in, much less want to do. Something that silently challenged some very core beliefs and values. This was a betrayal of "what's right" and they were asking me, no telling me, to betray my beliefs, my values, and myself. I felt shame for doing so even though I never killed anyone.

The sight and sound of "Huies," the all-purpose helicopter, began to set me off, trip me up and cause flashbacks, some more severe than others. I understood there was a reason for this other than just reminding me of the event. I just did not understand the reason. Each time I saw them I felt tremendous pain and fear. Fear that I never felt while I was in-country was making its way to the surface. These birds of war shuttled troops to and from drop zones, provided cover fire and medical evacuations for the wounded and dead. They were always in the air and identifiable by their very distinctive sound. I soon discovered they represented death to me and part of me took a ride on one in a figurative sense. Once I realized what they represented, their power to disturb me greatly diminished.

During the Gulf War, I continually monitored what I watched on TV (hyper vigilance/avoidance). I never knew when something connected with the war was going to set me off grieving for my losses. There were times when I consciously changed the channel to avoid the pain. When the troops came home, I had mixed feelings. They deserved the homecoming welcome, the hero's welcome that they got and I did not. I celebrated for them, grieved for them for I knew what they had been through and what was yet before them, and I grieved for me.

How has this affected my life? I have gone to events looking forward to having a good time, only to have my desire disrupted by something that re-stimulates the intrusive symptoms. Sometimes the National Anthem makes me angry or causes me to grieve. Unexpected programs or news clips on TV cause flashbacks or periods of grief. Writing this paper has caused grief and anger to surface. Part of the reason my marriage failed was because I was numb and angry. I have made poor relationship choices with very wounded women because I did not believe I was worthy of a good relationship with a good woman. I carried shame because I felt I had done something bad or wrong and felt unlovable because of my participation. There is an internal struggle for peace between that part of me which is angry and feels betrayed by the other part of me who gave in to the demands of the government and war. I lost a part of me, part of my spirit. That part of me is gone, dead or split off, never to be had again.

By no means do I even consider myself having a full-blown case of PTSD. I did, however, experience partial PTSD and actually feel like I moved in and out of the symptoms as I continue to do. The wounds inflicted by this experience are deep and remained hidden for 20 years. Healing has taken place and there is more to do. Unfortunately, the healing process takes much longer than the length of the trauma itself.

## **Summary**

Most of the psychological causes of most mental illness are unknown. The medical community believes that trauma causes some cases of Multiple Personality Disorders and Schizophrenia. We do know that trauma causes PTSD. In its most extreme forms, victims display antisocial, isolationist behaviors and may involve use of drugs, alcohol, or other substance abuses. The disorder affects all aspects of our lives because it challenges our system and beliefs of what is right. It is the ultimate betrayal when another human perpetrates the traumatic event, a situation that we should be able to control. We cannot control Mother Nature so we cannot eliminate natural traumatic events. What we can do is educate the public to the causes of PTSD and acquaint them with the symptoms, as we have done with the seven warning signs of cancer. We can and must encourage victims to seek professional help. Above all, we must work

toward a society that is willing to listen to the terrible truth, and does not support: 1) waging wars, 2) rape and domestic violence, 3) child abuse, 4) terrorism or any other man-made events that are traumatic and involve a betrayal of what's right.

## Epilog - 1998

### New Interventions

This article was originally written in 1996 and EMDR was relatively new on the scene. Since then, two other, gentler techniques have been developed that are very effective in treating PTSD and traumas of any type. They are

EMOTIONAL FREEDOM TECHNIQUE™ (EFT), and Tapas acupressure Technique (TAT). Many therapists that have been trained in all three have significantly reduced their use of EMDR in favor of the other two, or cousins of them for a variety of reasons.

I am well trained in EFT and TAT. I find them both easy to use and very effective on trauma and PTSD and a wide range of other issues that people bring to therapy. Energy based therapies greatly enhance the outlook for recovery and are becoming the therapy of choice for the treatment of PTSD as they significantly reduce (by 80% or more) the trauma quickly, gently, safely, effectively and minimize re-traumatization of the individual.

### Pre-disposition to PTSD

I have further come to understand the nature of pre-disposition. Another Veteran once said to me that I did not come home with anything I did not already have, referring to beliefs and decisions about myself. What I came home with, as all of us did, was more proof about what I already believed. The more dysfunctional the family, the more pre-disposed we are. Those men who were in combat came home with additional pieces from being exposed to the horrors of combat.

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