

Role, Drama Therapy, and Combat-Related Post-Traumatic Stress Disorder

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Abstract

Role, Drama Therapy, and Combat-Related Post-Traumatic Stress Disorder

Shea M. Wood

This theoretical research explores how the concept of role can be used to inform a drama therapy treatment approach for individuals living with combat-related Post-Traumatic Stress Disorder (PTSD) and understand the difficulties associated with reintegration following active military duty. The analysis and synthesis of relevant literature suggests that combining certain role-based techniques would produce a treatment model that is inclusive of the essential treatment components used to address PTSD symptoms, and would assist the combatant in dealing with the difficulties associated with reintegration. Recommendations for the application of this research and future work are discussed.

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It is important that I thank my high school drama teacher, Wayne Goodyer, for introducing me to drama therapy—for helping me snap together the puzzle pieces of theatre and therapy to reveal the image of my future. To my family, who has always supported me in navigating through the chaos of my numerous (and often ambitious) dreams, I will forever be thankful for your unconditional love. To my advisor Bonnie Harnden, you are a beautiful, supportive presence in my life and I am grateful for the wisdom you have shared with me. Jason, you have been a breath of fresh air in my education; Fellow bandits, you have allowed me to feel sane, loved, challenged, and alive when I needed it most—thank you.

Lastly, this research has opened my eyes to the large and frequent sacrifices made by the men and women in the Canadian military. I am indebted to you for your service—your strength, dedication, endurance, and incredible spirit.

*“Role as a concept derived from drama and the social sciences, and reflected in the arts,
may well serve as a cornerstone for conceptualizing personality structure and
psychological healing through drama therapy”*

- Robert Landy, 1993, p. 32

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I. Introduction

Drama therapy is form of therapy that utilizes creative mediums in order to work toward therapeutic goals. It is an active approach that facilitates the ability to tell one's story, solve problems, express feelings, improve skills, and strengthen the ability to play personal roles. The role is a highly valued concept in the field of drama therapy, and has been utilized in assessment and treatment in a variety of ways. Although it appears as though role theory could be applied to the understanding of a combat veteran's disrupted sense of self, difficulties with reintegration, and be of use in addressing symptoms associated with combat-related Post-Traumatic Stress Disorder (PTSD), drama therapists have yet to extend research in this direction. Through analyzing and synthesizing relevant literature, this research will explore how the concept of role can inform a drama therapy treatment approach for individuals living with combat-related PTSD and understand the difficulties associated with reintegration following active military duty.

II. Method: Theoretical Research

In this qualitative research study, a theoretical methodology has been used to analyze and evaluate literature and synthesize this data to create a new piece of theoretical knowledge. A theoretical methodology is appropriate given that, at this time, the concept of role has not been directly applied to the difficulties associated with reintegration or combat-related PTSD in psychology or drama therapy literature. In addition, no drama therapy treatment models have been developed (or at least published) that use role as the basis for addressing these issues in therapy. Before constructing such approach, it is necessary to synthesize literature and research in such areas as role, combat-related PTSD, soldier reintegration, and drama therapy. As stated in the *Research Paper/Project*

Handbook (2008), the historical/theoretical category of research allows for “the investigation, critical analysis, and synthesis of ideas” (p. 16). Establishing a link between theory, research, and practice (*Research Paper/Project Handbook*), this form of research can develop concepts that are important to the theoretical foundation of drama therapy (Landy, 1984). Junge and Linesch (1993) state that theoretical research “critiques and integrates existing theories in an attempt to generate new knowledge and theory” (p. 66). The theoretical methodology will allow for the application of the concept of role to combat-related difficulties and treatment due to its inherent nature of bringing together theories and concepts, and will lead to a new theoretical contribution to the field of drama therapy.

III. Combat-Related Difficulties

History of Combat-Related Diagnoses

Psychological trauma among individuals who have served in combat is not a new phenomenon. Stress related to combat was first identified as clinically significant during the American Civil War when “nostalgia” was reported among the troops (Oei, Lim, & Hennessey, 1990). Since then, psychological difficulties associated with combat have often been discovered and discussed in literature. In World War I, the term “shell shock” was used to describe these difficulties, and in World War II, the terms “battle fatigue” or “battle exhaustion” were most commonly used to describe psychological stress related to combat (Birenbaum, 1994; Ritchie, 2007). Despite the early recognition of neurosis associated with combat, research into the disorders that may be related to combat trauma only really began around the time of the Vietnam War (Oei et al.). The 1980 edition of the *Diagnostic and Statistical Manual of Mental Disorders* recognized combat stress as a

specific diagnosis under the classification PTSD (Oei et al.). Although this specific category has since been removed, PTSD resulting from combat has continued to be observed in veterans returning from war. Canada has developed a non-medical term that is now used to describe a persistent psychological difficulty resulting from operational duties performed by Canadian Forces personnel. This term is *Operational Stress Injury* and includes anxiety, depression, and PTSD (Rossignol, 2007). Although there are a variety of psychological difficulties that may be present following experience in combat, this paper will focus primarily on combat-related PTSD and the interpersonal difficulties that often exist following combatant reintegration.

Post-Traumatic Stress Disorder

Some individuals who have been involved in traumatic events, and are exposed to severe trauma, develop symptoms that have been labeled Post-Traumatic Stress Disorder (PTSD) by the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2000). The traumatic event(s) must involve an actual or perceived threat of injury or death to self or others, and the individual must experience intense emotions of fear or helplessness during the traumatic incident(s) (APA, 2000). Following the trauma there are three main categories of symptoms that an individual with this disorder will experience. The trauma is often *relived* in some way, and re-experiencing can take the form of distressing and intrusive thoughts, dreams, flashbacks, and increased distress in the presence of certain reminders of the trauma. An individual living with PTSD may also *avoid* any reminder of the trauma, including thoughts and feelings connected to the traumatic event, and may experience feelings of detachment and isolation. The third category of PTSD symptoms is *hyperarousal*, and an individual with

these symptoms may develop an increased startle response and have difficulty concentrating and sleeping. In order to qualify for a diagnosis of PTSD, all categories of symptoms must have lasted longer than one month and significantly impair personal, social, and occupational functioning (APA, 2000). Therefore, the life of an individual living with PTSD is severely disrupted by the reliving of traumatic events, efforts to avoid reminders of the trauma, and the experience of physiological hyperarousal.

There are specific aspects of PTSD resulting from military combat that make it unique to other forms (Johnson & James, 1997). A combat veteran may be viewed as a victim *and* a perpetrator—personally and by society—as these individuals may have been exposed to trauma that they personally had to inflict on others. The long duration and high frequency of trauma is also a unique feature of combat-related PTSD (Johnson & James). The process of homecoming and reintegrating into the civilian society can be another stressful event that contributes to the development of PTSD (Johnson, Lubin, Rosenkeck, Fontana, Southwick & Charney, 1997). The personal and interpersonal difficulties associated with homecoming and reintegration will be discussed in detail later in this paper.

There is some variability in the rates of combat-related PTSD among samples and this may be due to the way in which PTSD is operationalized and subsequently measured (Lapierre, Schwegler, & LaBauve, 2007). An estimated 40% to 60% of high combat Vietnam veterans have reported symptoms of PTSD (Foy, Donahoe, Gallers & Goldfarb, 1988). The National Centre for PTSD has stated that the estimated risk of PTSD from service in Iraq is 18% and the estimated risk of PTSD from service in Afghanistan is 11% (The National Association for PTSD, n.d.). It is more difficult to identify the amount of

individuals in the Canadian Forces (CF) who are suffering from combat-related PTSD. A special report released by the Ombudsman for National Defence and the Canadian Forces in 2002 claims that “there is currently no centralized CF-wide process to collect up-to-date statistics on the number of current and former CF members who have been diagnosed with PTSD or other stress-induced injuries” (Martin, p. 38). Although a national database is being developed that would enable the Canadian Forces to evaluate the prevalence rates of PTSD and the impact of clinical interventions, a review of the *Department of National Defence and Canadian Forces’ Action on Operational Stress Injuries* (2002) states that there has been a delay and the database will not be completed before 2011 (McFadyen, 2008). Noting that the evidence related to the prevalence of PTSD in the Canadian Forces is largely anecdotal, the special report claims that some health care providers believe the prevalence is between 20 and 13 percent (Martin, 2002).

Given the fact that military personnel have an elevated risk of developing PTSD due to the violent and traumatic nature of their work, it is important to understand how this disorder develops in combatants and how it can be treated.

IV. Etiology

Psychological Theories of PTSD

Conditioning Theories.

Many theorists have attempted to explain the development and maintenance of PTSD symptoms using conditioning theories. Cahill and Foa (2007) mention that Mowrer’s Two-Factor learning theory of fear and anxiety has been used by many to understand how PTSD develops in response to traumatic events. First, fear is thought to develop as a result of classical conditioning, with fear being the conditioned response to

certain stimuli in the environment. Next, avoidant behavior occurs due to the effects of instrumental conditioning, with the avoidant behavior reinforced as an appropriate response as it has previously resulted in survival during combat. According to this view, reexperiencing, arousal, and avoidance symptoms are emotional responses that have been developed through conditioning. These conditioned emotional responses are triggered in reaction to stimuli in the environment (Rothbaum, Meadows, Resick & Foy, 2000).

Keane and colleagues have attempted to expand this view to explain why Vietnam war veterans appear to have a wide variety of conditioned stimuli that can trigger behavioral responses typical of PTSD symptoms. In an effort to provide an overview of Keane's contributions to theories of PTSD, Cahill and Foa (2007) have clearly outlined this view, emphasizing that sights, sound, odors, and even the time of day can be included in the conditioned stimuli. Considering the large number of stimuli that veterans associate with a traumatic experience, reexperiencing and avoidant symptoms may be frequent for a combat veteran living with PTSD (Cahill & Foa).

Schema Theories.

Theories of the schema have been adopted from cognitive and social psychology for use in the explanation of symptom development in PTSD. A concept used by many theorists, a *schema* is a cognitive structure composed of an individual's beliefs and assumptions, which allows one to understand the world and interpret information. As described by Cahill and Foa (2007), when applied to PTSD, it is the difficulty integrating traumatic experiences that contradict information in the existing schema that contributes to the perpetuation of PTSD symptoms. A study by Dekel, Solomon, Elkit, and Ginzburg (2004), suggests that participating in the war may have a stronger impact on individuals

who have certain beliefs and assumptions about the self and the world. These beliefs include assumptions about the benevolence of the world (one expects more good events to occur than bad) and self-worth. The findings of this study can be viewed as consistent with the schema theory in that previously held assumptions and beliefs are disrupted by a traumatic experience.

Emotional Processing Theory.

The Emotional Processing Theory developed by Foa and Kozack is based on the premise of the *fear structure*, described by Cahill and Foa as including “interrelated representations of feared stimuli, fear responses, and the meanings associated with them” (2007, p. 62). When outlining this theory, Rothbaum et al. (2000) state that PTSD develops when a maladaptive fear structure is created in response to a traumatic event. Cahill and Foa (2007) explain that a fear structure is pathological when (1) associations with stimuli are not accurate, (2) relatively benign stimuli elicit physiological and escape-avoidant responses, (3) responses that are easily and frequently triggered interfere with adaptive, functional behavior, and (4) threat is associated with harmless stimuli. This theory can be applied to the understanding of PTSD symptoms. Hyperarousal, could be explained by the anticipation of, and exposure to, stimuli that activates an aspect of the fear structure. Rothbaum et al. (2000) communicate that it is the attempt to avoid the activation of this fear structure that leads to the avoidance symptoms present in PTSD. Conditioning theories and emotional processing theories share the view that physiological and behavioral responses are a result of conditioned behavior to a stimulus. Also consistent with conditioning theories, the emotional processing theory emphasizes that there are a large number of environmental stimuli that can elicit physical, emotional, and

behavioral responses. In contrast, however, the emotional processing theory incorporates meaning and associations in the attempt to explain responses to stimuli.

Cognitive Theories and Coping.

Cognitive theories also focus more on associations and the interpretation of an event rather than the traumatic event itself. Cognitive therapy was initially developed for the treatment of depression and was later expanded to the treatment of anxiety disorders (Cahill & Foa, 2007). Ehlers and Clark have designed a cognitive based model of PTSD which holds that individuals with chronic PTSD interpret the consequences of an event in a way that evokes a sense of current threat (Cahill & Foa). This model outlines two process involved in creating this sense of current threat: a negative evaluation of the trauma and the nature of the memory surrounding this traumatic event.

Arad, Mikulincer, and Solomon (1991) studied two cognitive styles individuals use in managing threatening experiences associated with combat-related PTSD: monitoring and blunting. *Monitoring* is described here as the process of seeking out informational stimuli in the environment and attending to it. *Blunting* is described as the tendency to avoid informational stimuli related to the threat and attend to stimuli that serve as a distraction or escape. This study found that individuals who are affected least by PTSD rely on monitoring strategies. More prevalent combat-related PTSD was associated with the use of blunting strategies. This is because the symptoms associated with PTSD, including flashbacks and hyperarousal, are maintained and reinforced by the avoidance of stimuli associated with the trauma (Glass, 2006).

Kaloupek, Keane, Mora, Wine, and Wolfe (1993) studied a group of Vietnam veterans exposed to heavy combat who made a positive readjustment. They found that

well-adjusted veterans employed non-avoidant coping styles. In addition, the authors concluded that the “type of coping strategy predicted current adjustment better than combat exposure” (p. 179). The findings of these two studies emphasize the importance of cognitive dispositions and coping strategies in the maintenance of PTSD symptoms. It appears that, in addition to being its own symptom of PTSD, avoidance of trauma-related stimuli may play a role in maintaining and exacerbating other symptoms of PTSD.

Multiple Representation Structure Theories.

Multiple representation theories are based on the idea that there at least two separate memory systems. Brewin, Dalgleish, and Joseph (1996) have extended this theory of human cognition to the explanation of the development of PTSD in their *dual-representation model*. The authors propose that there are two separate representation systems: verbally accessible memory (VAM) and situationally accessible memory (SAM). Brewin et al. describe VAM memory as containing information about the sensory aspects of the experience, emotional and physiological reactions, and how the meaning of the event has been perceived. These memories can be recalled and verbally communicated to others. It has been noted that secondary emotions may be experienced when an individual is evoking and recalling VAC memories. In contrast, SAM memories include information that has been obtained through sensory processing and cannot be recalled voluntarily. Rather, these memories are evoked involuntarily when internal and external reminders of the trauma are present (Cahill & Foa, 2007). According to this theory, cued hyperarousal and reexperiencing symptoms, such as flashbacks, are a result of the activation of SAM memories. VAM memories are responsible for emotions connected to the trauma and intrusive memories.

Another multiple representation structure theory proposes that there are four levels of mental processing. Cahill and Foa (2007) outline that Dalgleish's SPAARS model includes schematic representation, propositional representation, analogue, and associative representations. This model attempts to synthesize existing theories in the etiology of PTSD. The concept of the schema has been previously discussed. The *propositional representation* is verbally accessible information and *analogue* is composed of information stored across sensory systems. These two concepts are similar to those present in the dual-representation theory outlined above. *Associative representations* are described as being similar to fear structures, the concept utilized in the emotional processing theory. According to the SPAARS model, there are two routes to the generation of emotion. Emotions can be elicited automatically through associative representations or evoked during the appraisal process at the level of the schema (Cahill & Foa). Symptoms of PTSD can be viewed as being the result of both of these processes.

Which of these theories most accurately explains the way that trauma contributes to post-deployment psychological difficulties experienced by many soldiers is unknown. In fact, not all of these theories are mutually exclusive and many forces may influence the way that traumatic experiences in combat are understood, processed, and continue to effect behavior. Both an individual's personal characteristics and the conditions of the recovery environment, in addition to the nature of the trauma, are influential in the psychological processing of combat-trauma (Oei, Lim, & Hennessy, 1990).

Trauma and the Brain

In the past decade, there has been a high level of interest in, and research on, how stress and trauma can impact the brain and body. The way in which an individual's

neurobiology is altered in response to being exposed to trauma, which may result in the presentation of PTSD symptoms, is an important area of study that can be used to inform treatment approaches developed for PTSD.

Brain Structure and Hormones.

The limbic system is the part of the brain that regulates emotional expression and survival behaviors (Rothschild, 2000). Being closely tied to the automatic nervous system (ANS), the limbic system plays a large part in producing the neurobiological stress response. This stress response is an adaptive function that enables survival through initiating a change in how the brain and body function (Weber & Reynolds, 1999). Although the human stress response has been described by many, Rothschild, who clearly outlines this process in her book *The Body Remembers* (2000), has served as the primary source for the following overview.

When an individual is confronted with a traumatic threat, the amygdala alerts the hypothalamus of the threat, which responds by turning on two different systems. First, the sympathetic nervous system (SNS) is activated which, in turn, triggers the adrenal glands to release hormones (epinephrine and norepinephrine) that initiate the body's fight/flight response. In the other system, corticotropin-releasing hormone (CRH) has been released which activates the pituitary gland to release adrenocortio-tropic hormone (ACTH). The ACTH also activates the adrenal glands, but in this case it is to initiate the release of cortisol. Once the traumatic threat has ended, the cortisol will halt the stress reaction and the production of epinephrine/norepinephrine, and assists in restoring the body to homeostasis. This system is referred to as the hypothalamic-pituitary-adrenal (HPA) axis.

In cases of PTSD, something goes wrong with the HPA axis (Rothschild, 2000). Research has shown that “if the stress response is of sufficient intensity, frequency, or duration, the compensatory stress response mechanisms may become maladaptive (overactive or fatigued) and the individual is unable to return to pre-event homeostasis” (Weber & Reynolds, 1999, p. 116). This difficulty in returning to homeostasis is thought to be linked to the cortisol levels released, however there is a large debate over the inconsistent levels of cortisol that have been found in trauma victims (Weber & Reynolds).

According to Rothschild (2000), the adrenal glands of those with PTSD do not release enough cortisol to halt the alarm reaction, a discovery pioneered by Rache Yehuda (Yehuda et al., 1990). As a result, the limbic system continues to command the hypothalamus to activate the ANS leading to a chronic state of ANS activation and arousal. This dysfunction would account for the hyperarousal that is a typical symptom of PTSD. However, studies with animals (and to a lesser degree, humans) suggest that, in response to extreme and enduring stress, individuals with PTSD secrete *higher* levels of cortisol (Kimble, 2008; Glod & McEnany, 1995). Among other damaging effects, it is widely documented that high cortisol levels can result in cell death in the hippocampus. (Kimble; Glod & McEnany; Weber & Reynolds, 1999). Results of a study conducted by Bremner et al. (as cited by Glod & McEnany) show that the volume of the hippocampus was reduced in veterans with PTSD compared to those without PTSD. However, no causal conclusions can be made given that the direction of the influence is unclear (ie. whether the hippocampus is smaller as a result of PTSD or if PTSD is more common in those with a smaller hippocampus). Damage to the hippocampus may contribute to

symptoms associated with PTSD, as it plays an important role in modulating mood, heart rate, and memory (Glod & McEnany). Therefore, symptoms such as hyperarousal, mood liability, and disturbances in memory may be related to hippocampal atrophy.

The Brain and Memory Storage.

Extreme stress and trauma can influence the way memories of a traumatic event are stored and subsequently recalled. The limbic system hosts two areas that are central to memory storage: the hippocampus and the amygdala (Rothschild, 2000). The amygdala assists in processing extremely emotional memories, including terror and horror, both while it is occurring and when it is remembered (Rothschild). The hippocampus gives an event context, placing it in time and space on an individual's timeline, putting memories into perspective. During a traumatic experience, the hormones released suppress hippocampal activity but do not effect the functioning of the amygdala. Therefore the experience of terror is still processed however it is not stored in a way that allows the event to exist in an individual's memory of the past. The PTSD symptom of flashbacks may be the result, given that "the traumatic event is prevented from occupying its proper position in the individual's history and continues to invade the present" (Rothschild, p. 12).

The way the brain functions during a traumatic event, and is altered by this experience, should be considered when approaching treatment as it appears to be directly connected to the symptoms of PTSD. In addition to the previously described neurological effects of trauma, neural degeneration, neurochemical abnormalities, cerebral dysfunction, and neuroanatomical disconnection may result from psychological trauma (Weber & Reynolds, 1999).

Other Etiological Factors: Military Variables

The onset of PTSD may be due to a particularly stressful experience on the battlefield but may also result from prolonged exposure to combat or multiple stressful deployments (Oei, Lim, & Hennessy, 1990). In a comprehensive overview of the military variables that contribute to the development of PTSD, Oei et al. claim that “it is generally accepted that combat exposure is the most important factor” (p. 366) and, as a result, researchers are now focusing in on factors within the combat experience. Being wounded, involved in deaths of noncombatants, and exposed to war-related atrocities have been identified as critical factors in the development of PTSD in combat veterans (Oei et al.; Ritchie, 2007).

It is important to understand the conditions of current warfare and how these variables may contribute to the development of combat-related PTSD. In order to develop treatment approaches that accurately address the problems that military personnel experience, one cannot rely on descriptions of past conflicts—such as Vietnam or the Gulf War—for an understanding of what combatants are experiencing during deployments. Modern day combat is quite different.

The wars in Iraq and Afghanistan foster unique conditions that promote the development of post-deployment psychological difficulties (Schnurr, Lunney, Bovin, & Marx, 2009). Unlike the Vietnam and Gulf Wars, which were both considered fairly conventional conflicts with clearly demarked battle zones and safe zones, nearly every location in Iraq and Afghanistan is a potential battle zone, and military personnel are constantly at risk of being wounded or killed (Manderscheid, 2007). Deployments to Iraq and Afghanistan are longer, more frequent, and there are shorter intervals between

deployments in comparison to the Vietnam and Gulf Wars (Schnurr, Lunney, Bovin, & Marx). As pointed out by Schnurr et al., there have been advances in military medicine that increase the rate of survival from battle wounds and, therefore, more military personnel are surviving traumatic experiences and returning home with both physical and psychological impairments.

An overview of the etiological theories and military factors that contribute to the development of PTSD has demonstrated that there is no clear-cut answer to why or how combat-related PTSD develops. Reintegration may be an important contributing factor, as it is a stressful experience for both those who are already experiencing psychological or emotional distress related to their combat experience and those who are not.

V. Homecoming and Reintegration

Homecoming and PTSD

Most etiological theories of PTSD do not address the homecoming and reintegration experience as a possible factor in the development and maintenance of PTSD. This is because this experience is relatively unique to combat-related PTSD. Many articles have outlined the difficult reintegration experience of American Vietnam soldiers, returning home to a negative reception and the damaging impact this had on these soldiers. Johnson, Lubin, Rosenheck, Fontana, Southwick, and Charney (1997) did a study in the attempt to understand homecoming stress and develop a measure for this stress in relation to PTSD symptoms. The findings of this study indicate that “the veterans' experiences of their homecoming were the strongest predictors of frequency and intensity of their PTSD symptoms among the measures used in this study” (p. 273). Oei,

Lim, and Hennessy (1990) also cite the homecoming environment as being a powerful predictor of PTSD among Vietnam veterans. The stress related to homecoming, which contributes to the development of PTSD, may be related to many of the previously described etiological theories. The absence of threatening stimuli in the home environment may result in conditioned responses to generalized and benign stimuli. The adaptive responses necessary for combat become maladaptive when they continue to occur in the absence of the threatening stimuli. The conflict between the traumatic experience and the schema that previously accompanied the home life may contribute to homecoming stress. Integration and acceptance back into the civilian culture can take a variety of forms, which may impact the amount of stress experienced upon homecoming.

In addition to contributing to the diagnosis of PTSD, homecoming can be associated with other personal and interpersonal difficulties. When a soldier returns from deployment, he/she will find that their community, family, and job will have changed while he/she was away (Manderscheid, 2007). Within the family unit, children will have developed, elders may have died, and spouses may have become estranged from the soldier. Fitting back into the family unit and navigating who one is within the context of their family and community can be a difficult and stressful experience for soldiers who have just completed a tour of duty. As stated clearly by Thompson, Blais, Pickering, Febraro, and McCreary (2008), “the consequences of poor postdeployment reintegration and adjustment may be wide ranging and have considerable long-term consequences for both returning soldiers and their families” (para. 1). It is important that soldiers returning from a tour of duty receive the education, support, and assistance necessary to achieve a smooth transition from the combat zone to garrison life.

The Canadian Forces' Reintegration Process

Prior to the departure from the combat zone, CF members receive a reintegration briefing designed to make them aware of any potential problems that may arise upon returning to Canada and educate them on how to cope with such problems (Martin, 2001). It is also required that members complete a medical questionnaire, which includes a psychological component, before the process of reintegration begins (Martin). The CF recognize that the majority of returning soldiers report that they have no problems, as acknowledging the existence of a problem could delay the soldier from seeing their family.

Decompression is now required after a tour of duty in Afghanistan, and many Canadian troops spend a few days in Cyprus before returning to Canada (Rossignol, 2007). The *Report to the Minister of National Defence* (Martin, 2001) offers a definition of decompression used by the Land Force Western Area directive, which is: "the process by which personnel transit from a busy, stressful pace of operations to the less stressful and slower tempo of a garrison environment" (pp. 130-131). During the days spent in Cyprus, or other decompression sites, soldiers enjoy a restful break and attend information sessions on family reintegration, anger management, and suicide risk awareness (Rossignol). Although this added time away from family is resented by some of the soldiers, the CF feels that when soldiers board direct flights back to Canada, and the whole transition takes a matter of hours, reintegration from a combat zone to garrison life occurs far too quickly. The military believes that enforcing the "third level decompression" is a necessary step in reducing stress associated with homecoming and reintegration.

The next reintegration phase begins when soldiers arrive at their home base in Canada. It is required that these soldiers work approximately three half-days before going on leave (Rossignol, 2007). The rationale behind these half workdays is twofold. First, the half-days provide more adjustment time and ensure a slow disbanding of an often tight-knit group of soldiers. Secondly, as clearly pointed out by Rossignol, these half-days are also “a deliberate effort to ease the transition back into family life” (p. 2). Integrating back into family life can be a stressful process and it is generally held that a gradual transition holds less stress than ejecting the soldier back into the family full-time.

The Department of National Defence has put in place medical and mental health follow-up measures, such as questionnaires and medical examinations, to monitor the physical and mental health conditions of military personnel for approximately six months after returning from deployment (Rossignol, 2007). Those soldiers who are identified as in need of further support or psychological treatment are referred to an Operational Trauma and Stress Support Centre.

Many soldiers return home from deployment with no stress injuries or emotional/psychological difficulties. However, effective treatment methods should be made available for the soldiers who do return from combat with mental health injuries.

VI. Treatment for Combat-Related Post-Traumatic Stress Disorder

There are many theories that attempt to explain the development of combat-related PTSD, and a variety of treatment models have been applied to this population. Hypnosis (Cardena, Maldonado, Hart, & Spiegel, 2000 and Watkins, 2000) and Eye Movement Desensitization and Reprocessing (Chembo, Tolin, Kolk, & Pitman, 2000 & Cerone, 2000) have been cited as effective methods for treating PTSD. Surveyed

literature suggests that Cognitive Behavioral Therapy (CBT) provides safe and effective treatment for PTSD symptoms (Bryant, Harvey & Tarrier, 2003). Most psychotherapeutic approaches, including CBT, emphasize that treatment should include the following three components: exposure, anxiety management training (the development of coping skills), and cognitive restructuring, including the integration of the traumatic events into personal schemas (Bryant, Harvey, & Tarrier; Cahill & Foa, 2007; Paulson, 2008). These three aspects that overlap in the psychological treatment models for PTSD address all three categories of symptoms associated with PTSD, and can be viewed as important underlying components of treatment.

Important Components of Treatment

Exposure.

According to learning theories, reexperiencing, arousal, and avoidance symptoms associated with PTSD are the result of emotional responses that have been developed through conditioning, which are triggered in reaction to stimuli in the environment (Rothbaum, Meadows, Resick, & Foy, 2000). *Exposure* to anxiety provoking stimuli is the primary process used in therapy to address reexperiencing and hyperarousal symptoms associated with combat-related PTSD (Rothbaum et al.). Exposure treatment is directly associated with the decrease of intrusive images and cognitions, and physiological arousal (Beidel, Frueh & Turner, 1995). Two forms of flooding treatment, Implosive Therapy (Keane & Lyons, 1989) and Direct Exposure Therapy (Boudewyns, Harrison, Hyer, McCranie & Woods, 1990), have shown promising results when used with individuals living with combat-related PTSD. While some literature communicates that exposure techniques are also useful in treating avoidance symptoms (Foy et al., 2000;

Kean & Lyons, 1989), other research suggests that exposure does not adequately address negative symptoms such as avoidance and interpersonal difficulties (Beidel et al.; Boudewyns et al.). Providing comprehensive treatment for individuals living with PTSD requires additional treatment strategies, and further research is needed to determine how exposure can be combined with other methods of treatment (Beidel et al.).

Anxiety Management Training.

The purpose of including anxiety management training in the treatment of combat-related PTSD is to assist an individual in developing coping skills that will assist them in regaining a sense of control, dealing with daily stressors, and reducing their level of physiological arousal (Bryant, Harvey & Tarrier, 2003). A variety of studies suggest that coping skills, and styles of coping, are associated with the development and perpetuation of symptoms associated with combat-related PTSD (Arad, Mikulincer, & Solomon, 1991; Kaloupek, Keane, Mora, Wine & Wolfe, 1993). Overall, there is a positive relationship between the increased use of coping skills and a decreased presence of symptoms (VanGoda, 2001).

Cognitive Restructuring & Integration.

Cognitive-based models of PTSD hold that individuals with chronic PTSD interpret external stimuli in a way that evokes a sense of current threat (Cahill & Foa, 2007). Cognitive restructuring involves assisting an individual in learning to identify and evaluate the stimuli that are usually associated with negative automatic thoughts (Bryant, Harvey & Tarrier, 2003). This aspect of treatment also facilitates the evaluation of beliefs and assumptions about the traumatic experience, the self, and the world (Bryant et al.). Evaluating and modifying beliefs and assumptions requires altering one's existing schema

to incorporate the traumatic experience and new ideas about the self and world.

Therefore, treatment should include focusing on exploring currently held beliefs, and how an individual interprets events in the environment, and making the necessary alterations that allows the individual to function in their daily life.

Creative Arts Therapies Treatment

As Hudgins (2002) points out, “cognitive behavioral therapy has long proved useful in managing the disruptive symptoms of PTSD, but it does not directly treat the trauma that causes these very symptoms” (p. 2). Therefore it is important that, in addition to the processes outlined above, the treatment for PTSD utilizes a modality that has the ability to access and address the trauma directly. Literature suggests that some memories of traumatic events are composed of information that has been obtained through sensory processing and cannot be recalled voluntarily or communicated verbally to others (Brewin, Dalgleish, & Joseph, 1996). Creative modalities allow an individual to access and work through the trauma on multiple levels. Johnson (2000a) emphasizes that “the symbolic media of the arts may provide more complete access to implicit memory systems, as well as visual-kinesthetic schemas” (p. 305). Because some memories are visually encoded, art therapy may be particularly useful for addressing and working with these visual memories (Johnson, 1987). This medium, which provides distance from the body, may be a less threatening way to explore personal traumatic images. In fact, the varying amounts of distance offered in all creative mediums can help to modulate the directness and intensity of exposure or expression (Johnson, 1987). Music therapy, in the form of drumming, has proven to be useful in reducing some symptoms associated with combat-related PTSD, increasing interpersonal skills and feelings of self-control, and

serving as an outlet for emotional expression (Amir, Bensimon, Wolf, 2008). Creative arts therapy approaches designed specifically for this population will have a stronger impact than non-specific approaches (Johnson, 2000a), and Johnson recommends the design and development of such treatment models.

Drama-Based and Experiential Treatment Approaches

Because traumatic experiences are partially stored in the non-verbal, emotional centers of the limbic systems, experiential methods of treatment are ideal for individuals who suffer from PTSD (Hudgins, 2007). Greenberg, Elliott, and Lietaer (as cited in Hudgins, 2002) define experiential therapy as approaches that emphasize “the importance of active, process-directive intervention procedures oriented toward deepening experience” (pp. 25-26). Johnson and Lubin (1997) conducted a study to examine the treatment preferences of Vietnam veterans living with PTSD. The results of this study suggest that methods that require an individual to become actively engaged, and work with external representations, are beneficial and preferred in the treatment of combat-related PTSD (Johnson & Lubin). According to Hudgins (2007), “research shows that experiential methods *are equal* to psychodynamic and cognitive behavioral methods of treatment for general psychiatric difficulties and *better* for stress-related diagnoses such as PTSD and anxiety disorders” (p. 180). It appears as though drama-based approaches, which often require the individual to become physically engaged and active, should be included in the treatment of PTSD.

Developmental transformations has been used as a technique in the treatment of combat-related PTSD (Johnson & James, 1997). Johnson has described Developmental Transformations as a “form of drama psychotherapy that is based on an understanding of

the process and dynamics of free play” (Johnson, 2000b, p. 87). This progression of play and improvisation allows associations and experiences to emerge and transform within the playspace. When applying developmental transformations to the treatment of combat-related PTSD, Johnson and James emphasize that this treatment involves accepting, tolerating, and embracing the multiple aspects of the self. This method allows an individual to contain and understand the complexities of their situation following traumatic experiences in combat (Johnson & James).

Johnson and James (1996) also executed what they titled a Relationship Lab with Vietnam combat veterans diagnosed with PTSD that addressed maladaptive emotional responses that are associated with combat-related PTSD. Johnson and James claim that this form of treatment is “one way to access and transform diffuse, fragmented, and painful aspects of self and memory” (1996, p. 325). In addition to addressing the expression and containment of emotions, both of these treatment models implemented by Johnson and James aimed to accomplish the therapeutic goals of integration and exploring aspects of the self within the play space.

Psychodrama, a form of group psychotherapy developed by Jacob Moreno, was used by Cox, Eisler, Finn, and Ragsdale (1996) in their study on the treatment of individuals living with combat-related PTSD. The results of this study indicate that the dramatic processes present in psychodrama and role-play allow for exposure, emotional expression within a contained environment, and the rehearsal of coping skills (Cox, Eisler, Finn, & Ragsdale, 1996).

Kate Hudgins has developed a method to treat trauma based on the foundation of psychodramatic processes and techniques. This model is called the Therapeutic Spiral

Technique (TSM), and Hudgins (2007) describes it as a “modified system of psychodrama that makes practice safer for people working on trauma-related issues” (p. 175). The TSM adds a layer of safety and containment to classic psychodrama that is often necessary for individuals living with PTSD, as it is likely that an individual will experience emotions deeply and come across traumatic triggers when working with such experiential therapies. In her book *Experiential Treatment for PTSD: The Therapeutic Spiral Method* (2002), Hudgins outlines action interventions that provide the client with containment and opportunities for expression, repair, and integration.

Dramatic, active, externally based techniques used within the frame of therapy appear to contain many established components of treatment utilized in treating individuals living with combat-related PTSD. Psychodrama and role-play have the ability to address exposure and the development of coping skills. Developmental Transformations addresses the integration of traumatic experiences and self-exploration. It appears that, at this time, there is no drama-based treatment approach to combat-related PTSD that contains *all* of the essential components of treatment.

VII. The Concept of Role

A Brief History of Role

The concept of role has a long history both within the social sciences and theatre. In order to understand how this concept can inform drama therapy treatment for individuals living with combat-related PTSD, it is necessary to be aware of how both disciplines have contributed to the growth of the concept of role and how it is applied to the understanding of the self.

The term role has its origins in the theatre. Originally referring to the scroll on which actors' lines were written (Landy, 1991; Moreno, 1961), it soon became the term used to describe the persona or character assumed by the stage actor. Landy has engaged in a thorough exploration of the history of role in drama, theatre, and performance, and detailed this history in many publications, including *The Dramatic Basis of Role Theory* (1991). He points out that "theatre performance is the most prominent source of role, because it is predicated on the fact that actors take on a mask, persona, part, or character—all terms synonymous with role—in order to enter into the imaginative reality of another" (1993, p. 14). Therefore role is inherently connected to theatre and performance. Given that the genesis of role exists within theatre, it logically follows that role often accompanies a theatrical metaphor of life and social interaction when utilized in the social sciences.

In the social sciences, many theorists have viewed role as a set of behaviors that are prescribed by society (Doyle, 1998). Mead is one of these theorists who believed that behavior is expressed through roles that are assigned by the society to which one belongs (as cited by Doyle). Landy (1993; 1990) points out that Mead was the first to use the term role-taking to describe the process of internalizing the roles assigned by society to construct the self. Linton, an anthropologist, viewed role as being directly connected to status and consisting of socially-prescribed rights and duties (as cited by Landy, 1993; 1990). Although both Mead and Linton made considerable contributions to connecting the term role with the self, neither of them viewed role as important in the expression of the self but simply as a product of society.

Although Goffman also defined role as the enactment of the rights and duties associated with a social status, he embraced the concept of identity as a presentation of the self in role to a particular audience (as cited in Doyle, 1998; Landy, 1993, 1990). He did not make a distinction between self and role, and understood the concept of role as being essential to the expression of one's identity. Sarbin also adopted a theatrical frame for viewing social interactions and understanding the self. Landy describes Sarbin's viewpoint clearly when stating "as people take on and play out roles based on the events that make up their lives, they frame stories about themselves in role, which provide an understanding and give meaning to their existence" (Landy, 1993, p. 26). All of these theorists in the field of social sciences have contributed to how role has developed as a concept of identity and a form that allows interaction and expression in a social environment.

Moreno and Role.

L. J. Moreno moved beyond these social scientists in claiming that role is not only the clusters of qualities assigned by society, but that the self in fact emerges from the roles one plays (Doyle, 1998; Propper, n.d.). Whereas other theorists believe that the concept of role is tied to social interactions within socially defined categories, Moreno put forth the idea that there is no core self that exists as separate from one's collection of roles (Propper). He thus defines role as "the actual and tangible forms which the self takes" (Moreno, 1961, p. 62). Moreno goes on to describe the three basic role types that an individual possesses.

The first type of roles are *psychosomatic* roles, which are physical roles associated with fundamental biological human functions (Garcia & Buchanan, 2000; Propper, n.d.).

They are the first roles to develop and must be satisfied before one can progress to developing other role types (Garcia & Buchanan; Propper). Examples of such roles are The Sleeper and The Eater. According to Moreno, *psychosocial* roles make up the second category of roles. These roles emerge as an individual begins to interact with others in the social environment and are enacted in relation to other people (Garcia & Buchanan; Propper). These social roles are what most social scientists are referring to when they use the term role. Lastly, Moreno discusses the existence of *psychodramatic* roles. These roles exist within the mind of an individual and are “a manifestation of the imaginative process of who we think we are and who we would like to become” (Garcia & Buchanan, p. 165). These roles may be not-yet-actualized portions of an individual’s personality and sometimes operate as unconscious drives (Propper). All three types of roles, not just the roles one plays in a social context, contribute to an individual’s identity.

Despite the existence of psychosomatic and psychodramatic roles, and the influence they have on the self, Moreno placed a large amount of importance on how the role is executed through behavior in the external social environment. He offers a second definition of role that emphasizes the relational and behavioral aspect of role: “the functioning form the individual assumes in the specific moment he reacts to a specific situation in which other persons or objects are involved” (Moreno, 1961, p. 67). Moreno believed that every social role had two components, a private side and a collective side (Garcia & Buchanan, 2000; Moreno; Propper, n.d.; Sternberg & Garcia, 2000). The collective portion of these roles is that which is defined by society, reflecting the values and behaviors prescribed by cultural norms (Propper). This side of a role shares a high degree of similarity with others who play the same social role (Sternberg & Garcia).

However, each individual has their own personal way of playing a role and this is viewed as the individual or private portion of social roles. Every individual enacts a personal variation of a role that reflects the “particular inclinations, personal values, style and capacities of the particular person” (Propper, p. 2). With the private and collective components combined, individuals are able to enact a role in their lives, meeting the expectations held by society while adding personal elements to the role that give form to an aspect of the self.

Another aspect of role, according to Moreno, is the degree of creativity that exists in the enactment of a role. Moreno believed that an individual could play a role with varying degrees of creativity (Blatner, 2000). *Role taking* is the most basic form of assuming a role in which an individual simply imitates the model they have been provided (Blatner). Sternberg and Garcia (2000) define role taking as the most routine way to assume a role where one “rigidly follows the parameters of the role as the culture established it, with little or no deviation” (p. 121). Next on the continuum of creativity is *role playing*. Blatner clearly outlines that, when an individual gains familiarity or mastery of a role, they “begin to add elements of personal style, possibly some novelty and small degrees of innovation” (p. 161). When one is role playing, they begin to play the role with more spontaneity and freedom than was present when one was role taking (Sternberg & Garcia). *Role creating* occurs when more radical innovations are introduced to the role (Blatner). When an individual has become completely comfortable enacting a role, they may begin to transform it through adding elements and experimenting with the boundaries of the role. Often during role creation, the role is modified in a way that challenges general expectations, past representations, or cultural norms (Blatner).

When an individual is learning a new role, they begin with role taking, move on to role playing, and eventually progress to role creating (Garcia & Buchanan, 2000; Sternberg & Garcia, 2000). For example, take someone who wants to learn to be a painter. In the beginning, this person simply imitates the techniques he has seen modeled by other painters. As he becomes more comfortable with this role, he begins to experiment and become more flexible in playing the role, creating different kinds of pieces using different techniques. This painter may progress to role creating when he finds his own authentic way to use the medium of paint, such as shooting a paint-ball gun at a canvas.

Moreno made a significant contribution to role theory in that role was no longer viewed as socially assigned behaviors but as an expression and experience of the self. Through noting the presence of psychodramatic roles, Moreno drew attention to the fact that role gives form to aspects of the self both enacted in the external world and imagined within one's internal world.

Landy and Role.

Robert Landy, like Moreno, believes that the role concept relates to a larger understanding of an individual's personality rather than simply denoting a group of behaviors society assigns to a duty or status (Landy, 1993). According to Landy, each role is "a form, an expression in behavior containing feeling, thoughts, and values associated with a single persona rather than with a total personality. It is part rather than a whole..." (Landy, 1993, p. 31). The whole, or self, is composed of roles, counterroles, and a guide (Landy, 2000). The counterrole is not necessarily the polar opposite of a role, but rather what exists on the other side. Landy provides the example of a mother role with

possible counterroles being father or daughter (Landy, 2000). The guide has been defined by Landy as a “transitional figure” that assists with the management and integration of roles and counterroles.

Within his theory of role, Landy addresses how an individual develops this system of roles. During the progression of role development, an individual moves through being a role recipient, role taker, and role player. The developmental stage of being a role recipient occurs during infancy when one enacts somatic roles, such as the breather and eater, which are essential to survival (Landy, 1993). An individual at this stage is thought to be a recipient because these primary roles are given to an individual through genetics. Similar to the psychosomatic roles described by Moreno, all other roles are built on this primary stage of role development.

Next, an individual enters the phase of being a role taker. Role taking, or acquiring what Landy calls secondary roles, is initiated when the child begins to differentiate between “me” and “not me” and interact with the social environment. The process of role taking “begins in imitation and proceeds toward identification when children are more fully able to distinguish between themselves and others” (Landy, 1993, p. 36). Therefore, in the beginning the child simply imitates role models in the social world but then proceeds to internalize the desirable traits observed in these models to construct their own roles.

Finally, an individual becomes a role player because, as described by Landy (1993), a role must be enacted in order to assume its fully visible form. An individual becomes a role player when one begins to assert oneself in the world, and present aspects of themselves through the roles they play. Landy claims that people role play for two

reasons: to find a form for their thoughts and feelings, and to practice a role until they have mastered it within the appropriate context. This last stage of role development requires enacting roles in the social environment which have been internalized through the process of role taking.

Landy has traced role throughout the history of theatre in order to establish a taxonomy of roles. Searching through the roles present in hundreds of western plays, he has created a taxonomy inclusive of all of the role types, qualities, functions, and styles that exist in dramatic works. He uses this taxonomy in assessment and treatment as it is thought to contain all the roles and subroles that exist both in theatrical texts and in a human's possible collection of roles. Landy calls this collection of roles the role system. According to Landy, "a role system contains the substance of one's identity—all the pieces that, once assembled, represents a personality" (1993, p. 44). The role system is what many others refer to as an individual's *role repertoire*, a concept that will be discussed in detail when addressing role dysfunction.

As pointed out by Doyle (1998), Landy and Moreno depart from other social scientists with their view that roles are more than duties and behaviors assigned by society. Both Landy and Moreno believe that roles "portray the particles of the self, along with the expectations of culture and other external forces" (Doyle, p. 224). For the purpose of this dissertation, I am going to align myself with Doyle's definition of role, which he has put forth after a comprehensive overview of the concept of role according to social scientists, Landy, Blatner, and Moreno. This definition is as follows: "Role is an expression of an aspect of the self...roles provide tangible forms which articulate who we

are” (Doyle, p. 224). This definition clearly recognizes that a person is a collection of social and personal roles, and these roles give external form to an individual’s identity, or self.

VIII. Role Dysfunction

Through the lens of role theory, role health and dysfunction are directly related to the role repertoire. The role repertoire is “the totality of the various parts of self which are defined through roles” (Doyle, 1998, p. 225) or all the roles that exist within one’s psychological structure. The health of an individual, and a functioning role repertoire, is linked to the quantity of roles, the quality of roles, and the level of flexibility between roles that exist within the repertoire. Although these three qualities of the role repertoire are separate, they are interrelated and dependent on one another for health. As clearly stated by Emunah (1994), “expansion of role repertoire involves not only playing a greater number of roles, but playing each role with greater flexibility, commitment, and integrity” (p. 32).

Quantity of Roles

Emotional and psychological difficulties can arise when an individual’s role repertoire is too narrow, and the roles that do exist are unsatisfying or counterproductive (Propper, n.d.). From Moreno’s point of view, this translates into an individual lacking either social or psychodramatic roles (Garcia & Buchanan, 2000). Landy would hold that health is dependent on the ability to take on and play many roles in the taxonomy (Landy, 2000) whereas dysfunction can result when one has restricted access to the taxonomy of roles. Having a large role repertoire prepares an individual to deal with a wide range of life situations, cope with unexpected challenges, and respond to tasks in a creative and

innovative way (Emunah, 1994). When one's role repertoire is confined to a small amount of roles—possibly due to trauma, social or occupational obligations, or other restrictive forces—one may experience a large amount of distress, discomfort, and dysfunction.

Quality of Roles

Having a large role repertoire does not necessarily ensure that an individual will be free of dysfunction because, as Landy (2000) points out, health is associated with both the quantity of roles one has internalized *and* the quality of the enactment of these roles. The health of an individual is largely dependent on the ability to play roles with competence and personal satisfaction (Propper, n.d.). The ability to skillfully enact a role, and have this competence be recognized by one's self and society, can have a strong influence on the emotional and psychological health of this individual. For example, a man may be extremely competent in his ability to run a business and play the role of employer and business owner, but experience a large amount of distress at his inability to enact the role of father with a high degree of success. Enacting a suitable amount of roles with competency can contribute to a functional role repertoire and overall psychological health.

Role Flexibility

It is important that an individual has a flexible role repertoire in that he/she has the ability to transition into the role that becomes necessary during interactions with the external world. Blatner (2007) has proposed that, in addition to an individual's collection of roles, there is a meta-role, which is the aspect of a person that reflects on roles and negotiates how they are formed and played. This concept is similar to the guide concept

that Landy (2000) presents in his work in that there is a transitional force that exists between roles. Blatner emphasizes that dysfunction can arise when the meta-role fails to coordinate the roles in an appropriate and functional way. Landy would hold that if the guide is not functioning properly, an individual may experience role inflexibility or difficulty with role transitions. Difficulty transitioning between roles, or having a role repertoire that is highly inflexible, can result in personal dysfunction and distress.

A healthy individual is characterized by having a number of roles available in one's role repertoire that can be enacted competently, and the ability to transition between roles when it is required. Often, when an individual is experiencing distress, at least one crucial role is "unavailable, poorly developed, or inappropriately aligned with other roles..." (Landy, 2000). All of these aspects of the role repertoire can be applied to the difficulties often experienced by combat veterans upon their return home.

Combat Veterans and Role Dysfunction

It appears as though serving in combat may severely disrupt the role repertoire and, as a result, the emotional and psychological health of a combat veteran. In this discussion it is assumed that other factors, including the homecoming environment, can contribute to, or buffer against, the development of these difficulties.

Klion and Pfenninger (1996) claim that a primary issue observed in Vietnam combat veterans who seek treatment is their extremely restricted repertoire of social roles. These individuals almost exclusively view themselves as "Vietnam veterans" (Klion & Pfenninger) at the expense of all of the other roles that should exist in their repertoire. During training, combatants learn all the qualities of the soldier role and are given the impression that they are nothing but soldiers (Klion & Pfenninger). This role is

powerfully reinforced through combat, during which individuals spend long periods of time enacting only this role and their survival depends on them doing just that. Klion and Pfenninger describe some qualities of the soldier role that are developed and reinforced in the combat zone. While enacting this role, although comradery is developed, intimacy is avoided in order to protect oneself from the pain of losing a friend and fellow combatant in battle. Surviving in a combat situation requires a constant hypervigilant state in order to make decisions and problem solve quickly in this environment. Also, in order to function and not experience paralyzation due to fear and horror, a soldier must be able to suspend affect or suppress these emotions.

For many months, a soldier will play only this role, and his role repertoire will be comprised of this role alone. As previously discussed, a limited role repertoire can have detrimental effects on an individual when they are required to enact other roles in his/her social environment. When a combatant returns from a tour of duty, and is expected to re-expand his role repertoire to include other social roles including (possibly) husband, father, and citizen, this becomes a source of distress. Although the soldier role no longer serves the individual in their current environment, it is difficult to abandon this role as the individual has become dependent on this role for survival. Discussing the experience of the American Vietnam veterans, Klion and Pfenninger (1996) note that “without an adequate means of understanding themselves or the world to which they have returned, these individuals often found themselves paralyzed” (p. 130). Soldiers who are returning home from combat may need assistance and support in expanding their role repertoire to include the roles that are desired and required in order to understand the self and relate to family, friends, and society.

Serving in combat not only influences the quantity of an individual's roles, but also the quality of the roles in his/her repertoire. The combatant is able to enact the soldier role with a high degree of proficiency. However, when a soldier returns to their community and family, and attempts to re-expand the role repertoire to accommodate the social roles of husband, father and civilian, he is not able to play these roles with a comparable amount of skill. Some of the qualities that are useful to include in the role of the soldier, including suspended affect and a lack of intimacy, become troublesome if they happen to colour the other roles that the combatant is attempting to play. For example, if a reintegrated combatant is not able to be intimate in the role of husband, or demonstrates too much aggression with his children, he is not enacting these roles skillfully and marital or familial difficulties may arise.

Finally, the difficulties described above concerning the quality and quantity of the combatant's roles are hinged on the inability to transition from one role to the other and be flexible within one's repertoire. A combatant who is locked in the role of soldier, who is not able to easily transition to husband, father, or civilian, will experience distress when this is expected by his family, friends, and community. The combatant himself may not understand why he is not able to make the transition, and enact these other roles with skill. Indeed, the "abrupt return to 'normal' roles and activities at personal, family, and organizational levels, can be significant stressor" (Thompson, Blais, Pickering, Febraro, & McCreary, 2008, para. 1). It may be necessary to assist combatants with this transition back into "normal" roles through focusing on role quantity, competency, and flexibility in treatment.

In addition to the personal and interpersonal challenges that can result from the disruption of the role repertoire, role dysfunction can also inform some of the symptoms that are associated with PTSD. Although the reexperiencing cluster of symptoms appears to be the result of experiential memories being encoded in memory schemas through classical and operational learning, and triggered by environmental cues, role dysfunction may contribute to avoidance and hyperarousal. A combatant who is experiencing confusion or distress over not being able to competently enact personal roles, and is not able to connect with family members or friends, may feel a sense of alienation from these individuals. Detachment and isolation are often connected to the avoidance symptom category and a limited role repertoire, low competency in enacting roles, and lack of flexibility between roles may contribute to this detachment. As previously mentioned, the soldier role requires an individual to be hypersensitive to external stimuli in order to perform and survive in the combat environment. When a combatant remains in the soldier role upon reintegration, and retains this tendency in the absence of threatening stimuli in the environment, the hyperarousal category of symptoms may develop. Given that role dysfunction may contribute to combat-related PTSD symptoms, role-informed drama therapy may not only be useful in addressing the self and interpersonal relationships but also relieving these distressing symptoms.

VIII. Role Informed Drama Therapy for Combat-Related PTSD

Psychodramatic Techniques

Psychodrama, a form of psychotherapy originally introduced by J. L. Moreno, focuses on entering into the role of the self to enact personal scenes. This self-role can take the form of past, present, and future selves as well as real or imagined aspects of the

self. Actual events from an individual's life can be experienced in the role of self, and fantasy and dream worlds can also be explored in the realm of Psychodrama. When describing the goals of psychodrama, Buchanan and Garcia (2000) offer an ABCS acronym that stands for affect, behavior, cognition, and spirituality.

Within the goal of affect, two types of catharsis are described. *Catharsis of abreaction* "occurs when client regresses to a difficult experience and reexperiences an expression of emotion that is associated with that time" (Buchanan & Garcia, 2000, p. 176). This process is similar to exposure treatment in that individuals reexperience the traumatic event within a safe container and are exposed to traumatic stimuli. Emotional responses, typical of those present during the traumatic event, are thought to be evoked during catharsis of abreaction. As previously discussed, exposure treatment can be useful in treating the symptom of hyperarousal as individuals are taught how to regulate their physiological response in the presence of reminders of the trauma. Flashbacks are often reinforced through avoiding traumatic stimuli, therefore being exposed to, rather than avoiding, anxiety-provoking stimuli related to the trauma may be useful in treating this reexperiencing symptom. This goal of psychodrama, catharsis of abreaction, which shares many similarities with exposure, would be useful in treating the symptoms of PTSD.

The second type of catharsis emphasizes the distance created with the trauma through both time and the dramatic modality. *Catharsis of integration* requires a different understanding of the traumatic event when experiencing it again in this dramatic form (Buchanan & Garcia, 2000). The individual is experiencing catharsis of abreaction and reexperiencing the event, but they are also now observing themselves in this situation and are able to gain a new understanding of the way they reacted. Given the possibilities of

psychodrama, the individual can then dramatically explore alternate ways the situation could have played out, possible ways to cope with trauma in the future, and how to face daily stressors and reminders of the trauma. This goal of psychodrama clearly addresses the development of new coping skills necessary for individuals living with PTSD. The symptoms of avoidance and hyperarousal may decrease once an individual has developed the coping skills that will enable him/her to face reminders of the trauma. Also, as stated in the title of this process, integration of the traumatic event is emphasized through gaining a new perspective on how the trauma has affected one's life. Addressing affect through exposure, the development of coping skills, and the integration of trauma is emphasized as important, both in this goal of Psychodrama and in the treatment of individuals living with combat-related PTSD.

The second major goal of psychodrama addresses maladaptive *behavior* that may perpetuate personal difficulties. As previously discussed, psychodrama allows for the rehearsal of appropriate and helpful behavioral skills. Through this rehearsal, one is able to practice new ways of handling challenging situations (Buchanan & Garcia, 2000). Both coping skills and interpersonal skills can be addressed using psychodramatic techniques and are included in this behavioral goal of psychodrama.

The *cognitive* goal of psychodrama emphasizes that an individual is able to reorganize their cognitive perception of the self, the world, and their experiences by participating in their own psychodramas (Buchanan & Garcia, 2000). This goal of psychodrama is clearly aligned with a goal of PTSD treatment: altering persona schemas. Engaging in psychodrama allows an individual to explore currently held beliefs and the way in which he/she interprets and evaluates external events. It also provides the

opportunity to gain insight into one's experience and develop a new understanding of the trauma and the impact it had on one's life. Altering cognition through engaging in the dramatic process can be viewed as beneficial in the treatment of individuals living with combat-related PTSD.

The final goal of psychodrama, *spirituality*, is based on the idea that being involved in others' psychodramas can be a healing experience. An individual who is part of someone else's psychodrama may encounter many of their own issues in the work and also feel as though they are taking part in the healing of another. The isolation and disconnection with others associated with combat-related PTSD may be addressed through the group connection formed in sharing the experience of a psychodrama.

Overall, it appears that Psychodrama contains many of the essential components of PTSD treatment. The ABCS goals emphasize the importance of exposure, development of coping skills, integration, and interpersonal interaction. All of these processes are necessary in order to target the three main symptom categories associated with PTSD: Avoidance, hyperarousal, and flashbacks. Used within drama therapy, psychodramatic techniques would allow an individual to enter into the role of the soldier self and work through the trauma experienced during combat. Given how closely the goals of psychodrama resemble the goals of PTSD treatment, it may be a useful to incorporate these psychdramatic techniques into drama therapy treatment for individuals living with combat-related PTSD.

Role Method

Landy has proposed a method for working in drama therapy through role that aims to "help individuals reconstruct their mental schemas and find appropriate roles and

counterless to structure their lives” (Landy, 2000, p. 61). Through Landy’s Role Method, it may be possible to assist combatants in dealing with disruptions to the role repertoire that can lead to personal and interpersonal difficulties upon their return home from a tour of duty.

Although it is not necessarily a linear process, Landy outlines eight steps through which a client will progress throughout the duration of this treatment. The first step requires invoking a role, or choosing a role within the repertoire that needs to be explored and expressed (Landy, 1993). This role should emerge from a creative process and different drama therapy techniques can be used to invoke the role. Next, the client names the role in an attempt to concretize this role and move into the creative realm. Once the role has been chosen and named, the client will progress to exploring the role through different forms of enactment. This step is labeled “playing out/working through the role” because many of the issues associated with this role will be addressed and worked through during this stage. Landy notes that it is not uncommon to move from role to role and shift the focus to related roles when necessary (Landy, 1993). The fourth step in the role method involves exploring the qualities of subroles and delving deeper into the developed role by working through subroles. Next in the process it becomes necessary to reflect on the role play and identify the qualities, functions, and styles that are part of this role. Once the purpose and form of the role has been sufficiently examined, it comes time to move to the next step which involves relating the role to the client’s everyday life. This stage in treatment challenges the client to recognize how he/she plays the role in their life and how it impacts his/her interactions with others. Landy refers to the next stage as “integrating roles to create a functional role system”. The process of integration begins

once there is a shift in the relationship the client has with a role and how it is played out in his/her life. During this step, the role repertoire is reassembled and reconfigured with the appropriate alterations made to roles that, before treatment, were a source of distress. Finally, the last step involves bringing these changes into one's life. As Landy points out, alterations in the system of roles is often an internal process but, for these changes to be observed and felt by the individuals in the client's life, this transformation needs to be brought into behavior in social interactions. Landy (1993) states that "a client must be able to play out a revised version of a dysfunctional role in order to influence others within their social sphere" (p. 55). This is the final step of therapy in which the client brings their internal changes into the external world.

Drama therapy that utilizes this structure as a guide would provide the combatant with the opportunity to work with other roles in their repertoire that require attention, such as that of father or husband. Invoking, naming, working through, and exploring the qualities of these roles may be beneficial in identifying and addressing the issues that exist in connection with these roles. Once the individual had made the desired alterations to that role, made the connection to their own life, and reassembled their repertoire, the individual could then begin to work on his ability to enact the role of father or husband in a way that is satisfying and rewarding for him and his family. Landy (1990) has stated that drama therapy is "concerned with helping people achieve a fluidity, a capacity for excellence in playing a single role complexly and integrating that role within a well-developed repertory of roles" (p. 229). This goal of role-informed drama therapy is well suited for returning soldiers who need assistance in developing a healthy role repertoire that is flexible, expansive, and comprised of well-played roles.

X. Discussion

There are positive steps being taken by the Canadian Forces to assist and support soldiers with reintegration and treatment for stress-related injuries. On-site debriefings, information sessions during decompression, gradual integration, and a 6-month follow-up are all important measures in promoting the health of military personnel. The opening of five new Operational Stress Injuries clinics (in addition to the existing five) in Canada reflects that the military is active in its attempt to assist the soldiers who return from deployments with combat-related psychological injuries (Rossignol, 2007). The Canadian Forces is also working hard to remove the stigma attached to PTSD in the military and acknowledge that it is simply another form of injury, one that is psychological rather than physical.

The services offered and provided to soldiers, however, could be improved and expanded to more effectively address the difficulties associated with serving in combat. It is necessary to provide soldiers with a more comprehensive model of treatment and reintegration support system. This research demonstrates that it would be beneficial if these interventions utilized the concept of role as a primary lens for conceptualizing and treating combat-related difficulties.

The psychodramatic use of role provides a number of possibilities for addressing the other symptoms associated with combat-related PTSD: avoidance and hyperarousal. As previously described, the psychodramatic use of role in drama therapy would provide an opportunity for exposure, the development of coping skills, and integrating the traumatic event into an individual's schema, or understanding of the world. A common belief in the treatment of combat-related PTSD is that the experiences in combat must be

explored at a “reality level”; directly rather than working at a distance or through transference (Oei, Lim, & Hennessy, 1990). It is also essential that the implications of the soldier or veteran role be explored in treatment (Klion & Pfenninger, 1996).

Psychodramatic techniques offer the opportunity to address the combat experience directly and explore the implications of the soldier role, both during and following deployment.

Using the structure of Landy’s Method allows the individual to work with roles in the repertoire other than the soldier self. As Johnson and Lubin (1997) point out, working with external representations of inner material—in this case personal roles—is beneficial in treatment, and this can easily be achieved through the Role Method. Creating external representations of dysfunctional roles, working with these representations, and gradually gaining insight into how these roles connect to one’s personal life and role repertoire would provide the combatant with the opportunity to repair a repertoire that may be lacking in quantity, quality, or flexibility.

It appears as though working with roles in this way can also contribute to schematic integration. In a study that looked specifically at the schema of self, rather than schemas consisting of information about the world and other people, Benyakar, Kutz, Dasberg, and Stern emphasize that “it is the capacity for assimilating the new information, incorporating it within the schemes of self and reality while maintaining internal consistency, that provides a sense of growth through experience, while preserving wholeness” (1989, p. 442). These authors claim that the breakdown of the self-schema, or understanding of the self, may be a useful area of study in the maintenance of combat-related PTSD. Effective treatment of combat-related PTSD must incorporate the

reorganization of the veteran's self-structure (Quinn, 2008) because the experience of a flexible yet stable sense of self is essential to mental health (Benyakar et al., 1989; Quinn, 2008).

Both psychodrama and the role method engage the participant in an active, embodied experience. This can be useful in accessing the trauma stored in the body and non-verbal parts of the brain, addressing the traumatic experience and the symptom of flashbacks. These two techniques, which are both grounded in role theory, could be combined in a treatment approach for combat-related difficulties. Through analyzing and synthesizing relevant literature, this research suggests that using these role-based techniques would provide a treatment that is inclusive of the essential components of treatment for PTSD and would assist the combatant in dealing with the difficulties associated with reintegration. It is recommended that these findings be used to construct a role-based drama therapy treatment model for combat-related difficulties. This approach should be an experiential method that makes use of psychodramatic and Role Method techniques to address the main symptoms of PTSD and develop a healthy role repertoire. Further research should then be conducted in order to examine the effectiveness of this intervention.

References

- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders: DSM-IV-TR* (Rev. ed.). Washington, DC: Author
- Amir, D., Bensimon, M., & Wolf, Y. (2008). Drumming through trauma: Music therapy with post-traumatic soldiers. *The Arts in Psychotherapy, 35*, 34-48.
- Arad, R., Mikulincer, M., & Solomon, Z. (1991). Monitoring and blunting: Implications for combat-related post-traumatic stress disorder. *Journal of Traumatic Stress, 4*(2), 209-221.
- Beidel, D. C., Frueh, C. B., & Turner, S. M. (1995). Exposure therapy for combat-related PTSD: A critical review. *Clinical Psychology Review, 15*(8), 799-817.
- Benyakar, M., Kutz, I., Dasberg, H., & Stern, M. J. (1989). The collapse of a structure: A structural approach to trauma. *Journal of Traumatic Stress, 2*(4), 431-449.
- Birenbaum, R. (1994). Peace keeping stress prompts new approaches to mental-health issues in Canadian military. *Military Medicine, 151*(10), 1484-1489.
- Blatner, A. (2000). *Foundations of psychodrama: History, theory and practice* (4th ed.). NY: Springer.
- Blatner, A. (2007). The role of the meta-role. In C. Baim, J. Burmeister, & M. Maciel (Eds.), *Psychodrama: Advances in theory and practice* (pp. 53-65). New York: Taylor & Frances.
- Boudewyns, P. A., Harrison, W. R., Hyer, L., McCranie, E., & Woods, M. G. (1990). PTSD among Vietnam veterans: An early look at treatment outcome using direct therapeutic exposure. *Journal of Traumatic Stress, 3*(3), 359-368.
- Brewin, C. R., Dalgleish, T., & Joseph, S. (1996). A dual representation theory of

- posttraumatic stress disorder. *Psychological Review*, 102(4), 670-686.
- Bryant, R. A., Harvey, A. G., & Tarrier, N. (2003). Cognitive behaviour therapy for posttraumatic stress disorder. *Clinical Psychology Review*, 23, 501-522.
- Cahill, S. P., & Foa, E. B. (2007). Psychological theories of PTSD. In M. Friedman, T. Keane, & P. Resick (Eds.), *Handbook of PTSD* (pp. 55-77). New York: The Guilford Press.
- Cardena, E., Maldonado, J., Hart, O., & Spiegel, D. (2000). Hypnosis. In Foa, E., Keane, T., & Friedman, M (Eds.), *Effective treatments for PTSD* (pp. 247-279). New York: The Guilford Press.
- Cason, D. R., Resick, P. A., & Weaver, T. L. (2002). Schematic integration of traumatic events. *Clinical Psychology Review*, 22, 131-153.
- Cerone, M. R. (2000). Eye movement desensitization and reprocessing in the treatment of combat-related guilt: A study of the effects of eye movements. Unpublished doctoral dissertation, Temple University- Philadelphia.
- Cox, R. D., Eisler, M. R., Finn, P., & Ragsdale, K. G. (1996). Effectiveness of short-term specialized inpatient treatment for war-related posttraumatic stress disorder: A role for adventure-based counseling and psychodrama. *Journal of Traumatic Stress*, 9(2), 269-283.
- Dekel, R., Solomon, Z., Elklit, A., & Ginzburg, K. (2004). World assumptions and combat-related posttraumatic stress disorder. *The Journal of Social Psychology*, 144(4), 407-420.
- Doyle, C. (1998). A self psychology theory of role in drama therapy. *The Arts in Psychotherapy*, 25, 223-235.

- Emunah, R. (1994). *Acting for real: Drama therapy process, technique, and performance*. NY: Brunner-Routledge.
- Foy, D. W., Donahoe, C. P., Gellers, J., & Goldfarb, J. (1988). Post-traumatic stress disorder in Vietnam combat veterans: Effects of traumatic violence exposure and military adjustment. *The Journal of Traumatic Stress, 1*(2), 181-192.
- Garcia, A., & Buchanan, D. R. (2000). Psychodrama. In P. Lewis & D. R. Johnson (Eds.), *Current approaches in drama therapy*. Springfield, IL: Charles C Thomas.
- Glass, J. (2006). Working toward aesthetic distance: Drama therapy for adult victims of trauma. In L. Carey (Ed.), *Expressive and creative arts methods for trauma survivors* (pp. 57-71). London: Jessica Kingsley.
- Glod, C. A., & McEnany, G. (1995). The neurobiology of posttraumatic stress disorder. *Journal of the American Psychiatric Nurses Association, 1*(6), 196-199. doi: 10.1177/107839039500100607
- Hudgins, M. K. (2002). *Experiential treatment for PTSD: The therapeutic spiral model*. New York: Springer Publishing.
- Hudgins, M. K. (2007). Clinical foundations of the therapeutic spiral model: Theoretical orientations and principles of change. In C. Baim, J. Burmeister, & M. Maciel (Eds.), *Psychodrama: Advances in theory and practice* (pp. 175-188). New York: Taylor & Frances.
- Johnson, D. R. (1987). The role of the creative arts therapies in the diagnosis and treatment of psychological trauma. *The Arts in Psychotherapy, 14*, 7-13.
- Johnson, D. R. (2000a). Creative therapies. In E. Foa, T. Keane, & M. Friedman (Eds.), *Effective treatments for PTSD* (pp. 302-316). New York: The Guilford Press.

- Johnson, D. R. (2000b). Developmental transformations: Toward the body as presence. In P. Lewis & D. R. Johnson (Eds.), *Current approaches in drama therapy* (pp. 87-110). Springfield, IL: Charles C Thomas.
- Johnson, D. R., & James, M. (1996). Drama therapy for the treatment of affective expression in posttraumatic stress disorder. In D. L. Nathanson (Ed.), *Knowing feeling: Affect, script, and psychotherapy* (pp. 303-326). USA: Donald L. Nathanson.
- Johnson, D. R., & James, M. (1997). Drama therapy in the treatment of combat related post-traumatic stress disorder. *The Arts in Psychotherapy*, 23(5), 383-395.
- Johnson, D. R., & Lubin, H. (1997). Treatment preferences of Vietnam veterans with posttraumatic stress disorder. *Journal of Traumatic Stress*, 10(3), 391-405.
- Johnson, D. R., Lubin, H., Rosenheck, R., Fontana, A., Southwick S., & Charney, D. (1997). The impact of the homecoming reception on the development of posttraumatic stress disorder: The West Haven homecoming stress scale. *Journal of Traumatic Stress*, 10(2), 259-277.
- Junge, M. B., & Linesch, D. (1993). Our own voices: New paradigms for art therapy research. *The Arts in Psychotherapy*, 20, 61-67.
- Kaloupek, D. G., Keane, T. M., Mora A. C., Wine, P., & Wolfe, J. (1993). Patterns of positive readjustment in Vietnam combat veterans. *Journal of Traumatic Stress*, 6(2), 179-193.
- Keane, T. M., & Lyons, J. A. (1989). Implosive therapy for the treatment of combat related PTSD. *Journal of Traumatic Stress*, 2(2), 137-152.
- Kimble, M. O. (2008). Neurobiological models in posttraumatic stress disorder: Effects

- on public perception and patient care. *Journal of Psychological Trauma*, 6(4), 57-78. doi: 10.1080/19322880802096517
- Klion, R. E., & Pfenninger, D. T. (1996). Role constriction and Vietnam combat veterans. *Journal of Constructive Psychology*, 9, 127-138.
- Landy, R. J. (1984). Conceptual and methodological issues of research in drama therapy. *The Arts in Psychotherapy*, 11, 89-100.
- Landy, R. J. (1990). The concept of role in drama therapy. *The Arts in Psychotherapy*, 17, 223-230.
- Landy, R. J. (1991). The dramatic basis of role theory. *The Arts in Psychotherapy*, 18, 29-41.
- Landy, R. J. (1993). *Persona and performance: The meaning of role in drama, therapy, and everyday life*. London: Jessica Kingsley.
- Landy, R. J. (2000). Role theory and the role method of drama therapy. In P. Lewis & D. R. Johnson (Eds.), *Current approaches in drama therapy* (pp. 50-69). Springfield, IL: Charles C Thomas.
- Lapierre, C. B., Schwegler, A. F., & LaBauve, B. J. (2007). Posttraumatic stress and depression symptoms in soldiers returning from combat operations in Iraq and Afghanistan. *Journal of Traumatic Stress*, 20(6), 933-943. doi: 10.1002/jts
- Martin, A. (2001). Report to the ministry of national defence: Systematic treatment of CF members with PTSD. *Ombudsman Special Report*. National Defence and Canadian Forces.
- McFadyen, M. (2008). A long road to recovery: Battling operational stress injuries. *Special Report to the Minister of National Defense*. National Defence and

Canadian Forces.

Moreno, J. L. (1961). The role concept, a bridge between psychiatry and sociology. In

J. Fox (Ed.) *The essential Moreno*. NY: Springer.

National Association for PTSD. (n.d.). *A brief primer on the mental health impact of the*

wars in Afghanistan and Iraq. Retrieved February 19, 2009, from

http://www.ncptsd.va.gov/ncmain/ncdocs/fact_shts/fs_iraq_afghanistan_lay_audien.html

Oei, T. P., Lim, B., & Hennessy, B. (1990). Psychological dysfunction in battle: Combat stress reactions and posttraumatic stress disorder. *Clinical Psychology Review, 10*, 355-388.

Paulson, D. S. (2008). An investigation into the psychological effects of the U.S. occupation of Iraq on American troops (Doctoral dissertation, Institute of Transpersonal Psychology, 2008). *ProQuest Information and Learning Company*. (UMI No. 3304167)

Propper, H. (2009, September). *Moreno's role theory of personality and its convergence/divergence with/from aspects of other personality theories*. Paper presented in Psychodrama course at Concordia University, Montreal QC.

Quinn, A. (2008). A person-centered approach to the treatment of combat veterans with posttraumatic stress disorder. *Journal of Humanistic Psychology, 48*(4), 458-476.

Research Paper/Project Handbook. (2008). *Policies and procedures for art therapy, drama, or music therapy*. [Brochure/Handbook]. Montreal, QC: Author

Ritchie, E. C. (2007). Update on combat psychiatry: From the battle front to the home front and back again. *Military Medicine, 172*, 11-14.

- Rossignol, M. (2007). *Afghanistan: Military personnel and operational stress injuries*. Retrieved November 17, 2009, from <http://www2.parl.gc.ca/Content/LOP/ResearchPublications/prb0720-e.htm>
- Rothbaum, B., Meadows, A., Resick, P., & Foy, D. (2000). Cognitive behavioral therapy. In E. Foa, T. Keane, & M. Friedman (Eds.), *Effective treatments for PTSD* (pp. 60-83). New York: The Guilford Press.
- Rothschild, B. (2000). *The body remembers: The psychophysiology of trauma and trauma treatment*. New York: W. W. Norton & Company.
- Schnurr, P. P., Lunney, C. A., Bovin, M. J., & Marx, B. P. (2009). Posttraumatic stress disorder and quality of life: Extension of findings to veterans of the wars in Iraq and Afghanistan. *Clinical Psychology Review, 29*, 727-735.
- Sternberg, P., & Garcia, A. (2000). *Sociodrama: Who's in your shoes?* (2nd ed.). Westport, CT: Praeger.
- Thompson, M. M., Blais, A., Pickering, D., Febbraro, A., & McCreary, D. R. (2008). *The development of a multidimensional measure of reintegration issues for Canadian forces personnel: Initial scale development and group results*. Retrieved December 3, 2009, from <http://www.forces.gc.ca/health-sante/hp-ps/rd-dr/QOL-QV/ES-SE-14-eng.asp>
- VanGoda, K. L. (2001). Posttraumatic stress disorder and use of cognitive behavioral coping skills: Before and after a residential treatment program (Doctoral dissertation, The Ohio State University, 2001). *ProQuest Information and Learning Company*. (UMI No. 3022591)
- Weber, D. A., & Reynolds, C. R. (2004). Clinical perspectives on neurobiological effects

of psychological trauma. *Neuropsychology Review*, 14 (2), 115-129.