

USING THE HERO'S JOURNEY AND ROLE THEORY TOGETHER WHEN WORKING
WITH VETERANS LIVING WITH COMBAT-RELATED POSTTRAUMATIC STRESS
DISORDER: A THEORETICAL ANALYSIS

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ABSTRACT

USING THE HERO'S JOURNEY AND ROLE THEORY TOGETHER WHEN WORKING WITH VETERANS LIVING WITH COMBAT-RELATED POSTTRAUMATIC STRESS DISORDER: A THEORETICAL ANALYSIS

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This theoretical paper examines possible therapeutic intersections between the hero's journey as outlined by Leeming (1998) and Landy's (2009) role theory with the aim of serving Canadian male veterans living with combat-related posttraumatic stress disorder (CR-PTSD). The story of the hero's journey is not new to drama therapy. Both Landy (1993) and Silverman (2004) cited it as influencing their work, however, this research synthesizes elements from both of them. Specifically, Leeming's hero's journey stages provide a similar therapeutic framework to that of Silverman's (2004) *The Story Within*. The theoretical analysis portion of this research uses literature on CR-PTSD to support connections between Leeming's hero's journey stages and implementation of Landy's role and counterrole using roles taken from the Role Profiles card sort (Landy & Butler, 2012) in one analysis. The purpose of this theoretical analysis is to examine the potential of combining Leeming's stages with Landy's concepts of role and counterrole through dramatic exploration of archetypal roles. The analysis suggests that combining these three frameworks could potentially foster positive therapeutic outcomes for veterans by creating opportunities for them to find meaning in their experiences of living with PTSD. However, the nature of using them together is highly adaptable, flexible and not restricted to the theoretical arguments contained in this analysis. Strengths and limitations of this research are discussed, and recommendations for future research are addressed.

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The journey of life is the search for self -
David Leeming, 1998

And you may ask yourself, well, how did I get here?
Talking Heads, 1980

Introduction

My first encounter with the hero's journey happened during my grade 10 English course when my class completed a unit on Greek mythology. I remember being fascinated by the archetypal characters and what they represented. Years later, I was re-introduced to the hero's journey during a six-week acting intensive. I was given a handout on the stages of it according to Campbell (2008), and encouraged to consider not only how the hero's journey take on a life path might inform the character I was playing, but also how it shows up time and time again in my own life (J. Koltai, personal communication, May-June 2011). Since then, I have always had the hero's journey on my radar as a creative interest. As I began my drama therapy degree, I knew that I wanted my research to investigate links between the hero's journey and drama therapy.

When choosing the population for my research, I was interested in applying my ideas to veterans living with combat-related posttraumatic stress disorder (CR-PTSD). I contemplated how the contemporary concept of "hero" is most likely a negatively loaded term for veterans living with CR-PTSD. A hero is "a person who is admired for great or brave acts or fine qualities" (Simple definition of hero, para. 1, n.d.). This definition differs drastically from Leeming's (1998) definition of the hero's journey. Leeming (1998) wrote that the hero's journey is a "monomyth", ie: "an expression of the journey of the hero figure, of our own journey through physical and psychic life, and of the evolutionary path of humanity to full consciousness" (p. 6). The distinction between these two definitions is important. For veterans living with CR-PTSD, using the hero's journey in therapy may hold potential to transform complicated associations with the word "hero". As Woolf (2012) explained:

Two such culturally circulating narratives about veterans are "hero" and "PTSD mental illness" narratives. The former leads veterans to find themselves responded to as heroes while the latter leads veterans to find themselves responded to as ill people victimized by a disease process. The two are contradictory in the sense that they imply very different meanings about veterans as particular kinds of people. Indeed, they may be competing narratives in that to be a hero is to never be sick or have failings. Contemporary American society tends to imagine heroes as strong, independent, tough, heterosexual, persistent and sacrifice making individuals while PTSD tends to imply individuals have been damaged by the experience of combat and, as a result, are not fully functioning persons. According to the narratives themselves, it is contradictory to be both hero and ill. (p. 3)

Woolf (2012) suggested that unfortunately, “hero” and “PTSD” narratives are often viewed as mutually exclusive. My research purposefully aims to fuse these two narratives together, implying beneficial and stigma reducing outcomes for veterans living with CR-PTSD. As a way of achieving this, my research suggests aspects of how drama therapy and the hero’s journey could work together in facilitating positive therapeutic outcomes for veterans living with CR-PTSD. My research question is: How can the hero’s journey, as elucidated by Leeming (1998) and Landy’s (2009) role theory inform each other when working with Canadian male veterans living with CR-PTSD?

Ethical Considerations

Experience of the world. I, a drama therapy student who identifies as female will be investigating literature about veterans who identify as male and who have sustained trauma from their time serving in combat. My experience of gender and the world is remarkably different from theirs. This draws a similar parallel to the gender and power issues addressed in Dintino and Johnson’s (1997) article, wherein Dintino relayed her sometimes difficult experience working as a female drama therapist with Vietnam veterans who identify as male. The fact is, I am a woman who has never been to war, who knows nothing of what it is like to live with CR-PTSD: this is something I need to consciously attend to. In an effort to step outside of my comfort zone and expand my knowledge of clinical populations, I am deeply interested in researching male veterans. I feel stimulated and challenged by researching this population - one I know very little about. Similar to Woolf’s (2012) assertion that societal expectations of PTSD and hero narratives suggest they must be mutually exclusive, I am fascinated by Courtenay’s (2000) assertion that traditional constructs of masculinity suggest that in order for men to maintain an acceptable reputation as a “man’s man”, they must engage in destructive coping mechanisms and reject health promoting behaviours, since they are viewed as “feminine”. Similarly, Jakupcak, Blais, Grossbard, Garcia, and Okiishi (2014) studied emotional “toughness” in male veterans, finding that the veterans who placed high value on “toughness” ie: suppression of feelings, displays of emotion and vulnerability in favour of unfaltering independence and stoicism “were more likely to screen positive for posttraumatic stress disorder” (p. 100). For these reasons, I am drawn to examining strategies for deconstructing this unhealthy dichotomy in male veterans living with PTSD.

Imposing a model. Since my method is purely theoretical, I do not run into any ethical issues pertaining to using human participants. However, I must be cautious about not coming across as imposing my developing theory on others as something that will work for all Canadian veterans who identify as male living with CR-PTSD. This idea of imposing a theory relates to Tracy's (2010) assertion that even though the researcher has no control over how their work will be received, they can do their utmost best to ensure they communicate their ideas clearly, so as to avoid misunderstanding and misinterpretation of data. Since I am proposing a theory, I will aspire to maintain humility in my writing: by heavily employing use of the words "could", "possibly", "might" and "may", I remain in the realm of possibilities, not absolutes. In this way, my research presents as an option, not an imposition.

Promoting bias and prejudice. I recognize that I am using a very old archetypal story that suggests many stereotypes and archaic ways of thinking - particularly with regards to gender roles and gender affect, among others. Although Leeming (1998) cited that everyone is on their own hero's journey, he proceeded to refer to the hero exclusively using male pronouns. Although I will also be discussing the hero using male pronouns because I am researching male veterans, it is important to acknowledge that Leeming privileges the male pronoun in his commentary sections on each stage, which is where I took my data from. Since I am choosing to use Leeming's book as part of my data set, it is possible that my research may be perceived as reinforcing archaic ideas about people and their places in society and the larger world, thereby promoting "typifiable social identities" (Agha, 1998, p. 151). Although I am studying male veterans, I do not want to be misinterpreted as someone who views using the hero's journey therapeutically as only applicable to men. Ironically, this is the very thing I wish to get away from, since my research aims to suggest deconstruction of traditional masculinity by elucidating a different definition of the word "hero" for male veterans. In stating how Leeming (1998) privileged the male pronoun - and the irony of it given my goals - I hope to practice what Creswell (2014) cited as researcher self-reflexivity: the safeguard against potential for writing to be interpreted as insulting or alienating by its readers. Leeming (1998) wrote that, "we must lose ourselves to find ourselves in the overall pattern of the cosmos" (p. 7). The essence of this universality is what I wish to access.

For the combat veteran, PTSD is a result of their time spent in combat: witnessing the brutality of war and actively taking part in it. PTSD may occur in individuals when there is:

exposure to actual or threatened death, serious injury or sexual violation. The exposure must result from one or more of the following scenarios, in which the individual:

- directly experiences the traumatic event;
- witnesses the traumatic event in person;
- learns that the traumatic event occurred to a close family member or close friend (with the actual or threatened death being either violent or accidental); or
- experiences first-hand repeated or extreme exposure to aversive details of the traumatic event (not through media, pictures, television or movies unless work-related).

The disturbance, regardless of its trigger, causes clinically significant distress or impairment in the individual's social interactions, capacity to work or other important areas of functioning. It is not the physiological result of another medical condition, medication, drugs or alcohol. (Posttraumatic Stress Disorder, para 2-3, 2013)

These aforementioned causes of PTSD may manifest in four categories as “re-experiencing, avoidance, negative cognitions and mood, and arousal” (Posttraumatic Stress Disorder, para 4, 2013). Morrison (2014) posited that veterans have the highest likelihood to develop PTSD as a result of their time in combat.

Literature Review

CR-PTSD in Canada

Combat-related posttraumatic stress disorder currently affects significant numbers of Canadian veterans. In their study on PTSD symptom prevalence among Canadian male veterans aged 22-87, Konnert and Wong (2014) found that older veterans were less likely to report PTSD symptoms on the three DSM-IV clusters of re-experiencing, hyperarousal and arousal than younger veterans. According to Pearson, Zamorski, and Janz, regular force members reported a PTSD lifetime rate of 11.1% and a twelve-month rate of 5.3% in 2013 (p. 2, 2014). This has drastically inflated since 2002, when lifetime prevalence rates were 7.2% and twelve-month prevalence rates were 2.8% (The CF 2002 Supplement, 2002).

Between 2001 and 2014, over 40,000 Canadian military personnel served in the Afghanistan mission (The Canadian armed forces in Afghanistan, n.d.). With regards to recent statistics on PTSD prevalence in Canada, an estimated near ten percent of individuals who served during Canada's time in Afghanistan are now living with CR-PTSD (Galloway, 2016).

Richardson, Naifeh, and Elhai (2007) found that among over a thousand male

peacekeeping veterans who served in the 1990's, PTSD was reported at "10.92% for veterans deployed once and 14.84% for those deployed more than once" (p. 510). Richardson, Long, Pedlar, and Elhai (2008) found poor Health Related Quality of Life (HRQOL) in Canadian veterans living with PTSD "[stressing] the importance of including measure of quality of life in the psychiatric evaluation of veterans to better address their rehabilitation needs" (p. 594). Black and Papile (2010) conducted survey research on transitioning back to civilian life with Canadian veterans who had served for at least six months full time. Out of 173 veteran responses, 37.6% reported difficulties transitioning back to civilian life, and 20% of 190 veterans placed the most value on their mental health as a marker of successful transition to civilian life (Black & Papile, 2010). In a national sample of Canadian veterans, Elhai et al. (2011) looked at the potential underlying factors that may link PTSD and major depressive disorder, since they are highly co-morbid. Their findings suggest similarities between PTSD's dysphoria factor and symptoms of depression (Elhai et al., 2011). Armour et al. (2015) found correlations between high co-occurrence of PTSD and MDD symptoms and decreased health related functioning impairment (HRF) in Canadian veterans; this finding suggests the importance of further research for treatment of co-morbid PTSD and MDD. Physiological suffering is also an issue for veterans living with PTSD (Poundja, Fitkretoglu, Guay & Brunet, 2007; Irwin, Konnert, Wong & O'Neill, 2014). Poundja et al. (2007) administered the Brief Pain Inventory (BPI) to 130 French Canadian male veterans of which 86.9% reported high levels of ongoing physical pain. Richardson, Pekevski, and Elhai (2009) found that "PTSD severity was significantly related to gastrointestinal disorders, musculoskeletal problems, and headaches" (p. 366). Irwin et al.'s (2014) findings suggested further investigation into how anxiety and depression may facilitate the co-morbid relationship between PTSD and physical pain.

Psychotherapeutic Treatment for CR-PTSD

Schnurr (2008) stated that, "the largest number of studies on psychotherapy for PTSD indicates that cognitive-behavioral treatments, as well as Eye Movement Desensitization and Reprocessing (EMDR), are the most effective types" (p. 2). However, in a recent review of attrition rates among American veterans utilizing psychotherapeutic outpatient services, Goetter et al. (2015) found that "approximately one third of OIF/OEF/OND veterans with CR-PTSD drop out of PTSD treatment" (p. 406) calling for innovative and creative therapeutic interventions to combat this reality. Studies on the effectiveness of psychotherapeutic

interventions for combat veterans living with PTSD are often characterized by small sample sizes and warrant future evidence-based research (Arens, 2015; Arnedt, 2009; King et al., 2013; Kip, Shuman, Hernandez, Diamond & Rosenzweig, 2014; Swanson, Favorite, Horin, Solomon, 2006).

Eye movement desensitization and reprocessing therapy. Eye movement desensitization and reprocessing therapy (EMDR) may be best described as a process of having a client focus on details of their traumatic memory while simultaneously moving their eyes back and forth, which is usually brought about by an external stimulus such as the therapists' moving finger (Shapiro, 2001). The first controlled study of EMDR - called EMD at the time - produced promising results, indicating that one session of EMD helped clients desensitize to their traumatic memory and positively impacted the way they thought about it - results that were still present 3 months later (Shapiro, 1989). The name change to EMDR came about as more discoveries were made about the process: it is not only about desensitizing the client to traumatic material, but also about how the client processes the trauma and contextualizes it (Shapiro, 2001). van der Kolk et al. (2007) compared treatments of EMDR, Prozac and placebo effect on a group of participants diagnosed with PTSD: posttreatment results indicated the EMDR group had the largest reduction in PTSD symptoms compared with the Prozac or placebo group. van der Kolk (2014) posited that EMDR helps clients integrate their trauma into "a coherent event in the past" (p. 255) without ever having to voice one detail of it out loud to the therapist.

Cognitive processing therapy. With cognitive processing therapy (CPT) clients engage in written narrative focusing not on a detailed description of the trauma itself, but instead on thoughts and perceptions about how the trauma has altered their lives (Wachen et al., 2016). As a starting point for therapy, from their self-written statements clients identify the "red flags" consisting of distorted thoughts and perceptions of themselves and the larger world that contribute to the maintenance of their PTSD (Wachen et al., 2016). CPT was administered to veterans living with PTSD attending a Veterans Affairs outpatient clinic, resulting in the veterans "[experiencing] a significant decrease in PTSD symptoms over the course of therapy" (Dickstein et al., 2013). Boyd, Rodgers, Aupperle, and Jak (2016) described implementing CPT in treatment of a veteran living with CR-PTSD. Although CPT focuses in on restructuring narratives around the traumatic event, it does not address the details of the traumatic event itself (Boyd et al., 2016).

Group therapy. Group cohesion was found to be a substantial indicator of positive

outcomes in group therapy treatment for CR-PTSD (Ellis, 2014; Ellis, Peterson, Bufford & Benson, 2014) and cohesion may occur very rapidly (Kaiman, 2003). Possibly, rapid group cohesion may parallel the concept of a “combat family” during war, as veterans find comfort in others who can relate to their trauma (Kaiman, 2003). However, group cohesion may at times interfere with the therapeutic process, as it reinforces avoidance of uncomfortable material through supportively homogenous identification with other group members (Galloucis & Kaufman, 1988; Johnson, Lubin, & Corn, 1999). Therefore, veterans may also benefit from self-evaluations of their progress in therapy, as well as individual therapy in addition to group therapy (Galloucis & Kaufman, 1988; Johnson et al., 1999). Group dynamics were highlighted as therapeutically important for veterans processing the traumatic material of their nightmares (Brockway, 1987). In a group-based treatment program, Swanson et al. (2009) reported that, “preliminary findings suggest that combining CBT-Insomnia with exposure, relaxation, and rescripting therapy has promise for improving sleep and nightmares in combat veterans with chronic PTSD” (p. 641).

Makler et al. (1990) discussed themes which surfaced over the course of a three year group therapy intervention for veterans living with CR-PTSD, suggesting that, “special attention should be placed upon the developing of an effective working relation, upon the relevant curative factors, and problematic themes common to most combat-related, chronic PTSD victims” (p. 394).

Murphy and Rosen (2006) described a brief group therapy intervention called the PTSD ME Group, utilizing motivational interviewing between veterans and group leaders to target potential barriers they may encounter post-treatment. The PTSD ME Group aims to help veterans use each other to gain insight into problems they may encounter following treatment and how to circumvent them, fostering greater self-awareness and coping skills (Murphy & Rosen, 2006).

Foy, Ruzek, Glynn, Riney, and Gusman (2002) found that Trauma Focus Group Therapy (TFGT) which incorporates psychoeducation, exposure and group cohesion among other therapeutic factors holds potential for positive treatment outcomes for veterans. Similarly, Mott et al. (2013) described promising preliminary findings for group-based exposure treatment (GBET) that incorporates therapeutic components such as psychoeducation, exposure, group discussion and visual imagery. Since both TFGT and GBET incorporate many therapeutic

techniques, more research is warranted to parse out which techniques are most effective in these methods (Foy et al., 2002; Mott et al., 2013). Turner, Beidel, and Frueh (2005) discussed the promising efficacy of Trauma Management Therapy (TMT) for veterans living with PTSD, which addresses problem areas not addressed by exposure therapy. Turner et al. (2005) stressed that TMT is not a “cure all” for veterans, instead it employs group and individual work as a means of helping them manage and cope with chronic PTSD. Case study research demonstrated that TMT is effective in reducing symptoms of PTSD and hallucinatory nightmares through exposure and group therapy, warranting future research using TMT with larger populations (Arens, 2015). Keenan, Lumley, and Schneider (2014) described a group therapy model in which veterans write letters to friends who perished in combat and to those whom they may have harmed and subsequently read them out loud as a tool for accessing and dealing with their trauma.

Although cognitive therapy and EMDR are considered the frontrunner treatments for CR-PTSD, Schnurr (2008) asserted that, “there is not enough evidence to draw conclusions about other approaches, including creative, dynamic, and complementary and alternative treatments” (p. 2). Furthermore, therapies which utilize exposure and cognitive restructuring may alleviate distress associated with the trauma and help to schematize it, however they do not often address feelings associated with traumatic material and the lack of interpersonal connection veterans feel towards others (Keenan et al., 2014). Although more research is warranted on the efficacy of group therapy in treatment for CR-PTSD, it should not be dismissed (Hamblen, Schnurr, Rosenberg, Eftekhari, n.d). There exists great diversity and variability of PTSD symptomatology and presentation in combat veterans (Naifeh, Richardson, Ben & Elhai, 2010; Sharpless & Barber, 2011). Therefore, there is little to no evidence to support the notion that one recommended therapy will work well with all veterans, or effectively target their particular trauma (Sharpless & Barber, 2011). Smith, Currier and Drescher (2015) emphasized teamwork between disciplines: “clinicians should be prepared to assume a synergistic and holistic approach...which may combine evidence-based treatments for alleviating PTSD symptomatology with other strategies for promoting veterans’ health in physical, social and potentially spiritual domains” (p. 7). Owens, Steger, Whitesell and Herrera (2009) emphasized that meaning-making for veterans living with PTSD may be a positive treatment outcome worth pursuing.

Creative Arts Therapies and CR-PTSD

Poetry therapy, art therapy and music therapy have all been used in the treatment of CR-PTSD. Foley (2015) noted the presence of metaphoric language for veterans who have returned home from combat. Specifically, Foley (2015) outlined how the veterans' use of this language may unlock deeper meanings concerning their vantage point in relationship to their personal military experiences and underlying broader systemic military perspectives. Furthermore, Foley (2015) emphasized that although it may be difficult for a therapist to put themselves in the shoes of their client, these metaphors aid the therapist in relating to their clients, helping them feel seen and heard.

In her editorial note contained in a special edition of *Journal of Poetry Therapy* highlighting creative expression for military veterans, Albright (2015) notably favoured of using creative arts as a therapeutic treatment modality, stating that “creative expression is inexorably linked to the human condition” (p. 71). Albright (2015) ascertained that although little research exists using the creative arts to facilitate healing in military communities, there is “potential applicability of poetry and artistic therapies to elicit meaningful change in the lives of military-connected populations” (p. 71). Canada, Brinkley, Peters, and Albright (2015) discussed therapeutic gains occurring in a veterans' treatment court (VTC) in which seven male veterans and five staff members participated in a survey study on their experience of therapeutic journaling. All but one veteran and every staff member voted for the continued use of therapeutic journaling, touting its ability to build capacity for self-reflective thought and improve interpersonal communication between all parties involved in the VTC (Canada et al., 2015).

Spiegel, Malchiodi, Backos, and Collie (2006) relayed that although few studies have been completed using art therapy as treatment for CR-PTSD, the little that has been done implied potential as a salient treatment method, and that “other studies also have found art therapy to be more effective than verbal therapy for veterans with PTSD” (p.159-160). Spiegel et al. (2006) cited Morgan and Johnson's (1995) study in which a post-nightmare drawing task was effective in reducing nightmares for two Vietnam war veterans, although the researchers suggest that further research is warranted in this area.

Spiegel et al. (2006) obtained survey data from art therapists who work with clients living with CR-PTSD. Through thematic analysis, Spiegel et al. (2006) identified seven “therapeutic mechanisms” (p. 160) in support of the efficacy of art therapy in working with PTSD, and

concluded with “ ‘best practice’ recommendations” (p. 161) for art therapy highlighting how it is distinct from other treatments for CR-PTSD. Similarly, Kapitan (2006) discussed how many art therapists are interested in working with the veteran population, but such programs rarely take shape. Keeping this idea in mind, Mims (2015) conducted a pilot pre and post-test study targeting alleviation of PTSD and other mental disorders in which two military veterans kept a visual journal over the course of six weeks. Although small sample size, confounding variables and no difference in pre and post-test scores prohibits generalizability to the population, there was some positive change in the participants’ intrapersonal learning about self (Mims, 2015). With regards to music therapy treatment for CR-PTSD, Bensimon, Amir and Wolf (2008) conducted a study in which soldiers living with PTSD participated in group drumming sessions. Data was collected using interviews, video documentation as well as personal written accounts of the experience from the therapist themselves (Bensimon et al., 2008). This study suggested that drumming provided a safe and exploratory container in which the soldiers could explore their fury caused by the CR-PTSD, as well as an increased sense of affinity and relatability with their fellow group members, suggesting slight alleviation of their symptoms (Bensimon et al., 2008).

Drama Therapy and Trauma Treatment

Lahad (2014) described how the basis of uniting drama therapy with trauma treatment rests on the concept of “fantastic reality” wherein people use their imagination and inventiveness to re-author their stories by way of playfully exploring solutions to facets of their past, present or future issues. Furthermore, exploring imaginary worlds inherently cultivates flexibility and coping skills using experimentation, and has been attributed to healthy cognitive, social and emotional domains in children (Lahad, 2014). Lahad is careful to point out that “fantastic reality” already comes naturally to humans, as it is often used as a coping mechanism in times of traumatic stress. As drama therapy uses the body, it may be a critical link for converting visual or embodied traumatic memories into verbal accounts (Lahad, 2014). Regarding CR-PTSD specifically, Litz and Orsillo (2004) emphasized that clinicians need to be aware that non-verbal communication is just as important as verbal communication in creating a treatment environment where the veteran feels safe and secure in sharing their stories. Clinicians are discouraged from prompting verbal accounts of trauma if veterans are not at a point where they are ready to share them (Litz & Orsillo, 2004).

The story within. Silverman (2004) developed “The Story Within” approach and has employed it with survivors of trauma. Silverman (2004) described how contextualizing trauma within the frame of a myth or fairy tale provides a holding structure for personal exploration, while still offering a flexible template onto which the client can project their experiences in pursuit of personal insight and meaning. Utilizing the client’s personal choice of a character within a myth or story provides the basis of the therapeutic work realized through several expressive arts modalities such as art, music, and dramatic embodiment. Creative engagement with the chosen story often facilitates the gradual unfolding of personal trauma story (Silverman, 2007). Silverman (2007) details a case example using “The Story Within” method with a homeless adolescent girl who chose Grimm, Grimm and Zipes’ (1987) version of *The Handless Maiden*. This adolescent girl made hands in several sessions, and one day Silverman brought rope to the session. The girl subsequently tied the hands she made, helping bring into her consciousness her own story of sexual abuse which she had been repressing for many years (Silverman, 2007).

Developmental transformations. Johnson’s (2009, 2014) psychotherapeutic method called Developmental Transformations (DvT) has been used widely with many populations of traumatized people. As Johnson (2009) described, DvT is “the transformations of embodied encounters in the playspace” (p. 89). The playspace acts as a blank slate onto which the client may project their personal material as it is realized in embodied, interactional imagery between the therapist and client (James & Johnson, 1997). Johnson (2014) posited that despite the facades of structure humans create in attempt to create order, life is made up of moments that are never identical, which he calls “the prime discrepancy” (p. 70). The purpose of DvT is to help clients tolerate their encounters with life’s randomness using the playspace as the platform to explore and tolerate this ambiguity (Johnson, 2014). Although DvT is not specifically geared towards trauma work, “its aims are consistent with those of trauma treatment: to aid the client in desensitizing themselves to fear-based schemas that are distorting their lives” (Johnson, 2014, p. 72).

Developmental transformations and CR-PTSD. The most significant contribution to the body of research on drama therapy and CR-PTSD has utilized the DvT method (Dintino & Johnson, 1997; James & Johnson, 1997). James and Johnson (1997) worked with Vietnam veterans living with CR-PTSD in an in-patient veteran treatment centre where they received

different types of psychotherapy. By facilitating and maintaining the playspace, James and Johnson (1997) were able to provide containing power for the complex and multifaceted inner worlds of Vietnam war veterans. Within the DvT playspace, the veterans played with images evoking the continuum of suffering and healing that arose while progressing through developmental group therapy phases unique to their experience of CR-PTSD, (James & Johnson, 1997). These “rage”, “shame” and “empathy” (p. 385) phases were progressively moved through, helping the veterans to access and acknowledge the reality of sufferance and vulnerability in living with CR-PTSD while connecting to others like themselves through play (James & Johnson, 1997). Working on the same veteran inpatient unit, Dintino and Johnson (1997) articulated the struggles Dintino encountered as the group therapist for Vietnam war veterans. Dintino and Johnson (1997) both offer reflections on Dintino’s struggle of humiliation and frustration, as she was often enrolled as the sexualized female play object with her male clients. As the group play progressed and when a strong playspace was present, the veterans took more vulnerable risks - even experimenting with their own femininity, while Dintino also experienced a shift in her comfort and freedom to play with whatever was surfacing in the play (Dintino & Johnson, 1997).

Since drama therapy is a developing field with little to no quantitative research to support its efficacy in trauma treatment, there is potential for its presence to be drowned out of trauma-informed work (Johnson & Sajnani, 2014). In general, utilizing creative arts therapies as treatment modalities for CR-PTSD is fairly unknown territory (Albright, 2015), thereby requiring future research (Mims, 2015; Canada et. al, 2015). However, Kapitan (2006) may have presented a solution to this problem. In discussing implications for marketing art therapy for combat veterans living with PTSD, Kapitan (2006) stressed that researchers, professionals and community-based initiatives must work together to create a “straightforward agenda based on the powerful ‘multiplier effect’ that understands the potential of certain ideas, once disseminated widely, to transform knowledge” (p.155). Similarly, it is critical that drama therapy networks itself by investigating its similarities with other trauma models, while also promoting what it brings - which is freshly innovative - to the world of trauma treatment (Johnson & Sajnani, 2014).

The Hero’s Journey

Leeming (1998) asserted in the 20th century, the highly influential writings of Joseph Campbell re-ignited an exploration of myth and its modern-day relevance as a template for the life path. In his book *The hero with a thousand faces*, Campbell (2008) detailed several stages

which a protagonist, or hero, moves through in order to accomplish a great task while encountering helpers and obstacles along the way. Campbell (2008) referred to the hero's journey as a "monomyth" - which Leeming (1998) described as follows: "an expression of the journey of the hero figure, of our own journey through physical and psychic life, and of the evolutionary path of humanity to full consciousness" (p. 6). Campbell (2008) touched on life's paradox through his assertion that, although the monomyth encapsulates the hero's experience within a trajectorial story, there exists "the challengingly persistent suggestion of more remaining to be experienced than will ever be known or told" (p. 1). This draws similar parallels to Johnson's (2014) DvT theory: "representation of experience is always incomplete, inexact, and inaccurate, to some degree" (p. 70). Ultimately, the challenges and triumphs which shape the hero's experience reveals important lessons and wisdom for themselves on their quest for personal truth (Campbell, 2008). In his book *Mythology: The voyage of the hero* Leeming (1998) outlined eight stages through which the hero moves on a journey towards personal fulfillment.

The hero's journey and therapy. The hero's journey may provide a salient metaphor in which to frame the therapeutic process (Halstead, 2000; Lawson, 2005). Lawson (2005) posited that since the hero's journey signifies movement through stages wherein the hero is interacting with, learning from, and constantly incorporating new information into his environment, it fits well within cognitive developmental theory. A client may need to integrate personal experience of trauma into their worldview, thereby developing "a more complex way of seeing the world" (Lawson, 2005, p. 138). The therapist may serve as a kind of companion on this journey, walking alongside the client and bearing witness to their personal discoveries during the therapeutic process (Halstead, 2000; Lawson, 2005). The hero's journey is relatively underused as a clinical tool and has not gained much momentum (Lawson, 2005) although Nakanishi's (2012) research aims to combine object relations theory and the hero's journey in an effort to make object relations theory more graspable and user friendly to clinicians. Nadata (2014) emphasized the benefits of using the hero's journey as a therapeutic paradigm when doing Guided Imagery and Music (GIM), helping clinicians better gain a more holistic picture of who their clients are over the treatment process.

Solomon (2006) asserted that little research has been conducted on how combat veterans metabolize their traumatic material and ascribe meaning to it in the grander context of their present day lives. In favour of using myth in therapy, Pierraci (1990) found his clients made the

best strides “when they came to confront or understand some aspect of their inner lives that gave them a sense of meaning” (p. 208). Therapeutically, the hero’s journey has been implemented with and identified in the personal material of several clinical populations. Taylor (2012) wrote about how the hero’s journey could be used by patients suffering from myocardial infarction and progressive coronary disease, who often experience negative psychological effects resulting from their illness. The concept of a “heart” was metaphorically explored from the vantage points of many cultures, in an effort to help the patient heal their psyche in conjunction with their body (Taylor, 2012). Jones and Compton (2001) used narrative analysis to analyze interviews with hospice clients about their end of life reflections and experiences. One of the core themes identified was using the hero’s journey to make meaning of one’s life (Jones & Compton, 2001). Lukoff (1985) outlined a case study in which an individual was hospitalized for experiencing a psychotic episode drawing many parallels to the hero’s journey. The symbols and metaphors present in the episode helped the individual consolidate and integrate it into their life experience as they transitioned out of treatment (Lukoff, 1985). Solomon’s (2006) research examined how the myth of Odysseus could be used and creatively explored by combat veterans struggling with PTSD. Results supported the idea that the hero’s journey could be used as a psychoeducational compliment to the wide spectrum of treatments already available to veterans living with CR-PTSD (Solomon, 2006).

The Hero’s Journey and Drama Therapy

Six-piece story making. Drawing substantial parallels to the hero’s journey, Lahad and Dent-Brown (2012) described “the Six Piece Story-Making (6PSM) method as an assessment tool strongly influenced by fairy tales. Lahad and Dent-Brown (2012) highlight that the 6PSM method is primarily meant to ascertain the client’s coping skills repertoire in cognitive, social emotional and physical domains, among others. In this way, the 6PSM method helps the therapist determine how to help the client balance out or fill in blanks with their coping skills. During the 6PSM assessment, the client creates a story with a protagonist and a job they must do, followed by an antagonistic factor which stands in the protagonist’s way, then a climax of events and a resolution. The client creates their story by sketching it out on paper, then puts it into words to share with the therapist (Lahad & Dent-Brown, 2012).

The story within. As already mentioned, Silverman’s (2004) therapeutic approach called “The Story Within” draws significant parallels to the hero’s journey. Silverman (2004)

emphasized that “The Story Within” approach highlights a process of “not knowing” from the beginning what the process will reveal which is of personal significance to the client - mirroring the idea of the hero on a journey towards personal discovery. In this way, “clients who use *The Story Within* method...become heroes in their own personal mythic quest” (Silverman, 2004, p. 128).

Role theory. Role theory asserts that individuals are a composite of the various roles they take on in everyday life (Landy, 2009). As some roles are often exacerbated and other ones are minimized, role theory strives to help the client give voice to the minimized ones, and negotiate balanced equilibrium between all roles (Landy, 2009). When role theory is applied to therapeutic work, it becomes Role Method (RM) (Landy, 2009). In an effort to create a role classification system, Landy (1993) identified roles that he believed surfaced repeatedly in the hundreds of western plays he used as his data. His findings led him to create a taxonomy of roles which he classifies under six domains: somatic, cognitive, affective, social/cultural, spiritual and aesthetic (Landy, 1993).

The taxonomy of roles has undergone some modifications in its use as an assessment tool (Landy & Butler, 2012). One assessment tool based on role theory is the Role Profiles card sort, consisting of fifty-eight roles (Landy & Butler, 2012). Using roles derived from the taxonomy, the Role Profiles card sort asks the participant to categorize the roles underneath four categories: “This Is Who I Am, This Is Who I Want To Be, This Is Who Is Standing In My Way, and This Is Who Can Help Me” (Landy & Butler, 2012, p. 152). The Role Profiles card sort includes a discussion portion in which the test administrator poses questions to the participant - which inherently ask them to reflect on their sorting process (Landy & Butler, 2012). The nature of the Role Profiles card sort is projective and based on the participant’s subjective interpretation of themselves in relationship to roles how they should be sorted (Landy & Butler, 2012). This instrument is a malleable tool and at present, “the validity and reliability of the instrument cannot be confirmed”, however, it does give the test administrator “a great deal of information about a client in a relatively short period of time” (Landy & Butler, 2012, p. 160). Due to the highly adaptable nature of the Role Profiles card sort as an assessment instrument and therapeutic tool, it has been experimented with and modified by many drama therapists, and will continue to evolve in its implementation (Landy & Butler, 2012).

According to role theory, an integrated role repertoire where various roles are accessible to

the client is a sign of health (Landy, 2009). Similar to the hero's journey as detailed by Leeming (1998), the 6PSM (Lahad & Dent-Brown, 2012), Landy posited that with the help of a "guide", a client may work to overcome great obstacles through their dramatic exploration of "role", and "counterrole". Role refers to the protagonist, and the counterrole represents something that is in direct opposition to the role (Landy, 2009). However, this does not necessarily mean the counterrole is always an antagonist, it could be a role that competes with the client's desire to play one cardinal role (Landy, 2009). Drawing parallels to Halstead (2000) and Lawson's (2005) idea of the therapist as companion, Landy's role theory postulates that the therapist serves as the guide, aiding the client in negotiating their relationship between role and counterrole. Any role within Landy's taxonomy may be slotted into role, counterrole or guide: in this way, the therapist as guide may also be given any role in relationship to role and counterrole. Even though the therapist initially takes on the role of guide, through the unfolding of the therapy process it is the eventual goal that the client becomes their own guide (Landy, 2009).

Landy (1993) detailed a case study example wherein a graduate student offers the story of Hansel and Gretel to a group of her peers to enact. The story of Hansel and Gretel held deep personal significance for this student. She identified with the character of Hansel, dramatically exploring a variety of associations to this character and its relationship to other characters in the story (Landy, 1993). In his clinical work, Landy (2009) cited that he has used Role Method with individuals living with PTSD.

Distancing. Jones (2007) wrote that distancing encompasses the reflective aspect of the therapeutic process for the client in drama therapy. Distancing affords the client engagement with their process on two levels: they are both actively involved in the dramatic enactment and watching themselves engage in it (Jones, 2007). Landy (2009) asserted that the foundation of role theory rests on the concept of distancing as it applies to drama therapy. Landy (2009) stated that he was influenced by the work of Scheff (1981) who theorized that the act of feeling can be experienced as "overdistanced" ie: the client is very engaged with their material on a cerebral and conceptual level, and "underdistance" where the client is very emotionally engaged with their material. Scheff (1981) stated that aesthetic distance is the balance between over and under distanced relationships to personal material and that is most advantageous to the client's work. In the zone of aesthetic distance, the client "is simultaneously and equally a participant and an

observer” (Scheff, 1981, p. 46). Landy (1996) called aesthetic distance an awareness of and engagement with “self as subject and self as object” (p. 14).

Landy (1996) wrote that distancing theory also provides clients with the opportunity to be physically distant from their personal material through engagement of mediums outside of themselves, such as storytelling, masks, costumes, make up or objects. Keeping this idea in mind, Landy’s (1996, 2009) distancing theory readily applies to therapeutic goals in working with traumatized individuals: having the option of working with dramatic mediums outside of one’s own body may help a traumatized client “express feeling without the fear of becoming overwhelmed, and to reflect upon an experience without the fear of completely shutting down emotionally” (Landy, 2009, p. 73). Johnson (2014) asserted that trauma response usually renders the individual feeling saturated by or completely divorced from emotional states, with no space for simply being in a balanced state of presence with and attention to the emotion. Landy (1996) stated that aesthetic distance provides clients with the opportunity to “return to the past safely, that is, through both remembering and reliving a past event” (p. 17). It is the job of the therapist to help the client achieve aesthetic distance (Scheff, 1981; Landy, 1996, 2009). According to Landy’s (2009) role theory, this would be the job of the guide.

Methodology

Data Collection

Leeming’s (1998) book *Mythology: The Voyage of the Hero* constituted the first category of data. Leeming (1998) elucidated his eight stages of the hero’s journey by providing examples of myths manifesting each stage, and then writes commentary on the nature of each stage itself. This research used stages 4-8 as they appear in Leeming’s book. Since this research focused on the combat veteran’s experience of living with CR-PTSD as the hero’s journey, a relevant and meaningful starting point could be Leeming’s (1998) fourth stage, where the hero embarks on a great task as it may mirror the veteran’s “starting point” when they entered into combat (A. Winn, personal communication, May 24, 2016). To contextualize Leeming’s (1998) stages 4-8 from a natural starting point to an endpoint, they have been re-numbered as 1-5. The stages included from Leeming (1998) are called:

1. Trial and Quest
2. Death and the Scapegoat
3. The Descent to the Underworld

4. Resurrection and Rebirth
5. Ascension, Apotheosis, and Atonement

The second category of data consisted of information related to CR-PTSD. This information came from both peer-reviewed and non-peer reviewed sources. The databases Psycinfo and JSTOR were accessed through the Concordia University library website, and information was also found through the Veterans Affairs Canada and US Department of Veterans Affairs websites. The third category of data pertained to Landy's (2009) role theory, specifically the concepts of role and counterrole. The fourth category of data consisted of roles taken from the Role Profiles card sort instrument (Landy & Butler, 2012).

Data Analysis

This research design was approached from the standpoint of the theoretical/philosophical method by "showing [its] connection to other conceptual and theoretical systems, and using argument as a primary mode of inquiry and a presentational device" (Concordia University, p. 8, 2015). The arguments presented in this theoretical analysis were based upon the already established idea that the hero's journey could provide a fertile foundation for the therapeutic process (Landy, 1993, Halstead, 2000; Silverman, 2004; Lawson, 2005) and in this case, for the combat veteran to unpack his experience of PTSD. The analysis argued that the particularities of the themes contained in Leeming's stages could be meaningful for veterans to unpack and explore their experiences of living with CR-PTSD. As an application to drama therapy practice, elements of Silverman's (2004) *The Story Within* method informed the way in which Leeming's (1998) hero's journey stages were used in this analysis. Landy's (2009) constructs of role and counterrole were employed within each of Leeming's stages, suggesting a dramatically active therapeutic process. Finally, this research also suggested that roles taken from the Role Profiles card sort (2012) could support the veterans' engagement with projective techniques, and the meaning-making derived from delineating roles and counterroles in a way that is personally significant.

Because the nature of drama therapy is projective, subjective and highly interpretive, any number of role types from the Role Profiles card sort (Landy & Butler, 2012) could resonate with the combat veteran as applied to Landy's (2009) theory of role or counterrole in any one of Leeming's (1998) hero's journey stages. Therefore, specific roles taken from Role Profiles were chosen and matched with Leeming's stages in the following theoretical analysis. For each of

Leeming's stages detailed throughout the analysis, literature on CR-PTSD supported the argument for a relevant role and a counterrole, suggesting how they could symbolically encapsulate veterans' experiences and support therapeutic objectives within that specific stage. Using the stages and roles together could support simultaneous therapeutic processes: they could receive dramatic projections, but also inform and develop them. This analysis suggested only one of several potential projections a combat veteran living with PTSD could project onto role and counterrole when working in any of Leeming's hero's journey stages. Furthermore, the therapeutic benefits of aesthetic distance (Landy, 1996, 2009; Scheff, 1981) are suggested through using the projective frameworks of Leeming's hero's journey stages, Landy's theory of role and counterrole and roles from Role Profiles together for Canadian male veterans living with CR-PTSD.

Addressing Validity, Reliability and Quality

Golafshani (2003) wrote that, "reliability and validity are conceptualized as trustworthiness, rigor and quality in qualitative paradigm" (p. 604). Keeping this in mind, the terms validity, reliability and quality in the world of qualitative research are well represented and defined throughout Tracy's (2010) article on key components of good qualitative research. Through delineation these four data categories this analysis aspired to achieve Tracy's (2010) idea of rigor as a bounteously represented collection of data for analysis. Golafshani's (2003) mention of "trustworthiness" was interpreted (p. 604) as resembling Tracy's (2010) concept of "sincerity" (p. 841), and Creswell's (2013) concept of "axiological assumption" (p. 20) in which the researcher is open about their specific research interest and biases. As mentioned earlier, I have been explicit about my keen interest in the hero's journey and my obvious bias in favour of it. I have also recognized some potential for harm in using this archetype. Finally, I have aspired to achieve Tracy's (2010) idea of "meaningful coherence": thoroughly arguing a possible answer to the argument contained in this research question by maintaining an articulate, integrative synthesis of ideas derived from the four data categories.

Analysis

Trial and Quest

The first stage outlined in Leeming's (1998) hero's journey is called Trial and Quest. Leeming (1998) wrote that this stage marks the hero's quest to embark on a great task: "to suffer the agony of adult life, to gain its rewards, and to 'make a name'" (p. 152). Vukšić-Mihaljević,

Mandić, Benšić, and Mihaljević (2000) suggested that Croatian soldiers may feel a large sense of pride when they enter combat, for they are defending and making a difference for their country - a sentiment surely shared by other combat entry soldiers around the world. For the combat veteran, the concept of embarking on a great task could mirror Kaiman's (2003) assessment of World War II veterans in group therapy: after returning home from war, "they found themselves fighting a new battle - coping with delayed-onset or exacerbated PTSD" (p. 38). This grim reality may starkly oppose the remembrance of pride and sense of duty many veterans may feel as they entered war.

As already mentioned, another possible association for the veteran it is that the act of entering the therapeutic process parallels their entry into combat (A. Winn, personal communication, May 24, 2016). The phenomenon of "newness" described by Cozza et. al (2004) of entry into combat could also be said of commencing therapy. Experiencing several types of violent conflict may leave "service members questioning their purpose, as well as negative attributions about the importance and need for the sacrifices encountered" (Cozza et. al, p. 8, 2004). Similarly, James and Johnson (1997) detailed the initial stage of a drama therapy group for Vietnam veterans. The majority of these veterans had no previous experience using drama before, and they encountered "the drama therapy room as if it were an alien world" (James & Johnson, 1997, p. 385). James and Johnson's (1997) account of these veterans feeling like the therapy space is foreign territory may parallel memories of past deployment to foreign territory, relating to Cozza et al.'s (2004) assertion that during combat entry they may ask themselves, "why am I here?". Furthermore, the initial traumas the veteran sustains in his entry into combat and his subsequent avoidance of hyper-aroused emotions pertaining to them as outlined by Cozza et. al (2004) could parallel the avoidance of emotional engagement in the beginning phase of therapy. As James and Johnson (1997) recalled in working with Vietnam veterans, "the fact that the drama therapy session may involve intense emotion threatens to overwhelm their avoidant defenses" (p. 385).

Through implementation of role and counterrole, (Landy, 2009), the past reality of combat entry and present reality of CR-PTSD could be explored. One possibility might be that in reflecting back on his life as a soldier about to enter combat, the veteran may identify with the role of Special Person (Landy & Butler, 2012) as somebody who "found divine destiny within him and now must act on that destiny" (Leeming, 1998, p. 152). However, in lieu of returning

from combat with PTSD, it is very possible that the veteran does not at all feel like a Special Person, in fact, they may identify very strongly with the counterrole of Sick Person (Landy & Butler, 2012).

During Leeming's (1998) Trial and Quest stage, the counterrole of Sick Person (Landy, 2009; Landy & Butler, 2012) could represent the CR-PTSD and the complications of living with it. These complications may be the barriers to treatment that are often inherent in the experience of having CR-PTSD. It is not uncommon for the combat veteran to avoid seeking out psychotherapeutic treatment due to the stigmatizing labels associated with it (Carr, 2011; Mittal et al., 2013). Stigma concerns endured by the combat veteran include a fear of damaging their career reputation, being labeled as a mentally ill person, and feeling profound shame associated with needing to seek out mental health treatment (Carr, 2011; Mittal et al., 2013). Other factors contributing to stigma in the combat veterans include feeling singled out from other mental illnesses through negative CR-PTSD specific labels, as well as feeling a sense of blame from the outside world that they are the cause of their own illness (Mittal et al., 2013). As Carr (2011) wrote, it is very typical for the veteran to feel completely disconnected from people who have not been through the type of trauma they have endured from combat. In addition to these aforementioned stigmatizing factors, often there is a tendency for the combat veteran to feel reluctant to seek treatment due to factors internal to the therapeutic relationship (Carr, 2011). This may manifest as the veteran's ambivalence towards therapy as a result of feeling that their therapist will not be able to handle the details of their profound trauma (Carr, 2011). Feelings of intense shame surround the trauma of the veteran's combat narratives, therefore it is crucial for the therapist to contain and tolerate this shame in order for the therapy to progress (Carr, 2011; James & Johnson, 1997).

Death and the Scapegoat

Leeming (1998) wrote that during the Death and the Scapegoat stage, the hero comes face to face with death and the personal narratives that surround it. Having addressed some of the issues surrounding shame, stigma and the development of alliance in the therapeutic relationship during the Leeming's Trial and Quest stage, the veteran may be ready to begin examining the theme of death. Leeming's (1998) assertion that "the hero stands physically annihilated at the edge of the Kingdom of Death" (p. 181) may bring up many strong and complex associations for

the veteran living with CR-PTSD. Leeming suggested that death functions as the necessary catalyst for the hero to eventually be re-born again.

One potential theme for the veteran living with CR-PTSD that could hold salient meaning is Leeming's (1998) assertion that "the hero faces death and dies for us" (p. 181). Leeming (1998) articulated the hero's experience of facing death in two ways. The first one is that the hero perishes "by some violent means - hanging, dismemberment, castration or rape" (Leeming, 1998, p. 180). Upon returning from war, the veteran living with PTSD has put his life on the line to defend and protect others, and in the literal sense, he did not die. However, it is possible that the profound psychological hardship brought on by CR-PTSD could feel just as torturous as Leeming describes the hero's death to be, and symbolically felt as a type of personal death for the veteran. Keeping this in mind, Leeming's gruesome descriptions of the hero's end may closely parallel actions witnessed or performed by the veteran himself during combat. Veterans have often been exposed to or "committed atrocities such as raping, torturing, body mutilations, and the killing of innocents" (Singer, 2004, p. 377). These horrific actions - which are now traumatic memories for the veteran - are often characteristic attributes of combat and encapsulate the extreme sacrifice a veteran makes in performing the job of going to war. Furthermore, associations between the hero's grisly death and mortality the veteran may have witnessed or caused in battle during this stage may trigger the introduction of intense suffering and loss Leeming (1998) outlined in the following stage entitled *The Descent to the Underworld*, as this stage "is a continuance of the scapegoat process" (p. 213).

Another type personal death the veteran may resonate with during this stage could be exploration of maladaptive behaviours and coping mechanisms veterans often engage in after returning home, bringing to mind PTSD as an "emotional killer". In their writings of veterans returning from Iraq, Litz and Orsillo (2004) stated that these veterans sometimes "suppress, diminish or avoid their internal experiences of pain by using alcohol and/or drugs, disordered eating, self-injurious behaviors (such as cutting), dissociation and behavioral avoidance of external reminders or triggers of trauma-related stimuli" (p. 29). Anger issues are also very common in veterans living with PTSD. Novaco and Chemtob (2002) suggested that prevalence of intense anger in veterans living with PTSD may be due to the fact that combat life inherently demands utilization of aggressive attitudes and behaviour. According to Jordan et al. (1992) male veterans living with PTSD were more likely to report familial adjustment difficulties,

perpetrate domestic violence and live within a violent family dynamic than those without PTSD. This may be due to anger management issues: Novaco and Chemtob (2015) studied the relationship between anger and violence in veterans living with PTSD, finding that anger was essential in the presence of violent behaviour.

Evidently, male veterans living with CR-PTSD struggle with interpersonal and intrapersonal difficulties upon returning home. The state of unhappiness these veterans find themselves in as they return home already signifies a poor quality of life. However, this reality may contribute to their interactions with unhealthy behaviour and coping mechanisms, perpetuating a cycle of dismal life outcomes for veterans and the people surrounding them.

Leeming (1998) also pointed out that the hero may die by suicide. This mention of death by suicide during this stage could bring up several associations for the veteran. Many veterans returning home living with PTSD engage in suicidal ideation (Jakupcak et. al, 2009; Richardson et al. 2014; Smith, Currier & Drescher, 2015) they may attempt suicide (Smith, Currier & Drescher, 2015) or complete it (Singer, 2004). Veterans may be not only struggling with posttraumatic memories of their friends being killed in battle, but may also be mourning the death of a fellow veteran by suicide upon returning to civilian life. The theme of escape could be very prevalent as the veteran explores feelings towards suicide, or first-hand experiences of being affected by it. A scapegoat is “a person who is unfairly blamed for something that others have done” (Simple definition of scapegoat, para 1, n.d.). The scapegoat provides escape and freedom for others. Symbolically, the scapegoat seems to imply the idea of “an easy out” - a sentiment that may be rich with possibility when exploring the idea of suicide.

Leeming’s (1998) Death and the Scapegoat stage could imply some strong suggestions for Landy’s (2009) role and counterrole. Ultimately, the veteran suffering from CR-PTSD knows that living through war comes with a heavy price tag. Looking at the Role Profiles, (Landy & Butler, 2012) it is possible that during this stage, the veteran may imbue role as that of Survivor (Landy & Butler, 2012). If the counterrole is treated as the other side of surviving, that is, the metaphoric death that comes with life being forever changed by PTSD, it is possible that the veteran could use the role of Killer (Landy & Butler, 2012) in the counterrole position. Another idea for counterrole based on the second type of death previously discussed could be that of Suicide (Landy & Butler, 2012).

During Leeming's (1998) Trial and Quest stage, the client and therapist may have had the opportunity to begin the work by naming some of the complicated ironies of first going off to war. This pride and sense of duty starkly contrasts the sad reality of returning veterans coping with severe mental health problems due to their combat time. Using the metaphor of Leeming's Death and the Scapegoat stage, the veteran may move more deeply into exploring the darkness of their PTSD. The counterrole (Landy, 2009) may no longer be that of just being a Sick Person (Landy & Butler, 2012). Using the counterrole of Killer (Landy & Butler, 2012) the veteran could move into processing feelings of deadness by the experience of being a Sick Person. It is very possible that the phrase, "I feel dead, since PTSD is a killer" could resonate strongly with the combat veteran. During this stage, the combat veteran may be accessing feelings of intense anger and frustration as they contextualize their experience within the role of Survivor and the counterrole of Killer under the umbrella of the scapegoat. With the help of the therapist as guide (Landy, 2009) the veteran could dramatically give voice to exploring how he is alive but also dead as a glorified survivor of combat - and a casualty of PTSD.

The Descent to the Underworld

Leeming (1998) wrote that The Descent to the Underworld is also called the "dark night of the soul" (p. 213) - a metaphoric journey to an encounter with one's own shadow side. During this stage, the hero is forced to confront his own duality as someone capable of good and evil (Leeming, 1998). Being forced to encounter this monstrous aspect of self and realizing one's own capability to do harm - universal to mankind - is not easy work (Campbell, 2008; Singer, 2004; Carr, 2011; Politsky, 1995; Volkas, 2009). For the combat veteran living with PTSD, the descent into the underworld could serve as a rich metaphor for unpacking various aspects of their experience during combat and afterwards. Carr (2011) posited that due to the nature of their job, veterans have a higher likelihood than the general population of embodying this part of themselves and living with the upsetting aftermath of this reality. Often, the combat veteran identifies as both a victim and an aggressor, since they witness and often simultaneously commit the terrors of combat (Carr, 2011; James & Johnson, 1997). Johnson and Sajnani (2014) wrote that play provides a suitable arena in which the client may access both roles of victim and perpetrator through role reversal. The use of victim-perpetrator role reversal may advance the therapy in more nuanced and intimate ways by aiding personal realizations that may not be discovered otherwise (Johnson & Sajnani, 2014).

Using Role Profiles, (Landy & Butler, 2012) it seems plausible that a veteran may identify with the role as that of Villain and the counterrole as that of Victim (Landy, 2009, Landy & Butler, 2012). In illuminating this point, Carr (2011) detailed a therapy session wherein a combat veteran recounted how he fatally shot a man who had crawled out of a burning car and was on fire himself. As the body burnt, this veteran described feelings of pleasure at smelling it burn (Carr, 2011). For this veteran, the pleasure he gained from this experience is what led him to feel subsequent horror at his own self for reveling in it (Carr, 2011). Evidently, this veteran “seemed to fear that he had violated the laws of being human” (Carr, 2011, p. 483). In this way, the role Villain has the potential to strongly resonate with the veteran. Another possible association with the role of Villain could be tied up in the inherent complexity of what fighting in could mean for veterans: the job of military personnel is to kill “the bad guys” ie: “villains”, yet the trauma sustained from performing fatal actions may render the veterans feeling like villains themselves (Y. Silverman, personal communication, August 2016). In elucidating the counterrole of Victim, Carr (2011) described how the torment and shame the veteran carried about his own actions ate away at him: he seemed to be the prey of his own predator. Accessing the counterrole of Victim supports Carr’s (2011) notion that being confronted with and trying to cope with our own inhumanity is in itself an agent of personal suffering.

Leeming (1998) wrote that during this stage, “the hero, as man’s agent, faces in depth what man himself so fears” (p. 213). As he described his veteran client who disclosed traumatic memories of personal savagery, Carr (2011) relayed that the conversation began when he inquired about the veteran’s fears. This question led Carr (2011) to reassure the veteran that he was there to hear him. Having already begun working with the theme of death in Leeming’s (1998) Death and the Scapegoat stage, it seems plausible that a natural course of action could be that the veteran may be ready to move from examining personal feelings of deadness caused by the PTSD, to specifically confronting his past as someone who harmed and killed in combat.

Resurrection and Rebirth

Leeming’s (1998) stage entitled Resurrection and Rebirth signifies hope as “the hero progresses from a state of nonlife to one of life”. Leeming (1998) posited that the psychological implications of this stage suggest that, “in death is not only pain but the possibility of rejuvenation” (p. 239). One of the hallmarks of CR-PTSD is the profound feelings of loneliness and isolation resulting from the veteran’s maze of traumatic memories nobody else could

understand (Foley, 2015; Carr, 2011; Kaiman, 2003; James & Johnson, 1997). Having gone to the darkest place of inner anguish through disclosure of gruesome traumatic memories during The Descent to the Underworld (Leeming, 1998) stage, it seems plausible that the veteran would experience a degree of relief as a result of his sharing (Carr, 2011; Kaiman, 2003; James & Johnson, 1997). Carr (2011) stated that as his therapy work with his client in Iraq neared termination, he observed some positive change in this client's affect. As a testament to the therapeutic process, Carr (2011) noted that because he was able to receive the soldier's traumatic stories, contain them effectively, and foster an intimate interpersonal connection with his client, he observed his client begin to take steps towards re-connecting with other people in the world. These new feelings of connection were also observed in group therapy contexts where veterans took comfort in hearing and playing out stories similar to their own (Kaiman, 2003; James & Johnson, 1997; Dintino & Johnson, 1997). Possibly, the idea behind Leeming's Resurrection and Rebirth stage could serve as a symbol of beginning the process of re-connecting with the world post-combat.

Leeming's (1998) Resurrection and Rebirth stage may provide the veteran with the opportunity to address the feelings of excruciating loneliness he bears as a result of his PTSD. In considering role types, the role of Outcast and the counterrole of Free Person (Landy, 2009; Landy & Butler, 2012) could be relevant for the veteran in facilitating a degree of healing at this point in the therapeutic process. Carr (2011) relayed that the soldier he saw in therapy disclosed memories in session he had never shared with anyone else before. If the painful memories of combat give rise to ongoing feelings of extreme isolation and "otherness", then veterans may have the opportunity to unpack these feelings through dramatic exploration of the Outcast role. On the other hand, by imbuing the counterrole as that of Free Person, the veteran could explore any degree of relief or alleviation of pain he may feel as a result of communicating his traumatic experiences.

Ascension, Apotheosis and Atonement

Leeming (1998) wrote that during Ascension, Apotheosis and Atonement, the hero gains a level of self-understanding previously unknown to him. Leeming (1998) emphasized that, "to realize the self in its totality is to repossess the soul" (p. 257). Possibly, re-visiting and processing traumatic memories with the therapist during Leeming's (1998) Resurrection and Rebirth stage could allow the veteran to move towards a reconfiguring their trauma narrative,

since the therapeutic process often fosters within the veteran a greater understanding and acceptance of their PTSD (Foley, 2015; James & Johnson, 1997). James and Johnson (1997) discussed how in severe cases of PTSD, the aim of therapeutic treatment is to reduce “the extent to which the illness permeates and interferes with their entire existence” (p. 394). Living with PTSD does not exclude the veteran from enjoying a quality of life with respect to interpersonal relationships and career, and does not have to restrict their self-concept to be dominantly negative (James & Johnson, 1997). Furthermore, the therapeutic process can aid veterans in transforming their trauma narrative by finding meaning within it (Foley, 2015; Carr, 2011). Foley (2015) asserted that through metaphor, veterans can “articulate how they have accepted the trauma and how they also wish to use experience of the trauma to help others” (p. 145).

In considering role types for Leeming’s (1998) Ascension, Apotheosis and Atonement stage, several options present themselves. Mirroring James and Johnson’s (1997) and Carr’s (2011) idea that the therapeutic process can help veterans parse out the parts of himself that have been adversely shattered by the trauma from those parts that are resilient and intact, the theme of this stage itself implies all-encompassing inclusion wherein the hero can acknowledge his entire journey and all the roles he has played within it. Possibly, the veteran could find it meaningful to sequentially play out all roles he has invoked up until this point in the therapeutic process, witnessing his journey through his own body, or through a more distanced technique such as use of masks, costumes, make-up or objects as detailed by Landy (1996). Another option for the veteran to mark his acknowledgement and acceptance of PTSD could be realized through a kind of symbolic “mix and match”: the veteran could enact previous roles which represent the crosses he bears from living with PTSD, and roles which represent healing and the hope of better life outcomes in the future. An example might be taking on the role of Villain and the counterrole of Helper (Landy, 2009; Landy & Butler, 2012). In this sense, the veteran’s Villain role - which represents the shame he holds from killing and harming others in combat - is still very much a part of him. However, during this stage the veteran could find valuable meaning in the counterrole as Helper: he may resonate with Foley’s (2015) assertion that he can be a helper to others, but also be a helper to himself. In this way, invoking the role of Helper brings to mind Landy’s (2009) viewpoint that the therapist’s job as the guide figure is to help the client discover their own inner guide. Since the counterrole represents a role which needs to be more integrated into the client’s role repertoire, invoking the counterrole of Helper may symbolize any degree of

incoming transformation the veteran may be experiencing in the therapeutic process. This possibility manifests the veteran's potential to transform their restrictive experience of living with trauma into one that holds more flexibility and tolerance of ambiguity (Johnson, 2014). Indeed, the veteran who is nearing the end of therapy could be more equipped to - as the hero does - "find unity in all opposites" (Leeming, 1998, p. 257). For the veteran living with CR-PTSD, arriving at a point in the therapeutic process where he can feel supported by not only the therapist but also by himself suggests positive therapeutic outcomes.

Discussion

The primary basis for using the hero's journey with Canadian combat veterans living with PTSD rests upon the idea that this particular clinical population may have very complicated and complex relationships towards the word "hero". As previously mentioned, Woolf (2012) surmised that Western societal perspectives towards PTSD and the concept of a "hero" are divisive in that they separate these two narratives into absolutes. As Woolf (2012) explained, veterans who live with PTSD are seen as vulnerable and damaged by illness and therefore excluded from being associated with the strong, triumphant and brave connotations attached to the word "hero". Woolf (2012) argued that these veterans may feel caught between a "PTSD role" and a "hero role" since the divisive narratives associated with each one have determined "you can't be both". Keeping this in mind, Woolf (2012) implied that conventional societal treatment towards the concept of "hero" is inherently skewed and unfair for veterans, since the act of going to war is incredibly brave and involves huge self-sacrifice, but the nature of the work puts military personnel at great risk of developing PTSD from the horrific trauma they have sustained. For these reasons, it is very possible that veterans living with PTSD do not view themselves as "heroes" for the idea itself represents something deeply upsetting and may even factor into their experience of trauma. The purpose of this research is to use the hero's journey as a vehicle for suggesting a way in which the word "hero" could be reclaimed in a personally meaningful way for veterans living with PTSD. Using Leeming's (1998) hero's journey stages could potentially provide a platform for veterans to gain perspective on and contextualize experiences of living and coping with PTSD.

Leeming's (1998) five hero's journey stages presented in this analysis constitute the primary holding container for therapeutic exploration. The analysis suggested that the themes contained in each stage could inform the roles veterans may choose from Role Profiles (Landy &

Butler, 2012), dramatically exploring these roles within Landy's (2009) theory of role and counterrole. Veterans could explore how themes from each of Leeming's stages resonate with their experiences, and continue this process of projection by matching personally meaningful roles and counterroles to each stage. However, it seems conceivable that once roles are chosen and dramatically explored, these roles could further enrich or add to already existing associations with the themes, thereby fostering cyclical interplay and dialogue between the stages and roles. As previously discussed, Leeming states that during Death and the Scapegoat stage, the hero may take their own life. The analysis detailed a possible choice for counterrole as that of Suicide (Landy & Butler, 2012). Unpacking the personal significance of this role for the veteran may spark more associations with what suicide means to them, such as the idea of "an easy out". This association, in turn, could aid the veteran in circling back to the scapegoat theme with an enriched scope for what the theme of that stage signifies for them.

Another possible therapeutic benefit of using Leeming's (1998) five hero's journey stages as detailed in the analysis could be the diversity of themes put forward, offering veterans a multifarious foundation onto which they could project various aspects of living with CR-PTSD, and the process of being in therapy. Arguably, Leeming's Trial and Quest stage is about *commencement*, the Death and the Scapegoat stage is about *sacrifice*, The Descent to the Underworld stage is about *suffering*, the Resurrection and Rebirth stage is about *renewal* and the Ascension, Apotheosis and Atonement stage is about *reconciliation*. Similarly, there are fifty-eight roles listed in the Role Profiles (Landy & Butler, 2012) encompassing a vast number of options for archetypal roles the veteran could ascribe meaning to, and dramatically experiment with during the therapeutic process.

The process of projecting life experiences onto these frameworks could generate personally significant metaphors for the veterans. These metaphors may potentially add meaning to veterans' difficult experiences of living with PTSD, and may also provide opportunities for reflection and insight into personal process, all of which could be therapeutic. However, due to the nature of subjective experience, there may exist potential for a wide spectrum of personally meaningful metaphors within this population. Therefore, the arguments supported by literature on CR-PTSD in the analysis exemplify only some of many possible directions using Leeming's (1998) hero's journey stages, Landy's (2009) theory of role and counterrole and roles taken from Role Profiles (Landy & Butler, 2012) together could take. It is entirely possible that other

arguments could be generated using the same four categories of data. For example, the role of Killer (Landy & Butler, 2012) was argued as relevant for Leeming's Death and the Scapegoat stage, representing the act of being emotionally killed by the experience of living with PTSD. However, it may be just as plausible that the role of Killer could be slotted into Leeming's The Descent to the Underworld stage, in which the veteran may strongly resonate with feelings pertaining to causing death, yielding associations to inflicting brutality as supported by the literature from Carr (2011). Similarly, perhaps a veteran could feel the theme of *suffering* and facing one's own inhumanity as discussed in The Descent to the Underworld stage may bring up current struggles of living with the illness, such as being emotionally unavailable, abusing substances, struggling with anger management and performing violent acts towards family members (Jordan et. al, 1992; Novaco & Chemtob, 2002, 2015; Litz & Orsillo, 2004).

Keeping in mind this potential to generate other arguments using the four data sets, it is possible that some of the aspects of the data sets may yield stronger or more numerous connections than others (Y Silverman, personal communication, August 2016). It seems plausible that Leeming's two stages implying obvious themes of personal struggle such as *sacrifice* in the Death and the Scapegoat stage and *suffering* in The Descent to the Underworld stage may hold more potential than Trial and Quest, Resurrection and Rebirth, and Ascension, Apotheosis and Atonement for unpacking the harsh reality of living with CR-PTSD. Based on the literature that describes the dismal impact CR-PTSD has had on their lives, veterans may align themselves more closely with some roles as opposed to others. Roles with negative connotations such as Sick Person, Killer, Villain, Victim and Outcast may resonate more strongly with veterans as opposed to roles with more positive connotations, such as Survivor, Special Person, Free Person or Helper (Landy & Butler, 2012).

The potential for flexibility in combining these three frameworks could be beneficial for veterans at different stages of living and coping with PTSD (Y. Silverman, personal communication, August 2016). As already mentioned, it is possible that Leeming's (1998) Trial and Quest stage could compliment a veteran's feelings towards beginning therapy (A. Winn, personal communication, May 2016). Notably, the theme of *commencement* suggested during this stage could support a veteran who is just beginning to grapple with and make sense of the life-altering effects of PTSD (Y. Silverman, personal communication August, 2016). On the other hand, the arguments made in Leeming's Ascension, Apotheosis and Atonement stage

suggest that veterans could potentially use that stage to explore acceptance of living with the illness. A substantial amount of the literature used in this research discusses veterans who have been living with PTSD for a long time (James & Johnson, 1997; Kaiman, 2003; Murphy & Rosen, 2006). As James and Johnson (1997) asserted, living with PTSD does not mean veterans are unable to enjoy quality of life. For a veteran living with PTSD, coping with the day-to-day struggles of the illness could be seen as a process of integrating it into everyday life.

The concept of distancing could potentially play a critical role in assisting the potential therapeutic implications that may manifest through uniting Leeming's (1998) hero's journey stages with Landy's (2009) theory of role and counterrole as it applies to roles taken from Role Profiles (Landy & Butler, 2012). Landy (2009) posited that when working with individuals who have sustained trauma, beginning the therapeutic process in the realm of overdistance may be beneficial. Landy (1996) emphasized that the way in which drama therapy makes use of projective tools such as stories, objects, masks or make-up empowers the client to determine how they navigate distance, since these tools "[make] a clear separation between self and non-self" (p. 48). Although using the hero's journey stages and roles within the constructs of role and counterrole is already distancing, the veteran could also determine degrees of distancing by implementing Landy's (1996) idea of using objects outside of his own body instead. Landy (1996) noted gradations in distance, reasoning that projecting onto objects is inherently more distanced than wearing a mask, which is more distanced than using make-up on one's own face. In this way, the veteran may not necessarily begin the therapeutic process by jumping head first into exploring role-play with his own body. Projective tools could help him negotiate the amount of distance he feels comfortable with as he explores roles and counterroles within each the hero's journey stages.

Silverman (2004) stated that when clients use the framework of a story, it secures a container around their process, helping traverse difficult moments in personal exploration. Using Landy's (2009) theory of role and counterrole in conjunction with Leeming's (1998) hero's journey stages may provide the veteran with the opportunity to speak in third person instead of first person referring to "the hero" or any other role or counterrole he chooses for each stage. During Leeming's (1998) Death and the Scapegoat stage and using the role of Villain (Landy & Butler, 2012) a veteran may, for example, find that stating "I feel like a 'villain'" is too overwhelming. Instead, saying "they feel like a 'villain'" may afford him the ability to stay in

the moment with role-play while not becoming overwhelmed, bringing to mind the idea of Scheff's (1981) and Landy's (1996, 2009) aesthetic distance. Distancing theory could also play into the aforementioned idea that Leeming's stages could be used in a significant way for veterans at varying stages of living with PTSD. An example of this might be during Leeming's "Trial and Quest" stage, it is possible that veterans may feel "very close" to their PTSD as they begin to unpack the reality of living with the newness of it. On the other hand, possibly the theme of *reconciliation* contained in Leeming's (1998) Ascension, Apotheosis and Atonement stage could signify the presence of aesthetic distance (Landy, 1996; Scheff, 1981) in that some veterans could potentially feel more distanced from the experience of living with PTSD due to its long-standing presence in their lives, and they may want to explore acceptance of coping with a life-long mental illness.

Keeping in mind the concept of distancing (Landy, 1996; Scheff, 1981) the potential intersections between Leeming's (1998) stages, Landy's (2009) theory of role and counterrole and roles taken from Role Profiles (Landy & Butler, 2012) could provide opportunities for veterans to dramatically play with and determine degrees of distance from their personal material in a way that feels safe, manageable and therapeutically beneficial. Furthermore, as these three frameworks act as containers for therapeutic exploration, veterans could use them to contextualize their PTSD and the harsh impact it has had on their past and present functioning, which may in turn generate new and meaningful insights into living with the illness.

Conclusion

This research synthesized literature on CR-PTSD with Leeming's (1998) hero's journey stages, Landy's (2009) theory of role and counterrole, and roles taken from Role Profiles (Landy & Butler, 2012) in a theoretical argument supporting the therapeutic potential of combining these three frameworks together in an approach to working with Canadian males veterans living with CR-PTSD. Specifically, themes from each of Leeming's stages were explained, and arguments for their potential relevance to veterans living CR-PTSD were supported by literature on CR-PTSD. Based on these initial connections, roles taken from the Role Profiles card sort were argued as potentially salient roles and counterroles for the veterans within each of Leeming's stages.

This research is limited in the sense that it is theoretical, and therefore future research would be required to test out whether using Leeming's (1998) hero's journey stages in

conjunction with Landy's (2009) theory of role and counterrole as they apply to roles taken from the Role Profiles card sort (Landy & Butler, 2012) elicits therapeutic outcomes for Canadian male veterans living with CR-PTSD. However, the arguments presented in this research are purely hypothetical and have not been used in a clinical setting with this population. Further clinical research would be required to investigate the theoretical arguments presented in this paper. Case study or intervention research could potentially explore the implementation of using these frameworks together for Canadian male veterans living with CR-PTSD.

The theoretical arguments presented in this paper suggest that combining Leeming's (1998) hero's journey stages with Landy's (2009) theory of role and counterrole as realized through roles taken from Role Profiles (Landy & Butler, 2012) may produce an interaction of themes that could potentially be highly relevant to a Canadian male veteran's experience of living with CR-PTSD. The metaphors generated from using these three frameworks together could strongly support the contextualization of personal experiences in pursuit of self-reflective processes in a way that could perhaps be therapeutic for veterans. These processes could include finding new meaning in and perspective on the struggles associated with PTSD, which could help veterans accept living and coping with this extremely difficult illness. This research also suggests that the concept of distancing as outlined by Scheff (1981) and Landy (1996) is instrumental for the arguments presented here, as it supports potential therapeutic outcomes through using these three frameworks as highly symbolic containers for personal exploration. The potential strengths of this approach could offer veterans the opportunity to utilize creativity in treating their experience of living with PTSD as their own personal hero's journey. Possibly, using the hero's journey in this could help veterans unite the dichotomous "PTSD" and "hero" narratives as detailed by Woolf (2012), and re-author their own story of what it means to be a "hero" by validating and including their experiences of PTSD within their own unique narrative.

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