ENACTING CHANGE:

A THERAPEUTIC ENACTMENT GROUP-BASED PROGRAM FOR
TRAUMATIZED SOLDIERS

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ABSTRACT

During their missions, soldiers are exposed to potentially traumatizing events. Their return to civilian life is sometimes distinguished by difficulties from these mission-related traumas. These difficulties relate to social and occupational readjustment and if left untreated can result in various struggles including: aggressive behaviour, poor functioning in relationships, social isolation, poor self-esteem and depression. Therefore, building on previous research, this study, examined the changes of six male peacekeeping and combat veterans who participated in a group-based program with therapeutic enactment as a primary treatment modality for trauma reactions. The methodology for this study is a combination of qualitative and quantitative methods designed to answer the question: What is the effect of a group-based therapeutic enactment program on veterans who have experienced trauma? Narrative analysis of the 3 interview sets produced the qualitative findings and illustrate improvements in the soldiers emotional expressiveness, communication, relationships, relief from depression, increased confidence and a general decrease in trauma symptoms. Descriptive statistics were to analyse the quantitative findings of change as measured by the Trauma Symptom Inventory (TSI), the Beck Depression Inventory-II (BDI-II) and the Self-Esteem Rating Scale (SERS). The TSI, administered twice, illustrated a general decrease in trauma symptoms. The BDI-II and SERS were administered three times and demonstrate the inverse relationship between depression and self-esteem. A general trend of decreased depression with corresponding increases in self-esteem was evident. These findings have implications for the treatment of trauma generally, and soldiers specifically. Implications for group therapy, and therapeutic enactment as an effective and established group therapeutic intervention are clear.
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On a personal side, I have been privileged to know several friends who provided indispensable support, encouragement and suggestions. I have been honoured to bask in their insightful wisdom during the years leading up to this project. Their influence helped shape the outcome of this project in ways they may not recognise.

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much more to complete this project and enjoyed it much less. I am privileged to be part of his life.
DEDICATION

To the men and women
who willingly put their life on the line
in their duty to help others.
CHAPTER ONE: INTRODUCTION

Research and treatment of psychological trauma has a controversial history marked by periods of amnesia (Herman, 1997). Because psychological trauma focuses our awareness on human vulnerability and the capacity for cruelty towards people by people, it is sometimes easier to overlook trauma than to face the repugnance and shame it causes. Herman (1997) observes three occasions in contemporary history where the study and treatment of trauma was facilitated by a particular political movement and emerged into general awareness. Beginning in the late nineteenth century, with studies on hysteria as a disorder of women, trauma research and treatment was created in the modern field of psychology. ‘Shell shock’ or ‘combat neurosis’ was identified as men's experience of trauma following the First World War (English, 1999). The third area of study for trauma is sexual and physical violence. As a result of the feminist movement, these domestic forms of violence became recognized as trauma.

The contemporary view and treatment of trauma has evolved from these earlier perspectives. Focusing on peacekeeping and combat veterans, this current study builds on previous research on the treatment of traumatized people (Baum, 1994; Brooks, 1998; Buell, 1995; Herman, 1997; Keats, 2000; MacDonald, Chamberlain, Long, Pereira-Laird, & Mirfin, 1998; Martens, 1991; Morley, 2000; Rosebush, 1998; Westwood, 2001, Westwood, Black & MacLean, 2002; van der Kolk, 1996). The purpose of this study was to evaluate the efficacy of a therapeutic enactment group (Westwood & Black, 1999; Westwood, Black, & MacLean, 2002) with former peacekeepers and veterans while they engaged in the Transition Program for Canadian Peacekeeping Soldiers (i.e. http://www.educ.ubc.ca/faculty/westwood/) (Westwood & Black, 1999; Westwood, Black & MacLean, 2002). The program was designed to aid peacekeeping soldiers with their re-entry into Canadian society (See Appendix E).
Having been exposed to potentially traumatising events the soldiers receive limited attention and assistance upon returning home (English, 1999; Litz, Orsillo, Friedman, Ehlich & Batres, 1997; MacDonald, Chamberlain, Long, Pereira-Laird, & Mirfin, 1998; Rosebush, 1998). They are expected to return to civilian life and reintegrate into their families and society without incident.

The rationale and relevance of this study is based on three points. With the current global struggles that require intervention from military personnel, especially following the events of September 11, 2001, the men and women who are sent as peacekeepers and combat soldiers are exposed to incidents that may cause trauma reactions including Posttraumatic Stress Disorder (PTSD) (Herman, 1997; Litz, et al., 1997; MacDonald, et al., 1998; Rosebush, 1998). Peacekeeping veterans return to civilian life, sometimes within hours of leaving a hostile environment and receive little if any psychological support. While in that hostile environment, they are forced to be vigilant for their own life and those whom they protect and serve with. Because they do not have the weeks to debrief and defuse, which was once the norm due to less advanced forms of travel, they now return home sometimes carrying the troubles of their tour with them (English, 1999). Carrying these experiences result in intrapersonal, interpersonal, and occupational struggles (Westwood, Black, & MacLean, 2002). Several studies examining the impact and treatment of PTSD on family relationships including intergenerational transmission of trauma suggest that if trauma is treated in the primary individual, then the ‘ripple effect’ will be limited (Carroll, Rueger, Foy, & Donadoe, 1985; Errebo, 1995; Nelson, & Wright, 1996; Rosenheck, & Nathan, 1985; Solomon, 1988; Solomon, Waysman, Levy, Fried, Mikulincer, Benbenishty, Florian, & Belich, 1992). The result is a social interest to devise an effective
method of repairing the traumata and lessen the negative effect of trauma on individuals, families and society.

The second reason for this study relates to the first and continues to demonstrate my orientation as a researcher. As a society who trains men and women to be sent into hostile environments, we have a moral obligation to repair the trauma caused them. Peacekeeping and combat soldiers are sent into hostile environments to attain, or maintain peace, and be exposed to traumatic events during their tours or are have earlier life traumas triggered by peacekeeping activities. It is reckless to train personnel to go into a hostile environment, expect them to be exposed to traumatic events and not 'untrain' them. It is our moral obligation to ensure those who we send into life-threatening situations are treated for the trauma we expect them to endure while on a government mission.

The third reason for this study is academic. From the previous research on different aspects of therapeutic enactment (i.e. Baum, 1994; Brooks, 1998; Buell, 1995; Keats, 2000; Martens, 1991; Morley, 2000; Westwood, 2001, Westwood, Black & MacLean, 2002), none of the studies combines qualitative and quantitative methods to provide a more comprehensive picture of the findings. In other words, there is no study of this treatment approach that uses both interview methods and psychometric measures providing comprehensive findings to describe the participants’ experiences. Moreover, none of the researchers of therapeutic enactment to date collected data pre-enactment, post-enactment and follow-up to the therapeutic enactment. As part of an ongoing research project, this study constitutes the first of its kind as related to therapeutic enactment.

Included in the difference between this study and the foundational research, is that this study does not use the same therapeutic enactment practitioners as do the other studies.
Moreover, unlike previous studies, the participants here are not students equipped with psychological training. As will be described below, one or both of the creators (Dr. Marv Westwood and Dr. Patricia Wilensky, as cited in Morley, 2000) of therapeutic enactment were present with previous studies. The creators themselves may not have facilitated the enactments, in the previous research but were present and contributed to the enactment for all the previous research.

This study is also a first because the participants are not students who have been trained in psychological concepts. The participants here are veterans who sometimes distrust mental health workers. They are untrained and unconditioned in therapeutic processes. This study represents the first time therapeutic enactment has been researched when the creators were not physically present when the enactments were conducted and the participants are not trained in therapeutic interventions. That the architects of the model were not present, except in a clinical supervisory capacity and the participants are untrained in therapy only further supports the reliability of therapeutic enactment with its successful implementation.

With military veterans as the participants for this study, it is important to understand their trauma experiences and other trauma treatment methods employed for them. Therefore the review of literature includes: (a) a definition of trauma; (b) the psychosocial impact of trauma; (c) general psychotherapeutic treatment of trauma reactions, including group approaches with veterans; (d) group theory, and (e) a review of therapeutic enactment process and research.

The transition to civilian life by veterans returning from missions that include peacekeeping, is often distinguished by difficulty related to social and occupational readjustment (English, 1999; Westwood, Black, & MacLean, 2002). Little research attention has been paid to the lasting impact of such experiences (Litz, et al., 1997). The prevalence of stress-related
reactions is significantly higher in the veteran population, than the general population (English, 1999; Rosebush, 1998; MacDonald, et al., 1998; Westwood, Black, & MacLean, 2002). If left untreated these reactions can result in aggressive behaviour, poor functioning in relationships, social withdrawal and depression (English, 1999; Herman, 1997; Litz, et al., 1997; Scaturo, & Haroby, 1988; Rosebush, 1998; Ward, 1996). Therefore, it is important to create an effective reparative process for the treatment of stress reactions to trauma.

Helplessness in the face of unfixable suffering is the tenet in trauma research and treatment. The goal of trauma treatment is to help clients move from helplessness in the face of unfixable suffering to agency in the face of unfixable suffering. Therapeutic enactment is a group-based treatment approach used here to help clients move from helplessness to agency. This study is designed to answer the following question: What is the effect of a group-based therapeutic enactment program on veterans who have experienced trauma?

To answer that question, this study followed a quasi-research design combining qualitative and quantitative methods with six peacekeeping and combat veterans who participated in a group treatment program for trauma with therapeutic enactment as the principle intervention. Previous program participants and program facilitators recruited the six participants via word-of-mouth. Potential participants were screened for and excluded in the face of acute and untreated PTSD. A referral list of mental health professionals was available for any potential participant who was excluded and any participant who required further therapeutic support.

For this study, the six veteran participants were interviewed individually prior to the program, after the program, and had a group-based follow-up interview. At the time of the interviews psychometric instruments were administered to measure change. The three measures include: The Trauma Symptom Inventory (TSI) (Briere, 1995), the Beck Depression Inventory-II
(BDI-II) (Beck & Steer, 1987; Beck, Steer & Brown, 1996), and the Self-Esteem Rating Scale (SERS) (Nugent & Thomas, 1993; Nugent, 1994). The interview data was interpreted following a narrative analysis and the quantitative data was analysed with descriptive statistics. The findings provide implications for future applications of the model, and future directions for research.
CHAPTER TWO: LITERATURE REVIEW

The goal of this chapter is to review the literature relevant to this study. This review includes the broad areas of trauma and group therapy. In the area of trauma, this review consists of the operational definition of trauma for this study, the psychosocial impact of trauma, and a review of some common psychotherapeutic treatment approaches for trauma. The focus for the literature review is on veterans. The area of group therapy will be addressed by presenting the group theory that will be used in this study including the role and structure of a psychotherapy group. Finally, an explanation of therapeutic enactment including some research findings is presented to identify the model for change.

While describing the important areas for this study, I will illustrate some universal features of trauma. These features are understood to apply to both military and non-military personnel. However, the focus of this present study is on former peacekeeping and combat veterans who have resigned from active service. For clarity, the terms 'veterans' and 'peacekeepers' will be used synonymously.

Defining Trauma

The complexity of trauma is demonstrative in the attempts to create a clear definition. There are as many definitions of trauma as there are trauma researchers (i.e., American Psychiatric Association, 2000; Blake, & Sonnenberg, 1998; Briere, 1996; Brooks, 1998; Carlson, & Dalenberg, 2000; Herman, 1997, Janoff-Bulman, 1992; Klein & Schermer, 2000; Morley, 2000, van der Kolk 1996; Westwood & Black, 1999). With a range of views of what trauma is, the experience of it may be placed on a continuum (Klein & Schermer, 2000). The complex
continuum suggests that, for example, two people may be exposed to the same or similar event, but only one of them may develop a reaction to the trauma (Holman & Silver, 1998).

Throughout the trauma research literature, different experiences are provided as the universal feature of a traumatic reaction. Eight elements interact with each other to explain trauma and how it occurs. Figure 1 illustrates the interaction among the elements of trauma. For an event to cause a traumatic reaction, it must meet the following six characteristics. The event must include: (a) Exposure to a negative event, (b) an overwhelming experience, (c) be situation/context-specific, (d) be stressful, (e) have a lasting physical and/or (f) psychological consequences including a past temporal orientation (APA, 2000; Blake, & Sonnenberg, 1998; Briere, 1996; Brooks, 1998; Carlson & Dalenberg, 2000; Herman, 1997, Klein & Schermer, 2000; Morley, 2000; van der Kolk 1996; Westwood & Black, 1999). The last two elements influence the degree of the reaction to the trauma: severity and coping strategies/resources (APA, 2000; Blake, & Sonnenberg, 1998; Briere, 1996; Brooks, 1998; Carlson & Dalenberg, 2000; Herman, 1997, Klein & Schermer, 2000; Morley, 2000; van der Kolk 1996; Ward, 1996; Westwood & Black, 1999).

![Figure 1 Elements of Trauma](image)
For a complete definition, all eight elements are included. Trauma is defined as a reaction to the direct or indirect exposure of a negatively overwhelming event occurring in a definable time period that is experienced as stressful and results in lasting physical and/or psychological consequences. The level of severity of the event such as threat to personal safety or threat to one's own life, and the use and availability of supportive strategies/resources leads to the degree of the trauma reaction. In short, "trauma has a pervasive impact on the psychosocial life of the victim" (Klein, & Schermer, 2000, p. 6).

As an example of an early grass-roots attempt by consumers to create a space for talking about their experiences, Vietnam veterans organised informal rap groups starting in the mid-1970's across the United States (Herman, 1997). The veterans expressed needing groups of this type which took place in their realm of experience where they were in charge. From this self-help and peer-counselling model arose the awareness of the characteristics of the trauma syndrome which became the foundation for the diagnosis: Posttraumatic Stress Disorder (APA, 2000; Herman, 1997).

Psychosocial Impact of Trauma

The effects of traumata are dependent on the intensity of the reaction and the temporal orientation of the individual exposed to the traumatic event. Klein and Schermer (2000) explain how trauma impacts people's lives in four areas. The four headings that explain the effects of trauma include: 1) PTSD symptom clusters; 2) changes in the world-view assumptions and cognitive schemata of the victim; 3) pathology of internalized object relations and the self; 4) clinical syndromes other than PTSD.
Adding to the four areas identified by Klein and Schermer, Holman and Silver (1998) explain how an individual copes with trauma based on temporal perceptions. The two perceptions include: temporal perspective and temporal orientation. Temporal perspective is the overall span of cognitive involvement across past, present and future (Holman & Silver, 1998). According to Holman and Silver (1998), temporal orientation provides organization and structure for people’s view of themselves and the world. Therefore, temporal orientation is linked dynamically to highly stressful or traumatic experiences.

Focusing predominantly on the past and sometimes on the future can have negative consequences for identity formation, self-satisfaction and personal achievement. In the struggle to integrate a traumatic event, an individual may become ‘stuck’ in the past both voluntarily and through involuntary intrusions of repetitive thought processes (Holman & Silver, 1998). As the intrusive memories and thoughts of the trauma keep the memories and thoughts of the trauma active, they may alter temporal orientation (Holman & Silver, 1998). The past temporal orientation may draw an individual into a negative cycle with rekindling negative affect which leads to an intensifying past focus. This past temporal orientation is related to ‘intrusion’ as described below.

In their study of traumatized individuals, Holman and Silver (1998) found that temporal orientation was significantly related to psychometric scores of psychological distress, $F_{\text{change}}(2,56) = 4.79, p < 0.02$. Those with a predominantly past orientation were significantly more distressed one year after the traumatic event.
PTSD clusters

As Herman (1997) explains, the universal features of PTSD clusters fall into three categories: hyperarousal, intrusion and constriction. Figure 2 reflects the interconnection among the triad of PTSD categories.

![PTSD Triad Diagram]

Hyperarousal

Herman (1997) briefly explains that hyperarousal reflects a persistent expectation of danger. The visible symptoms of this persistent expectation results in sleep difficulties, irritability, concentration difficulties, and a heightened startle response (APA, 2000; Herman, 1997; Klein, & Schermer, 2000; Ward, 1996). After a traumatic experience, hyperarousal is the permanent physiological self-preservation reaction as if danger will occur again at any moment (van der Kolk, 1996).

Intrusion

Intrusion includes the indelible imprint of the traumatic incident. This imprint becomes intrusive and includes recollections of the traumatic event, disturbing dreams, physical
sensations that feel like the event is recurring and reactivity distress occurs when exposed to physical and psychological memory cues of the event (APA, 2000; Herman, 1997; Klein, & Schermer, 2000).

The intrusive and repetitious thoughts caused by and focused on a traumatic experience create a chronic pattern of arousal (van der Kolk, 1996). Persistent intrusions from the past can draw someone into a negative cycle of pessimistic affect which intensifies the tendency to focus predominantly on the past (Holman & Silver, 1998). As a result of the intrusive and repetitious thoughts, the traumatized person is victimized by both the recurring memories of the event, and the event itself. Many people who do not suffer from PTSD but have suffered trauma, will again become distressed when they are confronted with tragedy (van der Kolk, 1996). Returning peacekeeping veterans report stress including intrusive and repetitious thoughts from their tour of duty (English, 1999; MacDonald, et al., 1998; Rosebush, 1998).

**Constriction**

Constriction reflects a numbing response, avoidance or dissociation of thoughts or feelings related to the trauma. Constriction includes attempts to avoid thoughts or feelings related to the trauma and similar or related activities; amnesia aspects of the trauma; diminished interest in previously enjoyed activities; isolation or feelings of detachment from others; constricted affect and feelings of a foreboding future (APA, 2000; Herman, 1997; Klein, & Schermer, 2000).

In his study of 117 United Nations peacekeepers returning to Australia from serving in Somalia, Ward (1996) found that after 15 months of being home, the psychiatric morbidity of the veterans was almost twice as high than the control group. He administered four measures to the veterans: the General Health Questionnaire (GHQ-28), Impact of Events Scale (IES) Combat Exposure Scale (CSE) and a checklist of PTSD symptoms. Various risk factors contributed to
the aetiology of the trauma reaction including premorbid personality, past psychiatric history, family psychiatric history, nature and intensity of stressors and social support following the event (Holman & Silver, 1998; Ward, 1996). These findings suggest trauma reported by the veterans was not caused exclusively by exposure to combat. Instead, pre-existing traumatic experiences were triggered by peacekeeping duties.

Holman and Silver (1998) suggest that previous exposure to acute or chronic trauma impacts effects of subsequent trauma. In their longitudinal study of three samples of traumatized individuals (77 adult female victims of childhood incest, 158 Vietnam War veterans and 71 residents of two Southern California communities devastated by fire) Holman and Silver suggest that past exposure to trauma influences future reactions to trauma. With the first two samples, they administered a psychometric measure (Symptom Checklist-90-R (SCL-90-R)) and conducted interviews with open-ended questions. For the third sample, a series of brief interviews was conducted. From their studies, they concluded that exposure to acute trauma may provide an inoculation effect against subsequent reactions to acute trauma, whereas previous exposure to chronic trauma may make the individual more vulnerable to acute trauma reactions (Holman & Silver, 1998). In other words, a veteran who experienced acute trauma earlier in his/her life such as the family home being burned, may be protected from experiencing a trauma reaction in the future. However, a veteran who experienced chronic trauma in the past such as ongoing child abuse, may be more susceptible to future trauma reactions. The significance of this finding is that sustaining past trauma influences the effect and impact of future traumatic events.

This difference in reaction is due to the temporal perspective. Someone who experienced acute trauma in the past may not have a past temporal perspective because the trauma s/he
experienced was a one-time event. On the other hand, someone who experienced chronic trauma in the past will remain hypervigilant because of the uncertainty of when the trauma will occur again. In this case, conscious or unconscious mechanism of constriction provides a felt-sense of relief from the fear of impending trauma (Klein & Schermer, 2000).

Extensive research has been conducted on the experience of dissociation and trauma (Dorahy, Lewis, 1998; Hegeman & Wohl, 2000; Holman and Silver, 1998; Michelson, June, Vives, Testa, & Marchione, 1998; Millora, 1998). Dissociation is a break that occurs separating someone from themselves, or from the external world (Hegeman & Wohl, 2000). It is described as a 'glitch' or a dead spot that occurs inside the self or between the person and the world and is experienced when the self is overwhelmed by terror, dread or the perception of malevolence or danger. Dissociation blocks access to verbal expression and a coherent self-experience. A dissociative episode is like a trance where a person experiences sudden numbing, a loss of feeling or a flashback of an intense experience (Hegeman & Wohl, 2000).

Hegeman and Wohl (2000) explain the continuum of dissociation. They explain that dissociation may begin as ordinary ‘spacing-out’ and lead to complex layering and compartmentalization of a multiple personality. If untreated, dissociation becomes more pronounced over time.

In their study of several groups who experienced traumatic events described above, Holman and Silver (1998) found dissociation at the time of the traumatic event was affected by past events and interfered with treatment. They found that individuals who experienced the highest degree of temporal disintegration at the time of the traumatic event were more focused on the past after six months and exhibited higher levels of distress after one year (Holman & Silver, 1998). This temporal disintegration was highest among individuals who had experienced
the most severe loss, previously experienced trauma and had their identities threatened by the current traumatic event (Holman & Silver, 1998). Supporting the ‘inoculation’ effect theory, temporal disintegration was lowest for people who previously experienced acute trauma, moderate for people who had never experienced trauma, and highest for those who experienced chronic trauma (Holman & Silver, 1998).

Some researchers see traumatic dissociation as a last-ditch defence of a desperate person (Hegeman, & Wohl, 2000). However, Briere (1996) believes defences can be called 'solutions' rather than 'disorders'. With dissociation as a defence, it is an alternative experience to being flooded by panic, painful affect and working to avoid the processing and symbolization of the traumatic pain.

**World-view changes**

A traumatic experience changes the perception of self and others. These perceptive changes create a rupture in the assumptive world beliefs of the person exposed to a traumatic event (Janoff-Bulman, 1992). Changing self-perception and the perception of others affects views of agency, connection to the world, connection to the self, and can lead to maladaptive coping mechanisms. The changed world-view following a trauma may deepen into more profound feelings of being permanently wounded and a difference in how that person represents significant others. Compartmentalization of the traumatic event helps the individual cope with trauma-induced terror, but at the same time, intra- and interpersonal difficulties may arise from splitting experiences (Klein & Schermer, 2000). Veterans returning from peacekeeping missions report intrapersonal difficulties which are likely a result of traumatic events (MacDonald, et al., 1998; Rosebush, 1998; Ward, 1996).
Prior experience with trauma may exert a negative influence on the perception of present and future experiences (Holman & Silver, 1998). The cycle created from the past temporal orientation may make it difficult to deal with demands of present life resulting in high levels of psychological stress (Holman & Silver, 1998) and functional problems such as career and relationships (Westwood & Black, 1999; Westwood, Black & McLean, 2001).

Changes In View Of Self-And-Other

In addition to the changes in the assumptive world-view, the traumatized person may experience a deeper level of harm affecting the sense of self. Feeling as if they are permanently damaged (Herman, 1997), the traumatized person experiences themselves and other differently. Self-view may become ‘deformed’ including freezing developmentally at the point of the trauma (Carlson & Dalenberg, 2000). Deformation and developmental difficulties are accompanied by physiological changes to the limbic system which is the centre of emotions (van der Kolk, 1996). An example of a measurable physical change is that the hypothalamus has been identified as shrinking following exposure to a traumatic event (van der Kolk, 1996). The hypothalamus aids in regulating and storing memories. The combined effect of changes in the sense of self and physiological changes may result in genuine cognitive and affective deficits that impact a person's ability to process and express thoughts and feelings. As a result, a returning veteran may experience memory and concentration difficulties (English, 1999) which would make it challenging to maintain a job and reintegrate into civilian society.

Clinical Syndromes Other Than PTSD

Individuals who experienced a traumatic event frequently present with a psychological disturbance (Klein & Schermer, 2000). It is sometimes unclear if the disturbance was caused by
the trauma, or just present coincidentally. Van der Kolk (1996) illustrated that a traumatic experience leads to biochemical alterations that may cause characteristic changes such as major depressive disorder, bipolar disorders, or panic disorders. On a cognitive and social level, the changes in the assumptive world resulting from trauma can be elaborated into cognitive interference and distortions, and maladaptive schema that characterize depressive or avoidant and anxiety-based patterns typical of issues such as agoraphobia (Klein & Schermer, 2000).

Coping with the psychological and physiological changes that accompany a traumatic event becomes the focus. To cope with mood alterations resulting from trauma, an individual may turn to compulsive overeating, gambling, substance use, or sexual acting out (Klein & Schermer, 2000). Alcohol or drug use to anaesthetize the pain of trauma may escalate into substance abuse. Compounding the challenges for an individual who experienced a traumatic event, the coping mechanisms and psychological disturbances may interfere with other parts of the individual's life. Familial, and career relationships become affected and strained by the aftermath of trauma.

From this overview of the symptoms of trauma we better understand the challenges and struggles of someone who experienced trauma. Building on this understanding, we move into the treatment of trauma.

General Psychotherapeutic Treatment Approaches

Herman (1997) explained that emotional attachments among fighting men are important for treatment. Arguably the degree of cohesion among a regiment is the strongest protection against overwhelming terror. Even further, constant danger leads soldiers to develop extreme emotional dependency upon their regiment and commanders. It was believed that this emotional bond was sufficient for recovery from combat neurosis, therefore the early treatment of combat
neurosis included isolation from the regiment, shaming, threats and punishment (English, 1999; Herman, 1997).

Studies of trauma repair for hysteria began by focusing on hypnosis and the 'talking cure'. Pharmacological and non-pharmacological hypnosis was used to retrieve memories, but resulted in a simple cathartic experience (Herman, 1997). Using talking as the treatment modality for both hysteria and combat neurosis, it was quickly discovered that unburdening traumatic memories was insufficient to affect a lasting cure (Herman, 1997; Klein & Schermer, 2000). Because trauma is encoded differently and often at a nonverbal level, traumatic experiences need to be retrieved differently- to be lived through, not talked through (Hegeman & Wohl, 2000). If the trauma is not reexperienced or relived, the individual and the therapist is left to adopt an intellectualizing perspective from which to view, apprise, and evaluate the trauma and its impact (Blake, & Sonnenberg, 1998). Therefore merely retrieving memories and relating them verbally does not facilitate integration of those memories into consciousness and resolution of the negative impact of the traumatic event and memories. Re-living the trauma in a therapeutic setting best facilitates integration and resolution of the negative impact of the trauma (Morley, 2000; van der Kolk, 1996).

Trauma treatment evolved into not only retelling the trauma story, but re-living of the story including the emotions the veteran experienced such as terror, rage and grief (Blake, & Sonnenberg, 1998; Herman, 1997; Klein & Schermer, 2000). This re-living and re-experiencing the trauma allowed the memories to be spoken, the impact diffused and the experience integrated. Treatment of trauma includes not only the traumatic experience, but other variables that impact or moderate outcome. Using a cognitive-behavioural paradigm, Follette, Ruzek, and Abeug (1998), for example, stress the importance of situating symptomatic thoughts, feelings,
and behaviours in the client’s interpersonal and environmental contexts, instead of focusing on trauma history alone or viewing clients through a lens of individual dysfunction.

Multiple approaches to psychotherapeutic treatment of trauma have been researched and documented (i.e.: Blake & Sonnenberg, 1998; Briere, 1996; Brooks, 1998; Follette, Ruzek, & Abeug, 1998; Foy, Glynn, Schnurr, Janowski, Wattenberg, Weiss, Marmar, & Gusman, 2000; Herman, 1997; Klein & Schermer, 2000; Morley, 2000; Rothbaum, Meadows, Resick, & Foy, 2000; van der Kolk, 1996; Westwood, & Black, 1999; Westwood, Black, & MacLean, 2002). Blake and Sonnenberg (1998) report on the outcome of behavioural treatment of trauma. Later I explain some of the research on therapeutic enactment treatment for trauma but here I focus on treatment other than therapeutic enactment.

Blake and Sonnenberg (1998) explain the use of systematic desensitization, implosive therapy, flooding, and eye movement desensitization and reprocessing (EMDR) for treatment of trauma. They report that most of the research using behavioural therapy for trauma survivors involve case studies or single-subject designs (Blake, & Sonnenberg, 1998). Focusing on group-based treatment with rigorously controlled research methods, they identified nine different studies using forms of behavioural treatment of trauma. The target populations were homogenous for the most part; of the nine, seven focused on Vietnam combat veterans. The participants included both inpatient and outpatient groups with session conducted up to 48 times.

The conclusions drawn from the nine studies generally support the use of systematic desensitization, flooding, EMDR, and implosive therapy for treatment for trauma (Blake, & Sonnenberg, 1998). However, from the research conducted, it is clear behavioural therapy is not the panacea treatment of trauma because it does not resolve other intrapsychic variables that are
affected by trauma (Follette, Ruzek, & Abeug, 1998). Behavioural therapies are helpful with reducing the symptoms of trauma; however, there are limitations.

The prime limitation of most behavioural therapies is the direction of the change process. Specifically, behaviour analysts traditionally direct attention to external influences on behaviour (Follette, Ruzek, & Abeug, 1998) rather than the internal experience of that behaviour. To successfully treat an individual who experienced trauma, the subjective experience of the trauma that creates ‘fear structures’ (Foa, Rothbaum, & Steketee, 1993) or fear schemas and other attitudinal ‘stuck points’ (Resick & Schnicke, 1993) are explored while working to a resolution.

Behavioural therapies sometimes require a significant effort to conduct the treatment. Systematic desensitization and exposure therapies may require extensive time and resources to conduct. The effort required to implement some behavioural treatments other limitations are clear. Although the PTSD symptoms of reexperiencing and hyperarousal were reduced by exposure-based treatment, avoidance and numbing were not resolved (Blake & Sonnenberg, 1998). Moreover, exposure-based treatments may upset the participants who revivify their trauma, and require a lengthy treatment regime (Blake, & Sonnenberg, 1998).

Rothbaum, Meadows, Resick, and Foy (2000) conducted a meta-analysis of cognitive-behavioural therapy methods to treat trauma reactions from a variety of populations. Aside from their thorough review of the literature, a defining feature of their survey are the seven items they used to rate the studies they examined. The seven “gold standards” Rothbaum, et al. (2000) used as a rating system include:

1. Clearly defined target system
2. Reliable and valid measures
3. Blind evaluators
4. Assessor training
5. Manualized, replicable, specific treatment programs
6. Unbiased (random) assignment to treatment
7. Treatment adherence.

Reflected here are the studies they examined which have veterans as the participant population. Figure 3 below is a reproduction of their findings (Rothbaum, et al., 2000, p. 68-73).

The legend at the bottom of the table above provides the translation for the treatments, standards, rating and effect sizes. Of the studies reviewed, they all demonstrated some PTSD symptom reduction by the participants as measured by psychometric measures. Only some of the measures used in the studies are reported by Rothbaum, et al. (2000). Half the studies were designed with a control group for comparison. Only one of the studies met the standard of blind evaluators.
### Cognitive-Behavioural Therapy Treatment Studies of PTSD

<table>
<thead>
<tr>
<th>Study</th>
<th>Treatments a</th>
<th>Population/n</th>
<th>No./duration of sessions</th>
<th>Results</th>
<th>Standards met b</th>
<th>Rating c</th>
<th>Effect sizes d</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bowen &amp; Lambert (1986)</td>
<td>1. SD</td>
<td>Combat veterans, 10</td>
<td>Large no of sessions, over long time</td>
<td>SD showed significant decrease at posttreatment relative to no treatment</td>
<td>C</td>
<td></td>
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<tr>
<td></td>
<td>2. No tx</td>
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<tr>
<td>Cooper &amp; Clum (1989)</td>
<td>1. Standard tx</td>
<td>Vietnam veterans, 26 (16 completers, results are from 14)</td>
<td>Imaginal flooding, 6-14 sessions; 90 min ea.</td>
<td>ST + EX showed significant improvements over ST only on self-report symptoms directly related to the trauma, state anxiety, subjective anxiety in response to trauma stimuli, and sleep.</td>
<td>1, 5, 6</td>
<td>A</td>
<td>EX: 2.15 (reported SUDS during BAT)</td>
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<td></td>
<td>2. Standard tx + EX</td>
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<tr>
<td>Fruhauf, Turner, Beidei, Mirabella, &amp; Jones (1996)</td>
<td>1. EX</td>
<td>Vietnam combat veterans, 15 males</td>
<td>29 sessions over 17 wk, 90 min ea.</td>
<td>Treatment reduced anxiety.</td>
<td>1, 2, 3, 5, 7</td>
<td>B</td>
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<tr>
<td>Hyer, Woods, Bruno, &amp; Boudewyns (1989)</td>
<td>1. SD</td>
<td>50 Vietnam veterans with chronic PTSD, 17 wk</td>
<td>Stable personality measure improvement not seen.</td>
<td>1, 2, 4</td>
<td>B</td>
<td></td>
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<tr>
<td>Keane, Fairbank, Caddell, &amp; Zimering (1989)</td>
<td>1. EX</td>
<td>Vietnam veterans, 24</td>
<td>14-16 sessions; 45 per 90 min</td>
<td>EX showed significant improvement at posttreatment and 6-mo follow-up over WL on PTSD reexperiencing symptoms, depression, anxiety, also, therapist ratings of startle memory concentration, impulsivity, irritability, and legal problems all lower than WL.</td>
<td>1, 2, 4, 5, 6</td>
<td>A</td>
<td>EX: 0.22 (MMPI-PTSD scale)</td>
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<td></td>
<td>2. WL</td>
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<tr>
<td>Peniston &amp; Kulkosky (1991)</td>
<td>1. SD/BIO (brain-wave neurofeedback tx)</td>
<td>Vietnam veterans with PTSD, 29</td>
<td>30 sessions</td>
<td>SD/BIO resulted in a decrease in MMPI clinical scales. The traditional medical tx group showed decreases only in the schizophrenia scale. At 3-mo follow-up all traditional tx subjects relapsed, and 3 of 15 brain-wave neurofeedback subjects relapsed.</td>
<td>1, 2, 5, 6</td>
<td>A</td>
<td>SD/BIO: 2.50 (on MMPI-PTSD Scale, relative to traditional medical therapy)</td>
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<td></td>
<td>2. Traditional medical tx group</td>
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<tr>
<td>Peniston (1986)</td>
<td>1. SD/BIO</td>
<td>Veterans, 16</td>
<td>Large no. over long period of time</td>
<td>SD/BIO showed significant decrease at posttreatment relative to no treatment on nightmares, flashbacks, muscle tension, and hospital readmissions.</td>
<td>1, 5, 6</td>
<td>B</td>
<td></td>
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<tr>
<td></td>
<td>2. No tx</td>
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<tr>
<td>Pitman, Orr, Altman, Longpre, Poire, Macklin, Michaelis, &amp; Stakete (1996)</td>
<td>1. EX</td>
<td>Vietnam veterans with PTSD, 20</td>
<td>Average of 10.2 (6 sessions for 5 subjects, 12 sessions for 14 subjects)</td>
<td>Evidence of emotional processing, but only 13% overall decrease on measures; 20% reduction in intrusive combat memories on self-monitoring.</td>
<td>C</td>
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<tr>
<td>Silver, Brooks, &amp; Obenchain (1995)</td>
<td>1. Milieu + BIO</td>
<td>Veterans, 100</td>
<td>Large no. over long period of time</td>
<td>Neither BIO nor Relax showed any significant differences relative to the control group.</td>
<td>1, 5, 6</td>
<td>A</td>
<td>BIO: 0.14 (intrusive thoughts question on Problem Report Form)</td>
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<td></td>
<td>2. Milieu + EMDR</td>
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<td></td>
<td>3. Milieu + Relax</td>
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<td></td>
<td>4. Milieu (control)</td>
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<tr>
<td>Watson, Tuccia, Vickers, Gearhart, &amp; Mendez (1997)</td>
<td>1. Relax</td>
<td>Vietnam veterans, 90</td>
<td>10 sessions; 30 min ea.</td>
<td>All groups showed only mild improvement on only a few measures - no differences between groups</td>
<td>1, 2, 5, 6</td>
<td>A</td>
<td>Relax/BRT: -0.18 (on PTSD-4, relative to Relax only)</td>
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<tr>
<td></td>
<td>2. Relax + breathing</td>
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<tr>
<td></td>
<td>3. Relax + breathing + BIO</td>
<td></td>
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</tbody>
</table>

*AT, assertiveness training; BIO, biofeedback; CPT, cognitive processing therapy; CT, cognitive therapy; EX, exposure; IMF, imaginal flooding; IPF, in vivo flooding; PE, prolonged exposure; RT, relaxation; SD, systematic desensitization; ST, stress inoculation training; WL, wait-list; bx, treatment; ST, standard treatment.

1. Gold standards listed are based on what was in paper; only explicitly stated items are included here. 1. clear target symptoms; 2. reliable, valid measures; 3. blind evaluations; 4. assessor training; 5. manualized specific tx; 6. unbiased assignment to tx; 7. adherence.

2. Study type codes: A, randomized controlled studies; B, well-designed studies without randomization or placebo comparison; C, service/naturalistic studies combined with clinical observations.

3. ES in bold indicates that control was comparison, not WL, group. Items in parentheses refer to the main PTSD measure used, with which effect sizes were calculated.
Group Treatment Approaches with Veterans

Too many studies of the treatment of trauma with veterans have been previously conducted to cite them all. Due to the large number of studies with a diverse range of approaches, I am limiting this review. I will begin by examining the meta-analyses of outcome research on group-based treatment with veterans by Foy, Glynn, Schnurr, Janowski, Wattenberg, Weiss, Marmar, and Gusman (2000). Beyond the meta-analyses, I limit my focus of individual studies to methods using group-based psychodrama or similar action-oriented approaches with veterans (i.e. Fantel, 1948; Fantel, 1951; Fantel, 1969; Johnson, Feldman, Lubin, & Southwich, 1995; Ragsdale, Cox, Finn, & Eisler, 1996; Scaturo, & Hardoby, 1988;).

Fantel (1948, 1951, 1969) explained how he used traditional psychodrama with World War II (WWII) veterans. For these treatment models, Fantel explained that no pre-set script was discussed with the client or any of the other participants. Instead, pursuant to traditional psychodrama the script developed as the scene progressed (Brooks, 1998). The following is a summary of the findings as explained by Fantel:

1. Psychodrama was a useful method of 'clearing' a client in a comparatively short time.
2. Scenes guided and selected identified underlying personality problems of the client.
3. Psychodrama clarified the client’s mysterious feelings from which inferiority stemmed.
4. Psychodrama help build the client’s ego.
5. Psychodrama was a means of getting things off the clients’ chest.
6. Demonstrated courage through the psychodrama.
7. Careful coaching to avoid stuttering of the client.
8. Psychodrama served to bring into awareness the client’s own emotional development.
9. Repetition of the scenes allowed the clients to better understand the cause of the fears.
10. Rehearsal of future scenes helps minimize relapse.
11. Psychodrama was demonstrated to be a practicable method for handling “war neuroses” (Fantel, 1951).
The conclusions Fantel drew from his use of psychodrama as a treatment suggest that this approach is efficient to “help patients make proper revaluations of their attitudes” (Fantel, 1948, p. 64). From his case studies, the specific changes the clients made are unclear.

Scaturo & Hardoby (1988) reviewed literature from individual, group and family treatment with Vietnam veterans. They identified several symptoms as experienced by the veterans including: emotional numbing, social withdrawal, uncontrollable rage reactions, startle responses, violent nightmares, and interpersonal relationship problems. Based on their review of the literature, a homogeneous group of veterans facilitated an ‘in-group’ identity that was most effective for resolving the trauma reactions they listed, however, they did not explore treatment paradigms.

Johnson, Feldman, Lubin, and Southwich (1995) report on their use of ritual and ceremony with their inpatient program for veterans who suffer with PTSD. They operate a 27-bed unit that admits veterans in groups of fourteen for four months. The ceremonies they describe follow five stages: (a) opening the ceremony (departure), (b) family night ceremony (forgiveness), (c) the crossing over ceremony (return), and (d) ceremony for the dead (survival). Each stage has a scripted procedure that involves support staff, veterans and their families. Below I briefly describe the stages.

The purpose of ‘opening the ceremony’ is to acknowledge the veteran’s separation and departure from family and friends, and their return. This is done by the families and veterans symbolically re-enacting the veterans’ original departure by the use of a pre-written script read by the staff, veterans and families. The family night ceremony provides the veteran and family the opportunity to write a letter to each other. This stage assumes there was abuse or a lack of contact between the members and provides the opportunity for each to ask for forgiveness. The
crossing over ceremony marks the end of the program and dramatises the transformed veteran returning to the family. This is when the veterans are reunited with their families one-by-one in a large room. Ceremony for the dead provides the veteran with the opportunity to use a healing metaphor of mourning for the ‘buddies’ they lost. This last stage includes a collective visit to the Vietnam War memorial near the treatment centre. In their analysis of the helpfulness of the rituals, veterans, families and staff ranked rituals at the top on a 5-point Likert scale (100% of family members, 92% of veterans, and 87% of staff) (Johnson, et al., 1995).

Ragsdale, Cox, Finn, and Eisler, (1996) administered psychological tests to 48 veterans regarding war-related PTSD. Twenty-four received treatment immediately, the other 24 were on the waiting list. The psychometric instruments administered to measure change include: Beck Hopelessness Scale, Internalized Shame Scale, Revised UCLA Loneliness Scale, Fundamental Interpersonal Relations Orientation-Behaviour, State-Trait Anger Scale, State-Trait Anxiety Inventory, Mississippi Scale for Combat-Related Post-Traumatic Stress Disorder, and Exposure to Combat Scale (Ragsdale, et al., 1996). The experimental group participated in a 26-day treatment program. The participants engaged in out-door adventure-base activities that require group trust and group problem-solving. The use of traditional psychodrama begins on day four of the program. The results demonstrate a comparative improvement in PTSD symptoms as measured by post-test administration of the psychometric measures when compared to the control (wait list) group.

Foy, et al. (2000) conducted a thorough literature review for group-based treatment of PTSD. Included here is the only study they discovered that is group-based with veterans as the treatment group. Figure 4 below is a reproduction of the table Foy, et al. (2000, p. 161) used to reflect their findings.
Studies of Group Psychotherapy for Trauma Survivors: Cognitive-Behavioral, Psychodynamic, and Supportive Types

<table>
<thead>
<tr>
<th>Study (type)</th>
<th>Treatment group (% of enrolled)</th>
<th>Comparison group (% of enrolled)</th>
<th>No. of sessions/ group sizes</th>
<th>Population</th>
<th>Major findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frueh, Turner, Beidel, Mirabella, &amp; Jones (1996) (cognitive-behavioral)</td>
<td>11 social and emotional rehabilitation (group component of trauma management therapy) (73%)</td>
<td>10 weekly and biweekly / 2-5</td>
<td>Male Vietnam combat veterans</td>
<td>Relative to midtreatment scores (when treatment switched from individual to group), posttest scores improved in clinical global impressions, anxiety, and social activities.</td>
<td></td>
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</tbody>
</table>

**Figure 4 Group-based PTSD Treatment with Veterans**

The study cited is not a ‘pure’ group approach because the participants started in individual treatment and moved into group treatment midway through. The findings of this cognitive-behavioral group-based treatment indicate improvements from on PTSD symptoms based on the administration of the Clinician Administered PTSD Scale (CAPS) (as cited in Foy, et al., 2000). No comparison group was used.

**Group Theory**

Several clinicians and researchers consider group psychotherapy the treatment of choice for trauma (Goodman & Weis, 2000; Herman, 1997; Koller, Marmar, & Kanas, 1992; Morley, 2000; van der Kolk, 1993; Westwood, & Black, 1999; Westwood, Black, & McLean, 2001). However, the structure and type of treatment within that group is as different as the number of practitioners. A group facilitator who uses cognitive-behavioral theory to inform the group process, focuses on changing negative behaviours and on the teaching and practicing of new skills. A psychodynamic group approach stresses insight and promotes adaptive coping through developing a conscious understanding and resolution of trauma-related conflict (Lindy, 1993). 'Rap groups' originating in the 1970's were originally developed to provide Vietnam veterans a forum to discuss their war experience in a peer group without an authoritarian leader (Herman, 1997; Scarfield, Corker, Gongla, & Hough, 1984). More recent groups have the explicit goal of examining the trauma and reconstructing the history of what happened (Rozynko & Dondershine, 1991). Westwood and Black (1999) describe therapeutic enactment as a group-
based therapeutic intervention that focuses on the participants' acting out critical incidents from their past, present, or future. The goal of re-enacting the traumatic event is to experience it differently (Westwood, Black, & MacLean, 2002).

Goodman and Weiss (2000) list the five circumstances when referral to trauma group treatment is indicated:

1. Trauma work threatens to overwhelm the original focus of individual treatment;
2. The client desires more in-depth trauma-focused experience;
3. The client wishes for a more complete memory of the traumatic event;
4. The client needs to combat the social isolation, feelings of shame and self-deprecation associated with the trauma; and
5. The client needs to mend disrupted interpersonal relations stemming from a traumatic incident.

Goodman and Weiss (2000) propose a three-stage process where each stage is a different group. The stages they propose include: (a) crisis-originated group; (b) short-term trauma-focused group; and (c) relationship-focused group, not specifically targeted to trauma.

The first stage of this treatment is a crisis-originated group. The goal of this stage is establishing safety and self-care, encouraging discussion, and providing a cognitive framework for each client's traumatic event (Goodman & Weiss, 2000). Psychoeducational and cognitive-behavioural approaches are often applied (Stein & Eisen, 1996) to help reduce the crisis.

Stage two is a time-limited group (they propose a three-month group) with a trauma-focused intervention. For them, this second stage occurs with a homogeneous group with 12-18 members (Goodman & Weiss, 2000). The goal of this stage is to create a narrative of each individual's traumatic event, by remembering the trauma and beginning to experience the
feelings associated with the trauma. In order to remember and share the trauma narrative, group safety and a supportive environment is given a high priority.

Finally, the focus for stage three is interpersonal factors. This stage occurs over a long term and is not specifically trauma focused. Instead this stage is a general psychotherapy group treatment to help improve interpersonal relationships with the participants of the group (Goodman & Weiss, 2000).

For this present study, all three stages of Goodman and Weiss' model are demonstrated in a single time-limited group. It is at stage two that the therapeutic enactments were conducted. With a cohort group of peacekeeping and combat veterans over a limited time, the therapeutic enactments were the trauma-focused intervention. The model of the therapeutic group that is conducted for this study follows a combination of Goodman and Weiss’ (2000) and Herman’s (1997) tri-phasic model as explained below.

Herman (1997) proposes a similar three-stage group process to Goodman and Weiss’ model, but instead of three different groups, she suggests all three stages occur within one group. Herman's stages of trauma recovery include: (a) safety, (b) remembrance and mourning, and (c) reconnection. Establishing safety includes creating a relationship where the traumatized individual can trust and feel safe. Remembrance and mourning is the retelling of the trauma story and grieving the losses resulting from the trauma. Finally, reconnection is a conscious integration of the trauma story into the individual's life. These stages apply equally to a male combat veteran as they do to a female survivor of sexual assault. The universal applicability of the repair process is not surprising considering the predictable psychological harm trauma inflicts (Morley, 2000).
The therapeutic enactment group is based on the assumptions outlined by Herman (Westwood & Black, 1999). Herman emphasizes telling and retelling the story of the traumatic event but therapeutic enactment is more than a verbal retelling; it is a retelling through doing.

Role Of Group

The following is a list of some of the positive aspects of group treatment:

- Cost effective and time effective,
- Can diffuse transference away from an individual,
- Provides social support,
- Facilitates development of interpersonal skills,
- Provides an opportunity for new information such as coping skills and self-expectations,
- Peer feedback may be easier than feedback from a therapist,
- Mutual identification and mirroring of other group members, and
- Group process and dynamics allows insight into interpersonal processes that is not possible from individual treatment (Klein & Schermer, 2000).

Perhaps most importantly, a group treatment program provides a community where an otherwise isolated individual may return and feel safe (Goodman & Weiss, 2000; Herman, 1997; Klein & Schermer, 2000; Morley, 2000; Ragsdale, et al., 1996; Westwood & Black, 1999).

Group work may not feel good initially to the traumatized person. The symptoms of trauma may worsen before improving after joining a therapeutic group. This worsening is attributed to the isolation the traumatized person initiated to protect him/herself (Carlson, & Dalenberg, 2000; English, 1999; Herman, 1997; Ward, 1996). Prior to a therapeutic group, the traumatized person may have survived in isolation (Briere, 1996) and come to treatment with fear and trepidation of being hurt or betrayed (Hegeman & Wohl, 2000). Hurting and betrayal are the results of assumptive beliefs of the world being shattered by the traumatic event (Janoff-Bulman, 1992).
The group, in group therapy, plays an important role, especially for trauma-focused groups because trauma fragments people and their ability to connect with others (Herman, 1997; Morley, 2000; Rosebush, 1998; Yalom, 1995). Recovering from trauma includes reconnecting with others. This can be best accomplished in a group format. Herman (1997) explains,

The solidarity of a group provides the strongest antidote to traumatic experience. Trauma isolates; the group re-creates a sense of belonging. Trauma shames and stigmatizes; the group bears witness and affirms. Trauma degrades the victim; the group exalts her. Trauma dehumanizes the victim, the group restores her humanity (p. 214).

The group serves the purpose of restoring social bonds and facilitating the discovery that one is not alone (Morley, 2000). Groups provide support and empathy, with the goal of developing an observing ego, the ability to help others, and important feedback (Courtois, 1988; Yalom, 1995). The distinctive feature of a group is the validation of an individual's construction of their own narrative of the traumatic event.

An even better formulation is a cohort group consisting of others who have had a similar experience. In this case, the validation from the group is from others who have had a similar experience leaving the individual with the feeling that s/he is not alone (Goodman & Weiss, 2000; Herman, 1997). A common defining element is important; traumatized people feel more connected to others who have shared a similar experience but it need not be identical (Goodman & Weiss, 2000). As an example here, Herman (1997) explained that emotional attachments among fighting men are important for treatment.

Among his eleven "therapeutic factors," Yalom (1995) lists several that relate to the creation of social bonds as explained by Herman. Yalom's list of eleven primary factors of the therapeutic experience includes: hope, universality, imparting of information, altruism, recapitulation of the primary family group, development of socializing techniques, imitative
behaviour, interpersonal learning, group cohesiveness, catharsis, and existential factors. Because they operate interdependently, group process and success relies on the presence of the factors as the mechanisms and conditions for change. Therefore, the group is the community, container, witness and participant in each individual's therapeutic change process.

When working with a group of people who have experienced trauma, several factors, some specific to trauma groups, must be considered. The six factors listed here as issues to consider and be aware of when working with trauma-focused groups include: well established group rules, appropriate pacing of disclosure, minimizing dissociative behaviours, confronting acting-out behaviours, discouraging overidentification with being victims, and termination. The group rules and pacing of disclosure are to ensure safety, which is the first step of trauma groups (Herman, 1997). Minimizing dissociative behaviours, and confronting acting-out behaviours deals with the constrictive and intrusive behaviours that are indicative of trauma reactions (Dorahy, Lewis, 1998; Herman, 1997; Holman and Silver, 1998; Michelson, June, Vives, Testa, & Marchione, 1998; Miliora, 1998). Discouraging overidentification with being victims of trauma helps with reconnection to the community and integration of the traumatic experience (Herman, 1997).

Termination, the final stage, is difficult for any group. However, termination with a trauma group is especially important and must be done with particular awareness. As with any group, termination includes a reflection and integration of learning that resulted from the therapy (Borgen, Pollard, Amundson, and Westwood, 1989). For a trauma group, that reflection and integration is even more important because it includes the integration of the traumatic event (Herman, 1997).
Structure of group

When creating a group for people who have experienced trauma, the structure of the group is of paramount importance. Creating and maintaining the safety required for repair requires a clear structure. Goodman and Weiss (2000) explain parameters of psychotherapy groups. They identify the following features that must be considered: time frame, open or closed group, homogeneity or heterogeneity, group size, amount of structure in process, co-therapist, screening participants.

Time frame

For a safe and cohesive group a time-limited process is best. Time-limited groups are usually more structured and supportive. Open-ended groups are good for later stages and higher functioning groups where managing safety is not as important because individual group members can create safety for themselves.

The actual length of a short-term group depends on the goals and objectives of the group. Goodman & Weiss (2000) suggest that most time-limited stage 1 and 2 groups range from 10 weeks to 6 months in duration. The group for this study lasted less than 10 weeks to accommodate the participants.

Open vs. closed enrolment

For a trauma-focused group, a closed structure is best because it allows for cohesion and fewer disruptions throughout the program. For short-term groups where safety is important, open-enrolment can cause difficulty in managing safety. Because a closed group will not allow members to join once it has started, the group requires sufficient numbers in case of high attrition. The group for this study was closed (Westwood & Black, 1999).
**Group Size**

Differing from Goodman and Weiss (2000), Yalom (1995) suggests 8 members is the optimum number for effective group work. With a group larger than 10, safety becomes difficult to manage. For this study, the therapeutic enactment group comprised 6 participants (Westwood & Black, 1999).

**Homogeneous vs. heterogeneous composition**

The guiding principle is that earlier-stage groups are often more successful when they are composed of only traumatized individuals to facilitate bonding. In later-stage groups, heterogeneous groups are indicated to challenge overidentification with victim status and to fully integrate the traumatic experience to everyday living. For this present study, the group was comprised of a homogeneous group of military veterans. A heterogeneous group may be considered at a later time.

**Degree of Structure in Format**

The degree of structure in the format of the group depends largely on the theoretical orientation of the facilitator(s). Following Goodman and Weiss' (2000) group model, early stage groups are more structured to better manage and facilitate safety and trust. For this present study, the group had a clear outline of group activities as can be seen in Appendix B. Westwood and Black (1999) list five structured activities for the group participants. The activities include: introductions, interpersonal communication skills "basic training," a training exercise of sharing personal disclosures, a themed assignment, and therapeutic enactments that emerge from the themed assignment.
Use of Co-facilitation

To most effectively manage the group dynamics and facilitate the therapeutic enactment, co-facilitation is encouraged. For the purpose of this study, the group was co-facilitated by professionally trained group leaders and a peer support person with one doctoral level psychologist assisting through clinical supervision.

Screening

Because the presenting problems of some people are inappropriate for a particular group, screening the participants before the group is encouraged. For a trauma group, it would be difficult to have group members with acute and untreated PTSD. Once they received treatment for the acute symptoms, then they would benefit from a trauma-focused group. For this study, all participants were interviewed prior to beginning the group. Any potential group member with untreated PTSD was excluded from the group and referred for focussed treatment.

Therapeutic Enactment

To repair trauma, it is not fully curative just to tell the traumatic story (Blake & Sonnenberg, 1998; Herman, 1997; Hegeman, & Wohl, 2000; Morley, 2000; Tyson, & Goodman, 1996; van der Kolk, 1996; Westwood, Black, & MacLean, 2002). Instead of talk therapy, re-enacting the traumatic event is sometimes the only way to access the physical memories from trauma (van der Kolk, 1996). Tyson and Goodman (1996) explain, "reenactment is unconscious reexperiencing and behavioural re-creating of past events" (p536).

Therapeutic enactment is one method of repairing trauma that facilitates accessing all the memories associated with trauma, including physical. In this study, therapeutic enactment counselling interventions are used to identify critical incidents and facilitate the resolution of
stress-related reactions soldiers experienced sometimes during military missions (Westwood, Black, & MacLean, 2002). Briefly, therapeutic enactment involves a single individual, the lead client, who acts out a critical scene from his/her life, in a group setting.

By focusing on the past, people constantly reexperience a potentially painful and distressing event in their lives (Holman & Silver, 1998). While treating the trauma, dissociated memories are being returned to awareness and the re-enacted information means something to the lead client who must interpret it (Hegeman & Wohl, 2000). Therapeutic enactment helps bring the lead client to the present while re-experiencing and integrating the traumatic event of the past (Morley, 2000). Construction of an enactment narrative is helpful because traumatic memories return as sensory perceptions or as affective states even after verbal narrative has been formed (Hegeman & Wohl, 2000).

With verbal therapy, some traumatic memories cannot be accessed. Symptoms such as flashbacks may diminish over time but do not go away by verbal therapy (van der Kolk 1996). Action is required to access trauma memories and experiences.

Therapeutic enactment is a multi-modal, group-based change process. As an action therapy, it is used to repair trauma and other life struggles. Therapeutic enactment is distinct from earlier forms of psychodrama (Brooks, 1998). Adapted from Westwood, Black & MacLean (2002), figure 5 reflects the areas of an individual’s life addressed by therapeutic enactment. Therapeutic enactment is informed by multiple therapeutic systems. The systems include the following:

- Social Learning
- Interpersonal Communication
- Group Theory in Therapy
- Attachment Theory
- Psychodrama
- Narrative Theory and Action
Psychodrama was formalized by Jacob Moreno in the 1920's. A concise definition of psychodrama is impossible because of the diverse approaches and techniques. Kellerman (1987) has offered a comprehensive definition of psychodrama:

Psychodrama is a method of psychotherapy in which clients are encouraged to continue and complete their actions through dramatization, role-playing, and dramatic self-presentation. Both verbal and non-verbal communications are utilized. A number of scenes are enacted, depicting, for example, memories of specific happening in the past, unfinished situations, inner dramas, fantasies, dreams, preparations for future risk taking situations, or simply unrehearsed expressions of mental states in the here and now. These scenes approximate real-life situations or are externalizations of mental processes from within. If required,
other parts may be taken by group members or by inanimate objects. Many techniques are employed, such as role reversal, doubling, mirroring, concretizing, maximizing, and soliloquy. Usually, the phases of warm up, action, working through, closure, and sharing can be identified.

A prime difference between therapeutic enactment and classical psychodrama is in the scripting of the enactment. Therapeutic enactments are carefully planned and scripted, and not spontaneous as in classical psychodrama. With therapeutic enactments, there is little reliance on spontaneity, especially in enactments conducted to repair trauma (Morley, 2000).

Therapeutic Enactment Process

The three phases of therapeutic enactment identified in previous research include: warm-up, action and integration (Brooks, 1998; Morley, 2000; Westwood, & Black, 1999;). Those phases have been modified to a five-stage model for change (Westwood, Black, & MacLean, 2002). The five stages include: assessment and preparation, group building, enactment, group processing, integration and transfer (Westwood, Black & McLean, 2002). Twenty-one steps occur through the five stages. Figure 6 details the 21 steps through the five-stage model as described by Westwood, Black and MacLean (2002).
Figure 6 Phases of Therapeutic Enactment
Therapeutic enactments begin with an assessment phase followed by group-building to create an atmosphere of safety and trust (Morley, 2000), while building group cohesion (Borgen, Pollard, Amundson, and Westwood, 1989; Corey, 1982). An atmosphere of safety is essential for flow, genuineness, and a sharing and processing of the experience to occur in the absence of fear of judgment. Often the therapeutic enactment facilitator will begin by leading participant introductions or a time of brief group sharing. Information may be provided about the therapeutic enactment process and norms for the group are also established (Corey, 1982; Yalom, 1995). The intent of this phase is to create an atmosphere conducive to participation, and mutual support.

The enactment phase occurs when a lead client has been chosen from the group to complete the therapeutic enactment. Genuineness through spontaneity of experience and emotion increases as the enactment moves through the pre-established scene to a point of catharsis.

Blatner (1985) divides catharsis into four types: abreaction, integration, inclusion, and spiritual. Abreaction includes both the release of emotion and the awareness of experiencing new or dissociated feelings. Integration occurs when the lead client adopts and recognizes the scene from someone else's perspective or recognizes their own experience from a different perspective. Inclusion comes from the positive feelings when the lead client feels accepted and validated from the group. Finally, spiritual catharsis is a sense of integration with the cosmos.

The fourth phase involves the witness group sharing their experiences from the enactment phase with the lead client and each other. The purpose of the focused sharing is integration and consolidation by means of group process. Through sharing their experiences the group members and the lead client have the opportunity to integrate the experience of the enactment while
consolidating feelings, cognitions and meaning around the enactment. Sharing their genuine experiences, the group provides validation to the lead client.

The final stage, integration and transfer, occurs both within the group and outside the group. This stage is similar to Herman’s final stage of reconnection when the trauma is integrated and no longer causes feelings of helplessness.

Therapeutic Enactment Research Findings

Studies conducted at the University of British Columbia (i.e.: Baum, 1994; Brooks, 1998; Buell, 1995; Gilbert, 1992; Keats, 2000; Martens, 1991; Morley 2000) provide the most relevant research on therapeutic enactment. These studies form a unified and consistent body of literature with many overlapping qualities. Each study was based on the clearly defined intervention, conducted by, or in the presence of the same facilitator and collected qualitative data using semi-structured interviews. Each had a small participant sample because of the research method. Data analysis for each study was based on a variation of the phenomenological approach leading to themes identified from the transcribed interviews with the participants. Of the studies listed above, I will review only the ones that are most relevant to this present study.

*Martens (1991)*

Martens' (1991) research question was “What does it mean to be a protagonist in psychodrama?” This question addressed the experience of being a protagonist before, during and after the enactment. This included the experiences of the six participants long before the enactment workshop and several months after.

From the exhaustive list of Martens’ statements and descriptions, I retained eleven to list here. This list includes the eleven elements that are most related to this study:
1. Being ready is a necessary prerequisite
2. Must have a strong desire to go through the experience
3. Feeling of safety and trust of the leader and group
4. A transition occurs that differs between talking about the experience, and a
   movement to having the experience as a reality that is similar to one's life
5. An intensity of experiencing occurs with intermittent awareness of the
   group
6. Holistic experience including cognitive, emotional and physical realms
7. A release of energy
8. A feeling of completion
9. A feeling of wanting to be drawn back into the group for acceptance
10. A need to take action based on the experiences and insights derived from
    the enactment
11. Feeling that a change has occurred and a pattern of behaviour has been
    altered.

Martens concluded that the results of change are from the combination of relationships
among the participants of the group. In Brook's (1998) review, he identified that this conclusion
supports Moreno's description of enactment as a more life-like model of therapy. Martens' work
reflects the common structure among the participants of enactments and that significant change
is related to reliving through the enactment.

*Gilbert (1992)*

Gilbert's (1992) study focused on the common factors of three cathartic therapies as they
relate to counsellors. The findings related to the factors required for therapeutic enactment are
relevant here. Gilbert explained that four factors are considered necessary for a facilitator to
effectively conduct a therapeutic enactment. The four factors required to be effective include:
(a) qualifications of therapists, (b) qualities of the therapists, (c) trust and rapport within the
therapeutic relationship, and (d) therapist provided emotional safety. These findings emphasize
the necessity for only qualified and skilled facilitators to conduct a therapeutic enactment. In this
present study two trained and experienced facilitators conducted the therapeutic enactments.
Throughout the group process they received strong clinical supervision from one of the architects of therapeutic enactment.

_Baum (1994)_

Baum's (1994) study represents the first study to be conducted on therapeutic enactment as a distinct variation on classical psychodrama. By asking, "What is the meaning of the experience of 'significant change' as reported by participants in a psychodrama?" Baum created 32 themes based on the experiences of the enactment leads she interviewed. The group Baum collected her data from was a finite group, and not an ongoing group.

The themes are condensed into essential structures. As a precursor to the safety required for the therapeutic enactment, Baum concluded that an intellectual understanding of the process is a pre-requisite. This understanding comes from witnessing the process and the format.

A second essential structure echoes the findings of Martens (1991). Participant readiness for the enactment involves being engaged in some form of self-work prior to the therapeutic enactment. For the participants of this study, they engaged in a life-review process as part of the program (Rife, 1998).

Baum identified relationship with the director as a third essential structure. This structure supports Martens' (1991) 'safety'. A strong relationship with the director allows for trust. Baum (1994) furthers what Martens (1991) identifies as the lead client's perception that not only must trust of the facilitator be possible, but the added feeling that the facilitator must be responsible to the lead client during the experience. This point is significant because it is here that we see how therapeutic enactment shifts away from psychodrama because the therapeutic enactment facilitator takes a much more active and important role of support and guidance through the process. This is revealed further in the studies reviewed below.
An essential structure identified by Baum (1994), and not addressed by Martens (1991) is, the importance of the facilitator. When in the middle of the enactment after the lead client is taken through the experience and awareness of the traumatic event, the lead client relies heavily on the facilitator to guide the client through the experience. Baum states that at this point the facilitator’s voice and tone may be the only thing the lead client is aware of outside of the relived experience. Secondary to the facilitator’s voice and tone is the awareness of the other group members as participants and witnesses.

Baum’s study further supports Martens (1991) findings and seen again in Morley’s (2000) study, regarding the shock, shift, or release of energy in the lead client. This release is characterized by a strong expression of emotion, as well as the need for acceptance from the group after being emotionally expressive and physically rejoining the group. Here Baum includes the concept and importance of being witnessed as a essential for participants after enacting a personal and intimate experience in front of the group.

Emotional processing was reported first by Baum. Emotional processing involves the realm of emotions that may be experienced following a therapeutic enactment. These will range from peace to grief depending on the issue and how close the client is in the resolution of that issue and presumably the temporal orientation of the client (Holman & Silver, 1998).

Physical sensation was reported to involve a range of experiences. Following the enactment, the lead clients expressed being aware of different physical sensations. The sensations included a range from localized pain, physical lightness and changes in posture. Physical sensations and changes in physical awareness was identified again by Morley (2000).

Finally, Baum explains a type of reconnection. Baum explains this as a reconnection mainly with the facilitator of the enactment, but not the group. Because the group where Baum
collected her data was not an ongoing group, there was no need for the lead client to reconnect with the rest of the group. This finding of Baum’s demonstrates again the importance of the facilitator and to a lesser extent with other group participants. I suspect that with an ongoing group, this finding would be different because the lead would need to reconnect with the rest of the group as well as the facilitator.

*Buell (1995)*

Buell (1995) studied the lived experience of group members who witnessed the earlier form of therapeutic enactment. Her investigation produced exhaustive descriptions of eleven emergent themes over three stages of the therapeutic enactment (warm-up, action and integration) as later explained by Westwood and Black (1999). The themes are:

1. Sense of being fully present
2. Shift from thinking to feeling
3. Experience of highly intense all-encompassing feelings
4. Sense of vulnerability and embarrassment
5. Shift out of intense personal experience back to role as audience member
6. Perceived need to integrate experience
7. Emergence of personal themes for future work
8. Experience of fundamental change
9. Awareness of changed style of interaction
10. Sense of evolution of psychodrama experiences
11. Other factors influencing the experience of change

These findings indicate that even being a witness to a therapeutic enactment creates an emotional reaction to a traumatic event. A consequence of this finding is the awareness that people who have experienced their own trauma may risk experiencing a sense of being overwhelmed by the experience of witnessing an enactment. The findings suggest that for the group to help contain an individual cohesion, trust, altruism and universality (Yalom, 1995) are basic requirements.
Buell’s research was on individuals within a group, and not focused on being a member of a group. Therefore, further research is required to understand the group process beyond the individual process.

*Brooks (1998)*

Brooks (1998) asked the question, “What is the meaning of change through therapeutic enactment in psychodrama?” With eight participants, he identified an exhaustive list of 59 themes, which have been condensed into several core change processes. It is in this study that we see the clearest description of the importance of the director in facilitating change.

The ten multi-modal change processes Brooks identified relate to a new awareness the lead client gains from both enacting the scene and validation received from the group. The new awareness leads to new roles and integration of the trauma the lead client experienced. The themes and change processes have direct application to this present study by informing how change happens from engaging in a therapeutic enactment.

Introducing the term ‘therapeutic enactment’ Brooks discussed several essential structures. The core change processes are as follows:

1. Hope is engendered by the breaking down of the barriers of reality to allow for the resolution of issues previously perceived as unworkable, resulting in an increased desire to approach the problem.
2. The relationship with the director is of critical importance.
3. An increase in focused attention on the scene to be enacted results in increased emotionality building towards catharsis.
4. Acting out the scene in the group is the pivotal process via remembering through action.
5. Possibilities are opened through interaction with and in the enacted scene including:
   a. Possibility of doing, redoing, undoing, finishing, mastering scenes through action
   b. Possibility for differentiating between feelings and meanings, through interaction with others
c. Possibility for trying out and establishing new boundaries between self/other, present/past, somatic/mental, conscious/unconscious, beliefs/reality
d. Possibility for emotional catharsis and rescripting of old dysfunctional scripts
e. Possibility for shifts between conscious/unconscious during differentiation process
f. Possibility for developing new ways of feeling and practicing these new ways within the group

6. The importance of witnessing for validating and supporting change in the individual and experiencing the reality of interactional ethics.
7. The importance of debriefing with the group for integrating differentiated feelings, meanings, boundaries, and encouraging new behaviour outside the group.
8. Internalization of these new ways of being, thinking, feeling taken from the experience.
9. These internalized changes help to reinforce and support change in new and enhanced roles in ongoing life.
10. Practice with these new ways of being helps to integrate old ways of being and can reinforce new ways of being, thinking and feeling.

Morley (2000)

In his study of trauma repair through therapeutic enactment, Morley (2000) identified 27 themes from interview with the two participants when he asked: “What is the lived experience of trauma repair through therapeutic enactment?” The themes associated with the enactment, relate to the memories and physical experiences of the enactment lead client. The participants report feeling the enactment returned them to the trauma they experienced. However, because of the guidance of the facilitator, they were in control of the scene during the enactment in a way that was impossible when the trauma initially happened.

Many of the 27 themes identified relate to the relationship required between the lead client and the facilitator of the enactment. There is little support from the group identified. From the exhaustive list of Morley’s 27 themes, I retained eight to list here. This list includes the eight elements that are most related to this study:
1. The therapeutic enactment experience was precipitated by a trust building process with the director.
2. The enactment planning process was tentative, inclusive, and client-centred.
3. A sudden awareness of the trauma's continued impact on the co-researcher precipitated the enactment.
4. Co-researchers experienced an inability to recall specific details of their enactment, immediately following the enactment.
5. The co-researchers' main memories of the enactment are physical memories.
6. The enactment entailed high risks.
7. The enactment was experienced as intensely real and resulted in the protagonists experiencing a loss of control.
8. Co-researchers experienced substantial repair.

The focus of Morley's (2000) study was on the relationship between the lead client and the facilitator of the therapeutic enactment. There was little mention of the group because the group was constructed for the sole purpose of conducting the enactment. The present study conducted here differs from Morley's because the group was together for multiple sessions prior to the enactments occurring.

The research on therapeutic enactment as described above suggests the lead client (Baum, 1994) and other group members as witnesses and participants (Buell, 1995) have sometimes strong emotional reactions during therapeutic enactments. In the case when trauma results in some degree of amnesia for an individual, the physical movement during the therapeutic enactment has been shown to trigger memories, further thoughts, images and feelings (Brooks, 1998; Morley, 2000) of the participants witness and lead. The question of this movement triggering memories has not been studied systematically, but relates to van der Kolk's (1996), Tyson and Goodman's (1996), Blake and Sonnenberg's (1998), and Hegeman and Wohl's (2000) notion of acting through the memories and not merely talking through them. This increased experience facilitated through action can increase the accuracy of the relived event (Brooks, 1998).
From the findings of these studies, it is clear that emotional, cognitive, physical and behavioural change occurs from therapeutic enactment. This study works to demonstrate changes from the negative effects of trauma for peacekeeping and combat veterans while participating in a therapeutic enactment group.
CHAPTER THREE: METHODOLOGY

This study is part of a larger, ongoing research project. This study includes individual pre-group and post-group interviews, a group-based follow-up interview and psychometric data collected at each of the three interview times. The larger, ongoing study as conducted by Dr. Marv Westwood and Dr. William Borgen will include individual follow-up interviews and between group comparisons.

The research question for this study is: What is the effect of a group-based therapeutic enactment program on veterans who have experienced trauma? To answer that question, both qualitative and quantitative methods were used. The qualitative method answers the question as it relates to the lived experience of change. The quantitative method answers the question as it relates to personal functioning, specifically trauma symptoms and psychological functioning.

Both methods inform each other (Steckler, McLeroy, Goodman, Bird, & McCormick, 1992). Figure 7 reflects how the different methods inform the results. The convergence of results across both methods improves the validity (Morgan, 1998). Both methods informing the results on a more equal basis is considered triangulation of methods thus enhancing the validity of the findings (Morgan, 1998; Steckler, et al., 1992).

Because the sequence of data collection for both methods occurred simultaneously, and both methods were designed to support the other; the methods are considered complimentary (Morgan, 1998; Steckler, et al., 1992). Steckler, et al. (1992) explained that combined methods are usually generalisable and leave the participants' perspectives in tact. However, due to the
sample not being large enough to adequately reflect the larger population of veterans, a limitation of this study is the lack of confident generalizability. A larger sample-set is required for increased confidence and extrapolation to be possible. Therefore, with this study as an element of an ongoing research project, more data will be collected and supply what is required to extrapolate findings to the larger population.

Morgan (1998) identifies that paradigm conflicts can occur when combining qualitative and quantitative methods. However, due to the complexity of the issues being studied, Steckler, et al. (1992) explain that the social phenomena particularly in healthcare, require a combined method. The different methods provide answers in more complex ways than possible with a single method. The qualitative paradigm helps decipher meaning from social phenomena whereas a quantitative paradigm accentuates the study of social variables that lead to predicting social phenomenon.

The quantitative component of this study is not generalizable because it does not meet the appropriate n and randomization. The qualitative component is not a generalizable representation; rather it is illustrates the experience of the participants so the reader can connect with the participants' experiences. Methodologically and result-wise, this study will inform and add to the ongoing project and future studies.

As described in the review of the literature in chapter two, this study fulfills the following five 'gold standards' as defined by Rothbaum, et al. (2000):

1. Clearly defined target system
2. Reliable and valid measures
3. Assessor training
4. Manualized, replicable, specific treatment programs
5. Treatment adherence.
This study does not meet the following two gold standards as defined by Rothbaum, et al. (2000):

1. Blind evaluators
2. Unbiased (random) assignment to treatment

To make the findings of this study stronger, a control group for comparison may have been implemented. Recruitment difficulties of traumatised veterans post September 11, 2001 prevented a control group from being engaged.

Participants

Criteria for Participant Selection

As explained above, prior to the group beginning, soldiers were screened for active and uncontrolled PTSD symptoms. PTSD screening consisted of a clinical interview as conducted by an experienced program facilitator. Those with unmanaged PTSD symptoms were excluded from participation in the program at this time, and referred for specific individual PTSD treatment. At a future date, once the PTSD symptoms are managed, these veterans may participate in the program.

The participants were recruited for this study via word-of-mouth by the program facilitators, program director and previous participants of the program. I maintained ethical research guidelines by not directly approaching individuals to solicit them as potential participants (Nagy, 2000). To avoid influencing the research findings, I did not participate in the group process until the last session after the formal group ended.

Women were not included in this study so the unique impact of gender differences would not be lost. A comparative women’s only group would be beneficial as a future examination.
Participant Descriptions

Six male veterans of peacekeeping and combat missions were recruited. The soldiers were all exposed to traumatic events as determined by a pre-screening interview. The trauma that affected them the most was not necessarily military-related.

Below I present a brief introduction to the participants of this study. They are presented in no particular order. With these initial descriptions, as much identifying information has been removed as possible, and the participants are referred to in an impersonal manner to maintain their confidentiality. When the interview findings are presented, the participants are assigned pseudonyms for accessibility and conviviality.

This initial introduction includes the following demographic information: age, marital status, children, type of living environment, and important medical information including medications. The description also includes a brief statement about the length of time they served in the military, and the type of environment in which they served.

While I present the participants, I institute measures to preserve confidentiality. The participants are introduced here in a different order from the data presented later. The demographic information here is presented in a general way to limit possible identification.

Participant One

He presented as a 62 year-old Caucasian male. He has been married for 32 years and has 1 daughter (aged: 28). He retired in 1998 after more than 30 years working in a construction-related profession. He lives in a small urban city with his family in a house they own. He reported he received counselling from a psychologist on one occasion for work-related issues. He reports he is currently taking a mild anti-inflammatory medication for pain for a physical
ailment. He ended his military career in 1967 after 5 years of service. Throughout that service, he was posted overseas and was exposed to hostile environments including firefights.

Participant Two

He presented as a 55 year-old Caucasian male. He has been married for 27 years and has 3 children (aged: 25, 24, 23). He is employed as a nurse in an acute care hospital with cancer patients and works extra shifts in the emergency unit. He lives in a small urban city with his family in a house they rent. He denies he ever sought counselling for the experiences he had in the military. He reports he is currently not taking any medications. His military service lasted over more than 6 years and took him to a theatre where he was exposed to active combat for more than 5 years.

Participant Three

He presented as a 36 year-old Caucasian male. He has been married for 11 years and has 2 young children (aged: 29 months, and 11 months). He is self-employed with his own small business related to construction. He lives in a small urban city with his family in a house they own. He reported he never received professional support, but that he had talked to military-related friends about his concerns. He reports he is currently not taking any medications. His military service lasted approximately 5 years. He served both in Canada and overseas.

Participant Four

He presented as a 46 year-old Caucasian male. He has never been married and has no children. In 2001 after approximately 28 years of service, he retired from the military with a medical discharge and is living on a disability pension. He rents a suite from his sister in a small urban city living in the same house as his sister’s family and his mother. At the third group-
based interview, he reported that he has moved out of the suite in his sister’s home and is moving into his own apartment in the same town. He reported he has been receiving counselling from a psychologist since 1998 for trauma-related concerns. He reports he is currently taking an antidepressant as prescribed by his family doctor. At the second interview, he reported to be taking two different types of psychotropic medication.

**Participant Five**

He presented as a 32 year-old Caucasian male. He has been married for 7 years and has 3 children (aged: 7, 5, 3). He is employed in a management position of a construction-related field. He lives in a small urban city with his family in a house they own. He stated that he ever sought counselling for the experiences he had in the military. He reports he is currently not taking any medications. His military service lasted approximately 5 years. During those years, he served overseas in a hostile environment and was exposed to a firefight.

**Participant Six**

He presented as a 34 year-old Caucasian male. He has never been married and has no children. He has a long-term girlfriend with whom he does not live. He is employed in a computer and arts-related position and at the third group-based interview, reported to have returned to school as he had hoped. He lives with a roommate in an apartment he rents in a large urban city. He reported the professional counselling support he received consisted of debrief groups “in country” where he served. He reports he is currently not taking any medications. He reported that many years ago he sustained a closed head injury by falling from a height resulting in his being in a coma and hospitalized. He reports being aware of a difference in himself between before he sustained the head injury and after, and he reports he experiences no
significant effects from the head injury. His military career lasted approximately 5 years. During those years, he served overseas in a hostile theatre where he was exposed to firefights and hostile situations.

Data Collection

The method of collecting data from each participant was the same. The data collected from the participants for analysis includes both qualitative and quantitative measures.

Qualitative Measures

Each of the participants was interviewed regarding their experience of trauma, including trauma sustained on their military mission. The focus is on how the veteran experiences or re-experiences that trauma in his day-to-day life.

In this study, the interviews were conducted over two occasions. A pre-group and post-group interview was conducted individually. A group-based follow-up interview was conducted by the program director with all the participants and program team present. This interview consisted of asking the participants what they have experienced and what have they been doing since the program ended. Individual follow-up interviews will occur at a later date, as they will be included in the larger study associated with this smaller study.

The qualitative interviews were semi-structured with a small list of open-ended questions (see Appendix A) and ranged from sixty to ninety minutes each. They occurred in a location of the participant's choosing providing ethical research standards were maintained (Nagy, 2000).

All interviews were audio recorded pursuant to the participants' comfort. The field notes I maintained supplemented the audio tapes by relating the mood, pace, environment, interview length, changes in expression or feeling during the interview, my sense of the arriving and
departing feelings of the participants, and anything else that I feel is significant. The interview tapes were transcribed by professional transcribers.

Quantitative Measures

For this study, I had six criteria for the psychometric measures I chose. The criteria included: (a) measures that gauged the symptoms commonly associated with trauma reactions; (b) measures that are not excessively time-consuming or onerous for the participants; (c) self-administered, not clinician administered measures; (d) measures that are sensitive to change; (e) measures that could be manually scored; and (f) measures that possess strong psychometric properties. After explaining how I chose the instruments, I go on to describe each in detail. In the detailed description I explain how each measure fulfills the requirements I list above.

Of the six requirements, all but one of the reasons is clear. The reason I wanted self-administered measures is to avert possible distrust by the participants feeling as if they are being probed and assessed by an external force.

Shalev (2000) reviewed 24 measures that are commonly used in conducting PTSD treatment studies. He divided the measures into six categories: (a) diagnosis of PTSD, (b) PTSD symptoms, (c) Global clinical assessment, (d) comorbid disorders and symptoms, (e) disability and vulnerability to stress, (f) quality of life. Shalev (2000) cautions that treatment outcomes are often complicated by comorbid disorders. Due to comorbid complications, a battery of measures addressing more than one category is recommended.

Narrowing down the requirements for this study from the six categories presented by Shalev (2000), I determined that measures addressing PTSD symptoms, and comorbid disorders and symptoms were of higher importance here. Based on my criteria, and trauma literature I chose the following instruments to administer (a) the Trauma Symptom Inventory (TSI) (Briere,
1995), (b) the Beck Depression Inventory-II (BDI-II) (Beck & Steer, 1987; Beck, Steer & Brown, 1996), and (c) the Self-Esteem Rating Scale (SERS) (Nugent & Thomas, 1993; Nugent, 1994). The TSI, BDI-II and SERS meet the six criteria I established.

I chose the TSI for several reasons. Primarily it meets the criteria I established for the measures I included. A unique feature of the measure is that it has validity scales to assess consistency in responding and. It addresses the symptoms commonly described in trauma literature. Different from most PTSD symptom measures, it addresses sex-related concerns and tension-reducing behaviours.

Self-esteem measures are less common in trauma research, however, the inclusion of such measures is warranted. Janoff-Bulman (1992) explained that schemas about self and the world are challenged and altered in the face of trauma. She argues that one of the assumptive beliefs corrupted by trauma is a belief that the individual is a worthwhile human being. This sense of worth suggests self-esteem is effected by traumata and the reactions to traumatic events.

The BDI-II and SERS are considered together. Aside from the BDI-II meeting the six criteria I established, it is a commonly used measure of comorbid depression in studies of trauma (Shalev, 2000). Different from other self-esteem measures, the SERS is sensitive to change. This sensitivity is a result of the range on the Likert scale. The BDI-II and SERS are considered jointly because of the inverse relationship between depression and self-esteem (Nugent & Thomas, 1993).

Pursuant to the administration guidelines, each participant was administered the three psychometric measures up to three occasions. Due to the limitations on the frequency of administering the TSI, it was administered only twice; at the pre-group research interview, and the follow-up group session. The BDI-II and the SERS were each administered three times; at
the pre-group research interview, the post-group research interview and the follow-up group session. Below, I describe the tests in detail.

**Trauma Symptom Inventory (TSI)**

*Purpose and development.* The TSI is a 100-item test containing three validity scales and ten clinical scales. The three validity scales [Response Level (RL), Atypical Response (ATR) and Inconsistent Response (INC)] assess the following: (a) The tendency to deny symptoms that others commonly endorse (RL), (b) to over endorse unusual or bizarre symptoms (ATR), and (c) to respond to items in an inconsistent or random manner (INC). The ten clinical scales can be subsumed under three broad categories of distress (trauma, self, and dysphoria) and two general factors (trauma symptoms, and self-dysfunction). Figure 8 illustrates the interrelationship between the clinical scales and both the categories and factors. The ten scales include:

- Anxious Arousal (AA)
- Depression (D)
- Anger/Irritability (AI)
- Intrusive Experiences (IE)
- Defensive Avoidance (DA)
- Dissociation (DIS)
- Sexual Concerns (SC)
- Dysfunctional Sexual Behaviour (DSB)
- Impaired Self-Reference (ISR)
- Tension Reduction Behaviour (TRB)
The TSI is intended to evaluate acute and chronic traumatic symptoms. The symptoms may include those caused by the effects of rape, spouse abuse, physical assault, combat, major accidents, natural disasters and enduring trauma from early childhood experiences. Measuring
not only the symptoms associated with Posttraumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD), the TSI measures intra- and interpersonal difficulties that are often associated with more chronic psychological trauma.

<table>
<thead>
<tr>
<th>Population</th>
<th>N</th>
<th>Male</th>
<th>Female</th>
<th>Mean age</th>
<th>Relational status</th>
<th>Racial identity</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>General standardization</td>
<td>836</td>
<td>425</td>
<td>411</td>
<td>47.3 years (SD = 16.2, range = 18-88)</td>
<td>57.1% married</td>
<td>77.5% Caucasian</td>
<td>Bimodal income</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>16.6% separated</td>
<td>6.1% African American</td>
<td>$20,000 - $29,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>16.5% single</td>
<td>2.9% Hispanic</td>
<td>$40,000 - $54,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2.9% Asian</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2.3% Native American</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical (outpatient)</td>
<td>233</td>
<td>30</td>
<td>203</td>
<td>36</td>
<td>N/A</td>
<td>82% Caucasian</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>10% Hispanic</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>6% African American</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1% Asian</td>
<td></td>
</tr>
<tr>
<td>Clinical (inpatient)</td>
<td>137</td>
<td>36</td>
<td>101</td>
<td>67% single</td>
<td>19% married/cohabiting</td>
<td>40% Caucasian</td>
<td>Income Level: 47%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>32% African American</td>
<td>$+35,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>13% American</td>
<td></td>
</tr>
<tr>
<td>University</td>
<td>270</td>
<td>90</td>
<td>180</td>
<td>28</td>
<td>67% single</td>
<td>47% Caucasian</td>
<td>Education Level:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>39% African American</td>
<td>54% high school</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>13% Hispanic</td>
<td>graduate</td>
</tr>
<tr>
<td>Navy</td>
<td>3659</td>
<td>1,813</td>
<td>1,846</td>
<td>20.3</td>
<td>88.1% single</td>
<td>67.7% Caucasian</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>University</td>
<td>100</td>
<td>19</td>
<td>81</td>
<td>29</td>
<td>67% single</td>
<td>38% Caucasian</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>29% African American</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>26% Hispanic</td>
<td></td>
</tr>
</tbody>
</table>

**Figure 9 TSI Normative Data**

*Norms, reliability, and validity.* Normative data was collected from several groups across the United States. Separate norms were created for males and females, ages 18-54 and 55+ years. Figure 9 summarizes the demographics for the standardization sample and the groups from which norms, reliability and validity were calculated.

Following the test construction, the 3 validity scales and 10 clinical scales were analyzed for internal consistency. Reliability coefficients for the 3 validity scales were 0.80 (RL), 0.75 (ATR) and 0.51 (INC). Reliability coefficients for the TSI clinical scales ranged from 0.74 to 0.91.
Administration and scoring. Taking approximately 20 minutes, the TSI can be administered individually or in groups. Responses to the 100 items are entered on carbonless, hand-scorable answer sheets. Separate profile forms for males and females allow conversion of raw scores to T scores for comparison to norms. A graph of the profile may be drawn to portray the respondent's scores relative to general population scores.

Beck Depression Inventory – II (BDI-II)

Purpose and Development. The Beck Depression Inventory - II (Beck, Steer, & Brown, 1996) was originally developed to measure the severity of depression among people 13 years and older with a psychiatric diagnosis. Use of the BDI-II has gone beyond the initial intended application and is now commonly used by clinicians as depression screening instrument among normal populations.

Recent changes reflect current screening guidelines. Items on the BDI-II replace items from previous versions that dealt with symptoms of weight loss, changes in body image, and somatic preoccupation. The item on the BDI-II that tapped work difficulty was revised to examine loss of energy. Sleep loss and appetite loss items were revised by the authors to assess both increases and decreases in sleep and appetite.

DSM-IV guidelines require assessing depression symptoms over the preceding two weeks (APA, 2000). The time frame for the response set in the new edition was changed from one week to two to comply (Beck, Steer, & Brown, 1996).

Administration and Scoring. The BDI-II is a 21-item test that takes 5-10 minutes to complete. It can be written by hand, or for clients who have reading or concentration difficulties, it can be read to them. Each item is a list of four statements arranged in increasing severity about
a particular symptom of depression. These new items bring the BDI-II into alignment with DSM-IV criteria. Each item is rated on a 4-point scale (0-3) with a maximum score of 63.

Beck, Steer, and Brown (1996) provide the following cut off score guidelines for interpretation:

<table>
<thead>
<tr>
<th>Total score</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-13</td>
<td>minimal depression</td>
</tr>
<tr>
<td>14-19</td>
<td>mild depression</td>
</tr>
<tr>
<td>20-28</td>
<td>moderate depression</td>
</tr>
<tr>
<td>29-63</td>
<td>severe depression</td>
</tr>
</tbody>
</table>

Figure 10 BDI Clinical Ranges

*Interpretation.* Because the BDI-II is a screening test, and not a diagnostic test, the total score provides an estimate of the severity of depression. Specific items are closely scrutinized such as items 2 and 9 with a rating of 2 or 3 because of the possibility for suicidal ideation. More than an item-by-item analysis, the overall pattern of depressive symptoms is examined. The results are considered in context of the other psychometric tests and interviews.

*Norms, reliability and validity.* The psychometric properties of the BDI-II were based on an outpatient sample from 4 different psychiatric clinics (n = 500; New Jersey, Pennsylvania, Kentucky, and Philadelphia) and one college-student group (n = 120; New Brunswick). The coefficient alphas for the outpatient and college students was 0.92 and 0.93 respectively. Item-total correlations for the outpatient and college student group ranged from 0.27 to 0.74 with most greater than 0.50. A one week, Test-retest reliability of 0.93 was based on a sub sample of the outpatient group.

The BDI-II was developed to screen depressive symptoms as described in the DSM-IV, which provides evidence of the content validity. The convergent validity was assessed by
correlating BDI-I and BDI-II results from the Kentucky and New Jersey outpatient groups ($r = 0.93$) and by correlating the BDI-I and the BDI-II results from the Philadelphia outpatient group ($r = 0.84$). The authors provide evidence for discriminant validity by reporting that the BDI-II was more positively correlated with the Hamilton Psychiatric Rating Scale for Depression ($r = 0.71$) than with the Hamilton Psychiatric Rating Scale for Anxiety ($r = 0.47$).

Strengths and Limitations. The BDI-II is a simple measure that is easily and rapidly administered. It incorporates symptoms associated with depression and builds on 35 years of psychometric data and clinical experience. It is a useful and appropriate measure with cooperative clinical and non-clinical samples where there is no motivation to deceive.

Self-Esteem Rating Scale (SERS)

Purpose and Development. The Self-Esteem Rating Scale (SERS) was developed to measure self-esteem for use with adults. It differs from other measures of self-esteem because it samples both problematic and nonproblematic indices of self-esteem (Nugent & Thomas, 1993).

Comparative studies were conducted to determine the reliability and validity of the SERS (Nugent & Thomas, 1993; Nugent, 1994). Multiple studies were conducted with samples consisting of both men and women.

Two sample sets of respondents were used to determine the reliability and validity of the measure as compared to pre-existing self-esteem measures. One study involved 246 individuals and the second involved 107. Both samples included a range of demographic information including male and female adults from a range of ethnic backgrounds. Figure 11 below outlines the demographic information for the normative samples. Normative information is described further below.
<table>
<thead>
<tr>
<th>Demographic Information</th>
<th>Nugent &amp; Thomas, 1993</th>
<th>Nugent, 1994</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sample Size</td>
<td>246</td>
<td>107</td>
</tr>
<tr>
<td>Female</td>
<td>155</td>
<td>84</td>
</tr>
<tr>
<td>Male</td>
<td>91</td>
<td>23</td>
</tr>
<tr>
<td>Mean Age</td>
<td>32.5</td>
<td>31.3</td>
</tr>
<tr>
<td>Education</td>
<td>15.7</td>
<td>15.3</td>
</tr>
<tr>
<td>Married</td>
<td>104</td>
<td>38</td>
</tr>
<tr>
<td>Single</td>
<td>94</td>
<td>45</td>
</tr>
<tr>
<td>Divorced</td>
<td>33</td>
<td>15</td>
</tr>
<tr>
<td>Widowed</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Separated</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Common-law</td>
<td>11</td>
<td>5</td>
</tr>
<tr>
<td>Caucasian</td>
<td>175</td>
<td>100</td>
</tr>
<tr>
<td>Black</td>
<td>29</td>
<td>5</td>
</tr>
<tr>
<td>Hispanic</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td>Asian</td>
<td>19</td>
<td>1</td>
</tr>
<tr>
<td>Mideastern</td>
<td>9</td>
<td>0</td>
</tr>
<tr>
<td>Unspecified</td>
<td>3</td>
<td>1</td>
</tr>
</tbody>
</table>

Figure 11 SERS Normative Data Sample

Administration and Scoring. The SERS is a paper-and-pencil measure consisting of 40 items scored on a Likert-type scale. It can be administered individually or in a group. Twenty of the items are scored positively, and 20 items are scored negatively. The items are summed pursuant to the positive or negative value and result in a range from -120 to +120. For this study, the interpretation is based on the comparison of the SERS results considering the standard error of measure.

Interpretation. Given the high correlation between depression and self-esteem, Nugent and Thomas (1993) recommend the SERS be administered in conjunction with a well-validated...
measure of depression. They recommend a depression scale be administered at any time a respondent scores below 43 on the SERS. A score of 43 is not considered a clinically significant problem, however, it suggests the presence of depressive symptoms.

_Norms, reliability and validity._ The psychometric properties of the SERS were based on samples from 3 different studies. Figure 11 above outlines the demographic information of the normative samples. The studies included 107, 246, (Nugent & Thomas 1993) and 369 (Nugent, 1994) men and women with a diverse range of demographic particulars. The coefficient alpha was between 0.92 and 0.975 (Nugent & Thomas, 1993; Nugent, 1994) for all three studies. The standard error of measure was calculated at 5.67 (Nugent & Thomas, 1993). Convergent and discriminant validity was determined by comparing the SERS to other measures (Nugent & Thomas, 1993; Nugent, 1994).

_Credibility_

I worked to maintain research credibility throughout this study. I was concerned with the credibility of this study in three large areas including: transparency, consistency and communicability (Rubin & Rubin, 1995). Transparency ensures the reader is able to recognise the process, the description, and the strengths and weaknesses of the study. Consistency refers to my consistent reporting of the individual participant’s responses, within each interview and across interviews. Communicability refers to how the findings and discussion are expressed for the reader. High communicability is seen in vivid, detailed, transparent, coherent and consistent reporting.
Transparency

I attempted to prevent my framework from incorrectly influencing my interpretation of the participant’s experiences. I offered each of the participants the opportunity to review the transcripts from their own interview. I discussed the core narratives with each participant and provided each with a copy of both core narratives. The participants explained that they were satisfied with what they expressed during the interviews and stated that the core narratives reflected the message they were expressing.

I recognise that my reading of the transcripts displays a bias and that my influence and that it cannot be removed from this study. Consequently, I include a section about my personal experience doing this research below. Declaring my experience, I hope to inform readers of the impact of this research on me, and thus my influence on this study regarding the veterans’ experiences. Notwithstanding my influence, the analysis of this research is a co-creation between the participants and myself. For example, soliciting feedback from the participants regarding their core narratives contributes to the co-creation of the findings.

Consistency

To ensure I maintained consistency throughout this study I used a type of triangulation (Creswell, 1998; Maxwell, 1996). Triangulation includes collecting information from a diverse range of individuals using a variety of methods (Maxwell, 1996). By using triangulation, I reduce the risk that my conclusions reflect systematic biases and methodological flaws.

The triangulation I used covers several components, including: (a) Multiple sources of information including both quantitative and qualitative data collected from six different participants, (b) following a semi-structured interview approach, (c) audio-taping and transcribing interviews, and (d) maintaining field notes of the interview process. The men were
recruited by multiple sources, none of whom held a power influence over the participants. Maintaining ethical standards, I did not personally recruit or approach any potential participant for this study.

Following the same semi-structured interview format ensures I covered the same broad areas with each participant. Each of the men were asked the same questions while I asked specific questions to their unique experiences.

The tapes were transcribed by professional transcribers. Once the transcripts were complete, I listened to the audiotapes and corrected errors made by the transcribers to ensure accurate reflection of the interviews. At the same time, maintaining field notes of the interview process ensured that I collected the flavour of each interview.

Communicability

Communicability overlaps with the efforts I used to ensure transparency and consistency. I worked to ensure effective communicability, in several ways, including: audiotaping the interviews, transcribing the interviews, and maintaining field notes of the interview process. From these three steps, I maintained a detailed description of the men’s experiences throughout the period of the program, changes in their expressions and the trauma they reported.

With each interview, I sought to ensure that I obtained comprehensive data. At the end of each interview, I asked the participants if there was anything that I missed asking them, or if there was anything that they felt was important that they wanted to share. Moreover, I asked each of the men to contact me following the interview, if there was something important they did not present during the interview. Using these techniques allowed me to collected rich data without having successive interviews with the participants.
I felt that with the structural narrative analysis I used, I was able to create a vivid, detailed and accurate description of each participant and their experience. The consistent reporting was achieved by referring the discussion back to the original research question.

Ethical Considerations

Some ethical considerations are explained above and will not be repeated here. Due to the nature of the symptoms the men presented with and the potential for problems, a referral list was created for the men if they expressed a desire to talk with another professional. Contact information for counsellors and physicians was provided to each of the men and the two program facilitators maintained regular telephone contact with the participants between sessions. The telephone contact ensured that if there was a negative reaction from the group that it would be addressed immediately, and that the participants were reminded about the list of referrals. For one participant who travelled to the large city to attend the group, he was provided with a referral list for his local area (as supplied by reliable professional resources) and a list of referrals in the city where the group occurred. The participants also gave their own contact information to each other and maintained contact via email and telephone throughout the course of the program, and beyond.

Analysis

Because the data includes both quantitative and qualitative data for this study, I will briefly describe both methods of analysis conducted in this study.
Qualitative Analysis

For the qualitative data, I used both a structured narrative approach (Coffey & Atkinson, 1996; Mishler, 1986a, 1986b) and themes as generated by the participants through the interviews. The two types of analysis I describe below provided rich findings for interpretation.

The presentation of findings begins with a description of my experiences administering and interpreting the psychometric tests and interviewing the veterans. My experiences were compiled in field notes, providing the context and the relevant demographic information for the participants.

Core Narrative

Drawing on Labov's structural analysis I reduced each of the full interview transcripts into a "core narrative" and specified the elementary units (Coffey & Atkinson, 1996; Mishler, 1986a, 1986b). The elements of the core narrative include: orientation (places the narrative in a context), abstract (an overview of the narrative), plot or complicating action (the action of the narrative), resolution (how the narrative was resolved) and coda (a reflection on the narrative after the event has past) (Coffey & Atkinson, 1996; Mishler, 1986a, 1986b). Each core narrative may lack one or more of the elements.

Although the core narrative is straightforward, the elements of the narrative occur in an "invariant order" (Coffey & Atkinson, 1996, p. 58). In other words, the elements appearing in their final sequence of the core narrative are not presented in that order during the interview.

To create the core narrative, I read the interview transcripts several times and extracted what I believed was the core message each of the participants explained. Each of the core narratives answer smaller questions and contribute to answering the larger research question for this study. The core narrative from the first pre-group interview answers: What do I bring to the
group? The core narrative from the second post-group interview answers: What do I take from the group? The third group-based interview does not result in individual core narratives because field notes were used to document the findings, not an audio recording. In theme format, the third interview answers: What do I hold from the group? Although the three questions were not posed directly to the participants, the interview questions were designed around the themes they indicate. Each of these smaller questions contribute to answering the larger research question: What is the effect of a group-based therapeutic enactment program on veterans who have experienced trauma?

Each of the core narratives was given to the participants to review and provide feedback on. The participants were encouraged to review the narratives and discuss with me whether the core narrative reflects what they believe they were saying. None of the participants expressed a desire to change the narratives I gave them.

**Themes Across Narrative Analysis**

The final form of data analysis I used was to identify important themes described by the participants. The participants and I generated the themes jointly. The themes include concepts such as trauma symptoms the participants reported experiencing and changing, and the most helpful and least helpful experiences throughout the program. The transcribed interviews were coded and interpreted to identify both conjoint and disparate themes. The interview transcripts were examined for "patterns, themes and regularities as well as contrasts, paradoxes and irregularities" (Coffey & Atkinson, 1996 p.47). Both the regularities and irregularities provide rich findings for interpretation and conclusions.
Quantitative Analysis

Analysis of the quantitative data follows a simple descriptive model tracking scores across time. Because using advanced statistics to analyze 'n' samples (read as “small n samples”) results in findings with low power (Neter, Wasserman & Kutner, 1990), the findings are reported and analyzed using descriptive statistics. Simple histograms were used to illustrate the changes across time. The frequency charts allow for both a numeric and visual comparison over time.

Program format

The program is an intensive, experiential, group-based learning model. The group process is based on individual learning being mediated through interpersonal dynamics of the group. The two facilitators deliver a semi-structured group process that includes guided life-review and therapeutic enactment. Starting points, a career transition process, is briefly introduced in the group. Listed below are the other components of the group including the outline.

The team of people involved in administrating the program included: two paid program facilitators, one paid program coordinator, program director/clinical supervisor and myself as the researcher. The program director and the researcher were not paid for their participation in this project.

Prior to each group session, the program facilitators and the researcher met with the program director to plan the subsequent session. I participated in those meetings to maintain research notes of the program’s progress. The program facilitators were not informed of the findings from the pre-program research interview or the psychometric data, except as far as it aided session planning. The role of the program coordinator was to manage responsibilities including: booking accommodations, food, travel arrangements, working with the interview transcribers, and administrating sundry expenses.
I participated in the program facilitator debriefing and supervision sessions, but not the group treatment sessions. I did not attend any of the group sessions until the last session where the participants briefly discussed their experiences.

The Transition Program for Canadian Peacekeepers has been operating since 1998 (Westwood & Black, 1999). The program was originally conducted on an outpatient basis with once weekly evening sessions over 16 weeks. Prior to the start of delivering these sessions, the program format was changed from the once weekly sessions as described by Westwood and Black (1999), to five residential Friday evening and all day Saturday sessions. The change in format was to accommodate a participant who was flown in from a different town, concern about the length of the original program design as expressed by previous participants and the current participants during their screening interview and increased funding to research elements of the program. In spite of the change in format, the same number of group hours were accommodated over the weekend sessions as was experienced over the original 10-week design.

The sessions occurred over Friday evening (1900h to 2200h) and all day Saturday (0900h to 1700h). The participants were housed together in apartment-style hotel rooms with two men sharing each of the three rooms. Two of the Friday sessions included partner awareness nights. Below is a narrative that outlines the group content. For a comprehensive outline of the content of the group, please see Appendix B. For an overview of the program, please see Appendix E.

Outline of Group Content

The first group session began with the program director introducing the facilitators. The program director outlined some ground rules for the program such as abstaining from drinking alcohol during the program. He also provided an overview of the Transition Program. This overview included the history, vision, goals, benefits, and provided time for questions.
Following the program director's introduction, the lead facilitator began the formal introduction of group members. The participants were asked to introduce themselves and were prompted by pre-established questions. This introduction was considered the check-in (Corey, 1982; Yalom, 1995).

The facilitators provided a detailed overview of the program to inform the participants about what they can expect to experience as they progress through the program. They reviewed the expectations of the participants between weekend sessions including self-care activities.

They established a contact network. They created a 'buddy system' whereby the participants were linked in pairs for communication between sessions. The two lead facilitators also established a 'buddy system' in that they each took half the group to contact through the week. A phone list was created for all the participants to know how to contact each other and the facilitators.

After this out-of-group foundational work was established, they moved to within group issues. Group norms were established by prompting the participants through a sensitizing question (Corey, 1982; Goodman & Weiss, 2000; Yalom, 1995).

Before the first session ended, the facilitators outlined the group for the next day and a check-out of helping the participants become aware of their present state by asking, "where are you at now compared to when we started?" (Corey, 1982; Yalom, 1995).

The second group session began by reviewing the previous group, a check-in to draw awareness to their present experience and an overview of the group norms. For the remainder of the day, they began the communication skills section (Egan, 2002; Johnson, 1993). This began by the participants working through guided exercises in pairs and reporting back to the group. They moved through to introduction of basic communication skills including giving feedback
(Amundson, 1989). The day ended with a discussion of a life-review exercise for the following session (Rife, 1998).

The third session began with 'housekeeping' issues and psychoeducational issues regarding PTSD, group issues and therapeutic enactment. They engaged in a reflection on the issues from the previous week by facilitators and group participants. Communication skills training continued with giving and receiving feedback information and practice in pairs. The group ended with a preparation for the life-review (Rife, 1998) exercise and a check-out.

The fourth session began with psychoeducational activities by a physician experienced in psychological trauma issues. They conducted a discussion of PTSD and posttraumatic stress reaction (PTSR). The group moved into conducting the life-review (Rife, 1998) exercise and the session ended with a check-out.

The fifth session is the first partner awareness session (Westwood, & Black, 1999). After the check-in, the group generated themes for discussion regarding trauma and partners. The group ended with the group members and their partners declaring a commitment to each other, followed by a check-out.

After the check-in, the sixth session moved into a debrief of the partner awareness night. A psychoeducational session continued with a discussion of trauma issues. The day ended with the first therapeutic enactment. At the check-out of the group, they were reminded to use the buddy system and to use self-care techniques as needed.

The seventh session began with 'housekeeping' issues and a check-in. They continued to process the therapeutic enactment from the previous weekend. Integration of the therapeutic enactment and planning for the other participants' enactments. The group ended with the usual check-out.
The eighth session began with the usual ‘housekeeping’ and check-in. The remainder of the session consisted of the remaining participants engaging in therapeutic enactments and processing the enactments. Again at the check-out, they were reminded to use the buddy system and ensure they use self-care techniques as needed.

The ninth session was the second partner awareness night. Following the check-in, they reviewed the commitments made during the previous partner awareness session. The group ended with the usual check-out and a look forward with maintaining the commitments.

The tenth session began with ‘housekeeping’ and check-in with an emphasis on closure with this as the last session. A practicing counsellor was introduced and they were reminded of the referral list of healthcare providers. Processing and integrating the therapeutic enactments occurred for most of the session. After the integration of the therapeutic enactment, Starting Points, a career and future-planning model was introduced. Following the formal group process, the program director and I joined the group to debrief of the program experience and to prepare for the post-program and follow-up interviews. This debrief included a closure ceremony with dinner.
CHAPTER FOUR: FINDINGS

This chapter includes a presentation of the findings from the interviews and psychometric measures that were administered. To track the changes of each participant, the qualitative and quantitative findings for each are presented together. The order of how the findings are offered for each participant is as follows:

- Brief overview of the pre-program core narrative,
- Pre-program narrative,
- Brief summary of the narrative,
- Description of the therapeutic enactment the participant did during the group,
- Post-program narrative,
- Interpretation of the psychometric measures

To protect confidentiality as much as possible, the demographic information is not presented here. Instead, the participant descriptions are presented in chapter three and are in an invariant order from the findings in this chapter. As stated above, pseudonyms are assigned to the participants for accessibility and conviviality.

Following the narratives and the psychometric measures, I list the between-participant themes. The themes presented here reflect trauma-related symptoms and issues as identified by the participants from the individual and group-based interviews. Convergence of results across both the qualitative and quantitative methods suggests favourable validity (Morgan, 1998).

Core Narratives

The pre-program and post-program core narratives are grouped by individual. The first core narrative demonstrates the starting point for each of the participants before they begin the program. The second narrative identifies the experience of the participants following the program, and reflects changes they identified for themselves.
As explained in chapter three, some core narratives lack one of the five elements (orientation, abstract, plot, resolution, coda). As an example, some narratives lack the coda because the interview did not contain a reflection of the narrative that was related.

In the narratives, the text remains largely unchanged from the interview transcript. The narratives are cut and pasted from the interview transcripts as a series of direct quotes. The narratives are the participants’ own words about their own experiences. Minor additions have been included when the original sentence was unclear. The other minor change is, the features that can identify the participant have been removed. Any changes for clarity or confidentiality I made are recognisable by the use of square brackets.

Psychometric Test Interpretations

Below is a brief summary of the results of the Trauma Symptom Inventory (TSI), Beck Depression Inventory-II (BDI-II) and Self-Esteem Rating Scale (SERS) administered to the 6 participants over up to 3 occasions. Graphic representations of the results are presented to illustrate change over time. The BDI-II and SERS measures are presented together because of the inverse relationship between depression and self-esteem (Nugent, 1993; Nugent & Thomas, 1994).

I present the TSI profiles over the 2 administrations. In some cases, the TSI profiles are interpreted together because there are no or only a limited number of clinical elevations. If there are multiple elevations for either of the administrations, then the profiles are described independently to limit confusion. After the independent interpretation, both TSI profiles are considered jointly for comparison.

For the TSI interpretation, the ten clinical items are broken into two types of overlapping symptoms: trauma symptoms and self-dysfunction. The trauma symptoms include Anxious
Arousal (AA), Depression (D), Intrusive Experiences (IE), Defensive Avoidance (DA), and Dissociation (DIS) as primary scales and also include the Impaired Self-Reference (ISR) and Tension Reduction Behaviour (TRB). The Self-dysfunction includes: Dysfunctional Sexual Behaviour (DSB), Impaired Self-Reference (ISR), and Tension Reduction Behaviour (TRB) as primary scales and also include Anger/Irritability (AI) and Sexual Concerns (SC). Therefore AA, D, IE, DA, and DIS reflect distress associated with the impact of traumatic events or processes, whereas DSB, ISR and TRB may indicate the person lack the sufficient resources to modulate or address the distress. Impact of a traumatic event must take into consideration both the reflected distress and the personal resources to cope.

Interpretation of the TSI includes up to three steps. The interpretation begins with an examination of the validity scales to determine the potential reliability of the profile interpretation. Next, clinical elevations are identified based on scales exceeding a T score of 65. Included in this stage of identifying clinical elevations, the elevated scales are identified as either belonging to the trauma symptoms group of scales, or the self-dysfunction group. Finally, a single code-type may be described based on two or three related clinical elevations as identified by Briere (1995).

Following the TSI interpretation, I present the BDI-II and SERS results. Because these measures were administered over three occasions to track change over time, and they are screening not diagnostic instruments; there are no corresponding clinical interpretations. The results of these two measures are simply to observe over time the level of depression based on BDI-II results and the level of self-esteem as measured by the SERS.
Themes Across Narrative Analysis

The participants and I generated the themes jointly and are presented after the participants’ individual findings. The themes include concepts such as trauma symptoms the participants reported experiencing and the changes they became aware of while participating in the program. These experiences include the most helpful and least helpful experiences throughout the program.

As explained above, each of the pre-program, post-program and follow-up interviews answer their own question. The pre-program core narratives, themes and psychometric test results answer the question: What do I bring to the group? The post-program core narratives themes and psychometric test results answer the question: What do I take from the group? Finally the follow-up themes and psychometric test results answer the question: What do I hold from the group?

Duff

Throughout the first interview, Duff described how he had to adapt to multiple specialty occupations throughout his military career. He did not always choose these occupations. Following his first tour, he returned to North America and could not adapt to civilian life, so he re-enlisted. Upon leaving the military, he struggled to adapt to civilian life and left for an overseas posting because he knew he could not adapt to civilian life in North America. With these multiple adaptations, he knew that if he did not adapt, that he would be killed in combat, or die some other figurative or literal way.
Pre-Program Narrative: Adapt or Die

Orientation (places the narrative in a context).

Going in the military is a job right, but having to go through a combat situation or peacekeeping situation, that’s not normal. You’re… having to deal with certain situations at the spur of the moment in a certain way. You might have control over…, the outcome of it or you might not have… On the one hand you are trying to survive. You are trying to do your job. You are trying to save other people. But on the other hand, you have got all these other forces working against you too.

I put more life times in that five years and two months than people will in a thousand years. You try and equate that.

I am a survivor.

I had fourteen different military operational specialties in my five years and two months.

Fit in. Trying to fit in to where I was before I went over.

I think, its gotten worse actually. I’m just finding out now, and its because I haven’t dealt with it I waited thirty-four years to deal with these things because I put them on the back burner. Now things that wouldn’t have bothered me ten years ago are driving me nuts.

And you had to come down, one minute it was 110 in the shade the next one minute depending if you landed in Seattle or San Francisco there was, you had to deal with a change in weather. You had to deal with; nobody’s walking around with weapons anymore. Nobody’s going to blow you up (laughs).

I couldn’t handle the bureaucracy. I couldn’t handle the rules and regulations. Fill this piece of paper out. Call us back next week. We can’t help you.

If you wore your uniform, people literally, just like in the movies, people spat at you. Called you killer, of women and children…. So I just said, “To heck with that,” and went back to Hawaii.

I couldn’t adapt.

Abstract (an overview of the narrative).

You realize that certain things you thought about on day one, [on] day 365, it’s no longer relevant. It’s changed. It’s meaningless. So you have to, … get new values. I was looking to just adapt one way, you know, trying to get back to be normal. Although I don’t think one ever becomes normal after that.
So I re-enlisted again. I got out, couldn’t find a job; and probably within a few weeks I turned around and signed my name up for another three years, and went right back to [where I was stationed in the theatre of war].

Okay, I want to go to a military police unit in [a major city], which I read about in the paper as being the unit that basically saved the [major city] during the attack of ’68, which happened three months before I arrived the first time.

It was kind of like, well I am going back to a place that I know. I am going back to the fellows that I know are still over there, and its family. You’re, in combat situations.... It’s like the guy standing next to you, the closest I can equate to it. It’s your wife, your lover, whatever. That’s the guy that’s going to save your life, you’re going to save his.

It was home. They understood you.

You don’t worry; bullets will bounce off you, that’s your attitude. You have a job to do. Okay parts of buildings falling down, that’s part of the deal.... You are not thinking about, ... are they shooting at me or is that bullet going to hit me? ... When it happens, it happens and it happens in such a fast instant you have no control over that. Because you have no control over it, you don’t worry about it.

Either you adapt and do things to keep you occupied during, or you will be on the next plane out. So I adapted.

Although, and I picked the medical field because I think, even though when you are in [the combat theatre] and you see all this death and destruction, I figured the easiest way to survive this, is to maybe get out and look after other people. So it takes your mind off of, ... yourself and you are dealing with people that are actually, ... suffering from the same things but you’re actually dealing with it as a caretaker.

Plot (the action of the narrative).

You would be the first [into the scene], because you were the police. You’d get dispatched to any situation like that. We investigated murders.

It was like a restaurant with a bar, tables, and it was just like a normal restaurant. There was a fellow in the corner that said, “That guy over there started shooting.” There was a guy, a [local person], in a tiger, what we call a tiger camouflage uniform. He had an M-16 in his hand and, the guy in the corner said, “He’s the guy that was doing all the shooting.” I just let him have it, I just blew him away because he was still alive and he still had the gun.

A lot of the fellows didn’t even make the twelve months, they were wounded half way through or something like that and they got shipped back. I have five years
and two months of events that 34 years on have been eating away. For you to ask me which one is outstanding; basically I think the one was, I took a night off once because we worked 18 to 24 hours. Sometimes you’d work three days in a row, no sleep. So I took a night off, and I just booked sick and the precinct that I was going to work was the busiest and the heaviest in the city. That night that I took off, two of the fellows, who were almost old timers, they had been with the unit for quite awhile; had stayed more than just one tour. One of them took my place, and that night they were dispatched to an incident where those two fellows ended up being shot and killed. And I actually heard the gunfire. I was actually; I went to a bar and drank myself silly and basically found some gal. I was sleeping in somebody’s house and I could actually hear the gunfire going off.

One of those two fellows, took my place…. So that would have been me…. Those two fellows names are on the [memorial]. In ’93 I actually went there, got rubbings, you know. So I have always wondered (clears throat to fight tears), that fact that one of those guys died because I took the night off.

(Crying) So you survive that. So you have this guilt that, how come I survived; but they didn’t. Shouldn’t I have died too?

So here I am at [my age, later in life], and I remember … maybe he was 23. He’s missing out on all the things that I have experienced between that time and now.

I kept myself busy.

I hit the newspapers looking for overseas work.

Resolution (how the narrative was resolved).

Group started by other … Canadian Veterans…. We went into a meeting room and I think there were 60 of us…. All of a sudden you are in a room and there’s people who’ve been through exact same thing. We were all strangers but we were all friends…. It was, very overwhelming.

I’m not strange…. These fellows reinforced that.

Coda (a reflection on the narrative after the event has past).

I don’t relate. I don’t know if you would call it a badge. It’s something you’ve earned…. You just look at the world differently.

That’s why … I have been a survivor.
Enacting Change

Narrative Summary

Throughout the interview Duff explained that in order to survive in both the military and his life, he had to be able to adapt to whatever situation presented itself. Some examples of how he adapted were helpful in that sometimes adapting literally saved his life. However, other adaptive strategies were, in the long run, unhelpful for his ‘recovery’ from trauma. Notwithstanding helpful, or unhelpful adaptations, he survived whereas, as he stated, many men with whom he served, are either incarcerated, drug addicted, or dead, sometimes at their own hands. Examples of his adaptability include the number of military specialties he had throughout his military career, and when he returned from serving, he returned to an overseas job because he could only relate to people working in an overseas environment. When he returned from all his overseas work, he continued to adapt to his civilian life by isolating himself through hobbies and working in an intense medical environment.

Duff’s Therapeutic Enactment

Based on the branching points the participants were asked to write and share, Duff gave the two pieces of writing to the program facilitators as enactment options. The branching points he described were about the death of three men whom he served with while in a theatre of combat. He was trained by one of the men and told, "Look after yourself" by that trainer.

His enactment consisted of bringing back three men and talking with them. He felt guilty about the death of all three men. His trainer was shot at point-blank range by the commanding officer (CO) of their own unit. Duff explained that the official story was the CO was cleaning his gun when it accidentally fired, killing the trainer. Duff, however, had a looming feeling when the trainer was commanded to return to the CO’s office for a talk.
The other two men who he brought back during the enactment were colleagues whom he worked with. One of the two men was killed the night he called in ‘sick’ from work. That night he went out to a bar to drink and have sex.

During his enactment, he spoke with all three men, and they all spoke back to him. The men released him from his guilt. They forgave him for his actions and told him that it was not his fault they died. The trainer told him there was nothing Duff could have done to prevent his death. The other two men told him that they also knew the risks of their work, and that they do not hold it against him for taking the night off because they all did it occasionally.

**Post-Program Core Narrative: My Story has an Ending**

*Orientation (places the narrative in a context).*

I hadn’t seeked any help up to that point.

What’s catching up to me is some of these issues have probably been in the back on the back burner have always been there are now coming, and they’re putting their little fingers into me, and they’re saying, “You know, remember all those things you didn’t deal with in the twenties when you were 20, 30, and 40, well, we’re here, and we’re going to bug you, and you’re going to have to deal with us.”

Probably with from the time of my accident, the first bike accident where I broke my leg in 1998. Up to that point, I had never uh been in a situation where I had a lot of time to think, by myself, or due to circumstances that I had no control over, I and that’s what caused me to stop and think this time ‘cause I was stuck to a bed for 5 months.

The second accident.... On my mountain bike when a guy actually hit me. Blew a stoplight,... in 2001. So almost two years after the first accident although the second accident wasn’t as traumatic, it did turn out to be as traumatic. What it did to me was traumatic in the sense that it brought back things that weren’t there hadn’t been there for 30 years: flashbacks. I’d never had flashbacks in the sense that something I mean I a helicopter would go over, and I’d think about, but it wasn’t you know it was always there. This, I think, this accident the second accident I literally had a, I guess you’d call it a near death ‘cause it was a near death experience, and it brought all these ghosts, demons. Issues that had been there, but it opened the door from behind where they were all this time.
You either got used to that, or you couldn’t deal with it, and you got out of the theatre all together. I mean, you were either shipped back, you flipped out, or whatever. There were a certain percentage of the people that were over there, GI’s, civilians, newspapermen, that they fed off that. I mean, it literally was a drug for them. Yeah, I think it was [for me] (laughs).

Abstract (an overview of the narrative).

I’m probably class ‘A’ workaholic. Like, and that’s always been, but I used that as a barrier or a cover for probably some of my own problems that I just never went to seek professional help for.

I looked at it as kind of self-help.

I was just tired and frustrated, and I wanted to put my fist through the wall, rather than do that, and sustain an injury, I would go out on my bike for 3 hours, and swear (laughs) at the moon.

Before I didn’t get angry (coughs). I dealt with the issue in some other way that it didn’t have dire consequences, and it had a good ending, but now, it’s like (pause) all these things that I missed I want now. I want to get treatment. I want to avail myself of, although there are things that I’ll never be able to recover.

It’s time. Yeah, it’s just the time. I’ve realized that my clock is it’s gone past midnight (laughs). So I’m on the other side of midnight.

Because you’ll never know if it would’ve been good for you or not. If I’d have said if I’d have said, “That’s it. I’m not coming back,” or I’d have phoned Brian, “I’d have said screw this,” I would probably have really had a hard time later on saying I missed a good opportunity.

It would be a free space. It would be a neutral zone. It would be where you could say anything without fear or retribution, or being laughed at.

Even though you are in the group it does bring up some stress.

I didn’t like the reenactment part, but at then end of the group, like today, I have a different opinion from the day I walked into the group compared to when I waked out the door. So it was a big change.
Plot (the action of the narrative).

[The group] was like a 10,000-yard stare. It was being able to look at somebody and knowing that I didn’t have to explain myself to them. We understand each other.

[Check-in] was you came into the group, you sat down, you introduced yourself briefly. You said where you came from, where you served, what branch you served in, and basically why you were there. That brought out some familiarity. That brought out some knowingness that the person sitting to your left, the person sitting to your right is actually. You feel a little safer in saying the things that you’re going to say.

[The therapeutic enactment] made you, over a very short period of time; maybe in a 50 minutes or less, bring out something that’s actually lasted all this time since it happened. When it originally happened, it was probably minutes, or seconds; but it has lasted 34 years. And now you’re reliving that in a period of 50 minutes, and you're actually walking around, and then sitting. It’s [bringing back] all these people’s faces, all the noise, the cars, the weather. You hear the sounds that happened back then. You see the people, and it’s all done here in a very short period of time. All those emotions that have taken 34 years to accumulate. Thirty-four years to sit around and do their damage or do their good. In that 50-minute period, it all comes back.

You can actually put colours to it. Before, it’s black and white. When you’re doing [the therapeutic enactment], you can actually add colour.

Even though it’s a different person, you really put a name to that; I gave a name to them one of the other members of the group as the fellow [who replaced me and was killed]. That had brought these emotions to the foreground.

At the time, these incidents happen... over a millionth of a second, and you’re too busy getting on with the job at hand of surviving or just if you’re running, if you’re in a vehicle..., if things are flying through the air, you’re too busy looking around and looking for a safe place. Looking. There’s no emotions at that time. There’s nothing. You don’t feel emotions. You can’t hear, you know you could be wounded. Once it was finished, and you were able to look around.

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1 The following is a quote from this first participant’s interview where he defines the 10,000-yard stare. He is describing how the ‘new guys’ pass the ‘old guys’ on the airstrip. The 10,000-yard stare is a non-verbal exchange between the arriving soldiers and the departing soldiers. He said, “You can see 187 people waiting to go back home, been there for year or whatever. You can tell the difference between the new guy coming into the country and the old guy that has spent a year. He’s getting on a plane you just got off, and he is going home. So you make eye contact and its what we in the military call the 10,000-yard stare.” He went on to describe how they lock eyes and have a non-verbal form of communication; each lost in their own world of where they are coming from and wondering as he explained, “What the heck was in store for you.”
and feel safe, then you started thinking about it.... When you were reliving it here, you relived the whole thing.

I was able to bring out detail that has that I couldn’t remember 20 years ago or 10 years ago. Because of how the group was structured, how we were taught to do certain things I was thinking about things that I didn’t think about before because they were mentioned in the group.

Because the group was here to help me, I realized that you have to go for it. You have to experience it.

Resolution (how the narrative was resolved).
Refining your communication skills. I mean, before I had communication skills, but it just sitting there talking about it, and feedback. Speaking about an issue, but getting somebody else’s perspective on that issue that I’d never gotten that before.

[I am] now availing myself to all these things that are available, i.e. groups, courses, psychological, and psychiatric help.

It’s given me some tools. I’ve got a lot of tools that I didn’t have before.

We didn’t have alcohol when we did the group which was you know; I like my beer. But I agreed with [the program coordinator], who said he would like it alcohol free. I mentioned it that at the end of the group. I said, “That’s the only way to go, and that’s a beer drinker talking. That’s the only way to go because you have a clear mind....” It was something that I’ve kept with me.

Coda (a reflection on the narrative after the event has past).

It’s made me realize that things that you’ve put off, in my case for 34 years, should now be taken care of. You can have an end ‘cause up to this point, it’s been a story without an ending, and every story should have an ending.

Narrative Summary

After avoiding and self-isolating activities over more than 30 years, Duff expressed that when he was forced to stop and be alone while he was recuperating following a life threatening accident, he realized that he needed resolution for these long-standing issues. He said that skills he learned in the program, and the support of the group allowed him to begin to put closure to
some of the ‘ghosts’ from his past. He expressed surprise that due to the way that group was facilitated, he was able to remember some helpful things that he had forgotten.

*Duff's Psychometric Test Data*

**TSI First administration**

Examining the validity scales of the TSI suggests a valid and reliably interpretable profile. The Atypical Response (ATR) scale suggests a tendency to endorse statistically unusual TSI items. This pattern of responding may reflect, for example, an accurate reflection of a disorganized state. The Response Level (RL) scale suggests he responded to the questions with openness and a willingness to acknowledge traumatic symptoms. The Inconsistent Response (INC) scale suggests a possibility of inconsistent responses to TSI items. In spite of the INC scale, the profile is considered valid and reliably interpretable. The graphic representation of Duff's TSI profile appears below in Figure 12.

Examination of the clinical scales illustrates elevations on the following scales: Depression (D), Anger/Irritability (AI), Intrusive experiences (IE), Defensive Avoidance (DA), Dissociation (DIS), and Impaired-Self Reference (ISR). Four of these scales are primary trauma symptom scales (D, IE, DA, and DIS) and one is a primary self-dysfunction scale (ISR). AI is also considered a self-dysfunction scale.

The Depression (D) scale measures the extent to which he experienced depressed mood and depressed cognitions. High scores on this scale reflect frequent feelings of sadness and unhappiness and a general sense of being depressed. Individuals with high D scores report perceptions of themselves as worthless and inadequate. They tend to have a view of the future as hopeless. They have a tendency to dwell on thoughts about death and dying. Behaviourally, these individuals may describe periods of tearfulness and excluding or isolating themselves from
others. Suicidality, and self-injurious behaviour is always a possibility with high D scorers. Suicidality must be followed-up when the Tension Reduction Behaviour (TRB) score is also elevated. Three critical items are examined for suicidality. He did not endorse the item regarding suicidal behaviour (25), minimally endorsed the 2 items of thoughts of death (30 and 90) and the TRB is not elevated, therefore suicidality is not a concern as far at this measure is concerned.

**Figure 12 Duff's TSI Results**

High scores on the Anger/Irritability (AI) scale indicate the extent of angry mood and irritable affect. High scores on this scale may reflect either the irritability often associated with PTSD or a more chronic angry state. The AI scale taps not only the internal experience of anger or irritability, but also the presence of angry cognitions and angry behaviours. Individuals scoring high on AI often describe anger as an intrusive and unwanted experience and may see
their angry thoughts or behaviour as not entirely in their control. Such people often describe pervasive feelings of irritability, annoyance or having a bad temper such that minor difficulties or frustrations provoke inappropriate angry reactions for the immediate context.

Because aggression toward others is always possible among those who score high on AI, the critical item of hurting others must be considered. He minimally endorsed this critical item (19) and harm to others is not a concern at this time. Dangerousness is not a concern at this time because the TRB scale is not elevated.

The Intrusive Experiences (IE) consists of items reflecting intrusive posttraumatic reactions and symptoms. These include nightmares, flashbacks, upsetting memories that are easily triggered by current events and repetitive thoughts of an unpleasant previous experience that intrude into awareness. Such symptoms are typically perceived by the affected individual as ego-dystonic, and primarily involve reminiscence or reexperience of an especially unsettling event. Individuals scoring high on IE may report feeling out of control and a minority may fear that they are psychotic. High IE scores therefore typically reflect the intrusion of such traumatic material into current awareness, often inducing an associated state of distress.

The Defensive/Avoidance (DA) scale consists of items reflecting avoidance responses under the constriction group of PTSD and ASD symptoms. High scorers on this scale often describe a history of negative internal experiences that they attempt to avoid. DA endorsers attempt to avoid environmental experiences that might restimulate disturbing thoughts of memories. The patterns of avoidance here do not represent psychological defences as much as they represent conscious and intentional processes of behavioural avoidance to manage traumatic distress.
The DIS scale measures the extent to which the respondent experiences dissociative symptomology. Dissociation may be defined as a largely unconscious defensive alteration in conscious awareness, developed as an avoidance response to overwhelming, often posttraumatic psychological distress. Adapted from a previous measure the DIS scale measures a variety of dissociative experiences, including cognitive disengagement, depersonalization, derealization, out-of-body experiences and emotional numbing. These symptoms represent the most common dissociative responses and do not include the most severe and more rare dissociative reactions such as fugue states and Dissociative Identity Disorder (DID). Individuals scoring high on the DIS scale tend to report distractibility, 'spacing-out' and feeling out-of-touch with themselves and their bodies. They may report anxiety related to the aversive quality of intense depersonalization.

The Impaired Self-reference (ISR) scale measures a variety of difficulties associated with an inadequate sense of self and personal identity. ISR items include problems in discriminating one's needs and issues from those of others, confusion regarding one's identity and goals in life, an inability to understand one's own behaviour, a sense of emptiness, a need for other people to provide direction and structure, and difficulties resisting the demands of others. Individuals who score high on ISR often appear to have less self-knowledge and self-confidence than others, may be more easily influenced by individuals or groups, and may present as easily excitable and less functional under stress.

Some of the elevations indicted above are combined into an interpretable 2-point profile. The combination of IE and DIS or DA, or both, is a classic posttraumatic presentation. This combination suggests he is reporting intrusive and avoidant components of traumatic experiences. With the elevation of AI he is also reporting autonomic hyperarousal. Elevations
on these scales typically represent either an acute response to a recent traumatic stressor, or a more chronic PTSD response to an event. In the case of an acute reaction to a traumatic event, the score signals a highly disruptive state where the individual is overloaded by trauma symptoms and often feels out of control of his internal state. With the longer-standing traumatic history, such elevations indicate relatively chronic symptoms that may become incorporated into his personality. Although the chronic condition often appears less dramatically, the experience of chronic PTSD is aversive and can result in serious psychological disability.

Factor analysis of the test items suggest that the 6 elevations reflect distress associated with the impact of traumatic events or processes and the sufficiency of self-resources to modulate the distress. Five of the elevations (D, IE, DA, DIS, ISR) reflect the external experience of trauma symptoms, and 2 of the elevations (AI and ISR) reflect self-dysfunction. Elevations on both trauma and self-disturbance indicators suggest a more complex trauma victim evidencing chronic distress, overwhelmed by intrusive symptoms, and more likely to act out painful internal states by virtue of lesser self-resources to cope.

*TSI Second Administration*

Examining the validity scales of the TSI suggests a valid and reliably interpretable profile. The T score on the Atypical Response (ATR) validity scale suggests a pattern of responding where he does not attempt to present as disturbed or dysfunctional. The Response Level (RL) validity scale suggests he responded to the questions with openness and a willingness to acknowledge traumatic symptoms. The Inconsistent Response (INC) validity scale suggests a consistent pattern of responding to test items.

Clinical elevations are found on IE, DA, DIS, SC, and ISR. One critical item was endorsed.
The Intrusive Experiences (IE) consists of items reflecting intrusive posttraumatic reactions and symptoms. These include nightmares, flashbacks, upsetting memories that are easily triggered by current events and repetitive thoughts of an unpleasant previous experience that intrude into awareness. These phenomenon reflect the persistent re-experiencing group of symptoms associated with a DSM-IV diagnosis of both PTSD and ASD (Acute Stress Disorder). Such symptoms are typically perceived by the affected individual as ego-dystonic, and primarily involve reminiscence or reexperience of an especially unsettling event. Individuals scoring high on IE may report feeling out of control and a minority may fear that they are psychotic. High IE scores therefore typically reflect the intrusion of such traumatic material into current awareness, often inducing an associated state of distress.

The DA scale consists of items reflecting avoidance responses under the constriction group of PTSD and ASD. High scorers on this scale often describe a history of negative internal experiences that they attempt to avoid. DA endorsers attempt to avoid environmental experiences that might restimulate disturbing thoughts of memories. The patterns of avoidance here do not represent psychological defences as much as they represent conscious and intentional processes of behavioural avoidance to manage traumatic distress.

The DIS scale measures the extent to which the respondent experiences dissociative symptomology. Dissociation may be defined as a largely unconscious defensive alteration in conscious awareness, developed as an avoidance response to overwhelming, often posttraumatic psychological distress. Adapted from a previous measure the DIS scale measures a variety of dissociative experiences, including cognitive disengagement, depersonalization, derealization, out-of-body experiences and emotional numbing. These symptoms represent the most common dissociative responses and do not include the most severe and more rare dissociative reactions.
such as fugue states and Dissociative Identity Disorder (DID). Individuals scoring high on the DIS scale tend to report distractibility, 'spacing-out' and feeling out-of-touch with themselves and their bodies. They may report anxiety related to the aversive quality of intense depersonalization.

The SC scale measures sexual distress including dissatisfaction and dysfunction. The items address sexual dissatisfaction, negative thoughts and feelings during sex, confusion regarding sexual issues, sexual problems in relationships, unwanted sexual preoccupation, and shame regarding sexual activities. Individuals with high scores on this scale tend to report sexual conflicts, dysfunction of dissatisfaction with their sexual activities.

The Impaired Self-reference (ISR) scale measures a variety of difficulties associated with an inadequate sense of self and personal identity. ISR items include problems in discriminating one’s needs and issues from those of others, confusion regarding one’s identity and goals in life, an inability to understand one’s own behaviour, a sense of emptiness, a need for other people to provide direction and structure, and difficulties resisting the demands of others. Individuals who score high on ISR often appear to have less self-knowledge and self-confidence than others, may be more easily influenced by individuals or groups, and may present as easily excitable and less functional under stress.

As with the first administration, the elevations indicted above are combined into an interpretable 2-point profile. The combination of IE and DIS or DA, or both, is a classic posttraumatic presentation. This combination suggests he is reporting intrusive and avoidant components of traumatic experiences. Because AI is no longer elevated, he is not reporting autonomic hyperarousal. Elevations on these scales typically represent either an acute response to a recent traumatic stressor, or a more chronic PTSD response to an event. In the case of an
acute reaction to a traumatic event, the score signals a highly disruptive state where the individual is overloaded by trauma symptoms and often feels out of control of his internal state. With the longer-standing traumatic history, such elevations indicate relatively chronic symptoms that may become incorporated into his personality. Although the chronic condition often appears less dramatically, the experience of chronic PTSD is aversive and can result in serious psychological disability.

Factor analysis of the test items suggest that the 5 elevations reflect distress associated with the impact of traumatic events or processes and the sufficiency of self-resources to modulate the distress. Four of the elevations (IE, DA, DIS, and ISR) reflect the external experience of trauma symptoms, and 2 of the elevations (SC and ISR) reflect dislike or self-dysfunction. Elevations on both trauma and self-disturbance indictors suggest a more complex trauma victim evidencing chronic distress, overwhelmed by intrusive symptoms, and more likely to act out painful internal states by virtue of lesser self-resources to cope.

Comparison of the 2 measures indicates an improvement regarding the impact of the trauma symptoms. Both the SC and ISR scales fall at the cut-off score for clinical significance. The raw numerical elevations on both SC and ISR are such that a single numerical difference in 1 response on either scale would render the scales not clinically significant.

That he now endorses items making the SC scale significant is important. This suggests that he is either more open to revealing pre-existing sexual dissatisfaction, is reconnecting sexually with his partner, or is more aware of the issues that make him satisfied and dissatisfied. That he endorses these previously unendorsed items following the group experience is not viewed as a step backward. Instead, it is viewed as highly favourable reflecting his greater openness and awareness.
A more important change with the ISR scale is that it dropped from the first administration. This drop suggests he now has more self-knowledge and self-confidence than he reported previously.

It is significant for his social functioning that he no longer endorses the items that make the AI scale significant. Eliminating this scale suggests that he no longer reports experiencing angry and irritated thoughts that lead to distress.

TSI Profile Summary. Examining the two administrations of the profiles suggest an overall improvement in trauma symptoms. From the first administration to the second administration, Duff largely endorsed items corresponding with lower levels of trauma symptoms.

Beck Depression Inventory-II (BDI-II) and Self-Esteem Rating Scale (SERS). The inverse relationship between depression and self-esteem is evident from figure 13 below.

**Figure 13 Duff's BDI & SERS Results**

Over the course of the three administrations of the BDI-II, Duff demonstrated a progressive trend towards lower levels of depressive symptoms. Beginning with reporting
symptoms consistent with Mild Depression on the first 2 administrations, he endorsed items consistent with Minimal Depression at the third administration.

Over the course of the three administrations of the SERS, Duff endorsed items consistent with positive levels of self-esteem. Beginning with a minimum possible score of −120 up to a maximum possible score of +120, he began with a stable level of self-esteem. The level of self-esteem lowered slightly at the end of the group process, and rose sharply in the follow-up session. This sharp rise as measured at the follow-up session is likely due to a decision of self-care this participant reported demonstrating following the termination of the group.

Fred

Throughout the first interview, Fred explained that he is not emotionally expressive and that to be expressive was considered weak. He said that his purpose for being a member of the group was to help others and that he did not feel he carried residual issues from traumatic experiences.

Pre-Program Core Narrative: I am Hardnosed to Survive

Orientation (places the narrative in a context).
Hardnosed [means] don’t mess with me (laughs).

Hardnosed, and I think that part of me was shaped in those 5 years.

I don’t take no nonsense.

Abstract (an overview of the narrative).
But you know what, my wife was the anchor, and I never realized how strong this woman is ’cause she’s the opposite. She’s very soft spoken, very quiet. You would never know, but at the same time, there’s steel in there. An honour, there’s a core in there, and she proved to me over and over again.

The other side was shaped by my upbringing; and also other things like my father was quite strict. We never were well brought up, my family. We had a close-
knit family, and all this. My father was very strict, so but the other side is that that's army.

And I really enjoyed it. I had no problems with discipline, and I think I have to thank my strict Dad. My dad was strict (shivers).

Plot (the action of the narrative).
I sort of tried to tell [my daughter] what to do in her teenage years. I learned a quick lesson there. It doesn’t work.

When I got out of the army, the way the Canadian army does it, you serve for 5 years, they say goodbye, and you’re on your own. That’s how it is, how it still is. So here I was on Civvy Street, and it’s very confusing. I had to reinvent myself.

We’re not interested who cares, and even within your own family. My wife is not comfortable to talk about [my military experience].

I tried to tell her about something that you see on television, and I won’t talk. I know she’s very nice, she says, “Yes, yes,” but I know she couldn’t care less…. My wife doesn’t like violence…. on television, and sometimes when we see [recent military operations] and all this, and I say, we had a few tough times in [my tour] too, and, “Oh, yeah, yeah,” but she doesn’t, that’s it…. So I choose to forget it.

My knee went. I couldn’t work…. I really have strong work ethics. I always felt you don’t work, you you’re a parasite…. And when I couldn’t work; that was the end…. I even was thinking of blowing my head off…. I truly felt because I’m of a farm when an animal’s no longer useful, you shoot it.

Resolution (how the narrative was resolved).
Once I got to know what a beautiful child, not only beautiful in looks, but also the way she was brought up, I really fell in love with my daughter, and now I think now we have a super relationship.

Narrative Summary
Fred explained that from an early age he was trained by his father to be hardnosed in order to survive. In spite of the survival benefit of being hardnosed, it has cost him over the years. The unwavering way he applied this attitude almost resulted in his own suicide. The way he described being hardnosed and how he talked about his wife and his military experience, was
reminiscent of someone who had never been heard. He was never able to tell his story and relate his experiences. This not being heard only further isolated him and reinforced his need to be hardnosed.

He explained that he was not heavily involved in how his daughter was raised. He explained that when she became an adult, and he stopped working, he was able to begin to be less hardnosed and open up to his daughter. He explained that this relationship has helped him open himself to others.

Fred's Therapeutic Enactment

Drawing from the branching points homework, Fred told the facilitators that he wanted to resolve a long-standing issue with his father who died approximately 12 years ago while Fred was reaching middle age. He said that his father died in their home country approximately 12 years ago and he did not go to the funeral because his father told him not to attend. He had a group member as his double another as his father. Through the enactment he realised that he never heard from his father that he was proud of Fred or that he loved Fred. He became anxious to hear that his father loved him. Through the enactment Fred reversed roles so Fred took the role of his father and spoke to himself as portrayed by a double. Fred as father reminded Fred that when he was a young boy, his father went into the army in their home country to protect the family. If his father did not join the army the family would have been sent to a camp. The enactment ended with Fred embracing his ‘father’ and while being emotionally demonstrative, Fred told his father that he loved him.

Of significance, Fred said that he used to speak to his father in their mother tongue. During the post-program interview, Fred said that when he spoke with the participant who
portrayed his father, he heard his father's particular accent and dialect. He said that the participant disappeared and that he heard his own father.

Post-Program Core Narrative: Leaving a Rucksack I Didn't Know I Had

Orientation (places the narrative in a context).
In the army.... You just talk stupid things meaningless things. No, no deep thoughts, you know, like you talk about women, sex, beer. Maybe you talk about your job your profession, there was nothing deep thinking there..... You never would tell them about your feelings or your emotions, or you tell them you’re scared. There was sometimes we were all scared, but I even take the unwritten rule was, you don’t tell anybody you’re scared.

Abstract (an overview of the narrative).
I would’ve rather died before I say, “I’m scared.” No way, or “I’m crying,” no way. If I would need to cry, I’d go somewhere where nobody could see me, and I’m sure... all those guys would agree with me. You just you never wanted to, especially, I’m talking about infantry. You never wanted to be recognized as being [what] they call weak. It’s not weakness. It’s a strength actually.

I felt ashamed.... I was brought up, men don't cry.

I don’t like to cry in public.

Before, I would never I would rather walk away if there was an occasion in public. I would go in a room and if couple of occasions where I was it really disturbed me what I’ve seen and what I’ve experienced, so but I definitely would never cry in public in front of, especially, in front of other men.

I’m not the type of person who cries about every little thing. I always felt that I can have control over my emotions. I’m the macho type (laughs). It definitely proved me wrong, completely.

I’m a private person. Before I joined the group... I was determined not to reveal too much of my private life. They [were] basically strangers and so I said, “No way. I’m not. I’ll just be cool....” But it didn’t work out that way (laughs).

Plot (the action of the narrative).
I sort of built layers over my feelings over the years, and ... some of these layers definitely got stripped off.
You seen in a group of six grown-up men here, and we all bawl (pause). I mean, (pause) what more can I say because, ... I know some of those guys. Some of those guys are tough cookies.... When [one veteran] he started crying I couldn’t help it, and in a way..., I’m glad ... ‘cause it still shows that I’m a human.

It's a permission to break that code of... [not] showing feelings or emotions.

I could speak freely without being looked on as a bull-shitter, a liar, like you were there with soul mates. That’s how I felt anyway, and it was good. It was a good feeling.

I never even realized actually that it is baggage. Like you wear a rucksack all day long, you after the end of the day, you didn’t remember you’re carrying it.... When people have pain, they get used to it. You didn’t notice you have it. Which [is the same] I have with [my] bad knees. I didn’t notice sometimes, but the pain is there.

Resolution (how the narrative was resolved).
When you see a bunch of guys cry, I said, “Well, you’re in good hands.” I would’ve trusted those guys with my life.

I did the one side of me said, “No, I’m not saying anything,” but at the same time on the other side, like especially with my father my relationship with my father, but after once it all came out, I felt actually good about it, and I still feel good about it.

It was important that my comrades accepted my stories with no questions.

Sharing his grief is (pause).... I felt like giving him a hug.... and I’m not a hugger. I don’t really like to hug, other men especially. Because, there was a man there who bared his soul, and he definitely is hurting. This guy was really hurting, and somebody should go over there and say, “Hey, it’s Ok. You done nothing wrong....” I felt is saying, "It’s Ok. Don’t be ashamed of it."

Coda (a reflection on the narrative after the event has past).
I’m [at a later age in life]. Quite an old fogey like me needs to hear that, but maybe there’s something in all of us (crying). You got to be told [by your father], “You did well. I’m proud of you...,” especially maybe more so for men.

Narrative Summary
Fred held on to grief and would initially not release it. Once he saw others he respected in the group expressing difficult emotions, he felt he was given implicit permission to express
himself more freely. One important grief experience he expressed, as he explained, was hearing from his father. In spite of being one of the older men in the group, he carried the burden of long-standing grief. He explained that he had been carrying the grief for so long that he forgot it was there, and was relieved to release it.

Fred's Psychometric Test Data

*Trauma Symptom Inventory (TSI) First and Second Administration.* Examining the validity scales of both TSI profiles suggests valid and reliably interpretable profiles. The T score on the Atypical Response (ATR) validity scale suggests a pattern of responding where he does not attempt to present as disturbed or dysfunctional. The Response Level (RL) validity scale suggests he responded to the questions with openness and a willingness to acknowledge traumatic symptoms. The Inconsistent Response (INC) validity scale suggests a consistent pattern of responding to test items. The graphic representation of Fred’s TSI profile appears below in Figure 14.

Examination of the Clinical Items on both of the profiles demonstrates no elevations. Combined with the validity scale, this suggests he does not experience traumatic symptoms.

A qualitative comparison of these 2 profiles reveals that between the administrations, there was minimal change. Although not clinically significant, both profiles show comparative spikes on the IE and DA scales. With the second administration, the IE level dropped, whereas the DA scale remained identical with a clearer spike. This spike remains not clinically significant because the T-score of the item with 10 points of the other scales.
Fred's TSI Results

Qualitative analysis of the individual items indicates that the second administration response trend was a generally lower endorsement of all the items, except for one item. The single item that was endorsed higher the second time was item 59, which reads: Staying away from certain people or places because they remind you of something. Without knowing the specifics of this response, I am encouraged by the possibilities. With the higher endorsement in this second administration, it is possible that when he answered this item, he was referring a recent decision to leave a veteran-related organisation that he created due to conflicts among the executive members. If this is the case, then it demonstrates an increase in his self-care.

Beck Depression Inventory-II (BDI-II) and Self-Esteem Rating Scale (SERS). The inverse relationship between depression and self-esteem is evident from figure 15 below.
Over the course of the three administrations of the BDI-II, Fred endorsed items consistent with Minimal Depression. The pattern of the scores demonstrates that immediately following the group; he reported the lowest level of depression.

Over the course of the three administrations of the SERS, Fred endorsed items consistent with stable and positive levels of self-esteem. Beginning with a minimum possible score of −120 up to a maximum possible score of +120, he began with a strong and stable level of self-esteem. Over the course of the three administrations, he endorsed items consistent with an ever-increasing level of self-esteem. A noticeable rise in self-esteem is evident as measured at the third administration. This noticeable rise is likely due to a decision of self-care Fred reported demonstrating following the termination of the group.

Figure 15 Fred's BDI and SERS Results
Greg

Throughout the first interview, Greg explained how he continues to be troubled by multiple traumatic symptoms. He expressed distrust and scepticism about the program and its efficacy. He explained that he has been struggling for acceptance and understanding by those around him.

Pre-Program Core Narrative: I've been on Patrol for 26 years

Orientation (places the narrative in a context).
I've been involved with the military all my life. My dad was in the military.

I was brainwashed into being the military, and I was doing well in school. Well, I had a fear of coming home with my homework because ... my father was a real tyrant (Pause). Yeah, so this is another reason why I joined the military.

I trust nobody. I don't even trust myself at times.

I've got a lot of anger.

Douglas: Yeah, I can see when you're holding your hands up like that (sigh and breathing heavily). Douglas: And making fists like that, and I can see that... P: Take care of myself baby.

My whole life. I mean 25 years of my life is justpptttt! It's just shoved to shit! How do I regain it?

'Cause I knew there was something wrong with me. I didn't know what.

I have a clear, conscience memory of things during the past, but in the recent history since '97, '98, everything's been kind of a funny blur to me.

Chaos going on.

It's almost like I think I have Alzheimer's.

Or old age dementia (laughs) or something like that.

Like I try to socialize and not come off as being a bit of a flake or a nut because of my one-liners and stuff like that.

Abstract (an overview of the narrative).
I'm sure not raising my expectations.
You can't cure and you live with it this long. It's part of your life.

We were the guys who were the hairy-assed killers.

We were the ones that were trained to kill, kill, kill. You know you had it drilled into your head, kill, kill, kill or be killed.

This right now is fucking not going to go anywhere 'cause the military and the government will not fucking do anything about it because I've seen these surveys. I've seen all this shit done before.

Nothing fit for me.

Even trying to explain this goblin in the closet that people do not really understand.

I was told, "Oh, ... you don't need that anger."

I have a right to be angry.

Do you know 25 years of frustration, uh, February 16th, 1977, that's when the incident happened, and I'm not going to go any further with that.

I'm a nasty little secret.

The anger! That anger! .... It's a combination of the abandonment with ... the incident that happened. There's several incidents that happened.

I've just literally given up.

*Plot (the action of the narrative).*

I have busted my fucking balls for the military and the government and I get kicked in the nuts.

Stabbed in the back literally.

Being abandoned, and it being minimized was what happened.

Branded as a coward.

I wouldn't do it. I refused to kiss ass.... I'm not an ass kisser.... I was a lone wolf.

I do go on rages, and I destroy things because I'm just so frustrated. I don't know where to take my anger out on.
Also I couldn't handle being on Civvy Street.

I just felt, yeah, like a frog coming up my throat, the heartburn.

I'm always shaking.... I'm always sweating profusely.

Just getting into partying.... Going fucking wild.... All of a sudden I just (pause) I just started shying away from people because I was being used by a lot of people.

And then in '86 I went back over to [the theatre where I served] (laughs) in a blue beret cap. I was so fucking scared. I didn't want to go back there.

Run away, run away run away. That's our whole family - run away from the problem.

Resolution (how the narrative was resolved).

Douglas: How have you survived? P: I'd say there's got to be a light at the end of the tunnel 'cause it ain't an oncoming train. If it is an oncoming train, it's going to blow its fucking tracks off there. ... I've got hope in some aspects. I'm hoping for vindication.

Coda (a reflection on the narrative after the event has past).

It was a cumulative bunch of shit that happened there.

I've been on patrol for 26 years.

I'm still on patrol.

When the fuck am I coming home?

Narrative Summary

Greg explained that he holds deep anger and resentment toward the military and some of the people he served with. He expressed feeling very disturbed from multiple incidents that happened while serving in the military. One incident in particular continues to trouble him and he set that as a limit of how far he would go in the interview. He did not want to elaborate on that incident, and was not pushed to.
The troubling feelings he expressed suffering from continue to haunt him. He has been unable to let go of the issues and they hold him in the past.

Greg’s Therapeutic Enactment

Greg did the first enactment a week prior to the others. He enacted a conversation he had with a former colleague. Greg and his colleague were held hostage while serving overseas. Following the incident, when Greg spoke with his colleague, the man denied that the hostage taking occurred and called Greg a liar. After many years, Greg is haunted by the denial; the ensuing public shaming of being called a liar, and never received resolution from this issue. Through the enactment Greg had other group members play his double and the colleague. He was able to witness his double yell at his colleague and felt the support of his double and the group when he spoke to the colleague himself. Greg reversed roles with his colleague and gained a better understanding of his colleagues’ motivations.

Post-Program Core Narrative: More Control

Orientation (places the narrative in a context).
It’s like I was feeling restless... fidgety
I can’t handle noises and crowds. I can’t handle people.
Hesitation while I’m doing something myself.
I still have my anger spats but.... I just feel angry. Just ready to explode, I guess.
When I explode. I black out. I just go psychotic.

Abstract (an overview of the narrative).
I mean, not being relaxed like I am now. I can look at you in the eye.
I was mousy.... I hid in my computer room.
Plot (the action of the narrative).
I’m still fidgety at times, but not as bad per se. I have to keep in check.

I wasn’t relaxed. I was nervous. That’s part of the mistrusting and nervous, being mistrustful of other people.

Douglas: How do you see yourself as a bit more confident? P: Being able to look people in the eyes when I’m talking, when I carry on a conversation.

I’m starting to trust myself more.

Resolution (how the narrative was resolved).
[Witnessing an enactment] took you back to the time, to the spot, to the place. It was almost like a spiritual experience because you’re releasing negative energy. You’re getting rid of something that’s been lying there for years.

It was people [in the group] not being critical about what you’re saying or doing. (Pause) Running you down saying, “Oh, I don’t believe you. No, I don’t believe you. Oh, I don’t believe that.”

[Being able to] tell my story without being ridiculed. Just to share without being ridiculed because of someone else’s nervousness about what happened. Really wanting to acknowledge it.

It let me unload a lot of stuff.

Coda (a reflection on the narrative after the event has past).
People noticed a difference in me just in the time after the enactment. … I was talking … more calm. I noticed the same thing after … they told me…. I was quieter, and I could look them in the eyes. Assertive, less aggressive, but I wasn’t as angry. It felt good.

[The enactments] seemed to be the … transitional point because (pause), I had a feeling that it helps in a lot of ways. And there’s still more that I need to do.

Narrative Summary

Before the group, Greg explained that he was nervous, anxious, mistrusting of others, and mistrusting of himself. After the group, he felt a little more confident. The increase in confidence came from the group hearing his story, and not judging him. He did not feel ridiculed, misinterpreted, or dismissed as he was used to. He recognised that even though he
successfully completed the program, he has more work to do. This program provided him with some hope of success for the future, where he had very little hope before.

**Greg’s Psychometric Test Information**

*Trauma Symptom Inventory First administration*

Examining the validity scales of the TSI suggests a valid and reliably interpretable profile. The Atypical Response (ATR) validity scale suggests a pattern of responding where he does not attempt to present as disturbed or dysfunctional. The Response Level (RL) validity scale suggests he responded to the questions with openness and a willingness to acknowledge traumatic symptoms. The Inconsistent Response (INC) validity scale suggests a consistent pattern of responding to test items.

Examination of the Clinical Items identifies 2 elevations. Anxious Arousal (AA) and Intrusive Experiences (IE) are elevated. The graphic representation of Greg’s TSI profile appears below in Figure 16.

Scores on this scale reflect the extent to which he is experiencing symptoms of anxiety and autonomic arousal. Individuals with high scores on this scale may report periods of jumpiness, feeling ‘on edge,’ excessive worrying and fears of bodily harm. They frequently describe themselves as tense and may report reacting to stress or sudden intrusive stimuli with fearfulness or an exaggerated startle response. Such individuals often present as hyperalert and hypervigilant and may describe somatic symptoms consistent with sympathetic nervous system hyperarousal. Both generalized anxiety and specific tendency toward panic attacks are not uncommon among people with high AA scores.

The Intrusive Experiences (IE) consists of items reflecting intrusive posttraumatic reactions and symptoms. These include nightmares, flashbacks, upsetting memories that are
easily triggered by current events and repetitive thoughts of an unpleasant previous experience that intrude into awareness. These phenomenon reflect the 'B' group of symptoms associated with a DSM-IV diagnosis of PTSD and a category 'C' symptoms in the diagnosis of ASD. Such Symptoms are typically perceived by the affected individual as ego-dystonic, primarily involved reminiscence or reexperience of an especially unsettling event. Individuals scoring high on IE may report feeling out of control. And a minority may fear that they are psychotic. High IE scores therefore typically reflect the intrusion of such traumatic material into current awareness, often inducing an associated state of distress.

**Greg’s TSI Results**

![Greg's TSI Results](image)

Figure 16 Greg’s TSI Results

Factor analysis of the test items suggest that the 2 elevations reflect distress associated with the impact of traumatic events or processes. This suggests he has sufficient self-resources to
modulate his distress. These elevations suggest this participant presents as a more classic, uncomplicated trauma victim.

*Trauma Symptom Inventory Second Administration.* After writing the TSI measure, Greg informed me that he forgot to take his medication that morning as his physician had instructed him. Without his medication, he explained that he feels more ‘on edge’ and less settled. This less settled feeling is evident in the second profile. In the brief comparison of the profiles below, two other possibilities for the significant changes are proposed.

Examining the validity scales of the TSI suggests a valid and reliably interpretable profile. The Atypical Response (ATR) validity scale suggests a pattern of responding where he does not attempt to present as disturbed or dysfunctional. The Response Level (RL) validity scale suggests he responded to the questions with openness and a willingness to acknowledge traumatic symptoms. The Inconsistent Response (INC) validity scale suggests a consistent pattern of responding to test items.

The six clinical scales that are elevated include: Anxious Arousal (AA), Depression (D), Anger/Irritability (AI), Intrusive Experiences (IE), Defensive Avoidance (DA), and Dissociation (DIS).

The scores on the AA scale reflect the extent to which he experiences symptoms of anxiety and autonomic hyperarousal. People with high scores on this scale may report experiencing trembling or shaking, nervousness, jumpiness, feeling “on edge”, excessive worries and fears of bodily harm. They frequently describe themselves as tense and may report reacting to stress or sudden intrusive stimuli with fearfulness or an exaggerated startle response. Such individuals often present as hyperalert and hypervigilant and may describe somatic symptoms consistent
with sympathetic nervous system hyperarousal. Both generalized and specific anxiety including a tendency toward panic attacks are not uncommon among people with high AA scores.

The D scale measures the extent to which he experienced depressed mood and depressed cognitions. High scores on this scale reflect frequent feelings of sadness and unhappiness and a general sense of being depressed. Individuals with high D scores report perceptions of themselves as worthless and inadequate, a view of the future as hopeless and a tendency to have thoughts about death and dying. Behaviourally, these individuals may describe periods of tearfulness and secluding or isolating themselves from others. Suicidality, and self-injurious behaviour is always a possibility with high D scorers. Suicidality must be explored when the Tension Reduction Behaviour (TRB) score is also elevated. Three critical items are examined for suicidality. He did not endorse the item regarding suicidal behaviour (25), minimally endorsed the 2 items of thoughts of death (30 and 90) and the TRB is not elevated, therefore suicidality is not a concern as far at this measure is concerned.

High scores on the AI scale indicate the extent of angry mood and irritable affect. High scores on this scale may reflect either the irritability often associated with PTSD or a more chronic angry state. The AI taps not only the internal experience of anger or irritability, but also the presence of angry cognitions and angry behaviours. Individuals scoring high on AI often describe anger as an intrusive and unwanted experience and may see their angry thoughts or behaviour as not entirely in their control. Such people often describe pervasive feelings of irritability, annoyance or bad temper such that minor difficulties or frustrations provoke contextually inappropriate angry reactions.

Because aggression toward others is always possible among those who score high on AI, the critical item of hurting others must be considered. He endorsed the critical item (19) that
reads: Thoughts or fantasies about hurting someone. Dangerousness to self or others is not a concern at this time because the TRB scale is not elevated.

The Intrusive Experiences (IE) consists of items reflecting intrusive posttraumatic reactions and symptoms. These include nightmares, flashbacks, upsetting memories that are easily triggered by current events and repetitive thoughts of an unpleasant previous experience that intrude into awareness. These phenomenon reflect the persistent re-experiencing group of symptoms associated with a DSM-IV diagnosis of both PTSD and ASD (Acute Stress Disorder). Such symptoms are typically perceived by the affected individual as ego-dystonic, and primarily involve reminiscence or reexperience of an especially unsettling event. Individuals scoring high on IE may report feeling out of control and a minority may fear that they are psychotic. High IE scores therefore typically reflect the intrusion of such traumatic material into current awareness, often inducing an associated state of distress.

The DA scale consists of items reflecting avoidance responses under the constriction group of PTSD and ASD. High scorers on this scale often describe a history of negative internal experiences that they attempt to avoid. DA endorsers attempt to avoid environmental experiences that might restimulate disturbing thoughts of memories. The patterns of avoidance here do not represent psychological defences as much as they represent conscious and intentional processes of behavioural avoidance to manage traumatic distress.

The DIS scale measures the extent to which the respondent experiences dissociative symptomatology. Dissociation may be defined as a largely unconscious defensive alteration in conscious awareness, developed as an avoidance response to overwhelming, often posttraumatic psychological distress. Adapted from a previous measure the DIS scale measures a variety of dissociative experiences, including cognitive disengagement, depersonalization, derealization,
out-of-body experiences and emotional numbing. These symptoms represent the most common
dissociative responses and do not include the most severe and more rare dissociative reactions
such as fugue states and Dissociative Identity Disorder (DID). Individuals scoring high on the
DIS scale tend to report distractibility, 'spacing-out' and feeling out-of-touch with themselves and
their bodies. They may report anxiety related to the aversive quality of intense
depersonalization.

The profile for this second administration illustrates clinical elevations on all the trauma
symptom scales and no elevation on the primary self-dysfunction scales. Trauma symptom
scales reflect intrusive, avoidant and dysphoric symptoms. These symptoms may be interpreted
as external challenges. That only no primary self-dysfunction scale is elevated suggests that he
has sufficient self-resources to cope with the external challenges. Consequently, this profile
reflects a classic trauma victim.

Comparing the profiles of the first to the second administration reveals more clinical
elevations at the second administration. Without the benefit of an in depth clinical interview, it
is impossible to know the source of the elevations. I propose three possible sources of elevation.
As explained above, Greg reported that he forgot to take his medication the morning he wrote the
measure. A second possibility is that the increase in elevations may reflect a tendency towards
more openness. A third possibility is that the increased elevations may reflect the immediate
challenges and resolution the participant related in the follow-up group session.

*Beck Depression Inventory-II (BDI-II) and Self-Esteem Rating Scale (SERS).* Figure 17
below is the graphic reflection of the BDI-II and SERS results.
Over the course of the three administrations of the BDI-II, Greg endorsed items that suggest symptom, corresponding with severe depression. The first and second administrations of the measure resulted in the exact same number. The third administration resulted in a slightly lower score. It is favourable that the third administration was lower on the BDI-II, however, the result remains in the Severe Depression range.

Over the course of the three administrations of the SERS, Greg endorsed items consistent within both the positive and negative ranges of self-esteem. Over the course of the three administrations, he endorsed items resulting first in a very slightly positive range. The range at the second administration was in the slightly negative range. A noticeable rise in self-esteem is evident as measured at the third administration. This noticeable rise is likely due to a decision of self-care this participant reported demonstrating following the termination of the group.
Nate

Nate explained that he felt fortunate about his military career. He said that he was excited about the experiences he had and that he had looked forward to remaining in the military for a long time. However, he said that he gave up his military career to marry his wife. Leaving the military for marriage was a bitter sweetness for him.

Pre-Program Core Narrative: I Feel Incomplete

Orientation (places the narrative in a context).
I have a bit of a hole there that needs to be filled, I think.

None of us joined to go to war. That’s not why we joined. We joined to, you know, travel, meet people, adventures.

Abstract (an overview of the narrative).
It was busy ’cause I got put on a … course, with my friends again, and, … we talked about what I had done, what they had done, and life just like went on, right. You’re so busy there…. You’re hardly ever home, yet they don’t really give you time to think about it, and they definitely don’t talk to you about it, or they didn’t back then, right. It’s your job.

I thought I was going to stay in the military.

It’s kind of a weird feeling thinking I should still be in.

Plot (the action of the narrative).
[The Gulf War] was just starting then, and like my unit wasn’t going…. I had friends…. They went over there, so yeah, it was kind of weird. Definitely watched all the news footage I could on the whole thing.

When the [recent combat situation] started, my unit, my old unit … were the first ones to go, actually. My buddy was on the front cover of the [local newspaper] waving goodbye to his wife…. That was kind of unreal to see that. It … really felt like you should be there. I joined with these guys, went through boot camp, through all the stuff you go through. It was kind of, didn’t seem right. Didn’t seem like you know, I should’ve been there.

I’m more there [at the bar] listening to them, seeing it kind of through their eyes, you know what I mean…. (pause) I feel sorry for my friends for the things they
had to see and do, and *(pause)* I guess.... I wish I would had been there with them

I guess I don’t see how fortunate I was in not going.

Resolution *(how the narrative was resolved).*

I joined the militia at one point too, a few years after I’d gotten out. You’re getting all this thinking, “Well, you know,” and you miss it. I mean, you miss a lot of things that you did. Joined that, didn’t really fit in, no problem. But it wasn’t the same. It wasn’t the same as being with the regular force, so I got out of that.

I guess, I get my what I need hearing what they’ve done.... I’m craving whatever they tell me.

Like when my buddies talk, it’s like in my head. I’m there, and you’re trying to visualize, and you know, you see pictures and stuff and them talking.

I just feed off of this stuff. It would be good for me. I’m sure to go and actually hear more stories of what other units [did].

Coda *(a reflection on the narrative after the event has past).*

I still have that feeling that I’d like to go and do a UN tour. I just feel that it’s something I missed out on in my career that would’ve, I guess, made it complete then.

**Narrative Summary**

Nate expressed a longing for the camaraderie he experienced while he was in the military. He explained that he was very lucky throughout his military career because he was not exposed to traumatic events that the comrades even in his own unit were exposed to. He said that when potentially traumatising events occurred, he was somewhere else.

His luck contributed to the grief he still carries. His grief is that he left the military on the insistence of his then fiancé. Shortly after he left, his unit was dispatched to a combat zone and he could only watch from his television. He explained that he felt like he was letting his unit down by not being present with them when they were doing what they were trained to do.
Over the years, he attempted to compensate for the loss by joining a group similar to the military, but he said that it was not the same. By meeting with his former colleagues, who are still in the military, is the only way he has been able to cope with the loss.

Nate’s Therapeutic Enactment

Nate expressed that he wanted to enact a business meeting when he lost his voice and felt publicly humiliated by his former colleagues. Since that meeting occurred, every time he saw that colleague’s vehicle in town, Nate would be flooded with an overwhelming anxiety. He would sweat, feel anxious with a tightening of his voice and be distracted for a prolonged period after his the vehicle passed. The goal of the enactment was for him to retrieve his voice. Nate witnessed the enactment, and allowed his double to speak for him. He had group members participate as his wife, and as his former business associate who were present at the meeting. Because he himself did not participate in the enactment he experienced a vicarious catharsis. He witnessed justice occurring for him and did not feel the need to say anything.

Post-Program Core Narrative: Communicating with Confidence

Orientation (places the narrative in a context).

I kind of saw myself not being in the group. Seeing myself as kind of an outcast being in the fact that I had never done a [military] tour, [I] served [overseas], but had never done an actual [military] tour.... Well, not an outcast, but just kind of somebody on the outside. All these fellows had had some form of I guess you’d call it a combat experience. You know, and I have never had an actual combat experience.

Hoping for the acceptance.... As soon as we started to get into the group ... the brotherhood was there right away; ... even though I hadn’t done exactly what these fellows had done.

I knew I fit in the within the first hour. I knew that I was amongst my peers. It was great. I miss that. I hadn’t had that since I got out of the military
Abstract (an overview of the narrative).

I expected more of me to hold me back, and that’s the one thing that [the peer support worker] said, “The more you put into the group, the more you’re going to get back.” ... After hearing that, I thought, “Yeah, you know this is the place to do what you need to do.”

I notice a difference. I do. It’s hard to put an exact finger on. The exact difference like on my re-enactment with my ex-business partner; up until that time I still had a problem (pause) seeing him. My voice would crack..., your nerves are going (laughs), and the heart’s pumping, and I haven’t actually seen him face-to-face, but even when I would see his vehicle pass me, you could physically know that you have some anxiety or whatever. Just seeing his vehicle, you know he’s there, and now [after the enactment] I’ve seen his vehicle a couple of times .... I’ve let it go.... I just had some closure on the whole thing.

At home with my wife, little more tolerance.

Plot (the action of the narrative).

The closure on that one, the re-enactment. You’d feel the anger inside.... You just get all knotted up and anxiety.

You remember the incident. It’s so fresh in your mind. It’s pasted right there, and when you re-enact it, it brings it, right there.

You think you have control of your emotions (laughs), and you don’t. You have no control, and that’s the first thing that I noticed. I thought, “Ok, well, I’ll take deep breaths and walk through this, and it’ll be calm and cool and calculated,” and it wasn’t. It was real, and it was fast.

Resolution (how the narrative was resolved).

It’s a non-issue now to me. ... I know I’m confident that when I see him in face-to-face, I’ll be able to go, “Hey, how’s it going [former associate]?” And not worry that he’s going to hear my voice breaking and know that inside you’re still whole, and I know that won’t happen [because I have] ... confidence.... I know that for a fact.

My wife coming [to the group], was good ‘cause the second spouse night my wife made a statement that she said, “I didn’t honour my husband’s time in the service as much as I should’ve ‘cause obviously it meant a lot to him.” That meant a lot to me.

You realize that you were missing something. .... She needs to talk. That’s the one thing the group taught you was to listen, and the communication skills. You never think that you’ll use them. I thought they were teaching us these for the
group how they’re going to set up (laughs) the group, but you don’t realize that I need this in life.

I’ve noticed with a couple of my employees that I changed my (pause) tactics … from what I’ve learned from the course

*Coda (a reflection on the narrative after the event has past).*

The whole program has been great for my wife and I, and we’ve noticed that, and we’ve talked about that…. Just better communication.

You don’t realize it until you do the first [therapeutic enactment] how therapeutic it is. To just get rid of it.

We shared so much. … I’ve never (pause) shared anything like this, or done (laughs) anything like this with anybody but those guys. (Pause) It’s pretty uh pretty personal bond that we had.

*Narrative Summary*

The program was helpful for Nate in multiple ways. He expressed surprise that the skills he learned in the program were applicable beyond the group setting. He said that both he and his wife noticed the change in how they related to each other. He explained that one of the helpful experiences was when his wife attended the group and realised, through the group, how important his military experience was for him. With this realisation, she will have a better understanding of him.

A second helpful event was the peer support worker who challenged the participants to put as much into the group as they wanted to get out of it. Nate expressed that the statement from the peer support worker changed how he participated in the group. Initially thinking he was going to hold himself back, he decided that he would contribute as fully as he was capable, and hoped to benefit.
Nate’s Psychometric Test Data

Trauma Symptom Inventory First administration. Examining the validity scales of both TSI profiles suggests a valid and reliably interpretable profile. The T score on the Atypical Response (ATR) validity scale suggests a pattern of responding where he does not attempt to present as disturbed or dysfunctional. The Response Level (RL) validity scale suggests he responded to the questions with openness and a willingness to acknowledge traumatic symptoms. The Inconsistent Response (INC) validity scale suggests a consistent pattern of responding to test items. The graphic representation of this participant’s TSI profile appears below in Figure 18.

Examination of the Clinical Items demonstrates no elevations. Combined with the validity scales, this suggests he does not experience traumatic symptoms.

![Nate's TSI Results](image)

**Figure 18 Nate's TSI Results**
A qualitative comparison of these 2 profiles reveals that between the administrations, there was minimal change. Although not clinically significant, the trend in the profile pattern was generally lower clinical scores on at the second administration.

Of possible significance is that during the second administration, he endorsed a critical item, but during the first administration no critical items were endorsed. The critical item was number 58 and reads: Getting into trouble because of your drinking. The item was endorsed minimally suggesting that it has happened in the past 6 months, but has not happened often. Without further exploration, it is uncertain if this is an increasing trend, or an increased willingness to acknowledge alcohol use as a possible problem.

*Beck Depression Inventory-II (BDI-II) and Self-Esteem Rating Scale (SERS).* Figure 19 below is the graphic reflection the Nate’s BDI-II and SERS results.

Figure 19 Nate’s BDI and SERS Results
Over the course of the three administrations of the BDI-II, Nate endorsed items that were consistent with Minimal Depression. Even though the range was consistently in the minimal range, the results over the three administrations demonstrate a trend towards progressively lower levels of depressive symptoms.

Over the course of the three administrations of the SERS, Nate endorsed items consistent with stable positive levels of self-esteem. Beginning with a minimum possible score of $-120$ up to a maximum possible score of $+120$, he began with a strong and stable level of self-esteem. Over the course of the three administrations, he endorsed items consistent with an ever-increasing level of self-esteem.

Vic

Throughout the first interview Vic explained that he wished he could have done more while he was serving overseas and that he regrets some of the actions in his life. He said that he wished he could be in a different place at this stage in his life and feels like a failure because he has not accomplished the goals he has.

Pre-Program Core Narrative: I Am Afraid of Failing Again

Orientation (places the narrative in a context).

It's one of my greatest fears in life that I will live a wasted life, and I am feeling that very much.

Sense of excitement being out there when life and death is around you and you're in the middle of it and uh its almost like you have these questions, are you good enough to survive? You know the excitement, the adrenalin, being with your buddies, you feel confident and everything else.
Abstract (an overview of the narrative).

I enlisted in [the army in my home province].... This was shortly after I went to the University [near my home] one year and I didn’t do well. They put me on academic probation.

Plot (the action of the narrative).

I went on a C6 general alert.... I got pretty tense. I was like forgetting to do certain drills with the machine gun. As you know so we were all charged emotionally for sure.

I was upset when we came home and didn’t see that anyone was even aware that we were over there.

I don’t have my driver’s license, and that’s another fear I haven’t been able to tackle. And that’s another thing I’ve been, I think that’s one of the issues I have problems with.... You can get a military driver’s license, which I was terrified during the course because here was the fear I had to face but the thing with driving our armoured personnel carrier, which is a tank, you have a crew commander. So you have somebody there guiding you, helping you. It’s not like you are driving around yourself. I always had that link that I wasn’t totally dependent on myself.... After a couple of years I was confident to drive it on my own. But even after doing that, I still was afraid to get my license. I had some serious issues, fears, these fears that I’ve had since my childhood and I think the military helped me deal with lots of fears but once I got back out in the civilian world, its almost like I regressed back into that.

We were on a live fire exercise and that doesn’t happen very often where they give you, all the equipment. They give you to operate and I was on the rocket launcher. I had four [rockets]. I was designated, and given the order to fire at this one target and I missed it four times.... I just felt again, it was just, other guys were doing well. It just seemed like I didn’t do my part.... You could see the disappointment in your instructor’s eyes.

The military kind of helped for a short while but I got out of it. I think maybe I was afraid as well that they said they were going to give me courses for leadership and I didn’t know if I could handle that as well.

I had a lot of wasted time so basically I didn’t work for about half a year, all I did was party, enjoying life.

I was drinking so much hard alcohol, rum, that I would blank out and I would lose memory. I went to this party ... (extended pause) and I got extremely drunk and I fell from a roof. Fortunately I landed on my back and ... I still injured my brain...; and they had to drill a hole to relieve the pressure.
I kind of got stuck in a pattern of working odd jobs 'cause one of the disadvantages of getting out of the theatre, you didn’t have any skills for any kind of civilian work.

_Coda (a reflection on the narrative after the event has past)._ 

I think the medal was too little too late.

Maybe I needed to work for a couple of years or travel for a couple of years until I pursued any more education. Now, I have a desire, I have a very strong desire.

_Narrative Summary_

Vic expressed his feelings of ongoing failure throughout his life. This failure was only enhanced when he sustained a brain injury while drunk at a party. With the low confidence and esteem he felt for himself, he felt confined and frustrated in his life. He expressed he lacked the confidence to make a significant change and was afraid that if he tried, he would fail again.

_Vic's Therapeutic Enactment_

Vic did an intrapersonal enactment. Shame, fear and anger were elements of himself that held him back from succeeding. Each of the three elements were personified by group members. He sculpted how they appear in relation to himself by placing them in from of him. He spoke with each of them, and he moved them from where they were to having them stand behind himself. He wanted a memory of what is was like to have those three elements behind him and not holding him back.

_Post-Program Core Narrative: Fear Conquered_

_Orientation (places the narrative in a context)._ 

I was focusing a lot on the failures of my past and that I didn’t have a lot of confidence in myself and I would make some... off hand comments about not being able to do something.
I had some moments in my past which really ... gave me a blow to my confidence at a very young age.

I failed grade 2.

I was isolating myself with each progressive year since I departed the military. I came out with a good level of confidence and I had a lot of money saved up. But when it came to get my driver’s license, which I don’t have..., that’s based on my fear that I don’t think I could do it.

A level of shame and embarrassment, at most that I don’t have my driver’s license.

*Abstract (an overview of the narrative).*

I know from a physical point of view I don’t look weak; but when you are speaking from your mind and your talking from the heart it’s totally different.

I was aware that I was holding myself down. It was just like I knew I had to take some steps

The partying was the escape. So by limiting that escape I have to learn to use that time wisely but [instead I was] sitting around feeling sorry for myself.

Inside, I’ve been wanting this. I’ve been wanting to change for a long time but I feel that I’ve never had the strength to take that step.

*Plot (the action of the narrative).*

I told [the group] about Grade 2. I told them about the driver’s license.... I told them about flunking out of university.

Shame was strengthened after I had my accident. That time I became drunk. I fell from a roof but I was too drunk at that point in time to even remember that incident happening. I remember being at the party, I remember drinking a lot of alcohol but..., drinking and partying became one of my highest priorities in my life. I was establishing a pattern of getting blacked out drunk. Where I would lose several hours of memory while I was drinking. So that was a warning sign right there.... I was in the hospital for about a month and then in [the rehabilitation unit] for several weeks until they determined I was healthy enough and mentally strong enough to take care of myself. It took a few years to get all my memory back. They said your brain’s not going to be 100%.

*Resolution (how the narrative was resolved).*

You bring together soldiers who even though there may be age differences, we share a lot of the same experiences. We have gone through a lot of the same
feelings and that when you learn to communicate with one another and you can reach a point of being honest. When you earn some trust and respect that it will still be difficult to share most feelings you don’t want to share. But when you are within an environment of trust and respect and you know the people around you care about your well being.... It’s a tremendous feeling.... You can go places where you don’t want to go.

[The peer support person] said, “You get out of the course what you put into it.” So it’s like okay I could run it high which I’ve done a lot of in my life or I could just say, “Fuck it, what if you look weak. Go big because you’ve already established at the beginning of the group, everything in this group is confidential. No one is going to say anything about it.” So I figured why not, I’ve got nothing to lose.

Being too afraid to show that side of myself..... [Douglas: what was it that kept you there?] I trusted the group.... I even felt like I was in a safe environment.

Accepting that failure is a part of life it’s not such a daunting force that’s going to prevent me from going out there and doing it.

_Coda (a reflection on the narrative after the event has past)._ 
Looking at myself differently, and I have more confidence now.

Not only did it help me, but I see how it can help other people.

**Narrative Summary**

Prior to the group, Vic expressed he was afraid of looking weak and failing. Through the group process, he made a conscious decision to go all the way, or go home. He decided to go as far as he was able. From the group experience he regained the confidence in himself that he lost repeatedly while growing up.

_Vic’s Psychometric Test Data_

_Trauma Symptom Inventory First administration._ Examining the face value of the validity scales of the TSI suggests an invalid and not reliably interpretable profile. The Atypical Response (ATR) validity scale suggests a pattern of responding where he does not attempt to present as disturbed or dysfunctional. The Response Level (RL) scale was within the validity
parameters suggesting he responded to the questions with openness and a willingness to acknowledge traumatic symptoms. The graphic representation of this participant’s TSI profile appears below in Figure 20.

The Inconsistent Response (INC) score falls above the T score cut-off for a valid profile; however, a qualitative analysis of the items provides a possible explanation for the high score and provide support for interpretation. Briere (1995) suggests that high INC scores should be examined for the possibility of explainable inconsistencies because the cut-off for this scale is quite high (top 2%).

An elevated score on the INC validity scale suggests an inconsistent pattern of responding to test items. This result may be due to random responding, poor attention or concentration, dissociative phenomena, or reading difficulties.

Before the item analysis of the INC is presented, I will explain how INC is calculated. The INC is calculated by adding the absolute value of the difference between 10-paired items. Looking at the differences between the items, 2 results were identical indicating the same level of endorsement for each of the items. Six items had a difference of 1 indicating a minor difference between the item pairs. One item had a difference of 2, and one item had a difference of 3.

An item analysis of the pair that resulted in a difference of 3 may be explained by the participant’s understanding of vocabulary. Through the interview, he asked me to define several words that he did not understand and I rephrased questions because it was clear he misunderstood the words I was using. The item pair that resulted in a difference of 3 has a word that the participant may not have understood. Reporting ‘never’ (result of 0) to the item “Flashbacks (sudden memories or images of upsetting images)” may have been unclear to him.
He may have misunderstood what the word "flashbacks" means. While he fully endorsed the paired item by indicating that he often (result of 3) “Suddenly remembering something upsetting from your past.” If this item pair was endorsed by a difference of 1, then the INC would fall into the validity parameters. Following the direction of Briere (1995), I discount the numerical cut-off for scale validity, and guardedly interpret this profile.

Examination of the clinical items demonstrates three elevations. Elevations occur on the Depression (D), Anxious Arousal (AI) and Impaired Self-Reference (ISR) scales.

The D scale measures the extent to which the respondent experienced depressed mood and depressed cognitions. High scores on this scale reflect frequent feelings of sadness and unhappiness and a general sense of being depressed. Individuals with high D scores report perceptions of themselves as worthless and inadequate, a view of the future as hopeless and a tendency to have thought about death and dying. Behaviourally, these individuals may describe...
periods of tearfulness and excluding or isolating themselves from others. Suicidality, and self-injurious behaviour is always a possibility with high D scorers. Suicidality must be explored when the Tension Reduction Behaviour (TRB) score is also elevated. Three critical items are examined for suicidality. Participant 1 did not endorse the item regarding suicidal behaviour (25), and minimally endorsed the 2 items of thoughts of death (30 and 90).

High scores on the AI scale indicate the extent of angry mood and irritable affect experienced by the respondent. High scores on this scale may reflect either the irritability often associated with PTSD or a more chronic angry state. The AI taps not only the internal experience of anger or irritability, but also the presence of angry cognitions and angry behaviours. Individuals scoring high on AI often describe anger as an intrusive and unwanted experience and may see their angry thoughts or behaviour as not entirely in their control. Such people often describe pervasive feelings of irritability, annoyance or bad temper such that minor difficulties or frustrations provoke contextually inappropriate angry reactions.

The Impaired Self-reference (ISR) scale measures a variety of difficulties associated with an inadequate sense of self and personal identity. ISR items include problems in discriminating one’s needs and issues from those of others, confusion regarding one’s identity and goals in life, an inability to understand one’s own behaviour, an internal sense of emptiness, a need for other people to provide direction and structure, and difficulties resisting the demands of others. Individuals who score high on ISR often appear to have less self-knowledge and self-confidence than others, may be more easily influenced by individuals or groups, and may present as easily excitable and less functional under stress. High levels of ISR may be associated with early childhood losses or trauma and reflect difficulties that increase the likelihood of personality
disorder diagnosis. Because ISR reflects difficulties in maintaining a stable sense of an acutely destabilizing stressor, in which case personality dysfunction may or may not be relevant.

A 2-point elevation profile is evident. This profile is often associated with a long-standing dysthymia or a depressive style. Individuals with this profile may present with an anaclitic depression. Anaclitic-type depression suggests there may be considerable interpersonal or attachment issues associated with the dysphoria and its expression.

Factor analysis of the test items suggest that the 3 elevations reflect distress associated with the impact of traumatic events or processes and the sufficiency of self-resources to modulate the distress. Two of the elevations (D, ISR) reflect the external experience of trauma symptoms, and 2 of the elevations (AI and ISR) reflect self-dysfunction. Elevations on both trauma and self-disturbance indicators suggest a more complex trauma victim evidencing: chronic distress, overwhelmed by intrusive symptoms, and more likely to act out painful internal states by virtue of lesser self-resources.

Trauma Symptom Inventory Second Administration. Examining the validity scales of the second TSI profile suggests a valid and reliably interpretable profile. The T score on the Atypical Response (ATR) validity scale suggests a pattern of responding where he does not attempt to present as disturbed or dysfunctional. The Response Level (RL) validity scale suggests he responded to the questions with openness and a willingness to acknowledge traumatic symptoms. The Inconsistent Response (INC) validity scale suggests a consistent pattern of responding to test items.

With the second administration of the measure, no clinical elevations exist. The second profile suggests he does not experience traumatic symptoms. The general response pattern
demonstrates a lowering of clinical scales suggesting an overall improvement in trauma symptoms and self-resources.

Different from the first administration, only 1 critical item was endorsed at the second administration. Item 19 was minimally endorsed. Item 19 reads: Thoughts or fantasies about hurting someone. Due to the lack of associated clinical elevations, this endorsement is not considered critical.

Across the 2 administrations, the trend is a lowering of the clinical scales. Although only 3 scales were elevated at the first administration, the trend across most of the scales was a lowering of endorsements.

*Beck Depression Inventory-II (BDI-II) and Self-Esteem Rating Scale (SERS).* Figure 21 below is the graphic reflection of Vic’s BDI and SERS results.

![Vic's BDI and SERS Results](image)

**Figure 21 Vic's BDI and SERS Results**

Over the course of the three administrations of the BDI-II, Vic demonstrated a dramatic drop in endorsing depressive symptoms. The first administration resulted in a score in the
Severe Depression range. The two subsequent administrations resulted in scores in the Minimal Depression range.

Over the course of the three administrations of the SERS, Vic endorsed items within both the negative and positive range of self-esteem. Beginning with a minimum possible score of -120 up to a maximum possible score of +120, this participant began in the negative range. The second and third administrations were higher than the first and in the positive range. Over the course of the three administrations, he endorsed items consistent with an ever-increasing level of self-esteem.

Gilles

Like Vic, Gilles explained that he felt like he failed while serving overseas. This feeling of failure is strange for him because he explained that he succeeded in so many other areas in his life. The life successes Gilles that related are reflected in a drive he has to succeed, but that he was just going through the motions instead of seeking the goals himself.

**Pre-Program Core Narrative: I Failed**

*Orientation (places the narrative in a context).*

Military courses I took I topped.

Anything after that I was always at least in the top three ranking.

When I started carpentry I got the best marks in the class all the way through.

Got my journeyman's ticket even before I was a journeyman partner in a construction business. Turned it over to my other partners moved on to this management company all just because I knew I should advance myself; wasn't cause I wanted to do it but I knew I should, not true ambition.

Yeah and money I was 19 impatient and plus infantry was supposed to be the hardest yeah and you know, my grandfathers were in WWII and both soldiers, you know. So that was sort of what made me choose that and also what I really wanted to do was be a search and rescue technician.
We didn't think we'd actually need [the shell scrape] but you know, because everyone kinda, they aren't actually going to shoot at us, we got the big dumb blue helmets and the big white personnel carrier, they know who we are.

We had five months already you know. The only, it just kind of hit home because it all came to an end and the dirt was flying because we were digging holes and someone came up and said, you know these two Serbians were killed and it just kind of brought you back to reality punched it through that bit of surrealness you had going on.

600 to 800 hundred of us, there was only 20 of us that were in two-way combat. There was a lot of to do about being the first Canadians in two-way combat since Korea but I'm sure glad I was one of the ones in combat and not the guys that had to go forward you know, document the war crimes, you know recover bodies that were; that had whatever stuff done to them.

Abstract (an overview of the narrative).
As I am going on getting older I find I am less able to do that creates more stress and frustration.

My wife has noticed.

Feeling of listlessness and uh you know, and purposelessness, recurring theme.

Drifting around without much purpose.

I went where things kind of put me.
I will do this till the next thing comes up; stay here till there's something worthwhile to move on to.

I: Is this the first time that you have talked about this with other people? P: Yeah, I've talked to, just [a member of a previous group]. Mostly I've told him that I felt pretty helpless, you know, but I don't think that I ever said that I failed.

Plot (the action of the narrative).
Over the years it’s gotten worse.

I kind of isolated myself a lot.

It was still afternoon probably 5 o'clockish, and uh I was just kinda of wandering across there.

We were cooking in a resting area, basement of a farmhouse.
You hear a snap from the supersonic boom of the bullet going by you.

Went and ran got behind the armed personnel carrier, kinda got down behind there.

I was just, uh, they're shooting at us and I ran (laughs). Its kind of a, you know. What do I do? Where do I go? Because I was in the middle of the yard kind of half way between about four different places I could hide then I ran to my shell scrape. Got down in there, well that was kind of tough coming out from behind there running with shells screaming. It's probably 30 feet but you know 30 feet. So you know, only 30 feet. And I ended up there, in there on my back when I hit the shell scrape; and then the last set just hammered into the ground about you know half way between my trench and the house. They were coming right over the top of my head. It went right over the top of me.

Because all you can think of is wow, maybe after all that somebody's coming across the field here so you're looking.

Super adrenalized.

At the time that was the only thing that I was worried about was the other guys. You know, I mean maybe not right at the time but as soon as there was a lull.

The worst part for me uh you know wasn't the actual combat and so on because at the time it was pretty surreal, its like "oh shit, I can't believe they're shooting at us" and you get so adrenalized and the training takes over and you get in the hole.

It wouldn't, have been um bad to collect the bodies of the guys we were fighting with but its. Well yeah and there was none there, was none of that, none of our guys were hurt and we just, and that was, all kind of goes back to applying the training, we dug in and prepared defensive positions.

Nice green valley and little white houses with red tile roofs and you know, beautiful and then you get closer and start seeing the holes and the, shell holes and burn marks.

I: Were there dead bodies when you were there? P: No. Just dead live stock.

But you always have to wonder what happened there and in a lot of cases apparently they'd just tell them that, pack your stuff and get out.

Then that came on [TV] and they're showing around, you know, things that had happened and you know, that was fine, but then they showed that village. There were a couple of guys just standing there talking and you could see this big column of smoke rising behind them and uh, I knew what it was and [my wife] said, "what is that smoke?" and I couldn't even tell her.
Later on finding out you know what went on there what guys found there made it worse, probably the most traumatic thing that I experienced in the whole six months I was there.

The worst part, that it makes you feel like you failed. *(Pause)* I failed those people.

**Resolution (how the narrative was resolved).**

What really sort of tipped me off was a Sergeant, who was a great guy and uh you know, a soldier's soldier and everything and I actually knew his wife pretty well... anyways *(laughs)* I ended up sitting next to her on a plane out to Winnipeg for the awards ceremony and ah she is um a psychologist. I understand that she studied PTSD. She was telling me how all these guys were being diagnosed with PTSD so that kind of made me let down my guard a little bit.

I was really fortunate that I kind of gained that awareness on the way there to see all the other guys. You know, and kind of opened their eyes.

**Coda (a reflection on the narrative after the event has past).**

Things were pretty good when I first got out of the army I went back to [Northern BC].

I am actually glad, pretty fortunate I own my own house I got a good job.

I didn't know what I wanted to do, where I wanted to go. [My wife] and I got married, we had our first baby and um she's a [professional occupation] and there ended [up] being a job in [the current small town where I live]. So we moved out there.

That was probably the worst part of the whole thing for me is ah when we were fighting, ah more before actually, before we were fighting um looking back and probably from some of the video footage and stuff we've seen you can see off in the background this big plume of smoke and you know at the time you have this feeling this can't be a good thing but then later on when you found out why it was burning and you know they were trying to cover up, and uh you know, we sort of suspected what they were doing at the time and we wanted to go, you know..... Um we wanted to you know move in there and steam roll those guys, you know, and you know put a stop to it but we couldn't, they wouldn't allow us to go ahead for whatever, for a ton of good reasons.
**Narrative Summary**

In spite of all the successes and advancements Gilles had throughout his life, he believed that he failed in his duties because he was held back from being able to do what he believed was the right thing while he was in his combat theatre. He explained that even being involved in the firefight, which could have killed him, did not compare to the failure he felt by being constrained by military rules and unable to act. The grief he expressed was an overwhelming sense of failure for not being able to do more.

**Gilles’ Therapeutic Enactment**

Gilles’ enactment related to what he expressed as the most traumatising event while serving overseas. He said that the most traumatizing event was when he saw billows of smoke in the distance and knew that the smoke was an attempt by the local forces to cover up the ethnic ‘cleansing’ they were doing.

He began the enactment as a sculpture. He had a town person who remained silent and lay covered on the floor, a UN representative, a Canadian military representative and a double. He explained that he experienced disassociation during the enactment because he could not initially connect. He felt distant from the scene and struggled to verbalise his experience. Instead of verbalizing, he vocalized. He was encouraged to make a noise which ended in a very loud scream. He spoke to the villager and he came to the realization that no matter what he did, he could not have saved them.

**Post-Program Core Narrative: I am Back**

*Orientation (places the narrative in a context).*

Frustration sort of came as a result of [my] concentration wasn’t as good as it should have been. Little details would escape me or I would forget things that I
shouldn’t have forgotten. I’d be able to remember a couple of years ago I would never have a problem with it.

Patience. You know at home, with my kids and stuff. Being what they are, full of energy and tons of questions and stuff. I was having a really hard time dealing with that, especially if I was just trying to think about something else or you know maybe trying to decompress from the day. The kids are all over you. [I would] yell, send them to their room or whatever, … but they didn’t deserve it…. It happened really fast.

I guess you don’t want to admit ever that there is anything wrong with you…. As a soldier, if you are weak you are probably are going to die or your friend will because you couldn’t do your job.

A hollow feeling in the chest…. Admitting a weakness…. That’s the way you are trained.

The conditioning says that it shouldn’t even cross your mind…. To even think about that is admitting weakness.

I know it’s not really true, but it is something that needs to be fixed.

Abstract (an overview of the narrative).

The sense of brotherhood of the other soldiers…. You knew there were people there that understood…. Without it, the trust isn’t there…. And without the trust there wouldn’t be understanding and the willingness to get some of this garbage out.

[In the group] We learn the communication skills and so on. The feedback and all that which has worked great between my wife and I because it certainly eliminates a lot of that miscommunication that was a source of, … irritation before and sort of a precursor to, [a] blow up or something.

Just because it seems like she wasn’t paying attention. Or I wasn’t really communicating properly, but it really wasn’t her. [It was] mostly myself.

Plot (the action of the narrative).

It was really helpful that the course was structured in a way of working amongst ourselves so being among soldiers was a good thing…. Trusting each other to be honest and open.

Resolution (how the narrative was resolved).

We wrote about branching points in our life … read them to the group, … had feedback sessions afterwards and it sort of gave you a sense of understanding
from all the other guys. ...Once you were done you were sure they understood what you were trying to get across. Then we did the re-enactments, and after the re-enactment, ...it just got so much better.

[My emotions] seemed really welled up and filled you up and we walked around. The walk just... seems to bring it on.... That was happening [it was] just coming to the surface and then after a little while as I was getting really full. All of sudden it just seemed like it was going down again. It was just ‘cause I was shutting down the emotion. Like this is too much and started to sigh a little and I said to [the facilitator], “I’m not doing this, but this is how I feel.” And he says, “Well, you need is give that emotion a voice, and you need a sound, an action.” I growled or something.... It came back right back out. And he said..., “Well, I don’t think that’s it. You need to try again.” I let out a big yell. It bellowed and I’m sure that I scared the crap out of everybody. ‘Cause I think that’s what the drill sergeant voice [sounds like] (laughter).... It did it. Was sort of like a logjam bursting. I guess as the emotions started to flow out of me and, it was like a trickle, turning to a flow through me. It seemed like at that point, really nothing was really doing anything for just a few seconds. And I guess you could compare that [to] a river running through you almost.... I was really crying hard at that point ... crying all over poor old [group participant] (laughter) and ... the emotion just seemed like it was blowing out of me, like a firecracker.... It felt really sort of cleansing you know and enlightening. It was all getting out, it hurts, but it felt good at the same time.

Got rid of guilt.... And shame, by... forgiving myself.... By honouring the people that I couldn’t help.

I felt [at] home at the end of it. I felt like there was some closure. I felt like it had never gone like that. I felt raw. Very sensitive and raw at that point and tired, like I had been carrying some huge weight for days and finally got to set it down.... I could have just laid down (laughter).

My concentration is better so as a result the frustration is pretty much non-existent.

Coda (a reflection on the narrative after the event has past).

It’s definitely improved my family life. I find just being able to relax..., and concentrate. If you can’t relax your mind you can’t concentrate on anything.

Narrative Summary

Throughout this second interview, Gilles described how he has used the skills from the group to improve his relationship with his wife, children and his relationship with himself. The
communication skills were the most helpful skills he learned and applied outside the group. He also expressed that he is not able to accept that he can ask for help, express difficult emotions and not say that he is weak when he does.

_Gilles' Psychometric Test Data_

_Trauma Symptom Inventory (TSI) First and Second Administration._ Examining the validity scales of both TSI profiles suggests valid and reliably interpretable profiles. The T score on the Atypical Response (ATR) validity scale suggests a pattern of responding where he does not attempt to present as disturbed or dysfunctional. The Response Level (RL) validity scale suggests he responded to the questions with openness and a willingness to acknowledge traumatic symptoms. The Inconsistent Response (INC) validity scale suggests a consistent pattern of responding to test items.

Examination of the Clinical Items indicate a well-defined profile with a clear spike on 1 of the 10 Clinical Items. Anger/Irritability (AI) is the scale that is endorsed at a significant response level. The graphic representation of this participant's TSI profile appears below in Figure 22.

High scores on the AI scale indicate the extent of angry mood and irritable affect experienced by the respondent. High scores on this scale may reflect either the irritability often associated with PTSD or a more chronic angry state. The AI scale taps not only the internal experience of anger or irritability, but also the presence of angry cognitions and angry behaviours. Individuals scoring high on AI often describe anger as an intrusive and unwanted experience and may see their angry thoughts or behaviour as not entirely in their control. Such people often describe pervasive feelings of irritability, annoyance or bad temper such that minor difficulties or frustrations provoke contextually inappropriate angry reactions.
Factor analysis of the test items suggests that the elevation on the AI scale reflect distress associated with the processes and the sufficiency of self-resources to control distress. Someone with low trauma symptoms but significant self-difficulties would be seen as more likely to have identity and affect regulation difficulties. For this participant, with only 1 clinical elevation he is likely to have more self-resources than someone with multiple elevations and therefore more self-resources to moderate his distress.

With the second administration of the measure, no clinical elevations exist. The second profile suggests he does not experience traumatic symptoms. The general response pattern demonstrates a lowering of clinical scales suggesting an overall improvement in trauma symptoms and self-resources.

Across the 2 administrations, 3 critical items were endorsed. Items 19, 50, and 58 were endorsed. Respectively, these items read: Thoughts or fantasies about hurting someone; Sexual
fantasies about being dominated or overpowered; and Getting into trouble because of your drinking. Each of these 3 items were minimally endorsed.

**Beck Depression Inventory-II (BDI-II) and Self-Esteem Rating Scale (SERS).** Figure 23 below reflects the graphic representation of Gilles' BDI-II and SERS results.

![Gilles' BDI and SERS Results](image)

**Figure 23 Gilles BDI and SERS Results**

Over the course of the three administrations of the BDI-II, Gilles demonstrated a progressive trend towards lower levels of depressive symptoms. Beginning with reporting symptoms consistent with Mild Depression on the first administration, this participant endorsed items consistent with Minimal Depression at the second and third administrations.

Over the course of the three administrations of the SERS, Gilles endorsed items consistent with positive levels of self-esteem. Beginning with a minimum possible score of -120 up to a maximum possible score of +120, he began with a strong and stable level of self-esteem. Over the course of the three administrations, he endorsed items consistent with an ever-increasing level of self-esteem. A noticeable rise in self-esteem is evident as measured at the second
administration. This noticeable rise is likely due to his reported positive experiences through the
group process and improved experiences at home.

Overall Pre-Program Narrative Summary

In the first set of core narratives this group of men described what they brought to the
group. They describe feelings of anger, frustration, failure, emptiness, loneliness, isolation,
inexpressiveness, survival, and themes of hopefulness and hopelessness. Some of them have
been waiting for more than 20 years to resolve these issues and described coping strategies they
used to contain their experiences.

Overall Post-Program Narrative Summary

After the program, the participants expressed feeling increased confidence, more openness,
increased freedom to express difficult feelings, a renewed sense of camaraderie, a feeling that old
and sometimes forgotten burdens were released. Among all the participants, was an expressed
sense of optimism and anticipation of a better future.

BDI-II and SERS Combined

Because of the significance of the across participant findings, figures 24 and 25
demonstrate the complete series of administrations of the BDI-II and SERS. The results as seen
across all six participants illustrates that with the general decrease of endorsing items
 correspondingly with depression, there was a tendency for an increase of endorsement of self-
esteeem items.
Enacting Change

BDI Complete Series

0-13 Minimal Depression
14-19 Mild Depression
20-28 Moderate Depression
29-63 Severe Depression

Figure 24 BDI Complete Series

SERS Complete Series

Figure 25 SERS Complete Series
Interview Themes

This section contains the themes identified by the participants while they were interviewed. The themes are small quotes or statements made by the participants during the interviews and reflect common examples of trauma symptoms. The themes are divided into three categories: pre-group, post-group and follow-up themes. Each category corresponds with one of the three interviews. Again, the interviews answer smaller questions and the themes reflect those questions: 1) What I bring to the group; 2) What I take from the group; and 3) What I hold from the group?

The lists below are not an exhaustive reflection of all the themes identified by the participants because some themes are represented by the core narratives and psychometric measures. The themes included here are the most common themes among the group of participants and themes missed by the core narrative and psychometric measures. Figure 26 represents the categories of themes across the three interviews. The blocks of colour across the three interviews reflect related themes tracked across the interviews. In some cases, the themes were not represented in all interviews because themes were not asked about directly. Instead, they were derived from the text and spontaneously identified by the participant. The themes derived from the individual interviews are presented in more detail below.

Themes such as depression, self-esteem and mistrusting of others are grouped together as there are related experiences with those themes. Depression and self-esteem are inversely correlated. ‘Mistrusting of others’ is grouped with the other two themes because if depression is low and self-esteem is high, then it is easier to trust others.
'Largely unhelpful coping strategies' is grouped with tools and skills in subsequent interview sets. Coping strategies relate to tension reducing behaviours (Briere, 1995) and the improved communication skills the participants reported.

<table>
<thead>
<tr>
<th>Pre-Group</th>
<th>Post-Group</th>
<th>Follow-up</th>
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<tbody>
<tr>
<td>Limited emotional expressiveness</td>
<td>Emotional expression</td>
<td>Increased expressiveness</td>
</tr>
<tr>
<td>Relationship problems</td>
<td>Improved relationships</td>
<td>Improved relationships</td>
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<tr>
<td></td>
<td>Bond</td>
<td>&quot;Brotherhood&quot;</td>
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<tr>
<td></td>
<td></td>
<td>&quot;Camaraderie&quot;</td>
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<td></td>
<td></td>
<td>&quot;Comradeship&quot;</td>
</tr>
<tr>
<td>Depression</td>
<td>Relief</td>
<td>&quot;More than just surviving&quot;</td>
</tr>
<tr>
<td>Low Self-esteem</td>
<td>&quot;More confident&quot;</td>
<td>Renewed hope</td>
</tr>
<tr>
<td>Mistrusting of others</td>
<td></td>
<td>&quot;Renewed life&quot;</td>
</tr>
<tr>
<td>Largely unhelpful coping strategies</td>
<td>&quot;New tools&quot;</td>
<td>New skills/tools</td>
</tr>
<tr>
<td>No help seeking behaviour</td>
<td>&quot;New priorities&quot;</td>
<td></td>
</tr>
<tr>
<td>Flashbacks</td>
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</table>

Figure 26 Thematic categories across three interviews

*Pre-Group Themes*

Eight themes are identified from the pre-group interviews. Figure 27 is a listing of the themes with some quotes and descriptions for each. The themes listed include the following: no help seeking behaviour, largely unhelpful coping strategies, flashbacks, relationship problems, depression, mistrusting of others, low-self-esteem.
**Pre-Group**

**No help seeking behaviour**
- Trauma too long
- Unresolved personal issues

**Largely unhelpful coping strategies**
- Adaptability
- Isolating hobbies
- Walking and biking alone if troubled
- Workaholic
- Constructed barriers and hid problems
- Self help' by isolating
- Avoiding self
- Used humour to distract

**Flashbacks**

**Low Self-esteem**
- Failure
  - "Afraid of failing"
  - "Couldn’t do anything"

**Depression**

**Mistrusting of others**
- Nervousness
- Faith lost
- Bitter

**Limited emotional expressiveness**
- "It’s ok to express anger, but not ok to express anything else"
- "Not very emotional"
- "Short fuse"
- "Easy to get angry"
- "Private person"
- "Reserved"

**Relationship problems**
- Anger at: self, others and military
- Frustration and stress with family

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**Figure 27 Pre-Group Themes**

**Post-Group Themes**

Eight themes are identified from the post-group interviews. Figure 28 is a listing of the themes with some quotes and descriptions for each. The themes listed include the following: more confident, bond, new priorities, improved relationship, relief, new realizations, emotional expression, and new tools.
Enacting Change

Post-Group

"More confident"
"Optimistic"
"Energetic"

Bond
"Brotherhood" "Camaraderie"
"Comradeship"

Lost bond when left military
Group is a requirement
"Knew fit in within first hour"

"New priorities"
Now new issues become apparent

Improved relationships
"Better relationship now with father, even though he died"
With wife and children

Relief
"Closure - put it to rest"
"Don't need to worry about that anymore"
"Feel lighter with less baggage and didn't even know baggage was there"

New realizations
Seeking excitement to avoid own feelings and to feel alive
"A difference, at ease"

Emotional expression
"More expressive now"
"Show emotions"
"Cry more easily"
"Felt good to talk about issues"
Not as vulnerable/More vulnerable
"Never shared so much emotion outside of the family"
"Feel validated and realise it is not such a big deal to be so expressive"

"New tools"
"Have new tools and methods to deal with problems"
"Homework helped refine communication skills"
"Better communication with wife. I listen more"
"Feedback skills"

Figure 28 Post-Group Themes

Follow-up Themes

Seven themes are identified from the follow-up interviews. Figure 29 is a listing of the themes with some quotes and descriptions for each. The themes listed include the following: renewed life, more than just surviving, increased expressiveness, improved relationships, new skills/tools, brotherhood/camaraderie/comradeship, and renewed hope.
# Follow-up

<table>
<thead>
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<tr>
<td>New feeling of well-being</td>
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<tr>
<td>Given back life – released</td>
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<tr>
<td>Compassion without judgement for others</td>
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<tr>
<td>Ability to trust others</td>
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<table>
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<tr>
<th>&quot;More than just surviving&quot;</th>
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<tr>
<td>Increased expressiveness</td>
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<td>Ability to cry in public</td>
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<tr>
<th>Improved relationships</th>
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<td>New humour with wife</td>
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<th>New skills/tools</th>
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<tr>
<td>Communication skills</td>
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<p>| &quot;Brotherhood&quot; |
| &quot;Camaraderie&quot; |</p>
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<tr>
<th>&quot;Comradeship&quot;</th>
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<tr>
<td>Rekindled comradeship</td>
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<tr>
<td>Ability to work in groups</td>
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<tr>
<th>Renewed hope</th>
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<tr>
<td>Scepticism of group</td>
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<tr>
<td>Was sceptical of Therapeutic Enactment</td>
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**Figure 29** Follow-up Group Themes
CHAPTER FIVE: DISCUSSION

This chapter is divided into four sections. The first section is a review of the individual changes the participants demonstrated and reported. The second section includes an examination of the other critical factors that influenced the outcome. Implications are discussed in the third section. The final section is a reflection on the affects of September 11, 2001, and a personal reflection of the effects of conducting this research on the researcher.

Individual Change

Trauma symptoms

Determining the success or failure of the therapeutic enactment group as a means of increasing agency and self-understanding in the face of unfixable suffering is measured by the symptoms that traumatic experiences can create. For the participants of this study, the symptoms of trauma were examined and identified by the two methods previously described. Between the two methods, the quantitative measures reflect that individual change occurred and the qualitative methods show how change occurred.

During the pre-group interviews and measures the participants clearly presented a range of symptoms associated with their struggles to integrate traumatic experiences. The symptoms they presented correspond with experiences as identified by academic literature including: mistrusting others (Janoff-Bulman, 1992), depression, nervousness, self-isolating hobbies, limited emotional expressiveness, "short fuse," limited concentration, flashbacks, relationship problems, low self-esteem (APA, 2000; Briere, 1995; Briere, 1996; English, 1999; Herman, 1997; Janoff-Bulman, 1992; Klein & Schermer, 2000; Litz, et al., 1997; MacDonald, et al., 1998; Rosebush, 1998; Scaturo, & Hadoby, 1988; van der Kolk 1996; Ward, 1996).
Examining the post-program measures and interviews, it is clear that the participants expressed feeling a reduction in some of their symptoms. Increased confidence, improved relationships, increased concentration, improved communication skills, increased emotional expressiveness, general feeling of ease, general feeling of relief, identification of new ‘tools’ for life skills, renewed feeling of bond are some of the changes the participants related. These changes reflect reports from academic literatures when trauma becomes problematic (APA, 2000; Briere, 1995; Briere, 1996; Carlson & Dalenberg, 2000; English, 1999; Foy, 2000; Herman, 1997; Janoff-Bulman, 1992; Klein & Schermer, 2000; Litz, et al., 1997; MacDonald, et al., 1998; Rosebush, 1998; Scaturo, & Hadoby, 1988; van der Kolk 1996; Ward, 1996).

Comparing the list of pre-group experiences to post-group experiences helps determine the immediate success or failure of the program to alleviate the troubling symptoms. From the participants’ self-reports some of their symptoms improved. The symptoms that improved are seen in the core narratives, psychometric measures and the themes and include: depression, anger/irritability, self-esteem, emotional expressiveness, trust in others, communication skills, concentration, control of internal states (APA, 2000; Blake, & Sonnenberg, 1998; Briere, 1995; Brooks, 1998; Carlson & Dalenberg, 2000; English 1999; Herman, 1997; Janoff-Bulman, 1992; Klein & Schermer, 2000; Litz, et al., 1997; MacDonald, et al., 1998; Morley, 2000; Rosebush, 1998; Scaturo & Hardoby, 1988; van der Kolk 1996; Ward, 1996; Westwood & Black, 1999).

Following through with the follow-up interview, some of the enduring changes are striking. The men reported feeling more agentic as evidenced by sometimes significant and positive changes that were self-initiated. One example of an important change is how one participant reported he has moved out of the suite owned by his sister and where he lived with his mother. He explained that he will be moving into his own apartment for the first time. Other
similarly important reports include: increased expressiveness, improved relationships, improved communication and renewed hope. These significant changes reflect overall improvements from pre-group interviews and they are demonstrative of the changes from helplessness to agency.

The therapeutic factors that the participants attributed to their change in feeling was predominantly therapeutic enactment. By being able to return to a moment in their past and say what was not said, or correct what was done or not done, is what helped the most. By returning, via the therapeutic enactment, to those places where they sustained the trauma, they were able to unburden experiences of grief, shame, anger and helplessness which they felt and gain a new understanding of those experiences (APA, 2000; Briere, 1996; English, 1999; Herman, 1997; Janoff-Bulman, 1992; Klein & Schermer, 2000; MacDonald, et al., 1998; Rosebush, 1998; Scaturo & Hardoby, 1988; Ward, 1996).

Critical Factors that Influence Outcome

Therapeutic enactment

Therapeutic enactment was the defining feature of the total program. The participants all expressed that the therapeutic enactment provided the most significant therapeutic benefit. They participated in therapeutic enactment in one of three ways: as a witness (Buell, 1995), as a participant in someone else’s enactment, or as the lead (Baum, 1994; Brooks, 1998; Morley, 2000) in their own enactment.

Prior to the enactment stage of the program, several participants expressed scepticism about the therapeutic enactment. One participant said, “I was very, very sceptical about the reenactment. At the beginning [I thought] I don’t know. Is that going to work? I wasn’t too sure. I was actually was not even feeling comfortable with it.” What removed this doubt was the
group norm of ‘suspension of judgement’ and the participants witnessed other enactments. After witnessing, participating in other’s enactments, and doing his own enactment, the same participant said,

If anybody would ask me now, ‘...are you in favour of the re-enactment?’ [I would say] 100%, and coming from me, ‘cause I’m not what you consider an educated person. I look ... more down to earth than all this stuff. I’m all in favour.... I truly believe it helps them. ...Those guys definitely, they needed ... something that [so] they can express what they went through.

The participants here related very similar outcomes from their own enactments as explained by Morley (2000). The outcomes reflect issues such as new self-awareness, confidence and hope. However, the themes identified by Morley related more to the relationship between the lead client and the enactment director. For this group of participants, they relied more on their bond with the group, than on an individual bond with the directors.

Another difference in the reporting from Morley (2000) is the focus of the experience for the lead clients. For Morley’s study, the focus was on the physical experiences and memories of the participants. His study demonstrated how the lead clients were returned to the scene of the trauma and reported a strong focus on their memory and physical experience during the enactment. The participants here reported a stronger awareness of their emotional reaction, and had less emphasis on their physical experience. When questioned about their physical awareness, they related experiences such as sweating, and shaking, but only after probing. For the men here, their greatest awareness was on their emotional expression. Perhaps a future study can examine this difference by asking whether it was the director, participants or researcher who influenced the different foci.

As for when the men were participants and witnesses to other participants’ enactments, the focus again was on the emotional impact of the enactment. They were aware of empathic
feelings for the lead and explained that they were freely emotionally expressive. When talking about witnessing an enactment, one participant said, “Very powerful, very emotional.... You can just feel (pause) you’re a part of this person’s life right now.”

As both a participant and witness to other enactments, they expressed that they felt like they were taken directly to the time and place that was being re-experienced (Buell, 1995). As participants they expressed surprise at how they felt lost in the ‘role’ and how easy it was to understand the experience of the person who they portrayed. One participant explained,

You felt (pause) like that person. It was amazing. I had insight as to why he said what he did to [the lead client]. That made [the lead client] realize that was (pause) very possible[ly the] reason why this fellow reacted to him the way it was. I don’t know why (pause) I had that insight. I just felt like [person I was portraying].

The same participant attributed his understanding of the person he portrayed to, “The way [the directors] set up the whole scenario.” The skill with which the directors facilitated the enactments allowed the various scenes to unfold. The skill they demonstrated ensured that the participants and witnesses understood the experience, and the lead experienced what he needed and at the pace he needed.

As witnesses, they expressed surprise at the emotional impact of watching another group member re-experience a traumatic event from his life. The shared experience was expressed by one participant who said, “Once it started, it’s just like being, I mean, you’re in the room, and it’s just like being a participant. Even though you’re a witness, and you don’t get to say anything, you feel the same emotions.” This experience is similar to that which was reported by Buell (1995). The difference between this present experience and Buell’s study is the focus on the group. Buell’s focus was on individual experiences without a significant focus on being a
member of a witness group. For this study, the participants relied heavily on the group for implicit permission to openly express their emotions.

This group explained that to be emotionally expressive was considered a weakness. One participant explained, "To be weak as a soldier, ... you are probably going to die or your friend will because you couldn't do your job." By feeling free to be emotionally expressive, the overwhelming sentiment was a feeling of relief. They expressed relief that they felt they were finally able to say to a group of soldiers they trusted and respected, "I was scared."

Being able to say, "I was scared" without fearing retribution and public shaming (English, 1999; Rosebush, 1998) was significant. They never previously had the opportunity to share those feelings with another soldier. They privately carried and buried that fear for, in some cases, more than 30 years.

Being a member of a group where therapeutic enactments occurred provided the participants with the opportunity to repair the damage caused by the helplessness they felt when exposed to traumatic experiences (APA, 2000; Blake, & Sonnenberg, 1998; Briere, 1995; Carlson & Dalenberg, 2000; Herman, 1997, Klein & Schermer, 2000; Morley, 2000; van der Kolk 1996; Ward, 1996; Westwood & Black, 1999). Because it was a cohort group they felt freer than if it was a heterogeneous group (Herman, 1997, Klein & Schermer, 2000). They understood each other.

Perhaps the most significant finding is that when the enactments occurred just being present in the group created an impact on everyone. This impact was in spite of how some of the men described their attempts to remain distant. They explained that they could not help but be affected.
Action-Based Therapy vs. Verbal Therapy

Many researchers identify the need for action-based treatment for trauma, but do not propose a clear and viable method (Blake, & Sonnenberg, 1998; Follette, Ruzek, & Abeug, 1998; Hegeman & Wohl, 2000; Herman, 1997; van der Kolk 1996). Therapeutic enactment is an action-based method that is gaining research support and suggests it is a reliable method of gaining access to the verbal and non-verbal effects of trauma (Brooks, 1998; Buell, 1995; Morley, 2000; Westwood & Black, 1999; Westwood, Black, & MacLean, 2002). It is clear that verbal therapies are limited in their effectiveness to address the non-verbal effects of trauma (Morley, 2000; van der Kolk, 1996).

For this population, who report difficulties with verbal communication of personal experiences, difficulties with emotional expression and a lack of trust of mental health workers, action-based treatment best facilitates the therapeutic change process. Moreover, for this population, a cohort therapeutic group allows for more understanding among the participants. One-to-one verbal therapy is insufficient to express and resolve a traumatic experience, especially for this population.

Witnessing

Being witnessed by a group of other veterans increases self-acceptance only enhancing the reparative process (Buell, 1995). A cohort therapeutic group allows the trauma to be witnessed by the only type of group who can understand their shared experiences. For this population, it is even more important that the group consist of other military veterans because sometimes it is only another veteran who can say and do what is needed for the trauma to be repaired (Herman, 1997).
Expanding emotional expressiveness

The men expressed how participating in the program allowed them to express their emotions like they have never felt free before. Shame, fear of the consequences and the male image prohibited them from being emotionally expressive (Blazina & Watkins, 1996; Good, Dell & Mintz, 1989; Good, Robertson, Fitzgerald & Stevens, 1996; Robertson & Fitzgerald, 1992; Wilcox & Forrest, 1992; Whitaker, 1987). After participating in the program and feeling supported by other veterans, they have an increased comfort level to express themselves emotionally.

Grief

A public display of grief within the cohort therapeutic group serves multiple purposes. Letting go of the shame of expressing grief allowed for the isolated suffering to end (English, 1999; Ward, 1996). Ending the isolated suffering resulted in a decrease in depression, increase in self-acceptance, and joy.

Total Program

A surprising finding is the extent to which all the group processes in addition to therapeutic enactment facilitated change among the participants. A review of all the findings suggests that the biggest source of change was therapeutic enactment and the life-review branching points, however, all the components of the program were required for the openness that they expressed. This openness provided the group cohesion and trust for the men to do their own therapeutic enactments. Components from the group include the following:

- Communication skills training
- Discussion with physician of trauma-related medical issues
- Life-Review branching points
- Therapeutic Enactment
- Starting Points (a career transition program)
- Partner awareness sessions
- Follow-up group session

Other helpful features not in the group include:

- Residency
- Evening, followed by all-day sessions (as opposed to one evening a week)
- Extensive out-of-group conversations among participants occurred void of alcohol

The evening and all-day sessions allowed more time per week in the group for activities and processing. To have a shorter time within each group session would limit the time available for the processing that is required to integrate the new information (Herman, 1997, Westwood & Black, 1999) and to conduct the enactments.

**Group Format**

Some group format issues are discussed above; however, two additional issues require addressing. A peer support person who, like the other participants, is a military veteran and had previously completed the program, was included in the group. The participants reported that the peer provided a foundation that the facilitators could not. Because the facilitators were not military veterans, they were unqualified to make certain statements and observations. Several of the participants identified an important statement that made the difference for them. One participant explained,

I expected more of me to hold me back, and that’s the one thing that [the peer support person] said that is, ‘The more you put into the group, the more you’re going to get back’, so I thought, ‘Yeah, you know this is this is the place to do what you need to do’.
The second issue is an awareness of researched group format issues. Each of the issues of group format listed by Goodman and Weiss (2000) were addressed in the development of the group. Time frame, open or closed group, homogeneity or heterogeneity, group size, amount of structure in process, co-therapist, screening participants were all addressed throughout this process. Moreover, the close adherence to this model facilitated the 11 factors of group therapy as listed by Yalom (1995). Combining group theory and trauma theory, it is clear that group cohesion creates safety and trust which are required elements especially for this population to feel comfortable with openness (Goodman and Weiss, 2000; Herman, 1997; Westwood, Black & MacLean, 2002; Yalom, 1995).

**Intergenerational Group**

With no pre-planning, the group was intergenerational with half the participants being over 40. The men stated that because of the intergenerational group, they realised that it does not matter where or when a soldier served. No matter when they served, they are still a soldier who other soldiers can relate to. One participant said,

> We hit all the way from 30 to 60 so [it was a] pretty wide spectrum, and ... we never had to find things to say.... The age gap didn’t matter, and we were all soldiers, and we all had our stories and our experiences to share.

Following the program, they expressed surprise about how they did not have to struggle to understand each other (Briere, 1995; Herman, 1997; Janoff-Bulman, 1992; Klein & Schermer, 2000). ‘A soldier is a soldier’ was the common sentiment.

The participants expressed surprise that wisdom worked in both age directions. The older veterans learned as much from the younger ones as the younger learned from the older. An example of the cross-generational learning was the ‘permission’ to express be emotions. They witnessed each other being emotionally expressive, thus giving implicit permission to the group.
Both age groups reported that they learned from the other, and provided the permission they required to become emotionally expressive.

[Check-in] was you came into the group, you sat down, you introduced yourself briefly. You said where you came from, where you served, what branch you served in, and basically why you were there. That brought out some familiarity. That brought out some knowingness [about who] the person sitting to your left, the person sitting to your right is actually.... You feel a little safer in saying the things that you’re going to say.

Residential Model

A unique feature of this program resulted in a surprising finding. The residential component was identified as having a strong impact on group cohesion, trust, altruism and universality (Yalom, 1995). The participants collectively agreed that by staying together overnight reminded them of the barracks at military bases. They explained that by staying together facilitated trust and openness faster among the group member because they were able to learn about each other outside of the group (Goodman & Weiss, 2000; Herman, 1997; Janoff-Bulman, 1992; Johnson, et al., 1995). As one participant said,

You were kind of put in a familiar situation.... It was like going on a course in the military almost. You were walking around this place at night. It was like walking around a base you know. You know you are in a classroom and you are all staying in barracks sort of thing and then you put a whole bunch of guys from different places and ... and you kind of get to know each other a little bit. But as a result of the conditioning ... you don’t want to admit too much ... but at the same time you want to find out what was going on with the other guys.

The residential component was identified as a strong catalyst for helping the men open to each other. One participant said,
I think the biggest sense of comradeship I had [occurred] when we went one evening after we finished with the session... [we] went back over to the quarters and we had a bull session till about 2 o'clock in the morning... and we just talked about everything.... We used to do that too, many years ago.... Everybody sort of let their hair down, ... everybody talked and bullshit ..., we didn’t talk about the sessions, we talked about anything.... That’s how things start ... becoming comrades.

Without a residential component, it is very likely that all the participants would not have been able to be as open as they explained. Each participant expressed surprise at how open he was and attributed the openness to the intimacy in the group created by “bull sessions” in the evening after the program.

Brotherhood

The critical factor that all the participants identified is the sense of ‘brotherhood’, ‘camaraderie’, and ‘comradeship’ they re-experienced as participants in the group (English, 1999; Herman, 1997; Johnson, et al., 1995; Ragsdale et al., 1996). The men missed the bond that they felt when they were in the military and have not felt that bond since. Recapturing that special bond has been impossible. One participant said, “I joined the militia at one point too, a few years after I’d gotten out.... Joined that, didn’t really fit in.... It wasn’t the same as being with the regular force.”

Brotherhood is recognized as significant by other group-based treatment such as Herman (1997). Herman explained that especially among military veterans, cohort groups are the preferred method of treatment. As one participant said, “[The group] was like a 10,000-yard stare. It was being able to look at somebody and knowing that I didn’t have to explain myself to them. We understand each other.” The mutual understanding facilitated group cohesion through
trust, altruism and universality (Yalom, 1995). Trust within the group may have developed with a non-cohort group, but it would have taken longer and would not have been to the same degree.

The themes of the first narratives suggest the men have been in a survival mode. Survival has meant adapting by being largely emotionally inaccessible. Survival has also meant suppressing experiences such as fear because they have been trained to believe that expressing fear can result in ridicule, shame, and death.

The second set of core narratives suggest increased openness, improved communication, and regaining a life that was lost. These men explained that they were trained in groups in the army and they came to rely on those groups. They said that they would not have been able to do what they did without a group. They further explained that they felt more comfortable and safer because the group consisted of men who have been through the same, or similar experiences.

The group helped them feel comfortable to open themselves and confront long-standing issues. Some of these long-standing issues were ones they knew they had and ignored, whereas others were carried blindly and forgotten. The overarching theme of the second set of narratives is the relief the men expressed feeling.

**Communication Skills**

The participants all expressed that the communication skills (Egan, 2002; Johnson, 1993) they learned were helpful and provided them with the skills they said they needed to express themselves more completely (Westwood & Black, 1999). The surprise they expressed was that they thought the communication was only going to be helpful while in the group, but they were able to apply those skills to both their home life and work life. Demonstrating how it was helpful at home, one participant said,
"The feedback and all that ... has worked great between my wife and I because it certainly eliminates a lot of that miscommunication that was a source of ... irritation before and sort of a precursor to, a blow up or something."

Another participant explained that he found the skills helpful at work by saying,

"I’m [in my thirties]. I’ve been communicating my whole life. I thought I was doing a good job. Obviously, I could do a better job. I used it at work right away, with my employees and customers that you’re dealing with."

Implications

This research has multiple implications including those which are theoretical, and those which are practical. The theoretical implications that I will discuss relate to therapeutic enactment. The practical implications are for therapeutic practice.

Theoretical

How the model was applied in this research is clear. It is one component of a larger process. This model can be applied to an individual with support of a group, or to an entire group of individuals. The implication for theory is that this research witnessed a merging of processes. I see that the original therapeutic enactment is a stand-alone process for individual treatment and can occur over a single session that can last many hours. However, that isolated group process is preceded by individual therapy sessions and followed by individual therapy sessions.

The application witnessed by this research process is much more than the single event. This research demonstrated that when coupled with a homogeneous group that is trained in communication skills and eased into the process, therapeutic enactment is the feature in a line of techniques that help increase agency and self-understanding.
In other words, I see therapeutic enactment on two paths. One path is for individual work and includes individual therapy sessions. The second path is a group of individuals who each come with an issue to resolve, and benefit from witnessing and participating in the resolution of similar issues by the other members.

Practical

The practical implications are divided into two components, individual issues, and therapist issues.

Individual. The most striking individual issue here is the help-seeking behaviour of men who have sustained trauma. Men have a poor record of help-seeking behaviour only made worse by trauma.

The conclusions in the research literature regarding men's help-seeking behaviour are consistent. It is clear that men have difficulty seeking the counselling they require (Blazina & Watkins, 1996; Good, Dell & Mintz, 1989; Good, Robertson, Fitzgerald & Stevens, 1996; Robertson & Fitzgerald, 1992; Wilcox & Forrest, 1992; Whitaker, 1987). It is also clear that victims of trauma, especially soldiers, have difficulty seeking treatment (English, 1999; Herman, 1997; Klein & Schermer, 2000; MacDonald, et al., 1998; Rosebush, 1998; Ward, 1996). The solutions to this difficulty, however, are not simple.

Whitaker (1987) argues that men in US society both need and fear personal psychological services more than women do. Although Whitaker's conclusion about men needing more counselling help than women is specious, his suggestion that men resist the counselling help they need is consistent with other studies.

Good, Dell, & Mintz (1989) examined the results of surveys from 401 men. The men were questioned about a) their help-seeking attitudes and behaviours, b) attitudes toward the
stereotypic male role, and c) gender role conflict factors. The conclusions they reached about what prevents men from seeking counselling help stems from men's limitation of expressing emotions, and concern about expressing affection toward other men. These measures were each significantly related to negative attitudes toward seeking professional psychological assistance especially from people associated with the military. The researchers also found that restrictive emotionality significantly predicted decreased past help-seeking behaviour and decreased likelihood of future help seeking.

Finding that restricted emotionality limits men's help-seeking behaviour is the common conclusion (Blazina & Watkins, 1996; Good, Dell, & Mintz 1989; Robertson & Fitzgerald, 1992; Wilcox & Forrest, 1992). This finding bodes poorly for the soldiers who reported feeling unable or unwilling to express emotions until they began participating in the group.

Robertson and Fitzgerald (1992) offer a further cause and solution to men's help seeking. They reported that reluctance to seek counselling help is related to traditional gender role socialization and can be lessened by offering counselling interventions that are more congruent with that socialization. This again suggests a poor prognosis for soldiers who in this study reported that to be weak may result in death.

Wilcox and Forrest (1992) are less optimistic when they explain help-seeking difficulties as a "male problem" suggesting that counsellors must change men, change counselling, or change both. Their solution is similar to Irvine's (1995) discussion of looking more closely at the way in which gender is created and transmitted through cultural scripts. To examine the cultural understanding of gender reveals the biases of either exaggerating or minimising gender differences and the gender roles those individuals adopt.
Combined with gender roles, soldiers explain that to admit that they require help is paramount to admitting weakness. In their training, weakness can lead to their death, or the death of those who they are serving with.

The findings in the study can offer a solution facile-sounding solution: Have soldiers acknowledge they need help and acknowledge they are seeking help.

*Counselling Psychologist*

From this model, it is clear that group treatment benefits individuals in multiple ways. By participating in one’s own treatment and witnessing someone else’s treatment are both helpful. It is clear that group treatment models provide multiple benefits as described in chapter 2 and not possible by individual therapy.

The word of caution that must be spoken regarding this model for therapists is that it requires specialized training before it is attempted (Baum, 1994; Buell, 1995; Brooks, 1998; Morley, 2000; Westwood & Black, 1999; Westwood, Black & MacLean, 2002). If this model is attempted without specialized training in therapeutic enactment, it will likely further traumatize the client, and the group. For men who already struggle to seek treatment, to be traumatized by an untrained therapist who attempts to use this model will only support the men’s reticence.

*September 11, 2001*

Effects from the explosion that was heard around the world on September, 11, 2001, were also felt here and may have impacted this research. The transition program had been running with regular group sessions since 1998 (Westwood & Black, 1998; Westwood, Black & MacLean, 2002). There had always been a short waiting list of peacekeeping veterans for the program until September 11.
When September 11, 2001 passed, and recruitment for the group used for this research occurred, the men on that list seemed to disappear. A group was scheduled, and ran beginning January 2002, but in consultation with several colleagues, they believed that the men for that group had been screened and established a rapport with the program facilitators prior to September 11. The rapport seemed to maintain the men through the waiting period.

Speaking with colleagues and awareness of the literature suggests that with 'the war on terrorism' so widely televised and discussed in the media, those men who were traumatized from their own military experiences went into hiding. Avoidance and isolation are common coping strategies that people who have been traumatized use (Briere; 1995; Briere, 1996; Herman, 1997; Klein, & Schermer, 2000; Westwood & Black, 1998). More than a year passed after September 11, 2001 before a sufficient number of participants was recruited.

Therapeutic Enactment A Personal Reflection

Although this research contributes to the academic literature regarding group therapy and trauma treatment generally and therapeutic enactment specifically, it also has a personal influence. I did not conduct this research without it having an effect on me. I have never been in the military and have never witnessed first hand any of the military events the participants related. What I have learned is from speaking to the participants, other colleagues, and literature. That said, I have participated in therapeutic enactment as a client, a participant for others and as a witness. I have experienced first-hand the benefits from this intervention on a personal level, and witnessing others while they have been guided through the process. Although I do not have a vested interest in the success or failure of the intervention, I believe it is a very helpful process as it was helpful to me and others who I witnessed.
At every stage of this research I was affected. I experienced an impact that began while I read about the views and limited treatment options available to military personnel, through to my emotional reactions while relating the data to others. While conducting the literature search, I was disheartened to discover the limited options available for treatment of trauma among veterans. Included here, I was surprised at the length of time that passes between exposure to a traumatic event, and treatment; of course I recognize the delay is sometimes related to the symptoms of trauma.

On a personal level, I was most affected by the impact of hearing the stories of the participants. I often became teary-eyed during the interviews, and I was affected when each of the participants became tearful while we spoke. Because I remember each interview and the intensity with which we spoke, I also became tearful while reading the transcripts, and writing the core narratives from the transcripts. That I have not stopped becoming tearful is encouraging because although I will never know what it is like being a military veteran, I appreciate the impact of the unfixable suffering these men experienced and my tears remind me that I am not only an objective researcher looking at an event from a distance. I am a human being witnessing the tragic experiences of human beings who were traumatized at the hands of other human beings.

Through this study, I worked to find an answer to the question: What is the effect of a group-based therapeutic enactment program on veterans who have experienced trauma? To this end, a group of 6 peacekeeping and combat veterans were recruited and participated in a transition program that is described above (Westwood, Black & MacLean, 2002). The participants were interviewed prior to the program and answered the question: What do I bring to the program? They were interviewed immediately after the program and answered: What do I
take from the program? Finally they were interviewed more than 2 months later as a follow-up and answered: What did I hold from the program?

The qualitative and quantitative data provided rich findings. The findings suggest that the participants initially presented with symptoms consistent with individuals who have been exposed to trauma. Following the group, the participants largely improved. At the follow-up interview, the participants demonstrated increases in agency, emotional expressiveness and improved relationships with better communication. These experiences correspond with improvements in self-esteem and reductions in depression.

The participants attributed the changes they experienced to their participation in the program in general, and the therapeutic enactment in particular. They were surprised at the impact of the enactments to draw out emotional experiences and re-create events that occurred sometimes more than 30 years ago. The theoretical and practical implications of these findings are broad.

Building on these conclusions, future directions are clear. The following is a list of recommendations for future applications of the program

1. Include a formal intake process including a more thorough screening of medical needs, including medications and drug and alcohol use.

2. Track changes in medical treatment throughout the program.

3. Neuropsychological screening and input would be helpful regarding physical changes that can result from trauma.

4. For this population, this model is appropriate and must include a residential portion for continued effectiveness.

5. Non-military personnel such as police and correctional officers may be included in the group.
6. Closer exploration regarding the efficacy of the career transition portion is indicated because no one identified or seemed to recall the career section.

7. Apply this program model to humanitarian aid workers who are sent into hostile environments and are exposed to traumatic events.

Below is a list of unanswered questions for consideration in future research.

1. Conduct a women's only group for comparison.

2. Conduct a heterogeneous group that includes both peacekeeping and combat veterans and RCMP officers who were peacekeepers, or Correctional Service of Canada staff who work in institutions or those who work overseas beside peacekeepers.

3. What influences the findings and the focus of the investigation? How do the enactment facilitator, participants or researcher influence the different foci of the findings?

4. Could a participant who was not a soldier have fully understood their stories? What would be the effect of a heterogeneous group?

5. What is the importance of brotherhood?
   - Is the importance of brotherhood related to missing the bond they experienced in the military?
   - Is it related to the self-induced isolation?
   - Or is it related to the isolation that men feel due to socialization and the military helps break that isolating tradition of men?

6. Examine the physical movement of the lead around the circle, as related to the impact of the event on the witness and participants'. What is the 'correct' amount of movement for the lead and participants to feel the impact?

7. Conduct an experimental research model with a control group (those on a waiting list for the group) and an experimental group (participants in the group). This experimental model would control for confounds such as passage of time and attention by mental health workers not addressed in this study.
From this study, it is clear that therapeutic enactment has the positive effect of helping to alleviate the negative impact of exposure to trauma. Researching the effect of therapeutic enactment on other presenting issues, applying this program model to female veterans, and researching this program for application to heterogeneous groups such as Royal Canadian Mounted Police (RCMP) peacekeepers, Correctional Service of Canada staff who work overseas alongside peacekeepers and in local institutions are some directions for future exploration.
REFERENCES


APPENDIX A

Interview One

Demographic and Background Information

Age:
Relational Status:
Children:
Work/school status:
What is your current living arrangement? (rural/urban) (family/ alone)
(house/apartment) (own/rent)

What counselling have you received in the past?

What are the current medications you are taking?

Military Information

Where did you serve? How long? (age then)
What was your rank and regiment?
What were your orders?
How long have you been back?

Trauma-Specific Information

How did you hear about the program?
What are you hoping for from the program?
What trauma-related stressors are you experiencing from peacekeeping? (list effects)
Are there any events from your childhood, adolescence or training that caused trauma?
Interview Two

Introduction

While we talk here today, I am looking at your experience in as a whole way as possible. I am aware that you have just finished the group, and I am also aware that you have had experiences outside of the group. (I want to leave this as open as possible so as not to lead them and prompt them)

Interview questions
1. Describe to how you saw yourself before the group and how you see yourself now. What if anything have other people told you they notice?

2. I would like to talk with you about your experiences since the beginning of the group. First I would like to talk with you about things that happened that helped you in moving to how you see yourself now. Then I would like to discuss the things that were not so helpful, the things that hindered you or held you back. I am interested in hearing about things that happened both in and out of the group that were helpful to you and things that held you back.

3. Starting with the helpful things, what is the first thing comes to your mind, the second and so on?
   • What led up to it?
   • What was your experience of it?
   • What was the outcome?

4. Now let’s move to the things that held you back, what was the first thing comes to your mind, the second and so on?

5. Was there anything that didn't happen that you wish would have happened?

Review Group Experience
1. Tell me about your experience since beginning the group

2. What did you become aware of as a participant of the group?

3. What surprised you? (About others? About the leaders? About yourself?)

Therapeutic Enactment

1. What did you become aware of as a witness of the therapeutic enactment? (Thoughts, Feelings, Experiences)

2. What surprised you as a witness?

3. What did you become aware of as a lead client of the therapeutic enactment? (Thoughts, Feelings, Experiences)

4. What surprised you as a lead client?
5. What did you become aware of as a participant of the therapeutic enactment? (Thoughts, Feelings, Experiences)
6. What surprised you as a participant?
7. What made the biggest impact on you?
8. Effects on Trauma Experience
9. How has being a member of this group changed you?
10. What do you think accounts for that change?
11. Define trauma broadly and what trauma specific symptoms were you aware of before the group, and how have they changed?
APPENDIX B

Group Outline

Outline: Friday, January 17

7:00 -- 7:30  Introduction of “leadership team”
Overview of the Transition Program in general
History + vision, goals, benefits, questions.

7:30 - 8:00  Introduction of group members (Check-in) (also SW)
Question: Name, brief summary of military experience,
What you hope to get out of the group.
Leaders: why interested in this field, what we hope to get ...

8:00 - 8:15BREAK

8:15 - 8:30  Specific overview of this group
3 stages / Partners’ Nights / Research component
General outline for the next 4 weekends
General session structure
(Need decisions re: partner’s nights, post interviews, and ?)

8:30 - 8:40  Expectations re: participation
Preparation between weekends
Overnights + drinking, etc. ...
Buddy System (Dennis K) -- ensure a phone list generated
Self-awareness and self-care.

8:40 - 9:40Group Norms
Sensitization Ex: Take a few minutes to think of some of the best and worst
experiences you have had working in small groups.
Now write down (anonymously on a 3x5 card) two of your greatest fears of
working in groups.
Leaders take cards, generate a list of fears (including their own) on flipchart.
Norms then generated to address these fears. (If time, give one example of a norm
then split the group into two to generate more, then return to larger group to
develop final list of norms).

9:40 -9:45  Overview of Sat.
(relevance of group dynamics and comm. Skills to relationships / life / work)

9:40 - 10:00  Check-out:
where are you at now compared to when we started?
Outline: Saturday, January 18th, 2003

9:00 - 9:20  Check-in / Questions or comments re: Friday

9:20 - 9:30  Overview of Norms

9:30 - 10:30  Pairs Exercise:
Describe “re-entry experience” to a partner, partner then introduces individual’s
story to the group.
Questions
Break into pairs / Return and debrief with group.

10:30 - 10:45  BREAK

10:45 - 11:00  Didactic: Introduce basic communication skills
Interpersonal Gap / Active Listening / SOLAR

11:00 - 11:15  Demonstration (leadership triad):
What would you tell your son / daughter about your military experience?

11:15 - 11:45  Break into triads (10 min ea), practice Comm. Skills with above Q.

11:45 - 12:00  Debrief in large group.

12:00 - 1:00  LUNCH

1:00 - 1:15  Didactic: Giving Feedback

1:15 - 1:45  Break into triads:
Q: think of someone in your life now who you’d like to give some feedback to
(positive or negative) and feel comfortable discussing in the group. Practice -- 10
min each

1:45 - 2:00  Debrief in large group.

2:00 - 3:00  Lifeline exercise and debrief

3:00 - 3:30  Discussion of Branching Points exercise

3:30 - 3:45  BREAK

3:30 - 4:30  PTSD discussion; Self-soothing exercises -- teaching and practice.

4:30 - 5:00  Check-out
Outline: Fri., Jan. 2

7:00-7:10 “Business”
Reminder re: Norms, -- room after check in for questions / comments
Awareness night -- are significant others coming? / accom. Question
Return to PTSD discussion tomorrow (symptoms and strategies)
Tonight continue with Communication Skills Training -- note importance re:
transition / effectiveness / importance for work in group -- TE’s

7:10-7:45 Check in
A) Leader’s reflections from last week (what I remember from your story)
B) Members -- what stood out for them over the week
C) Members -- 3 new feeling words to describe where they’re at

[Leaders model paraphrasing, clarifying, summarizing]

7:45-8:00 Didactic: Giving and receiving feedback

8:00-8:15 Demo

8:15-8:30 BREAK

8:30-9:00 Practice in pairs:
Q: think of someone in your life now who you’d like to give some feedback to
(positive or negative) and feel comfortable discussing in the group. Practice -- 10
min each [1 positive + 1 negative?]
[Leaders check with ea. Member re: suitable ‘target’ for feedback]

9:00-9:15 Debrief in large group.

9:15-9:40 Prep for Branching Points
Demo (BW) Feedback (PW, then open for grp)

9:40-10:00 Check-out
Outline: Sat., Jan. 25

David Kuhl: Accessing Medical Care / Branching Points Exercise / Discussion of ‘Abnormal Events’ Exercise

8:30-9:00    Breakfast

9:00-9:15    Intro of David -- Check in of group (with names for DK)
Check in question?

9:15-10:15   David’s presentation and Questions

10:15-10:30  BREAK

10:30-11:00  PTSD/R discussion
overheads re: symptoms / strategies (from branching pts to TE’s) / dealing with anxiety

11:00-12:00  Branching Points
[If not covered Fri: Start with Demo of Branching Point]

12:00-1:00   LUNCH

1:00-4:30    Branching Points

4:30-5:00    Debrief and Check-out
Outline: Fri., Feb. 7

7:00-7:10 Business (Partner Awareness Night)
Brian couldn’t be present, but may come later
Reminder of 10:00AM start (to 6:00PM) tomorrow and getting to the “abnormal events” [PTSR as ‘normal response to abnormal event’]
Brief outline of the evening (family systems / basic themes and solution focused approach)

7:10-7:25 Introductions / Check-in
Name / how you’ve come to be here / what do you hope to get from being here?

7:25-7:30 Hand out cards and pencils anonymous answers to the following:
What are the main issues or themes you would like to have addressed here?
What are you hoping to have different or change in terms of your communication or relationship generally?

7:30-7:45 Cards gathered, read aloud -- categories listed on flipchart
Anything to add?
Establish priority to address (frequency of themes)

7:45-8:15 Discuss themes as a group
What are people’s experiences around this theme?
What is working so far?
Are there exceptions? I.e. are there situations where this theme is not a problem?
What could still be done to improve the situation?
What might be some other possible solutions?

8:15-8:30 BREAK (If needed -- take a few minutes for coffee/etc, then return)

8:30-9:00 Discuss themes as a group (as above)

9:00-9:30 Check-out:
Is there one thing that you feel you understand differently after the discussion tonight?

9:30-10:00 In pairs: discuss what commitments you are able to establish with each other in order to work toward positive solutions.
Write commitments on card (with name) and return the card to PW for safe keeping until next month.
Outline: Sat., Feb. 8th

10:00-10:30  Debrief Awareness Night / Check-in
            Snacks / coffee available, but not specifically breakfast

10:30-12:00  Abnormal Events
            (possible demo or introduction of TE process to start)

12:00-1:00   Lunch

1:00-5:30    Abnormal Events (Breaks as needed)

5:30-6:00    Check-out
            Buddy System
            Self-care re: memories, etc.
Outline: Fri., Feb. 21

7:00-7:15     Business Check-in
7:15-8:00     Review TE from last weekend
8:00-8:15     Break
8:15-9:30     Integration of TE experience
9:30-10:00    Check-out
Outline: Sat., Feb. 22

9:00-9:30  Business / Check-in

9:30-12:00  Therapeutic Enactments

12:00-1:00  Lunch

1:00-5:30  Therapeutic Enactments

5:30-6:00  Check-out

Buddy System
Self-care re: memories, etc.
Outline: Fri., Mar. 7

7:00-7:15 "Business" Partner Awareness Night
Introduction
Check-in “What do you need to leave behind to be present?”

7:15-7:20 Review last time
Themes/ Discussion
Commitment Cards

7:20-8:00 Check-in around how it went over the last month
What's been working?
What's changed?

8:00-8:15 Break

8:15-9:00 Review Themes
Anything new to add?
Any new insights/concerns/ helpful links?

9:00-9:30 Where to from here?
New commitment
Feedback on strengths

9:30-10:00 Check-out
What's one thing you're able to commit to changing/addressing from here?
What are you taking away from this?
Outline: Sat., Mar. 8

10:00-10:30 Business
   Tim B. Contact information
   Therapeutic Enactment possibilities
   Dr. David K. reminder of referrals
   Reimbursement information
   W5 video show over lunch
   6:00 wrap-up and debrief with Dr. Westwood

10:30-11:00 Check-in (Normalize closure)

11:00-12:30 Debrief and Integrate TE experience
   Re-cap: What you did
   What did you achieve?
   What surprised you?
   What reflections/insights since?
   How are you different now?

12:30-1:00 LUNCH
   W5 Video

1:30-2:30 Debrief Video

2:30-4:30 Starting Points (career and future planning)
   Where to go from here
   Plan of action

4:30-6:00 Closure and Check-out
   1 thing to each person: What I appreciate
   What I will do differently (Where/When/What/How)
   Follow-up

6:00- Closure Ceremony with Dinner
APPENDIX C

Recommendations

1. Include a formal intake process including a more thorough screening of medical needs, including medications and drug and alcohol use.

2. Track changes in medical treatment throughout the program.

3. Neuropsychological screening and input would be helpful regarding physical changes that can result from trauma.

4. For this population, this model is appropriate and must include a residential portion for continued effectiveness.

5. Non-military personnel such as police and correctional officers may be included in the group.

6. Closer exploration regarding the efficacy of the career transition portion is indicated because no one identified or seemed to recall the career section.

7. Apply this program model to humanitarian aid workers who are sent into hostile environments and are exposed to traumatic events.

8. This therapeutic intervention is a cross-theoretical intervention requiring further theoretical integration because the breadth of the theories used to inform the model is considerable.

Future Research.

8. Conduct a women’s only group for comparison.

9. Conduct a heterogeneous group that includes both peacekeeping and combat veterans and RCMP officers who were peacekeepers, or Correctional Service of Canada staff who work in institutions or those who work overseas beside peacekeepers.

10. What is the influence on the focus of the findings? How do the enactment facilitator, participants or researcher influence the different foci of the findings?
11. Could a participant who was not a soldier have fully understood their stories? What would be the effect of a heterogeneous group?

12. What is the importance of brotherhood?
   - Is the importance of brotherhood related to missing the bond they experienced in the military?
   - Is it related to the self-induced isolation?
   - Or is it related to the isolation that men feel due to socialization and the military helps break that isolating tradition of men?

13. Examine the physical movement of the lead around the circle, as related to the impact of the event on the witness and participants'. What is the 'correct' amount of movement for the lead and participants to feel the impact?

14. Conduct an experimental research model with a control group (those on a waiting list for the group) and an experimental group (participants in the group). This experimental model would control for confounds such as passage of time and attention by mental health workers not addressed in this study.
The Transition Program for Canadian Peacekeeping Soldiers

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Purpose of the Study: The purpose of this study is to evaluate the Transition Program for Canadian Peacekeeping Soldiers. The Transition program is a structured group-based program designed to facilitate Canadian Peacekeeping soldiers' re-entry into Canadian society by aiding with their personal and career readjustment. The evaluation of this program will examine the immediate and longer-term effects of participation in the program. Specifically, this evaluation study will investigate whether or not the program meets its goals of reducing stress-related and problematic reactions soldiers can experience following peacekeeping tours, and if the program also facilitates the participants' self-initiated career exploration activities.

Procedures: Because this study involves the evaluation of the Transition Program for Canadian Peacekeeping Soldiers, below for your information is an overview of the Transition program. This is followed by a description of the procedures that you will be consenting to as part of this research study.
Program Description
In the Transition program, you will be involved in a small group with five to seven other Peacekeeping soldiers facilitated by two experienced group leaders. This group will meet for fifteen, three-hour sessions. The sessions are broken down into four phases: initial sessions, life review, therapeutic enactment and consolidation sessions. The initial sessions will focus on activities designed to help you get to know and feel comfortable with your fellow group members. You will then be introduced to the life review method that is used to aid you in making sense of your general life experiences and your experiences on tour. The Life Review process entails the writing of your own autobiographical essays related to certain themes and then reading these stories in the group. After you read your story, the other group members have an opportunity for comments and discussion related to their own experiences that arose from listening to you. Each group session will focus on a different theme, such as “Major Branching Points in My Life”, and sensitizing questions will be given to help you write your autobiographical essay related to each theme. You may choose not to read all that you have written into the group and the group leaders will ensure that appropriate group norms regarding feedback are followed.

The life review method may allow you to identify critical events that have remained unresolved. You may then wish to explore a critical event further during the next stage of the program’s sessions focusing on therapeutic enactment. Therapeutic enactment is a planned, highly structured group experience that involves an individual group member recreating a critical event coached by the group leaders. If you choose to do an enactment of an event you will plan this with the group leaders in advance. Then, during the group session designated for your enacted event, you will recreate the event with the help of the group leaders and other group members who will take various roles of significant others who were part of your critical event. Following the enactment, you and the rest of the group members will spend time debriefing and exchanging reactions. It should be stressed that you may not identify or choose to enact any critical events during the Transition program. Participation in another group member’s enactment is also not required: You may “pass” at any time if another group member asks you to take on a role that makes you uncomfortable.

In the final phase of the Transition program, you will be encouraged to consolidate new learning and form goals and objectives for the future. It is a priority in the final sessions of the program to assist you in pursuing employment, retraining or education if desired. Although what is described above is the basic phases of the Transition program it should be stressed that the groups in the program are tailored to meet the needs of the participants in the program.

Study Procedures
As a participant in the evaluation of the Transition program you will be asked to complete some questionnaires that are intended to measure your level of well-
APPENDIX E

Transition Program Web Page

I designed, created and uploaded to the internet this web page as seen below. It was created as a method by which other military veterans can learn about the program. Not available on the printed page are video clips of other veterans who were interviewed about their participation in the program. Based on the feedback from this group of participants, the web page will be amended to include a message board for communication with each other.

http://www.educ.ubc.ca/faculty/westwood/
The Transition Program for Canadian Peacekeepers was created at the University of British Columbia and funded by the Royal Canadian Legion to meet the needs of returning Canadian forces personnel.

*If the experiences described below are familiar to you or someone you know, this program will be of interest to you.*

**Reverse culture shock** is a term typically used to describe the unanticipated adjustment difficulties that many soldiers experience when returning to civilian life. Soldiers attempting to move beyond their military experiences can find themselves feeling disoriented, confused, neglected, frustrated, unemployed, or underemployed and generally struggling in their career as well as personal relationships following peacekeeping tours.

**Stress reactions** as a result of their peacekeeping experiences can also harm soldiers' readjustment to civilian life. Many peacekeeping soldiers are exposed to events such as witnessing atrocities and torture, casualty handling of civilian adults and children as well as other distressing experiences that can lead to stress reactions. Left unattended, these reactions can lead to feelings of anger, isolation and loneliness as well as alcohol and substance abuse problems.
WHAT IS THE TRANSITION PROGRAM FOR CANADIAN FORCES PERSONNEL?

Many Canadian forces personnel have not had the help and support needed to resolve stress-related issues and focus on their careers. Developed at the University of British Columbia by Dr. Marv Westwick and by Canadian forces personnel including soldiers in peacekeeping roles, this free program provides assistance for military personnel in a confidential environment.

The program is NOT affiliated with the Department of Defence. To date, this program has helped WWI, WWII, Korea and Vietnam veterans, and Peacekeepers who served in Croatia, Kosovo, Yugoslavia, and East Timor. Input from all the participants continue to help develop the program to better aid other Canadian forces personnel.

"This short program saved my life and I am so grateful for it."

-Lee, Peacekeeping soldier, Program participant.

Funding for pilot projects have already helped over 100 military personnel integrate their war experiences and helped their transition to civilian life.
CANADIAN FORCES PERSONNEL:
Part of a project that includes two programs

1. The Life Review Program for Canadian Veterans: In a confidential group format, this program is designed to provide Canadian Veterans with an opportunity to reflect on your tour(s) of duty and the impact of your military service on your life experiences.

   "It helped lay some ghosts to rest."
   ~Dick, WWII Veteran, Program participant

The life review program is currently funded by Veterans Affairs Canada

2. The Transition Program for Canadian Forces Personnel who have served in peacekeeping and other special duty areas: Using a confidential group format this more intensive program is designed to help repair stress and trauma issues and help soldiers in their transition to civilian life.

   • A way to begin talking about their tour experiences in a non-judgemental environment
   • An opportunity to share experiences with others who have been there
   • Drop psychological "baggage"
   • A way to develop future goals and possibilities

The Transition program offers Canadian Forces Personnel veterans:

Veterans Affairs
WHAT HAPPENS IN THE PROGRAM?

You meet as a small group with other veterans of the Canadian forces (usually six people) and at least 2 professional group leaders. Group activities include life review (a structured way of helping you write and then tell your story), and a spousal/partner awareness meeting to help your family understand your experiences and support you. In the group you will also learn specific approaches for dealing with stress and have an opportunity to explore goals for the future.

Lee, Peacekeeper Soldier, Program Participant

Who is eligible for the program?
Anyone with military experience (ie. peacekeeping/special duty tours) can participate if this program.

BASIC PROGRAM FORMAT:

- You will meet in a supportive and confidential group environment with other Canadian forces personnel.

- You will be given the opportunity to review challenging aspects of returning to civilian life and other major branching points in your life.

- You will help other Canadian forces personnel come to terms with their challenging tour experiences.

- At the end of the program you will focus on planning and forming goals for the future.

- Learn effective coping with stress strategies.

- We stress that each group is tailored to meet the needs of the Canadian forces personnel participating in the program.

"This program is necessary for our own health and for our families."

~Mark, Peacekeeping soldier, Program participant.

Why should I do this now? It is never too late to tell the story of your military experiences. It is never too late to start on a new path to reach personal and career-related goals.

Jarrett, Peacekeeper Soldier, Program Participant
WHAT WILL I GET OUT OF THE PROGRAM AND HOW CAN I HELP OTHERS?

Involvement in this program will help you better understand and cope with your transition to civilian life. It will also aid you in the resolution of stress-related issues. We have found that veterans who are freed from the distraction of these issues can better concentrate on career strategies.

"I learned how to be proud of what I have done, not ashamed of it, scared or remorseful."

~Graham, Peacekeeping soldier, Program participant.

Many veterans of peacekeeping missions and other special duty area missions feel very alone in their experiences. By being in this program and listening to other's stories you will help your mates resolve issues they carry from their military experiences. Participants in this program contribute to its continued growth and help change it to better meet the needs of other Canadian forces personnel. All the participants are asked for feedback that help improve the program each time it is run.

Tony, Peacekeeper Soldier, Program Participant
Enacting Change

Benefits of the Program:

Previous program participants identified the following benefits:

1. Relief from trauma symptoms such as nightmares and depression.

2. The experience of healthier emotional responses when working with other people — calmer, fewer angry outbursts.

3. Appreciation of involvement in a safe forum, away from the military establishment, in which they get to talk about their military experiences and receive peer support — often regarding events they had previously kept to themselves.

4. Identification with and learning through others' experiences.

5. Release from personal frustrations they did not realize they were carrying.

6. Pride replacing previously held feelings of shame, fear, and remorse about their peacekeeping experiences.

7. Feelings of energy and motivation for career pursuits in civilian life.