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Connecting With Our Roles Through Post Traumatic Growth After Experiencing Medical Trauma

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Abstract

This paper explores the combination of drama therapist, Robert Landy's (1993), Role Theory and the psychological concept of Post Traumatic Growth (Tedeschi, 2018). The author created a protocol that involved psychoeducation surrounding the five domains of Post Traumatic Growth and a role card sort involving the drama therapeutic process of role theory. A young adult client experiencing significant medical trauma participated in these processes during a three session intervention. Results indicated that the client viewed negative experiences as potentials for growth toward furthered resilience and future hope and optimism. The sample size was limited to one person and further search is needed to further understand if this intervention has efficacy.

Keywords*:* Medical trauma, Post-Traumatic Growth, Drama Therapy, Role Method, Role Theory, Resilience

Author Identity Statement: I'm a 26-year-old Cis Gender, white female who was born in America. I self-identify as someone who suffers from chronic pain, and someone who has experienced a large amount of medical trauma starting from a young age.

Connecting With Our Roles Through Post Traumatic Growth After Experiencing Medical Trauma

The intersectionality between post traumatic growth (PTG) (Tedeschi, 2018) role theory (RT) (Landy, 1993), and medical trauma (McBain, 2019) is non-existent in scholarly literature. Though no research explores the three concepts together, there may be benefits in working with people experiencing medical trauma through the use of RT to explore PTG by examining the roles played before the medical trauma and after, and potential roles for the future. Using the framework of PTG creates a lens of growth for the participant and may highlight areas to further develop to help reveal the roles needed to achieve and maintain those areas of growth.

Williams (2020) defined medical trauma as "a set of psychological or physiological responses of a patient or patient's family member or loved one to the pain, medical injury, or invasive and terrifying medical treatment that the patient experiences" (para. 1). Witnessing substantial medical trauma in a short amount of time can affect an individual's mental, physical, and emotional wellbeing (Williams, 2020). Drama therapy (DT) may be an effective modality for aspects of healing the emotional indicators that the physical trauma may have brought on (Grinberg, 2018). In addition to being useful in hospital settings, despite space constraints, RT is an appropriate DT intervention for people with medical trauma since it can be adapted easily to meet the needs of each participant. This is important because medical trauma can affect people of

all ages, backgrounds, trauma history, and experiences. Medical trauma can also occur as a result of second-hand trauma and witnessing or being told about the injury or illness (Williams, 2020). RT may allow for the exploration of experiences of medical trauma, and it may be an effective treatment modality for the mental and emotional effects that might occur alongside medical trauma.

Medical trauma in general is not thought of as an automatic criterion for the development of PTSD. According to the *DSM-5* (American Psychiatric Association [APA], 2013):

> A life-threatening illness or debilitating medical condition is not necessarily considered a traumatic event. Medical instances that qualify as traumatic events involve sudden catastrophic events (e.g., waking during surgery, anaphylactic shock). Witnessed events include, but are not limited to, observing threatened or serious injury, unnatural death, physical or sexual abuse of another person due to violent assault, domestic violence, accident, war or disaster, or a medical catastrophe in one's child (e.g., a life-threatening hemorrhage). (p. 274).

Despite the *DSM-5* not acknowledging a wide range of medical traumas as traumatic events or as a cause for PTSD, research indicates that medical trauma can lead to the presence of PTSD symptoms (McBain, 2022; Williams, 2020). People are often effected by the sudden loss of a loved one, witness or experience life-threatening illnesses, abuse, and experience other adverse events. McBain (2022) recognized that symptoms similar to PTSD criteria may develop, along with anxiety surrounding medical procedures, illness, and injuries; fear around death of a loved one or self; and feeling scared or frightened of doctors and hospitals. All such symptoms signal a

"psychological or physiological response" (Williams, 2020, para. 1) to medical procedures and settings, aligning with definitions of medical trauma from Williams (2020) and the *DSM-5* (APA, 2013).

The basis of my protocol was to explore PTG and the roles one may have experienced during a medical crisis. I aimed to break down these roles and discover if PTG is present after a medical crisis. Understanding what roles we play and how they can shift is a step into making meaning. Then, discovering how we can grow within each role following trauma can be informed by the PTG system, including how PTG is understood and measured (Keiseri, 2021). Marrying RT and PTG might give one the opportunity to examine their trauma, look at the roles surrounding it, and achieve PTG following the experience.

I am a 26-year-old female, who has a long history of childhood medical trauma. I have anecdotally found a personal correlation between these three concepts to be very prevalent in recovery. I believe an integration of these concepts could benefit others who share a similar background to myself and others regarding medical trauma. My hope is that this study will be able to expand societal understanding about medical trauma and how it is formed. Additionally, this study aimed to bring awareness to the importance of recognizing medical trauma and to offer suggestions on how to effectively treat it. The methodology and protocol discussed in this study is of my own creation and something that I hope becomes applicable to other cases of medical trauma with room for adaptation to other categories of trauma as well. It is my hope that this protocol could be the first step of research into the intersection of RT, PTG, and medical trauma interventions.

In this thesis, I use RT to explore traumatic medical events, how those roles may shift and change, and what growth we may see after the trauma. First, I present a review of the literature on post traumatic growth and RT. Following the literature review, I discuss the protocol that I created for this study. I designed this protocol to take place over three sessions, but it has the flexibility to be expanded over more sessions if needed. This protocol has been designed to lead us to the ultimate goal of connecting and recognizing the shift in our roles as a result of trauma. Finally, my observations about the client's interactions, perceptions, and interpretations of their roles is analyzed to inform future research and practice.

Literature Review

Post Traumatic Growth

Post Traumatic Growth can be defined as new growth that one might experience from living through or witnessing a previous struggle with a traumatic or very hard situation. (Tedeschi & Calhoun, 2018).

In this idea of PTG, Tedeschi and Calhoun (2018) introduce the 5 domains of PTG. These domains are the 5 areas of life where growth would be expected to take place. The five domains include: greater appreciation of life and changed sense of priorities, warmer and more intimate relationships with others, a greater sense of personal strength, spiritual development, and new possibilities (Israel & Nugent, 2020).

The Five Domains of Post Traumatic Growth

As mentioned above, PTG contains five domains of growth which are areas of life where growth would be expected to take place after trauma. Greater appreciation of life and a changed sense of priorities are being able to notice and give appreciation to the smaller things in life and for the people and things that surrounds us (Tedeschi, 2018). Warmer and more intimate relationships with others means being able to see and experience a new relationship with others and continuing to give to current relationships and gain a deeper connection with your relationships. A greater sense of personal strength is being able to notice your own strengths and expressing and experiencing more self-confidence and the positive self-perception of yourself. Spiritual Development isn't just speaking from a religious viewpoint but, being able to reflect on the changes of things such as harmony in life, our connections with others, and morality. New Possibilities can be exploring the idea of taking a new path in life when it is time for a change and/or exploring new interests, activities, hobbies, a new career, and new things in general (Tedeschi, 2018).

Post Traumatic Growth Research

A review of the literature regarding PTG by Harmon and Venta (2020), investigated the effect of PTG in adolescents to determine its effect on psychological change in relationships, positive change in self, and in overall philosophy of life measured. The review of the literature included 22 published journal articles that were written in English with participants ages 12-18. Harmon and Venta found that there is a lack of imperial data to support PTG because of the lack of longitudinal studies. However, this review also found "initial support in the form of correlational evidence that such growth occurs." (Harmon & Venta, 2020, p. 604)

Another study on PTG in adolescents was conducted by Asgari and Naghavi (2022), who explored the experience of PTG among adolescents experiencing the sudden loss of their father. This study was done with Iranian adolescents ($N = 14$) and used a phenomenological approach to collect and analyze their data. Two main themes and seven categories of PTG were found during the study. The first theme found was the initial phase, with two categories: initial confusion and reaction to grief. The second theme was growth over time, and there were five categories found: taking time with a positive outlook, strengthening the bonds, academic competency, psychological wellbeing, and existential improvement. "The findings are consistent with previous studies that show PTG may happen after encountering traumatic events and passage of time is imperative for the development of PTG" (Asgari & Naghavi, 2022, pp. 183-184).

Role Theory

Role Theory was created by Robert Landy in the early 90s. Landy's Role Theory (1993) is based off the idea that every individual has many different roles that we play in everyday life. All these different roles combined make up one entire person. Everyone has the ability to play different roles; these roles are formed from one's biological disposition, social construct, the environments they are surrounded by, and their own morals. Everyone has roles that they knowingly play and have roles that they are not aware of because these roles may have faded due to neglect, abuse, or not needing a certain role in an area of life (Landy, 2020).

Role Theory Research

Keisari (2021) documented the integration of life review and playback theatre in a population of older adults by conducting four different studies with diverse groups, settings, and

interventions over the course of 3 years. Two studies used self-reporting questionnaires, while one used semi-structured face-to-face interviews, and another involved videotaping the experience, then analyzing the video post-intervention with participants and staff.

The use of RT explored by Keisari (2021) suggested that social roles played in everyday activities can be altered and changed throughout life. It was also suggested that RT can impact a participant and bring a new social role to the forefront for enhanced life-drama connection. Qualitative results showed that there was overall improvement in mental health, meaning of life, self-acceptance, relationship with others, self-esteem, and satisfaction of life in participants who engaged in integration of life review and playback theatre.

Role Theory and Post Traumatic Growth

Although there is no research connecting role theory and PTG, Quan (2022) used demographic variables that we can think of as *Known Roles* as a tool to gather more information on a trauma evaluation. These demographic variables could be considered social roles, similar to those explored by Keisari (2021). These social roles include gender, only child status, left behind experience, parental marital status, father's educational level, and mother's educational level.

Quan (2022) recruited 1,028 college students from eight universities who were only children. Quan used the surveys Childhood Trauma Questionnaire—Short Form and Cognitive Emotion Regulation Questionnaire, and Posttraumatic Growth Inventory, to examine relationships among childhood trauma and acceptance, positive reappraisal, and posttraumatic growth among the college students. Quan also considered how the previously mentioned social roles could have a direct impact on the levels of trauma.

Quan (2022) found that with a higher score on the traumatic event scale, the lower level of acceptance one would show. Additionally, lower scores on the traumatic event scale showed higher rates of acceptance to the trauma, resulting in higher probability of experiencing PTG. Finally, the results showed that the social role of gender had a great effect on PTG ($p < 0.05$). Quan's findings showed that PTG is directly related to trauma levels, some social roles effect PTG, and acceptance is necessary for someone to experience PTG after trauma.

Role Theory and The Medical Patient

Some research exists on the use of RT in hospital settings, which can inform RT's application to medical trauma. Medical clowns are performers who make visits to hospitals to encourage patients and improve their wellbeing through the use of humor, magic, puppetry, and improvisation (Grinberg, 2012). According to Grinberg, medical clowns have been known to use and explore many different role strategies that can be linked to Landy's (1993) perspective on RT. By taking notice of the patient and their qualities, the medical clowns are able to start looking at other roles outside the one role the patient is being witnessed in. Grinberg (2012) explained, "Implicit in the role of the patient is the jealousy of the 'healthy ones'...By undertaking the feeling of jealousy so totally the clown gives recognition to and legitimizes the existence of that feeling" (p. 45). Being able to explore these feelings gives patients the ability to have aesthetic distance with this feeling and see it expressed on someone else, validating the emotional experience.

Grinberg (2012) connects medical clowning with Landy's (1993) RT in that both drama therapists and medical clowns can take on new and different roles in order to help the patient

explore and cope with new situations. Medical clowns are particularly adept in RT since the nature of their performance is flexible, allowing them to shift between different roles quickly and readily. Drawing from Landy (1993, 2001, 2008, 2009), Grinberg (2012) summarized:

> Life is essentially dramatic, and dramatic action is a central feature of human existence. Therefore engagement in dramatic play may enhance an individual's ability to support and maintain a healthy and flexible role system, the kind which is required in order to cope with the complex and paradoxical nature of the human condition. (p. 43)

Grinberg (2012) expressed that RT is a safe way to explore all the differing emotions one might be feeling about these complicated medical situations. This is especially important in the hospital because there are many unfamiliar situations that regularly happen and using role might give the patient the ability to explore these events from a safe distance.

Medical Trauma

"Medical trauma is defined as a set of psychological and physiological responses to pain, injury, serious illness, medical procedures and frightening treatment experiences" (McBain 2021, p. 1). Medical trauma is different than other types of trauma because one experiences both psychological and physiological responses. All trauma, including medical trauma, is seen as living in the body. What makes medical trauma different is that it is perceived by the person as ongoing events with bodily origins. These traumas are brought to the surface when there is attention or trauma directed toward the physical body. (McBain, 2022)

In a PTSD and coping with trauma sourcebook, Williams (2020) described the impact of medical trauma, how children respond to it (including how their behaviors might change), and

their perceptions of trauma. Williams broke down the types of traumatic stress reactions to medical trauma: reexperiencing, avoidance, and hyperarousal. Williams noted that these responses to the trauma may vary depending on the subjective experience and the intensity of the trauma. She also noted the risk factors and prevention of medical trauma, as well as how the health field can help prevent medical trauma. Williams noted that, in some cases, although the trauma is not preventable, health care providers must learn to treat the medical trauma without risking re-traumatization, rather than dismissing the trauma and its responses.

McBain (2022) emphasized why an expansive approach to medical trauma treatment matters, as well as how to effectively help treat medical trauma. McBain suggested that rather than moving on and simply noting the physical and/or mental health diagnosis, the team of care providers should think about how the diagnosis might effect the mental health of the patient. McBain emphasized how support can be provided from the start rather than ignoring it and risking letting it get out of hand later. McBain wrote about different ways to incorporate this type of care into everyday practice. This included integrating more quality-of-life assessments, and starting the process of assessing traumatic stress symptoms that could be related to past or current treatment/management for a chronic health condition.

Post Traumatic Growth and Medical Trauma

The connection between PTG and medical trauma is less researched. One study by Smart (2006) discussed how the medical population has started to emerge as a group that has a significant risk of trauma because of various medical events like the diagnosis and treatment of a life-threatening illness. These individuals are at a significant risk to experience symptoms of

PTSD, but also have a unique opportunity to take their lived experiences and produce life changing growth, or PTG. For instance, patients who have reported PTG after experiencing some kind of medical trauma have demonstrated health gains and psychological benefits, such as reduced risk of repeated heart attack, lower levels of morbidity, and reduction in PTSD symptoms. However, more research is needed to understand what factors are involved when treating medical trauma. A more detailed understanding of what makes an effective treatment for medical trauma is needed to adjust current care.

Conclusion

It is important to note when looking at events in life that can cause trauma, the loss of a loved one, abuse, survivors of national disasters, among others, immediately come to mind. Events that may not be thought of right away can also have a long-term traumatic effect such as childhood hospitalization, witnessing medical trauma, or having medical procedures at a young age. This medical trauma is not studied or researched as thoroughly. The literature review revealed that more research needs to be done on how medical trauma might stem from these experiences.

The research done on each of these topics separately indicates that the topics are related. Combining the research on PTG, medical trauma, and RT could provide the information needed to help individuals experience PTG after medical trauma.

Methodology

This protocol was created to explore PTG and the roles one may have experienced during a medical crisis. Its aim was to break down these roles and discover if PTG is present after a

medical crisis. The client that participated in this study identified as a cis-gender, bi-racial 18-year-old female. I began working with this client in September of 2022 at the mental health agency where I am completing my second internship. This client was chosen to participate in this protocol because her history of trauma, including witnessing medical trauma.

Prior to starting the protocol with the client, a grief timeline was created in session. The client was asked to place different losses and traumatic events in chronological order. Events placed on this timeline included witnessing medical trauma, loss of a childhood home, and sibling relapse of substance addiction.

Utilizing Landy's(1993) role card assessment, the client was instructed to sort the roles into the categories of *Who I Am*, *Who I Want to Be*, *Who Can Help Me*, and *Who is Blocking Me*. During these sessions the client interacted with a set of role cards that were written on sticky notes and then stuck to giant sticky notes of each category. The roles in the card assessment were adjusted for the use of this intervention and with the client in mind. Roles that were removed from the assessment were Sinner, Orphan, Beauty, Free Person, Outcast, Wife, Vampire, Saint, Clown, Suicide, Slave, Beast, Zombie, and Killer. I removed these roles based on client history and to use roles that were more concrete rather than requiring abstract thinking. Roles that were added include the roles of Doctor, Nurse, Caretaker, and Student. These roles were added because of this study's focus on medical trauma.

PTG was incorporated into the protocol by using the five domains (Tedeschi, 2018) in the last role sort (Sort Four). Rather than using Landy's original role sort categories, this sort used the five domains of PTG as its categories. The client was instructed to sort the same roles used

previously into the five domains while thinking about that role and what the role needs in order to show growth. During all role sorts throughout the 3 sessions the client was instructed to eliminate a role if it did not fit in to any categories or mark it if a role fit into multiple categories.

As part of this protocol, I took notes during the session on the role sorts, what was happening, and how the client appeared to be feeling based on observations. After each session was completed, I took photographs of each category to document the sort and took additional photos of the sort as a whole. After all the sorts were completed, I created an artistic reflection in response to what I witnessed during the role sorts. This artistic reflection was done using blackout poetry with pages from medical textbooks as a creative reflection. I then deleted all photo documentation.

Session One

The goal of the first session was to start exploring the idea of roles and learning about the role sort assessment categories. During the first session time was taken to explain how a role sort works and how to complete the role sort. Once the role sort was finished, there was a conversation around these roles and which roles were easy to notice and place, which roles were hard, roles we were drawn to, and which roles the client had transference around. After all roles were sorted, the client picked a role from each category to explore further. The client then created an artistic reflection on this role, what it means, and how that role might change if it was placed in a different category.

Session Two

The main goal of session two was to use the roles with the understanding of the theme of medical trauma. In this session the goal was to have two different role sorts completed and explored. The first role sort was around a selected age range, where the client embodied this age and explored the roles from that age. The previously created grief timeline was used to help pinpoint an age range in which a traumatic event was experienced. The client was asked to notice the shifts in where each role was sorted, which roles were easier and harder to place, and which roles the client had transference to in this embodied age. The second sort included selecting a different age range from the grief timeline, one that has an underlying focus of medical trauma. This did not lead to conversation about the trauma, just knowledge of the time frame where this trauma took place. After all roles were sorted the same questions used in session one were asked of the client to further explore her role sorts. As in session one, the client was asked to use an artistic reflection to explore the role and what it meant in this age range that was embodied.

Session Three

The main goal of session three was to introduce the idea of PTG to the client, explore what it meant, and how it related to the roles the client plays in life. The session started by explaining to the client the idea of PTG and what it means. Another role sort was done, but instead of the four role sort categories that had been used in Sessions one and two, the five domains of PTG were used to sort the roles. The client was asked to sort the roles into the domain that role would need to experience growth. After the role sort was finished, we continued exploring the five domains and how they have given that role the growth it wanted, and how it can continue to receive the growth it desired. Finally, we explored and discussed what growth

means, how we can find these moments of growth from trauma, and how the trauma itself allows us to grow.

Results

In working with the role sorts done in session with the client, patterns began to emerge. When looking at the roles used in the protocol and the sorts, I broke the roles into separate categories to start to label, and notice shifts and changes in the roles. Each category was given a color to be able to see the shifts in roles more clearly. The categories that were used in this data analysis consisted of *Negative Roles* (e.g., Egotist, Pessimist, Rebel) which are color coded as red, *Helper/Healing Roles* (e.g., Doctor, Nurse, Wise Person) which are color coded as blue, *Personality Description Roles* (e.g., Artist, Dreamer, Optimist) which are color coded as green, and *Known Roles* (e.g., Daughter, Sibling, Student) which are color coded as pink. Not every role fit into these four categories, and as they were not the focus of the results that emerged, I did not include them on the tables. Using this system, I was able to locate and see where different roles shifted depending on the sort and what that sort was focusing on.

First Sort

Table 1 shows the initial sort done with the client during the protocol. This sort was done to gain information. The client thought of these roles as represented to them in the current situation of their life (e.g., age, time, place, experiences). The client placed all roles into categories; no roles were eliminated, while some roles were marked as belonging in multiple categories.

Table 1

Role sort 1

Who I Am	*Who I Want To Be*	*Who Can Help Me*	*Who Is Blocking Me*

Note: Negative Roles = Red, *Helper/Healer Roles* = Blue, *Personality Description Roles* =

green, and *Known Roles* = Pink.

When looking at the negative roles, they only appeared in two columns: *Who I Am* and *Who is Blocking Me*. The *Personality Description Roles* also fell into two columns: *Who I Am* and *Who I Want to Be*. The last two role categories were only in one column each. The *Known Roles* fell into the *Who I Am* Column, and the *Helper/Healing Roles* only fell into the *Who Can Help Me* column. These patterns were observed throughout the rest of the role sorts to see what changed, what stayed the same, noting all changes.

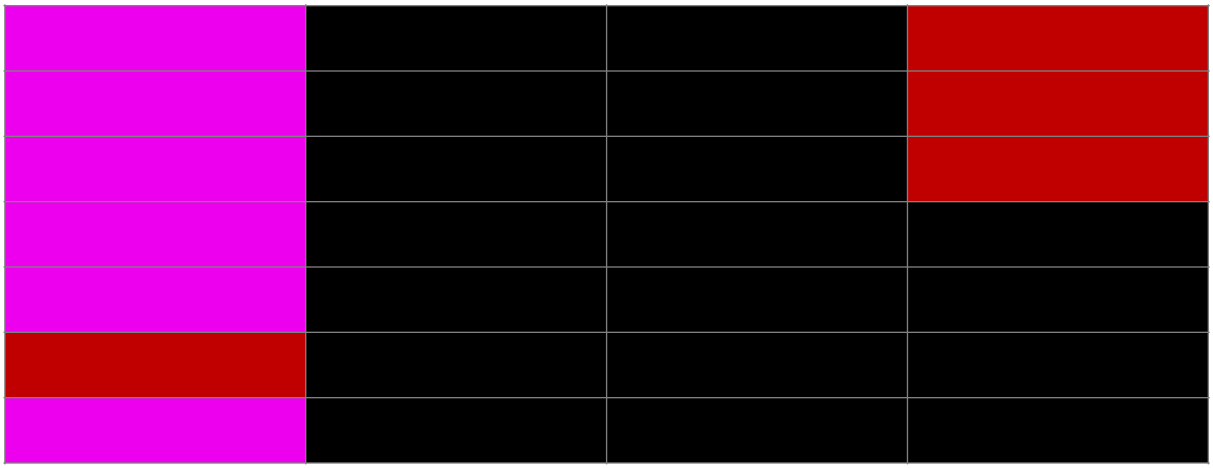
Second Sort

Table two represents the second sort in the protocol. This sort was done from the embodiment of an 8–9-year-old. The client looked at the grief timeline that was created before sessions and chose this time frame to be able to explore the trauma she experienced when she was younger. As in the first sort, the client placed all roles into categories; no roles were eliminated, while some roles were marked as belonging in multiple categories.

Table 2

Role Sort 2

Who I Am	Who I Want To Be	Who Can Help Me	Who Is Blocking Me



Note: Negative Roles = Red, *Helper/Healer Roles* = Blue, *Personality Description Roles* = green, and *Known Roles* = Pink.

While Table 2 looks similar to Table 1, there was a slight difference in the patterns that are noted in these tables. First, there were more negative roles in the *Who Is Blocking Me* column in sort number two (Table 2), leaving only one negative role in the *Who I Am* column. Another difference between these two sorts was that there is one less *Personality Describing Role* in the *Who I Want To Be* column, and there was one more in the *Who I Am* column. I noticed that even though sort two was using an embodiment of a different age, some things stayed the same between sort one and two. The *Known Roles* stayed the same between these two sorts, and all the *Known Roles* stayed in the *Who I Am* column. Also, all the *Helper/Healer Roles* stayed in the *Who Can Help Me* column between sort one and two.

Third Sort

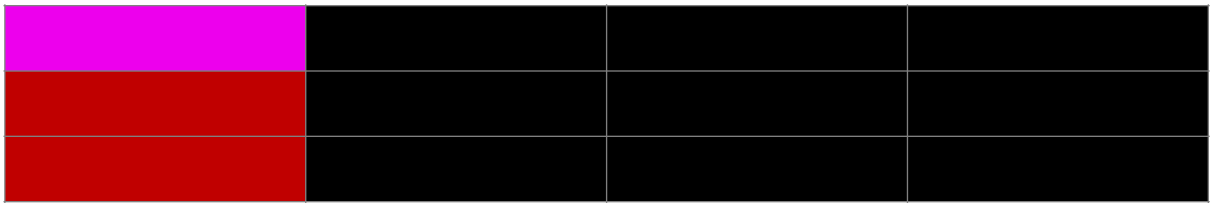
The third sort that was completed in this protocol (Table 3) was from embodying the age range of 15- 18 years old. This time frame was chosen by the client based on the grief timeline

and focused more on recent years and recent trauma. Within these more recent years the trauma that occurred was the most impactful and life changing for this client which was why it was chosen to explore. As in the previous two sorts, the client placed all roles into categories; no roles were eliminated, while some roles were marked as belonging in multiple categories.

Table 3

Role Sort 3

Who I Am	Who I Want To Be	Who Can Help Me	Who Is Blocking Me



Note: Negative Roles = Red, *Helper/Healer Roles* = Blue, *Personality Description Roles* = green, and *Known Roles* = Pink.

During this sort, bigger shifts were noticed in the roles from where they were in previous sorts. One of the biggest changes noted in this sort versus the past two was in the *Personality Role* category. In role sort 3, these *Personality Roles* were in 3 different columns (instead of one): *Who I Am*, *Who I Want to Be*, and *Who Can Help Me*. The only place they were not noted in was the *Who is Blocking Me* column. Three of the negative roles ended up in the *Who I Am* column like in the first sort; this was different from the second sort which only had 2 negative roles in this column. The constant between all three sorts was the role categories of *Helper/ Healer* and *Known Roles*. The *Helper/Healer Roles* stayed consistent in the *Who Can Help Me* column, while the *Known Roles* stayed consistent in the *Who I Am* column throughout all three sorts.

Fourth Sort

The final sort was introduced with the columns as each different domain of PTG; Greater Appreciation of Life and Changed Sense of Priorities, Warmer More Intimate Relationships with Others, A Greater Sense of Personal Strength, Spiritual Development, and New Possibilities (Tedeschi, 2018). The client did this sort from the positionality of where they were that day. The goal of this final sort was to place the roles that have been used for the past 3 sorts into what that

role needed to experience a change or growth. Table 4 shows how the roles were sorted and the spread of role categories across all the domains. The client continued to place all roles into the given categories and no roles were eliminated.

Table 4

Role Sort 4

Greater Appreciation...	Warmer, More Intimate...	Personal Strength...	Spiritual Development	New Possibilities

Note: Negative Roles = Red, *Helper/Healer Roles* = Blue, *Personality Description Roles* = green, and *Known Roles* = Pink.

This was the first time across all the sorts where the role categories were seen across almost all 5 domains. The table shows that every role category was seen across 4 out of 5 domains, except for the one category of *Helper/Healer*, which was spread into 3 out of 5 domains. Additionally, *Negative Roles* were in 4 out of 5 of the domains. Most of these roles were sorted in the Personal Strength domain, followed by Greater Apperception for Life, Warmer and More Intimate Relationships with Others, and finally Spiritual Development. The only domain the *Negative Roles* did not fall under was the domain of new possibilities. Another role category that appeared in 4 out of 5 domains was the *Personality Roles*; these roles were noted in all domains except for greater appreciation for life. The *Known Roles* appear in 4 out of 5 of the domains; all domains except for spiritual development. The *Helper/Healer Roles* occurred in 3 out of 5 domains with most of them in Spiritual Development, then Warmer More Intimate Relationships, and Greater Appreciation for Life.

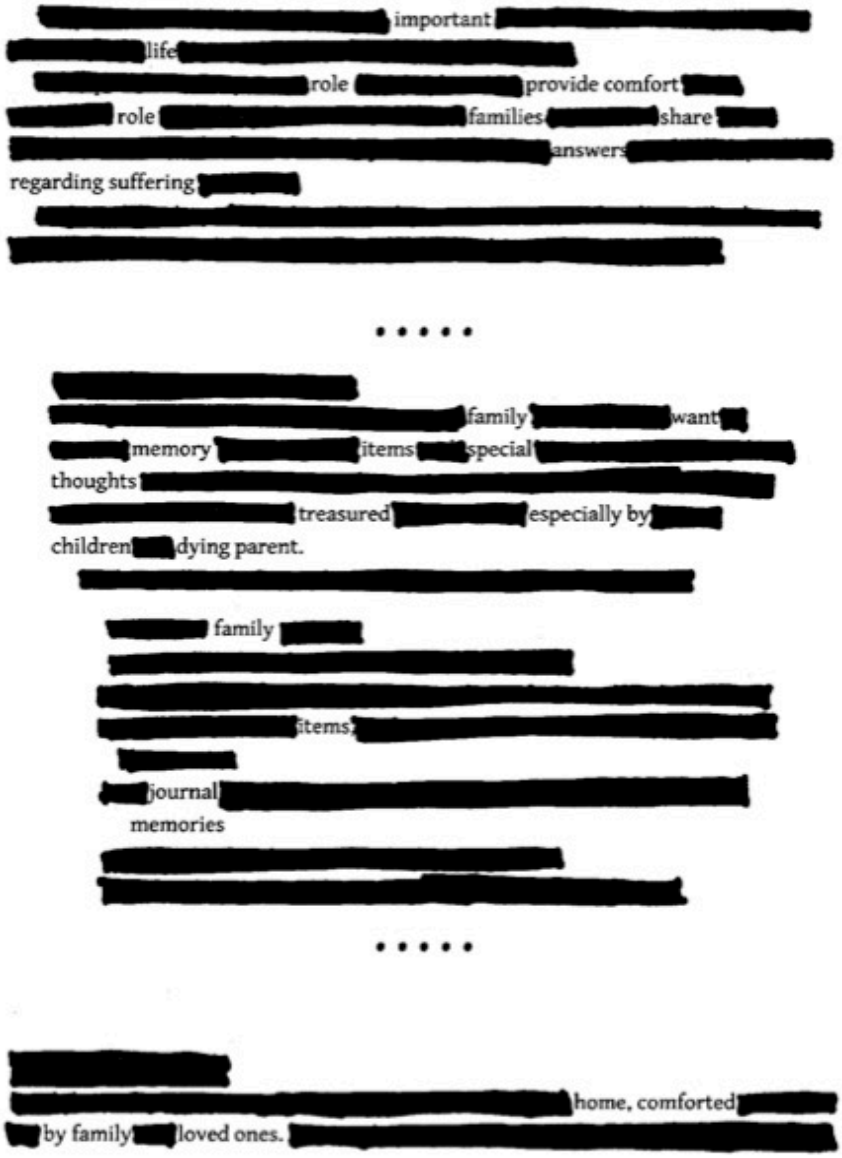
Artistic Reflection

As previously mentioned, the final part of the protocol included my own artistic reflection after witnessing the client's final role sort after session three (Fig. 1). I decided to use blackout poetry as a way to reflect on what I witnessed. Because of the nature of this protocol,

the piece of literature I used was from a medical textbook to highlight the focus on medical trauma.

Figure 1

Post-Protocol Artistic Reflection


important
life
role
provide comfort
role
families
share
answers
regarding suffering
family
want
memory
items
special
thoughts
treasured
especially by
children
dying parent.
family
items
journal
memories
home, comforted
by family
loved ones.

Discussion

The first three sorts took place over two different sessions with the client, with the final sort in the third session focusing on the element of Post Traumatic Growth (PTG). One of my hypotheses speculated that certain roles within the medical field (e.g., Caretaker, Doctor, Nurse) are viewed positively by society but may also be viewed negatively by those who have experienced medical trauma. However the medical roles were consistently placed in the *Healer/ Helper* . In Table 1 almost all of the N*egative Roles* were placed in the *Who Is Blocking Me* column. What became apparent is that during medical events clients may experience *Negative Roles* in the *Who I Am* position, while experiencing roles in the *Healer/Helper* category in the *Who Can Help Me* column. It would appear that societally perceived *Helper/Healer Role* were not self-identified but rather placed as other (outside of the person), however *Negative Roles* were prominently featured as roles of the present self. Perhaps, soon after a medical trauma has occurred, some psycho-education or processing about self as healer, or what resilience through healing can create, would be helpful in scaffolding more positive outlooks. This would align with McBain's (2022) thoughts on recognizing the trauma sooner to be able to provide resources, so the trauma can begin to be contained and contextualized.

Initially, I thought that the thematic roles in the *Helper/Healer* category may switch throughout the process between blocking positions and helping positions. This concept was formed based on my knowledge of the client's medical history and the rapport I had built with her. I believed that she might have some confusion whether helpers were helping or blocking her given the severity of her experience. However, as the results showed she only placed *Helpers/ Healers* in the *Who Can Help Me* positions. This demonstrates to me that perhaps, even though suffering, my client was able to step back and reflect on the overall purpose of the treatment.

This brought me to the idea that the societal view of these roles has not changed from when the client was 8 or 9 years old to now.

As previously noted, Grinberg (2018) indicated that medical clowns can be helpful to patients as they help the patients to identify roles inside of them that they have not had the opportunity to play yet. I observed that in playing with these roles with my client she was able to expand the roles she is able to identify and play herself, outside of session.

This methodology and protocol provided an eye-opening experience for both myself and the client. New insights included a recognition of the client's strengths, and role profile, and how she sorted her roles into specific categories. For example, the Optimist who was included in the *Helper/Healer* category came into play often, supporting the notion that even when the situation is difficult, *Helpers/Healers* were necessary. Also, the role of Fearful Person was viewed as a strength-based role by the client because she thought it was healthy to have some fear in traumatic situations. She transformed the role of the Fearful Person to the Warrior to create a more strength-based framework to allow space to accept pain for a promise of a better future.

Another salient finding is that when the client was younger, she expressed fewer *Negative Roles* in the *Who I Am* category and more positive roles in the *Who I Want to Be* category. However, now these roles have expanded into her *Who I Am* category. To me, this shows that she has actualized her understanding of her own resilience and becoming. She has stepped into the roles of positivity and optimism despite constant medical hardships. This observation of how she positively framed many of these roles also emerged in my artistic reflection that was created in response to the client's sorts. (Fig. 1).

Further Considerations

Something that I would change to the protocol in the future would be adding a session at the beginning to focus on the grief/trauma timeline. This is something that was done with this client a few sessions before the protocol started, and it ended up being extremely helpful to have a visual representation for the client to look at and use when thinking of what ages the client was when effected by the trauma. This would make it a four-session protocol and give more time and space to have conversation around the protocol in general. Furthermore, I wonder if the concept of Post-Traumatic Growth could be confusing to a different client. The connection between appreciation, growth, and trauma can be a lot to understand. Post-psychoeducation my client was able to complete the fourth sort, however there may be a simpler way to describe the five domains of grief in the context of this protocol for user-friendliness.

Clearly, the limited sample size of this study and my position as a student completing a thesis limits the results of this study to the context of the time, place, and framework in which the study took place. Still, the results indicate that further research into the intersectionality of medical trauma, role theory, and post traumatic growth could be beneficial, especially as the literature review indicated that further research is needed to understand these intersecting topics. I feel that my sentiments might be best reflected in my arts-based response included in Figure one and written out below.

Important life role provide comfort.
Role families share answers regarding suffering.
Family want memory items special thoughts treasured

especially by children dying parent.

Family items journal memories.

Home, comforted by family loved ones.

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In the judgment of the following signatory this thesis meets the academic standards that have been established for the above degree.

Angelle Cook

Thesis Advisor:_____
_____ _____
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