Beyond Words:

Learning to Use Role-Play to Treat Posttraumatic Stress Disorder

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Scholarly research conducted by former National Institute of Mental Health Director Frank Ochberg (2006), the American Psychological Association (2003), and Rosenberg et al. (2001) show that cognitive-behavioral therapy (CBT), especially exposure therapy, is effective in treating posttraumatic stress disorder (PTSD) on a psychobiological level. Yet according to studies by Becker, Zayfert, and Anderson (2003) and Cahill, Foa, Hembree, Marshall, and Nacash (2006), many psychologists and master's-level clinicians do not include an exposure therapy component in their treatment of PTSD.

KEYWORDS: Posttraumatic stress disorder; role-play; archetypes; mental health; health education; psychobiology; biopsychology; exposure therapy.

With the hope of bridging the divide between research findings and common practice, I developed and delivered a continuing education workshop to assist participants in learning ways to safely use role-play as a form of exposure therapy. The workshop is specifically aimed at increasing confidence in using role-play as a form of exposure therapy. Quantitative data from this research reveals that participant levels of confidence rose in response to learning safety precautions that may be implemented when using role-play as a form of exposure therapy. Qualitative data revealed that participants appeared to gain confidence in the use of role-play during the experiential components of the workshop. Data also suggest that refinements for future workshop delivery require a reduction in the amount of time spent on teaching the psychobiology of treating posttraumatic stress disorder (PTSD) using action-oriented interventions. Learner feedback and targeted observations also indicate a need to promote group cohesion, thereby imbuing a sense of emotional safety that could result in a greater number of individuals willing to actively participate beyond observation and reflection.

The data gathered during the research led to workshop refinements that are expected to improve workshop delivery and so lead to improved learning outcomes.

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Central to this research was the implementation of three best practices.

1. A curriculum was developed that teaches mental health professionals (MHPs) the psychobiological underpinnings supporting the use of role-play as a form of exposure therapy, as well as clinical methods and ethical considerations for the practical integration of role-play into current practice.
2. Assessment tools, including pre- and post-workshop surveys and targeted observation forms (TOFs) were developed for collecting quantitative and qualitative data.
3. Standard operating procedures were established to allow for the reliable and consistent implementation, evaluation, and refinement of the curriculum.

BEYOND WORDS: LEARNING TO USE ROLE-PLAY TO TREAT PTSD

Along with the evidence of rising rates of posttraumatic stress disorder (PTSD) diagnosed in America and "despite all the evidence for the efficacy of exposure therapy and other cognitive behavioral therapy programs, few therapists are trained in these treatments and few patients receive them" (Cahill, Foa, Hembree, Marshall, & Nacash, 2006, p. 597). With the intent of bridging the divide between evidence-based theory and common practice, a continuing education workshop was developed and delivered to mental health professionals (MHPs). The 1-day training was delivered four times over the course of 12 weeks. Workshop participants were volunteers who self-identified as being interested in learning about using role-play as a form of exposure therapy when treating PTSD.

Workshop Design and Educational Theory

I developed and delivered a 7-hr workshop made up of 10 modules that included lecture and experiential learning components. The goal was to assist participants in learning ways to safely use role-play as a form of exposure therapy. The workshop is specifically aimed at increasing confidence in using role-play as exposure therapy. Quantitative data from this research reveals that participants' confidence levels rose in response to learning safety precautions that may be implemented when using role-play as a form of exposure therapy. Qualitative data revealed that participants appeared to gain confidence in the use of role-play during the experiential components of the workshop. Data also suggest that refinements for future workshop delivery require a reduction in the amount of time spent on teaching the psychobiology of treating PTSD using action-oriented interventions. Learner feedback and targeted observations also indicate a need to promote group cohesion to imbue a sense of emotional safety that could result in a greater number of individuals willing to actively participate beyond observation and reflection.

Development and delivery of this training was built upon the theories of constructivism and experiential learning. As the instructor and researcher, my goal is to deliver the workshop material in a learner-centered fashion, so the knowledge and skills imparted have personal meaning and relevant application for each participant. According to constructivist theory, "The role of the teacher

is raised from someone who simply dispenses information to someone who structures activities that improve communication, that challenge students' preconceived notions and that help students revise their world-views" (University of Massachusetts Physics Education Research Group, 1999). Constructivists provide learners with opportunities for scaffolding knowledge. *Scaffolding knowledge* means building upon "what students already know and believe, based on the sense they have made of their previous concrete experiences" (Kolb & Kolb, 2005, p. 207). In the case of facilitating this continuing education training, the participants have a wealth of information to share.

Experiential learning involves a "direct encounter with the phenomena being studied rather than merely thinking about the encounter" (Smith, 2001, para. 1). This training provided experiential activities, including opportunities for large and small group discussions, writing, and kinesthetic learning through the use of role-play. Offering opportunities to scaffold knowledge experientially assists participants in transforming information into practical knowledge. It also familiarizes participants with the methods they may employ when presenting treatment ideas and practices to their clients. For example, consider Rogers' client/student-centered principles. Counselors must experience the empowerment inherent in facilitated learning and feel the benefits of being validated for their unique intelligences if they are to employ these principles in clinical practice. The same is true for experiential learning. Counselors who wish to learn to use role-play safely were invited to experience the safe use of role-play.

The Psychology of PTSD

For many clients with PTSD, memory problems and cognitive distortions are part of the clinical presentation. Various aspects of memory are processed by different brain structures. Factual memory is primarily stored in and processed by the hippocampus. The amygdale is in charge of storing and processing the emotional content of memories. Trauma causes "hippocampus and amygdale malfunctions that may result in the distortion and fragmentation of memories and at times even amnesia" (Bremner, 2002, p. 1). Nijenhuis, van der Hart, and Steele (2004) report that patients with PTSD often present with cognitive distortions resulting from an inability to integrate the facts and implications of a traumatic event.

In 1889, Pierre Janet described *dissociation* as "the most direct psychological defense against overwhelming traumatic experiences" (van der Hart & Horst, 1989, p. 397). This precept, according to van der Hart (2005), is widely accepted to this day. van der Kolk, van der Hart, and Burbridge (1995) propose that dissociating at the moment of the trauma (peridisociation) is the ultimate predictor for the development of PTSD. Ludwig (1984) proposed "dissociation is a process whereby certain mental functions such as emotional and factual memory operate in a compartmentalized or automatic way, usually outside the sphere of conscious awareness or memory recall" (Bremner & Marmar, 1998, p. 115). Rubenfeld (2000) reports it is evident that emotions and memories are stored both in our minds and bodies. Although operating

unconsciously, repressed mind-body memories drive attitudes, actions, and reactions.

Psychological treatment of PTSD requires reintegrating dissociated experiences into conscious awareness. For more than a century, researchers and clinicians have sought a theoretical framework from which to understand and develop effective treatment for accessing and addressing dissociated psychic. According to Hudgins (2002), neurobiological research into PTSD has shown that dissociated content "rooted in the unconscious mind and stored in the right-brain cannot be easily accessed through traditional talk therapy" (Hudgins, 2002, para. 5).

Role-play directly engages the mind and body, facilitating emotional and cognitive processing of dissociated memories by effectively facilitating the recall of mind-body memories, emotions, and thoughts. Role-play "gives us the opportunity to suspend (trauma) in time, allowing one to study a memory in its concrete form" (Dayton, 1994, p. 3). As such, memory becomes as much an act of creation as a repository for trauma.

The Biology of PTSD

Understanding the biological underpinnings of PTSD helps explain the nature of symptoms and is important to providing effective treatment. According to van der Kolk (1994), the body responds to danger or fear by releasing powerful neurohormones, such as cortisol, norepinephrine, oxytocin, and endogenous opioids. Norepinephrine is an activating agent responsible for initiating body's emergency response system, often referred to as the fight, flight, or freeze response. "Cortisol allows a person to think clearly in the midst of a triggered fight, flight, or freeze response" (Sturgeon, 1999, p. 2). Endogenous opioids defend against emotional or physical pain.

The fight, flight, freeze response is an effective survival mechanism that marshals all the body's resources to prevent pain, injury, or death. PTSD is the result of misinterpretation of life events where stress-responsive neurohormones are released astronomically, triggered only by memories and not in the event of actual danger. In his article "The Body Keeps the Score," van der Kolk (1994) explains how specific symptoms experienced by clients with PTSD can be correlated with the release of certain neurohormones. Symptoms such as a pounding heart, excessive sweating, and anxiety are directly correlated with the release of norepinephrine. Physical and psychic numbing, fragmented memories, and dissociation are correlated to the conditioned release of endogenous opioids. Conversely, Sturgeon (1999) cites studies that show the hypothalamic-pituitary-adrenal axis may be conditioned to release lower levels of cortisol in those who experience a traumatic event. This likely explains increased feelings of confusion and anxiety in clients with PTSD.

The reexperiencing of physical sensations resulting from the release of stress hormones conditions and further engrains the unnecessary triggering of the fight, flight, freeze response. The unwarranted rerelease of stress-induced

neurohormones causes clients to constantly reexperience the somatic feelings associated with the original trauma. This causes avoidance behaviors.

Consider the victim of a car accident who drives by the scene of the accident—even weeks after it occurs—and feels anxiety, a pounding in the chest and sudden, excessive perspiration. Simply passing by the scene of the accident elicits the release of endogenous, stress-responsive neurohormones. This re-experiencing of symptoms reinforces the fear associated with the memory and may cause the client to avoid the accident site in the future or perhaps avoid riding in a car altogether. For clients with PTSD, terrifying events result in psychological and biological hypervigilance, activating the body's emergency response system at the slightest sign of danger. This hypervigilance becomes generalized to such a degree that symptoms can be triggered by everyday events only vaguely similar to the original trauma.

USING ROLE-PLAY AS A FORM OF EXPOSURE THERAPY

According to Ochberg (2006), exposure therapy engages the client in a way that reconditions the patient's emergency response system on a psychobiological level. Role-playing scenarios addresses trauma at a biological level. By role-playing a difficult or fear-provoking scenario, one intentionally elicits memories of a prior trauma with the expectation of eliciting the stress-responsive neurohormones. The goal, then, according to Fosha (2003), is "assisting clients in focusing on the regulation of the affective states and the experience of intense emotion" (p. 9).

Exposure therapy requires one to directly confront situations that trigger extreme anxiety. Commonly, exposure therapy is employed either in vivo or through re-imagining past events. In either case, the challenge is to recall a memory with "optimal emotional intensity" that is "strong enough to elicit the body's emergency response system but not so strong as to overwhelm the ability to manage the ensuing symptoms" (Ochberg, 2006, para. 62).

Human beings call upon historical, factual, and emotionally learned data to draw conclusions about present-day events. This function is critical to survival. For instance, when an individual experiences emotional or physical pain associated with an activity, the emotionally charged memory of the event or even the slightest sign of impending pain is likely to cause them to respond quickly or even dissuade them from repeating the activity. This emergency fight, flight, or freeze mechanism releases neurohormones just as they were issued during the original event. This results in the symptoms described by those with PTSD. If clinicians are to employ effective interventions, they must consider the research that shows memories are stored both in mind and body.

The mechanical retelling of events in counseling is insufficient for the effective treatment of PTSD. Counseling must offer an experience that engages the senses so one can recall memories at the somatic level, as well as the opportunity to process the scene on a cognitive level, guided by a clinician. Hudgins (2002) proposes role-play to address the very symptoms of PTSD, facilitate developmental repair, provide structures for safe reenactment of core trauma scenes, and promote control, containment, and stability in the therapeutic setting.

Role-play is an effective supplement or alternative to in vivo and imaginal approaches to treatment. It can be employed safely while eliciting a response that can recondition the client's stress-response, and it is a malleable technique that can be integrated with many different theoretical orientations. Informed by the wealth of knowledge about the psychobiology of PTSD, MHPs can use role-play effectively as a form of exposure therapy. van der Kolk et al. (1995) posit two conditions relevant to treatment of PTSD: First, MHPs and clients must engage in activities that directly activate fearful memories to modify the psychobiological conditioning. Second, the client must successfully cope with the trauma memory and experience mastery over symptoms. Role-play engages the many senses involved in the original traumatic event, which leads to emotional and cognitive processing. Role-play engages motor skills—as well as sight, smell, touch, and other senses—as all-important gateways to the original trauma memory. Furthermore, it allows for the repeated and powerful pairing of a fear-producing situation with a positive experience of improved management of somatic sensations, along with validation and support. It may even result in the creation of an alternate memory that brings open-ended tensions to a close. Role-play brings problems and fears to a conscious level in order to affect a psychic purge" (Dayton, 1994, p. 14). This catharsis occurs "on a physical level, cleansing the body, causing a cellular release of the held memory within the brain and body" (Dayton, 1994, p. 16). Thus, one may unlearn previous psychological and physiological conditioning.

Minimizing the Potential for Retraumatizing Clients

Role-play is a potent modality for healing psychic wounds from a terrifying, life-threatening trauma. To guide clients through trauma memories as well as current and future anxieties, MHPs must create a psychologically safe environment. To that end, "it is particularly useful to explore previous experiences of safety and competency and to activate memories of what it feels like to experience pleasure, enjoyment, focus, power, and effectiveness before activating trauma-related sensations and emotions" (van der Kolk, 2006, pt. 4). In her book *The Drama Within*, Dayton (1994) offers the following safety precautions in using role-play and prolonged exposure therapy:

- Counselors must not push clients beyond their ego strength and emotional capacity. Therapists must accept limits, shifts in script and role, and be acutely attuned to body language that indicates when the protagonist needs a check-in, grounding, or a break.
- A client must be fully informed of the powerful impact role-play can have and be given the choice whether the counselor is to set a scene or if the protagonist wishes to establish the parameters of the role-play.
- The counselor must remain present and in close psychic and emotional proximity so the client can feel your presence and support.

- In cases of extreme trauma, the protagonist may wish to witness or co-direct auxiliaries in the reenactment of the event. This allows him or her to bear witness and verbalize feelings while telling the full story. It also allows the protagonist to connect with her extreme helplessness and develop compassion for herself as a victim. (pp. 82–83)

Although dropout rates for clients undergoing exposure therapy are not significantly higher than dropout rates of other cognitive-behavioral therapies, clinicians still must be sensitive to the reality that role-play (when used as a form of exposure therapy) does induce symptomatology as part of the therapeutic process. In this light, it is "prudent to avoid viewing increases in PTSD symptoms related to the introduction of exposure therapy as an adverse occurrence that should be avoided and instead these reactions should be seen as part of the path towards recovery" (Wells, 2004, p. 5). Nevertheless, Hudgins (2002) emphasizes informed consent, effective assessment and evaluation, accepting client limits, as well as a strong therapeutic alliance between client and counselor as key protocols for safely employing role-play when treating PTSD.

Using Archetypes Rather than Personal Narratives in Role-Play

Carl Jung proposed archetypes are primordial images "inherited from one's ancestral past including all human ancestors as well as is pre-human and animal ancestors" (Hall & Nordby, 1973/1999, p. 39). Not fully developed at birth, "they are more like a negative that has to be developed by experience" (Hall & Nordby, 1973/1999, pp. 39–43). The "Personal Unconscious contains all the psychic material that is incongruous with one's consciousness" (Hall & Nordby, 1999, p. 34). Thus, traumatic experiences such as rape or natural calamity are repressed and delegated to the Personal Unconscious. Memories relegated to the Personal Unconscious must be retrieved and proactively reintegrated into consciousness, as part of treatment.

PTSD is a psychobiological response to a traumatizing event. "If past experience is embodied in current physiological states and action tendencies and trauma is reenacted in breath, gestures, sensory perceptions, movement, emotion and thought, therapy may be most effective if it facilitates self-awareness and self-regulation through these same processes" (van der Kolk, 2006, p. 289). Recalling the details of trauma memories is common practice among cognitive-behavioral therapists using exposure therapy, yet recalling trauma memories is a burdensome challenge for many clients, as they elicit uncomfortable, sometimes disabling, symptoms. Using archetypes rather than personal narratives in role-play offers clients the opportunity to practice accessing their personal unconscious, as well as develop skills for symptom management. Using archetypes in role-play still has the potential to illicit the necessary, psychobiological responses required for the effective treatment of PTSD without requiring the client to draw from autobiographical narratives from their conscious past.

IN-CLASS ACTIVITY I: ROLE-PLAY USING ARCHETYPES

In the workshop that I developed and delivered, participants were taught a method of role-playing using archetypes. Archetype cards designed by Caroline Myss (2010) were used as an instructional tool. These cards illustrate light-and-shadow attributes of over 80 different archetypes. Each participant, with an archetype card of their choosing, was paired with a partner. Each took turns engaging in spontaneous role-play. To best prevent the unconscious unveiling of any past trauma or internal conflicts while practicing the method, training participants were instructed to recall an innocuous event in their lives and role-play a correlated archetypal concept.

For example, one participant chose to address the feeling of being unappreciated at work. She had chosen the "vampire" and role-played how her vampire-employer was metaphorically sucking her dry. The partner played the employee role. She adopted the light attribute of vampirism. This role depicts one who gives of him or herself, entirely, to the employer.

The goal of this exercise was not to resolve the employee–employer conflict. Rather, the role-play raised the participant's awareness of gestures, expressions, postures, and incongruities between verbal and nonverbal communications. The exercise also provided an opportunity to practice the essential action-therapy skills of creativity and spontaneity. Drawing from Froggatt (2005), the participants practiced several other experiential exercises, including the following:

- The double-standard dispute: If the client is holding a "should" or is self-doubting about his or her behavior, use role-play to explore how the patient might respond to another person for doing the same thing.
- Catastrophe scale: Role-playing a worst scenario can demystify the unknown factors or release tensions that have been building in one's mind but that hold little power in the light of the day.
- Devil's advocate: This useful and effective technique (also known as reverse role-playing) is designed to get the client arguing against his/her own dysfunctional belief. The therapist role-plays adopting the client's belief and vigorously argues for it; while the client tries to "convince" the therapist that the belief is dysfunctional. Through role reversal, the protagonist discovers many viewpoints that expand his own insight and help him to choose more adaptive responses. Not only are the new ideas talked about, but by using psychodramatic methods, they are tried out in a simulated situation.

  Successful and spontaneous behaviors are reinforced, while ineffective adaptations become immediately apparent and are gradually extinguished. This calls for the counselor to elicit these sensations and teach the patient ways to cope with those very somatic sensations elicited by the recalling of a traumatic experience through role-play.
- Reframing: Another strategy for getting bad events into perspective is to reevaluate them as "disappointing," "concerning," or

"uncomfortable" rather than as "awful" or "unbearable." Through role-play, a variation of reframing is to help the client see that even negative events almost always have a positive side to them.

- Time projection: This technique is designed to show that one's life and the world in general, continue after a feared or unwanted event has come and gone. Ask the client to role-play the unwanted event occurring, then role-play going forward in time—a week, then a month, then six months, then a year, two years, and so on—considering how they will be feeling at each of these points in time. They will thus be able to see that life will go on, even though they may need to make some adjustments.
- The "blow-up" technique: This is a variation of "worst-case" imagery, coupled with the use of humor to provide a vivid and memorable experience for the client. It involves asking the client to role-play whatever it is he/she fears happening, then blow it up out of all proportion until he/she cannot help being amused by it. (p. 15)

IN-CLASS ACTIVITY II: DEVELOPING A GROUP-GENERATED TREATMENT PLAN

Employing role-play as a form of exposure therapy is flexible enough to be assimilated into most counseling practices and allows for individualized treatment planning. After affording participants time to practice using role-play techniques, they were then challenged as a group to develop a pragmatic (albeit generic) treatment plan. The plan incorporated the theoretical information presented in the first part of the day combined with objectives congruent with participants' insights gained through experimenting with the various role-play techniques practiced earlier in the day. This activity provided the opportunity for participants to apply theories and techniques learned in the training into a tool commonly used in clinical practice.

Research Design, Implementation, and Analysis

Participants of this continuing education training were taught the theoretical underpinnings and methods for the safe use of role-play within their current practice, when treating PTSD. Participants volunteered based on a brief description of the workshop goals and objectives posted through a local mental health agency. The full-day training was delivered four times, in different locations around the State of Maine. I evaluated each workshop to improve its design and delivery in subsequent workshops. The sample population included 36 state-licensed mental health practitioners ($n = 36$).

Methodology

I designed best practices and protocols that were followed for the delivery of this training and for the collection, assessment, and evaluation of data in a reliable and valid manner. A mixed design of qualitative and quantitative methodologies

was employed. Quantitative and qualitative research has limits and benefits. A mixed methodology allows me to counterbalance the shortcomings of each approach without compromising the benefits each offers.

The training was delivered in two parts: The first part dealt with the psychological and biological theories for using role-play as a form of exposure therapy. The second part of the day was devoted to practicing safe techniques for using role-play and creating a group-generated treatment plan. The results of the surveys and targeted observations were utilized to evaluate the effectiveness of instructional strategies for workshop refinement.

Data Collection

Four evaluation tools were used to collect qualitative and quantitative data: A pre-workshop survey and a post-workshop survey supplied quantitative data. From a quantitative perspective, the pre-workshop survey collected demographic data, as well as information establishing baseline participant knowledge of psychobiology in regards to PTSD and the implications of such on effective interventions. The survey also assessed participant level of confidence in employing role-play into their treatment modality. The post-workshop survey reassessed participant knowledge of psychobiology in regards to PTSD and the implications on effective interventions, as well as reassessed participant level of confidence in employing role-play into their treatment modality. Targeted observation forms were designed to provide qualitative data and formative feedback regarding class discussions and practicum efforts. Data were collected in real-time by two research assistants. I aggregated, correlated, and analyzed data to evaluate workshop outcomes. I also used these forms to document his impressions following the delivery of each workshop.

Drawing from "Experiential Learning Theory" (Kolb & Kolb, 2005, p. 194), the TOFs categorized observations into four categories: (a) concrete experiences, such as participant responses to lecture, class activities, and other workshop experiences; (b) abstract conceptualization, including participant capacity to reflect on lecture, activities, the workshop agenda, and research goals; (c) reflective observation, offering participants the opportunity to observe and reflect on activities; and (d) active experimentation in the form of participant contribution in actively experimenting with ideas exchanged in the training. These categories organize the data for content analysis.

Data Analysis

Pre- and post-survey results were entered into and organized using Microsoft Excel. Microsoft Excel was also utilized for data analysis of the dependent variable (participant knowledge) and the independent variable (training curriculum). Data were collected from the sample population before and after the educational intervention. On a 1 to 4 scale, the quantitative results from surveys indicate an average increase of 7% in understanding the psychology of PTSD, an average increase of 16% in understanding the biology of PTSD, and an

increase of 33% in understanding the safety precaution required when using role-play to treat PTSD.

A paired *t* test was used to determine to what degree the mean averages of the pre- and post-surveys differed from each other. The *t* test allowed for the mean of the difference between the pretest and related post-test responses to be calculated. Ascertaining the mean on a normal distribution with an estimated standard deviation, I calculated percentages of similarities and dissimilarities within the sample population with a confidence interval of moderate width. This allowed me to make inferences as to how the data from the sample population might be generalized to a broader population.

Using a correlation coefficient formula, I endeavored to determine the relationship between an increase in confidence in using role-play:

1. an increase in understanding of the psychology of PTSD,
2. an increase in the understanding of the biology of PTSD, or
3. an increase in the understanding of safety precautions for using role-play.

To determine the relationship between an increased confidence in using role-play to treat PTSD and an understanding of the psychology and biology of PTSD, a correlation coefficient was calculated. When using a correlation coefficient, an *r* value of "−1" indicates that the two data sets are almost certainly related. The correlation coefficient of the variables (understanding vs. confidence) for the study was $r = -.18894$. This indicates a very weak correlation coefficient (relationship between the two data sets).

The data collected from pre- and post-workshop surveys indicate that, on average, participants were 10% more confident in using role-play to treat PTSD after learning about safety precautions. To determine the relationship between increased understanding of safety precautions and increased confidence levels in using role-play, a correlation coefficient was calculated. In this analysis, the correlation coefficient of the variables (safety precautions vs. confidence) was $r = .43945$. This shows that learning about safety precautions was more significant in raising confidence levels than was understanding the psychological and biological theories underlying the importance of using role-play as a form of exposure therapy when treating PTSD.

Interpreting the Data

Qualitative data drawn from the TOFs documented that in the first two iterations of the workshop, "a few" workshop participants expressed concern at the onset of each workshop that exposure therapy threatened the "emotional safety" of clients diagnosed with PTSD. The specific concern most commonly cited was "retraumatizing the client." After viewing a 15-min teaching video that explained the foundation of psychodrama and provided a real-world example of a psychodrama group, my research assistants noted on the TOF that "the majority of participants" expressed concern for the safety of clients undergoing such a treatment modality. The research team analyzed this feedback and determined that the video introduced more than basic "role-play" and was

not conducive to an introductory workshop on role-play. The instructional video module was omitted for the two, latter workshops. Noted on the TOF, I independently affirmed that objections to role-play did not exceed the "few" that self-identified in the beginning of the day. Other data gleaned from the TOFs include the following:

- Participants appeared to gain confidence in the use of role-play during the experiential components of the workshop.
- The majority of participants requested copies of the group generated treatment plan, without being prompted to do so.
- Participants from each cohort were more or less able to engage the role-play practicum where they were paired together to practice using the archetype cards and other instructions as prompts. I had to be flexible and use professional judgment to identifying participants with a comfort level sufficient to role-play with me in a fish bowl–type setting.
- Those who were less comfortable with the active practice of role-play provided reflective feedback that deepened the process in the moment.

Interpreting the data is important to the goal of workshop refinement. Qualitative data describes participant expressions of concern for client safety and documents a participant's hesitation in participating in role-play activities designed to practice skills. Moreover, data reveal that the rise in confidence levels in the use of role-play after taking the workshop is less associated with a theoretical understanding of the psychobiology that supports the use of role-play when treating PTSD than with the learning of specific skills that promote emotional safety and precludes re-traumatizing clients.

It was clear from the qualitative and quantitative data that participants of each of the four continuing education workshops were almost entirely unfamiliar with using role-play as a form of exposure therapy. Future iterations of this workshop will include the following refinements:

- For this introductory workshop to use role-play, tailor the materials and experiential components to the needs of the learner, being sure not to overwhelm the learner but still engender confidence in future use of skills learned in the workshop.
- Expand upon experiential components to afford the opportunity to develop group cohesion and promote a sense of emotional safety that could result in creative, spontaneity, and a greater number of individuals willing to actively participate beyond observation and reflection.
- Reduce the amount of time spent on the psychobiology of treating PTSD using action-oriented interventions.
- Make the group-generated treatment plan easily and readily available to workshop participants.
- Provide opportunities for follow-up data collection to track the degree of actual, post-workshop, implementation of skills.
- Provide follow-up trainings to participants based on feedback from survey regarding future needs.

SUMMARY

This article provides a rationale for the use of role-play as a form of exposure therapy when treating the psychobiological aspects of PTSD. The literature presents exposure therapy as an effective—if not most highly effective form of therapy—for treating PTSD. However, exposure therapy is viewed with skepticism by many MHPs who perceive a correlation between exposure therapy and a potential for retraumatizing clients. Moreover, many also associate exposure therapy with rigid, manualized interventions that leave little room for the providers' own creativity and clinical acumen.

To bridge the divide between research findings and common practice, a continuing education workshop was created to teach mental health professionals the psychobiological underpinnings supporting the use of role-play as a form of exposure therapy, as well as clinical methods and ethical considerations for the practical, safe integration of role-play into current practices. The principles for workshop development were drawn from the constructivist theory of education. The training was learner-centered, including traditional pedagogical approaches and experiential learning opportunities. Furthermore, efforts were made to integrate role-play techniques in a way that promotes spontaneous, creative interventions that may be easily adapted to a variety of theoretical orientations.

Standard operating procedures were established to allow for the reliable and consistent implementation, evaluation, and refinement of the curriculum. To that end, assessment tools including pre- and post-workshop surveys, and TOFs were developed for collecting quantitative and qualitative data.

Results of the research indicate that increases in participants' confidence levels using role-play were correlated with learning specific ways to safely employ role-play as a form of exposure therapy. These results, as well as qualitative data regarding the need for greater focus on fostering group cohesion as a necessity for meaningful learner participation in experiential learning activities, are important in guiding the refinement of the workshop for future delivery. The article also provides a model for how a course involving the use of role-play can be grounded in educational and clinical theory as well as an approach for evaluating the effectiveness of training.

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