Perspectives and contexts of arts, social health and the military

Michael Balfour and Donald Stewart

Citation: Balfour, M., & Stewart, D. (2015). Perspectives and contexts of arts, social health and the military. *Arts & Health*, 1-9.

Corresponding author: Michael Balfour, Griffith University, Chair, Applied Theatre
Griffith University, Mt Gravatt campus, Brisbane, QLD 4122, Australia
Tel. (61 7) 373 55688. E.mail: m.balfour@griffith.edu.au

Professor Donald E. Stewart, Griffith University, PO Box 3370, South Brisbane, QLD 4101,
Tel. (61 7) 373 53218. Email: Donald.Stewart@griffith.edu.au

Bio

Michael Balfour is Professor and Chair of Applied Theatre at Griffith University, Australia. His research expertise is in the social applications of theatre: theatre in communities, institutions and areas of disadvantage and conflict. He has authored and edited numerous books including *Applied Theatre: Resettlement Drama Refugees and Resilience* (with Bundy, Burton, Dunn and Woodrow, 2015), *Refugee Performance* (2012), *Performance: In Place of War* (with Thompson, Hughes, 2009), and *Prison Theatre* (2004). Michael is currently completing work as a Chief Investigator on 3 Australian Research Council grants focussed on arts based work with returning servicemen, playful engagement and dementia and mapping performing arts practice in Australian prisons.

Donald Stewart is currently Professor of Health Promotion and formerly Vice President of the South West Pacific Region of the International Union for Health Promotion and Education. His main research interest is in settings for health promotion focusing on inter-sectoral approaches to promote both physical and mental health. He has a long term interest and publications in the area of resilience and how organisations and social activities can help build resilience. Currently, he is a chief investigator on an NHMRC Partnership Grant, an ARC Discovery grant, and two UBS – Optimus Foundation research grants.

Work towards this Special Edition was supported by the Australian Research Council Discovery Grant [DP110102780].

Perspectives and contexts of arts, social health and the military.

These shattered men believe that they failed friends and neglected moral meaning when the chips were down, and they blame themselves. They are welded to their guilt using the reminder of their lives to expiate their past sins. (Nadelson, 1999)

In the last few years, thousands of military personnel from USA, UK, Europe and Australia have returned from Afghanistan and the conflict in Iraq. Between 18-30% of those returning from war zones to civilian life can be expected to suffer mental health issues, which can lead to family breakdown, homelessness and other problems. In the USA for example, there have been 103,792 cases of posttraumatic stress (PTS) diagnosed in returned service personnel (in the period of 2000-2012). There has been a projected estimate that 1 in every 5 military personnel who have returned from Iraq and Afghanistan will develop some form of PTS (Burnam, Meridith, Tanielian and Jaycox, 2009). Military researchers are warning that a new generation of veterans with PTS and severe mental health disorders will emerge in the next five years (Dunt, 2009).

Mental health issues in the Defence Forces often exist within a culture of stigmatisation with many service personnel reluctant to admit to having a problem. Military personnel may not seek treatment for psychological illnesses because they fear it will harm their careers. Even among those who do seek help for PTS or major depression, only about half receive treatment that researchers consider minimally adequate for their illness (Tanielian and Jaycox, 2008). Brewin (2011) argues that military service can lead to profound changes in identity, affecting both military personnel's perception of themselves and their relationship to the world. These perceptions of the world include disillusionment about human nature in general and a more specific rejection of civilian life. Brewin (2011) shows that some veterans report estrangement, with the dominant theme being a sense of being 'out in the cold' after leaving the forces and returning to civilian life. Emotional fragility and a loss of confidence and self-worth are prevalent (Brewin, 2011, pp. 1737-38).

The impetus for this special edition was a 3 year interdisciplinary project funded by an Australian Research Council Discovery grant, entitled *The Difficult Return: arts-based approaches to mental health literacy and building resilience with recently returned military personnel and their families*.¹ As part of the research we developed practice in three areas: (1) awareness - online digital films; (2) motivation - the development of *The Return*, a research-based theatre piece featuring ex-servicemen and actors (Hassall and Balfour, 2015); and (3) action - The Veterans Transition Program, a psycho-educational program that used elements of role-play and enactment, in partnership with the University of British Columbia, Canada (Balfour, Westwood, & Buchanan, 2014).

Our experiences of implementing these programs in partnership with veteran support organisations, ex-service personnel and their families led us to consider international practice and the extensive history of how the arts and military have been used in different ways over time. In this paper we'd like to provide some context for current policy and practice in the area of arts and health with veterans, and also trace some of the antecedents of how arts-based approaches have been integrated into the history of a developing understanding of combat related stress (in all its definitions) and its treatments.

Policy and the recent growth in arts practice

One of the most critical policy initiatives in arts, health and the military sector in the last few years, was the establishment of the National Initiative for Arts and Health in the Military in the USA. This initiative has hosted three summits (the most recent in 2015), published a white paper and a national plan for action outlining challenges for policy, practice and research, and started a data base of arts and health projects working with veterans. The interest in the transition needs of military personnel has also been explored in the UK with the continuing work of Combat Stress and a new Research Hub as part of the Veterans and Families Institute, Anglia Ruskin University, Cambridge. So while the term sector should be

---

¹ The research team consisted of: Professor Michael Balfour, Professor Donald Stewart, Griffith University; Associate Professor Peter Nasveld, Centre for Australian Military Veterans Health, University of Queensland; Professor Patrick Fuery, Chapman University, USA; Elena Volkova, Research Assistant, Griffith University.

used tentatively, the social imperative to explore ways of supporting transition and resilience in the military is the focus of substantive international interdisciplinary work.

As many of the papers in this Special Edition reflect, much of the arts practice with veterans have developed from a complimentary and/or third sector space (e.g. outside of, or marginal to 'official' programs). Often these spaces are surprising both to the artist and the veteran community. For example it would be hard to mandate for the work of Royal Danish Ballet dancers with veterans, or the development of choral music with veterans in an addiction setting. In our own work in developing a documentary theatre performance with ex-servicemen and actors, it has been surprising how adept soldiers are at performing and how readily audiences from a military background respond to and engage in the arts.

The associated growth in arts and health practice has aligned strongly with the development of grass roots, veteran-led community organisations. These organisations have often developed out of veterans' sense of frustration, a desire for advocacy and better support/services. Veteran organisations typically range from small to medium size, on a not-for-profit basis and operate in a range of ways. In the USA there are organisations like Dry Hootch that operate a drop in centre, group counselling, and a 'dry' place to hang out with other veterans. Similarly in Australia organisations such as Young Diggers have an online information and advocacy site as well as a drop in centre that includes clinics about dealing with Veterans Affairs claims and benefits, activities, social nights and camps. A more formal initiative has been Mates for Mates that is funded as a one stop shop for veterans and their families offering a gym, outdoor pursuits, counselling, and other forms of support. The significance of these organisations is the experience that as soon as personnel move out of the military there is inadequate aftercare. While departments such as Veteran Affairs (in USA and Australia) exist to provide benefits, they are often viewed by veterans as overly bureaucratic organisations.

Contemporary arts and health practice therefore often grows out of these associations with veteran groups who are looking for a wide range of opportunities and options for their members, rather than necessarily formal sections of the military. However, forums such as the National Initiative for Arts and Health in the Military, and stand alone projects like the

Australian Defence Force partnership with Sydney Theatre Company, demonstrate that senior military personnel are open minded and engaged with the potential of new approaches.

An important perspective that is missing from the general debate and with great sadness in this special edition, is non-Western approaches to working with returning veterans. There has been significant work in this area, particularly with returning child soldiers in Africa (Betancourt, Simmons, S, Borisova, Brewer, Iweala and de la Soudière, 2008; Edmondson, 2005) and some work in Columbia (van Kesteren, 2011). We suspect there is considerable work in non-Western contexts and it would be an important next step to document and assess how different cultures have explored this territory. The absence of non-Western perspectives restricts the focus of the issues and debates in the journal to the impact of combat on coalition forces, a perspective that is one-sided and problematic at best. An alternative perspective on the role of the arts in coming to terms with conflict circumstances would also be offered by those who live in countries in conflict and who remain in combat zones, once international forces have departed. And it is important to not side step the fact that ex-service personnel may well be perpetrators and victims simultaneously. Depending on your politics the rationale and devastation wrought by conflicts may lead to questioning the function of arts in this area. Why devote time and resources to people who have fought and possibly killed other military personnel and/or civilians, rather than the victims, families, survivors and refugees left behind? The issue goes to the heart of any rationale for arts occurring in extremis or in unexpected contexts. The arts seem to be needed and have a role to play with individuals and groups struggling to return to civilian lives. The same question might be asked of arts work in prison, why work with a violent offender rather than their victim? The function of arts and health is not necessarily to make a moral judgement about the rights and wrongs of a behaviour, but to explore the value of creating arts-based strategies that seek to support, help, provide insight and critical hope for individuals dealing with a particular issue.

In a sense the link between the arts and the military has been intimately tied to the impact of combat on individuals. The political and social history of psychological and medical terms for combat-related mental health injuries is an important one to understand, as the arts, as previously mentioned, have been used both as an intervention and as a response by soldiers using the arts to deal with trauma.

By way of introduction to the issues that will be explored in this special edition, we thought it might be useful to provide a brief overview of this history.

The emergence of a condition and early arts interventions.

Previously called war neurosis, shell shock, battle fatigue, soldier's heart and nostalgia, and other names, posttraumatic stress disorder (PTSD) was formally acknowledged in 1980 (recently re-phrased as PTS); this recognition grew out of pressure from professionals and USA Vietnam veterans who were suffering from the disorder (Miller & Johnson, 1997). Since 1980, the term has become a unifying concept for a wide range of traumatic experiences, for example, child abuse, rape, natural disasters, torture, and war. The main symptoms of PTS include: re-experiencing symptoms, such as flashbacks, intrusive memories, and dissociative experiences; avoidance symptoms, including numbing, isolation, and avoidance of reminders of the traumatic event; and hyper-arousal symptoms, including sleep disturbance, anxiety, anger, impulsivity, and increased startle responses (van der Kolk, 1987). These symptoms were documented and identified for the first time (in any comprehensive way) during the First World War. Shell shock emerged as an acknowledged term, although initially was thought to be the result of a physical injury to the nerves and exposure to heavy bombardment. The war poet Siegfried Sassoon describes the psychological experience of shell shock in his poem *Survivors*. He writes of soldiers with "dreams that drip with murder" and their "stammering, disconnected talk" (Sassoon, 1983, p.35).

Shell shock was often perceived as a sign of emotional weakness, and soldiers were routinely convicted with desertion from duty and, in certain cases, shot by their own side for cowardice. French physicians were the first to conclude that shell shock was essentially a psychological phenomenon (Marlowe, 2000). British military physicians divided the classification into two categories: shell shocked wounded – those exposed to direct physical trauma – and shell shocked sick – those for whom there was no exposure to direct physical trauma (Babbington, 1997). World War I undoubtedly produced a major shift in recognising and evaluating 'combat stresses'. A report written in 1915 by a Company Quartermaster Sergeant, Gordon Fisher (cited in Macdonald, 1995, p.476), reflects the change in attitude:

I went further along and looked into the next dug-out and there was a guardsman in there. They talk about the psychology of fear. He was a perfect example. I can see that

Guardsman now! His face was yellow, he was shaking all over, and I said to him, "What the hell are you doing here?" He said, "I can't go. I can't do it. I daren't go!" Now, I was pretty ruthless in those days and I said to him, "Look, I'm going up the line and when I come back if you're still here I'll bloody well shoot you!" . . . when I came back, thank God, he'd gone. He was a Coldstream. A big chap six foot tall. He'd got genuine shell shock. We didn't realize that at the time. We used to think it was cowardice, but we learned later on that there was such a thing as shell shock. Poor chap, he couldn't help it. It could happen to anybody.

Despite the growing recognition of shell shock being a psychological condition, the treatment of it was diverse and often severe, including solitary confinement, electric shock treatment, shaming, physical re-education and emotional deprivation. Treatment of enlisted men tended to be harsher than that of the officers (Ellis, 1984). The context of these treatment ideas and therapies was a political need to develop quick and effective approaches in order to return as many men as possible to combat (Marlowe, 2000). However, many of these radical treatment methods were not used with officers in the British Army. Typically, officers were encouraged to rest and were withdrawn from the battlefield for longer periods. Nascent forms of psychoanalytical approaches were experimented with, and were accompanied by appeals to repress fears and encourage patriotism and loyalty.

Many county lunatic asylums, private mental institutions, and disused spas were taken over and designated as hospitals for mental diseases and war neurosis. By 1918 there were over 20 such hospitals in the U.K. One of the most progressive hospitals was Seale Hayne in Devon, under the directorship of Dr. Arthur Hurst. Hurst developed a range of therapeutic approaches with a focus on positive and purposeful activities. Patients were taken to the countryside for walks, and undertook voluntary work on local farms. Hurst promoted creative projects, listening to music, painting, and writing and producing a ward magazine. He also experimented with re-exposure to guns, by taking patients shooting, and initiated combat reconstructions to help the men relive their experiences under controlled conditions. One of these exercises was caught on an extraordinary piece of film archive, called *Re-enacting the Battle of Seale Hayne*, which was directed, photographed, and acted by convalescent war neurosis patients.ⁱ The rationale for Hurst's work foreshadows the development of occupational therapy, in focussing the patient on purposeful rehabilitation. It also pre-empts psychotherapeutic approaches to PTS treatment, which include hypnosis (Crasilneck & Hall, 1985), and implosive therapy and flooding techniques which try to desensitize the client to the trauma while in a relaxed state (Lyons & Keane, 1989).

The political imperative for treatment during war time was to get the military personnel fit again for further engagement, as can be demonstrated by the orientation of the military hospitals during the First World War. The wide spread acceptance (evidenced by the establishing of specialist hospitals) of shell shock as a medical condition during the war seemed to retreat during the immediate postwar period, driven perhaps by cost and pensionability issues. Many of the medical officers who testified during the British War Office Committee on Shell Shock in 1922 perceived the phenomenon as cowardice or of manipulation to obtain discharge from the danger zone (see Leed, 1981). In postwar US the condition was described as “pension neurosis”, and even attributed to certain ethnic groups (Benton, 1921, p.362).

There has been a historical reluctance to accept the validity of combat-trauma under any definition by Governments and the military. An acceptance of the condition, of the effects and impact of conflict, has considerable implications at a political, military, and societal level. The fight to acknowledge PTSD in the late 1970s was born out of a culture of official negation, bureaucratic backsliding, and concern about the economic and legal implications of defining such a condition.

Responding to Vietnam: The Development of Treatment Programs for US Veterans.

The nature of combat-related PTSD clients differs from that of patients suffering from non combat-related PTSD (James & Johnson, 1996). While PTSD sufferers in general are often victims of an event, military personnel may be perpetrators *and* victims. Many combat veterans develop PTSD as a result of traumas they have caused, such as killing people. Veterans are also likely to have experienced sustained exposure to traumatic experience over weeks and months. Further, the ontological impact of engaging in legitimized acts of violence, authorised and sanctioned by the nation, places an individual in a complex and confusing moral and immoral, legitimate and illegitimate weave. This can present profound challenges for medical interventions, because the symptoms are not just emotional or cognitive, but deeply moral and philosophical in that a patient may be suffering from the commission of unspeakable atrocities (Haley, 1974).

In the case of Vietnam veterans the conditions are complicated by the length of the time it took to get support and treatment. These veterans often suffer from what is referred to as the “secondary trauma of return” (James & Johnson 1996, p. 385). This form of PTSD is only indirectly related to the original trauma, and is connected to the hostile reception of troops returning from Vietnam after the war leading to maladaptive patterns which internalised blame.

The chronic nature of PTSD has also led to different phases of treatment over time. Johnson, Feldman, Southwick, and Charney (1994) identified the need for the development of first and second generation programs in which initial treatment focusses on core PTSD symptoms, while follow up work emphasises the reintegration of veterans into the social context of family and work. Johnson et al. (1994) state:

First Generation programs aim to provide a corrective emotional experience for Vietnam veterans, by being highly responsive to their needs, recognizing their entitlement to services previously not given, and by welcoming them back home with respect. These programs emphasize a review of the war, particularly the primary traumas, and management of the core PTSD symptoms of re-experiencing, avoidance, and hyper-arousal (Gusman, 1990; Scurfield, 1985; Silver, 1986). The optimal environment for First Generation work occurs when the treatment setting is experienced as a sanctuary in which their special needs are attended to, and they are given a great deal of support. The primary task of the therapist is listening to their story. Hope is generated by the idea that if you can “get it out,” your load will be lightened, and your recovery can begin.

Second generation programs lead on from these processes, but focus on the present and future rather than the past. Heterogeneous groups rather than homogeneous groups are formed in which veterans are encouraged to make connections outside of the Vietnam trauma circle:

Traumatized persons need to abandon their identity of being a victim. This requires active re-exposure and attention to other people’s lives, interests, and difficulties. . . It is crucial to avoid the formation of a group of victims united against a dangerous world, with an idealized leader who will protect the members against further harm. (van der Kolk, 1987, p. 165)

The concept of first and second generation interventions helps to map out a discourse of the ways in which the chronic needs of people with PTSD shift over time. Within a medical paradigm art-based therapies have quickly established themselves as contributing to an integrated approach to the needs of people with combat-related PTS (Golub, 1985; Johnson, 1987; Malchiodi, 1990; Simonds, 1994; Bensimon, Amir, & Wolf, 2008). As with the work

of Hurst and the early pioneers, the arts have been used not just as recreation but in exploring the ways in which “traumatic memories are coded nonverbally in kinaesthetic and visual forms” (James & Johnson, 1996, p.384).

Contemporary arts, health and military practice.

As evidenced by the articles in this special edition, and in recent publications like Scurfield and Platoni’s (2013) *Healing War Trauma*, there is a growing interest and diversity in the field of arts and health in military contexts. Arts and health practices are either integrated within mainstream treatment modalities or exist as alternatives to more traditional psychiatric and psychological (cognitive behaviour) approaches. The work covers culture-specific and community-based, expressive-experiential, mind-body approaches, animal-assisted (dog and horse therapy) and outdoor approaches (camps, treks), technological and web-based approaches (digital films, advocacy and information).

Many claims have been made about the impact of arts and culture in the context of military-related trauma, but there is also considerable scepticism about the evidence base of the arts. It is not clear precisely which components of a therapy are necessary and which components lead to treatment success. The creative therapies often utilise multi-modal designs where patients engage in both creative and cognitive components, making it difficult to establish what specifically caused the positive effects. As the number of treatment sessions ranges from three (expressive writing) to upward of a hundred (art and multi-modal therapies) and follow-up intervals vary, it is not clear how much of each treatment is necessary for symptom reduction or how long the effects of a given treatment may last (Smyth, 2011, p.3).

The evidence, in some cases at the practice level, from the projects described in this Special Edition illustrates the importance to participants of working through the arts to build and strengthen protective health factors. The circumstances of deployment typically provide the raw material for participants’ engagement in the various creative activities outlined in the articles, but they also offer an opportunity for veterans and their families to understand and negotiate the difficulties involved the process of transition back to civil society. In many cases, the projects are claimed to help participants to deal with feelings of isolation and to develop their self-sufficiency and resilience.

These projects often take place outside, or at the fringes of traditional therapeutic settings, but they offer support and a chance to reconstruct a meaningful life post-deployment. In many cases the projects described offer arts-based resilience training with opportunities for engagement, concentration, active participation, communication and beneficial social and personal outcomes. Additional research is needed to analyse the efficacy of different art forms and associated activities in health terms, but what is emerging is strong international interest in projects that demonstrate the benefits of arts-based health programs for service personnel, post-deployment.

References

- Babington, A. (1997). *Shell shock: A history of the changing attitudes to war neurosis*. London, Leo Cooper.
- Balfour, M., Westwood, M., Buchanan, M. (2014). Protecting into emotion: therapeutic enactments with military veterans transitioning back into civilian life, *Research in Drama Education*, 10, 161-185, doi: 10.1080/13569783.2014.911806.
- Bensimon, M., Amir, D., & Wolf, Y. (2008). Drumming through trauma: Music therapy with post-traumatic soldiers. *The Arts in Psychotherapy*, 35 (1), 34-48, doi: 10.1016/j.aip.2007.09.002
- Benton, G. H. (1921). 'War' neuroses and allied conditions in ex-service men. *Journal of the American Medical Association*, 77, 356-374, doi:10.1001/jama.1921.02630310030008.
- Betancourt, T. S., Simmons, S., Borisova, I., Brewer, S. E., Iweala, U., & de la Soudière, M. (2008). High hopes, grim reality: Reintegration and the education of former child soldiers in Sierra Leone. *Comparative Education Review*, 52(4), 565. doi: [10.1086/591298](https://doi.org/10.1086/591298)
- Burnam, M. A., L. S. Meredith, T. Tanielian, and Jaycox, L.H. (2009). Mental-health care for Iraq and Afghanistan war veterans. *Health Affairs* 28(3), 771-782, doi: 10.1377/hlthaff.28.3.771.
- Crasilneck, H., & Hall, J. (1985). *Clinical hypnosis*. Orlando, Grune & Stratton.
- Edmondson, L. (2005). Marketing trauma and the theatre of war in northern Uganda. *Theatre Journal*, 57(3), 451-474, doi: 10.1353/tj.2005.0098.
- Ellis, J. (1984). *Eye deep in Hell: Trench warfare in W.W.I*. Baltimore, Johns Hopkins University Press.
- Feldman, S., Johnson, D., & Ollayos, M. (1994). The use of writing in the treatment of PTSD. In J. Sommer & M. Williams (Eds.), *The Handbook of post-traumatic therapy*, Westport, CT, Greenwood.
- Golub, D. (1985). Symbolic expression in post-traumatic stress disorder: Vietnam combat veterans in art therapy. *The Arts in Psychotherapy*, 12, 285-296. doi:10.1016/0197-4556(85)90041-3
- Gusman, F. (1990). *Description of specialized PTSD program at VA Medical Center*. Menlo Park, CA.
- Haley, S. (1974). When patients report atrocities: Special treatment considerations with the Vietnam veteran. *Archive of General Psychiatry*, 30, 191-196, doi:10.1001/archpsyc.1974.01760080051008.

- James, M., & Johnson, D. (1996). Drama therapy in the treatment of affective expression in post-traumatic stress disordered patients. In D. Nathanson (Ed.), *Knowing feeling: Affect, script, and psychotherapy*, New York, Norton.
- Johnson, D. (1987). The role of the creative arts therapies in the diagnosis and treatment of psychological trauma. *The Arts in Psychotherapy*, 14, 7-14. doi:10.1016/0197-4556(87)90030-X.
- Leed, E. (1981). *No man's land: Combat and identity in World War I*. Cambridge, Cambridge University Press.
- Lyons, J., & Keane, T. (1989). Implosive therapy for the treatment of combat-related PTSD. *Journal of Traumatic Stress*, 2 (2), 137-152. Doi: 10.1007/BF00974155.
- Macdonald, L. (1995). *The death of innocence*. New York, Henry Holt.
- Malchiodi, C. (1990). *Breaking the silence: Art therapy with children from violent homes*. New York: Brunner/Mazel.
- Marlowe, D. (2000). *Psychological and psychosocial consequences of combat and deployment with special emphasis on the Gulf War*. Retrived October 16, 2014, from http://www.gulflink.osd.mil/library/randrep/marlowe_paper/index.html
- Millar, J., & Johnson, D. (1997). Drama therapy in the tratment of combat-related post traumatic stress disorder. *The Arts in Psychotherapy*, 23(5), 383-395.
- Nadelson, T. (1999). Journey of Healing: An Outpatient Therapy Group for War-Related PTSD. *Psychiatric Services*, 50(5), 627-628.
- Sassoon, S. (1983). *The war poems*. London, Faber and Faber.
- Scurfield, R. (1985). Post-trauma stress assessment and treatment: Overview and formulations. In C. Figley (Ed.), *Trauma and its wake*, Vol.1, New York, Brunner/Mazel.
- Scurfield, R.M. and Platoni, K.T. (Eds). (2013). *Healing War Trauma. A Handbook of Creative Approaches*. London, Routledge.
- Silver, S. (1986). An inpatient program for PTSD: Context as treatment. In C. Figley (Ed.) *Trauma and its wake*, Vol. 2, New York, Brunner/Mazel.
- Simonds, S. (1994). *Bridging the silence: Nonverbal modalities in the treatment of adult survivors of childhood sexual abuse*. New York, Norton.
- Smyth, J. (2011). *Arts & Healing Creative, Artistic, and Expressive Therapies for PTSD*. Arts and Healing (pdf) Retrieved from: http://artandhealing.org/wp-content/uploads/PTSD-White_Paper_040612-2.pdf

Tanielian, T. L., & Jaycox, L. (Eds.). (2008). *Invisible wounds of war: Psychological and cognitive injuries, their consequences, and services to assist recovery* (Vol. 1). California, Rand Corporation.

van Kesteren, J. (2011). ACTING for PEACE Participatory theater in peace education in Colombia (unpublished Masters thesis). University of Amsterdam, Netherlands.

van der Kolk, B. (1987). *Psychological trauma*. Washington, DC, American Psychiatric Press.

ⁱ War Neuroses: Netley 1917, Seale Hayne Military Hospital 1918, made by Pathé (British branch) in 1918. At least three versions of the film exist. There are copies at the Wellcome Trust Moving Image and Sound Collection, the BFI National Archive and the Imperial War Museum, and British Pathé (currently managed by ITN).