Katia El-Eter

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By: Katia El-Eter

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Research Advisor:

Jessica Bleuer, MA, M.Ed, CCC

Department Chair:

Yehudit Silverman, MA, R-DMT, RDT

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Abstract

Since the current war in Syria began in 2011, millions of people have been internally and externally displaced. This has greatly contributed to the increase in refugee numbers throughout the world (UNHCR, 2017). Women and children are more vulnerable because, under certain regimes, they do not have the same agency as adult men (Vieira ,2014). Of further relevance, while adult refugees deal with their own survival, their children may experience physical and/or emotional neglect (Rutter, 2006). Canada is one of the countries currently receiving Syrian refugees (Immigration, Refugees and Citizenship Canada, 2017). This heuristic research paper argues that storytelling is a particularly powerful tool that can greatly benefit refugee children and respond to their specific needs. This is especially true for Syrian children and children of other cultures who have grown up with rich storytelling traditions. I will explore and justify the use of storytelling as a dramatic therapeutic intervention for Syrian refugee children, arguing that it can be beneficial in treating children refugees who have experienced war trauma. I will also explore why this intervention has been so meaningful to my immigration story and my own journey to wellness.

Dedication

It has been seven years since the Middle East is struggling with conflicts. This explains the increase in the number of refugees all over the world. These refugees experience multiple stresses and are exposed to different traumatic events throughout their displacement process. As I continue to work with children refugees in Montreal, I dedicate my research to them.

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Chapter 1. Introduction

Before proceeding, I would like to situate myself as a researcher: I am a female in my late thirties, a wife, and a mother of four children aged 6, 11, 15, and 17. I grew up in Tripoli, a small seaport city in northern Lebanon, situated 85 kilometers north of the capital, Beirut. My two eldest children were born in Lebanon, and my two youngest in Canada. My family and I moved to Montreal in October 2010. Currently, I am working as a trauma-informed psychotherapist, and I use drama therapy techniques with some of my clients. After I finished the coursework for the Master's in Drama Therapy at Concordia University in 2015, I started working for a resettlement organization where I provided psychosocial and practical support to refugees. Due to my language skills in Arabic, French, and English, I was offered the opportunity to work with many Syrian refugees, both adults and children. While working with these clients, I used various drama therapy techniques, including storytelling.

The majority of the Syrian refugee population is made up of children, and it is crucial to ensure adequate psychological help to support their healing. Between November 2015 and October 2017, Quebec received a large number of Syrian refugees, 3925 of whom were children, 3170 women, and 3285 men (Immigration, Refugees and Citizenship Canada, 2017). Canada continues to receive refugees from Syria.

When I worked as a psychosocial service worker for the Centre Social d'Aide aux Immigrants (CSAI), I provided support in the resettlement process of Syrian refugee families in Montreal. My job was to help families find housing, open bank accounts, attend medical appointments, and engage in other survival necessities. As I worked with these families, I observed anxiety symptoms and high levels of stress, particularly in the children. Through my

work at CSAI, I noticed the lack of therapeutic support offered to families, children, and individuals. This served as a catalyst for me to think about how to best address Syrian refugee children's trauma symptoms.

Definitions

For the purpose of my research the terms children, refugee, and trauma will be operationalized as follows:

This study will focus on *Children* between the ages of 9 and 12.

Refugee will be defined according to the United Nations (1951) definition,

> any person, who owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his/her nationality and is unable or, owing to such fear, is unwilling to avail himself/ herself of the protection of that country; or who, not having a nationality and being outside the country of his/her former habitual residence as a result of such events, is unable, or owing to such fear, is unwilling to return to it.

The DSM-5 outlines many criteria for the definition of post-traumatic stress disorder and complex trauma, this paper will use a broader definition and define *Trauma as:* "an experience that creates a lasting, substantial, psychosocial, and somatic impact on a child" (Malchiodi, 2008, p. 4).

Biases

I am a psychotherapist specialized in trauma, and a Master of Arts drama therapy candidate in the Creative Arts Therapies Program at Concordia University. I have an ingrained bias towards the power and efficiency of drama therapy and trauma informed psychotherapy, as well as towards the power of storytelling with refugees. I am very aware of this bias; when I was

asked to choose my research subject, the first idea that came to mind was the creation of a storytelling intervention for Syrian child refugees arriving in Montreal. Before I discovered my bias, most of my work consisted of synthesizing the literature on refugees and the use of storytelling with refugees, just as one finds in any pure theoretical paper. However, this second bias became very evident when I remembered that storytelling, the technique that I assumed to be beneficial to this population, was the same one that my parents employed when I was in a bomb shelter during the Lebanese War. Due to the nature of heuristic methodology, I discovered that the content of this research is extremely personal. Hence, my conclusions have been drawn through this lens.

Assumptions

I held a belief that storytelling could address war-related trauma in Syrian refugee children, and that it would be a culturally-appropriate technique. Furthermore, I wanted to incorporate Jones' (1996) *drama therapeutic core processes* in a storytelling intervention that aims to treat traumatized Syrian refugee children.

Chapter 2: Methodology

Research Questions

In my research, I attempted to find answers to the following research questions: My primary research question asked, *How can storytelling help address war-related trauma in Syrian refugee children?* My subsidiary research question asked (a) *How can drama therapy principles benefit storytelling used to address war related trauma with Syrian refugee children?*

The Six Phases of Heuristic Research

Heuristic research: This research follows a heuristic methodology process. I followed Moustakas' (1990, p.12) "initial engagement, immersion into the topic and question, incubation, illumination, explication, and culmination of the research in a creative synthesis." Moustakas (1994) defines heuristic research as:

> "A process of internal search through which one discovers the nature and meaning of experience and develops methods and procedures for further investigation and analysis. The self of the researcher is present throughout the process and, while understanding the phenomenon with increasing depth, the researcher also experiences growing self-awareness and self-knowledge. Heuristic processes incorporate creative self-processes and self-discoveries" (Moustakas, 1994, p. 17).

Moustakas (1990) describes the initial engagement as the discovery of an intense interest or passionate concern for a social and personal topic. In this phase, the researcher chooses their research topic. I chose to research the use of storytelling with refugee children. The immersion phase focuses on exploration and discovery. The chosen subject becomes pivotal, and the researcher revolves around it not only when awake, but also when sleeping (Moustakas, 1990).

The immersion phase was delayed by inaccurately choosing to engage in a theoretical research methodology that did not help me understand the roots of my passionate concern. I began the research by reading multiple articles, as if there was a mathematical concept that I needed to solve through intellectual processing. I felt resistant and avoidant of my research tasks, and I was unable to complete my research in a timely fashion. When some deeply personal experiences of storytelling surfaced, I began to realize that perhaps my paper would be best served by a more personal heuristic methodology.

The incubation phase is "the process in which the researcher retreats from the intense, concentrated focus on the question" (Moustakas, 1990, p. 13). It is in this phase where the researcher engages in non-research related activities. In this phase, I was extremely avoidant of my research, and I did not want to connect to the subject theoretically or heuristically, and I found many ways to occupy my time that did not include thinking about my research. It was only after the university granted me an extension and informed me that it was my last semester to finish my research paper that I was forced to apply myself more diligently.

The next phase, illumination from Moustakas' "…occurs naturally when the researcher is open and receptive to tacit knowledge and intuition" (Moustakas, 1990, p. 14). In this phase, the researcher learns important insights about their research, these insights are often referred to as "aha moments". The illumination began when I started to experience challenges in my life. I became emotional at work and built overly dependent relationships with my clients at CSAI. Then I began to experience conflict within my own family, and this served as the alarm bell that made me realize that something had to change. I was engaging in a heuristic process before I even knew this was the appropriate methodology for my paper. However, it was only with the support of a colleague and a supervisor I began to explore my personal connections to the topic

of child refugees that my personal healing began. One of my illuminations was that I was using the wrong research methodology, and when I committed to changing my research methodology to a heuristic research process, I cycled through Moustakas' heuristic research phases once again, but this time, with consciousness and intention.

My explication phase began, and because I selected a more appropriate methodology, I was able to explicate fluidly and coherently, searching for the underlying meaning and importance of storytelling in my own life. Moustakas explains that "the entire process of explication requires that researchers attend to their own awarenesses, feelings, thoughts, beliefs, and judgments as a prelude to the understanding that is derived from conversations and dialogues with others" (Moustakas, 1990, p. 15). Moustakas heuristic processes are not linear and it was in my explication phase, when I began reviewing the data from my conversations with my supervisor, my friends, my therapist and I returned to the immersion, incubation and illumination phases, deepening my work through a heuristic process. In this process, a new data collection and analysis emerged.

I read excessively about child refugees' needs, mental health challenges, and techniques used to address refugee trauma, including storytelling. Although I had originally attempted to write a theoretical paper, I discovered many relevant repressed and unwanted memories directly related to the research topic. I began to digest the contents of my dreams and flashbacks. The process resembled that of a caterpillar metamorphosing into a butterfly. My personal healing journey was painful but necessary and liberating. This experienced helped me personally in regaining my voice and my sense of safety and security. It was a process in which the theory enhanced my learning and reinforced my trust in the power of storytelling and its role in my life.

Chapter 3. Literature Review

Storytelling is a common tradition across the Middle East, from Egypt to Lebanon. In Syria, it first appeared over two centuries ago during the Ottoman Empire. In a time well before television, storytelling was considered an attractive leisure activity (Alittihad, 2010; Howes, 2016; Sheppard 2003). There was a time when every coffee shop in Damascus would hire a *hakawati* [storyteller]. The roots of this word originates from the Arabic word *hekaya,* which means "story", and *haki*, meaning "talk" (Chaudhary, 2014). The *hakawati* would begin to tell a story in the early evening and continue it for a month or longer. Stories would honor kings, warriors, and social values. The *hakawati* was both the storyteller and the actor; he had the capacity to catch the interest and imagination of his audience by performing, mimicking and changing his voice to perform different roles (Chaudhary, 2014). Abou Shadi is the last remaining *hakawati* in Syria, and the most famous one. He learned the craft of storytelling from his father in the early 1970s (Moubayed, 2010). He has worked as a professional storyteller for thirty consecutive years, and he boasts that one of his stories could last upwards of a year. Abou Shadi argues that people gain wisdom from the art of storytelling, and locals worried that this oral tradition would die with him. Fortunately, his son, Shadi, inherited his talent. He is a *karakoz,* which means "puppeteer". He performs stories to children in Aleppo, Syria (Dunston, 2014). Storytelling is a traditional part of Syrian culture.

Syrian Civil War and Refugees

According to the UN Refugee Agency Report (United Nations High Commission for Refugees, UNHCR, 2017), the global rate of displaced populations hit a record in 2016, and refugee numbers continue to rise. The report revealed a jump of 300,000 people in the past year alone. According to UNHCR statistics, 65.6 million individuals worldwide were forcibly

displaced in 2016, and only 189,300 refugees were resettled. The UN declared 22.5 million people refugees and another 10 million stateless persons (UNHCR, 2017). It is of consequence to mention that in 2016, 55 % of all worldwide refugees came from Afghanistan, South Sudan and Syria, with the majority from this region, 5.5 million originating from Syria (UNHCR, 2017).

The Syrian War started on March 18, 2011 (CNN Library, 2017). More than five million people have fled the country, and 6.3 million have been displaced within the country's borders, and only 3% have been resettled. The estimated number of people killed is more than 220,000. In December 2015, Canada's Trudeau government approved the "National project" for Syrian refugees fleeing the civil war. By the end of February 2016, Canada received 25,000 Syrian refugees (Friesen, 2016).

Mental Health Related to Young Refugees

Joshi and Fayyad (2015) explain that a child's environment is *multi-layered*, so when any of these layers is disrupted, it affects the child's life. Refugee children are affected by the war and displacement as well as the current stresses from resettlement. Children who face multiple losses and threats are at a greater psychological risk, and their development is often negatively impacted.

Brymer, Steinberg, Sornborger, Layne, & Pynoos, (2008) explain that refugee groups experience many losses, including home, material belongings, family members, friends, neighborhood, school, values, daily routines, and culture. They also mention that refugee children can be exposed to severe traumatic events in their countries of origin, while fleeing, and after arrival to the host country. Refugees' journey consists of three stages, the pre-migration, migration and post-migration, also known as "preflight, flight, and resettlement" (Brymer et al,

2008, p.625).

Multiple losses and distress causing events occur throughout the pre-flight and flight stages. In the pre-flight stage, or war stage, children experience severe war-related trauma, including physical injury, physical abuse, malnutrition, severe cold, lack of access to schools and healthcare, persecution, humiliation, maltreatment, arrest of family members, loss of family members, home destruction, and loss of income leading to dependency on aid (Brymer et al., 2008). The flight stage also incurs many losses, manifesting in depression, anxiety (Brymer et al., 2008; Felsman, Leong, Johnson, & Felsman,1990; Hodes, 2000; Marwa 2012, 2013; Ozer, Sirin, & Oppedal, 2013), post traumatic stress disorder, somatic disorder, sleep problems, conduct disorder, social withdrawal, attention problems and regressive manifestations (Abou-Saleh & Mobayad, 2013; Felsman et al., 1990; Quosh, Eloul, & Ajlani, 2013; Sack, Clarke & Seeley, 1996).

In the resettlement stage, children move to host countries expecting to be protected, but experience shows that this stage is marked by more instability within which they can experience trauma and loss once again (Brymer et al., 2008). In addition to the daily stress of adapting to a new culture, refugees experience multiple losses including the contact with their own cultures. To adapt to their new culture and community, they must learn the local language, adapt to its cuisine, politics, religion, and traditions. Furthermore, refugees can face difficulty building new social network, challenges finding the services they need, and discrimination. Children, who learn new languages more quickly than their parents, assume the roles of translators *and advocates* for their parents who need to access resettlement services (Brymer et al., 2008, p.627).

Psychosomatic Symptoms in Child Refugee

The International Medical Corps (IMC) (2011, 2012) reported that Syrian refugee children experience grief, apathy, distress, and exhaustion. Children (particularly those below school age) can also present psychosomatic symptoms. According to researchers, children's responses manifest concretely, experiencing physical pain when enduring a difficult emotional situation (Almqvist & Brandell-Forsberg, 1997; Hodes, 2000; Joshi & Fayyad, 2015; Ozer et al., 2013). Some children showed sleeping problems (Almqvist & Brandell-Forsberg, 1997; IMC Report, 2011), and others eating disorders (Hodes, 2000; IMC report, 2011). Almqvist & Brandell-Forsberg, 1997 identified additional psychological difficulties such as attention problems, social isolation, and conduct disorder. Hodes (2000) argues that many young refugees face academic difficulties and show restlessness and recurring nightmares.

Symptoms in Refugee Children Between the Ages of 9 and 12

For the purposes of my study, it is important to be aware of the symptoms that are particular to children between the ages of 9 and 12. Joshi and Fayyad (2015) explain that between the ages of 7 and 11 children have concrete thinking making it very difficult to understand their complex situation. As a result of trauma, they can manifest symptoms such as fear, confusion, anxiety and regression to previous developmental stages. They may also experience physical manifestations such as headaches, loss of appetite, and stomach aches. Moreover, some children may refuse to go to school or face difficulties in concentration, they may show aggressiveness or hyperactivity and even lose interest in their everyday activities.

Risk and Protective Factors

Although there are many similar symptoms between children who experience war, there are also many differences. Each child has different biological, family, and societal factors that can influence their development and well-being and how they respond to trauma. After exposure to trauma, some children may show immediate symptoms, while others may manifest symptoms of distress weeks or months later, and some children will not show symptoms at all (Joshi & Fayyad, 2015). Each child holds different risk and protective factors that influence how they will be impacted by trauma.

It is mandatory that therapists understand the risk and protective factors of child refugees. A literature review conducted by Fazel, Reed, Panter-Brick & stein (2011) found many challenges affecting child refugees' mental health. The authors discuss four categories of risk and protective factors: the individual, family, community, and society. Individual factors are understood by the authors as "pre-existing vulnerability" (Fazel et al., 2011, p.270), and physical and mental disabilities fall into this category. Gender, although non-conclusive was another individual factor. Education appeared to be positively correlated with post-traumatic symptoms and one study showed that more educated adolescents had more severe post-traumatic symptoms (Fazel et al, 2011; Sujoldzic, Peternel, Kulenovic, & Terzic, 2006).

In a review conducted by Fazel et al. (2011), some studies showed that unaccompanied children demonstrated more psychological problems than accompanied children (Bean, Derluyn, Eurelings-Bontekoe, Broekaert, Spinhoven, 2007; Derluyn, Broekaert, & Schuyten, 2008; Geltman et al, 2005; Hodes, Jagdev, Chandra, & Cunniff, 2008; Fazel et al, 2011). However, another studies stated there was no difference between the two groups (Ellis, MacDonald, Lincoln, & Cabral, 2008; Fazel et al, 2011). Unaccompanied children showed psychological

difficulties in three cases: when they were separated from their relatives, lost contact with them, or when a family member was imprisoned (Fazel et al, 2011). Their findings show that children can be more affected by the violence their parents experience than by that which they experience themselves, and of specific relevance in cases where parents were tortured or have gone missing (Montgomery & Foldspang, 2006).

In contrast, positive family functioning was an important protective factor since family support diminished children's psychological problems (Berthold, 1999; Fazel et al, 2011; Grgic Vidovic, Soldo-Butkovic, & Koic, 2005; Kovacev, 2004; Rousseau, Drapeau, & Platt, 2004; Sujoldzic et al., 2006). While some studies showed that the education of the parents had a positive impact on children (Fazel et al, 2011; Montgomery, 2008, 2010; Rousseau, Drapeau, & Corin, 1998), other researchers found that parental education could even constitute a potential risk factor when those parents were involved in political issues (Fazel et al, 2011; Rousseau, Drapeau, & Corin, 1997).

Community Factors

According to Fazel et al. (2011), children's sense of inclusion in their new community has a great impact on their psychological well-being. This explains children's speedy adaptation to their new country when they feel accepted or the converse when they are bullied and excluded. Boys reported greater bullying than girls, which may account for some of the different ways trauma impacts gender. Sense of safety at school and the presence of parents' friends in and outside the home represent other key protective factors.

Societal Factors

Fazel et al. (2011) note that religious beliefs are a significant protective factor linked to children's psychological well-being. Montgomery (2008) explained that Muslim and Christian-practicing adolescent refugees who came from the Middle East and resettled in Denmark were more resilient and had fewer symptoms than minority groups or adolescents who changed their faith and felt persecuted. Believers thought that God was responsible for their difficult situation and that he would be protecting them through it all. Of relevance, prayer was the key initial coping mechanism for many Syrian refugees living in camps (Ontario Centre of excellence for Child and Youth Mental Health, 2016; Rudoren, 2013).

Exposure Techniques Used with Child Refugees

Most of the therapeutic techniques used with child refugees are trauma focused and rely on exposure to the traumatic material. The purpose of these techniques is to separate the traumatic event from its anxious response in clients (Shin & Liberzon, 2010). This technique also helps clients gain mastery of the traumatic material, enabling them to engage emotional regulation when thinking about their past experiences (Johnson, & Lubin, 2015). Cognitive Behavioral Therapy (CBT), Trauma Focused Cognitive Behavioral Therapy (TF-CBT), Narrative Exposure Therapy (NET), The version adapted for children is called KID Narrative Exposure Therapy (KIDNET) (Foa, Keane, Friedman, & Cohen, 2008). Prolonged Exposure (PE), testimonial psychotherapy, and EMDR are all interventions focused on exposure therapy.

CBT consists of applying relaxation prior to exposing the child to recollecting the traumatic material. Whenever the child becomes anxious, relaxation is reapplied until the anxiety subsides (Schottelkorb, Doumas, & Garcia 2012). A specialized CBT approach known as the TF-CBT is a family-focused intervention that includes parents in the therapeutic process of

their traumatised children. It follows the same principles of CBT by exposing children to their traumatic events. This technique has three stages: stabilization, trauma narration and processing, and integration and consolidation (Cohen & Mannarino, 2015).

Narrative exposure therapy (NET) follows the same principle as CBT. The version adapted for children is called KID Narrative Exposure Therapy (KIDNET) (Foa et al., 2008). Similar to the CBT approaches, the child is invited to speak about his traumatic event in a chronological order. The therapist then explores the emerging emotions and invites the child to identify and work through these emotions. This exposure exercise normalizes trauma-based emotions and reactions, and its narration techniques are repeated until the child reaches a form of mastery over their difficult emotions. Mastery refers to a state in which the emotion no longer controls the child and is also less frightening and disruptive to the child and their world. The effectiveness of the KIDNET method has been tested, and results show its potential to rapidly treat chronic PTSD and enhance traumatized refugee children's functioning in only eight sessions (Catani et al., 2009; Ertl, Pfeiffer, Schauer, Elbert, & Neuner, 2011; Ontario Centre of excellence for Child and Youth Mental Health, 2016; Onyut et al., 2005; Ruf et al., 2010).

Like CBT and KIDNET testimonial psychotherapy also relies on personal transcription of traumatic situations, but this intervention is usually conducted in educational and advocacy settings (Lustig, Weine, Saxe, & Beardslee, 2004). The intervention also aims to encourage young refugees to overcome mental health stigma and use psychiatric care. This technique had previously been used with adults, so Lustig et al. (2004) attempted to test its efficacy with child refugees. They described the testimonials of three Sudanese adolescents and decided that it is a safe and effective intervention for that age group. They argued that when traumatised children express their lived traumatic experience and expand on it, it engages a catharsis effect. However,

the technique is not appropriate to all clients, especially in some culturally conservative societies.

Eye movement desensitization and reprocessing (EMDR) is a psychological technique that consists of facilitating and processing traumatic memories. This technique is also primarily used with adults, but it seems to be beneficial when applied to traumatized children in a therapeutic context (Oras, de Ezpeleta, & Ahmad 2004). The aim of EMDR is to normalize traumatic memories so that the client can have control over them. Briefly, when used with children, EMDR is adapted to their needs. EMDR begins with asking children to recall their traumatic event, this recall initiates their anxiety. They are then asked to follow the therapist "through tapping the hands or sounding by fingers in front of the child's ear" in order to separate the traumatic event from the emotion that accompanies it (Oras et al 2004, p.201). In their study, Oras et al. (2004) found a decrease in PTSD symptoms, an amelioration in depression and an increase in the child's general functioning. Oras et al. conclude that (EMDR) is effective when used with child refugees.

Gaston (2017) has a different perspective on exposure therapy. She argues that therapists should not categorically ask all patients to retell their traumatic event in details. It is important to note that therapists do need to know enough about the traumatic event to understand the clients current distress and in order to make links and appropriate interpretations. However, Gaston believes that certain conditions are necessary before engaging in exposure therapy. Only in cases in which the individual is highly functional, a well-established alliance exists, the patient has a clear capacity to regulate dysphoric emotions, and the patient gives clear consent, is exposure therapy recommended. Otherwise, re-experiencing a traumatic event may lead to re-traumatizing patients as shown in a seminal psychophysiological study (Blanchard, Kolb, Pallmeyer, & Gerardi, 1982).

Similarly, while Wimberly (2012) understands the power of telling one's trauma narrative they also provide caution, stating that storytelling can be a double-edged sword. It can be extremely beneficial yet very destructive if the right supports are not in place. Storytelling can evoke the reliving of horrifying experience, and a safe space that incorporates emotional self-regulation techniques is required.

Many trauma experts and practitioners do not use of trauma-focused therapies such as Prolonged Exposure (PE), due to a concern about adverse side effects (Becker, Zayfert, & Anderson, 2004; van Minnen, Hendriks, & Olff, 2010). Salberg, (2017) notes that "under the great stress of trauma, telling becomes difficult, problematic and at times impossible." (p.246). The concern for many therapists is the fear of side effects or re-traumatization, when asking clients to retell their trauma stories. Although this is a controversial topic in the field of trauma-informed psychotherapy, with many therapists believing in the importance and efficacy of exposure therapy, I share the above author's concerns about the potential for re-traumatization.

As a drama therapist, I see creative arts therapies as an alternative non-exposure therapy, with potential to engage in a less direct, more distanced way. Richman (2014) maintains the creative arts are powerful tools used for healing (as cited in Salberg, 2017). Richman argues that the creative arts therapies can help us express our distress and form stories that help make meaning about our traumas. The field of using the creative arts therapies to address trauma is young, and there is a dearth of evidence-based research to measure its effectiveness (Sullivan & Simonson, 2016; Van der Kolk et al., 2014; Van Westrhenen & Fritz, 2014). Between 2002 and 2014, Van Westrhenen & Fritz (2014) reviewed the research conducted in the creative arts field and found only two empirical studies focused on the effectiveness of creative arts therapy techniques (Orr, 2007; Eaton, Doherty, & Widrick, 2007). Despite the lack of empirical

research, many clinicians can attest to its benefits in their own clinical work when working with traumatized children (Malchiodi, 2008; Sullivan & Simonson, 2016; Van der Kolk et al., 2014).

Contrary to popular belief, the creative arts therapies are not novel approaches. Freud (1963) stated that dream contents constitute unconscious representations and symbols and that dreamers would often say, "I could draw it but I don't know how to say it" (p. 90). Brooke (2006) observes that despite the fact that he did not include art in his practice, Freud's statement served as the catalyst for the development of the modern art therapy practice. Jung was considered by some to be the first art therapist (Brooke, 2006), who, upon his separation from Freud, participated in the actual development and practice of the field. Jung considered art to be at the core of cross cultural commonalities, perceiving symbols to be universal. Like Jung's symbols have great value in psychotherapy because of their ability to reveal the unconscious.

Many researchers support the use of creative arts therapies for traumatized children. Van Westrhenen & Fritz (2014) clarifies that creative arts therapies constitute an *umbrella* that comprises of art therapy, music therapy, dance therapy, drama therapy, poetry therapy, play therapy, sand-play therapy, and psychodrama. Malchiodi (2008) highlights the multi-sensory nature of art in therapy: it is visual, tactile, and kinesthetic. Due to trauma's impact on the body and its multiple somatic repercussions, Malchiodi posits art therapies tactile and kinesthetic qualities as one of their greatest trauma healing strengths. Amongst its many benefits, she mentions stress reduction, self-awareness, increased self-esteem, the development of social skills, a decrease in clients' anxiety and healing from trauma. Creative arts therapies are flexible techniques that can be adapted to different populations.

These techniques are specifically beneficial with children since many children often have difficulty expressing themselves verbally (as is required for talk therapy). Malchiodi (2008)

defends the usefulness of arts-based therapies, stating that "children intuitively use expressive arts and play to act out what they are reliving and what they may find unspeakable" (p.xiv). She asserts that various creative interventions can treat trauma stemming from events like "family violence, abuse, grief and loss, accidents and injuries, bullying, terrorism, and crisis due to natural or man-made disasters" (p. 86). Van Westrhenen & Fritz (2014) concur expressing the multiple benefits of using the creative arts therapies to help children heal after trauma.

Creative Art in Psychotherapy (CAP) Treatment Protocol

Van Westrhenen et al. (2017) developed a Creative Art in Psychotherapy (CAP) treatment protocol based on their work with South African children aged 8 to 12 years who had experienced different kinds of non-war-related trauma. The CAP treatment protocol emphasizes the importance of group dynamics when working with traumatized clients. These clients often lose their trust in people, and CAP gives them the opportunity to reconnect with others, re-establishing trust through healthy interactions that happen in a safe therapeutic environment. CAP provides the following trauma informed stages: creating a safe space, telling the trauma story, and preparing the children to return to the community.

Van Westrhenen et al. create a safe space with their participants in order to engage in deep trauma work that enables children to identify and heal from the emotional consequences of abuse. By helping children express their emotions as they tell their trauma stories, PTSD symptoms decrease. The last process of this model focuses on promoting children's resilience, enabling them to engage in healthier interactions and return to their community with new skills that help them cope with life's challenges. Using Van Westrhenen et al.'s (2017) CAP protocol, I will argue that storytelling can support deep trauma work. CAP will be my organizing framework to synthesize five different psychotherapy interventions that use storytelling in a way

similar to CAP to create safe spaces, tell the trauma story, and prepare refugee children to return to the community. Although the techniques explored in this section employ storytelling, they are not drama therapy techniques, but rather techniques that use other psychotherapeutic methods.

Creating a safe space. All trauma treatment approaches emphasise the importance of safe space as a condition for therapeutic progress. Many treatments speak about safety and stabilization work as a precursor to the more difficult work of sharing of trauma narratives. Although not therapists, Butterwick & Selman (2004) explain this phenomenon well when describing the space, they try to promote order to invite youth's difficult stories, they create a space that is "safe enough to be dangerous" (2004, p.4). In the therapeutic context, Psychological First Aid (Brymer et al., 2008), Tent of Stories (Veerman, 2004), Rousseau & Guzder, 2008; and (Valenzuela-Perez, Couture, & Arias-Valenzuela, 2014) all speak directly about the need to engage safety before any other intervention takes place.

Psychological First Aid (PFA) uses self-regulation techniques in order to promote psychological and physiological safety. The PFA focuses on short-term solutions, and is often used in refugee camps (Brymer et al., 2008). Safety and comfort are two of its core principles, both engaged early in contact with the child. Its authors maintain that anxiety and other forms of regression emerge when children feel unsafe. The technique prioritizes the importance of reducing physiological and psychological trauma-based responses first. Children learn breathing, relaxation, and other grounding techniques before being invited to share elements of their trauma experience. They learn to self-regulate.

In a refugee centre in the Netherlands, Veerman (2004) used the Tent of Stories technique: the therapist set up a colored tent where children could tell stories every Saturday. Structure and predictability are two elements that support the creation of psychological safety.

Amongst other interventions, children are invited one at a time to sit on a higher seat, called the *story throne*, and choose a fictional or real-life story of their choice to share with the other children in the tent. Giving clients a choice is a deliberate intervention that intends to encourage choice, autonomy and a sense of control or self-efficacy, the opposite of what happens during trauma, where a person's autonomy is violated. The physical structure of the tent also creates a physically contained space intended to create a feeling of cohesion, community and containment while exploring difficult trauma material.

Telling the trauma story. Telling the trauma narrative is a common process in many trauma treatment approaches, including those that use storytelling. Stories are told in many different ways, some by the therapist, others are told by the clients. Storytelling approaches are also imbued with different levels of aesthetic distance; the equilibrium between emotions and rational thought needed to create the optimal circumstances for a client to access all of their international resources (Landy, 1983). Aesthetic distance is achieved by using a series of both *underdistanced* and *overdistanced processes*. Underdistanced processes are often real-life narratives that can bring up ample emotion when sharing. Overdistanced processes rely more on fictional, metaphoric content that creates distance from one's psychic material (Jones, 1996).

Many trauma-informed interventions can be found on the spectrum between overdistanced (fictional storytelling tends to engage distance) and underdistanced (real-life storytelling tend to engage emotions or underdistanced states). Valenzuela-Pérez (2014) used an overdistanced storytelling assessment technique to learn about the needs of refugee children. During a four-session assessment, the therapist focused on a series of metaphorical exercises and fictional stories. She then asked the children to respond to stories that she told through drawing or re-enactment. They were also asked to identify the main character's needs. At no point

during the assessment were children asked to share their lived experiences of war. In this technique, the processing of emotions and needs happens through the fictional stories and metaphors.

Psychological First Aid (PFA) is another overdistanced approach. While it does not use metaphors and fictional stories, it does refrain from asking clients to directly share their trauma narratives. PFA is a time-sensitive intervention that is done quickly; it guides therapists to proceed cautiously around traumatic material. It asks clients to focus on practicality, only sharing elements of the trauma narrative that can be supported by practical assistance. This intervention focuses on connecting children to social support services and teaching them short-term coping strategies. "PFA providers are cautioned against asking for in-depth descriptions of traumatic experiences" (Brymer et al., 2008 p. 634). Many storytelling techniques favor a more distanced approach to sharing one's trauma narrative.

Approaches to storytelling, that use more distance, or fictional storytelling help prepare children to have enough internal stability and/or safety to express aspects of their trauma narratives (Brymer et al., 2008; Rousseau & Guzder, 2008; Valenzuela-Pérez et al., 2014). Some clinicians work with myths, tales and other fictional stories in order to access the imaginary world of children. Rousseau, Lacroix, Bagilishya, & Heusch, (2003) work with myth and metaphors to help refugee children make meaning of their trauma experiences and integrate into their school settings. Children project their own experiences and emotions onto these stories and make meaning of their trauma.

Some trauma-informed interventions use both fictional and real-life stories. Rousseau et al. (2003) began their work with children in an overdistanced way. They first used mythological stories about a journey in which the main character experiences many difficulties, overcoming

his challenges in the end. They continued this exploration with a focus on addressing fears and internal dangers, using the metaphor of a kite and how difficult it can be to control. Both these exercises invited children to express their feelings and responses towards the story and the metaphor through drawings. After these overdistanced exercises, the therapist invited refugee children to tell their trauma narratives through drawings that represent the four stages of their own journey: war, displacement, re-settlement, and the future. Rousseau et al. (2003) worked with both the distancing effects of fiction and mythology as well as the underdistancing impact of connecting to one's real-life trauma narrative.

The Tent of Stories approach (Veerman, 2004) uses both fictional and real stories. Before the children are invited to tell their own stories, the therapist begins by telling fictional stories about themes related to trauma. Veerman finds fairy tales are useful in introducing universal trauma themes through the distance offered in fairytale. Then, each child is invited to tell their own story (whether fictional or real, from their own lived experience). Essential to trauma work, the choice of which type of story they tell is made by the children, giving them a sense of control over their own treatment.

Other trauma-informed storytelling techniques ask clients to tell their trauma narratives directly from the onset of treatment. In Rousseau et al.'s (2008) school-based intervention using Playback Theatre, adolescents are invited to share their war stories with their peers and teachers. Therapists and students embody the different characters in the story, and they act out the trauma story. This process is embodied and underdistanced, meaning that it evokes emotions and connection to the clients' own material.

Preparing children to return to the community. Preparing children to return to the community is the last process engaged through the Creative Art in Psychotherapy (CAP) treatment protocol. Rousseau's (2003) approach concludes with children identifying and sharing their strengths and coping strategies with their parents or guardians. Children are encouraged to adapt to the new culture while integrating their culture of origin and identity. The PFA approach advocates a return to community by connecting refugee children and their families with existing community structures such as religious establishments, schools, or women's organizations. They also facilitate support groups to provide a social network (Brymer et al, 2008).

In the *Tent of Stories*, participants aligned their experiences with the protagonists in fairy tales. This allowed them to leave the group with a stronger sense of hope and resilience, which in turn helped them to better reintegrate into their community (Veerman, 2004). Playback Theater aims to shift adolescents' traumatic stories to ones with more positive outcomes and to improve their interpersonal skills (Rousseau & Guzder, 2008).

Storytelling and Drama Therapeutic Core Processes

As a drama therapist, I am interested in the dramatic processes involved in storytelling. I concern myself with the reasons behind storytelling's efficacy. Many of Jones (1996) core drama therapeutic processes can be used to understand the therapeutic processes behind the storytelling techniques. Jones nine core processes explain the benefits of drama therapy. Since storytelling is a drama therapy technique, Jones' core processes are part of it. The most prevalent core processes present in the above storytelling interventions involve active witnessing, dramatic projection and the drama-life connection.

In all five storytelling techniques, the therapist and fellow group members act as witness to some aspect of the clients' story. Regardless of their use of distanced or underdistanced

approaches, all five techniques provide opportunities to bear witness to clients' pain, helplessness and other emotions related to trauma. Jones, (1996) argues that witnessing happens on three levels; a client can witness others, a client can also witness himself when playing different roles, and a client can be witnessed by others. The Tent of Stories (Veerman, 2004) involves many opportunities for witnessing. Throughout this intervention the therapeutic power of witnessing is activated. Everything slows down and time and attention is given to the child storyteller to make meaning of part of their trauma through their storytelling. This is of particular importance because many traumas do not have an active witness who acknowledges the terror and consequences of what is happening.

Dramatic projection is another core process used in four of the five trauma-informed techniques. Projection was first used by Freud (1912) who referred to it as being a defense mechanism. However, in drama therapy, Jones (1996) argues that dramatic projection can be used as a tool towards healing, helping the client externalize a part of their experience so that they can see it more clearly. The concretization of the experience allows for insight, a connection to unconscious material and perspective (Jones, 1996). Dramatic projection was used by Rousseau et al. (2003) through symbols and metaphors that were chosen to represent elements of clients' traumatic experiences. Similarly, Rousseau et al.'s (2008) playback theatre work asked clients to project their real-life trauma narratives onto people who would play characters from their story. Valenzuela-Pérez et al, (2014) asked children to respond to metaphors and fictional stories, and they inevitably projected their own traumatic experiences onto these stories. In the Tent of Stories, the therapist begins the exercise by sharing fictional stories that are connected to trauma material, creating an invitation for children to project their own experiences onto these fictional stories. This becomes evident when the children are asked to share their own

stories and their choice of story reflects connections to the trauma material found in the original fictional story told by the storyteller.

As is evident in the above examples, the drama-life connection is inescapably connected to dramatic projection. Jones, (1996) explains that when a client plays a certain role or witness someone's else role, he could experience a certain connection to this role. Similarly, when a client engages in distanced use of metaphor or fiction, and they come to an insight about their own lives, this mechanism is known as the drama-life connection. Although Valenzuela-Pérez et al, Rousseau et al. (2003) and Veerman (2004) never explicitly ask for the child's trauma narrative, children project their own trauma material making connections between the symbols, metaphors and fictional stories and their own lives.

Many other core processes are evoked through these techniques, including therapeutic performance, embodiment, impersonation and personification, and empathy and distancing. It is beyond the scope of this research paper to speak about each core process, however I would be remiss if I do not acknowledge one of the most relevant core processes of empathy and distancing. Empathy and distancing is the mechanism by which a client connects to the therapeutic material. They may engage empathically with connection to their emotions, and they may also engage with more distance, employing their cognitive processes (Jones, 1996; Landy 1997). As discussed above, concepts of underdistance and overdistance have been interweaved through all five techniques. Valenzuela-Pérez (2014) and Brymer et al, (2008), used overdistanced interventions while Rousseau et al (2003) used both underdistanced and overdistanced techniques to respond to traumatized children's needs.

Chapter 4. My Creative Synthesis

The Heuristic Research Story

Stage 1: Initial engagement. Originally, I had hoped to do an intervention research project about storytelling with refugee children. I had no intention of engaging in a heuristic methodology. For two years, I tried to write a literature review. I would read copious amounts of literature, but I was not able to organize my thoughts. I felt frustrated and avoidant, and I wanted as much distance from the research paper as possible. I asked a friend for help, and during her questioning of my interest in this project, I realised that I had a very personal connection to the material.

Stage 2: Immersion. I engaged in many activities during the immersion phase: I read over 80 articles and most of the UNHCR reports about Syrian refugees, I worked directly for Centre Social d'Aide aux Immigrants (CSAI) with arriving refugees, and I observed recently-arrived refugee children through my work as a psychosocial social service worker. I spoke to my research supervisor about this work and why it was important to me. I participated in a two-year advanced training on PTSD treatment and worked as a volunteer assisting refugees for Réseau d'Intervention auprès des personnes ayant subi la Violence Organisée (RIVO). I eventually started to see a therapist to address both the block I had with my research paper and many somatic symptoms that I did not understand. I set aside two hours for my research every day, but I always found reasons not to write.

Stage 3: Incubation. There were long periods of time when I did not work on this research. During the three-year period in which I attempted to write this research paper, I visited Lebanon, my home country, three times. I switched jobs thrice, moving from CSAI to Morneau Shepell and finally to my private practice and I performed in an ethnodrama about mental illness.

I also continued to raise my four children, devoting many hours to food preparation, play dates, discipline, and daily home-life activities. And, in my spare time, I also helped a recent Palestinian immigrant family that I had met through friends of friends. I cooked meals for them, registered their children in school, and bought furniture for their apartment. During this time, my father had a heart attack and my mother, who has bipolar disorder, had an intense depressive episode. I dropped everything and flew to Lebanon for three weeks to take care of them.

Stage 4: Illumination. Helping the Palestinian family impinged on my time with my own family, and I began to have conflicts at home with my husband and children. I found the disciplining of my children difficult and I began to see a psychologist who specialised in trauma. Many themes emerged during this period. I began to notice my strong avoidance of my research topic. I busied myself with various responsibilities and work, taking part in extracurricular activities related to my research topic instead of dedicating time to the research project itself. I identified a felt experience of loss of control in both my family life and my ability to complete my research. I had many somatic responses, including unexplainable intense shoulder and chest pain. I spent many nights in emergency thinking that I was having a heart attack. I desperately tried to find out the reason for my pain, but found no medical diagnosis. I often cried during work meetings and my supervisor shared that he was worried about me burning out. Through my therapy process and conversations with my research supervisor and colleagues, I realized that storytelling saved my life and that of my family more than once.

Stage 5: Explication. I choose this research topic unconsciously; in reality, I feel that it chose me. When I began to work on this paper, my experiences of war and childhood trauma were not at the forefront of my thoughts. At this point, my history with war and displacement was repressed. As I began to dig into my personal interest in the topic, I became flooded with

memories of being in the underground bomb shelter with my family, and the adults taking turns telling stories to keep us calm and grounded. In a recent conversation with my supervisor where we were reviewing the data, I remembered a recent assignment in a drama therapy class about fairytales. For this assignment, I chose to play the role of Scheherazade from One Thousand and One Nights. I had not realized the connection at the time, however upon reflection, I recognize the salience of Scheherazade's relationship with storytelling. Scheherazade had married a king who had the habit of killing his wives the day after he married them. In order to stay alive, Scheherazade would tell him stories whose endings she would save for the next day, each day she continued the story, pushing back the ending to the following day, and as a result each day she lived. In the end, the king fell in love with Scheherazade and her life was spared. Effectively, storytelling saved her life, as in an emotional sense, storytelling saved mine, providing me with containment, a sense of structure and an expected happy ending while I was a child on bomb shelters during the Lebanese Civil War. In conversations with my supervisor, I also realised that while I was writing my research paper, I was experiencing the same symptoms as many of my refugee clients: anxiety, avoidance, disorganisation, lack of concentration, flashbacks, forgetfulness (e.g., losing my keys, missing meetings), somatic symptoms, sleeping problems, and feelings of not being good enough.

These realizations did not allow me to continue my defense mechanism of denial, it was clear that my attraction to this topic arose from my personal experience with storytelling while I was internally displaced during two wars in Lebanon.

Stage 6: Creative Synthesis. My creative synthesis comes in the form of a story. I will take some time now to tell you my story. After my most recent visit to Lebanon in the fall of 2017, I dreamt that I was trying to escape from gunmen. I had magical powers: I was jumping from tall buildings, flying, and transforming into transparent creations. Yet, even with all this power, I was not able to escape some intangible feeling of danger. This dream captures some of the raw feelings involved in my own refugee experience. The dream also seemed to represent some of my more recent trauma related symptoms that I experienced while working on this paper. I felt helpless, I knew my potential as a creative human, but I did not feel capable or safe, and I didn't know who to turn towards for help. I felt isolated and panicked, a similar feeling to the lack of agency I experienced in my dream. As I unpacked the above dream through therapy and journaling, my trauma story began to emerge more clearly, more organized and with more structure. Slade (2002) believes in the self-narratives capacity to "regulate, modulate, organize, soothe and ultimately make meaning of the experiences of the child" (as cited in Salberg, 2017, p. 245). And while I am no longer a child, this heuristic research process has served as an organizer of my own trauma narrative that happened in childhood. And here is a much re-worked and brief version of what I now understand about this experience.

Once upon a time, there was a little girl living with her parents and 3 siblings. She was raised during the Lebanese Civil War that occurred between 1975 and 1990 (BBC News, 2017). She remembers when the war started in 1983 in her home town of Tripoli. The war was between the Syrian army and the Palestinian forces, and it lasted for over three months (Abou Fakhr, 2014) during which 1000 individuals were killed and 3000 injured (Reaves, 1983). All of the residents of the building in which she lived had to move to an underground bomb shelter. They were nine families comprising of twelve children and eighteen adults. She recalls the

successiveness of the bombing, and she remembers hearing adults wondering out loud about which bomb would be the one to end their lives. She was scared and hungry. She also felt some safety in the gathering of families in the underground shelter.

They used storytelling to connect with each other and to regulate their nervous systems. Salberg (2017) says that stories may "help parents as much as it does children" (p.245). The parents in the shelter alternated telling stories to children to help them forget their hunger and fear. The act of storytelling provided security and distraction; it gave them all structure in a dangerous, chaotic and unpredictable situation.

Her second displacement was in 1986, and this time the war was between an Islamic extremist group and the Syrian army. Her family was displaced to Deir Amar, her father's childhood village. That war lasted for several weeks, and there were huge numbers of displaced and murdered persons. In the first two weeks, 5000 individuals were forced to leave Tripoli for the village of Shekka, 275 people were killed, and 650 injured (Hijazi, 1985). In the city of Bab al Tabaneh, the Syrian forces and the Arab socialist Baath party committed a massacre. In three days, they killed more than 700 people; most of them were youth aged 17-20 (Karabi, 2013).

Again, in this difficult situation, storytelling was a powerful intervention the adults used as a way to cope. The stories provided structure: a beginning, a middle, and an end. This structure was supportive amidst a chaos that had no timeline. Parents told stories like Sindibad also called Sinbad in English, Ali Baba, Alf Leila w Leila (One Thousand and One Nights), Antar and Abla, Layla and the Wolf (Little Red Riding Hood), Cinderella, Hansel and Gretel, Snow White and the Seven Dwarfs, Jack, the Beanstalk, and many others. Their happy endings were the only common factor uniting these diverse stories. This little girl is me, and my personal

experiences made me acutely aware of the power of storytelling with children experiencing trauma.

In one of the last conversations I had with my research supervisor before completing this research paper, I realized that storytelling had saved my life not only when I was a little girl but also more recently. The following memory, or its conceptualization, had not occurred to me before. During a traumatic incident that impacted my children negatively, my psychologist told me that the only way to tell my children messages was through stories. I helped them understand the trauma they had experienced by telling fictional stories that addressed their guilt, imparted the knowledge that it was not their fault, and reinforced that their parents would always be there to listen, and help them to regain trust in adults discerningly. I realize now how this storytelling technique proposed by my therapist many years ago, reflects the stages of my research process. Although I had read many articles and taken many notes, I was frozen to move ahead with my research. My supervisor acknowledged, "You have read so much you could teach a class about war related trauma and its effect on children!" (J. Bleuer, personal communication, May 5, 2017). Despite this newfound knowledge, I could not move forward, I was frozen in trauma. And it was not until I began to tell the stories of my trauma that I was able to complete this research process. Like, the stories I told my children to support them in healing from their trauma, I too needed stories to support my healing.

This research paper is the second creative synthesis of my heuristic research process. It is here that I have finally been able to organize my thoughts in a cohesive manner. Throughout my life, I was able to play multiple roles simultaneously: mother, wife, student, employee, therapist, activist, actress, volunteer, and more. Not only was I playing these roles, but I was hyper-performing in each of my duties. It was only when I chose my thesis subject that everything

shifted, I collapsed emotionally, and I was not able to return to the person I was before. I asked myself the famous question that I often hear at the beginning of the therapeutic process from clients who have experienced trauma: "Am I going to find the person I was before?" I discovered that I had been attempting to distract myself and escape my personal trauma. Traumatized people do not only suffer from PTSD; they also repress or supress traumatic events by exaggerating or compensating with the varying responsibilities they take on (Boscarino & Figley, 2009).

Although it was not intentional, I realize that my research process followed the Creative Art in Psychotherapy (CAP) treatment protocol. I was not able to do this work until I had created my own safe space through therapy. There, I began to tell my trauma narrative and vocalized my experiences of being told stories in the bomb shelters. This paper, the final requirement of my Master's thesis, is equivalent to the phase that prepares children to integrate into the community. Like the nine months It takes to incubate a baby, it took me nine semesters to write my paper. And finally the paper was born in Lebanon where I did my final edits and returned to my family of origin home because of a family emergency. Eventually, after these nine semesters post course completion, including one semester extension that was beyond the time limit for graduation, I am finally able to present a cohesive account of why storytelling can benefit refugee children. With the completion of this paper I become a graduated drama therapist, and I can now have the professional designation to use drama therapeutic storytelling in the healing of other children.

In trying to synthesize the deeper reasons for which storytelling has been vital to my own personal journey, I am left with this: storytelling gave me a sense of safety when I had none, a

sense of containment and predictability when I was unsafe, and a sense of encouragement, connectedness, and calmness when I felt isolated and panicked.

Chapter 5. Discussion

I hope I have been able to impart the many important benefits I received through storytelling: First, when I was a child in the bomb shelters during the Lebanese civil war. Next, as an adult, telling my children stories to help them make sense of their trauma. And now, as I revisit some of my early childhood traumas and I tell you my story, helping me organize my narrative, make meaning, reducing trauma symptoms and beginning to function again as a student capable of completing her final research paper. Storytelling has many psychological benefits, they support the creation of safe spaces, verbalization of the trauma experience, and re-integration into society.

Through my own heuristic journey, I have realized that storytelling also enables a sense of safety, predictability, and containment that can help regulate children in times of crisis and unrest, even bolstering a sense of self- and community efficacy. Storytelling is a powerful technique that is reliable, adaptable, and secure when used as a treatment with children. (Bettelheim, 1976; Gardner, 1971; Valenzuela-Pérez et al., 2014; Wimberly, 2012). Stories help child refugees formulate their experiences, supports their integration efforts, and increases their self-esteem (Bagilishya, 2000; Costantino, Malgady, & Rogler, 1986; Rousseau, Bagilishya, Heusch, & Lacroix, 1999; Rousseau et al., 2003; Rousseau, Drapeau, Lacroix, Bagilishya, & Heusch, 2005; Valenzuela-Pérez et al., 2014).

Storytelling is a long-standing psychotherapeutic approach (Bergner, 1979, 2007; De La Torre, 1972; Gardner, 1971; Ossorio, 1976; Rennie, 1994; Roberts, 1985; Rosen, 1982). In both clinical and community settings, storytelling has a long history of supporting children who have

been affected by war trauma (Lamwaka, 2004; Rising, 2016; Rousseau et al., 2003; Rousseau et al., 2005; Costantino et al., 1986). It is also applied by priests in pastoral care to enable people to cope with socioeconomic stress, conflicts, sickness, death, and other difficult situations (Wimberly, 2012).

"Storytelling contain seeds of healing" (Lamwaka, 2004). It can be used in different ways, either as an assessment tool or as a therapeutic method. Valenzuela-Pérez et al. (2014) used it to assess the psychological needs of child refugees, while other clinicians use it in treatment, Bergner & Bateson (2007) argue storytelling's use in the psychotherapeutic treatment of different disorders.

When reviewing the extensive literature about the benefits of storytelling, I noticed that many storytelling benefits coincided with the categories outlined by Hobfoll et al. (2007) when describing five essential elements of immediate and mid-term mass-trauma intervention: (a) a sense of safety, (b) calming, (c) a sense of self-and community efficacy, (d) connectedness, and (e) hope.

A Sense of Safety

Hobfoll et al, (2007) consider that traumatised people lose their sense of safety because of the adversities they face. In their opinion, this safety could be re-established by identifying a safe place in a direct and clear way. Hobfoll et al. encourage "coping skills and grounding techniques" as a way of promoting safety. As seen in the section above (Creating a safe space), multiple storytelling trauma interventions begin with the creation of safety (Brymer et al., 2008; Rousseau & Guzder, 2008; Valenzuela-Pérez, 2004; Van Westrhenen et al., 2017; Veerman, 2004).

Calming

Refugee children traumatized by war need support calming their overly activated nervous systems (Hobfoll et al., 2007; Valenzuela-Pérez et al., 2014). Many therapists have helped children reach a state of calmness through their interventions with refugee children traumatized by war (Brymer et al., 2008; Hobfoll et al., 2007; Veerman, 2004)

Self-Efficacy

Storytelling (and enactment) can help refugees regain a sense of self-efficacy through organizing and structuring their experiences, gaining awareness, reducing stigma, increasing self-esteem, and ultimately regaining control of their bodies and lives (Bergner & Bateson, 2007; Bonanno, 2004; Ho, 2015; Kleber & Brom, 2003; Koch, Kunz, Lykou, & Cruz., 2014; Lamers-Winkelman, 1997; Wimberly, 2012). Bonanno (2004) states that people who have experienced trauma lose their sense of control, making them feel helpless and unable to find solutions to their problems. This explains the theoretical emphasis on establishing a sense of control and self-efficacy in trauma victims in therapeutic settings (Bonanno, 2004; Kleber & Brom, 2003; Valenzuela-Pérez, 2014).

In the same context, Bergner and Bateson (2007) explained the advantages of therapeutic storytelling in promoting *cognitive organization*. By decreasing clients' defensiveness, the approach enables them to express their problems and therefore regain control over difficult situations (Bergner & Bateson, 2007; Wimberly, 2012). Social skills and self-esteem are often affected in people who have experienced trauma. Group storytelling is an appropriate tool for improving these areas in children and adolescents because it invites the child to connect with peers (Malchiodi, 2008). People who have experienced trauma have many mental health and

physiological challenges. Stigma disables them from seeking help and reduces their sense of self-efficacy, but storytelling can help counter this, re-establishing what has been lost (Bergner & Bateson, 2007).

Connectedness and Community

Research demonstrate that lack of connectedness was an important risk factor of PTSD (Hobfoll et al, 2007; Solomon, Mikulincer, & Hobfoll, 1986). Hobfoll et al, (2007) stressed the importance of connectedness and community support (Hobfoll, 2007; Norris, Friedman, & Watson 2002; Vaux, 1988). They state that connectedness helps in providing people living in war situations with important information for their survival. Connectedness promotes acceptance of others and offers opportunity for sharing traumatic experiences which lead to important therapeutic factors of normalization and universality (Yalom, 1995).

When it is applied in a group setting, storytelling fulfills traumatized children's need for connection. The need for connection can be satisfied through psychotherapy (Redekop, 2002; Valenzuela-Pérez, 2014). In the same context, Bergner and Bateson (2007) argue that stories capture children's attention, enabling them to connect to its therapeutic messages and retain these messages through the story. Moreover, Hobfoll et al. (2007) state that storytelling has a positive influence when applied to intergenerational families as it enhances connection between group members. Similarly, Veerman's (2004) tent story intervention shows how participants connect to each other telling and listening to stories, each story building upon the story that was told before.

Hope

Numerous therapists maintain that storytelling instills hope in people, helping them to move forward and project into their future (Hobfoll et al., 2007; Veerman, 2004). Wimberly (2012) explains that a story with complicated events and a happy ending gives hope to its listeners, inspiring them to think of potential solutions to their own problems. Barudy (1998) highlights that hope is particularly essential for trauma patients who have experienced war.

Both the literature on storytelling and my own experiences corroborate the multiple arguments made about storytelling helping refugee children.

Accessibility

It is clear that storytelling benefits child refugee treatment in many important ways. My hope is that in addition to being beneficial, storytelling may also increase trauma treatment accessibility for cultural minority communities. Mental health stigma is an important barrier making it difficult for child refugees to access mental health services. Sewilam et al. (2015) state that in Middle Eastern countries, this stigma blocks people from asking for the help they need. Therefore, it is crucial to choose a non-stigmatised technique when considering how to apply psychotherapy to Syrian refugee children. It is possible that parents would be more open to using storytelling than other psychotherapeutic treatment methods.

The reality of professional regulations and licensing makes it such that only trained mental health professionals are able to intervene with child refugees' mental health support, and this acts as an accessibility issue, making it more challenging for children to access healing. Therapeutic techniques such as Eye Movement Desensitization and Reprocessing (EMDR), Narrative Exposure Therapy (NET), Child-Centered Play Therapy (CCPT), and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) require specialised training and licensed professionals

for implementation. In order to increase child refugees' access, researchers have tried to create school-based techniques that do not need therapists for implementation (Brymer et al., 2008).

Numerous studies recommend community-based interventions when working with child refugees (Brymer et al., 2008; Ehntholt, Smith, & Yule, 2005; Montgomery, 2010; Wolmer, Hamiel, Barchas, Slone, & Laor, 2011). The many Syrian refugee children currently living in Montreal would greatly benefit from more research conducted about the feasibility of trauma-informed storytelling methods being used by parents, religious figures, teachers and other non-psychotherapy professionals. My hope is that this would reduce the stigma of accessing trauma treatment as well as many financial barriers, geographical and time constraints that are associated with engaging in more formal psychotherapeutic processes. Storytelling is an accessible tool that people use naturally with little or no training. Its accessibility is of great importance that should be studied further in the treatment of refugee children around the world.

Cultural sensitivity

Storytelling has important implications for cultural relevance when working with Syrian refugees. Cultural sensitivity has been a critical aspect in the mental health field for decades (Asnaani & Hofmann, 2012; Draguns, 1997; Seiden, 1999; Sue,1977; Sue & Zane, 1987; Sue, Zane, Nagayama Hall, & Berger, 2009; Vandenberghe, 2008; Wohl, 1989). What is more, it has been considered as an ethical obligation (Pedersen & Marsella,1982). Fortunately, there has been a growing demand for multiculturalism and cultural competency in psychotherapy especially in countries characterized by their cultural diversity (Pistole, 2004; Sue et al 2009, Whaley & Davis, 2007). Similarly, Drama Therapy highlights the importance of "commitment to cultural responsibility" as a way to effectively achieve therapeutic goals (North American Drama Therapy association, 2015). As previously mentioned, storytelling is an integral part of Syrian

culture (Alittihad, 2010; Howes, 2016; Sheppard 2003) and children rearing. When storytelling is applied from a Drama Therapy perspective, its familiarity may increase therapists' ability to connect with Syrian children refugees.

Chapter 7. Conclusion

As a drama therapist and psychotherapist, mother, and former refugee from Lebanon, I examined how storytelling remains a vital intervention for myself and for traumatized refugee children. All arguments speak in favour of the implementation of storytelling as an intervention tool for this population. Storytelling connects with many trauma informed approaches, including the CAP Treatment Protocol, and Hobfoll et Al. 2007 five essential elements of immediate and mid-term mass-trauma intervention. I have also been able to demonstrate how storytelling is culturally relevant and developmentally appropriate for Syrian refugee children.

Most treatment methods for traumatized children engage storytelling in some form. Cognitive Behavioral Therapy (CBT), Narrative Exposure Therapy (NET), testimonial therapy, Eye Movement Desensitization and Reprocessing (EMDR), and prolonged exposure therapy all rely on the trauma narrative of children for treatment. Some approaches engage with more distance, using fairytales, myths and fictional stories (Brymer et al., 2008; Rousseau & Guzder, 2008; Valenzuela-Pérez et al., 2014), while others ask children to engage in the real life trauma narrative at the onset of treatment (Rousseau et al, 2003; Veerman, 2004). Sometimes the therapist tells the story, and other times the children tell the story. The differences between storytelling approaches are multiple, as are their benefits.

This research has inspired me to own the importance of storytelling in my personal life and in my practice as a drama therapist. I hope that it leads to more committed work in

developing storytelling workshops with Syrian newcomers in Montreal, and an attempt to produce further research measuring the efficacy of storytelling interventions with this population.

Dear reader, as this research story comes to an end, I conclude by thanking, my audience for engaging in the drama therapeutic process of witnessing. You have listened/read my story throughout the above 40 pages. You have learned about my multiple journeys with storytelling and the story of how this research came to be. I share my desire for us to enter this relationship of storyteller and listener once more, in the near future, I hope to contribute to the domain of drama therapy by adding empirical research to the field as well as study how storytelling may be used by paraprofessionals, parents and other responsible adults in the healing of refugee children. Stay tuned for further stories told by Katia El-Eter.

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