The Empowerment Project: Construction of a Drama Therapy Program for Children Affected by War

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ABSTRACT

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Millions of children are living in unsafe environments, due to warfare. This affects these children on many levels, and can lead to enormous psychological long-term effects. This paper explores the literature on some treatment methods that have been found effective in the past when working with children living in warzones. These include cognitive behavioral therapy, eye movement desensitization and reprocessing, testimonial therapy, narrative exposure therapy, play therapy, and art therapy. From a comparison of the findings I learned that exposure and desensitization seem to be an important aspect of trauma-treatment. I have also investigated the literature on drama therapy and trauma treatment for children. This search resulted in a rational for drama therapy as well as ideas to incorporate gradual exposure to the traumas through play and story. From the information gathered from other treatment modalities, as well as drama therapy theories, I have attempted to provide a model for a drama therapy program consisting of three phases.

The past, despite its wrenching pain, cannot be unlived, but if faced with courage, need not be lived again.

Maya Angelou

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Introduction

I grew up in a very small village in the South of The Netherlands, with everything a child could wish for: two loving parents, a safe home, plenty of food, easy access to education, and lots of time to play. But even as a small child in her safe little cocoon, I have always been very conscious of the fact that there are children living in the same world that are not as privileged as I am. And ever since I can remember I have searched for ways to make a difference. In the process of becoming a drama therapist for the past six years everything came together and I came to realize that I could use drama therapy to make a small, but meaningful change in the lives of children, living in unsafe environments.

Research by UNICEF (1996) estimates that 2 million children have been killed due to war-related injuries, 4 million have been disabled, 1 million orphaned, and 12 million are dislocated from their homes. From the World Health Organisation's (WHO) Global Burden of Disease Project we learn that less than 9 percent of causalities due to intentional violence occur in high-income countries and thus over 91 percent in low to middle-income countries (WHO, 2008). We can conclude that violence is a problem that seems to affect our most vulnerable people the greatest. This makes research about prevention as well as recovery from violence very valuable.

Two years ago I lived in the Palestinian Territories for six months where I worked as a drama therapist with children living in a village and various refugee camps under constant threat of violence from the army and settlers living nearby. The children I worked with had been exposed to violence on a daily basis ever since birth. I could see how the circumstances these children live in affected their development. Many of the

children showed aggressive behavior, difficulties concentrating and they had issues in trusting others, especially outsiders. Seeing the circumstances these children grow up in, I could understand these children's reactions and an immense feeling of powerlessness and anger at the injustice came upon me. At the same time I was amazed by the strength and resilience these children showed, as well as their ability to support and protect each other, showing me there is hope. I tried to provide these children with a safe place where they could freely express themselves through play.

However, I felt I did not have enough to offer these children and decided to go back to school to further study drama therapy, in order to specialize in working with traumatized children. In this paper you can read the results of my search for a way to work with children, like the children I met two years ago in Palestine, in order to empower and support them and help them change their future.

Research Methodology

Before I will describe what I learned in this research, I will first elaborate on how I collected this data and how I analyzed it. In this first part of the paper I will explore and describe the research methodology that was used in conducting this research.

Statement of Purpose

The purpose of this study is to collect information about effective treatment methods and interventions in order to construct a drama therapeutic treatment model to help traumatized children living in warzones. The results of this study will help therapists who work, or plan to work with this population in their practice, offering some guidelines for the focus of treatment. The framework offered here can provide several professionals with a guide for treatment. By using a common framework, further research in this field

can be compared, thus making it more cumulative. As such, this study is intended to be a first step towards a stronger research program on the treatment of children affected by war.

Assumptions.

It is my assumption that drama therapy has additional value in the treatment of traumatized child war survivors compared to better established treatment methods, like cognitive behavioural therapy (CBT). I am also assuming that drama therapy can effectively incorporate techniques from other modalities, like exposure techniques. A third assumption is that techniques developed for treatment of trauma which is not caused specifically by war can be used in my research. And lastly, I carry the assumption that children do not have to be diagnosed with PTSD in order to benefit from drama therapy. In the settings in which this program is intended to be executed, most children will not have been diagnosed by a psychiatrist. However, seeing the effects living in an unsafe environment has on children, confronted with violence on a daily basis, I am assuming that all of them could benefit from drama therapy.

Operational definitions.

Children: for the purpose of this research I will focus on people in the age range from 8 to 15 years old.

Warzones: An area marked by extreme violence, affecting all inhabitants.

Psychological trauma: damage to the psyche as a result of either living or witnessing a traumatic event

Traumatic event: Event that is (perceived as) threatening to someone's life or physical integrity.

Research Questions

In this research I tried to find the answers to the following questions, consisting of one primary research question and two subsidiary questions.

Primary research question.

How can drama therapy be used to address the psychological trauma experienced by children in warzones?

Subsidiary research questions.

1. What are common therapeutic methods for addressing the psychological trauma experienced by children in warzones and how do they compare to drama therapy?
2. What factors inform the focus of the drama therapy when working with children affected by war?

Study Design

From the literature it appears there is an interest for the development of practical methods in treatment of PTSD (Johnson, 2009; Möhlen, Parzer, Rench, & Brunner, 2005; Onyut et al., 2005; Smith, Perrin, Yule, & Clark, 2010). My goal is to describe how drama therapy can be used to address the psychological trauma experienced by children affected by war. Data will be collected from the literature and connections between more evidence based interventions and drama therapy will be made in order to start the development of a drama therapeutic treatment protocol for helping child war survivors. A construction paper seems to be the appropriate research method in order to answer the research questions.

Construction research is part of the area of theoretical research. Construction research incorporates many of the techniques of the historical-documentary method in the

sense that it is also a critical analysis and synthesis of sources in the literature in order to explain a certain phenomenon or explore an issue thoroughly. The difference is that construction research takes it one step further and has as its goal to produce a useful product, based on this analysis. (Concordia University, 2009)

Junge and Linesch (1993) point out in an article about research in the field of creative arts therapy, that theoretical research can be of value in the development of a more integrated, comprehensive and powerful theory. The authors describe the goal of this kind of research as: "Theoretical research, including critical theory, critiques and integrates existing theories in an attempt to generate new knowledge and theory." (p. 66).

Kumar (2005) explains in his book that we can classify research from three different viewpoints, being: application, objectives and inquiry mode. I will use Kumar's model to clarify the research methodology of this paper. If we look at this research from the perspective of its application, we can say that it is purely theoretical at this point in time and there is no direct practical application of the results. Kumar calls this pure research. From an objectives point of view, there are four different categories for research, being: descriptive, correlational, explanatory and exploratory. The goal of this research is to describe the effects of war on children and treatment methods as found in the literature, but it also looks at similarities between these treatment methods. We could therefore say that this research is both descriptive and correlational. This study is also exploratory in a sense, because there is so little known in this field, and I am exploring the possibilities for drama therapy with this population based on the correlations I found between other treatment methods. The last classification for research according to Kumar is that of inquiry mode, consisting of two categories, namely quantitative and qualitative. This

research is qualitative in nature, because it does not aim to collect statistical data, but rather to describe and investigate the effects of war on children and possible treatment methods (Migchelbrink, 2004).

Data collection.

All data used in this research is collected from relevant literature. I have studied research and literature relevant to children, trauma, war, drama therapy and other methods of treatment often used with this population, such as exposure therapy. I also took a course about treatment of war trauma at McGill University in May 2010. The information I gathered there, as well as in classes that are part of the program Creative Arts Therapy - Drama Therapy Option at Concordia University, is used in this research when relevant. In order to create a sufficient degree of validity to this research, I have collected my data from a diverse collection of articles and books. I have aimed to gather articles from a theoretical perspective, as well as case studies and research from the field. In that way I was able to gather many different perspectives, from different professionals. This research is based on case studies from around the globe and within different modalities, theories from several different treatment methods, as well as studies after the effectiveness of these interventions.

Data analysis.

The information collected was analysed through coding, which is a technique based in grounded theory (Migchelbrink, 2004). For each article or book chapter code words were written down which represent different themes relevant to my research questions. The gathered information was then further critically analysed by examining similarities as well as differences in the research and methods in the literature. My goal throughout this

process was to make connections between theory and research from the field of drama therapy and other, more established and researched methods of treatment in order to eventually develop a drama therapy program for children affected by war.

Results

In this section of the paper I will provide a summary of my findings. I will start with a description of what trauma is and how war trauma impacts children's development. Then I will explore what resiliency is and how this can be important in therapy, followed by an exploration of common methods in the treatment of trauma. Secondly I will look at trauma through the lens of drama therapy and explain why drama therapy can be a useful intervention in working with children affected by war, based on my findings in the literature. Then I will explore cultural considerations I consider important to keep in mind when working in non-Western cultures, including considerations when working with interpreters. Lastly I will present a phased drama therapy model, based on my findings, which I named The Empowerment Project.

The Effects of War on Children

Trauma is a word used very often in our day to day language. A friend of mine claimed to be traumatized by a delayed train and my roommate used the word traumatizing to describe his experience spending Christmas with his family, because his mother embarrassed him with singing a song. In order to have the least confusion possible in this research it is important to define what I mean when using the word trauma.

As described in the operational definitions, I define trauma as damage to the psyche that affects a person's daily functioning, as a result of either living or witnessing a

traumatic event. A traumatic event is an event that is (perceived as) threatening to someone's life or physical integrity (American Psychiatric Association, 2002). Van der Kolk (2005) points out that at the core of trauma lays a debilitating loss of control (see also: Goodyear-Brown, 2010).

One can imagine that every child living in warzones must witness and/or live several traumatic events, which leads to what we call complex trauma (van der Kolk, 2010). However, children in war torn countries are rarely seen by psychiatrists and therefore often have not been labelled with a DSM disorder. In this research I will not focus on a specific diagnosis, but rather look at the effects it has on children to live surrounded by violence in a search for a way to help them.

Several studies show the effects of living in an unsafe environment like war on children (Ahmad, Mohamed, & Ameen, 1998; Baker & Kanan, 2003; Bosnjak, Vukovic-Bobic, & Mejaski-Bosjnak, 2002; Cairns, 2001; Ehntholt, & Yule, 2006; Goldson, 1996; United Nations, 1996; Walton, Nuttall, & Nuttall, 1997). These studies show that conflicts hurt children both physically and psychologically. Armed conflicts affect children in their bodies because of the effects of injury, torture, sexual violence or the multiple deprivations of war that expose them to hunger or disease. In this research I have focused on the psychological impacts of war on children. The psychosocial impacts of violence on children are as severe as, if not more severe than, physical wounds. Children respond to the stress of armed conflict with increased anxiety, withdrawn behaviour, sleep disturbance and nightmares, lack of appetite, learning difficulties, developmental delays, and aggressive behaviour. (see also: Elbedour, ten Bensel, & Bastein, 1993)

Shaw (2003) explains that "[t]he impact of war-related stressors may occur as the direct result of physical and visual impact, media exposure, or through the various forms of interpersonal experiences" (p. 237). Duffy and Gillespie (2009), in their chapter on therapy in the context of ongoing civil conflict and terrorist violence, point out that trauma reminders are often very prominent and in many post-conflict areas victims are likely to meet a former perpetrator. This can cause the traumatized person to have intrusive memories of past trauma. However, Duffy and Gillespie argue that prevention and treatment of PTSD is possible even when the conflict is still ongoing.

Duffy and Gillespie (2009) explain that comorbidity is very common among survivors of civil conflict and terrorist attacks. Complicated grief, panic disorder with agoraphobia, and major depression are examples. Cloitre et al. (2009) show that exposure to multiple traumatic events, influences the presence of complex PTSD symptoms in both childhood and adulthood. The authors show us that the greater the trauma exposure, the more complex symptom presentation occurs, and consequently they state that the current definition of PTSD is not always sufficient in capturing all the symptoms involved. Especially when it comes to childhood trauma the authors argue for a new diagnosis, considering the wide spectrum of effects trauma has on a child's development. Van der Kolk (2005 and 2007) shares this opinion and has proposed a new diagnosis for children with complex trauma histories which he named Developmental Trauma Disorder.

De Jong et al. (2001) did research after risk factors for PTSD in 4 post-conflict, low-income areas, namely: Algeria, Cambodia, Ethiopia, and Gaza. This research shows that "[t]he determinants and prevalence of PTSD vary with context" (p. 561). This makes it difficult to predict the effects of life in conflict-areas on people's psyche, especially since

every conflict as well as every person is different. However there is evidence to be found in the literature that exposure to cumulative trauma increases the risk for emotional distress (Ehntholt & Yule, 2006). In other words, the more a child is exposed to traumatic events, the more likely she will develop mental health difficulties.

According to Shaw (2003), adult's and children's psychological responses to trauma are very similar except that, because children are still developing physically, emotionally, cognitively and socially, trauma can interfere with their natural development to becoming a healthy adult. A child is in the process of separation and individuation and still has to figure out who she is: to define what is self and what is other (see also: Van der Kolk, 2007). Also, a child is in the midst of consolidating adaptive mechanisms for coping with stressors, both internal and external. Because of the developmental stage in which a child finds herself, exposure to war related stressors can affect the "elaboration and consolidation of personality structures, identity formation, adaptive and coping mechanisms, internalized standards of right and wrong, intrinsic mechanisms for modulating aggressive impulses, the habitual mode of relating to others in addition to having enduring neurobiology consequences." (Shaw, 2003, p.238)

Van der Kolk (2005) explains that traumatized children often experience developmental delays in cognitive, motor, language, and socialization skills. Young children have no choice but seeing themselves as the centre of the universe and they will therefore connect everything that happens to their own sensations. Van der Kolk states that "being left to their own devices leaves chronically traumatized children with deficits in emotional self-regulation" (p. 404). Living in a warzone causes children to feel unsafe, often combined with a loss of caregivers. This can lead to a lack of a continuous sense of

self, problems with intimacy and relationships, and poorly modulated affect and impulse control, including aggression against self and/or others. Furthermore, chronically traumatized children can suffer from nightmares, flashbacks, dissociation, difficulties concentrating, amnesia, and hypermnesia. (Van der Kolk, 2005).

The effects of trauma exposure on children can be divided into problems of affect, behavior and cognition. Affective problems: difficulties in regulating emotions like anger, sadness and anxiety. Behavioral problems: avoidance of reminders of the trauma, oppositional behavior, difficulty separating from parents, regressive behavior, and re-experiencing the original trauma. Cognitive problems: distorted ideas about why the trauma happened, thoughts of shame and worthlessness, self-blame, and loss of trust. (Cohen & Mannarino, 2008)

Every child responds different to traumatic events and it is therefore hard to make any generalizations. However there is some research in which it is found that in general girls are more vulnerable to symptoms such as anxiety and depression, whereas boys seem to manifest more disruption in their behavioral adaptations, such as aggressive behavior (Shaw, 2003). Elbedour, ten Bensel, and Bastein (1993) have found some studies indicating that boys suffer more psychological problems than girls in the aftermath of war trauma. It should be noticed that only few studies exist to support these findings (Burke, Moccia, Borus, Millstein, and Beasley, 1982; Lifshitz, 1976; Milgram & Milgram, 1976).

In a review of studies on the effects of war on children Elbedour, ten Bensel, and Bastein (1993) conclude that living in a warzone is of bigger emotional impact on a person’s life than any other event. A child might not always manifest symptoms in the

immediate postwar years but it is still possible for them to suffer emotional distress years later when the trauma resurfaces, and even following generations might be effected. (Elbedour, ten Bensel, & Bastein, 1993)

Lastly I would like to mention that children involved in war often have feelings of revenge towards the people that harmed them and/or their family and are therefore less willing to reconcile (Bayer, Klasen, & Adam, 2007). There are studies indicating a relation between PTSD symptoms and aggressive behaviour and considering violence as a means to achieve peace (Ursano & Shaw, 2007). This is very important because the children of today are tomorrow's adults and possibly the ones continuing the war. Elbedour, ten Bensel, and Bastein (1993) describe how the character of children is made by their war experience and how "their behavior [sic] becomes the mirror image of the violent adult world surrounding them." (p. 806). Although more research is needed on the subject, I consider it likely that helping children cope with their traumatic experiences will help them break the cycle and create a better and more peaceful future for themselves and others.

Now that we have clarified how children are affected by war, we can move on and explore how we can help these children. First we will have a look at protective factors that can help children in coping with the stress they experience from living in an unsafe environment. In the literature, these protective factors are named resiliency.

Resiliency.

As pointed out before, every child responds differently to a traumatic event; some children are heavily affected while others seem to bounce back to 'normal' quite easily. We therefore need to investigate what determines a child's resiliency in order to look at

possible therapeutic goals for helping these children strengthen their ability to cope. There are several factors that influence a child's resiliency. Shaw (2003) explains that "family and social support, shared ideology, religion, and a sense of community may contribute to resiliency, and facilitate a habituation phenomenon as a coping mechanism" (p. 238).

Recent research suggests that genetic factors partly determine how a child responds to trauma (Caspi et al., 2002). Interesting as this may be, there is nothing we as therapists can change about a child's genes and therefore we can't do much with this information in order to help children affected by war. However, it is worth noting that children with pre-existing vulnerability in individual characteristics, such as chronic illness or conduct problems seem to be at greater risk for psychological problems than other children after living through a traumatic event. Individual characteristics like a good temperament, positive self-esteem and the ability to respond spontaneously to new situations all strengthen resiliency in a child. (Ehntholt & Yule, 2006)

Another important factor in resiliency is social support (De Winter, 2007). With social support we refer to family, care givers, peers and teachers that can offer support to a child. Strong social support will protect children against the development of psychopathology following stress or traumatic events. A lack of social support on the other hand, will enlarge the risk for children confronted with any kind of trauma to develop symptoms of depression, anxiety disorders and/or PTSD. (Entholt and Yule, 2006)

Ahmed and Mohamad (1996) conducted research that supports the idea that children cope better with their trauma when in the care of safe attachment figures. The authors

describe a comparison study with orphans in Kurdistan of which half were brought to foster care (in which case a near relative to the child would become the primary caregiver) and the other half was to live in orphanages where a family environment is totally lacking. Results of this research show that children that came into care of a family member had improved on mental health and behavioral problems in a one-year follow-up, more than the children in orphanages (Ahmad & Mohamad, 1996). The significance of parental influence and secure attachment (vs. preoccupied parents) on children's posttraumatic reactions as well as the value of social support is also shown in studies done by Ahmad, Mohamed, and Ameen (1998), as well as Baker and Kanan (2003). Ehntholt and Yule (2006) agree that '[a]daptability and cohesion within families appears to protect the emotional well-being of very young children following traumatic exposure." (p. 1200)

A child's ability to cope seems to depend on individual qualities as well as their environment and the social support coming from the system a child lives in. There is also some evidence from research conducted with Israeli adolescents and a separate study with Tibetan refugees suggesting that a strong belief system with strong ideological commitment to the war or struggle is a protective factor against the development of psychopathology after being exposed to war related traumas (Ehntholt & Yule, 2006). This suggests that a child who is convinced of the need for a struggle and feels personally involved in fighting for a good cause will cope better than a child who doesn't understand or agree with the reason for war.

Now let's ask ourselves the question, what could be the clinical applications of this knowledge concerning resiliency? First of all, when possible it will be important to work

together with the family of the child, in order to help them to be a supportive factor in the child's life (Goodyear-Brown, 2010). Elbedour, ten Bensel, and Bastein (1993) note that the way parents cope with stress is of great influence on the way their children will, which indicates that providing support for the parents will also help their children. Secondly, social support can also be built within a therapy group. Connecting children with each other, giving them the opportunity to share their feelings and stories with each other, and providing a place to experience pleasure together might help children cope with their traumas (Elbedour, ten Bensel, & Bastein, 1993).

We also learned that a child's individual characteristics, like ego strength, can contribute to resiliency (Ehntholt & Yule, 2006). A third conclusion I'd like to make in elaboration of this information is the importance of empowerment as a focus in the treatment of these children, because an increase in self-esteem and ego-strength can also help children cope with trauma.

Common treatment methods

In a practice guideline by the American Psychiatric Association for the treatment of patients with acute stress disorder (ASD) and PTSD, Benedek, Friedman, Zatzick and Ursano (2009) explain that, due to small numbers of subjects, non-standardized measures, lack of replication, variable inclusion criteria, and inadequate controls, "the generalizability of findings from available studies on treatments for PTSD is limited" (p.2). Research is very limited on the subject, but there are some interesting studies about the effectiveness of certain treatment methods worth mentioning.

Ehntholt and Yule (2006) name cognitive behavioral therapy (CBT), Testimonial psychotherapy, Narrative exposure therapy (NET) and eye movement desensitization and

reprocessing (EMDR) as promising treatments for war-related PTSD. Johnson (2009) points out that it is CBT that rules the field of trauma treatment at the present, because it is the best researched and can therefore proof its efficacy better than other treatment methods.

The Institute of Medicine of the National Academies (IMNA) conducted research to assess scientific evidence on different treatment strategies as reported in the literature since 1980 (IMNA, 2008). This research was commissioned by the Department of Veterans Affairs, but is not limited to research on treatment of veterans. In the results of this assessment it appears that the treatment modality most represented in the research is CBT. IMNA assessed 52 studies of which 23 concerned exposure-based treatment, which is an aspect of CBT. They conclude that there is sufficient evidence for efficiency of exposure therapy in PTSD. IMNA did not find enough studies done on the efficacy of other psychotherapy modalities, to draw any other conclusions. This does not mean that other treatment methods are not efficient, but rather that there is more research needed.

In the following section of this paper I will describe common treatment modalities as described in the literature about working with traumatized children. I will conclude with an exploration of commonalities between the different methods.

Cognitive behavioural therapy.

The field that is best represented in the literature when it comes to trauma treatment is cognitive behavioural therapy. Benedek et al. (2009) write about exposure based CBTs as an effective, short-term treatment method for people with psychological trauma. In a review of studies done since 2004 they found that trials of exposure based CBT "included components of psychoeducation, breathing, and relaxation training." (p. 6). As the name

does suggest, re-exposure to the traumatic content is also involved in this treatment modality. This exposure usually happens through storytelling, listening to the story and/or visual images.

Trauma-focused cognitive behavioural therapy (TF-CBT) is an evidence based treatment for traumatized children and their parents (Cohen & Mannarino, 2008). This method is well researched and used in different situations all over the world including in response to natural disasters and terrorism. TF-CBT is a short-term program, which makes it very applicable to work in the aftermath of disasters. TF-CBT consists of eight components: psycho-education, parenting skills, relaxation skills, affective modulation skills, cognitive coping skills, trauma narrative and cognitive processing of the traumatic event(s), in vivo mastery of trauma reminders, conjoint child-parent sessions, and enhancing safety and future developmental trajectory. Goals are to first learn skills that will help the child cope and to then create a narrative of the trauma in order to 1) overcome avoidance of traumatic memories; 2) identify cognitive distortions (like self-blame); and 3) contextualize the traumatic experience into the larger framework of the child's life (to make meaning, to realize she is more than just a victim). The child will be gradually exposed to trauma reminders and gain in vivo mastery. Important in the TF-CBT-model is the participation of parents. Parents are often an extra source of information, but can especially be seen as an important support for the child. The last phase of treatment is gained towards the future. Its goal is to provide the child with safety-skills and prepare her to deal with possible difficult situations in the future. (Cohen & Mannarino, 2008).

In a cognitive therapy treatment for PTSD related to civil conflict the focus lies on what Duffy and Gillespie (2009) name cognitive restructuring, which entails changing certain delimiting convictions a client has. By exploring the ideas and thoughts that go through a client's head and limit her in her daily functioning, therapist and client challenge these thoughts and search for alternatives together. Many of these thoughts involve self-blame, anger and fear. In this treatment protocol desensitization through telling and re-telling the traumatic memories is an important tool. (Duffy & Gillespie, 2009)

Young (2009) raised the question of where to start and what to focus on in the exposure-based treatment in cases of multiple or chronic trauma exposure as is mostly the case when working with children affected by war. One could focus on those memories that are affecting the client most, possibly manifesting as flashbacks or nightmares, but Young argues that in order to deal with certain convictions about self and others, which limit a client's functioning and happiness, it is necessary to explore a client's entire traumatic history.

Narrative exposure therapy.

In narrative exposure therapy (NET) a client is encouraged to create a timeline from birth to present, involving a detailed description of all traumatic events that happened, but also other important events are included. The reason for this is that important positive events are also of influence on how a person thinks, feels and behaves at this time in her life. (Schauer, Neuner, & Elbert, 2005). Schauer et al. (2005) argue a contradiction of Maslow's hierarchy of needs by saying "mental health is a pre-requisite of self-efficacy and meeting one's basic needs" (p.23). Therefore, the authors argue for the importance of

immediate psychosocial care after disasters together with taking care of the basic needs for safety and health.

NET is a short-term treatment method, based on principles from exposure treatment in which a process of desensitization occurs while the client is repeatedly reminded of the traumatic memory in as much detail as possible as well as being coached in calming their physiology. The story of the traumatic events is told by the client and recorded by the therapist. Then the story is repeated while monitoring the client's stress level. Through relaxation techniques the client is trained to calm herself down. The goal is to create a coherent narrative, documented by the therapist, which can function in the desensitization process as well as in helping the client to regain dignity and justice. The therapist helps her client to remember details of the traumatic events, by exploring cognitive, sensory and physiological, behavioral, and emotional aspects of the memories. It is important to finish a narrative once the client starts telling her story. (Mueller, 2009)

Onyut et al. (2005) studied NET as a treatment for child war survivors with PTSD and found that NET can be a safe and effective treatment for those children living in refugee camps in Africa. The researchers found significant symptom reduction right after treatment and in a nine-month follow-up these treatment outcomes were sustained.

Narrative exposure therapy for children (KIDNET) is a short-term approach based on the principles of narrative exposure therapy as I described above adjusted specifically for children. In KIDNET the child creates a detailed chronological account of her history, particularly traumatic experiences in story and art (Schauer, et al., 2005). This creative approach makes therapy more accessible as well as enjoyable for children.

A comparison study between KIDNET and meditation-relaxation protocol (MED-RELAX) as a short-term interventions for children traumatized by war and Tsunami in Sri Lanka shows that both are effective in decreasing PTSD symptoms (recovery rates: KIDNET: 81 % and MED-RELAX: 71%). In MED-RELAX a child is trained in relaxation and meditation techniques and encouraged to practice at home. It should be mentioned that the meditation-relaxation techniques are culturally very appropriate for children in Sri Lanka and might therefore not be as successful in other cultures. NET has been researched and found efficient in several different cultures. (Catani, Kohiladevy, Ruf, Schauer, Elbert, & Neuner, 2009)

Testimonial psychotherapy.

Testimonial psychotherapy is specifically designed for people who survived torture and other severe human right violations. In this treatment the client is asked to talk about what they have experienced and this is recorded by the therapist, often using a tape recorder. These recordings are then revisited by the therapist and client, and the client has the opportunity to rearrange fragmented memories of the traumatic events and a written document of the events is created. This document can be presented to human rights organizations as evidence for the abuse, which makes the purpose of this treatment also sociopolitical. (Ehntholt and Yule, 2006)

There is not much research done on the effectiveness of this treatment, but some clinical observations and case studies show a decrease in symptoms of distress, PTSD and depression in survivors of torture, imprisonment, political persecution as well as adult political refugees (Agger & Jensen, 1990; and Weine, Kulenovic, Pavkovik, & Gibbons, 1998). There is no literature on the use of this approach with children, but three

case studies describe the method as effective with adolescent Sudanese refugees (Lustig, Weine, Saxe, & Beardslee, 2004).

Eye movement desensitization and reprocessing.

Eye movement desensitization and reprocessing (EMDR) is another short-term intervention, which involves a combination of both exposure and distraction. While recalling a traumatic event the client is exposed to bilateral stimulations. Usually this is done in the form of eye movements, but tones or tapping are also used. So while the client is recalling her traumatic memory she has to follow a light with her eyes, hears short sounds in her ears or is tapped on the shoulders. There is no well-established theory explaining the mechanism of action of EMDR, but according to its founder Francine Shapiro, EMDR neutralizes the traumatic memories by reprocessing the information while both hemispheres of the brain are activated. (Shapiro, 1995)

Oras, Cancela de Ezpeleta, and Ahmad (2004) conducted a pilot study examining the effects of EMDR in the treatment of traumatized refugee children. This study shows significant improvement in the functioning level of these children after treatment. Another study, done by Ahmad and Sundelin-Wahlsten (2008), also shows positive results in the use of a developmentally adjusted EMDR-protocol with traumatized children. As the authors point out “the similarity of the structured EMDR technique and its components to the principles of cognitive psychotherapy is striking. The cognitive character of the EMDR makes it suitable for child applications as various cognitive therapeutic techniques do.” (p. 131). Both these studies should be interpreted with some caution because of the small sample size and lack of a control group. More research

involving control groups is needed to prove the effectiveness of EMDR in comparison to other treatments.

Art therapy.

In a review of 12 studies involving art therapy with traumatized children Eaton, Doherty, and Widrick (2007) conclude that art therapy appears to be "an effective method of treatment for the negative psychosocial consequences of childhood trauma"(p. 261). The authors point out that art making seems to be an excellent medium for building rapport between child and therapist. The therapeutic relationship is very important in any kind of treatment.

War Child Holland examined the effects of a creative workshop intervention on the psychosocial wellbeing of children in Kosovo (de Graaff, 2006). In these creative workshops children had a chance to participate in activities involving art, drama, movement and sports. The workshop cycles were adjusted to the specific needs of the children in group, but all groups started with structured, high-energy activities and would later move on to more challenging, demanding activities. The research provides some evidence that these "creative workshops can have a beneficial effect on social behavioural skills, thought skills, and attention skills of the children involved" (de Graaff, 2006, p. 5).

Play therapy.

The well established play therapist Ann Cattanach (2008) explains in her book about play therapy with abused children how play therapy can be beneficial for children who have survived trauma. Play therapy is based on the principle that "play is the most important way that children make sense of the world" (Cattanach, 2008, p. 55).

According to Cattanach children use play as a journey of self discovery and the playspace can provide children with a safe environment to do so. Child and therapist engage in play together in order to make sense and give meaning to what happened to them through metaphors. (Cattanach, 2008)

Goodyear-Brown (2010) wrote a book about her approach to play therapy with traumatized children. This approach is a combination of directive and non-directive play therapy techniques. The author argues that it is important in working with traumatized children to balance non-directive play with more structured activities because a child can be too confused or stuck to be able to move forward on her own, which is when the therapist should have a more directive approach in helping the child to get unstuck. It is important to follow the child's lead and at the same time not to fear to offer some direction or structure when a child is stuck in repetitive play.

Goodyear-Brown's (2010) approach, which she named flexible sequential play therapy for trauma treatment, entails seven components which could be seen as chronological phases of the therapy. These are: 1) Enhancing safety and security; 2) Assessment and augmentation of coping; 3) Soothing the physiology; 4) Increasing emotional literacy; 5) Play-based gradual exposure; 6) Addressing the thought life; and 7) Making positive meaning of the post-trauma self. In her work Goodyear-Brown always tries to work together with the parents or caregivers of the child.

Another play therapy approach for traumatized children is described by Gil (2006) as Trauma-Focused Play Therapy (TF-PT) in which she focuses on the following therapeutic goals: 1) Developing a therapeutic relationship of mutual trust and respect; 2) Identify thoughts, feelings and behavior; 3) Express and externalize important thoughts

and feelings; 4) Manage and regulate expression of affect and behavior; 5) Understand and broaden self-definition, self-regard and feelings of competence; 6) Bring trauma memories into conscious awareness; 7) Integration of memories and creation of narratives of the trauma; 8) Release energy and affect through symbolic expression; and 9) Process the traumatic experience within the family context.

Unfortunately there is no evidence in the literature proving the effects of play therapy with traumatized children, but case studies in both books show us great strengths of this way of working. I will elaborate more on the important qualities of play, beneficial for trauma treatment later in this paper when describing the rational for drama therapy.

Commonalities between treatment methods.

Most, if not all, programs as discussed above emphasize the importance of creating a sense of safety for the client before working directly with traumatic material. Based on the literature review we could conclude that in the first phase of trauma focused treatment therapeutic goals should entail: increasing ego-strength and self-confidence, building good rapport between therapist and client, creating group cohesion (when working in groups), establish trust, and learning coping skills.

Another commonality between treatments lies herein that therapeutic work aims to connect a client's affect, behavior and thought processes of an experience. When describing past trauma the therapist should support the client in focusing on all three categories in order to help them make connections. This will help the client in creating a coherent narrative as well as to gain insight in her own experience.

Often treatment involves some sort of psycho-education for the children and/or their families about trauma and the effects it has on a child. It is herein important to convey the

message that their reactions are normal reactions to an abnormal event. Psycho-education can help clients and their families understand their physical and psychological reactions like hypervigilence, nightmares, intrusive thoughts, dissociation, angry outbursts, somatic responses, etc.

Also important to note is that most of the treatment protocols as discussed above are short-term. Very often time and financial resources are limited when working with this population. It is therefore comforting to know that short-term interventions, like NET and CBT programs are found to be effective. These short-term programs are fairly structured in their organization, providing the therapist and client with a step by step protocol. Less structured interventions, like non-directive play therapy tend to require a more long-term therapeutic process.

From the literature review I have also learned that it is important to find a balance between holding/containing pain and at the same time reconnecting with pleasure (Stepakoff, 2007). This links with the philosophy of Goodyear-Brown (2010) who writes about the importance of allowing the child to move away from the traumatic content when it becomes too painful or overwhelming. Creative means are used in NET to create a safe distance for the child so feelings won't become overpowering. The idea of using both positive and negative major events in creating the narrative also supports this thought.

Drama Therapy and Trauma

Now let us have a look at the possibilities for drama therapy when working with children affected by war. Drama therapists are convinced of the power of play and believe in its healing capacities. Its projective nature allows clients to externalize their

feelings and thoughts which can help them to process what has happened to them from a safe distance where it is in their control. Role play can provide opportunities to practice coping and in play clients can experience pleasure and mastery. For all these reasons I assume drama therapy to be helpful for child war survivors. In this section of the paper I will investigate support for this assumption in the literature.

Garbarino, Zurenda, and Vorrasi (2008) in their chapter in the Encyclopedia of Violence, Peace, and Conflict conclude that it is important to attempt to communicate a message of safety to children living in warzones. The authors explain how creating a safe space for these children to engage in play is essential in this. De Graaff and de Knocke van der Meulen (2007) did research after the effectiveness of a community based program done by War Child Holland in Sierra Leone. In this intervention children were provided with a safe place to play and adults were educated about the importance of play for their children. A survey done among children and adults from the community shows that the intervention has led to positive change with regard to both awareness of children's rights and positive communication and interaction between children and adults. A safe space for children to engage in play is recognized as an important need for children all over the world. Article 31 of the Convention on the Rights of the Child recognizes "the right of the child to rest and leisure, to engage in play and recreational activities appropriate to the age of the child and to participate freely in cultural life and the arts." (Office of the United Nations High Commissioner for Human Rights, 1990, p. 9).

De Winter (2007), in an article about child friendly spaces in Darfur, also argues that it is important for traumatized children to have a safe place where they can engage in

recreational activities together in order for them to cope with their traumatic history. It is important to provide a space where these children can "fulfil basic social needs such as a sense of connection, relationships with peers, developmental stimulation and personal attention by caring adults." (p. 61).

Landy (2010) in an article about drama as a means of preventing post-traumatic stress following trauma points out that in drama therapy we can use the playspace as a safe place to re-enact an actual event, so that "the player and/or observer of the play can discern a safe way to see it more clearly and to cope with its consequences, thereby discovering a certain degree of mastery and balance."(p. 8). In dramatic play the traumatized child can experience mastery which can empower the child and increase the ability to cope with what has happened. At the core of trauma lies a feeling of loss of control, therefore empowerment should be an important therapeutic goal in the treatment of traumatized children (Goodyear-Brown, 2010).

An important aspect of drama therapy is its use of metaphor and symbolism in order to express difficult stories, emotions and thoughts from a safe distance. Stepakoff (2007) writes about the healing power of symbolization in the treatment of war survivors. According to the author, psychological functions of symbolization are threefold. First of all, the act of giving form to an internal experience outside of oneself in words, art, scene work and/or movement, causes a sense of relief and comfort. Secondly, externalization leads to transformation. Once an internal experience is externalized we can have a better look at it and it becomes playable, movable and changeable. And lastly, symbolization opens up the possibility of being understood by others. In sharing ones inner pain in a symbolic way, others can relate and this can be a great source of support (Stepakoff,

2007). As pointed out earlier, social support is an important factor in building resilience and therefore and important goal in therapy.

Goodyear-Brown (2010) argues that play is appropriate in the work with traumatized children because it is developmentally appropriate, offers the child a sense of power and control and is inherently fun and as natural to children as breathing. It makes sense for a therapist to meet children in the playspace, because it is very natural for children to use play in order to make sense of the world. Gil (2006) supports these thoughts by stating that where adults tend to talk about their traumatic experiences in order to process them, children are prone to play out these experiences.

Children tend to communicate their traumatic experiences by repeating it in their play and fantasy lives (van der Kolk, 2005). Repetitive play seems to be a child's natural way of gradual exposure. "The intent of post-traumatic play appears to be mastery and control through repetition." (Gil, 2006, p.157). To explain this further Gil (2006) explains how "children's ability to externalize and narrate their stories through action can allow for gradual integration of feared affect or cognitions" (p. 157). Repetitive play therefore seems to be a natural and healthy way for children to express their stories and find ways to cope with their stress and experience mastery. However, Gil does warn of the dangers of what she calls stagnant posttraumatic play in which children are stuck in repetitively enacting their trauma without any change or movement. This stagnant posttraumatic play can be harmful when it is not helping the child to relieve anxiety, because it will not make any shifts happen in the child's experience.

According to Van der Kolk (2005) treatment must focus on three primary areas: establishing safety and competence, dealing with traumatic re-enactments, and integration

and master of the body and mind. Van der Kolk (2007) also describes how play, soothing physical activities, and sensory integration techniques are essential in helping traumatized children to acquire skills essential to deal with and master their emotional and physical distress. Drama therapy can be an excellent method to incorporate these aspects.

Rousseau et al. (2007), in a pilot study of the effectiveness of a classroom drama therapy program for immigrant and refugee adolescents, consider drama an excellent means to work preventively with young people who have been exposed to war and violence. The authors name advantages of drama such as the non-verbal expression which eliminates language barriers, the opportunity to explore alternative behaviour in the safety of the play space, metaphorical distance which allows clients to look at and play with very painful content and lastly the interaction inherent to drama helps the clients in social growth.

James and Johnson (1997) use developmental transformations (DVT) in the treatment of combat related PTSD in war veterans. This case study involves adult clients, but is none the less interesting for this research because of the observed and described function of the playspace. According to James and Johnson, the playspace functions as a safe container for all the anger, shame, guilt and grief the clients are experiencing. The authors describe a natural process, in which clients will expose themselves gradually to traumatic content and under guidance of the therapist they can learn to master their experience again.

Drama therapy seems to be an applicable treatment modality for children affected by war. To provide drama therapy for children in warzones it is essential for the therapist to make herself knowledgeable of the political, social and cultural situation and history of

the area she plans to go to. In the next section of this paper I will pay some attention to important cultural considerations.

Cultural Considerations

As Abramowitz and Kleinman (2008) point out, the history of mental health interventions is stained with attempts to use psychological interventions for social control in areas of violence and uncertainty. The authors argue for the need for understanding of power and culture in order to do no harm. I consider it therefore important to be sensitive to the fact that this program will most likely be executed in a non-Western, collectivistic culture.

The Inter-Agency Standing Committee (IASC) has established guidelines on Mental Health and Psychosocial Support in Emergency Settings in which cultural awareness and the need for a holistic, contextualized framework for understanding suffering and resiliency are emphasised key issues (IASC, 2007).

Coleman, Parmer, and Barker (1993) point out that the history of counselling is rooted in a Euro-American, middle class culture where individualism, hard work and perseverance are considered important aspects of success. It is important to realize that these values might be different in other more collectivist cultures, and as therapists we should be sensitive to these cultural differences. It is important to be consonant with the cultural norms of the society in which we work and we should never try to impose our own values upon the children we work with. Coleman and his colleagues emphasise the importance for a therapist to make herself familiar with the culture of her client.

Fernando (2004) writes about the stigma that surrounds seeking mental health in many cultures and emphasises the importance of cultural sensitivity for mental health

professionals. She especially focuses on including collectivistic perspectives into clinical practice when it comes to assessment and treatment. In order to be affective as a therapist, Fernando argues, the client's belief system and social support systems should be included in assessment of the client's distress and coping strategies. In treatment it is working with groups and storytelling as well as local rituals and practices (such as meditation and yoga in Sri Lanka) that can help in providing a culturally considerate intervention with which the clients feel comfortable. (Fernando, 2004)

Drama therapy has an advantage above other forms of therapy in that its key mode of communication is play. Play is an important element in most cultures and children are usually expected to play and use play in an attempt to make sense of the world. Differences can occur in stereotypical roles and role playing and the therapist should use caution when interpreting this play and always keep the cultural context, values, beliefs, customs and traditions in mind. (Coleman, Parmer, & Barker, 1993)

It might be wise to use culturally familiar games or activities in therapy. Stepakoff (2007), when working in West-African culture, incorporated singing, drumming and the telling of folktales in treatment, because it is already part of the culture there.

Lastly I would like to give some attention to the importance for the therapist to become aware of her own biases towards the culture she works in. A therapist's biases should never become a focus in therapy. To give an example: I remember working with a group of girls in a refugee camp in Palestine. After a few weeks of working with them I was confronted with girls who started wearing their hijab (headscarf). The girls would feel so proud that they were now women and allowed to wear it, but I felt sorry for them. It was very important for me to recognize my feelings towards this cultural phenomenon

in order not to react to it. My role as a drama therapist is not to change their values into mine, but rather to accept the clients as they are, give them a place to freely express themselves and gain confidence, so they themselves feel empowered to make up their minds about what is right and wrong.

Working with interpreters.

A possible obstacle in working in a foreign country is the language barrier. When a therapist is not familiar with the language her clients speak, she has to work together with an interpreter. From personal experience I can say it is not always easy to work with an interpreter, because it alters the communication between therapist and client and because having an interpreter as a third party is of great influence on the therapeutic relationship.

D'Ardenne, Farmer, Rauro and Priebe (2007) describe several different models of the therapist-interpreter-patient relationship in which the role of the interpreter varies on a spectrum from an almost invisible presence towards a cultural consultant or even co-therapist. Important to realize is that in any of these roles the interpreter influences the therapeutic process. D'Ardenne, Farmer, et al. point out that even though there are no consistent guidelines as to how to use interpreters, there is agreement among professionals about the ethical nature of interpreted psychotherapy. Having an extra person there as an interpreter changes the power dynamics and the therapist should be aware of this and make sure that the client understands what the roles of the different people present are. It is important that the client trusts the interpreter and that she agrees to working with an interpreter before therapy starts. It is also important that there is supervision and support for the interpreter to ensure his well-being and knowledge of

what the goals and rationales of therapy are. It is very important that the interpreter knows what is expected of him. (d'Ardenne, Farmer et al., 2007)

Engstrom, Roth, and Hollis (2010) explain that "interpreters must interpret accurately and completely, without embellishing or editing any content from the clinician or the client." (p. 70). The interpreter should translate in order for the therapist to understand what the client is saying, but the interpretation of the client's words should be the responsibility of the therapist. The authors suggest that interpreter and therapist discuss the structure of a session beforehand where possible. Furthermore Engstrom et al. point out that the interpreter should "adopt a non-dominant, pass-through stance that simulates, as closely as possible, a trusting, two-way communication between clinician and client" (p. 70) and continue with stating that an interpreter should be a trained professional rather than a random community or family member. Ehntholt and Yule (2006) add to this that it is important to ensure continuity by using the same interpreter throughout the sessions.

A comparison study of clinical outcomes in three groups of traumatized people receiving CBT (refugees with interpreters; refugees without an interpreter; and English speaking non-refugees) shows equal positive clinical results in all groups, indicating that working with an interpreter can be as effective as monolingual therapy (d'Ardenne, Rauro, Cestari, Fakhoury, & Priebe, 2007).

D'Ardenne and Farmer (2009) name some practical points worth considering when working with an interpreter. According to the authors it is important to meet the interpreters before inviting them into the therapy session. This will give the therapist an opportunity to explain what the therapy entails, and what is expected from the interpreter, as well as to explore possible cultural considerations of importance. It is also very important to provide the interpreter with an opportunity to vent about what happened in

therapy, especially considering the often horrific content of conversation. Supervision might be necessary in order for the interpreter to debrief and process what she is exposed to. This is not only important for the interpreter's wellbeing, but also for the therapeutic process. It is important that the interpreter's biases, feelings and needs stay out of therapy, where the focus should be on the client and interpreter and therapist should be neutral. (D'Ardenne & Farmer, 2009)

The Empowerment Project

From the reviewed literature as discussed above we can conclude that it would be wise to divide treatment for children with war-related trauma into phases. There seems to be a very similar model in most treatment methods we discussed, which we could summarize in three phases, namely: 1) Establishing safety and trust; 2) Trauma-focused therapy; and 3) Reintegration. In the next segment of this paper I will describe each of these phases, including possible treatment goals and activities, based on the results from the research in which I analysed different treatment methods and their commonalities.

We learned earlier that when therapy has to be short-term, it is often best to provide the client with a clear step by step structure with the possibility of flexible adjustments in the best interest of the client. The phase-model I provide here is to be seen as a rough structure which can be used by therapists to create their treatment plan following the needs of the client.

Phase 1: Establishing safety and trust.

In this first phase it is important to build trust and rapport between child and therapist. Safety, predictability and fun are essential in this phase. Therefore activities should be relatively easy, enjoyable and least anxiety provoking. Fun and physically

engaging games are suitable for this phase, in order to make the child familiar with the playspace and the therapist, as well as possible group members.

This phase is also the time in which the therapist can assess her clients. Gil (2006) offers us five topics to explore in assessment when working with traumatized children: 1) determine child's overall developmental functioning; 2) identify current problems and symptoms; 3) identify traumatic impact, if any; 4) get an idea of a child's internal resources; and 5) explore a child's perception of parental support and guidance.

Specifically important in this work is learning about the child's current coping skills, in order to determine what coping skills are going to help this child in the trauma focused therapy and which skills should be worked on beforehand. Mooli Lahad's Six-Piece Story-Making could be a good method to use in order to assess how the child copes with stress (Lahad, 1992). In order to assess a child's support system, the creation of genograms, either on paper or in play, could be helpful.

This phase could also incorporate some psychoeducation in order for children (and their parents) to understand their physical and psychological reactions to the traumatic events they have survived and how this affects their day to day lives. It is important to communicate that the reactions the children are having are normal responses to abnormal events in order to decrease stigma.

It is important to provide the child with techniques to calm her physiology. Cohen and Mannarino (2008) offer ideas to teach relaxation skills to gain mastery over stress responses, such as listening to music, blowing bubbles, singing, progressive muscle relaxation, guided fantasy, yoga and mindfulness exercises, and reading stories.

Other drama therapy activities applicable in this phase to create safety and trust are: trust-games, fictional storytelling, movement to music, and the creation of a hut, or other safe spot, in the playspace.

Phase 2: Trauma-focused therapy.

Once safety and trust are established the therapeutic work can shift its focus towards the traumas the child has survived. This phase has as its goal to express and share the trauma narrative with accompanying feelings and thoughts. Focus should be on connecting thought-processes with feeling and behaviour in order for the child to create a coherent narrative of their experiences.

The goal in this phase is to desensitize the child to their trauma experiences and reintegrate the memories in a way that they will not disable the child any further in her functioning. “Through generic or dynamic posttraumatic play, children contain and manage the memories symbolically by making them concrete … and then manipulating or changing elements of the play, often producing an increased sense of mastery and control.” (Gil, 2006, p. 159).

Creative means can help the child in maintaining some distance from the trauma, and in that way enable the child to work with the painful memories without getting overwhelmed. With projecting the painful content into the play space, it can be seen more clearly and be manipulated and changed by the child, providing her with a sense of empowerment.

Storytelling can be an intervention applicable in this phase. Both Landy (2010) and Stepakoff (2007) write about the use of storytelling to share collective stories in group work with traumatized clients. Hearing other group members telling similar stories can

provide the child with support and recognition. When it is too hard for children to talk about what has happened to them, they can use the metaphor of the story, like a hero's journey, to express their experience, wishes and accompanying feelings.

Other creative means to use in expressing behaviour, feelings and thoughts around the traumatic memories are song writing, play with objects, role play, play back theatre, script writing, poetry, creating a book with pictures, improvisation, dance and movement. It depends on a child's individual preferences, as well as cultural appropriateness which of these would be most effective.

As pointed out earlier, it is very important for the traumatized child to re-connect to their emotions. Children often don't possess the vocabulary to verbally express the often complex feelings they experience. Goodyear-Brown (2010) and Gil (2006) both let their clients use colors to identify feelings, because they feel this gives the child the necessary distance to express them. In drama therapy we can also create some distance towards overwhelming feelings by having others play with our story and witness this, by the use of sculpts, and as mentioned before through the metaphor.

Phase 3: Reintegration.

In this last phase of treatment focus goes out towards the future. (Re)building relationships and a connection with the community is essential for the child to retain the benefits from therapy and the skills learned in therapy have to be generalized in order for the child to be able to use them in the future.

In order to reconnect, children could prepare a small performance for the community in which they share part of their therapeutic journey. This will allow community members to empathize with the children and maybe understand their experience better. A

performance can also have great empowering effects on the children. (Landy, 2010; see also: Emunah, 1994)

In this phase the therapist should encourage the children to explore fears they have for the future and possible situations they might find challenging. Through role play and improvisation these situations can then be explored and the child can practice different ways of responding. This will prepare the children as well as give them confidence.

It is important to make sure the child has people in her life that she can rely on for support after the therapy is over. When a performance doesn't seem feasible, the therapist might invite the children to bring their care givers and/or friends to the last session for a goodbye party. That way, children can share parts of their process with their loved ones, through role play for example.

It might also be a good idea to create something together with the therapist and group members, either in art or in play. This will provide the child with a tangible memory of the therapeutic process you went through together and might serve as a transitional object.

Discussion

Conclusions

War affects children's development in several ways. The impact of living in an unsafe environment, surrounded by violence often combined with the losses of loved ones, affects children physically and psychologically. Every child responds to trauma differently, but common reactions are anxiety, withdrawn behaviour, sleep disturbance and nightmares, lack of appetite, learning difficulties, developmental delays, and

aggressive behaviour. We have seen that a good supportive system, like family, is a protective factor in the development of psychosocial problems.

In this paper I have discussed several treatment methods for traumatized children, namely: cognitive behavioral therapy, narrative exposure therapy, testimonial therapy, EMDR, art therapy and play therapy. We found most evidence in the literature for exposure-based treatment methods when working with children who are traumatized by war.

After a description of these different modalities and their commonalities, we explored the rationale for drama therapy when working with children affected by war and found that drama therapy can provide the child with a safe container (the play space) in which she can express and process traumatic memories from a safe distance.

This paper provides the reader with a phased model for drama therapy with children affected by war, divided in three phases, namely: 1) Establishing safety and trust; 2) Trauma-focused therapy; and 3) Reintegration.

Limitations of Research

The first limitation of this research concerns the lack of evidence in the literature for the effectiveness of drama therapy with war related trauma in children. The conclusions, on which The Empowerment Project is built, are based on theories and commonalities between other, more researched treatment methods. The actual effectiveness of this program has yet to be determined.

The project design is based purely on the literature review and does not include any field research. I consider it therefore very important that, when planning to provide a drama therapy program for children in warzones, the therapist should first of all

investigate the specific needs of the children there and test the applicability of the ideas as described in this paper in reality.

Recommendations for Further Research

As this paper is based solely on theoretical research, the next logical step would be to implement the project ideas and conduct research on the actual results in the field. It would be very helpful to document difficulties one encounters when trying to implement The Empowerment Project, in order to improve it. In addition to existing evaluation methods, I would consider the opinions and ideas of children who participated, as well as their parents', very valuable for pointers towards improvement.

It would also be of great value if we could do some research on the effects of the project on the children that participate in it. In order to do this one should use measurements before, during, and after treatment. Focus could be on reducing symptoms of anxiety, or increasing self-esteem. Standardized questionnaires could be used for this.

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