Field Report

Drama Therapy as a Mental Health Intervention for Women in the Shatila Refugee Camp, Lebanon

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Abstract

Shatila camp is the largest refugee camp in Lebanon and home to many refugees needing psychological support as a result of war and postmigration stress. However, there is a severe lack of mental healthcare resources and strong social stigma towards psychological and psychiatric interventions. This field report describes four drama therapy programmes implemented by Intisar Foundation between 2018 and 2019 in Shatila camp. The first is an intensive five-phase programme that tackled trauma and improved wellbeing. The second, a follow-up, is a long-term programme aimed at providing continued community support. Approaches and techniques used in drama therapy are presented. The impact of the programmes is shown through compiled qualitative findings from over 50 interviews, focus group discussions and subsequent programme reports. The findings include emotional regulation, benefits of movement and exercise, a sense of belonging and changes within the family after the intervention. Drama therapy can be an effective psychological intervention for refugee women as it provides inclusive care and avoids stigma.

Keywords: drama therapy, Lebanon, mental health intervention, Shatila refugee camp

Introduction

Background: Palestinian and Syrian Refugees in Lebanon

Most Palestinians in Lebanon are protracted refugees experiencing low socioeconomic status perpetuated by restricted employment opportunities and generally low-paying and menial jobs (Hanafi et al., 2012). Access to education for Palestinians in Lebanon is limited to The United Nations Relief and Works Agency (UNRWA) for Palestine Refugees in the Near East schools, which are often overcrowded and decrepit, while healthcare services are severely underfunded (UNHCR, 2016).

Due to the 2011 Syrian war, the influx of Syrian refugees further strained existing resources. Syrian refugees face similar challenges, including severe economic challenges, as competition for jobs increased upon their arrival (Atrache, 2020). Additionally, negative attitudes from the host community have sparked racist sentiments towards newly resettled populations, causing feelings of alienation, lack of social support and harassment. The pressure and frustration associated with living in harsh conditions have, in turn, increased cases of domestic violence, bullying and deterioration in mental health (Syam et al., 2019). Further, as Lebanon is not a signatory of the 1951 Refugee Convention (UNHCR, 2015), all Syrian refugees must gain either sponsorship or pay for a residence and work permit to live and (formally) work in Lebanon. However, in reality, very few can afford to overcome these legal hurdles and end up working illegally to sustain a living (Essex-Lettieri et al., 2017).

As for Palestinian refugees, many of them remain stateless, thereby having fewer rights and protections than both Lebanese nationals and other foreign residents in Lebanon, including other refugees (Amnesty International, 2017). Furthermore, legal restrictions on Palestinian refugees in the labour market limit the sectors in which they are allowed to be employed (UNHCR, 2016), excluding them from professions in the medical, legal and engineering fields as only Lebanese nationals can join these professional syndicates (International Labour Organization, 2014). Consequently, many refugees work through informal means (Essex-Lettieri et al., 2017; UNHCR, 2016), leaving

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them vulnerable to unfair pay, lack of benefits and reduced chances of social mobility.

Shatila Camp

Shatila camp is the most populated refugee camp in Lebanon. It was established in 1949 by the International Committee of the Red Cross to accommodate refugees from Palestine after 1948 (UNRWA, 2020). Since the eruption of the Syrian Civil War in March of 2011, Lebanon's population swelled with more than 1 million Syrian refugees, many residing in Shatila camp. Some estimates state that over 22,000 people are living within a 1.5-km square area (Hauswedell, 2017). Residents of the camp have witnessed several violent episodes, including the Sabra and Shatila massacre of 1982 (during the Israeli invasion of Lebanon), and the Lebanese civil war between 1975 and 1990 (Hauswedell, 2017). The Lebanese government does not generally exercise authority within the camp, leaving security in the hands of competing local political and ideological factions (UNHCR, 2016). Living conditions are defined by crumbling infrastructure, inadequate and overflowing houses with unaffordable rents, and a lack of general safety (Syam et al., 2019).

Mental Health Resources in Shatila Camp

The harsh living conditions leave many residents of Shatila camp vulnerable to mental illness and distress. Palestinian refugees living in camps across Lebanon reportedly suffer from high levels of mental disorders. Médecins Sans Frontières reports that 22% of its refugee patients in Lebanon suffer from anxiety, 33% from depression and 14% from psychosis (Forgione, 2012). Although no specific data exists for the Syrian refugee population in Lebanon, a systematic review found that over 40% suffer from posttraumatic stress disorder, 26% suffer from anxiety disorders and up to 40% suffer from depression (Peconga & Høgh Thøgersen, 2019).

Additionally, Lebanon's healthcare services include very few options for mental healthcare, with only 1.5 psychiatrists per 100,000 people, and many cases are treated by a general physician rather than a specialist. As efforts to provide mental health support by nongovernmental organisations (NGOs) and international NGOs (INGOs) exist on a large scale in Lebanon, there remains a stigma and lack of education and knowledge surrounding such initiatives. Social and cultural constructs, such as the belief that it is reserved for "crazy" people, may contribute to an unwillingness to seek psychological or psychiatric intervention (International Medical Corps, 2017). Additionally, the financial costs of mental health and psychosocial support (MHPSS) for a population that suffers from low socioeconomic status in a (mainly) private healthcare system forms an additional barrier for refugee families that do seek help (El Chammay et al., 2013).

Use of Drama Therapy with Refugees

Drama therapy is an art-based psychological therapy approach that utilises theatre as a tool for psychological healing and improvement. Using theatre as a setting enables the use of characters and storytelling to emote by proxy, creating a buffer, while simultaneously allowing emotional expression (Landy, 1990). Drama therapy revisits and decontextualises traumatic events in a "playful manner" (Newman, 2017), offering a safe way to address and tackle trauma. Drama therapy also aims towards achieving catharsis through the expression of painful memories (Emunah, 1994), a process in which forgotten memories are recalled and associated emotions are released (Weiner, 1978).

Drama therapy has been used with many populations. With at-risk youth, for example, it has improved emotional resilience (Vietri, 2018); for university students, it has shown a significant improvement in decision-making, interpersonal and communication skills, self-awareness and self-expression (Chang et al., 2019). When used with refugee populations, drama therapy has been effective in improving mood (Diener et al., 2006), overcoming home sickness while maintaining identity (Dieterich-Hartwell & Koch, 2017), and reducing negative emotional experiences (Sakhi et al., 2020). Additionally, this approach aligns with recommendations for mental health support for refugees as it offers a cultural approach that is removed from clinical settings (Miller, 1999).

Drama Therapy in the Arab World

Drama therapy is still in its infancy in the Arab countries. The delicate nature of social standards in the Arab world results in a high level of stigma for individuals who seek mental health support (Merhej, 2019). Therefore, art-based therapies provide a way around this stigma by presenting to clients and their social circle as a cultural activity, rather than a psychological intervention. This allows for the full benefit of psychological support without potential social repercussions. Drama therapy was shown to reduce both self-stigma and public stigma associated with mental health (Orkibi et al., 2014). Unfortunately, this approach does not currently have a governing body that regulates or oversees it in the Arab world, such as the North American Drama Therapy Association in the United States or The British Association of Drama therapists in the United Kingdom. This developing field should be properly funded, researched and advanced in countries where mental health services are a neglected, but growing, need.

Drama Therapy Intervention Programme

Before the Programme

The programme was first implemented in Shatila camp in October 2018. Before implementation, the coordinator in Lebanon contacted partner NGOs who have centres in Shatila camp and coordinated the implementation process including NGO centres that have previously delivered cultural and MHPSS programmes, have direct contact with potential beneficiaries and were able to help in the recruitment of potential beneficiaries. The social workers of the centres: (1) recruited participants that were adult women above 18 years in need of psychological support, (2) explained to the potential participants the nature of the programme including the number of hours for each session, dates and times, and (3) created a list of names

and phone numbers of the interested women to be passed on to the coordinator of the programmes.

The sessions were held in two different centres within Shatila camp that usually host adult education, vocational training and cultural activities. The following is the detailed description of the four programmes, which is derived from 48 session reports that were written after attending sessions, taking notes of the activities and gathering the participants' reactions to them. The programmes, which were conducted by an expressive theatre facilitator, were structured into three "intensive" programmes that involved 12 weekly sessions, and one "follow-up" programme which consists of monthly sessions that participants attended after they completed an intensive programme.

The Intensive Programme

The intensive programme is designed to improve emotional awareness and self-awareness, create a sense of belonging, tackle negative psychological symptoms and focused on providing a structured and sequential MHPSS intervention. All three "intensive" programmes followed a similar structure based around a *Five-Phase Model* created by Emunah (1994), although not all programmes were able to utilise all five phases due to the unpredictable nature of group therapy progression. The programme was also designed and adapted with the specific population of Arab, Muslim refugee women in mind, who may have years of cumulative trauma and stress, often resulting in low levels of emotional awareness and high levels of repression and resistance. In all, 64 women joined the intensive programmes, averaging 21 women per group, which ran for 12 sessions, totalling 36 sessions of the "intensive" programme.

The Five-Phase Model

The first phase, *Dramatic Play*, allows the group to develop a rapport and build trust among each other and the facilitator. During this phase, name games and games promoting basic levels of personal disclosure and community building are used, along with rudimentary theatre games. For example, a game where the participants say the name of the person, they are throwing an imaginary ball towards uses name repetition and mental focus to encourage group members to remember each other's names. Another game used in the first phase is a game called *Roses and Thorns*, in which the participants take turns sharing one positive (the rose) and one negative (the thorn) aspects of their lives. This game encourages participants to gradually build towards personal disclosure as they see and hear others in the group sharing their life details. A simple introduction to theatre techniques and group work is established by the use of exercises like *Image Theatre*, where smaller subgroups are tasked with using their bodies and working together to create a still image that represents a certain concept. These exercises allow the use of creativity and imagination to convey social or personal messages. In this phase, participants are reminded to maintain the privacy of the sessions by never discussing what transpires within them outside the sessions. Boundaries are established throughout all the phases by encouraging respect and openness among the participants. Negative or judgemental comments are rare but met with a discussion among the facilitator and participants in which the different perspectives are offered for all to understand.

The second phase, *Scene Work*, uses games to introduce the participants to theatre techniques that help them better manage and understand their emotions and facilitate a starting point for self-exploration. Simple forms of meditation and physical exercise are introduced to allow for physical relaxation to counteract the heavier or more serious activities that take place. A commonly used physical exercise is a walking activity that has modifications like jumping at intervals, speeding up and slowing down and dancing while walking. Another commonly used activity is *Sound and Movement* check-in, where the participants spontaneously demonstrate their current emotional state using a physical expression, like jumping, screaming and dance moves, whereas the rest of the group echoes the movements back.

The third phase, *Role Play*, encourages the use of imagination to distance oneself from their own issues to gain a different perspective, while emphasising group solidarity and a sense of community. Group activities are heavily utilised in this part of the programme to allow the participants to build bonds through exploring similarities and developing empathy. Guided meditation is used to encourage the participants to discover areas of themselves that they do not speak about or acknowledge openly. In this phase, more advanced games and techniques like *Life Map* are typically used, where one participant uses the space within the room to map out her life in a monologue style, highlighting the life-defining events that she experienced. This exercise is performed while the rest of the group is seated in an audience formation as witnesses, which introduces the participant to the idea of exposing more personal aspects of her life to others. Another exercise is where a participant is given a mirror and asked to examine and describe her face to the group, often resulting in a great deal of personal disclosure in the process. Working in a group setting allows for different levels and forms of disclosure. While privacy and confidentiality are well established at this point, personal preferences are respected throughout the programme.

The fourth phase, *Culminating Enactments*, uses previously developed skills such as personal insight, memory recollection and trust in the group to give the participant a safe space to openly express significantly personal issues and experiences. Tangible and nonspecific items (such as small toys or colourful shawls) are used in the sessions to provoke memory retrieval or metaphorical dramatic projection. This is carried out through a game where the items are laid out, the participants are encouraged then to find one that "speaks to them", often triggering a cathartic experience. The use of theatre in this phase is highly present, enabling the participants to feel in control and to be seen by others. *Expert lecture* is often used in this phase, where group members come to the stage

one by one and give a brief lecture on any topic of their choice, whereas the rest of the group watches. This activity is meant to increase self-confidence and self-worth. In this phase, a significant change occurs, as many participants feel unburdened and at ease.

The final phase, *Dramatic Ritual*, closes the work of the group through a public or private performance where the participants use the activities taught throughout the programme to create a play or a collection of vignettes. The group members look at their achievements draw a vision towards their future and get the chance to say goodbye. *Appreciation Circle* is one of the exercises where the participants thank each other for moments of vulnerability, realisation and good times. Participants are invited into highly skilled exercises where they make full use of sounds, movement and expression. In this phase, the changes that happened throughout the programme through the efforts of the participants culminate in their own creative endeavour.

The Follow-up Programme

The follow-up programme offers all-encompassing sessions that provide a space for expression and continued community support. Attendance for this programme totalled 41 women, with fluctuating attendance, as the sessions were held monthly rather than weekly. The average attendance per session was about 18 participants. This programme had an open attendance policy, any woman from any group who completed the intensive programme was able to attend as many sessions as she could. This meant that participants from different groups were able to work together, having finished the first 12 weeks of intensive programmes. Combining different group members for the follow-up sessions allowed the sessions to be more sustainable with passing time, as many participants relocated, changed their employment status and for many reasons were no longer able to commit to the sessions.

The programme is designed to provide sustained community support and combat the feeling of alienation imposed by everyday life as refugee women. Each session starts and ends ritualistically, whereas the main activities are designed to have a sense of closure. The length of time between the sessions made this approach necessary so as to not leave any unresolved issues for an entire month. Hence, the sessions were designed in a way that each one has an independent theme, opening and closing, with all the issues brought up being resolved within the session itself. Each session had either one main activity that took up a large portion of the session or smaller activities all revolving around the same idea or concept.

The opening activity used in the follow-up programme was *Ball*, a game where the group stands in a circle and throws a ball around, counting out loud every time it is received. The closing activity was an in-depth reflection on the events of the session which allowed the participants to share their thoughts and feelings regarding what had transpired. Using the same opening and closing activity for every session ensured a sense of consistency and containment throughout the programme. The main activity or set of smaller activities usually revolved around a theme or an idea that ranged from social constructs to the stages of life and were explored using theatrical techniques.

As the follow-up programme does not follow a specific objective, the impact of the programme differed for each participant. Some of them sought safety and advice from their peers, some used the sessions to disclose personal memories and traumatic experiences, and others benefited from the ability to vent about everyday issues. For both programmes, sessions lasted for 3 hours. The facilitator for this programme is an expert in theatre with an academic background in psychology who has fulfilled the course and hour requirements for Drama Therapists. The field of drama therapy is a new field in the Arab world. However, Intisar Foundation has enlisted experts in drama therapy, creative arts therapies and psychology in its technical committee to provide oversight and supervision of its field activities.

Research

Research Protocol

Research was done in four phases. Phase 1 took place prior to the start of the intensive programme. The researcher obtained the list of participants and contacted the women to arrange individual interviews. These interviews aimed to collect demographic data and to get to know the group profile better, which in turn helped the facilitator customise the programme. Biographic information included: name, age, nationality, education level, working status, marital status, number of children and area of residence.

Before each interview, the participant was asked for her consent to give an audio-recorded interview to help the documentation process. Informed consent sheets were used to ensure the participant's right to privacy and anonymity is fully protected. If agreeable, she was asked to choose a pseudonym, which would then be used to address her throughout the interview and ensure anonymity. The recordings were translated from Arabic to English and transcribed.

Phase 2 was the focus group discussion (FGD) that took place midway through the programme, at the end of the sixth session or beginning of the seventh session. This consisted of a discussion with all the participants. The FGD was audio-recorded, translated and transcribed. The discussion was facilitated by the researcher, who asked basic questions about the programme, about the positive and negative experiences of the participants, and about possible areas of improvement. Open discussion was then highly encouraged to grasp the personal narratives of the participants. Reflection was also used at the end of each session to gain a better understanding of the impact of individual sessions. This, however, was not used as a part of the research and was reserved for the facilitator's session planning.

Phase 3 consisted of post programme, qualitative, individual interviews. These interviews were usually carried out within 2 weeks from the final sessions and last between 20 and 40 minutes for each participant. The

same process for consent, anonymity and audio-recording was carried out before the interview begins. The interview questions were open-ended and designed to be general, allowing the participants the full freedom to explore their preferred areas of discussion in regard to the impact of the programme on her life and psychological state. The interviews were then translated from Arabic to English and transcribed.

Phase 4 was the analysis of the findings to gain a deep understanding of the impact of the drama therapy intervention, interpretative phenomenological analysis was utilised with the transcribed interviews to find common themes among the participants. This process started with reading the transcripts, rereading with codes and refining several times (depending on the level of details presented in each transcript). Common codes were then drawn out and clustered into themes, and later, superordinate themes.

Limitations and Challenges

This research relied mainly on the exploration of personal narratives through qualitative data collection and analysis. Qualitative analysis may result in a number of limitations in this setting. First, the results do not provide a statistical understanding of the impact of the programme. Instead, the only insight gained is based on personal narratives and experiences. Second, although a standardised set of questions were used for participants to eliminate researcher bias, the possibility of researcher and participant bias is never fully eliminated. Third, the possibility that some participants may have avoided sharing negative experiences of the programmes due to friendliness bias or social desirability bias.

Findings

For the three combined groups, the total number of participants who were interviewed after programmes was 59, with the age range of 18–71, the average being 39. The nationalities within the group were 74% Syrian, 23% Palestinian and 3% Lebanese (who had moved to Syria at a young age and came back to Lebanon after the civil war started, residing inside Shatila camp). The following findings are clustered from over 50 individual interviews and four FGDs.

Emotional Regulation

Emotional regulation is an important for everyday life skill, the ability to internally manage emotions, how they are experienced, expressed and the kind of response that is produced towards them (Gross, 1998). Previous research has linked drama therapy to better emotional regulation in refugee children (Gürle, 2018), and among adult nonrefugee patients and clients (Keulen-de Vos et al., 2017; Klees, 2016). Results showed a greater ability for emotional regulation. During the programmes, several contributing factors to this improvement among most of the participants were observed, as reflected by this participant:

> Our upbringing was very conservative and we were taught that showing emotions is not okay. We had to keep everything buried inside us. It is shameful to cry, it is shameful to complain, it is shameful to confide in anyone because they will turn around and mock us. That made me very paranoid about people's intentions. So, I always avoided talking about my feelings or my problems. But the sessions here taught me that it is okay to be expressive. I can and should talk to my friends and my colleagues about what is bothering me.

It is important to note that the programme provided a safe space for the exploration of both positive and negative emotions, which in part can lead to a better understanding of one's emotional processes. Many of the exercises facilitated catharsis from traumatic memories, which may lead to reduced levels of unresolved emotions, whereas other exercises provided a healthy and manageable outlet for stress. Taken together, this approach of resolving previously accumulated distress and providing tools for everyday management may lead to better emotional regulation such as reducing anger and improving overall wellbeing.

Benefits of Movement and Exercise

Life in Shatila camp is challenging, and one of the many obstacles faced in daily life is the lack of personal space due to small and overcrowded housing and the complete absence of any natural scenery or public spaces. Due to these restrictions, it is very difficult for residents of the camp to lead an active lifestyle or be able to perform physical exercise such as walking or aerobics.

Throughout the programme, movement and exercise were heavily used as an essential part of the sessions, such as the use of dancing, stretching and walking. Many of the participants would later credit this as a definitive advantage in helping them feel more active, and in some cases, in helping them deal with chronic pain.

Other forms of psychical engagement throughout the programme included activities like *Emotional check-in*. The psychical aspect of the programme ensured that participants are actively engaged in receiving the sessions, as opposed to lecture or talk group therapy type MHPSS where the participants tend to be passive recipients. For this participant, dancing during the sessions was a liberating experience: 'When we first started the sessions, I was stiff, I could not move easily. But when I let my mind wander with the music, it felt like I was flying'.

Dancing can also help to reduce anxiety (Lesté & Rust, 1984), and physical exercise can reduce depression and improve wellbeing and self-image (Weyerer & Kupfer, 1994). A meta-analysis on dance therapy found that this form of therapy is an effective treatment for depressive syndromes (Koch et al., 2019). Physical movement and exercise are intrinsically beneficial because they provide a distraction from negative emotions or thoughts, trigger a meditative state while keeping the body active and prompt the release of endorphins in the body (Weyerer & Kupfer, 1994). The integration of the body into the therapeutic process is hence a beneficial practice.

A Sense of Belonging

Scholarly work has emphasised community-based

interventions for refugees can be effective in reducing depression and trauma-related mental health issues, as well as improving functioning (Williams & Thompson, 2010). Drama therapy supports this finding and adds improvement in the sense of belonging as a form of psychological comfort. As the programme progressed, mainly after the first and second phases that were intended to build trust and rapport, the women became more at ease with open and honest dialogue, and eventually developed a more cohesive sense of community among each other.

This sense of belonging is pertinent in reducing the psychological distress among the participants who have lost their original communities, sometimes even family and friends, and now live in a generally unfamiliar and unfriendly environment at Shatila camp. Throughout the sessions, most of the participants expressed the unforgiving nature of their communities, which was reduced as the participants shared vulnerabilities and felt safe and welcome to do so. This is distinctly stated by this participant:

> Frankly, I do not have many friends. I always felt that I bring people down because I constantly felt depressed. As the sessions went on, I found myself more comfortable with the women around me because they were open, and this helped me become more open. We were able to talk without fear or restrictions, we were in a sacred place together. Usually, we would whisper our secrets, but not in the sessions.

For women who have been living as refugees for years, or their entire lives, loneliness and solitude may be common issues. By promoting belonging and personal disclosure during the sessions, the participants felt at ease and accepted.

Changes within the Family

Over 90% of the participants were married with children. Accumulated stress, trauma and a lack of a support system can all lead to dysfunctional parenting and family dynamics in refugee families (Eruyar et al., 2018). Throughout several sessions of the programme, relationships with spouses and children were tackled. In some activities, the women were encouraged to reflect on their childhoods and relive memories from the past, which may have facilitated higher levels of empathy with their children. As for partners, the relief from built-up stress and better self-regard may play a role in bettering maladaptive behaviours in relationships. One of the participant's statements reflected this sentiment:

> My daughters used to be scared of me. I used to yell at them and beat them over the smallest thing, it was living in a constant state of stress that made me so irritable. The drama therapy sessions were a chance to expel all the negative energy and come home feeling light. This allowed me to be more understanding with my daughters, as I realised that violence would make them hate me and less responsive to me. Many things have changed, we do not yell anymore, the girls finish their homework quicker and help me around the house without causing a fuss.

In many cases, participants who had admitted to using corporal punishment against their children reported having stopped by the end of the programme. This can be attributed to reduced accumulation of stress and negative emotions which may lead to heightened tensions when dealing with familial issues or disciplining children. Another contributing factor is improved emotional awareness, where the mother may become more attuned to her child's needs and realise the adverse effects of physical punishment.

Discussion and Conclusion

War and postmigration-related distress can have effects on the psychological wellbeing of refugees, as clearly observed in Shatila camp in Lebanon. MHPSS is a necessary intervention to help Shatila residents regain some semblance of normalcy and wellbeing. This report describes and analyses the impact of drama therapy in filling the caveats faced by the traditional forms of therapy. Drama therapy circumvents stigma associated with MHPSS as participants would often explain to their families and friends their attendance as a cultural theatre workshop, thereby avoiding any negative connotations while still receiving the benefit of therapy. The use of the body and voice as a means of expression allowed participants to express nonverbal and metaphorical thoughts and feelings, rather than relying strictly on verbal expression. Another added value of drama therapy has been its community-based meetings that reduce the cost of one-to-one counselling. Up to 20 participants can benefit from one programme, cutting down the need for resources and hours usually associated with traditional therapy.

Furthermore, the nonspecificity of drama therapy as a psychological intervention allows different participants to find different benefits within the programme. Creative liberties in the sessions allow the participants to explore taboo topics or introduce personal issues to the group. As drama therapy is not an alternative for psychiatric intervention, it can play an important part in restoring the wellbeing of deeply marginalised and disadvantaged communities, like a refugee community. Further research is needed in both fields of drama therapy and refugee psychological wellbeing, and future research on community-based, art-based psychological interventions for refugees should explore quantitative research approaches to create a more comprehensive understanding of these interventions' impact.

As world governments and nations grapple with the largest number of forcibly displaced people in recorded history (UNHCR, 2020), civil society remains at the forefront of the efforts employed to help those individuals live better lives. Mental healthcare is an integral part of rehabilitation for displaced people, and drama therapy can be a valid approach to helping many overcome psychological distress and flourish.

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Conflicts of interest

There are no conflicts of interest.

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