Lessons Learned From an Inner-City Boys Trauma Group

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Abstract

This article describes a study of two male clinicians' implementation of a 10-week, school-based integrated cognitive-behavioral group counseling intervention with psychodynamic process elements at a school in the Bronx, NY for inner-city middle school boys who have experienced complex trauma. The authors define complex trauma and describe the therapeutic concepts that framed their work with students over the course of an academic year. Through case study methodology, the authors offer lessons learned about a pilot intervention treating complex trauma in an underserved inner-city school through their observations, clinical notes, and clinical supervision. Suggestions are provided to counselors for cultivating a therapeutic space amid the often disruptive environment of middle school, with special emphasis on how counselors may develop trust and may increase resiliency for middle school boys within interpersonally aggressive academic environments and inner-city neighborhoods.

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Exposure to acute and complex trauma often has both short- and long-term developmental effects on the lives of children and in its myriad manifestations, indelibly shapes the lives of its victims, affecting their cognitive development, behavioral control, affect regulatory capacities, the ability to attach to others in healthy ways, and their development of a coherent and unified sense of self (Cook et al., 2005; D'Onofrio, 2007; van der Kolk, 2014). Inner-city youth are susceptible to trauma exposure at significantly higher rates than their suburban and rural counterparts (D'Onofrio, 2007; van der Kolk, 2014). Early exposure to trauma is associated with poverty, community violence, untreated mental illness in the home, and substance abuse (Aymer, 2008; Garo, 2013; Gorman-Smith & Tolan, 1998).

Increased risk of exposure to violent forms of trauma, such as exposure to gangs and gang violence in schools and the community may be inevitable for inner-city youth, particularly boys (Howell, 2011). The intersection of masculine gender expression with the complexities of life in the inner city places children and adolescents at risk for increased: exposure to violence, both as a victim or witness; susceptibility to aggressive behavior through social expectations; symptoms of acute and complex trauma and their sequelae; and negative perceptions and beliefs about help-seeking behavior (Loeber, Capaldi, & Costello, 2013).

This article examines the experience of exposure to trauma and chronic stress in boys at an inner-city middle school in the Bronx, NY. Attempts to provide middle school boys with additional ways of coping with and processing their stress and trauma through a group intervention are presented. Through qualitative methods using case study

methodology and the school environment as the bounded system of study (Creswell, 2013; Denzin & Lincoln, 2005), observations from a short-term, in-school, pilot group intervention for middle school boys suffering from the sequelae of chronic stress and trauma and our interactions with the teachers and school administrators are presented. First, we provide an overview of complex trauma and its impact on development. Then, we explore countertransferential pitfalls of this work, share our observations from the group intervention, and provide recommendations for developing a refined treatment stance.

Complex Trauma and Developmental Effects

Urban youth, particularly youth of color, are exposed to chronic stress and multiple forms of trauma at significantly higher rates than their White counterparts in suburban or rural environments (D'Onofrio, 2007; van de Kolk, 2014). Complex trauma is associated with chronic exposure to stressors that take place during key developmental periods beginning in early childhood and occurring over an extended period (D'Onofrio, 2007; van der Kolk, 2005, 2014). These stressors may include poverty, abuse, neglect, single-parenting, domestic violence, sexual assault, gang involvement/violence, fatal accidents, substance abuse, racism/discrimination, immigrant- and acculturation-related issues, crime, witnessing violence in the home or community, and traumatic deaths of friends and/or family members (Courtois & Ford, 2013).

The outcomes of complex trauma are pervasive for individuals, affecting psychological, emotional, cognitive, and physical development (Finkelhor, Turner, Ormrod, Hamby, & Kracke, 2009). Complex trauma manifests through symptoms

including increased and continuous anxiety, depression, anger, hypervigilance, impulse control and attention difficulties, substance use, premature onset of puberty, suicidal and homicidal ideation, self-injurious behavior, affect dysregulation, and behaviors leading to problems with law enforcement agencies (D'Onofrio, 2007; Roach, 2013). Gorman-Smith and Tolan (1998) found that boys growing up in poor, urban communities are exposed to high levels of community violence, which was associated with aggression and depression following exposure to violence in the past year. These symptoms are often a means for survival and may serve as coping mechanisms to deal with chronic stress and complex trauma. In addition, other post-trauma effects include a restricted range of affect, emotional numbing, detachment, dissociation, physiological hyperarousal, nightmares, flashbacks, somatic complaints, poor school performance, socialization problems, heightened risk of delinquent and criminal behavior, depression, increased suicidal ideation, and a belief that the world is an unsafe place, increasing the likelihood that an individual will experience derailments in socio-emotional, cognitive, physiological, and psychological development (Allwood, Bell, & Horan, 2011; Cook et al., 2005; Flannery, Singer, & Wester, 2001; Garo, 2013; Lambert, Nylund-Gibson, Copeland-Linder, & Ialongo, 2010; Margolin & Gordis, 2000, 2004; Schwartz & Gorman, 2003).

Children are impacted by direct victimization to violence and witnessing/hearing violence (i.e., vicarious victimization), although many children have experienced both (Saltzman, Pynoos, Layne, Steinberg, & Aisenberg, 2001; Schwartz & Gorman, 2003). Finkelhor et al. (2009) reported that more than 60% of children in the US are exposed to violence daily, with numbers exceeding this percentage in denser inner-city locations.

Exposure to violence for youth tends to take place in two primary settings: their community (including home) and their schools (Centers for Disease Control and Prevention, 2012; Howard, Flora, & Griffin, 1999). Children residing in violent communities exposed to multiple forms of violence are at risk for adverse psychological challenges and functional impairments throughout life (Saltzman et al., 2001). Many parents have experienced traumatic events in their lives and some may be involved in gangs or other violent and/or illegal behaviors as a means of survival (Gorman-Smith & Tolan, 1998). In these situations, the transmission of intergenerational trauma is likely (D'Onofrio, 2007; Courtois & Ford, 2013). In addition, children and adolescents respond to family/community violence and trauma in disparate ways as a result of individual differences and variations in risk and resilience factors, further complicating the assessment of violence-related trauma (Margolin & Gordis, 2004). Violent communities diminish and dilute the ability of parents to raise their children in healthy and nurturing ways (Garo, 2013).

In a nationally representative sample of children and adolescents (n = 4,549), Finkelhor et al. (2009) found that 60.6% of children had at least one direct or witnessed experience of victimization in the past year. They also found that 46.3% were victims of physical assault, 25.3% witnessed violence, and 9.8% witnessed violence among family members. Rates were higher among African American, Native American, and Latina/o youth, because of increased social inequality, experiences of racism and discrimination, exposure to crime and poverty, and other intersections of their social identities (Brady, Gorman-Smith, Henry, & Tolan, 2008; Finkelhor et al., 2009; Foster & Brooks-Gunn, 2009). African American youth (ages 12 to 17) living in segregated inner-city urban

areas are at greater risk of experiencing violence than those in suburban and rural areas and are victims of violent crimes at rates twice that of their same aged counterparts (Bureau of Justice Statistics, 2012). Exposure to violence has been linked to mental health and physical health morbidity (Finkelhor et al., 2009).

Boys living in the inner city who act out are often struggling to handle the unique and complicated set of stressful circumstances associated with living in underserved communities in which witnessing violence is a common occurrence (Ferguson, 2001). Boys often cope through social withdrawal, exhibiting disruptive behavior in school, endorsing self-injurious behavior or suicidal ideation, and truancy (Aymer, 2008). In some cases, boys who act out in school may be victims of violence, chronic stress, and complex trauma (Ferguson, 2001). Accordingly, children and adolescents who have experienced complex trauma in the inner city, where living situations may be unsafe and higher in density, continue to be an underserved population (D'Onofrio, 2007).

Method

Participants

Data were obtained over the course of the academic school year. Data consisted of group facilitator observations of the middle school boys and the group dynamics during the group intervention, clinical notes written following the groups and individual meetings with the students, and clinical group supervision with the third author, a licensed psychologist. A description of the observations and case-based themes (Creswell, 2013) are outlined in the observations section below.

Participants were 61 (of which 58 provided their demographic information) male students who were 10 to 16 years old and in Grades 6 to 8 at an inner-city middle

school in the Bronx, NY (see Appendix Table A1 and A2). Participants were referred to the intervention by school staff, including social workers, teachers, and the school principal. They were identified by school staff as having "behavioral issues" (e.g., acting out) inside the classroom as well as dealing with significant stress in their non-academic lives. Group sizes ranged from 5 to 11, with the average group size of about 6. Groups were largely grade specific, although seventh and eighth graders were combined for one group. In addition, groups were closed, meaning no new group members outside of the original members could join once the groups began.

The school was identified as an underserved and underperforming school in part due to underachievement on statewide standardized tests. In addition, at the end of the previous academic year (2013-2014), two male students engaged in a fight outside on school grounds during which one student stabbed another student with a knife. Tragically, this led to the student's death. This event was witnessed by many other students and had a traumatizing impact on the students, faculty and staff, families, and community at large. In fact, discussion of this incident would later emerge in some of the groups as participants began to verbalize past traumatic incidents in their lives.

Intervention

Among several similar school-based trauma treatment programs, the authors selected the 10-session structured group intervention Cognitive Behavioral Intervention for Trauma in Schools ([CBITS], Jaycox, 2004). Originally created for the Los Angeles Unified School District, CBITS was supported by a decade of research displaying its effectiveness in underserved middle schools and communities in the Los Angeles area. CBITS was chosen due to the similarities between Los Angeles and New York City:

they comprise the two largest public school systems in the country and are two of the most diverse urban cities in the world.

The focus of CBITS is manifold: (a) to provide students, as well as teachers and parents through separate modules, with psychoeducation about stress and trauma; (b) to assist students in understanding which types of past experiences are traumatic in nature; (c) to educate students about symptoms and trauma-related sequalae; (d) to facilitate group discussion in a safe environment to begin to process traumatic experiences; and, (e) to meet individually with each student to provide an additional opportunity for students to tap into the depth of their trauma-related experiences and emotional resources. Thus, the primary goals of the group intervention were to: (a) introduce the sources and effects of stress and trauma through psychoeducation; (b) begin to explore how group members' lives have been affected by stress and trauma; and (c) address process issues that arose.

In addition, the group facilitators paid special attention to therapeutic framework issues throughout the group process. Individuals with histories of trauma are particularly sensitive to the effects of inconsistent and unpredictable settings as they are evocative of the lack of safety experienced in their original traumatizing environments (Langs, 1997; 2004). Therefore, conscious attempts were made to maintain a consistent therapeutic structure from week to week. This included establishing agreed upon ground rules in the first group meeting and maintaining those ground rules throughout the process. Efforts were also made to keep consistent group membership, have clear start/end time and location, and for the facilitators to be consistent in their presence as well as their management of the group process (Goldberg, 2009). More specifically,

group facilitators created the conditions for a healing experience for students by maintaining a *basic posture* of acceptance, positive regard, and genuineness (Yalom & Leszcz, 2005). By exhibiting behaviors consistent with these attitudes, the group facilitators thus modeled to their students' ways of being that are adaptive, assertive, vulnerable, and fertile for personal growth.

Group counseling can be curative by helping students learn from each other, understand the universality of suffering in the human condition, provide support to other members, and improve socialization skills (Yalom & Leszcz, 2005). In order to facilitate these healing factors, Yalom and Leszcz further propose that effective group treatments should take into consideration the structure of the groups and the spaces in which they meet. Group meetings held in rooms free from distraction lend themselves to greater protection of confidentiality. Seating group members in the shape of an open circle with no barriers between members or within the circle allows all members to be able to see each other and relate to each other as equally as possible. Such considerations are simple and practical yet immensely beneficial to growth and healing in group therapies (Yalom & Leszcz, 2005).

Observations

The primary observations and case-based themes made below were drawn from the collective experience of two counseling psychology doctoral students who were involved in the delivery of clinical services for this project. The observational data were collected through the two group facilitators' group observations, clinical notes, and weekly clinical supervision with the third author, a licensed psychologist. The academic year case study project consisted of integrated process groups, split into three 10-week

cycles (three groups per cycle) with inner-city middle school boys and focused on treating chronic stress and complex trauma. While we provided psychoeducation on trauma and exposure-based cognitive behavioral counseling, the group processing explored the relational issues at play in the room from an integrative behavioral-psychodynamic perspective (Wachtel, 1997).

Aggressive Behavior Within the Groups

Aggression among group members was a central feature of the group dynamics from the outset. The lack of safety created by verbal and physical acts of aggression posed a significant threat to group cohesion and its ability to operate as a therapeutic group. Within each group in the first cycle, typically an identified student became the target of aggression. That student was a more vulnerable individual—one who was seen as an "outsider" to the pre-established cliques that were present in the room. The occurrence of this initial aggression seemed to be a reaction to the novelty of the group as well as the seriousness of the topics to be discussed. Students seemed to adopt the same power dynamics that were observed to take place in the classrooms and in the hallways of the school. These dynamics constituted the initial power structures within and between group members and with facilitators that became an explicit focus of processing within the group.

Facilitators observed that boys in the group displayed their dominance, hypermasculinity, and/or aggression over other group members by using homophobic epithets. Fasoli et al. (2015) found that exposure to homophobic epithets are experienced as dehumanizing and distancing, which was in line with what unfolded in the groups. Targeted members isolated themselves further from the group, were least

likely to participate, or withdrew altogether. For the aggressive and dominant group members, the use of homophobic epithets clearly functioned to enhance their own sense of masculinity (Carnaghi, Maass, & Fasoli, 2011). We observed that if the student is able to devalue/diminish the masculinity of the other, then in his mind he raises his own sense of manhood. When these situations occurred, facilitators first endeavored to help the students involved establish a dialogue around the observed behavior. On occasion, the participants involved were able to work out the issue within the group, with the assistance of other group members and facilitators. However, particularly in the early group meetings, the problematic behavior often continued. In those cases, the facilitators asked the students involved to excuse themselves from the group. In some instances, the aggressor left the group on his own when confronted with the behavior; in others, the target left because the comments were too painful. These disruptions often took considerable time away from the group content and required processing following the incident to help regulate the group.

The facilitators recognized that there are advantages, albeit maladaptive, for children who engage in aggressive behaviors, such as gaining power and popularity among peers by exerting control over others (Rodkin, Espelage, & Hanish, 2015). However, there are many negative outcomes associated with being victim to aggression, such as increased symptoms of depression, anxiety, and a decreased self-esteem and self-worth (Swearer & Hymel, 2015). Thus, facilitators found themselves in a position to prevent further harm toward victims while also making explicit meaning of the aggressive students' behaviors.

In addition, the group members also felt the need to test limits by attempting to display dominance over the group facilitators. Challenging group leaders is not uncommon in group counseling (Corey, 2008; Yalom & Leszcz, 2005). In fact, for a group to become a "working group," group leaders must be able to demonstrate that they can continue to manage the group and keep the members safe even in the face of conflict and direct attacks. While members of counseling groups often attempt to jockey for position and power in early phases of group formation, the attempts at dominance and the expression of aggression toward group leaders dominated a significant part of the process early on.

Resistance to and challenging of group leaders is particularly evident in involuntary groups (Schimmel & Jacobs, 2011). Since referrals came from teachers and school administration, the students had the impression that the groups were mandatory. Students in our first cycle of groups often displayed their challenge by refusing to participate in group discussion or activities, getting up and walking around the room, leaving the room to roam the hallways, teasing the group facilitators (e.g., through racial/ethnic discrimination of the Asian facilitator or through homophobic comments about the facilitator's hair length/style; by ridiculing the White facilitator's Spanish dialect or use of words in speech), or engaging in cross-talk or side discussions while other members were sharing.

Given the disruptive dynamics of the group process, it quickly became evident that the group leaders needed to manage the tension between two goals: (1) to continue to implement the structured format (i.e., CBITS) and, (2) to help cultivate a shift in attitude—from feeling like they are part of an involuntary group, to taking ownership

and being voluntary (Schimmel & Jacobs, 2011). This requires group leaders to be attentive to both content and process, but in this case to more creatively work to recapture "control" of the group and reestablishing safety. This can be done in many ways but when there is significant resistance, effective group leadership requires creativity, a willingness for the leaders to lean in to the conflict and resistance, to be willing to do the unexpected (Schimmel & Jacobs, 2011), and to able to identify and manage one's own countertransferential reactions to uncooperative members. The specific strategies used to address these power dynamics will be addressed below but first we turn to the facilitators' own countertransference reactions.

Countertransference and Group Process

Some authors have suggested that the clinician's countertransference reactions to patients is the most significant form of resistance to clinical process, even more than the patients' own transference or resistance (Bion, 1998; Langs, 1980; Russell, 2008). Russell (2008) notes that "the most important source of resistance in the treatment process is the therapist's resistance to what the patient feels" (p. 19) and additionally what is evoked in the therapist by the patient's feelings. In the face of the chaotic, aggressive, and uncooperative behavior of some of the group members, the facilitators developed very conflicted and even outright negative feelings to those group members. While they ought to remain professional, non-reactive, and therapeutic, the facilitators found themselves being pulled into a parallel process in how they were attempting to "control" the student's behaviors that mirrored how they had witnessed teachers in the school react to "misbehaving" students in the first cycle. The facilitators became easily frustrated at the uncooperative group members, raised their voices, attempted to

impose their control through the tone of their comments and the aggressive subtext implied by that tone. The facilitators had been drawn into the aggressive culture of the school and were now reenacting similar dynamics.

During clinical supervision, the third author/supervisor hypothesized that the group leaders were involved in a parallel process enactment with the group members. In response to the aggressive behavior, the group leaders were reacting by asserting their power in an attempt to "control the group." For example, the more the boys would bully a group member, the more the group leaders felt they needed to intervene to protect the victim by disempowering the aggressive student and reasserting their own power. This dynamic further activated the uncooperative boys and reignited the cycle of aggressive acting out. With the third author's suggestion, the group facilitators began to adjust their collective stance to paradoxically "letting go" of a sense of "needing to control" the group by asserting their power in explicit and authoritarian ways. Group facilitators were encouraged to reflect on what was being activated for them, how they were made to feel powerless, and how out of control they felt at the hands of a few middle school boys. They processed their deeper countertransference feelings and sense of vulnerability as well as their feelings of being stuck and helpless in working with these students. These feelings chipped away at their sense of professional competence and self-esteem and, as a result, their countertransferentially driven goal became to reestablish their power in the group at all costs forsaking the clinical understanding and skills they clearly possessed.

In processing the relationship of the group members lack of cooperation and aggression, their traumatic histories, and how these disruptive behaviors were triggering

for the facilitators in terms of their own relationship to aggression, power, and their sense of masculinity, the facilitators were able to depersonalize the group members behaviors and respond in increasingly therapeutic ways rather than reacting to the student's behaviors. They understood that the aggressive attitudes of the group members could not be extinguished by force. Rather, it had to be replaced with something else (see Glick & Gibbs, 2011), and, that something else would be a qualitatively different kind of relationship than those with which these students had experienced. This would be accomplished by returning and recommitting to the single most important therapeutic principle that had failed to be established, namely, that no therapeutic change could be reasonably expected to occur without safety, particularly in group settings (Corey, 2008; Yalom & Leszcz, 2005).

The facilitators addressed this issue by redoubling their efforts at securing the therapeutic frame. As mentioned above, stable and consistent ground rules tend to create safe and inherently supportive therapeutic environments while unstable, inconsistent or nonexistent ground rules disrupt and are harmful to those affected by them. A secure frame acts as a backdrop and container for students' suffering—particularly unexpressed affect that results from exposure to complex forms of trauma. Unless the therapeutic frame can be secured thus creating a sense of safety for the group, no real engagement in the deeper issues of students' suffering can take place as they will need to protect themselves from potentially hurtful others (Langs, 2009).

The facilitators took several measures to re-secure the therapeutic frame. First, they brought the issue of safety to the group's attention. They noted that the ground rules that were established in the first group meeting were not being honored. As a

result, the group could not continue under those circumstances as it was clear the group was unsafe for members and that all members needed to refocus their efforts on creating safety, especially the facilitators. Second, group members were engaged in rearticulating the ground rules and engaged in active problem solving to explore why the original ground rules were ignored. Their comments suggested that the original ground rules did not account for some of the problematic behaviors of some of the group members and that the facilitators did not address the problematic behaviors; therefore, the consequences for violating the rules were not adequate. The facilitators then offered to reestablish the group ground rules and norms of behavior and recommitted to enforcing the rules more consistently. Group members were now actively involved in deciding what was allowed and what was off limits in the group. Aggressive behavior and bullying were not acceptable and members who could not refrain from behaving in such ways would be asked to leave the group. Finally, if any group member left the group, he would not be permitted to return.

These process changes became a powerful turning point in the life of the group and in the clinical work that transpired. While some testing of the group norms continued, the majority of the group members were more responsive—there was a greater sense of mutual ownership for what happened in the group—and the facilitators did not experience the same kind of power struggle as in the past. Once the members experienced that the facilitators carried through on enforcing the ground rules, members clearly demonstrated an increased commitment to the group and to each other individually. They came to group on time, did not resist participating in more serious discussions, and explicitly identified moments when the agreed-upon rules were broken

or when members were not participating or were unsupportive of the work of other members. After this shift occurred, the group members who had been the most disruptive stopped attending as they had been made the minority and were no longer being reinforced for their problematic behavior. Once the facilitators took the risk of disengaging themselves from the power struggle with the aggressive members, the other members felt increasingly protected, were able to rally around the facilitators, and found greater courage to stand up for themselves.

Private Suffering and Disclosure Within the Group

Most evidence-based group treatments for childhood complex trauma (including CBITS) encourage identifying and retelling of specific traumatic experiences within the life of the group but, to date, there is no clear determination of how to structure that retelling without iatrogenic reactions to the discloser as well as to the other members of the group that may be retraumatized by hearing potentially intense traumatic narratives (Ford, Fallot, & Harris, 2009). For children and adolescents exposed to violence, group settings can be a hotbed of trauma reenactment and retraumatization (Glodich & Allen, 1998). When safety within a group is lacking, as was the case in the early stages of our groups, group members are more reluctant to disclose their painful traumatic experiences and share with the group how their suffering manifests itself in their lives (Corey, 2008; Yalom & Leszcz 2005).

Throughout the course of the group, there was a clear distinction between what was discussed during group sessions and what had been disclosed in individual intake sessions held at the beginning of the process. While many of the students openly shared their traumatic experiences to the counselor during the individual sessions,

many failed to discuss those same experiences within the group. They often withheld from the group the experiences they considered most painful and the ones needing the most attention. The experiences included: the death of a parent, grandparent, family member, or friend; the incarceration of a parent or family member; being mugged in the community; experiences of bullying; sexual molestation; witnessing violence among friends or family; watching a friend die; drug and alcohol abuse among family members; familial gang involvement; parental divorce; frequent moving and transferring schools; loss of apartment and belongings from Hurricane Sandy; being bitten by a dog; and, immigration to the United States and separation from homeland and family. Rather than sharing their pain regarding these experiences during group, the students often masked their suffering through avoidance of feelings, use of humor, and minimizing the significance of their own pain. They felt it would be a sign of weakness if they revealed their vulnerability to the other boys in the group. If they did so, the feeling was that they would be ridiculed and mocked for displaying their vulnerability.

As a result, tenderness and sensitivity in the groups were not easily tolerated by most group members. Rather, *bravado* and *machismo* were often communicated through sexually suggestive comments about women, statements about one's skill level in sports, or how "cool" one's shoes were compared to the rest of the group. These findings are consistent with the notion that gender identity expression and the desire to communicate masculine traits are largely influenced by the presence of others (Brinkman, Rabenstein, Rosen, & Zimmerman, 2014; Maccoby, 1990). The group facilitators remained cognizant of this dynamic throughout and remained diligent in meeting with group members individually who were too frightened or ashamed to

discuss their traumas in the group setting. The exception was with some of the eighth-grade groups in the third cycle. They openly discussed their past traumatic experiences and displayed vulnerability and tenderness with one another.

Discussion

In reflecting upon the challenges that occurred in implementing the CBITS group intervention in our target school, several insights emerged. First, the school and classroom environments differed dramatically from the kind of environment the facilitators attempted to create. Structure and consistency seemed to be absent in how many classrooms were managed. Teachers often complained about feeling overwhelmed by the number of students they had in each class and the fact that they received little support from administration in helping with classroom management and discipline. The frustration some teachers experienced led to either giving up in trying to hold students accountable for their failure to comply with rules or using inappropriate language and aggressive tones to respond to problematic students. Transitioning students from the noisy, dysregulating school classrooms and hallways to attend a therapeutic group was a significant challenge.

Setting a therapeutic tone was challenging due to the inability to maintain a consistent and uninterrupted group space during the first cycle of groups. Given the school's space limitations, the location of the group room was subject to change from week to week. This destabilized the functioning of the group as it delayed the start of group sessions and students needed to acclimate to the new setting each week. Additionally, because of the inconsistent space, teachers would occasionally walk into the rooms and interrupt the group process. Students were often derailed from the group

work when interruptions occurred, and it took time to return to the topic at hand. It is not surprising that students struggled to feel safe and focus on the group conversation. This resulted in students acting out and exhibiting behavioral resistances, as safety is precluded when the therapeutic environment is not stable (Langs, 2004).

The nature of the work in the groups changed dramatically following the first cycle. The first two authors and the school social worker met with the school principal to address these systems issues after these problems were identified in supervision. A parallel process occurred with the principal and other administrators as had occurred with the student members of the group—namely, the needs and ground rules for the project were being revisited with school administrators. A recommitment to the project was secured from the principal who in turn communicated the needs to the other school administrators and teachers. From that time forward, the same room was designated for the groups to take place each week and that room remained free from interruptions. In addition, group size was reduced from approximately 10 students per group to six students per group. These two modifications significantly improved the group counseling process for the second and third cycles.

Limitations

As may be the case with any pilot program testing an intervention in a new setting, several factors limit the conclusions of our project from being generalized to other groups. At the outset, the process for generating referrals to our group, as well as the group's primary purpose, appeared unclear for school administrators and teachers. Group members were often referred by teachers for nebulous reasons. Although our

group aimed to treat complex trauma, we found ourselves seeing a heterogeneous sample of group members referred for varying problems.

For example, during the first cycle of groups, most students were referred for behavioral problems such as acting out in class, perpetrating and/or being victim of bullying, and hyperactivity/inattention symptoms. Upon assessing the students individually, we began to see diagnosable disorders that reflected depression, anxiety, attention issues, and other sequelae from exposure to trauma. Teasing out students who were appropriate for the groups rather than who were referred to the groups because teachers wanted them out of their classroom became a challenge. While most students referred had identifiable histories of exposure to complex trauma, some were referred because they had discipline problems. It would likely have been more effective and less time consuming to establish a more rigorous screening and referral mechanism with teachers but given the chaotic nature of the school environment and the short time frame between receiving the grant and initiating the intervention, this was difficult to do in the initial stages of the project.

This lack of clarity regarding the group's purpose also extended to the students themselves. When the group facilitators first recruited students by going to their classrooms following up on our referrals, identified students explained they did not understand why they were being taken out of class, wondering if they were being punished, and at times stating they felt embarrassed and refused to leave the classroom. When these students joined the group and were informed what it was intended to help them with, their confusion persisted and likely led to some of the ongoing group conflicts we have described earlier in this paper. These students

eventually accepted the group work midway through the process as the structural issues (e.g., safe and consistent meeting space, agreed upon ground rules, reasonable group size, etc.) began to be addressed and there was greater clarity as to the function, the content, the process, and the ground rules within which the group would operate.

Lastly, given the Bronx is a unique county in that more than 58% of its nearly 1.5 million inhabitants speak a language other than English at home, and 56% of the borough is Hispanic (US Census, 2017), our program was limited from achieving a greater effect on participants because we lacked a fully bilingual treatment team. In addition, the training manual used, CBITS, was only available in English at the time of the program's implementation.

Future Recommendations

To address the critical developmental needs of adolescent boys in at-risk, urban areas, there are several considerations counselors and researchers may consider when implementing complex trauma programs in public schools. First, counselors working with boys in inner cities may benefit from conceptualizing *bravado* seen in schools and group counseling primarily as an adaptive response to chronic stress in underserved and dangerous community and school environments. *Bravado* or *machismo* may help these boys with their gender identity development according to cultural and societal messages about what being masculine and being a man mean in the inner city.

By shifting the focus away from group members' "bad behavior" and helping group members better understand the adaptive nature of that behavior as well as its relation to their gender identity development, facilitators may paradoxically encourage greater participation. Helping participants understand and appreciate the significance

and adaptive nature of their behaviors rather than judging them and labeling the behaviors as "bad," engaged members in a non-distancing way. This therapeutic stance may be challenging for counselors: to be able to see unruly behavior as both a nuisance *and* a necessary reaction to the complex trauma that urban youth and adolescents experience. By putting these dual yet competing concepts into words–verbally reflecting students' behavior back to them without punitive judgment–counselors can serve to integrate students cognitively and affectively, helping them understand the effects that their undesirable behaviors have on themselves as well as others.

Second, group facilitators may benefit by being prepared to withstand a barrage of hypermasculine assailments from boys who have experienced complex trauma. This can be achieved through the facilitators' increased cultural self-awareness and confidence in their identities as adept counselors. Furthermore, facilitators may benefit from being aware of and comfortable with their own gender identities, especially for males treating boys in this population. Boys who experience their group facilitators as confident and consistent in their gender identities, as well as other dimensions of identity, and as displaying a more fluid conception of gender (i.e., modeling a male capacity for vulnerability, tenderness, emotional expression) may internalize the facilitators' balanced coping styles, and ideally use them to approach the unpredictable and confusing challenges of life the inner city.

Third, facilitators may expect to encounter a paradoxical process leading to changes in boys' behavior in group trauma work. As the first two authors observed, greater effort to control the bullying behavior exhibited by some boys was met with greater resistance to being controlled. The more facilitators attempted to exert change

upon the "misbehaving" boys, the less powerful facilitators felt and the more defiant boys became in response to these attempts. It is imperative for group facilitators to be attentive to process issues around power and control and to consider that, at times, the most efficacious way to shift power dynamics in entrenched interpersonal systems is through paradoxical interventions (Goldberg, 1980; L'Abate, 1984). As observed by Gestalt therapist Arnold Beisser (1970, para. 2), "by rejecting the role of change agent, we make meaningful and orderly change possible."

Fourth, since students felt safer discussing their traumatic experiences in individual counseling sessions, it may be helpful in future interventions to focus more on students' personal trauma experiences in individual sessions, as well as offer more individual sessions when possible. This would allow group activities to serve primarily as psychoeducational opportunities to engage in here-and-now interpersonal processing without asking students to discuss their past traumas. More research as to the efficacy of this split modality is clearly needed.

Lastly, group facilitators may benefit from ensuring that there is a safe and consistent group space from week to week from the outset of the group intervention. In addition, the space that was eventually secured by the school principal going into the second cycle of groups was a private room in the back of the library. Thus, the door was not connected to the hallway. This space proved to be very practical, as it allowed the students added privacy as they entered and exited the group room. Additionally, it prevented students and teachers from attempting to interrupt the group by physically entering the room, knocking on the door, or walking by the room and looking in through

the classroom window. This added layer of privacy was helpful in securing the therapeutic frame.

As the first and second authors witnessed firsthand, by giving students the opportunity to choose the extent to which they participated in the groups and to help revise and enforce the group ground rules, the attitudes and behaviors of students shifted significantly toward a more active and productive group dynamic. In sum, facilitators may find that shifting the therapeutic stance from one that *controls* to one that *invites* group members has the effect of reducing defensiveness and resistance toward facilitators' interventions. In a sense, by letting the group members make their own decisions to attend or not, to follow the rules or not, and to share their suffering with the group or not, the students were communicating to the facilitators what they needed to be healed. The enduring lesson that the facilitators relearned through this experience was that, in the difficult work of meeting our clients' suffering, the first rule is to learn to listen well to our clients and then to enlist them as partners on the journey we are to take together. Our interventions emerged from our listening and we should trust that our clients, regardless of the nature of their suffering, bring with them a deep wisdom that can help shed light as to what they need and how we may best help. Our job is to try to hear their most authentic cries beneath their distancing *bravado* and make room for that suffering to begin to be shared. Only then may real healing begin.

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Appendix

Table A1

Group Sample Self-Reported Demographics

	N	%
Dominican	38	65.5
Puerto Rican	6	10.3
Black/African American (non-Latino)	6	10.3
Mexican	4	6.9
Mexican-Ecuadorian	1	1.7
Honduran	1	1.7
Ecuadorian	1	1.7
"Brown" American (non-Latino)	1	1.7

Table A2

School Population Demographics

	N	%
School Population	618	100
6th Grade	210	34.0
7th Grade	197	31.9
8th Grade	211	34.1
Asian	12	2
Black	99	16
Hispanic	501	81
White	7	1
English-language learners	235	38
Special needs	173	28
Met NY standards on state English and math tests	31	5
Eligible for free lunch	619	90
Have an Individualized Educational Programs (IEP)	173	28
Receive temporary housing	179	29

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