This paper presents a detailed clinical description of work with severely traumatized and disturbed hospitalized adolescents, and a model for their long-term intensive treatment through the use of group psychotherapy. Many of these concepts and techniques may prove equally applicable to work with adolescents who are less disturbed and in less intensive treatment.

The Bronx Children’s Psychiatric Center offers a full range of services (inpatient, outpatient, day hospital, emergency services, and school consultation) to children and adolescents in a depressed, traumatized community of about 1½ million people. This paper will describe a group therapy program on the Adolescent Inservice.

The Adolescent Services have two coed units of youngsters ranging from 12 to 15 years of age. This paper describes work in the Long-Term Unit, which has a census of 18 beds. Most of the youngsters stay for several months and a few for well over a year.

Upon entering the unit, one first sees a Living Day area where youngsters spend most of their free time watching videos and television and playing different types of games in interaction with the nursing and recreational staff. On the left is the nursing station. Staff gather there to discuss the daily interactions and to make weekly notes on the children. There are three additional areas. A and B are the boys’ areas and C is the girls’ area. These units have small sleeping sub-areas.

The facility attempts to offer the youngsters quasi-normal life experiences through the Educational and Recreational Program. There are also different types of activities such as camping trips, summer jobs, special assemblies, music, dance, and art. The clinical staff provides a more specific psychiatric experience through individual, family, and group therapy.

The group therapy program was established for two reasons. First, most of the adolescent boys verbalized a need to share, learn, and relate to each other.
in a safe and protected environment without feelings of embarrassment or shame regarding their feelings. The boys also presented an extensive preoccupation with themselves and their growth changes. They expressed a wish to learn about themselves without feeling criticized or attacked by other patients in the unit (especially the girls). The other major factor was a state mandate for frequent group meetings.

The confluence of the boys' desire for a group and the administrative requirement led to the establishment of a group program. We, therefore, created what we called "Sub-Unit Therapeutic Community (T.C.) Meetings." These met twice a week for one-hour sessions in area A. They have met regularly for over one year. On occasion, additional group meetings have been held to deal with specific crises (for instance, new admissions or sudden discharges). Members of the boys group must follow rules and regulations established by the therapist, although all members of the group provide input and reinforcement.

The therapist (Ramos) was chosen because of her interest in the project and her availability. There were some reservations about an adolescent boys group being led by a young woman. We had some concern that it would be overstimulating, and that a negative transference to females would prevent the group from getting started. We worried how comfortable the boys would be in sharing personal and sexual experiences and feelings with a woman. After consideration we decided that awareness of these issues would enable us to deal with them constructively as they arose.

DEVELOPMENT OF THE GROUP PROCESS

The primary task during the early phase of the group was to establish a treatment contract. The adolescent boys were told the purposes of the group. In addition, they participated in forming and building the group structure. The rules of the group were: 1) members must attend group meetings on time; 2) members must raise their hands in order to be recognized to speak; 3) members must demonstrate respect and listen to each other; and 4) members must maintain confidentiality. The process of establishing and maintaining the rules was a constant issue. The stance of firm control helped set the tone throughout the group's history.

The issue of confidentiality became very important during the beginning phase of the group. The boys felt a great deal of anxiety, insecurity, and mistrust of each other and also of the leader. They were cautious and guarded in talking about their backgrounds. Feelings were denied or expressed in a disguised way. The disclosure of traumatic experiences in their lives was studiously avoided. They needed each other but feared and mistrusted each other. It was clear that they wanted to discuss these issues but had a great deal of fear about exposure. The ambivalence was profound.

Initially, the boys were perplexed as to how to relate to the leader. They verbalized loyalty to their individual therapists. In other ways they also indicated fear of and anxiety toward the leader. Each of these patients was clinically known to the leader. All of them were in individual therapy, some with the leader, others with other therapists. The weekly group sessions were considered a supplement to the individual therapy.

For the patients on the unit, attendance in the group was mandatory, with the exception of two patients who presented pictures of extremely low frustration tolerance, poor relatedness, and aggressive/assaultive behavior. Consequently, they were initially excluded from the group. Later, as the group