

My Story, My Way: Conceptualization of Narrative Therapy with Trauma-Exposed Black Male Youth

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This manuscript conceptualizes narrative therapy as a therapeutic intervention for race-based trauma experienced by trauma-exposed Black males. Urban youth, particularly Black males in high-risk communities, frequently witness community violence and endure multiple ongoing traumas, including those that are race-related. Such trauma may be overlooked or exacerbated in schools through teachers' implicit bias, inappropriate zero-tolerance disciplinary measures, out-of-school suspension, and misdiagnosis of trauma-related mental illnesses (e.g., anxiety, depression, post-traumatic stress disorder) as attention deficit hyperactivity disorder. This research explores race-based trauma from a blended theoretical framework incorporating trauma and narrative theories. Narrative therapy is presented as a collaboration-based counseling approach that emphasizes client experiences. Traditional talk therapies typically ignore race-based trauma as experienced by Black males. A culturally responsive narrative therapy model is proposed that incorporates the client's preferred mode of story-sharing, such as poetry, song/rap, drama, dance, writing, and illustration. Model significance and recommendations for school administrators, counselors, and therapists are provided.

Keywords: Black males, narrative therapy, urban schools, race-based trauma

Children living in impoverished urban areas are often exposed to several forms of violence (Finkelhor, Turner, Ormrod, Hamby, & Kracke, 2009; Listenbee et al., 2012; Smithgall, Cusick, & Griffin, 2011). Although many children exposed to violence exhibit amazing resilience, many more suffer long-lasting harm to their physical, mental, and emotional well-being (Buffington, Dierkhising, & Marsh, 2010; Finkelhor et al., 2009; Listenbee et al., 2012). The balance of risk and protective factors may influence whether a child experiences either short- or long-term trauma from such exposure (Howell, 2003). Aggression, for example, may result from the pain, fear, anger, and grief children feel when chronically exposed to youth, family, and community violence, including drive-by shootings and murder of peers, in "toxic" environments plagued by poverty, alcohol, drugs, gangs, availability of guns, and socio-cultural glamorization of violence (Prothrow-Stith & Spivak, 2004).

Race-based incidents are an additional form of violence that affect the well-being of African-American and other ethnic-minority children. Race-based incidents may be described as "cognitive/affective assaults on one's ethnic self-identification" (Bryant-Davis & Ocampo, 2005, p. 480). Such assaults may occur in many forms, including verbal or physical attacks or threats to one's safety and daily activities or emotional insults to one's intellect or culture. These may be inflicted infrequently or in systemic fashion by individuals and groups, through institutionally racist practices, or via cultural hegemony (Bryant-Davis & Ocampo, 2005). Given the multitude of forms in which individuals experience race-based incidents as violence, the exposure is often chronic and reoccurring. As with other forms of chronic violence exposure, race-based incidents

can result in posttraumatic stress disorder (PTSD) among vulnerable individuals (Bryant-Davis, 2007; Bryant-Davis & Ocampo, 2005; Carter, 2007; Sanders-Philips, 2009).

Chronic exposure to violence and race-based incidents and the associated traumatic impact disproportionately affect Black children (Adams, 2010; Garo, 2011a; Garo, 2011b; Nicholson-Crotty, Birchmeier, & Valentine, 2009; Toldson & Lewis, 2012). The trauma these children experience may be exacerbated in school by inappropriate discipline via “zero tolerance” policies that involve swift punishment for essentially minor offenses in attempts to deter crime or reduce the likelihood of reoccurrence (Braz & Williams, 2011). According to Teske and Huff (2011, p. 15), “Zero tolerance policies contribute to the existing racial and ethnic disparities in public education. These [and other inequalities, formed out of implicit bias among school staffs], more often than not produce lower graduation rates among minority youth, which contributes to higher rates of criminality among these youth.”

Black males and other youth of color are disproportionately affected by arrests by school resource officers/police (Dahlberg, 2012), and juvenile justice system involvement in itself can be a traumatizing experience (Adams, 2010). The disproportionate incarceration of Black males lends further evidence for race-based trauma as institutional racism. Further, Black and Latino males who originate from communities of concentrated poverty are more likely to adopt maladaptive, trauma-related coping strategies that result in their becoming both perpetrators and victims of violence (Adams, 2010; Allen & Lo, 2012; DeGruy, Kjellstrand, Briggs, & Brennan, 2011; Noguera, 2003).

Violence exposure has health, education, and employment consequences, causing Black males to also experience high rates of chronic disease, disproportionately high suspensions, special education placements, low test scores, and high unemployment rates (Garo, 2011a; Garo, 2011b; Patton et al., 2012; Rich et al., 2009). Yet, Toldson and Lewis (2012, p. 9) indicate that “Black males with and without disabilities can excel in schools that have adequate opportunities for diverse learners and a structure that supports personal and emotional growth and development.” For this, however, a shift is needed away from zero tolerance and campus police presence, classroom racial bias, and tendency for school staff members to view Black males as juvenile deviants and toward a host of preventative and rehabilitative strategies (Scott & Saucedo, 2012; Steen, Kotsoeva, & Kotsoev, 2016). The likelihood of Black males’ enduring violence-related trauma and being further traumatized through inappropriate “treatment” provides evidence that schools should adopt culturally responsive and trauma-sensitive practices. Narrative therapy is one such practice and forms the topic of this paper.

Purpose of the Paper

Given the increased exposure to violence and the associated trauma Black children experience, K–12 school teachers and administrators lack a culturally sensitive approach that meets the needs of this population. While the trauma-sensitive school model introduces trauma-informed practices in an educational setting, the model lacks an approach specifically for Black males. In addition to coping with the primary trauma (community-based or race-based), this population must also deal with challenges related to their gender and as well as their race (Meija, 2005). Because Blacks often view mental health services as “medicalizing” behavioral and emotional concerns (Caldwell, Assari, & Breland-Nobles, 2016), there is a reluctance to participate in traditional mental health practices such as talk therapy.

This article conceptualizes the use of narrative therapy as a culturally responsive approach to use with this population. Unlike traditional therapeutic approaches, narrative therapy is a non-pathologizing approach to counseling. Through collaboration between the client and the therapist, clients provide an “insider’s point of view” on their perspectives on their lives,

including the past and the future. Viewing clients as the experts on their own lives, therapists using a narrative approach help clients separate from internalized stories, allowing them to develop alternative “identity stories” that are empowering and not problem-focused. The authors propose a model that expands upon the trauma-informed school intervention model through the utilization of narrative therapy. The model allows the clients, Black adolescent males, to tell their stories their way, utilizing creative mediums such as rap, dance, spoken word, poetry, and music. The model aims to reduce behavioral, educational, and emotional problems that are often associated with PTSD.

Literature Review

The link between exposure to violence and trauma has been clearly demonstrated (Buffington et al., 2010; Perry, 2003; Perry, 2007; Van der Kolk, 2014; Zyromski, 2007). According to Buffington et al. (2010, p. 2), “A key condition that makes [dangerous or threatening] events traumatic is that they can overwhelm a person’s capacity to cope, and elicit intense feelings such as fear, terror, helplessness, hopelessness, and despair.” When children are exposed to violence, the resulting feelings of insecurity and powerlessness undercut the required tasks of developing mastery and competence in their environments. Traumatic response is most serious when exposure is chronic and severe, leading to complex trauma, which is associated with increased risk for delinquency and school failure (Buffington et al., 2010).

Abused and traumatized children have more severe academic problems than their non-abused counterparts, as child maltreatment has the potential to change the structure and chemical activity within the brain and has numerous effects on the child’s cognitive, behavioral, and social-emotional functioning (Child Welfare Information Gateway [CWIG], 2015; Thompson & Trice-Black, 2012). Such children are thus more likely to receive special education services, have below-grade-level achievement test scores, and have poor work habits, and they are 2.5 times more likely to fail a grade (Bethell, Newacheck, Hawes & Halfon, 2014; CWIG, 2015). Chronic or recurring exposure to traumatic events or experiences may create permanent memories, causing a child to remain in a relentless state of fear that interferes with concentration in class. Structural and chemical damage to areas of the brain that control behavioral and cognitive functioning may result in learning difficulties, lesser academic achievement, diminished IQ, and declining attentiveness or focus (CWIG, 2015; NSCDC, 2010; NSCDC, 2012). Violence may further affect behavior in that the brain creates permanent memories of traumatic events. These memories leave the child hypersensitive to imminent danger, as perceived in such nonverbal clues as eye contact, swift movement, or a touch on the arm or tap on the shoulder (CWIG, 2015). Often misdiagnosed as having learning disabilities, traumatized children may be inappropriately placed in special education, when the issue is actually alteration of the brain’s executive functioning (Perry, 2007).

Race-based incidents form yet another source of emotional injury leading to traumatic stress (Carter, 2007). Race-based traumatic stress may occur as a result of “(a) an emotional injury that is motivated by hate or fear of a person or group of people as a result of their race; (b) a racially motivated stressor that overwhelms a person’s capacity to cope (c) a racially motivated, interpersonal severe stressor that causes bodily harm or threatens one’s life integrity; or (d) a severe interpersonal or institutional stressor motivated by racism that causes fear, helplessness, or horror” (Bryant-Davis, 2007, p. 135–136). Such stressors may negatively impact the mental health of affected persons in several important ways. Institutional racism may result in inequitable access to services related to areas such as physical and mental health, education, employment, and housing, thus creating stress on multiple levels. Racist experiences can adversely affect the state of one’s psychological and physiological health, and the internalizing

of negative stereotypes may lower self-esteem and decrease personal wellness (Bryant-Davis & Ocampo, 2005). Studies have revealed positive associations between internalized racism and cardiovascular disease, diabetes, psychological distress, alcohol consumption, lowered self-esteem and a lack of socioemotional development among the children of mothers with internalized depressive symptoms, and other health problems (Bryant-Davis & Ocampo, 2005).

Social narratives and norms also impact how Black males respond to trauma exposure. The unfiltered nature of social media and a 24-hour news cycle contribute significantly to the negative narrative associated with Black males (Graham et al., 2017). Thomason et al. (2015) conducted a study comparing the amygdala of 21 trauma-exposed urban youth and 21 age- and sex-matched urban youth without histories of trauma. The results of the study demonstrated that “urban-dwelling trauma-exposed youth lacked negative prefrontal to amygdala connectivity that may be critical for regulation of emotional responses” (Thomason et al., 2015, p. 1460). This lack may result in a lifelong deficit of socioemotional functioning manifesting in behavioral, educational, and mental health problems.

As awareness of trauma increases, schools are beginning to consider and implement trauma-informed mental health approaches. Blitz, Anderson, and Saastamoinen (2016), for example, proposed a model for culturally responsive trauma-informed schools by adapting the sanctuary model (after Bloom, 1997). The culturally responsive, trauma-informed model promotes safe and supportive schools by utilizing open and democratic forms of communication and decision-making that also incorporate and validate the perspectives of all members of the school community and that foster emotional intelligence and socially responsible behaviors. Their actual study, however, strongly emphasized teacher professional development for classroom management, primarily for White female teachers, but did not offer therapeutic approaches to assist those students experiencing race-based trauma or the teachers experiencing “secondary” trauma resulting from stressful teaching environments (Blitz et al., 2016). Allison and Ferreira (2017) reported on a successful application of a Spanish-language Cognitive Behavioral Intervention for Trauma in Schools (CBITS) for Latino middle school students in New Orleans who exhibited symptoms of trauma and depression. They noted, “CBITS is a brief, standardized skill-based, group intervention designed to address the needs of multi-cultural youth populations, ages 9 to 18 years with difficulties managing and understanding symptoms of trauma and depression, resulting from exposure to traumatic and stressful life events” (Allison & Ferreira, 2017, p. 183). Their research demonstrated significant reductions in trauma and depressive symptoms among the participants.

Other research on school counseling among Black male students discusses culturally relevant approaches that utilize elements of narrative therapy, although it focuses on improving academic achievement rather than directly addressing mental health. Booth and Washington (2016) discuss the importance of fostering meaningful therapeutic relationships or alliances between counselors and Black male students as a way to counter deficit thinking and the effects on students’ self-efficacy and learning. They stress the importance of empathy, genuineness, and unconditional positive regard to self-actualization of the student (Booth & Washington, 2016). Similar relationship-fostering counselor philosophies that also utilize empowering Afrocentric principles within a culturally relevant curriculum to promote positive self-image and self-advocacy and improve academic achievement have been incorporated within group counseling among Black males (Steen, Kotsoeva, & Kotsoev, 2016; Trottman Scott, Mayes, Garret, Griffith, & Watkins, 2016). Trottman Scott et al. (2016, p. 179) recount the findings of Wade A. Boykin regarding the cultural elements manifested among Black males, namely, spirituality, verve (hands-on, active stimulation), harmony, movement, oral tradition, communalism, expressive individualism, affect (emotions), and social time perspective. School counselors have utilized

elements of these principles in individual and group therapeutic sessions with Black male students. School counselors, for example, have utilized hip hop and poetry therapy for self-expression and storytelling among counseling groups as an African-American oral tradition of sharing thoughts, dreams, histories, and experiences (Steen, Kotsoeva, & Kotsoev, 2016; Washington, 2016).

Trauma-sensitive schools promote the use of a tiered Response to Intervention approach that identifies problems, investigates why they occur, and develops problem-relevant intervention responses. There are three tiers or levels of intervention. Tier 1 interventions are evidence-based, culturally and socially responsive curricula for all students. School-wide positive behavior interventions and supports are an example of Tier 1 interventions and often serve to reduce the number of Black students referred to special education but are not particularly designed to address Black male race-based trauma (Trotman Scott et al., 2016). Tier 2 consist of more intensive psycho-educational behavior interventions and supports, also provided within schools in small group settings. Those not responding to Tier 2 interventions and supports are then referred to Tier 3 for more intensive interventions and comprehensive evaluations that lead to special education placement and related services. Some students may be referred out for intensive individual cognitive behavioral therapy (Rosanbalm, 2014; Trotman Scott et al., 2016). Universal screeners are a recommended mode of referral for Tiers 2 and 3 but have been demonstrated to “incorrectly identify students from non-White backgrounds as those in need of behavior interventions due to subjective views of the causes and possible solutions to the problem behavior” (Trotman Scott et al., 2016, p. 185). These currently implemented culturally responsive and trauma-sensitive approaches show promise for the inclusion of narrative therapy among Tiers 2 and 3 in adequately meeting the mental health needs of Black males experiencing race-based trauma.

Perception of Counseling by Black Males

Research shows that underutilization of mental health services by Black youth and their families can be attributed to alternate coping styles, such as religion and prayer, and resistance to “medicalizing” behavioral problems and emotional concerns (Caldwell, Assari, & Breland-Nobles, 2016). The juvenile justice system serves as a de facto mental health service entry point for Black youth with few resources. The findings of a research study conducted by Costello, He, Sampson, Kessler, and Merikangas (2014) indicate that among racially diverse American youth, the poorest youth are much more likely to receive mental health services from the juvenile justice system than youth from the wealthiest families.

Caldwell et al. (2016) reported that, based on the seminal 2010 Huey and Polo review of evidence-based interventions for youth mental health, there are no well-established evidence-based treatments for youth of color. The authors cautioned that this does not mean that current evidence-based treatments are ineffective. It simply identifies a significant gap in knowledge regarding the effectiveness of standard interventions to address major mental health issues in Black youth, as most of the literature focuses on disruptive and delinquent behaviors.

Because of the scant research on Black adolescent males utilizing counseling, the authors will explore males in general and their perceptions of counseling. Men who seek counseling have been stereotyped as being uninterested in the process, uncomfortable about attending, and reticent to participate (Brooks, 1998; Wexler, 2009). Schermer (2013) maintains that scholars have supported this belief by purporting that traditional masculine qualities are not conducive to the psychotherapeutic process (Bruch, 1978; Kiselica, 2001; Wexler, 2009).

Gilmore (1990) identified five common themes among traditional male sex roles that are narrated cross-culturally. These five themes are (a) showing strength, (b) taking risks, (c)

avoiding the feminine, (d) expressing aggression, and (e) having sexual initiative. Given this common thread, the literature encourages counselor practitioners to discuss with male clients their views about masculinity and what it means to be a man because that meaning can impact their perceptions of and reactions to situations (Mahalik, Talmudge, Locke, & Scott, 2005). Silverberg (1986, p. 167) cautioned therapists to “be mindful of the assumptions that they hold about men and masculinity, whether working from a narrative approach or not, as masculinity is a story about how to be in the world, which varies by culture, community, and individual. There is no one correct way to be a man.”

Recognizing that Black adolescent males coping with trauma exposure must deal with challenges related to their gender and their race, Mejia (2005) found that the social and cultural norms around masculinity can be viewed as secondary trauma. These unwritten rules enforce Black males’ being strong, emotionally tough, and aggressive (Thompson, Pleck, & Ferrera, 1992). Therefore, many will not voice or acknowledge their emotional pain or share their experiences.

Theoretical Framework – Trauma Theory

The study and paper approach the conceptualization of narrative therapy from a blended theoretical framework that merges trauma and narrative theories to explain root causes and offer solutions responsive to the experiences and needs of Black male students. Trauma theory provides an explanation for emotional and behavioral responses to violence among children exposed, often chronically, to adverse experiences that “involve harm, such as physical, sexual, and emotional abuse and/or neglect or abandonment by parents, caregivers and other ostensibly responsible adults . . . [These] occur at developmentally vulnerable times in the person’s life, especially over the course of childhood, and become embedded in or intertwined with the individual’s development and maturation” (Bloom, 2013, p. 20).

PTSD is a common response to trauma. Initially, PTSD was considered a mental illness resulting from war-related violence (Bloom & Reichert, 1998). However, PTSD has come to also be associated with adverse and urban adverse childhood experiences (The Research and Evaluation Group, 2013), which include witnessing domestic and community violence, child physical and sexual abuse, parental substance abuse and incarceration, bullying and other violence at school, discrimination, racism, oppression, and other stressors associated with concentrated poverty (Carter, 2007; Listenbee et al., 2012; Rich et al., 2009). Black children are disproportionately subjected to concentrated poverty and chronic violence exposure (Adams, 2010; Rich et al., 2009), along with race-based incidents (Bryant-Davis, 2007), and are adversely affected by zero tolerance discipline in schools (Dahlberg, 2012; Toldson & Lewis, 2012).

Trauma negatively impacts mental and emotional well-being. Children experiencing PTSD may become more easily angered, upset, and hypervigilant in anticipation of danger, even when no danger is present (Bloom, 2013). Post-traumatic stress can inhibit thinking and learning in children, with effects that include attention deficit hyperactivity disorder (ADHD) misdiagnoses (Perry, 2007) and other learning disabilities, decreased cognitive abilities, substance abuse issues, and externalizing disorders like aggression, conduct problems, and defiant and oppositional behaviors when exposed to violence (Buffington et al., 2010; Federal Interagency Forum on Child and Family Statistics, 2013; Listenbee et al., 2012; Smithgall et al., 2011). Trauma theory enables understanding of aggressive behaviors as symptomatic of trauma rather than mental illness or deviant moral character. Interventions thus focus on healing from traumatic experiences instead of drug treatments and punishment.

While trauma theory is useful for understanding the effects of violence on behavior and learning, the concept was developed from a Western perspective that ignores “traumatic

experiences of non-Western or minority cultures [and tends to] take for granted the universal validity of definitions of trauma and recovery that have developed out of the history of Western modernity . . . the theory [thus] risks assisting in the perpetuation of the very beliefs, practices, and structures that maintain existing injustices and inequalities” (Craps, 2014, p. 46). Narrative therapy is a respectful, non-blaming approach to counseling that uses externalizing as its central approach (Morgan, 2000; Ramey et al., 2009). The role of the therapist is to use language to externalize or separate the clients’ problems from their problem-saturated stories (Ramey et al., 2009). Narrative therapy offers a healing-oriented intervention that is adaptable to trauma experienced by Black males as well as others exposed to race-based incidents. Narrative therapy assumes that individuals are natural storytellers and are able to make sense of their life experiences through continuing narratives or storytelling (Lee, Fawcett, & DeMarco, 2016). The theory is particularly suited to non-Western cultures for which storytelling is a means of passing on knowledge, beliefs, and life experiences through oral tradition. Within this theory, clients are allowed to tell their stories in their own ways, choosing the modes of communication with which they feel most comfortable. Through telling one’s story, one may reflect on and ultimately release traumatizing memories. The empowering aspects of their stories help to enable healing, which ultimately leads to changes in self-concept and behavior (Lee et al., 2016). The theory is thus adaptable to non-Western cultural expression among Black males experiencing race-based trauma.

Treatment of Community Violence and Race-Based Trauma

The criteria for PTSD as defined by the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* involve exposure to a traumatic event, including direct experience, witnessing the event, learning the event occurred to a close friend or family member, or experiencing repeated or extreme exposure to the details of a traumatic event (American Psychiatric Association, 2013). Additionally, the presence of one or more intrusive symptoms must be present, including recurrent, intrusive, and distressing memories of an event; distressing dreams about the event; dissociative flashbacks about the event; prolonged intense distress when reminded of the trauma by external cues; and physiological reactions to these external cues. Criteria also include avoidance of stimuli associated with the trauma, such as avoidance of distressing feelings, thoughts, or memories about the trauma (American Psychiatric Association, 2013).

The most recent edition of the DSM-5 does not limit trauma to direct experience but expands the above-noted definition of trauma into four possibilities: direct, witnessing, learning about a trauma occurring to someone close to you, and experiencing repeated or extreme exposure to details of trauma. DeLapp, Williams, Davis and Sawyer (2016) suggests that with the expanded definition, it may now be possible to consider sociocultural factors that influence PTSD symptoms in ethno racial minorities, such as community violence exposure and racial discrimination.

Because community violence is more frequent in urban neighborhoods, some Black youth may perceive it as normal. Therefore, Black youth may not report the experience as traumatic (DeLapp et al., 2016). Additionally, others may not agree whether or not the event was traumatic, considering the nature of racism and race-based trauma (Bryant-Davis & Ocampo, 2005). Sue et al. (2007) found that others often meet experiences of racism with suspicion and invalidate them. Williams et al. (2014) advises both Black and non-Black clinicians to be genuine and transparent (e.g., “I don’t understand, but I want to.”) to validate the client’s experience and strengthen the therapeutic alliance (DeLapp, et al., 2016, p. 244).

Assessing Trauma

Turner and Mills (2016) noted that there are few psychological assessments developed specifically for use with Black youth, and these assessments have limited research to evaluate reliability and validity (Mano, Davies, Klein-Tasman, & Adesso, 2009). Mental health professionals are strongly urged to consider cultural factors when conducting psychological assessments, as failure to do so could lead to an incorrect diagnosis. Considering the limited assessments available for this population, Turner and Mills (2016) suggested using a non-traditional, Afrocentric prospective approach that is not based on Western assumptions. The authors noted several ways to apply an Afrocentric approach in clinical practice with Black youth but emphasized that the approach may not be useful for all Blacks. It is the clinician or evaluator's responsibility to assess the client's level of cultural identity. Second, the authors encouraged the clinician to incorporate the *DSM-5* Cultural Formulation in the assessment and treatment plans. This section of the *DSM-5* integrates cultural factors and "will help decrease misdiagnosis of blacks due to misinterpretations of cultural related information" (Turner & Mills, 2016, p. 31). Last, the authors advised clinicians to include factors such as social environment, social stressors, and culturally relevant social support systems, such as spiritual leaders and influential family members, when assessing Black youth.

Treatment of PTSD for Youth

DeLapp, et al. (2016) noted that cultural adaptations to prolonged exposure therapy are a useful treatment for Black children and adolescents with PTSD. These adaptations include more thorough psychoeducation, the integration of values relevant to Blacks, and in vivo exposure that is also more relevant (Dyrerogov & Yule, 2006; DeLapp et al., 2016). Cognitive behavioral therapy (CBT) has also been shown to improve symptoms in Black youth with PTSD (Cooley-Strickland et al., 2011; Scheeringa et al., 2011); however, Scheeringa et al. (2011) noted that Black youth as are more likely to drop out of treatment. This may be due to the number of sessions necessary to see an improvement.

Narrative Therapy Defined

The narrative approach is based on the work of Michael White and David Epston (White, 1986; White & Epston, 1990). It is considered a theoretical approach because it is a combination of theory, ethics, and respectful speaking and listening rather than an adherence to a series of defined concepts (O'Connor, Meakes, Pickering, & Shuman, 1997). Narrative therapy is a collaborative and non-pathologizing approach to counseling that examines the significance of relationships, communities, and other contexts, such as class, age, size, race, gender, sexual orientation, and ability, that influence one's thinking and behavior. Viewing the client as the expert on his or her own life, the approach is based on the concept that the client can solve his or her problem through the co-construction of the conversation between the client and the therapist.

The narrative perspective views problems as "internalized stories that have negative effects on the life of the person and/or the people in their lives" (Gaddis, 2004, p. 12). Culturally dominant discourses support these internalized stories. By separating the client from the problem, the therapist helps the client separate from the internalized stories so that he or she can explore the effects of his or her relationships with these stories on various domains of his or her life (Bird, 2000; White, 2007; White & Epston, 1990). Once separated, clients can critique and revise their relationships with their stories according to their preferences (Gaddis, 2016), allowing them to develop alternative, preferable relationships with the stories.

Using Vygotsky's (1987) theory of scaffolding, White (1995) developed the narrative approach from a stance of curiosity, using therapeutic questioning as a way for clients to learn

previously unknown information about themselves. Scaffolded questions enable people to move from what is known and familiar to what is possible to know. Bruner (2001) introduced the concept of world making to narrative therapy, suggesting that stories do not simply “happen;” rather, people actively construct them in their heads.

Stories in a narrative therapy context are made up of events, are linked by a theme, occur over time, and follow a plot (Morgan, 2000). A story emerges as certain events are privileged and selected over other events as more important or true. As the story takes shape, the teller further selects only certain information while other events become neglected. This results in the same story’s being continually told. These stories both describe and shape the clients’ perspectives on their lives, histories, and futures. By the time people come to therapy, the stories they have for themselves and their lives have more often than not become completely dominated by problems. These narratives, often referred to as “problem-saturated” stories by narrative theorists, can also become “identity stories.” For example, a teenager may describe himself as a high school dropout versus a young person who had difficulties with math. Narrative therapy challenges prevailing socio-cultural narratives and illustrates an alternative, richer understanding via deconstructive listening as individuals share their stories without pathologizing.

As an illustration of addressing trauma among youth, Aymer (2016) applied an integrative therapeutic approach that included aspects of narrative therapy, relational factors, and critical consciousness development. He used a case vignette involving a Black adolescent male who presented symptomatology due to his experience of being frisked and detained by the police. Aymer (2016) reported that it is beneficial for Black men to re-author their narratives in a manner that “can counteract the daunting effects of internalized oppression and can lead to self-empowerment” (p. 374). The author noted that after psychotherapeutic intervention, the client’s symptoms and feelings of anxiety, anger, and confusion regarding being profiled decreased significantly.

Significance of the Proposed Program for Black Males in Urban Education

This paper contributes to the counseling of Black males in urban education by providing a model that depicts a method for assessing race-based trauma and therapeutic interventions for clients who have experienced multiple traumas and require individual cognitive behavioral or other in-depth mental health treatment. Up to now, we have introduced the concepts and characteristics of narrative therapy and where such treatment fits within current, more traditional counseling models. These models have been modified through the incorporation of Afrocentric approaches within group settings and through facilitation by same-race counselors or well-trained personnel of differing races. Existing models, however, lack attention to the individual therapy needs of Black males exposed to multiple traumatic events, including race-based incidents. Traditional CBT is race-unspecific (Meija, 2005) and thus is not responsive to therapy needs of Black males in urban education settings. Our narrative therapy model, depicted in Figure 2, is significant in its provision of culturally responsive, trauma-informed individual therapy for Black male clients assessed for Tier 3 intervention, as illustrated in Figure 1. The final section of this paper offers recommendations for the design and implementation of the narrative therapy model for clients experiencing race-based and other multiple forms of trauma.

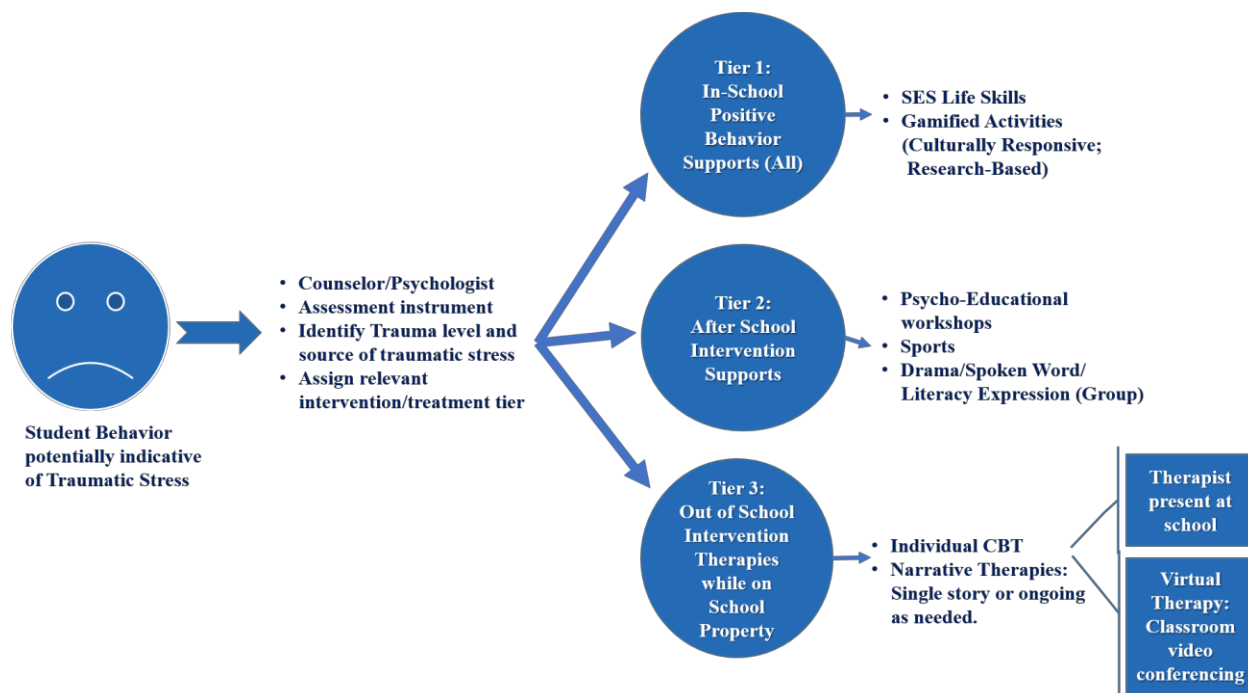


Figure 1: Narrative Therapy within a Traditional Trauma-sensitive Schools Tiered Response to Intervention Approach

Recommendations

Schools are the primary environments for coping with and responding to traumatic experiences, as youth spend the majority of their time there. Using school-based interventions to address the trauma may be more acceptable than recommending individual counseling sessions with therapists in the community. Blacks may have a negative opinions associated with mental health treatment, such as concerns about the social consequences of disclosing their disorders and a distrust of providers (DeLapp et al., 2016). “Trauma-informed schools” is a movement to address the needs of students who have experienced trauma (Graham, Yaros, Lowe, & McDaniel, 2017). However, the literature is limited regarding ways for trauma-informed schools to address specific races or ethnicities (Graham et al., 2017). The authors (Graham et al., 2017) proposed an optimal development model for boys and men of color exposed to trauma that includes nurturing environments that promote masculinity and cultural and racial identity. The model is based on the developmental perspective of youth, focuses on protective factors, and “highlights the need for positive behavioral interventions in schools; abundant recreational and cultural outlets; presence of intergenerational programming; community-accountable policing; and positive self-regard, self-esteem, and self-concept to counteract adversity and risk at different developmental stages” (Graham et al., 2017, p. 112).

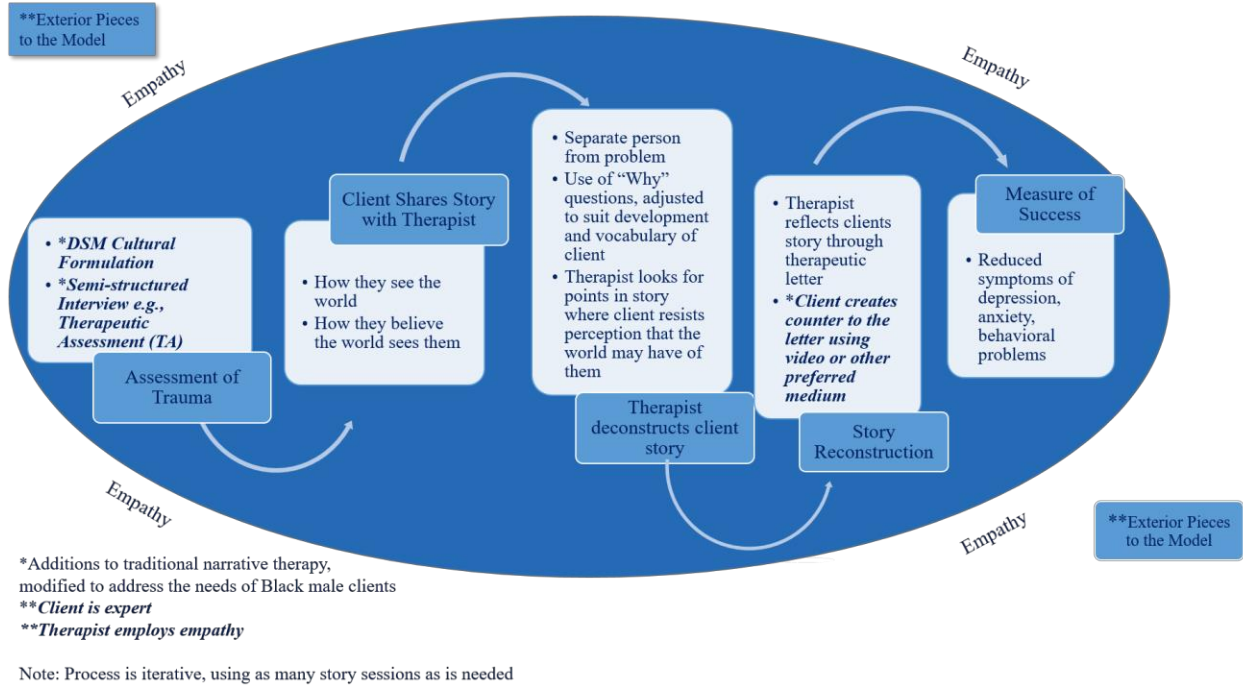


Figure 2: Integrative Narrative Therapy Model with Additions Specific to Black Male Clients
 Because the model for trauma-informed schools does not address specific ethnicities, we propose the use of the integrative narrative approach model for addressing trauma-exposed youth (Figure 2), which expands upon the trauma-informed school intervention model utilized at Tier 3. The Integrative Narrative Approach model views the client, not the therapist, as the expert. This perspective allows the client to feel he or she has some sense of authority in the process, reduces the fear of judgment, and alleviates, to some extent, the concern of “medicalizing” behavioral and emotional concerns. This approach empowers the client by giving him or her the freedom to express in a way that is comfortable. Throughout the model, empathy and genuineness are used to build a working alliance between the client and the therapist, which Hanson, Curry, and Bandalos (2002, p. 661) define as “the extent to which a client and therapist work collaboratively and purposefully and connect emotionally.”

Assessment

The authors propose the use of a semi-structured interview assessment rather than a traditional psychological assessment. As discussed previously, Turner and Mills (2016) noted that there are few psychological assessments developed and normed for Black youth. Additionally, semi-structured interviews will allow clients to share their perceptions of themselves using their words and nomenclature. This gives the therapist an opportunity to ask questions for clarity and meaning, making the client the expert versus the client’s having to ask the therapist to re-word or reframe a question because of a lack of understanding or a misinterpretation. As Turner and Mills (2016) suggested, the *DSM-5* Cultural Formulation should be incorporated into the semi-structured interview to address culturally relevant factors.

Therapeutic Process

The authors propose introducing the use of narrative therapy to the client during the first session, focusing on the process and the intended outcomes. This will reduce the client’s apprehension regarding what to expect and will also give the client an opportunity to consider

which medium he would like to use to re-tell his story during the last few sessions. Throughout the therapeutic process, the client will share his story, describing how he sees the world and how he believes the world perceives him. The process is iterative, allowing the client time to tell his story his way. It is projected that an average of seven sessions will be needed.

During this stage, the role of the therapist is to ask questions with empathy and curiosity. This reinforces to the client that he is the expert and is educating the therapist. The therapist uses this as an opportunity to notice any points in the story at which the client resists perceptions that the world may have of him. The therapist uses this gathering of information to aid in deconstructing the client's story and reflecting back to the client what he or she heard via a therapeutic letter to the client.

Measure of Success

Through the iterative process of sharing their stories, clients reflect upon traumatic memories. The client separates himself from the trauma and focuses on his response and healing. This leads to a change in how the client views himself, specifically his self-concept and behavior. The client creates a counter to the letter and reconstructs his story using video, hip hop, music, poetry, or another preferred medium. The reconstructed story showcases the therapeutic change that the client has experienced. The story is recorded for the client to reflect upon in the future.

It is the authors' recommendation that a licensed mental health professional with training in narrative therapy implement the model. If such a professional is not available, the model can be implemented using distance counseling. The American Distance Counseling Association (ADCA) defines distance counseling as the "practice of seeking and receiving help through the internet" (www.adca-online.org). It is also referred to as telehealth, online counseling, online therapy, and eTherapy. Distance counseling can occur via asynchronous email, synchronous chat, and video conferencing. While the literature suggests that the proposed model could be successful with this population, the authors propose future empirical research on narrative therapy as it relates to Black male youth.

Concluding Remarks

This paper has expounded on an existing model for trauma-informed schools by recommending an Integrative Narrative Approach Model that specifically addresses treatment for race-based and other trauma among Black youth. Using narrative therapy as the culturally responsive and trauma-informed approach, clients are encouraged to deconstruct and reconstruct their stories using their preferred mode of story-sharing such as a poetry, song/rap, drama, dance, writing, and illustration. It is the authors' hypothesis that such approach will reduce negative responses to trauma among Black male youth, particularly when the trauma is race-based.

Such therapeutic in-school intervention is timely. The longstanding and well documented disparity in school discipline for Black males is exacerbated by race-based incidents outside of school. And challenges in access to mental health may be alleviated through in-school or after school care. As America continues to be divided, hate crimes have increased thereby also compounding the risk for race-based trauma. The August 28, 2017 edition of Time Magazine, for example, discusses numerous race-based hate crimes that have targeted marginalized populations during the past year. Not all states have hate crime protections, and some incidents have involved injustices committed by officers of the law. Disenfranchised individuals may well feel overwhelmed and unable to seek help.

The DSM-5 Cultural Formulation specifies that PTSD can be triggered by exposure to trauma whether witnessed in the community, occurring in the home, or viewed on outlets such as

social media or television. Given the detrimental impacts of trauma on youth (e.g., decline in grades, increased aggression, depression, etc.), and the gender and culture-based barriers to seeking mental health services, schools and school settings offer the opportunity to address race-based and other trauma among Black male youth by implementing a culturally sensitive Narrative therapy approach.

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