Group Therapeutic Resourcing Interventions for the Treatment of Trauma (FORTHCOMING)

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Abstract

Group therapies possess a great number of benefits for trauma survivors, yet there exists a lack of clarity in the literature surrounding the application of trauma principles in group settings, or an awareness of the role of mindfulness-embodiment technologies for resourcing individuals prior to trauma processing. This article explores the value of structured-format auxiliary groups for trauma treatments that orient towards resourcing participants. We utilise the example of mindfulness and embodiment-based resourcing technologies, as illustrative of top-down and bottom-up approaches to trauma resourcing. It is demonstrated that these technologies cultivate the ability to orient attention towards the present moment, increasing bodily and affective self-awareness, which serves to reduce patterns of reactivity, thereby supporting: symptom stabilisation; improved reflective and mentalising ability; and the cultivation of the self- and co-regulatory capacities necessary for trauma-processing group work. An overview of best-practice principles for establishing auxiliary resource groups is then provided, outlining: the phasic introduction of these resources in 'group settings' when and where they are applicable; the necessary screening requirements and exclusion criteria; the role and function of group norming and relational approaches; the importance of pendulation and titrations principles; and how to work with distinct populations and in-group heterogeneity. In this way this article elucidates the foundations for both developing an auxiliary resourcing group and for implementing such groups into a treatment plan for individuals living with trauma.

Introduction

Alongside one-to-one treatment approaches there is great value in group treatment in supporting individuals living with trauma. The primary goal of adopting a trauma-informed approach to group-based therapeutic support is a balance of *resourcing* participants whilst preventing their inadvertent re-traumatization during service provision. We can differentiate 'primary' or processing-oriented group therapy—that is group therapy which directly focuses on the processing of trauma—from 'auxiliary' or resourcing-oriented, group programmes—which focus on supporting clients in cultivating *regulatory* skills and capacities. This resourcing-orientation serves as an important prerequisite for later primary processing of traumatic experience, either in group or individual therapeutic sessions.

Despite the growing recognition of the need for trauma-informed group work, inadequate attention in the literature has been given to the application of trauma principles in group settings, and in particular the principles for auxiliary-groups in resourcing individuals (Baird & Allaggia, 2021). The focus in this article is to provide group facilitators with information and pragmatic cautionary guidance in understanding the role of auxiliary resource-oriented

programs, which may be integrated across phases of trauma treatment, ideally as adjuncts to individual treatment. Such support and recovery-oriented programs, as will be suggested, must be considered in the context of working with specific populations. Many of the principles that apply in primary processing-oriented group therapy for trauma may be successfully carried across to adjunct programmes for specific skill cultivation. In this way, group settings can provide an auxiliary toolkit for trauma-recovery without engaging in direct trauma processing.

Group therapies possess a great number of benefits for trauma survivors, explored for instance by Foy (2008), Ford et al (2009) and Classen (2007). Group therapies have been demonstrably valuable to those who routinely dissociate or are diagnosed with dissociative conditions, and for those struggling with relational difficulties, as group work directly and experientially addresses interpersonal patterns with *in vivo* interaction and feedback (Fine & Madden, 2000). In recent years a number of treatment approaches for trauma have emerged that may be adopted in group settings. This article will explore these approaches by considering auxiliary groups that utilise both top-down and bottom-up, embodiment and mindfulness, resourcing strategies. This will involve evidencing the role of such modalities in group work settings, offering specific cautionary remarks for group work practitioners and illustrating the benefits of applying trauma-informed approaches in group contexts.

This article turns first to establishing the distinction between primary-processing and secondary-resourcing groups; as well as the distinction between top-down and bottom-up approaches. This provides the groundwork for an exploration of the particular virtues of embodiment and mindfulness-based groups for resourcing trauma-survivors, and the foundations and best-practice principles for establishing auxiliary resourcing groups.

Primary Processing and Auxiliary Resourcing Interventions

In recent decades vast progress has been made in our understanding of psychological trauma; its forms, effects and treatment. Earlier models of trauma emphasised solely post-traumatic stress, without recognising the significant role of complex and developmental trauma in the range of psycho-social outcomes in individuals presenting for treatment (Cloitre, 2005). As many clients had been exposed to early and severe childhood abuse and neglect, their difficulties were frequently complex, involving not only symptoms of PTSD, depression and anxiety, but also problems with identity, affect regulation and interpersonal relationships; alongside issues with substance abuse, dissociation, somatisation and self-harming behaviours (Briere, 2004; van deer Kolk, 2005). For this reason, this article focuses on both PTSD as well as the broader developmental and complex trauma effects, and implications for treatment.

Given our broader focus we will use the term 'trauma' as a catch-all referring to post-traumatic stress disorder (PTSD), complex PTSD (C-PTSD) and developmental trauma. Whilst there are significant divergences between these forms, we are concerned with group interventions applicable across the range of trauma presentations. From a summary review of the many

forms of therapy applied to the problem of trauma, we can note two distinct and quite different approaches to its treatment; primary and secondary approaches (Ogden & Minton, 2000; Solomon & Heide, 2005; Ford, 2018). Each approach claims various mechanisms of change. These mechanisms will typically, but not exclusively, involve exposure—either cognitive, affective or somatic—in an effort to re-temporalise, and thus serve as a corrective to, the traumatic experience via the creation of some sense of ordering of memory and agency (Dowie, forthcoming).

The first category of approach, *primary*- or *processing*-focused models, are specifically focused on processing traumatic experience; which involves reorganising the mind of the client along the domains and across cognitive, affective and sensate levels. The second category might be called *secondary*- or *auxiliary-, resourcing-focused* models for the support of traumatised individuals. These models are generally focused on the tasks of improving affect regulation capacities via positive affective inputs. Whilst often insufficient in themselves for the treatment of trauma, these resourcing skills are proving to be essential supplements in effective trauma treatment.

This article will demonstrate the applicability of well-established trauma-processing principles to groups focused on auxiliary resourcing. The ambition is that the reader may utilise this work as a basic principled scaffold in establishing such resourcing-oriented group programmes. In particular, we will consider the value of auxiliary resouring group programmes focused on cultivated both *bottom-up* and *top-down* regulation strategies—in the form of mindfulness and embodiment practices. We turn now to the research concerning the distinction between bottom-up and top-down approaches to trauma treatment, before offering an illustration of the nature and range of mindfulness and embodiment practices that can be applied in resourcing group settings.

Bottom-Up and Top-Down Interventions

A clear distinction can be drawn between what are called bottom-up or top-down interventions for trauma treatment (Music, 2012). *Top-down* interventions utilize the influence of mental processes, for instance, volition or will, upon the organisation of other processes at affective or sensate registrations of experience. Such approaches are well-documented and exemplified, for instance, in cognitive exposure models. *Bottom-up* approaches to trauma-treatment, by contrast, attend to traumatic experience from 'lower' levels or registrations of experience. That is, bottom-up approaches may begin with information acquired at the sensate or affective level; sensations or feelings in the body. These approaches are apparent in somatic experiencing or somatosensory models for trauma interventions, which focus upon bodily awareness in the present moment and the role of acceptance of felt-sense information (Levine et al, 2015; Fisher & Ogden, 2009; Fisher, 2019).

The strengths of top-down approaches are widely evidenced in the literature. Traditional talk-based psychotherapy, and cognitively oriented therapies are illustrative of 'top-down' approaches to trauma treatment. Cognitive-behavioural therapy work is a classic example of a top-down strategy as it works principally with cognitions to create change. Enhanced cognitive regulation, by the prefrontal cortex over the limbic system, may support a traumatised individual to alter the relevance of certain environmental stimuli, such as perceived threats, stressors and trauma triggers. Luyten & Fonagy (2019), *in Mentalizing and trauma*, illustrate how trauma not only disrupts the attachment system but also impacts mentalizing abilities. As such top-down approaches, that support the client in cultivating higher-order reasoning skills, may improve an individual's reflective functioning and metacognitive capacities.

A limitation of top-down processing approaches, however, concerns the fact that higher-order executive functions lose their potency when the body's physiological alarm system is activated; when individuals enter a dysregulated state of hyper-arousal or hypo-arousal in response to perceived threat. In light of these limits of top-down approaches, the strengths of bottom-up approaches are gaining recognition and proving highly relevant to trauma treatment. For instance, there is growing recognition that contacting memories of trauma-laden affect can be re-traumatising if the client is unable to do anything with those dysregulating feelings (Grabbe, 2018). A bottom-up approach allows the client to explore the dysregulated affect and sensations only after safety and stabilisation in the body have been established. Establishing a felt-sense of safety in the body creates an experiential sense of safety in the present. This increases the client's bandwidth for contacting dysregulating affect or memories, as they can return to the present moment felt sense as a resource. As such bottom-up approaches have been linked with improved capacity to regulate arousal, to tolerate fluctuations in arousal, expanding a clients 'window of tolerance', as will be discussed (Siegel, 2010).

Both top-down and bottom-up intervention approaches can prove of utility in either the auxiliary-resourcing or primary-processing of trauma—as both may involve the development of positive strengths such as resilience, flexibility, nurture and self-regulation—capacities critical to both resourcing and processing ends. Neither approach need be taken in isolation. 'Dual-awareness' modalities and approaches, which integrate therapeutic action from the bottom-up and top-down, are common (Fischer, 2019). In what follows, we will explore how mindfulness and embodiment practices, offer a synthesis of top-down and bottom-up approaches. We will then outline the relevant principles for establishing a resourcing group that utilises both mindfulness and embodiment technologies.

Mindfulness and Embodiment in Trauma Treatment

Both in the popular imagination and in the field of clinical practice, there has been a bloom in trauma-awareness and a burgeoning in interest in bottom-up technologies for trauma intervention, this is most apparent in the field of 'embodiment'. Embodiment refers to a varied

and expanding list of activities that intentionally orient the individual towards establishing a relationship between the conscious mind and bodily sensations or experiences (Biehl, 2015). For this reason, Embodiment practices are bottom-up approaches to treating trauma. Interestingly we are rediscovering the treatment value of embodiment technologies that generally developed outside clinical scientific contexts, originating instead in Indigenous and non-western cultures. In the domain of 'positive psychology', for instance, we are seeing the emergence of therapeutic approaches which offer renewed attention to body-based somatic modalities including: synchronised-movement; physical postures or asana; progressive muscle relaxation and breathing exercises; nature-connection; and relational practices, such as group ritual, ceremony, theatrical performance, intentional dance and relational movement (Caplan et al, 2013; Hübl & Avritt, 2020). These technologies have been predominantly drawn from Eastern and Indigenous Contemplative traditions.

Similarly to embodiment technologies, mindfulness-based therapeutic interventions have their roots in meditative practices which derive from Eastern, particularly Buddhist tradition. Mindfulness in this sense is a mode of awareness that is present-centred and nonevaluative; this form of awareness is widely believed to have intrinsic value in promoting positive mental health and adaptation by interrupting discursive thoughts that give rise to suffering (Kirmayer, 2015). Mindfulness practices are an interesting anomaly in the case of bottom-up and top-down interventions. This is as contention exists over whether mindfulness ought to be understood as a top-down, or bottom-up, emotional regulation strategy. Mindfulness is sometimes viewed as 'top-down' as it involves the conscious mind regulating affect and sensate response; yet at other times considered bottom-up, because many embodiment practices are described as 'mindfulness' technologies (Chiesa et al, 2013). This is an interesting discrepancy that speaks to the poor articulation of the distinction and cross-over between mindfulness and embodiment practices, a subject I explore in a forthcoming publication. In exploring the principles of resourcing approaches in group settings, we will focus upon both embodiment and mindfulness, as a synthesis of bottom-up and top-down technologies.

Such embodiment and mindfulness practices utilise in distinct ways interoceptive perception of physical sensations in order to gain insight into what is occurring on a bodily and emotional level; as well as relational insight into the experience of the other in connection. One illustrative example may be the practice of mindful breathing in order to observe directly the relationship between quickening breath and heart rate that may occur in tandem with a perceived threat. An underlying ambition in practices that attend to physical sensations and prompts, is to cultivate a dialogue with the body, an atunement to the body's needs, and improved regulatory capacities (Khoury et al, 2017).

There is significant research supporting the linkages between increased somatic awareness, through mindfulness and embodiment practice and increased relational insight as well as self-regulatory and co-regulatory capacities. Recognition of the meaningful relationship between embodiment and mentalisation, or reflective function, is currently in emergence (Køster, 2017;

Rappoport, 2015). Such technologies, however, have been historically derided by empirically focused psychological researchers, on account of the positivist epistemology and scientistic tendency of the western academy (Laungani, 2006; Mazur, 2021). However, as Courtois and Ford note, not only are such practices derided but, more broadly, so too are the *relational* components of interpersonal therapeutic modalities; including the psychodynamic, client-centred, mentalisation-based therapeutic principles (Courtois & Ford, 2012, p. viii). Just as there is a growing recognition of the importance of traditional bottom-up embodiment practices the emerging science of interpersonal neurobiology and affective neuroscience is leading to a recognition of the importance of right-brain to right-brain connections in facilitating therapeutic change (Schore, 2020). We will explore the role of relationship in greater depth below. Importantly, for our purposes, mindfulness and embodiment practices serve as valuable modalities for resourcing individuals, and thus lay a foundation for the later processing of trauma—given their integration of present-centred, mentalisation-based, and somatosensory principles. They also have a role in skills training for seeking safety, interpersonal regulation and trauma-affect regulation: all of which are fields that have received recent investigation and garnered significant empirical support in the treatment of trauma (Ford, 2016).

It is important to begin by discussing the value of utilising embodiment and mindfulness-oriented resourcing approaches to trauma specifically in *group* settings. Trauma's 'triad of symptoms'—intrusive re-experiencing, avoidance and hypervigilance—may all surface either during or following group sessions (Schore, 2020). As such processing-group participation requires individuals to possess a solid foundation of emotional regulation skills and resources, in order to engage in trauma processing whilst avoiding crises or regression. Groups utilising auxiliary embodiment and mindfulness-oriented resourcing approaches, when facilitated with care and drawn upon in tandem with one-to-one therapeutic support, are well situated to serve as the skill-building spaces need to develop the capacity to participate and gain from primary-processing oriented group work. This is as in these spaces participants may develop their sense of felt-safety, emotional organisation, self- and co-regulatory capacities. These resources can lead to the development of greater self-esteem, improved relational dynamics and strengthened tolerance for discomfort. We turn to phasic models of trauma treatment, to explore how these resourcing interventions may best be applied. As will be seen, groups ought to orient in the first instance towards building emotional-regulation and stability, the foundation essential to later trauma processing and resolution, however these skills prove applicable at all stages.

Multi-Phasic Treatment Models: where to place resourcing groups?

Following the pioneering work of Pierre Janet (1889/1973) and its later evolution in the work of van der Hart, Brown and van der Kolk (1989), we have seen the reintroduction of a three-stage sequenced treatment model applied in the context of treating complex developmental

trauma relating to dissociative disorders. Courtois & Ford's (2012) sequenced, relationship-based approach to the treatment of complex trauma has built upon these foundations. Further work is required in mapping the application of resourcing technologies for groups across these multiphasic stages. Nonetheless the three treatment phases, described by Courtois & Ford, offer a basic scaffold for determining where embodiment and mindfulness resourcing groups fit into trauma treatment. Let us briefly review the sequenced three-phrased treatment approach.

The first phase emphasises establishing personal and environmental safety and safety planning. If a client is still actively in danger from others, or actively involved in significant compulsive activities or addictions, then the impacts of trauma cannot be safely treated. In such instances, early intervention is required to establish safety prior to trauma treatment. Psychoeducation around trauma and post-traumatic reactions serve as a critical foundation during this phase, alongside establishing the therapeutic relationship and the cultivation of specific skills, such as emotion identification and methods to achieve self- and co-regulation. Given this focus, the first phase is a natural starting point for the integration of embodiment-mindfulness modalities. The introduction of these technologies may support participants in stress-management and self-care, this begins to address post-traumatic symptomology as the primary goal of these modalities is to sustain and enhance gains in trust and relational security; resourcing individuals whilst simultaneously promoting symptom relief and improved functioning. This occurs as achieving felt-safety and emotional regulation are essential functions of mindfulness and embodied technologies.

The second phase of Courtois and Ford's model emphasises the client's processing of trauma and its attendant emotions, beliefs, and cognitions. The ambition is to achieve mastery over the memory and the emotion-states associated with traumatic stress. The third phase concerns the application of the skills and knowledges accrued in the first two phases to future daily life. This consolidation is vital to a complete integration, and a fully functional life post-trauma, intimately related to what is described in the literature as 'post-traumatic growth' (Jayawickreme et al, 2021). Embodiment-mindfulness resourcing skills are applicable in this context as they foster the development of regulatory capacities required to remain in relation with dysregulating sensations and emotions associated with trauma; without regression or re-traumatisation. As such while groups engaging in processing-oriented trauma-treatment are generally introduced in the *later* phases of treatment, the auxiliary resourcing skills-based group approaches remain applicable across phases although apply most critically, in phase one.

Founding Principles of Trauma-oriented Group Work

Let us turn towards the structure and important facets of Phase I treatment of trauma, and the consequent considerations required of the clinician intending to integrate group resourcing interventions, utilising embodiment-mindfulness technologies, into a treatment plan. It is important to recognise that the therapeutic facets identified below are not to be applied in a

linear sequence, trauma-oriented group work is highly dynamic in practice, and the technologies applied or emphasised, will be influenced by factors such as the client's clinical status, emotional-regulation capacity, motivation and response to treatment; as well as the group population. This of course, occurs alongside emergent group dynamics that come into play in the therapeutic setting. As such the below principles are not to be applied progressively or in a linear fashion but rather serve as founding principles that 'saturate' the methods of the facilitator. This requires the facilitating clinician to engage in a dynamic process of case formulation, prior to and across the group treatment process (Horwitz, 1977). It is important to acknowledge at the outset that depending upon their presentation, trauma history, and level of interpersonal resourcing, some participants may move through these skill acquisitions with ease whilst others may require significant time and repetition to master these skills. This will influence at which stage in their treatment, it is appropriate for participants to enter processing-oriented group settings.

Open Process or Structured Group Format

Group therapy can be carried out both in 'open process' format, as well as in strictly didactic, educational and 'structured' formats (Yalom, 2020). As described mindfulness and embodiment technologies, which may be applied in either open or structured groups. The format will have important implications for group selection criteria, as open-process groups pose certain risks and are contra-indicated for some trauma presentations. As such prior to intake the first point to establish is whether the therapy groups will be open process or structured in format.

Open-process groups focus upon trauma-processing. In these sessions therapeutic benefit derives from interpersonal learning that occurs in dynamic interaction between group members. This proves particularly valuable for complex trauma presentations in which a history of formative trauma of omission and commission, neglect and abuse, has shaped an individuals' internal working model of self, world and other, in ways that are detrimental to their later life functioning. Interpersonal learning offers an opportunity for reality testing, and insight raising, which may redress distortions in the perception of self, in relation to world (Bowlby & Ainsworth 2013; Brown & Elliott 2016). As such in these settings the mechanism of therapeutic change involves the relational space created in the group setting, as such the sessions are oriented towards increasing relational awareness and in this way reflective function. The mechanism of action for complex trauma work often involves explicitly: the ability to learn from others; to share your experience, problems, and struggles; to see how you interact in group spaces; and to gain insight into how your interaction with the group is informed by your history—each of these interpersonal factors may play an important role in trauma-processing.

In general, in seeking to meet Phase I goals, embodiment-mindfulness oriented resourcing groups are likely to be highly structured and presented in educational or didactic form rather

than in open-process format. This is as open-process formats, given their minimal structures and open discussion, can prove overstimulating and dysregulating to trauma survivors who may be inadequately skilled or resourced. By contrast groups that are structured in format may seek to derive therapeutic benefit, by placing emphasis upon psychoeducation, skill development or 'witnessing' group members experiences, without direct interpersonal exchange (Yalom, 2020). Highly-structured groups have multiple benefits for early skill-building: they limit and contain generated emotions; client's learn skills for managing trauma stress reactions which may be practiced in between sessions; they provide lower risk opportunities for connection and overcoming isolation; and they offer empowerment through shared expression and mutual aid in coping.

With a lower risk of re-traumatisation, participants in structured groups may develop an increased sense of personal control, empowerment and hope; self-understanding, –esteem compassion; alongside improved capacity for healthy self-assertiveness and increased boundary recognition (Krishna, 2011). It is only once greater emotion modulation capacities are achieved, via increased safety and stabilisation, that participation in more open-ended or process-oriented work would begin (Courtois and Ford, 2012, p. 194). Following Foy et al (2011), then, the suggestion made here is that auxiliary therapies, oriented to resourcing traumatised individuals, should avoid open processing formats unless they are facilitated with the careful attention of a highly experienced trauma specialist. On account of the complicated interactive dynamics occurring in groups a co-therapy facilitatory team is preferable across group models (Roy et al, 2013).

Intake, Selection and Exclusion

Caution must be taken in the intake process, as some individuals may require unique attention and support or may meet exclusion criteria from group settings. Auxiliary resourcing groups, even if not directly targeted at trauma processing, must take the practical preparatory steps necessary for supporting clients with complex post-traumatic conditions. This includes policies around managing reasonable risk, crisis prevention and management, and initial assessment.

*Initial Assessment: a*ssessment and treatment pre-planning is the groundwork for all group work. Intake must involve questions surrounding past and present-day trauma with the recognition that disclosure may not readily occur even when clients have a trauma history. Assessment may be repeated over the course of treatment to redirect sessions if needed. Exclusion criteria must be established for the personal safety of clients and the group structure; as participants require a solid foundation of personal safety and emotional regulation skills and resources in order to engage in group settings whilst avoiding crises or regression. These exclusion criteria will vary given the nature of the group work and the intended participants, as will be discussed in the screening process.

Screening: Screening interviews and pre-treatment preparatory sessions assist in both the process of participant selection and in ensuring the informed consent of participants. Screening ought ideally be conducted by therapists in order to meet and assess potential members and answer questions. This must involve screening out individuals for whom it would not be safe to participate in this level of relational engagement, who would benefit more from one-to-one therapeutic work, and those who would prove disruptive to the group process by virtue of impulsiveness or learned patterns of aggression. Particular attention should be given to participants' attachment styles, including clinical-level attachment disorders and clinical-level personality disorder presentations—as well as questioning around participants' levels of interpersonal resourcing. Courtois and Ford (2012) suggest the need for care here in relation to survivors with severe dysregulation, poor object relations, borderline personality characteristics, or severe sexual abuse histories (Cloitre & Koenen, 2001; Follette, 1991; Piper et al, 2007). However, as suggested, for such group applicants the auxiliary resourcing groups highlighted here, explicitly oriented towards skill-building, may serve as the necessary precursor to process-based groups. Nonetheless, even for resourcing groups, it is important to acknowledge that group participation is not possible for all who seek to participate.

Establishing Safety prior to Stabilisation

Whilst embodied-mindfulness resourcing may lead to symptom stabilisation this should by no means be confused, or taken as sufficient, when real world safety needs remain unmet. It is critical that during intake screening, or in consultation with a participant's therapist, life-safety is established prior to engaging in group work. This is as lowering emotional defences is nearly impossible in situations of persistent external threat. Similarly, while some symptoms may not pose immediate threat to safety, they nevertheless may compromise an individual's ability to function in daily life and thus also to function in a therapeutic group setting. For this reason, screening for appropriateness of participation is of great importance.

It is important when discussing 'safety' to clarify what is meant by the term. This is particularly relevant today considering our linguistic tendency to use the word 'unsafe' in situations that could be more accurately described as 'uncomfortable'. This misperception of discomfort as unsafety frequently may occurs as a result of diminished capacities for emotional regulation, and an ineffective window of tolerance—trauma can recalibrate and distort a person's abilities to assess and respond appropriately to potential threats. As such a participant may perceive threat and be dysregulated by that perception, during a group therapy session, even though this encounter is intrinsically non-threatening. When writing here of the necessity for establishing 'safety', then, reference is being made to safety as the absence of real-world external threats. This may be accomplished whilst the individual retains a felt lack of safety. It is important to introduce this caveat, as there is a danger of facilitating a cultural mode of fragility under the guide of trauma-informed care which proves counterproductive to trauma-processing, for further see Taleb's (2012) work on anti-fragility and Lukianoff & Haidt (2019).

The real-world safety of the client is a necessary prerequisite to moving into the second phase of responding to Trauma. A level of psychosocial stability can come from membership within a group of peers in a facilitated space where they are not threatened; and such re-modelling can expand a client's field of vision and enhance the felt sense of security. Indeed, data demonstrates that sessions designed to enhance skills in emotional regulation and interpersonal effectiveness dramatically improve the trauma-memory processing component of therapy down the line (Cloitre et al,. 2010). Nonetheless external life-threatening situations will not, in and of themselves, be resolved through group work. As such it is necessary to ensure participants have relatively safe external life situations. Questions must be addressed, such as: are they homeless, are they experiencing domestic violence, are they engaged in significant addictive or harmful behaviours? Diminishing exposure to life stresses, instabilities, and imminent danger is of paramount importance before either trauma-resourcing and processing can proceed. Once real-world safety needs are met, symptom stabilisation is the obvious point at which auxiliary modalities come in. As such, attention can now be placed on the actual work of resourcing participants. We will explore modes of resourcing in the subsequent sections.

Emotional Regulation and Psychoeducation

Methods for resourcing participants may draw from a range of models, including those developed for PTSD treatment more specifically. That is, they may involve a focus on identification of clients' strengths and resilience; survival skills and adaptations; as well as psychoeducation around trauma, its symptomology, secondary elaborations, and developmental impacts. Yet they may also, as is the focus of the proposed embodied-mindfulness resourcing groups, offers skills training for emotional regulation and stabilisation. This requires careful lesson planning and deliberate psychoeducation. Supporting individuals to understand the role and function of embodiment-based practices and mindfulness technologies, in relation to emotional regulation, relational safety, and expanding the window of tolerance, can offer psychoeducation tools for supporting an individual with their self-regulatory capacities. This offers an important framing device concerning how to 'show up' when engaging in group process; in this way increasing relational safety by implicitly norming the group work environment (Yalom, 2020).

Focusing and Mentalisation

To illustrate the applicability of mindfulness and embodiment modalities we need note only that the first step in symptom stabilisation is to gain a presence of mind: the space to observe problems and symptoms without being flooded or needing to habitually escape and evade their associated discomforts. Symptom stabilisation relates closely to the cultivation of a capacity for self-reflection. Sophisticated self-reflection, or 'mentalising' abilities, are required in the therapeutic processing of memories of traumatic stress symptoms. These abilities begin with the capacity to mentally reorient attention towards the present moment (Allen et al., 2012; Fonagy & Adshead, 2012).

As Courtois and Ford (2012, p.128) suggest; there are various terms to describe this act: grounding (Horowitz, 1997), mentalisation (Allen, 2012), mindfulness (Hayes et al, 2006), experiential focusing (Gendlin, 1982) or mental focusing (Ford & Russo, 2006). Therapeutic modalities such as sensorimotor psychotherapy (Fisher & Ogden, 2013) and somatic experiencing (Levine, 1997; 2008) provide various technologies for guiding clients in the direction of their attention to the present moment, as well as in stilling and quieting patterns of reactivity. There is much to be written on this subject; the notion of Yoga Nidra or 'No Sleep Deep Rest', as it has come to be called (Boys, 2022), alongside progressive muscle relaxation techniques, support clients in mentally scanning physical sensations for tension and bringing awareness to internal experiences (i.e. tension, pain, warmth, pleasure) etc. In brief: mindfulness and embodiment auxiliary treatment supports the stabilisation that accompanies increased mentalising and self-reflective capacities, which serve as necessary pre-requisites for trauma processing.

Attentional Reorientation

Related to focusing and mentalising, embodiment and mindfulness-based modalities may engage clients in attentional reorientation towards: the non-judgemental self-observation of spontaneous thoughts; body awareness of simple movements; tensing and relaxing muscle groups; or imaginal exercises to associated feelings of peacefulness and safety (Vujanovic et al*,* 2009; Nidich et al, 2018). Such practices can have multiple benefits, shifting attention away from symptoms and their associated distress whilst supporting clients to experientially develop capacities for disengaging from ruminative troubling thoughts which may preoccupy or overwhelm them. The preliminary steps involved in stabilisation of symptoms require resourcing clients with the tools required to experientially understand the way in which thoughts and feelings need not govern their minds; in this way supporting individuals in cultivating modes of personal control, consequently achieving behavioural change.

Reframing and Enhanced Awareness

Embodiment and mindfulness-based practices may also constitute methods for developing the self-monitoring of symptoms—capacities which, even when taken alone, often leads to the reduction in the frequency and severity of symptoms, as well as producing insights into the original traumatic experience and its ramifications. The i*ncreased* awareness, mindfulness offers, of both symptoms and their precursors may lead to symptom reduction. By gaining an awareness of the manner in which every symptom is part of a chain involving antecedent stimuli: the symptom and its consequences may be consciously recognised and made more manageable (Brown & Elliot, 2016).

PTSD is typified by first avoiding symptom awareness and then ruminating obsessively upon these symptoms. Rather than repeating the habituated pattern of avoiding or dissociating

from this chain of stimuli, embodiment and mindfulness practices may offer means by which one can consciously and intentionally attend to symptoms and their antecedents. In this way symptoms become objective targets for observation, rather than intolerable sources of anxiety, dysphoria and frustration (Courtois & Ford, 2012, p.129). The relief associated with reframing symptoms as 'acceptable'—in the vein of Acceptance and Commitment Therapy (Hayes et al., 2006)—may enhance a participant's willingness to reflectively observe, and thus 'be with', feelings of overwhelm, terror or powerlessness. Embodiment and mindfulness exercises can achieve this reframing in multiple innovative ways. This bears upon stress-management skills and 'stress-inoculation training' or anxiety management—i.e. via physiological arousal management; through progressive muscle relaxation, guided imagery or autogenics. These are skills that may substantially improve hyper-and hypo-arousal symptom clusters (Hembree, 2008). For those who have received poor role-modelling or a lack of guidance in coping with stress in their formative environments, these techniques are highly valuable in cultivating self-regulatory capacities and developing towards the co-regulatory skills necessary for trauma-processing group work.

Positive Therapeutic Relationship

The use of relational principles and techniques, alongside therapeutic qualities of atunement and empathy, have been historically undervalued in cognitive-behavioural trauma treatment approaches. As Courtois and Ford (2013), as well as Meichenbaum (2017) demonstrate, however, findings in the therapy outcome literature have consistently supported the importance of the interpersonal elements of the therapeutic relationship in addressing trauma. Such a view is reinforced in the literature on the value of relationship as a universal non-specific factor in therapeutic benefit (Chatoor, 2001; Brown, 2015). These findings, it is here contended, carry across into group settings. Relevant interpersonal elements include: the importance of a positive therapeutic relationship; the value of a caring empathic psychotherapist attentive to the fluctuations present in the therapy container; client-therapist attunement and connection; awareness of transferential and counter-transferential dynamics; and careful boundary negotiations and attachment-based responses (Courtois & Ford 2012, p. *viii*).

Supporting interpersonally distressed clients, who will often have multiple and entrenched post-traumatic adaptations and self-concepts, poses special difficulties for facilitators who are inadequately trained in the above relational principles. This is as participant's successful uptake of the resources offered in these settings is predicated upon the trustworthy and secure relationship formed between facilitator and participants, as well as participants amongst each other.

Group Norming

The relational impacts of both developmental and later life interpersonal trauma are indisputably both complex and significant. Mistrust and isolation, conflict and difficulties across the full spectrum of relationships, are persistent styles of relating for those with complex trauma, given the impacts such experience has on the individual's internalised model of self in relation to the other and world. The group container may serve as a healing corrective to the influence of the formative interpersonal harms experienced by participants. It is for these reasons that in group settings an emphasis on establishing implicit group norms around caring and supportive relationship, prove to be critical facets of treatment planning (Lubin & Johnson, 2008). The person of the facilitator plays an important role in achieving this group norming by setting the tone of the interaction, hence the importance of the facilitator's exhibition of qualities of empathy, self-awareness, positive regard, and compassion (Gilbert, 2009; Lambert & Barley, 2001).

Related to positive therapeutic relationship, groups that model safety, respect, honesty, privacy, and dedication to recovery—as operating norms—provide a unique opportunity for traumatised or shamed clients to be witnessed and supported by peers. This opportunity will likely be unique for many participants, in light of the pervasive sense of anxiety, rejection, betrayal and abandonment common to trauma survivors (Leehan & Webb, 1996). The significance of the discovery of a group container in which survivors are treated in a trustworthy and nonexploitative manner cannot be overstated. Similarly significant is the opportunity to join with others with relatable histories in order to gain perspective and companionship in examining the impacts of one's past upon one's present.

Establishing Expectations

Laying the ground rules at the outset, making explicit the expectations for group participation, and the rights and responsibilities that exist between facilitators and participants is essential to ensure members feel safe, respected, and that their privacy is protected. Foundations of privacy and confidentiality, alongside freedom from criticism, serve to challenge the trust violations which are often ubiquitous to the prior life experience of trauma survivors. As Courtois and Ford note, complex interpersonal trauma frequently results in a deep mistrust of authority figures; a stance that might occur in conjunction with a simultaneous longing to be rescued by them (2012, p. 196). This bears on the need for clear boundary maintenance awareness, by the facilitators, as will be explored in the following section.

Emotional Wellbeing of the Facilitator

A cornerstone of support for survivors of complex trauma, is the mindful attention the facilitator pays to their own selves. This is examined in the works of Murphy and Joseph (2013) on trauma and the therapeutic relationship as well as Lipsky (2009) in "trauma stewardship". Both emphasise the fact that the facilitator's emotional health is critical to the relationship formed between the facilitator and the group members, as well as the implicit norms

established in the group container. Group facilitators, as with therapists, are called to attend to their own emotional regulation and wellbeing, in order to achieve effective treatment. Furthermore, they are required to develop skills in maintaining therapeutic availability whilst recognising and holding professional boundaries and limitations.

This requires that a working alliance be established between facilitators and participants in much the same way as traditional therapy. Critical too, is awareness of the complexity of the transferential and counter-transferential dilemmas likely to be encountered in working specifically with clients with complex trauma histories. This calls for a high degree of therapeutic awareness, generally attained through specialised training (Hayes, 1995). This suggests the need for facilitators to engage in both trauma-informed consultation or supervision, and their own personal therapy. It is unfortunately still the case today that the professional training of most therapists fails to include attention to trauma response, despite the high number of traumatised individuals in clinical caseloads.

Titration and Pendulation

The treatment of trauma is complex and multifaceted, and so it comes as no surprise to note that trauma processing is not a neatly contained occurrence that happens at a facilitator's discretion, but rather a process that occurs over a prolonged duration, at different stages for different individuals. Indeed, in a resourcing-oriented group the processing of interpersonal trauma may begin spontaneously within session. This frequently occurs due to the activating nature of engaging in embodiment practices and mindfulness of body sensations, which bring to conscious awareness undigested traumatic content. Similarly, interpersonal trauma history will inevitably be provoked through the basic interactions that occur in group. As such, even if not engaging in direct trauma-processing, facilitators need to be versed in an understanding of principles of titration and pendulation, which can be conveyed through psychoeducation for group participants to gain an awareness of how to regulate in relation to a trauma-response.

'Titration' refers to the exposure of group participants to small amounts of trauma-related distress at a time as a means of supporting the build-up of tolerance, thereby avoiding individuals becoming overwhelmed and dysregulating or regressing (Grabbe, 2018). This requires that careful attention be paid to the exposure to traumatic and triggering content (Black, 2006). 'Pendulation', also known as 'looping', refers to switching between *resourcing* an individual and *titrating* traumatic content, in this way allowing a client to move between a state of arousal triggered by a recalled traumatic event, and a state of calm. Through this process the individual is better situated to regain homeostasis and cultivate skills for entering dysregulating memories or events by choice, whilst retaining a state of emotional regulation. The individual's window of tolerance expands as a result of this process (Siegel, 2010).

A number of modern evidence-based approaches to trauma fail to recognise the significance of titration, pendulation and staging. For instance, many clinicians utilise trauma-focused

cognitive-behavioural therapeutic approaches, which involve direct engagement with the traumatic memory, and frequently utilise techniques such as prolonged exposure (PE), systematic de-sensitisation, cognitive processing, stress inoculation (SIT), and anxiety management techniques. Yet frequently these frames are made with only haphazard redress of titration, pendulation and staging concerns. Without making these considerations, such approaches may prove unsuitable for treating certain trauma presentations (Gaston, 2015). The integration of pendulation and titration principles in trauma therapy is critical to ensure facilitators are responsive to the specific capacities, difficulties and interpersonal needs of the client living with complex trauma (Cloitre, 2010). In group settings special attention to these principles is particularly critical; as there are many individuals involved simultaneously and a much less adequate client-to-therapist ratio (Ford et al, 2009).

Group Heterogeneity: Working with Unique Populations

Clients are individuals with idiosyncratic needs, resources and histories. As such, an effective therapeutic working alliance in a group setting begins in a recognition of the diversity of client presentations. Our ability to hold to the principles elucidated in this article, in particular the role of empathy and compassionate care, can be challenged depending on the social location of group participants, either from a place of prejudice or ignorance. In relation to prejudice: Kavanagh and Levenson (2022), offer a valuable insight into the need for tailoring trauma-informed practice skills and tools for facilitating support services for highly stigmatised populations. The parallel problem of ignorance must also be addressed, as such cultural competence requires investigation into how to best meet the needs of the specific populations we are working with. There is value in tailoring programmes towards the needs of the unique populations served. Group work may be organised to treat a specific subpopulation, such as for example the disabled. However, in this population, there must be an awareness of the impacts of heterogeneity, i.e., the wide spectrums of disability experienced, intersection between various psycho- and social- disabilities, and intersection with various other social locations. For this reason, facilitators should involve co-design input from the relevant communities, when structuring programmes in order to ensure their needs are met (Farr, 2018).

Conclusion

This article has explored the value of group psychotherapy for trauma treatments that orient towards resourcing participants, utilising the example of mindfulness and embodiment-based resourcing technologies, as illustrative of top-down and bottom-up approaches to trauma resourcing. It is demonstrated that these technologies cultivate the ability to orient attention towards the present moment, increasing bodily and affective self-awareness, which serves to reduce patterns of reactivity, thereby supporting: symptom stabilisation; improved reflective and mentalising ability; and the cultivation of the self- and co-regulatory capacities necessary for trauma-processing group work. We then outlined: the phasic introduction of these

resources in ‘group settings’ when and where they are applicable; the necessary screening requirements and exclusion criteria; the role and function of group norming and relational approaches; the important of pendulation and titrations principles; and how to work with distinct populations and in-group heterogeneity. In this way this article has elucidated the foundations for both developing an auxiliary resourcing group and implementing such groups into a treatment plan for individuals living with trauma.

References

Allen, J., Fonagy, P., & Bateman, A. (2008). Mentalizing in clinical practice. Washington, DC: American Psychiatric Association.

Allen, J. (2012). Treating trauma with plain old therapy: Restoring mentalization in attachment relationships. Washington, DC: American Psychiatric Publishing.

Baird, S. L., & Alaggia, R. (2021). Trauma-informed groups: Recommendations for group work practice. Clinical Social Work Journal, 49(1), 10-19.

Biehl, R., Bingham, R., Braude, H. D., East, A., Lester, K. F., Rugman, K., ... & Way, R. (2015). Moving consciously: Somatic transformations through dance, yoga, and touch. University of Illinois Press.

Black, T. G. (2006). Teaching trauma without traumatizing: Principles of trauma treatment in the training of graduate counselors. Traumatology, 12(4), 266-271.

Bowlby, J., & Ainsworth, M. (2013). The origins of attachment theory. Attachment theory: Social, developmental, and clinical perspectives, 45(28), 759-775.

Brown, J. (2015). Specific techniques vs. common factors? Psychotherapy integration and its role in ethical practice. American journal of psychotherapy, 69(3), 301-316.

Brown, D. P., & Elliott, D. S. (2016). Attachment disturbances in adults: Treatment for comprehensive repair. WW Norton & Co.

Caplan, M., Portillo, A., & Seely, L. (2013). Yoga psychotherapy: the integration of western psychological theory and ancient yogic wisdom. Journal of Transpersonal Psychology, 45(2).

Chatoor, I., & Kurpnick, J. (2001). The role of non-specific factors in treatment outcome of psychotherapy studies. European Child & Adolescent Psychiatry, 10(1), S19-S25.

Chiesa, A., Serretti, A., & Jakobsen, J. C. (2013). Mindfulness: Top–down or bottom–up emotion regulation strategy?. Clinical psychology review, 33(1), 82-96.

Classen, C, Fourt, A., Langmuir, J. I., Dalton, E. J., (2007). The experience of trauma recovery: A qualitative study of participants in the Women Recovering from Abuse Program (WRAP). Journal of Child Sexual Abuse, 16(2), 55–77.

Cloitre, M., Cohen, L. R., & Koenen, K. C. (2006). Treating survivors of childhood abuse: Psychotherapy for the interrupted life. New York: Guilford Press.

Cloitre, M., Miranda, R., Stovall-McClough, K. C., & Han, H. (2005). Beyond PTSD: Emotion regulation and interpersonal problems as predictors of functional impairment in survivors of childhood abuse. Behavior therapy, 36(2), 119-124.

Cloitre, M., Stovall-McClough, K. C., Nooner, K., Zorbas, P., Cherry, S., Jackson, C. L., et al. (2010). Treatment for PTSD related to childhood abuse: A randomized controlled trial. American Journal of Psychiatry, 167, 915–924.

Courtois, C. A., & Ford, J. D. (2012). Treatment of complex trauma: A sequenced, relationship-based approach. Guilford Press.

Courtois, C. A., Ford, J. D., & Cloitre, M. (2009). Best practices in psychotherapy for adults. In C. A. Courtois & J. D. Ford (Eds.), Treating complex traumatic stress disorders: An evidence-based guide (pp. 82–103). New York: Guilford Press.

Elliott, D. M., Mok, D. S., & Briere, J. (2004). Adult sexual assault: Prevalence, symptomatology, and sex differences in the general population. Journal of Traumatic Stress, 17(3), 203–211.

Farr, M. (2018). Power dynamics and collaborative mechanisms in co-production and co-design processes. Critical Social Policy, 38(4), 623-644.

Fine, C. G., & Madden, N. E. (2000). Group psychotherapy in the treatment of dissociative identity disorder and allied dissociative disorders. In R. H. Klein & V. L. Schermer (Eds.). Group psychotherapy for psychological trauma (pp. 298–325). New York: Guilford Press.

Fisher, J. (2019). Sensorimotor psychotherapy in the treatment of trauma. Practice Innovations, 4(3), 156.

Fisher, J., & Ogden, P. (2009). Sensorimotor psychotherapy. Treating complex traumatic stress disorders: An evidence-based guide, 312-328.

Follette, V. M., Alexander, P., & Follette, W. (1991). Individual predictors of outcome in group treatment for incest survivors. Journal of Consulting and Clinical Psychology, 59, 150–155.

Fonagy, P., & Adshead, G. (2012). How mentalisation changes the mind. Advances in psychiatric treatment, 18(5), 353-362.

Ford, J. D., Fallot, R. D., & Harris, M. (2009). Group therapy. Treating complex traumatic stress disorders: An evidence-based guide, 415-440.

Ford, J. D., & Saltzman, W. (2009). Family system therapy. In C. A. Courtois & J. D. Ford (Eds.), Treating complex traumatic stress disorders: An evidence based guide (pp. 391–414). New York: Guilford Press.

Ford, J. D., & Courtois, C. A. (2009). Defining and understanding complex trauma and complex traumatic stress disorders. In C. A. Courtois & J. D. Ford (Eds.), Treating complex traumatic stress disorders: An evidence-based guide (pp. 13–30). New York: Guilford Press.

Ford, J. D. (2012). Enhancing affect regulation in psychotherapy with complex trauma survivors. In D. Murphy, S. Joseph, & B. Harris (Eds.), Trauma, recovery, and the therapeutic relationship. London: Oxford University Press.

Ford, J. D. (2018). Trauma memory processing in posttraumatic stress disorder psychotherapy: A unifying framework. Journal of Traumatic Stress, 31(6), 933-942.

Ford, J. D., Steinberg, K., Hawke, J., Levine, J., & Zhang, W. (2012). Evaluation of trauma affect regulation: Guide for education and therapy (TARGET) with traumatized girls involved in delinquency. Journal of Clinical Child and Adolescent Psychology, 41(1), 27–37.

Ford, J. D., & Russo, E. (2006). Trauma-focused, present-centered, emotional self-regulation approach to integrated treatment for posttraumatic stress and addiction: Trauma adaptive recovery group education and therapy (TARGET). American Journal of Psychotherapy, 60(4), 335–355.

Foy, D. W. (2008). On the development of practice guidelines for evidence-based group approaches following disasters. International Journal of Group Psychotherapy, 58, 569–576.

Foy, D. W., Eriksson, C. B., & Trice, G. A. (2001). Introduction to group interventions for trauma survivors. Group Dynamics: Theory, research, and practice, 5(4), 246.

Gaston, L. (2015). Limitations of trauma-focused therapies for treating PTSD: A perspective. Quebec, Canada: Traumatys. Retrieved from www. traumatys. com.

Grabbe, L., & Miller-Karas, E. (2018). The trauma resiliency model: a “bottom-up” intervention for trauma psychotherapy. Journal of the American Psychiatric Nurses Association, 24(1), 76-84.

Gendlin, E. T. (1982). Focusing (2nd ed.). New York: Bantam Books.

Gilbert, P. (2009). Introducing compassion-focused therapy. Advances in Psychiatric Treatment, 15, 199–208.

Hayes, J. A. (1995). Countertransference in group psychotherapy: Waking a sleeping dog. International journal of group psychotherapy, 45(4), 521-535.

Hayes, S. C., Luoma, J. B., Bond, F. W., Masuda, A., & Lillis, J. (2006). Acceptance and commitment therapy: Model, processes and outcomes. Behaviour Research and Therapy, 44(1), 1–25.

Horwitz, L. (1977). A group-centered approach to group psychotherapy. International Journal of Group Psychotherapy, 27(4), 423-439.

Hübl, T., & Avritt, J. J. (2020). Healing collective trauma: A process for integrating our intergenerational and cultural wounds. Sounds True.

Janet, P. (1973). L'automatisme psychologique. Paris: Societe Pierre Janet. (Original work published 1889).

Jayawickreme, E., Infurna, F. J., Alajak, K., Blackie, L. E., Chopik, W. J., Chung, J. M., ... & Zonneveld, R. (2021). Post-traumatic growth as positive personality change: Challenges, opportunities, and recommendations. Journal of personality, 89(1), 145-165.

Jenkins, S., & Baird, S. (2002). Secondary traumatic stress and vicarious trauma: A validation study. Journal of Traumatic Stress, 15, 423–432.

Kavanagh, S., & Levenson, J. (2022). Supporting those who love the loathed: Trauma-informed support groups for family members of registered sex offenders. Families in Society, 103(2), 208-220.

Khoury, B., Knäuper, B., Pagnini, F., Trent, N., Chiesa, A., & Carrière, K. (2017). Embodied mindfulness. Mindfulness, 8, 1160-1171.

Kirmayer, L. J. (2015). Mindfulness in cultural context. Transcultural psychiatry, 52(4), 447-469.

Køster, A. (2017). Mentalization, embodiment, and narrative: critical comments on the social ontology of mentalization theory. Theory & Psychology, 27(4), 458-476.

Krishna, M., Jauhari, A., Lepping, P., Turner, J., Crossley, D., & Krishnamoorthy, A. (2011). Is group psychotherapy effective in older adults with depression? A systematic review. International journal of geriatric psychiatry, 26(4), 331-340.

Lambert, M. J., & Barley, D. E. (2001). Research summary on the therapeutic relationship and psychotherapy outcome. Psychotherapy, 38, 357–361.

Laungani, P. D. (2006). Understanding cross-cultural psychology: Eastern and Western perspectives. Sage.

Leehan, J., & Webb, L. (1996). Group treatment for adult survivors of abuse: A manual for practitioners. Thousand Oaks, CA: Sage.

Levine, P. A. (1997). Waking the tiger, healing trauma: The innate capacity to transform overwhelming experiences. Berkeley, CA: North Atlantic Books.

Levine, P. A. (2008). Healing trauma: A pioneering program for restoring the wisdom of your body. Boulder, CO: Sounds True.

Lubin, H., & Johnson, D. (2008). Trauma-centered group psychotherapy for women. New York: Routledge.

Lukianoff, G., & Haidt, J. (2019). The coddling of the American mind: How good intentions and bad ideas are setting up a generation for failure. Penguin.

Luyten, P., & Fonagy, P. (2019). Mentalizing and trauma. Handbook of mentalizing in mental health practice, 2, 79-99.

Mazur, L. B. (2021). The epistemic imperialism of science. Reinvigorating early critiques of scientism. Frontiers in Psychology, 11, 609823.

Meichenbaum, D. (2017). The therapeutic relationship as a common factor: Implications for trauma therapy. In The Evolution of Cognitive Behavior Therapy (pp. 195-206). Routledge.

Murray, H., Grey, N., Warnock-Parkes, E., Kerr, A., Wild, J., Clark, D. M., & Ehlers, A. (2022). Ten misconceptions about trauma-focused CBT for PTSD. The Cognitive Behaviour Therapist, 15, e33.

Music, G. (2014). Top down and bottom up: Trauma, executive functioning, emotional regulation, the brain and child psychotherapy. Journal of Child Psychotherapy, 40(1), 3-19.

Nidich, S., Mills, P. J., Rainforth, M., Heppner, P., Schneider, R. H., Rosenthal, N. E., ... & Rutledge, T. (2018). Non-trauma-focused meditation versus exposure therapy in veterans with post-traumatic stress disorder: a randomised controlled trial. The Lancet Psychiatry, 5(12), 975-986.

Ogden, P., & Minton, K. (2000). Sensorimotor psychotherapy: One method for processing traumatic memory. Traumatology, 6(3), 149-173.

Ogden, P., Goldstein, B., & Fisher, J. (2013). Brain-to-brain, body-to-body: A sensorimotor psychotherapy perspective on the treatment of children and adolescents. Current applications: Working with young persons who are victims and perpetrators of sexual abuse, 229-258.

Payne, P., Levine, P. A., & Crane-Godreau, M. A. (2015). Somatic experiencing: using interoception and proprioception as core elements of trauma therapy. Frontiers in psychology, 93.

Piper, W., Ogrodniczuk, J., Joyce, A., Weideman, R., & Rosie, J. (2007). Group composition and therapy for complicated grief. Journal of Consulting and Clinical Psychology, 75, 116–125.

Rappoport, E. (2015). Dynamic linking of psyche and soma: Somatic experiencing and embodied mentalization. In Relational Psychoanalysis and Psychotherapy Integration (pp. 154-176). Routledge.

Roy, V., Lindsay, J., & Dallaire, L. F. (2013). Mixed-gender co-facilitation in therapeutic groups for men who have perpetrated intimate partner violence: group members' perspectives. The Journal for Specialists in Group Work, 38(1), 3-29.

Schore, A. N. (2020). Forging connections in group psychotherapy through right brain-to-right brain emotional communications. Part 1: Theoretical models of right brain therapeutic action. Part 2: Clinical case analyses of group right brain regressive enactments. International Journal of Group Psychotherapy, 70(1), 29-88.

Siegel, D. J. (2010). The mindful therapist: A clinician's guide to mindsight and neural integration. WW Norton & Company.

Simons, M. (2010). Metacognitive therapy and other cognitive-behavioral treatments for posttraumatic stress disorder. Verhaltenstherapie, 20(2), 86-92.

Solomon, E. P., & Heide, K. M. (2005). The biology of trauma: Implications for treatment. Journal of interpersonal violence, 20(1), 51-60.

Taleb, N. N. (2012). Antifragile: how to live in a world we don't understand (Vol. 3). London: Allen Lane.

Van der Hart, O., Brown, P., & Van der Kolk, B. A. (1989). Pierre Janet’s treatment of post-traumatic stress. Journal of Traumatic Stress, 2(4), 379–395.

Van der Kolk, B. A. (2005). Developmental trauma disorder: Toward a rational diagnosis for children with complex trauma histories. Psychiatric Annals, 35(5), 401–408.

Vujanovic, A. A., Youngwirth, N. E., Johnson, K. A., & Zvolensky, M. J. (2009). Mindfulness-based acceptance and posttraumatic stress symptoms among trauma-exposed adults without axis I psychopathology. Journal of Anxiety Disorders, 23(2), 297–303.

Yalom, I. D., & Leszcz, M. (2020). The theory and practice of group psychotherapy. Basic books.