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ARTICLES

The Role of Mindfulness and Embodiment in Group-Based Trauma Treatment

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Embodiment and mindfulness interventions provide a range of benefits for individuals living with trauma yet a lack of clarity surrounds their integration in group work practice. This article provides a framework for the integration of embodiment and mindfulness interventions in group settings for trauma. While such interventions can be utilised in primary trauma processing and open process group psychotherapy, this article provides particular guidance for the more general integration of these tools in structured format resourcing groups. Attention is given to the value and features of a phasic, staged integration of these interventions for specialised trauma-oriented group work. This article details how mindfulness and embodiment interventions support participants to cultivate the capacity to counter experiential avoidance and reorient attention towards the present moment, consequently increasing bodily and affective self-awareness. This serves to reduce patterns of reactivity, thereby supporting symptom stabilisation, improved reflective and mentalising ability, and cultivation of the self- and co-regulatory capacities necessary for trauma-processing group work. These interventions also possess supportive implications for the facilitator's wellbeing, the formation and cohesiveness of the group, and, crucially, the norming process, both implicit and explicit. Attention is given also to safety considerations, including contraindications of mindfulness practices with certain trauma presentations, and the necessary screening requirements and exclusion criteria in the formation of a trauma-oriented group.

In an increasingly uncertain world, characterised by both climate and biodiversity crises and facing population-based insecurity and global instabilities, there is a great need now and into the future for increased competency in trauma processing and care within the clinical professions. Alongside one-to-one treatment approaches, there is particular value in group treatment for supporting individuals living with the impacts of trauma in group settings. The primary goal of adopting a trauma-informed approach to group-based therapeutic support is to achieve a balance between resourcing participants and preventing their inadvertent re-traumatisation during service

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provision. I differentiate *primary* or *processing-oriented* group therapy—that is, group therapy that directly focuses on the processing of trauma—from *auxiliary* or *resourcing-oriented* group programs—therapy that focuses on supporting clients to cultivate regulatory skills and capacities. Resourcing orientation serves as an important prerequisite for the later primary processing of traumatic experience, either in group or individual therapeutic sessions.

Despite 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 to the principles for resourcing individuals in auxiliary groups not oriented towards trauma-processing per se (Baird & Alaggia, 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 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 programs 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 to those struggling with relational difficulties, since 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 explores these approaches by considering auxiliary groups that utilise both top-down and bottom-up embodiment and mindfulness resourcing strategies. This involves demonstrating the value 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.

In consideration of what is required of the clinician intending to integrate group resourcing interventions using embodiment and mindfulness techniques, it is important to recognise that the therapeutic facets are not to be applied in a linear sequence. Rather, they serve as founding principles that "saturate" the methods of the facilitator. Trauma-oriented group work is highly dynamic in practice, and the techniques 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 by the group

population (Courtois & Ford, 2013). This requires the facilitating clinician to engage in a dynamic process of case formulation prior to and across the group treatment process (Horwitz, 1977).

Group Work for Trauma: Models and Approaches

This article turns first to establishing the distinction between primary-processing and secondary-resourcing—or *auxiliary*—groups (terms that will be used interchangeably in this paper) 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, how embodiment and mindfulness can be applied in both open process and structured format group work, and the foundations and best practice principles for establishing auxiliary resourcing groups. I also examine the staged introduction of these interventions according to a phasic model of trauma treatment. With these foundations established, I then turn to elucidating the core principles for specialised trauma-oriented group work.

Primary Processing and Auxiliary Resourcing Interventions

In recent decades, vast progress has been made in the understanding of psychological trauma, for example, 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 psychosocial outcomes in individuals presenting for treatment (Cloitre et al., 2005). Because many clients have been exposed to early and severe childhood abuse and neglect, their difficulties are frequently complex, involving not only symptoms of post-traumatic stress disorder (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 (van der Kolk, 2005). For this reason, this article focuses on both PTSD and complex and developmental trauma, in addition to the implications for treatment.

Consequently, *trauma* will be used as a catch-all term referring to PTSD, complex PTSD (C-PTSD), and developmental trauma. This, of course, includes intergenerational trauma, that is, the intergenerational ripple effects of unresolved traumatic events down the generations, markedly, the transmission of patterns of attachment disturbance (Allen, 2012; van der Hart et al., 1989). While there are significant divergences between these forms, I am concerned with group interventions applicable across the range of trauma presentations. It is also worth mentioning that the delineation between complicated grief reactions and unprocessed trauma is not a distinction that can be made with ease. Important complicating factors may lead a grief reaction to be prolonged or complicated, which thus may result in interruption of the grieving process, such that an individual presents to participate in a trauma-processing group. These factors include, for instance, the presence of compound sources of grief, traumatic or disenfranchised

loss, and chronic or ongoing grief (Worden, 2018). For our purposes, the principles elucidated here may be equally of value to individuals processing complicated grief reactions.

From a summary review of the many forms of therapy applied to the problem of trauma, there are two distinct and quite different approaches to its treatment already mentioned: primary or processing-focused and secondary or auxiliary resourcing-focused approaches (Ford, 2018; Ogden & Minton, 2000; Solomon & Heide, 2005). Each approach claims various mechanisms of change. These mechanisms 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 & Denning, 2022). The first category of approach, using processing-focused models, specifically focuses on processing traumatic experience, which involves reorganising the mind of the client across cognitive, affective, and sensate levels of experience (Allen et al., 2008). The second category, resourcing-focused models, generally focuses on the tasks of improving affect regulation capacities via positive affective inputs. While often insufficient in themselves for the treatment of trauma, these resourcing skills are proving to be essential supplements in effective trauma treatment.

As argued below in relation to multiphasic approaches to trauma treatment, while trauma processing is of vital importance, establishing well-resourced foundations is the necessary prerequisite. For this reason, this paper demonstrates the applicability of well-established trauma-processing principles to groups specifically focused on the resourcing of individual members. My hope is that the reader may utilise this work as a basic principled scaffold for establishing such resourcing-oriented group programs particularly focused on cultivating both bottom-up and top-down regulation strategies in the form of embodiment and mindfulness practices.

It is also worth noting that recent years have witnessed the emergence of a range of forms of non-traditional and non-clinical group work. For instance, the emergence of *rites of passage* or *initiatory work*, *deep ecological* or *nature-based group work*, and *circle work* for men and women (Nicholson, 2010; van Gennep, 2019). In light of the particular problems faced under modernity, the emergence of community-driven group work provides a means for a broader systems-based response to the escalating need for psychological support in community. Such community-led initiatives also benefit from their direct response to the generalised experiences occurring within particular populations—for instance, communities that are climate emergency–affected, or those that are racially or culturally conflict affected. An additional virtue of greater discourse concerning the establishment of trauma-informed principles, then, is the potential trickle-down benefits for non-clinical groups, thereby supporting a broad response to the needs of individuals in collective groups and the groups themselves.

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, 2014). *Top-down* interventions utilise 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 (Fisher, 2019; Fisher & Ogden, 2009; Levine, 2010).

The strengths of top-down approaches are widely supported in the literature (de Kloet et al., 2018; Taylor et al., 2010). 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 since 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 and Fonagy (2019), in "Mentalizing and Trauma", illustrate how trauma not only disrupts the attachment system but also affects mentalising abilities. For this reason top-down approaches, by supporting the client to cultivate higher-order reasoning skills, may improve an individual's reflective functioning and metacognitive capacities, thereby reversing the deleterious impacts of various forms of trauma. Significant work is being carried out, in a related regard, to the role of psychedelic psychotherapy, and further non-ordinary states, in bringing about increased metacognitive capacities (Dowie & Tempone-Wiltshire, 2022, 2023; Tempone-Wiltshire & Dowie, 2023c; Tempone-Wiltshire & Matthews, 2023).

A limitation of top-down processing approaches, however, is that higher-order executive functions lose their potency when the body's physiological alarm system is activated, that is, when individuals enter a dysregulated state of hyper-arousal or hypo-arousal in response to a perceived threat. In light of this limitation 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 work with those dysregulating feelings (Grabbe & Miller-Karas, 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 since they can return to the present moment felt sense as a resource. Therefore, bottom-up approaches have been linked to improved capacity to regulate arousal and tolerate fluctuations in arousal, thus expanding a client's "window of tolerance", as discussed below (Siegel, 2010).

Both top-down and bottom-up intervention approaches are useful in the auxiliary resourcing and primary processing of trauma since both call for 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 (Fisher, 2019). What follows explores how embodiment and mindfulness practices offer a synthesis of top-down and bottom-up approaches. The relevant principles for establishing a resourcing group that utilises both embodiment and mindfulness techniques are then outlined.

Embodiment and Mindfulness in Trauma Treatment

Both in the popular imagination and the field of clinical practice there has been a bloom in trauma awareness and a burgeoning interest in bottom-up approaches 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 (Fraleigh, 2015). Consequently, embodiment practices are bottom-up approaches to treating trauma. Interestingly, contemporary scholars are rediscovering the treatment value of embodiment techniques that generally developed outside clinical scientific contexts, originating instead in Indigenous and non-Western cultures (Tempone-Wiltshire, in press; Tempone-Wiltshire & Dowie, 2023a). In the domain of positive psychology, for instance, presently there are emerging a range of therapeutic approaches that offer renewed attention to body-based somatic modalities, including synchronised movement, physical postures or asanas, 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 interventions have been predominantly drawn from Eastern and Indigenous contemplative traditions.

Similarly to embodiment-based interventions, mindfulness-based therapeutic interventions have their roots in meditative practices that derive from Eastern, particularly Buddhist, traditions (Tempone-Wiltshire & Dowie, 2024). Mindfulness in this sense is a mode of awareness that is present centred and non-evaluative; this form of awareness is widely believed to have intrinsic value since it promotes positive mental health and adaptation by interrupting discursive thoughts that give rise to suffering (Kirmayer, 2015; Thakchoe & Tempone Wiltshire, 2019). Mindfulness practices are an interesting anomaly in the case of bottom-up and top-down interventions

because 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, because it involves the conscious mind regulating affect and sensate response; yet, at other times it is considered bottom-up, because many embodiment practices are described as mindfulness techniques (Chiesa et al., 2013). This is an interesting discrepancy that speaks to the poor articulation of the distinction and crossover between embodiment and mindfulness practices, and the neural correlates of these practices (Tempone-Wiltshire, 2024).

To explore the principles of resourcing approaches in group settings, I focus on both embodiment and mindfulness as a synthesis of bottom-up and top-down interventions. Embodiment and mindfulness practices utilise in distinct ways interoceptive perception of physical sensations to gain insight into what is occurring on a bodily and emotional level, and relational insight into the experience of the other in connection (Tempone-Wiltshire, 2024). One illustrative example may be the practice of mindful breathing 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 attunement to the body's needs, and improved regulatory capacities (Khoury et al., 2017).

Significant research exists supporting the linkages between increased somatic awareness through embodiment and mindfulness practice, increased relational insight, and increased self-regulatory and co-regulatory capacities (Fisher & Ogden, 2009; Fuchs, 2012). Recognition of the meaningful relationship between embodiment and mentalisation, or reflective function, is currently in emergence (Køster, 2017; Rappoport, 2015). Such techniques, 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 (2013) 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 (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; Tempone-Wiltshire, 2024; Tempone-Wiltshire & Dowie, 2023b). The role of relationship is explored in greater depth below. Importantly, embodiment and mindfulness 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 play 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 (Badenoch, 2017; Courtois & Ford, 2013; Fuchs, 2020).

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). Therefore, processing-group participation requires individuals to possess a solid foundation of emotional regulation skills and resources in order to engage in trauma processing while 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 needed to develop the capacity to participate in and gain from primary processing–oriented group work. This is because in these spaces participants may develop a sense of felt safety, emotional organisation, and self- and co-regulatory capacities. These resources can lead to the development of greater self-esteem, improved relational dynamics, and strengthened tolerance for discomfort. As demonstrated below, 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.

Resourcing: Open Process or Structured-Format Groups?

One way of delineating group therapies is to distinguish between "open process" formats and strictly didactic, educational, "structured" formats (Yalom & Leszcz, 2020). As described, embodiment and mindfulness interventions may be applied in either open or structured groups. However, the format will have important implications for group selection criteria, since open process groups pose certain risks and are contra-indicated for some trauma presentations. Open process groups focus upon trauma processing. In these sessions, therapeutic benefit derives from interpersonal learning that occurs in dynamic interactions 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 individual's internal working models 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 (D. P. Brown & Elliott, 2016).

In these settings the mechanism of therapeutic change involves the relational space created in the group setting; consequently, the sessions are oriented towards increasing relational awareness and reflective function. The mechanism of action for complex trauma work often involves, explicitly, the ability to learn from others; to share one's experiences, problems, and struggles; to understand how one interacts in group spaces; and to gain

insight into how one's interaction with the group is informed by history. Each of these interpersonal factors may play an important role in trauma processing. Embodiment and mindfulness-oriented techniques can be drawn upon effectively in such open process therapy as methods for fostering reflective function; attentional re-orientation; countering experiential avoidance; and reframing perceptions. In this way they can serve as valuable instruments in the group formation and maintenance, and the interpersonal learning process.

For our purposes, however, we are orienting herein to structured format groups as, in general, the embodiment and mindfulness-oriented resourcing groups developed are likely to be highly structured and presented in educational or didactic form rather than in open process format. This is because open process formats, given their minimal structure 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 emphasising psychoeducation, skill development, or "witnessing" group members' experiences without direct interpersonal exchange (Yalom & Leszcz, 2020). Highly structured groups have multiple benefits for early skill building: they limit and contain generated emotions; enable clients to learn skills for managing trauma stress reactions, which may be practised in between sessions; provide lower risk opportunities for connection and overcoming isolation; and offer empowerment through shared expression and mutual aid in coping.

Participants in structured groups, with their lower risk of re-traumatisation, may develop an increased sense of personal control, empowerment, and hope; self-understanding, self-esteem, and compassion; improved capacity for healthy self-assertiveness; and increased boundary recognition (Krishna et al., 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 & Ford, 2013). Following Foy et al. (2001), then, the suggestion made here is that auxiliary therapies, oriented to resourcing traumatised individuals, should avoid open process 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).

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 et al. (1989), there has been the reintroduction of a three-stage sequenced treatment model applied in the context of treating complex developmental trauma related to dissociative disorders. Courtois and Ford's (2013) sequenced, relationship-based approach to the treatment of complex trauma has built upon these foundations alongside Judith Herman's (2015) triphasic model, elucidated in her work

Trauma and Recovery. Further work is required to map the application of resourcing tools for groups across these multiphasic stages. Nonetheless, the three treatment phases, described by Courtois and Ford (2013), offer a basic scaffold for determining where embodiment and mindfulness resourcing groups fit into trauma treatment.

Phase 1 emphasises establishing personal and environmental safety and safety planning (Courtois & Ford, 2013). 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 about trauma and post-traumatic reactions serves 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 (Lee & Rawlings, 2023). Given this focus, Phase 1 is a natural starting point for the integration of embodiment and mindfulness modalities; the introduction of these interventions may support participants in stress management and self-care. Taking this approach begins to address post-traumatic symptomology since the primary goal of these modalities is to sustain and enhance gains in trust and relational security, thereby resourcing individuals while simultaneously promoting symptom relief and improved functioning. This occurs because achieving felt safety and emotional regulation are essential functions of embodiment and mindfulness interventions.

Phase 2 of Courtois and Ford's (2013) model emphasises the client's processing of trauma and its attendant emotions, beliefs, and cognitions. The aim is to achieve mastery over the memory and the emotion states associated with traumatic stress. Phase 3 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 and is intimately related to what is described in the literature as post-traumatic growth (Jayawickreme et al., 2021). Embodiment and mindfulness resourcing skills are applicable in this context because 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. Therefore, while individuals are generally introduced to trauma processing in the later phases of treatment, the techniques and resources acquired in skills-based groups remain applicable across phases, though apply most critically in Phase 1.

How Mindfulness and Embodiment Practices Support Stabilisation Goals

The following sections detail the ways in which mindfulness and embodiment practices support Phase 1 stabilisation goals, increasing participants' emotional regulation capacities through the increase in reflective function and mentalising capacities, countering experiential avoidance,

reorienting attention, and reframing experience. The supportive implications of these practices for the facilitator's wellbeing, the formation and cohesiveness of the group, and, crucially, the norming process, both implicit and explicit, are then described.

Emotional Regulation and Psychoeducation

Methods for resourcing participants may draw from a range of models, including those specifically developed for PTSD treatment. That is, they may involve a focus on identification of clients' strengths and resilience; survival skills and adaptations; and psychoeducation about trauma, its symptomology, secondary elaborations, and developmental impacts. Yet they may also, as is the focus of the proposed embodiment and mindfulness resourcing groups, offer 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 interventions, 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 a group process, thereby increasing relational safety by implicitly *norming*—that is, establishing the relational and structural expectations and behaviours—in the group work environment (Yalom & Leszcz, 2020).

Focusing and Mentalisation

To illustrate the applicability of embodiment and mindfulness modalities, consider that the first step in symptom stabilisation is for clients to gain 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 reorient attention towards the present moment (Allen, 2012; Fonagy & Adshead, 2012).

As Courtois and Ford (2013) suggest, there are various terms to describe this act, for example, grounding, mentalisation (Allen, 2012), mindfulness (S. C. Hayes et al., 2006), experiential focusing (Gendlin, 1982), or mental focusing (Ford & Russo, 2006). Therapeutic modalities such as sensorimotor psychotherapy (Fisher & Ogden, 2009) and somatic experiencing (Levine, 2008) provide various methods for guiding clients in the direction of their attention to the present moment, as well as in stilling and quietening patterns of reactivity. There is much to be written on this subject; the notion of yoga nidra or "no sleep deep rest", and progressive muscle relaxation techniques support clients to scan physical sensations mentally for tension and bring awareness to internal experiences (i.e., tension, pain, warmth, pleasure). In

brief, embodiment and mindfulness 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 for associated feelings of peacefulness and safety (Nidich et al., 2018; Vujanovic et al., 2009). Such practices can have multiple benefits, shifting attention away from symptoms and their associated distress while supporting clients to develop capacities experientially for disengaging from ruminative troubling thoughts that may preoccupy or overwhelm them. The preliminary steps involved in stabilisation of symptoms require resourcing clients with the tools required to understand experientially how thoughts and feelings need not govern their minds, thereby supporting individuals to cultivate modes of personal control and consequently achieve 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 lead to reduction in the frequency and severity of symptoms, as well as producing insights into the original traumatic experience and its ramifications. The increased awareness that 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 (D. P. Brown & Elliott, 2016).

PTSD is typified by first avoiding symptom awareness and then ruminating obsessively upon these symptoms (Basharpoor et al., 2015). 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, 2013). The relief associated with reframing symptoms as "acceptable"—in the vein of acceptance and commitment therapy (S. C. Hayes et al., 2006)—may enhance a participant's willingness to observe reflectively, and thus "be with" feelings of overwhelm, terror, or powerlessness. Embodiment and mindfulness exercises can achieve this reframing in multiple innovative ways. This draws upon stress-management skills and "stress-inoculation training" or anxiety management—that is, via physiological arousal management through techniques such as progressive muscle relaxation, guided imagery or autogenics. These are skills that may

substantially improve hyper- and hypo-arousal symptom clusters. 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 for cultivating self-regulatory capacities and developing the co-regulatory skills necessary for trauma-processing group work.

Embodiment, Mindfulness, and the Wellbeing of the Facilitator

An interesting and important corollary benefit of groups oriented towards mindfulness-based interventions is that 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 and Burk (2009) on "trauma stewardship". These authors emphasise that the facilitator's emotional health is critical to the relationship formed between the facilitator and group members, as well as to 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 while recognising and holding professional boundaries and limitations.

Therefore, a working alliance should be established between facilitators and participants in much the same way as in traditional therapy. Critical too is awareness of the complexity of the transferential and counter-transferential dilemmas likely to be encountered when working specifically with clients with complex trauma histories. This calls for a high degree of therapeutic awareness, which, whilst generally attained through specialised training, is also closely supported by the practice of the techniques described herein (J. A. Hayes, 1995). Of course, this does not discount the value of the facilitator consulting or seeking supervision from experts in the field, and undergoing 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 (Dowie & Denning, 2022).

Embodied Mindfulness and Group Cohesiveness

The role of relationship in therapeutic change, whilst recognised within the humanistic tradition, has received insufficient attention in regard to group-based approaches to trauma treatment. The use of relational principles and techniques, alongside therapeutic qualities of attunement and empathy, have been historically undervalued in cognitive behavioural trauma treatment approaches. However, as Courtois and Ford (2013) and Meichenbaum (2017) demonstrate, 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 (J. Brown, 2015; Chatoor & Kurpnick, 2001).

These findings carry across into group settings. Authors such as Yalom and Leszcz (2020) have empirically demonstrated the centrality of group cohesiveness as a therapeutic factor of group work, akin to the role of relationship as a common factor in one-to-one therapy. Participants' therapeutic progress generally, and successful uptake of the resources offered in these settings specifically, is predicated upon the trustworthy and secure relationship formed between facilitator and participants, and between participants themselves, in the form of group cohesiveness.

There are compelling reasons to suggest that a group that actively and successfully integrates mindfulness and embodiment practices may foster therapeutic relatedness and generate greater group cohesiveness. As elucidated above, the effects of mindfulness and embodiment practices upon participants are to enhance awareness, reframe disturbing encounters, counter experiential avoidant tendencies, and reorient attention towards non-judgemental observation of spontaneously arising feelings or encounters. As described, this increased reflective function is not just of a personal nature but relates to the interpersonal domain as well. This provides compelling grounds to suggest that the group work facilitator, if sufficiently trained with these technologies, will be better equipped to cultivate a therapeutic environment characterised by non-judgemental observation, curiosity, and reflectiveness, a container capable of weathering the storming stages naturally occurrent in any group work setting.

This is true not just in regard to the facilitator's management of the group dynamic as a whole but the relational qualities directed to the members individually. A positive therapeutic relationship begins with a caring empathic counsellor or 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, 2013). Intentionally wielded, mindfulness and embodiment technologies support the cultivation of these relational therapeutic capacities. 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 aforementioned relational principles. Further beneficial flow-on effects of a group centred around mindfulness and embodiment technologies begins with an understanding of the norming process.

A Mindful Cultivation of Group Norms

The orientation towards mindfulness, characterised by non-judgemental present-centred awareness and self-reflexivity, plays an important part in the group norming process, with the potential to foster an environment that is resilient, supportive, and present-centred. This is particularly valuable when working with individuals living with the impacts of trauma, given the relational impacts of both developmental and later life interpersonal trauma are indisputably both complex and significant. Mistrust, 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 models of self in relation to the other and world. Sullivan's (2015) interpersonal theory of psychiatry explains how the group therapeutic container, as social microcosm, may offer a corrective emotional experience for participants concerning the influence of the formative interpersonal harms experienced by participants (Sullivan, 2015; Yalom & Leszcz, 2020). However, to achieve this goal, care must be taken to establish supportive implicit and explicit relational norms in the group setting. Embodiment and mindfulness practices, with their implicit focus upon countering experiential avoidance, present-centredness, reframing from fixed patterns of thinking, cultivating reflexivity, and non-judgemental, compassionate observation, contribute to the norming processes of the group.

Explicit norming occurs via literal means; it is generally part of the preparation stage in which members establish "group agreements" and intentions for how the therapeutic container will be held. This explicit container setting is an important structuring element of any group work. *Implicit* norming naturally refers to a non-explicit process of fostering ways of relating between the group members; this begins through the modelling of the facilitator, and the relational dynamics fostered as the group progresses. Again, the facilitator plays an important and implicit role in achieving this group norming by setting the tone of the interaction; hence, the facilitator's exhibition of qualities of empathy, self-awareness, positive regard, and compassion are key (Gilbert, 2009; Lambert & Barley, 2001). This has a ripple effect upon dynamics between group participants in fostering norms of care and mutual support, authenticity and resilience, vulnerability and attunement. Creating such a therapeutic environment, via both implicit and explicit norming, proves critical to treatment planning (Lubin & Johnson, 2008).

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 others with relatable histories in order to gain perspective and companionship in examining the impacts of one's past upon one's present.

Safety Considerations in Integrating Mindfulness Practices

In considering the application of embodiment and mindfulness technologies in Phase 1 of trauma treatment, the resourcing stage, there are a number of additional important safety considerations that ought to be

addressed by facilitators. It is important, firstly, to acknowledge the potential contraindications of mindfulness practices with certain trauma presentations. This section describes these client presentations, followed by the principles of titration and pendulation which meet the safety needs, and address some of the concerns raised, in relation to these vulnerable populations. The following sections outline the need to meet real-world safety needs prior to emotional stabilisation; the importance of care in the intake, assessment, and screening process particularised for trauma treatment; the importance of expectation setting; and how to address the heterogeneity that exists within specialised groups.

Mindfulness, Dissociation, and Contra-Indication

There is value in exploring in greater detail the contraindications of mindfulness practices with certain trauma presentations. As argued by Compson (2014), there is good reason to suggest that, despite all its undisputed benefits, mindfulness practice can have psychologically deleterious effects. Further work is required to anticipate, prevent, and mitigate these effects. One potential contraindication concerns clients with significant dissociative tendencies. Research has recently suggested that clients with dissociative tendencies face particular danger of being overwhelmed by the inevitability of experiential flashbacks and the re-emergence of embodied memories. Some scholars have explored some of the limitations of mindfulness-based interventions in relation to individuals who experience dissociative disorders (Forner, 2019; Treleaven, 2018).

Treleaven's (2018) work on the potentially adverse effects of meditation is particularly valuable here. The author identifies particularly psychologically challenging aspects of contemplative practice that may exacerbate existing conditions. In brief, he suggests that without careful guidance, the client in distress or disorientation may slip into a dissociative state as a coping mechanism to avoid the emotional intensity of exposure to unconscious traumatic material. Not only does this render integration of the experience, the traumatic material, impossible, but also such dissociation may become habitual, causing chronic problems for the client. Indeed, one of the major problems with how mindfulness-based therapeutic interventions have proceeded is the failure to understand the manner in which traumatic events can disrupt and disorder one's experience of time, defence, relationality, memory, resource, and agency (Tempone-Wiltshire & Dowie, in press). In the absence of this understanding, mindfulness's application can have reduced efficacy because it is less targeted to the specific metacognitive deficits faced by individuals, and may even encourage a sort of bypass, in which traumatic facets of selfhood are overlooked (Tempone-Wiltshire & Dowie, 2024).

While these concerns speak to the need for careful guidance by experienced group facilitators, there are grounds for believing that mindfulness, when handled with care, may in fact be uniquely well suited for the treatment of dissociation. This is because while dissociation involves retreating from the experience of the present moment through various processes, mindfulness

cultivates the ability to stay in the present moment (Zerubavel & Messman-Moore, 2015). There are, of course, different types of dissociative processes—detachment (e.g., depersonalisation, derealisation), absorption (e.g., daydreaming, "blanking out"), and compartmentalisation (e.g., amnesia, conversion symptoms)—and ongoing research is required to identify challenges to implementation of mindfulness with dissociative clients. Nonetheless, there are reasons to hope that mindfulness reduces reliance on avoidance, which in turn diminishes the need for dissociation. This may occur via facilitators providing clients with specific techniques for enhancing prediction of and control over dissociation via building awareness of dissociative processes and offering tools to enable staying in the present moment. Mindfulness tools, when transmitted to the client by a closely attuned and attentive facilitator, may thereby reduce reliance on avoidance, which in turn diminishes the need for dissociation. The discussion of mindfulness and dissociation is a complex, multifaceted one; at this stage great care must be taken by facilitators when teaching mindfulness skills to vulnerable populations, such as dissociative clients, and further inquiry is required to protect against these potential psychological harms better. Nonetheless, the following principles are of particular value in ensuring the safety of participants, in the majority of cases.

Titration and Pendulation

The treatment of trauma is complex and multifaceted, and it is therefore unsurprising 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 (Courtois & Ford, 2013). This frequently occurs because of the activating nature of engaging in embodiment practices and mindfulness of body sensations, which bring to conscious awareness undigested traumatic content (Levine, 2008, 2010). Similarly, interpersonal trauma history will inevitably be provoked through the basic interactions that occur in the group. Hence, even if not engaging in direct trauma processing, facilitators need to be versed in the principles of titration and pendulation, which can be conveyed to group participants through psychoeducation, as well as through guided exercises, in order that they may 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 & Miller-Karas, 2018). This requires that careful attention be paid to 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 (Siegel, 2010). Through this process,

the individual is better situated to regain homeostasis and cultivate skills for entering dysregulating memories or events by choice, while retaining a state of emotional regulation. The individual's window of tolerance expands as a result of this process.

A number of modern evidence-based approaches to trauma fail to recognise the significance of titration, pendulation, and staging—or phase-based approaches to treatment (Levine, 2010; Miller-Karas, 2023). For instance, many clinicians utilise trauma-focused cognitive behavioural therapeutic approaches, which involve direct engagement with the traumatic memory and frequently use techniques such as prolonged exposure, systematic desensitisation, cognitive processing, stress inoculation, and anxiety management techniques. Yet, frequently, these techniques are used only with haphazard attention to 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 et al., 2010). In group settings, special attention to these principles is particularly critical, given there are many individuals involved simultaneously and a high client-to-therapist ratio (Ford et al., 2009).

Establishing Safety Prior to Stabilisation

While embodiment and mindfulness resourcing may lead to symptom stabilisation, it is important that real-world safety needs must be met first. 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 because lowering emotional defences is nearly impossible in situations of persistent external threat. Similarly, while some symptoms may not pose immediate threat to safety, they 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 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 (Dana, 2018; Porges, 2022). Therefore, 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 while the individual retains a felt lack of safety. It is important to introduce this caveat because there is a danger of facilitating a cultural mode of fragility

under the guise of trauma-informed care, which proves counterproductive to trauma processing (see Taleb's 2012, work on anti-fragility and Lukianoff & Haidt, 2019, for further information).

The real-world safety of the client is a necessary prerequisite to moving into Phase 2 of responding to trauma. A level of psychosocial stability can emerge from membership within a group of peers in a facilitated space in which they are not threatened, and such remodelling can expand a client's field of vision and enhance the felt sense of security. Indeed, data demonstrate 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. Hence, 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 or processing can proceed. Once real-world safety needs are met, symptom stabilisation is the obvious point at which auxiliary modalities are relevant. Therefore, attention can now be placed on the actual work of resourcing participants.

Intake, Selection and Exclusion

Caution must be taken during 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 establishing policies for crisis prevention and risk management. This process begins in initial assessment and screening protocols.

Initial Assessment

Assessment and treatment pre-planning represents the groundwork for all group work. Intake must involve questions concerning past and present-day trauma, recognising 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, since participants require a solid foundation of personal safety and emotional regulation skills and resources to engage in group settings while avoiding crises or regression. These exclusion criteria will vary given the nature of the group work and the intended participants, as discussed below in the screening process.

Screening

Screening interviews and pre-treatment preparatory sessions assist in both the process of participant selection and ensuring the informed consent of participants. Screening ought ideally to be conducted by therapists in order that they 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, or who would prove disruptive to the group process by virtue of impulsiveness or learned patterns of aggression (Chouliara et al., 2020). Particular attention should be given to participants' attachment styles, including clinical-level attachment disorders and clinical-level personality disorder presentations; additionally, questions should be asked about participants' levels of interpersonal resourcing. Courtois and Ford (2013) suggest the need for care here in relation to survivors with severe dysregulation, poor object relations, borderline personality characteristics, or severe sexual abuse histories (Piper et al., 2007). However, 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.

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 while 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.

Establishing Expectations

It is crucial to lay 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 and respected, and that their privacy is protected. Foundations of privacy and confidentiality, alongside freedom from criticism, serve to challenge the trust violations that are often ubiquitous to the prior life experience of trauma survivors. As Courtois and Ford (2013) 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. This has a bearing on the need for clear boundary maintenance awareness by facilitators, as explored in the following section.

Group Heterogeneity: Working with Unique Populations

Clients are individuals with idiosyncratic needs, resources, and histories. Therefore, an effective therapeutic working alliance in a group setting begins with a recognition of the diversity of client presentations. The therapist's

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 to tailor trauma-informed practice skills and tools for facilitating support services for highly stigmatised populations. The parallel problem of ignorance must also be addressed; consequently, cultural competence requires investigation into how best to meet the needs of specific populations. There is value in tailoring programs towards the needs of the unique populations served. Group work may be organised to treat a specific subpopulation, such as people living with a disability. However, in this population, there must be an awareness of the impacts of heterogeneity, that is, of the wide spectrums of disability experienced, the intersection between various psychological and social disabilities, and the intersection of disability with various other cultural variables and social locations occupied by group members. How might the program be tailored to serve individuals who are wheelchair bound? How would this diverge from tailoring programs for individuals with a learning disability? For this reason, where appropriate, facilitators should involve co-design input from the relevant communities when structuring programs to ensure participants' 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 embodiment and mindfulness-based resourcing interventions as illustrative of top-down and bottom-up approaches to trauma resourcing. Such interventions "resource" group members by cultivating the ability of participants to direct attention towards the present moment and increase bodily and affective self-awareness, which serves to reduce patterns of reactivity and thereby supports symptom stabilisation, improved reflective and mentalising ability, and the cultivation of the self- and co-regulatory capacities necessary for trauma-processing group work. Also explored are the phasic, staged introduction of these resources in group settings, when and where they are applicable, necessary screening requirements and exclusion criteria, the role and function of group norming and relational approaches, the importance of pendulation and titration principles, and how to work with distinct populations and in-group heterogeneity. Thus, this article has elucidated the foundations for both developing embodiment and mindfulness-based auxiliary resourcing groups and implementing such groups into a treatment plan for individuals living with trauma.

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