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ORIGINAL PAPER

Trauma-Informed Groups: Recommendations for Group Work Practice

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Abstract
The need for helping professionals to provide services from a trauma-informed perspective has been receiving increasing attention. The primary goal of adopting a trauma-informed approach is to prevent inadvertent re-traumatization during service provision, and to ensure people receive appropriate services in a non-pathologizing manner. However, despite the growing recognition of trauma-informed approaches, there is lack of clarity in the literature about their application to group settings. This paper examines this area of service provision by: outlining the key concepts of trauma-informed practice; describing the relevance of these concepts to group work; identifying specific benefits of becoming trauma-informed; and providing best practice recommendations and cautionary notes for group work practitioners. These recommendations include: (1) assessing for past trauma prior to commencing groups; (2) developing safety and respect within the group setting; (3) focusing on building affect regulation and self-care skills at the beginning of groups; (4) minimizing possibilities for re-traumatization through containment strategies; and (5) recognizing and responding to the potential contributions of oppression and marginalization to traumatic life experiences.

Keywords Trauma-informed group practice · Trauma · Group work · Group treatment · Group therapy · Service provision

Introduction

The need for helping professionals to provide services from a trauma-informed perspective has been receiving increasing attention (Garza et al. 2019; Knight 2015). Emerging out of trauma theory, trauma-informed approaches emphasize the need for all service providers to recognize and respond to the possible role that trauma plays in the lives of the individuals they serve (Reeves 2015). The primary goal of adopting a trauma-informed approach is to prevent the inadvertent re-traumatization of clients and to have them receive appropriate services in a non-pathologizing manner (Harris and Fallot 2001). As such, the move towards the provision of trauma-informed services has been driven by a credible body of research (Elliott et al. 2005; Harris and Fallot 2001; Goodman et al. 2016; Kelly and Garland 2016).

While recognition of trauma may seem intrinsic to trauma-related group interventions such as therapeutic groups for sexual abuse or intimate partner violence (IPV) (Gold 2002; Poole and Greaves 2012), it remains unclear how trauma-informed approaches are being applied throughout group settings. A trauma-informed approach specifies that practitioners recognize and respond to the possibility of past trauma regardless of the presenting issue (Knight 2015). This involves recognizing the potential influence of trauma on all individuals, even if the objective of the group is not identified as the treatment of trauma. One such instance is in groups specified for issues such as substance abuse or depression. Therefore, regardless of whether the focus of a group is trauma-specific or not, a trauma-informed approach allows practitioners to be alert to the possibility of trauma, and to use best practices to ensure participants are not re-traumatized from their group experience. This awareness of the possibility of past trauma is particularly important for group work practitioners, where there is a potential for participants to be triggered or re-traumatized by hearing other group members speak about their traumatic experiences, and

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then in turn relive their own traumatic experiences (Baird 2015; Courtois and Ford 2013).

The following paper examines this area of service provision by: (1) outlining the key principles and concepts of trauma-informed practice; (2) describing the relevance of trauma-informed concepts to group work; (3) identifying specific benefits of becoming trauma-informed; and (4) providing best practice recommendations and cautionary practice notes for group work practitioners. After describing the theoretical development of trauma-informed approaches, the paper summarizes findings from the research literature on trauma-informed groups. Theoretical frameworks and empirically-based findings will provide a foundation from which to ultimately make best practice recommendations for group work to be truly trauma-informed. Case examples will be provided to illustrate how groups can become trauma-informed, and how these core concepts play out in practice. Five recommendations are proposed for group practitioners: (1) assessing for past trauma prior to commencing groups; (2) developing safety and respect within the group setting; (3) focusing on building affect regulation and self-care skills at the beginning of groups; (4) minimizing possibilities for re-traumatization through containment strategies; and (5) recognizing and responding to the potential contributions of oppression and marginalization to traumatic life experiences (Elliott et al. 2005).

Method

In order to identify guidelines for trauma-informed group work, the authors broadly searched the peer-reviewed literature. The databases ProQuest, PsycINFO, and Social Work Abstracts were searched using variations of the terms: trauma-informed, group(s), and treatment/therapy/practice/intervention. The authors also conducted manual searches of specific group work and clinical social work journals (e.g., *Clinical Social Work Journal, International Journal of Group Psychotherapy, Social Work with Groups*). Search criteria were limited to peer-reviewed articles published in English over the last 20 years (1999–2019) and focused on a trauma-informed approach to group work. A total of 852 references were retrieved, of which 167 articles were identified as eligible during pre-screening. After removing duplicates and reviewing titles and abstracts, 23 articles remained for full text review. Of interest, despite the growing recognition of trauma-informed approaches and their relevance to group modalities, only ten articles met the full criteria, showing a paucity of research in this area. The relevant articles included reviews, brief reports, and exploratory, pilot, or descriptive studies, as are described below. Given the lack of research in this area, key trauma-informed literature (e.g., Elliott et al. 2005; Harris and Fallot 2001; Knight 2015), as well as literature on trauma-focused and trauma-specific groups (e.g., Kelly 2015; Kelly and Garland 2016), were included in the development of recommendations for practice.

The Development of Trauma-Informed Approaches: Principles and Concepts

In their pioneering text, *Using Trauma Theory to Design Service Systems*, Harris and Fallot (2001) spurred a movement towards the recognition of the high prevalence of trauma among individuals seeking support from social service agencies. Their work articulated concerns that trauma is not adequately recognized and that its impact on people's lives is vastly underestimated, in turn outlining the ways in which trauma-informed approaches differ from traditional service delivery approaches. In particular, they investigated how trauma was addressed among women who were receiving outpatient mental health, addiction, and inpatient psychiatric services. They argued that while service systems often serve survivors of childhood trauma, they do not actually treat them for the trauma, or else serve them without being aware of the childhood trauma. They pointed out that failure to recognize past trauma results in people not being referred to appropriate services, but of greater concern "can also result in inadvertent re-traumatization when a service system's usual operating procedures trigger a re-emergence or an exacerbation in trauma" (Harris and Fallot 2001, p. 3).

Elliott et al. (2005) later identified ten core principles to guide the development of trauma-informed services: (1) recognizing the effects of violence on development and coping; (2) identifying trauma recovery as a key goal; (3) focusing on empowerment; (4) ensuring survivors have control; (5) focusing on collaborative relationships; (6) creating a sense of safety, respect, and acceptance; (7) emphasizing strengths and resilience; (8) minimizing possibilities of re-traumatization; (9) recognizing the role of culture and context in life experiences; and (10) including input from survivors in the evaluation and design of services. These principles are key for practitioners aiming to use a trauma-informed lens in their work.

A trend towards advancing trauma-informed services has followed the ground-breaking work of Harris and Fallot (2001) and Elliott et al. (2005). Trauma-informed texts (Evans and Coccoma 2014; Poole and Greaves 2012), commentaries (Bent-Goodley 2019; Sweeney and Taggart 2018), reviews (Knight 2015; Muskett 2014; Reeves 2015), and empirical studies of trauma-informed interventions (Serrata et al. 2019; Sullivan et al. 2018) have all been increasingly prevalent in the literature. For instance, trauma-informed practice been found to be effective in reducing trauma reactions in children and adolescents (Black et al. 2012), in work

with women with co-occurring substance use and mental health problems and a history of past traumatic experiences (Gatz et al. 2007), in health care and community settings (Hamberger et al. 2019; Loomis et al. 2019), among other populations and settings.

Recently, trauma-informed services have been further defined, with scholars such as Knight (2015) articulating how instead of either ignoring or focusing only on someone's experiences of past trauma, trauma-informed practice involves being attuned to how someone's "current difficulties can be understood in the context of past trauma" (p. 25). Similarly, Poole and Greaves (2012) describe the role of trauma-informed services in identifying how trauma can impact the beliefs, confidence, and behavior of people seeking services for other reasons, such as substance use, or mental health problems. More broadly, trauma-informed services recognize the importance of ensuring safety and empowerment across all agency or system policies and practices (Loomis et al. 2019; Kusmaul et al. 2018; Walsh et al. 2019), not just in targeted interventions for certain populations (Levenson 2017; Poole and Greaves 2012).

The term trauma-informed practice is often used interchangeably with the term trauma-informed care, however, these terms should not be confused with trauma-centered, trauma-specific, or trauma-focused interventions (Levenson 2017; Sweeney and Taggart 2018). Knight (2015) describes the distinction between trauma-centered interventions, in which trauma is the central focus, and trauma-informed interventions, where practitioners recognize and respond to the possibility of past trauma. Thus, where trauma-informed services recognize the impact and possibility of past trauma on current difficulties, trauma-centered or trauma-specific services "more directly address the need for healing from traumatic life experiences and facilitate trauma recovery through counselling and other clinical interventions" (Poole and Greaves 2012, p. xvii). Poole and Greaves (2012) also discuss the possibility of overlap between trauma-informed and trauma-specific services, describing how an intervention that focuses on building emotional regulation skills could be included in both trauma-informed and trauma-specific group programs.

Although trauma-informed principles may be well understood by those primarily focusing on therapeutic trauma work, Elliott et al. (2005) argued early on that this understanding is not always consistent across service settings. Trauma-informed systems require a commitment from agency administrators to review policies and procedures, and adequate budgets for necessary resources so that programs meet the needs of service users, and to ensure that all staff have training to understand the impact trauma may have on the lives of service recipients (Harris and Fallot 2001). Additionally, universal screening for trauma is recommended in all social service settings, including mental health, housing, and addictions services (Harris and Fallot 2001). In summary, to ensure a trauma-informed approach, all staff in an organization need to "understand how violence impacts the lives of the people being served, so that every interaction is consistent with the recovery process and reduces the possibility of re-traumatization" (Elliott et al. 2005, p. 462).

Understanding a Trauma-informed Approach to Group Work

Proponents of group work acknowledge the profound impact that groups can have on recovery for individuals facing a range of difficulties. Yalom's (1998) instrumental work summarizes the benefits of groups, including the creation of hope through hearing the challenges and successes of others with similar experiences, the change and growth that can occur through the creation of group cohesion, and the therapeutic benefits of helping others in the group through altruism. Group interventions can uniquely provide ways to combat isolation and stigma (Yalom 1998). A key benefit of group modalities is seen as the development of mutual aid, which is described as a "hallmark of social work with groups" (Steinberg 2004, p. 8). Mutual aid is outlined by Gitterman and Shulman (2005) as a small group process that involves nine key processes, including sharing data, mutual support, mutual demand, and strength in numbers, among other processes. Mutual aid has also been described as a result of small groups, with Steinberg (2004) articulating how when mutual aid is present, group members find it "comforting to be with others who share common concerns, [and that] when group members realize that their co-members do share common feelings or concerns, for example, that reflects mutual aid" (p. 10). However, despite the proliferation of group approaches and their positive outcomes in helping individuals with a myriad of presenting difficulties, a trauma-informed lens suggests that group practitioners must use a measure of caution when working with group members who may have experienced past trauma.

The significant work of van der Kolk (2006) on trauma, outlining its effects on people and therapeutic approaches, provides a strong rationale for practitioners to consider a trauma-informed lens in group work. His extensive research on psychotherapy with trauma survivors demonstrates how traumatic reminders can elicit neurobiological responses, which can in turn create unexpected responses in trauma survivors (van der Kolk 2014; van der Kolk et al. 2005). For example, traumatic memories can lead to unexpected physical responses or body sensations, known as somatizations, which can make it difficult to predict which stimuli will cause a traumatic response (Reeves 2015; van der Kolk 2014). For this reason, traumatic reminders are often referred to as *triggers*, or as triggering or leading to certain

responses in trauma survivors (Courtois and Ford 2013). Specifically, traumatic reminders can activate areas of the brain that are responsible for intense emotions, while deactivating areas of the brain that inhibit emotions (van der Kolk 2006). For this reason, van der Kolk warns that therapeutic interventions that invoke traumatic reminders can be harmful for people. In particular, he argues that this research provides evidence that talk-therapy that focuses on creating new insights or awareness may not be enough to prevent experiences of feeling triggered and re-traumatized.

In group work there is potential for each individual participant's past traumatic experiences to be triggered unexpectedly by a description of an experience by another group member. One group participant's description of an event could trigger another member's past traumatic experience; with the potential for individuals to be inadvertently re-traumatized (Courtois and Ford 2013). In groups targeted to individuals who have experienced trauma, there is often already an awareness and a sensitivity to trauma, and therefore this is usually carefully watched and monitored. However, in groups for clients with other presenting issues—such as self-esteem or grief—practitioners and group members may not be prepared for traumatic responses, creating a greater potential for concern. In these situations, confusion about the group's purpose among group members may also diminish the possibility of the development of mutual aid within the group, also creating greater anxiety among group members (Gitterman 2005). In response to these concerns, a trauma-informed approach recognizes the role that certain stimuli in service settings could play in triggering traumatic responses in someone who has experienced a past traumatic event (Reeves 2015). It is with this theory and research in mind that the authors set out to determine the state of the literature on describing and making recommendations for becoming trauma-informed in group work settings.

Current State of the Literature on Trauma-Informed Groups

Preliminary work has been done in describing trauma-informed approaches when working in groups with individuals with mental health difficulties. A brief report by Spei et al. (2014) describes their work in combining group cognitive remediation and trauma-informed approaches for individuals with serious health problems, as well as recognizing the multiplicity of factors contributing to mental health problems. The authors report that empirical findings are pending.

Another growing area of trauma-informed research is specific to work with youth. Black et al. (2012) provide a review which summarizes therapeutic approaches with adolescents utilizing trauma-informed techniques, of which a few are group interventions, but these are specifically focused on trauma-specific presenting difficulties. Bulanda and Byro Johnson (2016) describe the use of trauma-informed techniques with empowerment groups for vulnerable youth. Vitopoulos et al. (2017) outline the development of a trauma-informed mental health group for youth who were transitioning out of homelessness. Vitopoulos and colleagues' article describes the process of developing this pilot trauma-informed group intervention, and the role of trauma in the lives of the group members. Key recommendations of the pilot intervention included promoting early attendance at the group, building mindfulness and grounding techniques into the group sessions, responding effectively to difficulties experienced by group members, and recognizing the role of multiple experiences of trauma in the lives of the group members.

A brief report by Gudiño et al. (2014) describes a trauma-informed approach used with adolescents in an inpatient psychiatric setting. Their work included the use of Brief STAIR-A, a skills-training program developed out of an earlier adult-version originally developed by Cloitre et al. (2006). The authors describe the aim to provide adolescents with an intervention that focuses specifically on developing emotional regulation skills through training on: (1) education about trauma; (2) education about emotions; and (3) the development of additional skills in understanding and coping with emotions. The authors also describe the importance of including experiential exercises in the program so that youth can practice their skills. The study's preliminary results show that this may be an effective way to help adolescents with difficulties related to trauma in psychiatric settings, but that further research is necessary.

There has also been recent research outlining trauma-informed approaches when working with specific populations in groups. Levenson's (2014) article on trauma-informed care with individuals who have sexually offended describes how a trauma-informed lens shifts practice within groups, articulating a holistic approach of considering the role of childhood trauma in influencing someone's life and behavior in broad, life-long ways. Similarly, Murphy et al. (2015) describe the application of a trauma-informed approach to an attachment-based group for mothers and children aged 0-3, and the next steps necessary to further develop and test this approach. More recently, Myers et al. (2018) work describes the development of a six-week trauma-informed substance use and sexual risk reduction group for young women in South Africa. Their work outlines the expansion of a previously-used evidence-based HIV-prevention program to include trauma-informed components, and its subsequent evaluation using focus groups.

Although the above studies advance understandings of trauma-informed practice in group work, further research is needed to identify and test the particular elements that make groups trauma-informed, and to illustrate the importance

of trauma-informed approaches across all group work practice. Encouragingly, there is burgeoning research on trauma-focused and trauma-specific groups, which is helpful in the initial development of basic guidelines to apply generally to trauma-informed group work (Boel-Studt 2017; Kelly 2015; Kelly and Garland 2016).

Towards Trauma-Informed Group Practice

Case Examples: Two practice examples will be used to illustrate and draw out recommendations for group work from a trauma-informed perspective. The application of the principles of trauma-informed practice to group work, coupled with the literature, allows for some basic recommendations for practitioners to consider in their group work. Let's start with Annika.

> Annika's husband has an acquired brain injury (ABI) from a serious fall at work at a construction site where he was a foreman. He has cognitive impairment, short-term memory loss, mood swings marked by anger, and his bodily functions have been affected so that he needs assistance with basic personal needs. Their adult children are away at college/university and as a couple they were anticipating retiring soon to free up their time for travel and other interests. The neurosurgical team have prepared Annika for a very different life with her husband given the limitations to his capabilities. She has already had to take a leave of absence from her job as a para-legal assistant to help with her husband's transition home. The medical social worker has recommended a support group for Annika for partners of people with ABI to help her adjust to the changes in her life with her husband, help with resources, and receive social support from others going through, or having gone through, similar experiences with their partners. Annika agrees to attend but after the second session she stops attending and does not respond to attempts to be invited back in. In group, she heard stories and descriptions from group members, in vivid detail, about how bad things were with their partners, which are likely to occur with her husband. Hearing about things that she had not even thought of triggered fears about the future, which depressed and scared her. As well, she grew up in a family where there was domestic violence and child abuse. Her husband's terrible mood swings and anger have re-kindled a life that she left behind in her childhood, but is now becoming a reality in her own marriage after 25 years of relative calm.

Next, let's go to the example of Al's group experience.

> Al joined a 10-week psychoeducational group to help improve his self-esteem and improve his mood. Al works in an administrative role at a community college, and has been having recent difficulties coping with stress from an increased workload, as well as conflict with co-workers. When he returns home from work, he finds himself feeling stuck on the remarks made by coworkers, feeling down, and that he no longer wants to see family, friends, or participate in activities he previously enjoyed. With growing concern, Al's partner Jay encouraged him to see their family physician to discuss these changes in his mood. Al's family physician referred him to the group to help identify and shift negative thinking patterns possibly impacting Al's self-esteem and signs of depression. Al found the first two weeks of the group and the homework exercises helpful, but during the third week, which focused on childhood messages, another group member began recounting in detail a specific instance of physical and verbal abuse from her father. Hearing this story brought back Al's memories of his father's verbal abuse and homophobic rants towards him, as well as specific instances of being bullied, beaten up, and verbally assaulted because of his sexual orientation. These memories were followed by flashbacks of a particularly violent night when he was beaten up by teenagers in his neighborhood. For several nights following the group, Al had nightmares about that particular night. As the next group session approached, Al became increasingly fearful about being reminded of more difficult times from his childhood, and did not attend the group.

Recommendations for Group Practitioners

Assessing for Past Trauma Prior to Commencing Group

Harris and Fallot's (2001) initial recommendation for service providers to screen for trauma is important to consider. They recommended that service providers screen by asking about whether people accessing services have been exposed to any violence or threatened violence, physical assault, sexual assault, or sexual touch that was unwanted. To allow for a broader definition of trauma, additional items to screen for would include any form of abuse by a partner, traumatic loss, or potentially traumatic experiences such as oppression, discrimination, or marginalization based on one's racial, cultural, spiritual, or gender identity, sexual orientation, or ability (Timothy 2012). Or, as recommended by Murphy and colleagues (2015), potential group participants could be asked about any traumatic experiences they may have had in a more open-ended way, creating an opportunity for

a discussion about the role of trauma and its potential to contribute to difficulties someone might be having.

Developing Safety and Respect Within the Group Setting

An important first step in group development is to create guidelines for safety and respect for participants at the beginning of each new group. Also in these initial stages, it is essential that group practitioners ensure that the group purpose it presented clearly and agreed upon by group members, so that members have distinct guidelines about the parameters of the group in the introductory stages (Toseland and Rivas 2017). Although practitioners take different approaches to developing safety and respect, this is an essential part of developing a cohesive group and a space conducive to therapeutic growth (Berman-Rossi 1993). This stage in the group can include information and exercises aimed to build trust among participants (Boel-Studt 2017). As part of this stage, psychoeducation on trauma and triggers can be included, to foster acceptance and knowledge about how members can be impacted by group materials, setting the tone for building an emotionally safer space for participants. As discussed by Vitopoulos et al. (2017), this can include "the inclusion of group rules that [encourage] participants to take safe breaks from topics should the need arise… and the availability of individual support for participants outside of the group setting" (p. 507). As stated by Levenson (2014) in discussion of trauma-informed practice in groups for people who have sexually offended, group practitioners need to focus on creating an atmosphere that encourages group members to develop supportive relationships and interactions, rather than confrontational ones. Also, an important consideration raised by Bulanda and Byro Johnson (2016) is the identification and reduction of potential triggers, in order to create a safer group space. Importantly, this may include the setting itself, and identifying aspects about the physical space of the room, potential for noises that could be alarming or triggering, or include the creation of an emotional climate that is free from judgment or criticism (Bulanda and Byro Johnson 2016).

Knight's (2015) description of trauma-informed principles in work with adult survivors of childhood trauma can also be considered in group work. Knight warns against not adequately acknowledging or addressing the role of trauma, or on the other extreme, pushing for too much detail related to traumatic experiences. Knight also argues that establishing safety and stability is an important step in trauma-informed practice, and discusses the importance of stable, ongoing relationships between clients and clinicians. The fostering of an empowering environment, as recommended by Knight, is an important goal for group practitioners as well, where group members can feel supported to begin to make the changes they need to make in their lives.

Building Affect Regulation Skills

A key focus in both trauma-specific and trauma-informed interventions is often the development of strong emotional regulation skills prior to delving into potentially upsetting or triggering memories or discussions (Gatz et al. 2007). In the group described by Vitopoulos et al. (2017), this included providing techniques to help cope with trauma-related responses as part of the group program. In groups where it is often unknown what could bring up traumatic memories for participants, a recommendation is to ensure that affect regulation skills are included as part of the group. In skill-based groups focused on teaching certain strategies (i.e., mindfulness groups), affect regulation skills are often already built into the group structure. However, many other groups may risk delving into emotional topics without perhaps preparing participants adequately. In response, a trauma-informed approach ensures adequate preparation of group members prior to delving into emotional material. This could include an educational component at the beginning of the group that provides education on trauma and its impacts on the brain, or could include strategies to cope with overwhelming emotions within the group and between group sessions. A weekly section on self-care skills specifically linked to what is being covered in the group, with time to practice the new skill within the group setting, may also help build affect regulation skills among group participants.

Minimizing Possibilities for Re-traumatization Through Containment Strategies

In group settings, the concept of containment can hold different meanings, one of which is to safely allow the sharing of experiences with a group of others who might understand, and who will provide support and encouragement (Phillips 2015). As such, this concept includes a holding of one's potentially traumatic experiences safely within the group setting, containing them there (Phillips 2015). However, when applying this concept to trauma-informed groups, the term containment is meant to not only contain or hold traumatic images or stories in a safe way within the group, but to try to ensure the containment of potentially traumatic descriptions within the group members themselves. While this may seem in contrast to a truly therapeutic, cathartic group experience (Yalom 1998), it helps ensure the safety of other group members by steering conversations away from potentially detailed and re-traumatizing depictions of traumatic experiences. Someone who attends a group aiming to improve self-esteem may choose this purposefully and may not be ready to delve into past experiences of sexual abuse, for instance. The importance of clearly articulating the group purpose is crucial here, which is essential to the development of mutual aid processes among the group members (Shulman 2005).

Once the group purpose is clear, the group facilitator's skill in redirecting conversation is critical, not only to keep the group focused on its purpose, but to try to ensure members do not inadvertently affect the emotional safety of other members by triggering past traumatic experiences.

Kelly (2015) describes the use of containment strategies in a trauma-informed mindfulness group for survivors of interpersonal violence. The group addressed potential for harm through re-traumatization by focusing on teaching self-containment strategies, rather than on describing past experiences of trauma. Self-containment strategies, described as techniques to help regulate emotions, were taught in the form of mindfulness skills. In addition, the group facilitator mitigated re-traumatization by ensuring that group members did not discuss details of the abuse. Finally, there were no expectations for group members to share their experiences because of the priority placed on establishing safety within the group, and the understanding that sharing past stories of abuse may impact another group member's safety.

Acknowledging the Potential Role of Oppression and Marginalization in Trauma

Elliott et al.'s (2005) emphasis on the importance of responding to the potential contributions of oppression and marginalization to traumatic life experiences in trauma-informed practice, should not be neglected in group work. Trauma experienced through racism, for instance, needs to not only be clearly identified during individual assessment, but then also returned to during the group itself, with the group member's consent. A racialized group member entering a group of mainly white group members, for example, may experience re-traumatization in the group setting. A pitfall of some group practitioners is to focus solely on the topic of the group and avoid acknowledging potentially uncomfortable or contentious topics such as experiences of oppression, discrimination, and marginalization. This can lead to not recognizing how these experiences contribute to trauma, and potentially the issue being focused on. This can be a challenging balance for group practitioners who are simultaneously aiming to create group safety by avoiding delving deeply into traumatic experiences that could be re-traumatizing. An example of achieving this balance can be seen in Clark's (2012) discussion of trauma-informed practice in a therapeutic group for girls. Clark details how she works to ensure the group "locates the source of girls' challenges within structural and systemic problems such as racism, poverty, sexism and the intersections of these in their lives" (p. 154). This highlights the importance of recognizing systemic and structural violence in people's lives, and its importance in group work.

Acknowledging the role of oppression, stigma, and marginalization in people's lives also addresses a critique that trauma-informed approaches focus only on the impacts of trauma on an individual level, rather than adequately recognizing the broader impacts of marginalization and oppression on people (Baird et al. 2019 ; Reeves 2015; Timothy 2012). Reeves (2015) completed a review of the use of trauma-informed care within health care services, concluding that more work is needed to understand "how trauma occurs within the context of culture, and how culture affects the ways in which meaning is attributed to trauma" (p. 706). Importantly, group practitioners can discuss the role of structural oppression related to the difficulties in people's lives, ensuring that potential relationships between systemic oppression and discrimination and the difficulties people face do not go unexamined (Reeves 2015).

Now let's return to our practice examples of Annika and Al and applying these trauma-informed concepts.

> With Annika, assessing for past trauma may have averted her decision to leave the group. An assessment to ask about past experiences may have revealed the abuse in her parents' relationship. This may have helped her to identify similarities between her father's violence towards her mother and her husband's current aggression towards her, and any recurring fears she might be experiencing, and to develop safety strategies. This indicates that pre-group sessions with a social worker would be necessary to help Annika voice her fears in a contained environment before having these activated in a group setting with no preparation. As well, laying groundwork about the content that would be covered in the group would have helped Annika anticipate this emotionally-loaded content, but also anticipate a balance where group members would also share coping strategies, problem solving suggestions, and other helpful input. Building affect regulation skills, helping her to develop additional ways to handle strong emotions, would assist her in anticipating content delivery related to her husband's prognosis. However, the current situation is such that she left the group precipitously, indicating that follow-up would be critical in going through these steps with Annika. A group facilitator reaching out to her would ensure a proper de-briefing, but also may engage her to return and finish out a more adequate course of group participation. Annika's situation with her husband will not change and her reality of their life together will be unaltered. Thus, it is incumbent on the helping professionals to offer help in the face of her changing situation.

A review of the current structure of the group is necessary to determine how the group program goals fit with trauma-informed principles, and to determine how they can be embedded in the structure of the group.

Consideration must also be paid to whether the group should be open or closed. Annika joined a group that had been well-established and most members were further into their process of accepting their situations, and finding means to deal with their new realities. Perhaps Annika would have been served better in a group where all members were at the same starting point so that she would not have been as emotionally overwhelmed, while being not properly prepared to handle these difficult emotions. Another area for group practitioners to pay attention to is the composition of the group (Toseland and Rivas 2017). For instance, group practitioners need to ensure group homogeneity as far as members sharing a similar purpose for being in the group and sharing some characteristics with other members, while also ensuring there is heterogeneity in group composition in other areas such as coping, experiences, and expertise (Toseland and Rivas 2017). In Annika's situation, there does not appear to be a balance in these areas, as she was the only one in the group at such an early stage of this experience, resulting in an unbalanced group.

There are several further questions to consider here, such as whether the group had safety features built in, and to what degree, and how these are being observed on a weekly basis. The group practitioner must consider what containment strategies are being used to avoid unnecessary triggering of emotions among group members, and whether there are affect regulation exercises that can be practiced during each session. Safety planning related to the violence in Annika's marriage must also be explored. Whether her husband's violence is inadvertent and unintentional as a result of his ABI, she is at risk for further trauma, a risk that needs to be mitigated.

For Al, as with for Annika, a trauma-informed approach would have meant that the group facilitator would have screened for the possibility of prior traumatic experiences before the group started, which may have given the facilitator a sense of what was happening during the group. This initial screening meeting and discussion may have built a stronger relationship between Al and the facilitator, also making him more comfortable reaching out to the facilitator for help with the flashbacks when they occurred. During the group itself, the addition of affect regulation skills and psychoeducation on trauma may have helped prepare Al for this experience, to normalize traumatic responses, and to provide him with some additional tools to cope with nightmares and upsetting images. Containment strategies that focus on building group safety by discouraging and redirecting detailed depictions of past traumatic experiences, may have helped as well. Clarity in group purpose from the beginning of the group may have also helped to prevent this from happening, and in turn helped in the development of mutual aid among group members (Shulman 2005). Finally, the acknowledgement of the possible links between forms of oppression such as homophobia and traumatic experiences, may have created a context in which Al felt open to discuss the difficulties he was experiencing with the group facilitator, or in the group, instead of choosing to stop attending.

Conclusion

Trauma-informed group practitioners must walk a fine line between recognizing the role and potential harm of trauma in people's individual lives and on the group process as a whole, while exercising caution to not over-emphasize its magnitude. Trauma-informed group practitioners must to the best of their abilities mitigate chances for re-traumatization, while understanding that traumatic experiences may not be defining experiences for all who experience them (Harris and Fallot 2001). At the same time, strengths and resilience need to be identified from the start of therapeutic work and continuously built on to promote each individual's positive adaptation. Coming from the position that resilience is not an individual characteristic that one has or does not have, but rather a process that needs to be intentionally encouraged (Alaggia and Donohue 2018; Evans and Coccoma 2014), group work is ideally positioned to be able to foster resilient outcomes.

Organizational commitment to creating a trauma-informed culture for all staff is also necessary for group practice to move into this paradigm competently (Elliott et al. 2005; Harris and Fallot 2001; Walsh et al. 2019). Staff should be trained in trauma-informed principles, agency policies and procedures need to be reviewed, and measures such as the Attitudes Related to Trauma-Informed Care (ARTIC) scale (Baker et al. 2016) or the Trauma-Informed Practice Scale (TIPS) (Goodman et al. 2016) could be implemented to make regular checks on how the trauma-informed principles are being integrated and acted on within organizations.

Group work provides an essential area of clinical practice. However, as illustrated in this paper, group practitioners must take time to ensure their practice allows for clients to gain from the benefits of groups, while reducing risks for re-traumatization. This means that the possibility for underlying trauma to be triggered in group settings is recognized and met with care. In response to these concerns, several key principles of trauma-informed practice have been applied within group settings in this paper, providing initial best practice recommendations for practitioners in the

development of trauma-informed groups. However, further work is required to investigate and evaluate how these principles play out in the context of different group settings, and to provide empirical research on the effectiveness of trauma-informed groups.

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