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An integrated trauma-informed, mutual aid model of group work

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ABSTRACT
This article presents an integrated trauma-informed, mutual aid model of group work. It applies the concepts and evidence of the trauma-informed care movement in mental health to the group work model of mutual aid. Implications for social work practice, education, research, and theory-building are forwarded.

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Literature review

Trauma-informed care

Social workers frequently encounter clients who present for treatment where the underlying cause is trauma. Unfortunately, treatment providers can feel unequipped to deal with trauma and be unable to integrate trauma informed principles into their treatment modalities (Substance Abuse and Mental Health Services Administration (SAMHSA), 2014b). While several definitions of trauma exist, the SAMHSA definition will be used for the purposes of the article as it presents a broad representation of trauma:

> Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being. (SAMHSA, 2014a, p. 7)

The devasting effects of trauma's long-term impact have been studied extensively in populations such as active-duty military personnel and veterans who experienced "shell shock" or, as it more well-known today, Post Traumatic Stress Disorder (PTSD) (Gallers, Foy, Donahoe, & Goldfarb, 1985; Jones & Wessely, 2005; Van der Kolk, McFarland, & van der Hart, 1996) and survivors of childhood sexual abuse (Beitchman et al., 1992; Finkelhor & Browne, 1985; Knight, 2004). It is important to note that the earliest studies, understandably, focused exclusively on trauma-specific populations.

However, key differences distinguish the terms "trauma-informed" versus "trauma-specific" where trauma-informed treatment incorporates an

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understanding of the impact of trauma on the client in all aspects of service delivery (Fallot & Harris, 2008). In contrast, trauma-specific services treat trauma and facilitate recovery from traumatic events. Trauma-informed care provides a framework for understanding that difficulties that clients are presently experiencing are often evidence of the long-term sequelae of trauma (Harris & Fallot, 2001). Consequently, treatment should not focus only on the presenting problem, but how this problem fits in the context of the person's life. While the trauma-informed approach does not assume that every client has experienced trauma, it does recognize that trauma is pervasive and its effects last long after the traumatic event.

One of the studies that aided the shift in awareness of the widespread prevalence of trauma (as it was the largest study to examine effects of early childhood trauma) is the Adverse Childhood Experiences (ACE) study; this study found that ACEs were directly correlated with early death (Felitti et al., 1998). Subsequently, Harris and Fallot's (2001) work on establishing a trauma-informed service delivery detailed how trauma-informed treatment differed from traditional treatment. These two publications paved the way for the current paradigm known as trauma-informed care (TIC). It is important to note that there has been some discrepancy in the literature regarding the terminology used to describe trauma-informed care. While some authors use the term trauma-informed care (TIC) to refer to principles for both organizational and clinical practice (Berger & Quiros, 2014) other authors such as Knight (2018) differentiate between "trauma-informed care," referring to the organizational components, and "trauma-informed practice," referring to the practice components. For this paper, Knight's differentiation will be used for consistency and clarity.

Harris and Fallot (2001) conceptualized trauma-informed care as having five principles: safety, trust, choice, collaboration, and empowerment. Subsequently, SAMHSA (2014a) convened a task force, comprised of national experts who extensively studied the field of trauma, to create an understanding of trauma-informed concepts across a variety of service systems that "builds upon Harris and Fallot's work" (p. 12). The task force relied upon practitioners in the field, researchers, trauma survivors, and other programs such as SAMHSA's National Child Traumatic Stress Initiative and SAMHSA's National Center for Trauma Informed Care (SAMHSA, 2014a). Because of the applicability to a wide array of service delivery systems, SAMHSA's conceptualization of their six trauma-informed principles will be used for integration of the mutual aid model. These principles are: safety, trustworthiness and transparency, collaboration and mutuality, peer support, empowerment, voice and choice, and cultural, historical, and gender issues (SAMHSA).

Safety refers to both the physical and emotional safety of clients. Two of the notable features of trauma are the powerlessness and fear that survivors feel during the experience (Hopper, Bassuk, & Olivet, 2010). For trauma

survivors to engage in the therapeutic process, they need to feel emotionally safe to explore that trauma and through that safety, *trustworthiness and transparency* can be established in the therapeutic relationship (Knight, 2015; Levenson, 2017). Through consistency, predictability, and transparency in service provision, the therapeutic alliance can be used as a tool to challenge distortions in thinking and develop a trusting relationship (Banks, 2006; Knight, 2015; McCann & Pearlman, 1990).

Collaboration and mutuality require clinicians to be intentional about engaging clients in the therapeutic process (Levenson, 2017). Engaging clients who have experienced trauma can be challenging because their experiences have made them feel powerless to those around them. It is the role of the clinician to assist survivors in combining their own life experiences with the worker's professional knowledge to form a truly collaborative relationship. The *peer support* that is received from those who have shared lived experience with trauma promotes hope in an otherwise hopeless experience.

By emphasizing *empowerment, voice, and choice* in trauma survivors, survivors are able to make their own choices and re-assert control over their lives which was taken away by the traumatic event(s) (Hopper et al., 2010). Furthermore, by addressing the *cultural, historical, and gender issues* that arise during treatment, clients are able to engage in the therapeutic process knowing that their individual needs will be valued and respected. As clinicians work to ensure that their practices reduce stereotypes and prejudice, it creates a culture and service delivery system that is free of discrimination and provides a culturally responsive approach to treatment. Linked to this component, Mohatt, Thompson, Thai, and Tebes (2014) present a model of historical trauma that suggests when historical trauma is compounded with current trauma, the overall impact of the trauma is more significant. As a result, clinicians' knowledge about the impact of historical trauma allows them to be more responsive to the struggles faced by clients.

The mutual aid model

The mutual aid model of group work emphasizes the relationship between members that plays a significant role in the problem-solving process (Schwartz, 2005). The impetus for change comes from the connection between members who share common problems that they must work together to solve. This was a paradigm shift for groups from leader as "authoritarian" to leader as "democratic facilitator" to foster mutual aid.

This model is comprised of ten different dynamics that occur during the life of the group. These dynamics are: sharing data, "all-in-the-same-boat" phenomenon, the dialectical process, discussing a taboo areas, developing a universal perspective, mutual support, mutual demand, individual problem

solving, rehearsal, and the "strength-in-numbers" phenomenon (Gitterman & Shulman, 2005; Shulman, 2015).

Sharing data addresses the exchange of ideas and information between group members. The *"all-in-the-same-boat' phenomenon* refers to the solidarity among the members who realize that they are not alone in what they are thinking, feeling, and experiencing which allows them to pool those collective responses to resolve their problems. *Discussing a taboo area* occurs when members can discuss difficult or uncomfortable topics such as an abuse history or mental health crisis. *The dialectical process* references the exchange of counter or alternative viewpoints that allows group members to tolerate disagreement as well as synthesize the information to form new viewpoints. *Developing a universal perspective* helps members identify how the problems in their lives have been created, in part, through structural oppression.

Mutual support is manifested when members empathically express their understanding of the problem and their care for each other. In contrast, *mutual demand* is placed on a member to confront both the realities of how they may be avoiding working on their goals and how they need to bolster their motivation to work. With *individual problem-solving*, the group provides individual assistance such as active listening and advice to a particular member. *Rehearsal* allows members to practice scenarios in the sanctity of the group that they can transfer to their lives. The *"strength-in-numbers" phenomenon* addresses the group's collective power to engage in a goal external to the group itself.

Group work and trauma

Group work with members impacted by trauma is well-documented. For example, group work has focused on helping those with trauma include natural disasters (Huang & Wong, 2013), interpersonal trauma (Mendelsohn, Zachary, & Harney, 2007), and bereavement and community trauma (McLea & Mayers, 2017). In a landmark article, Knight (2006) identified essential considerations for groupwork facilitation when working with trauma-specific groups; a major recommendation is for workers to acknowledge that group members may present with a "traumatic narrative" in which they may share stories of trauma where their safety and trust had been damaged. Group tasks such as preparing, member screening, intervention by stage, and supervision are discussed with the trauma-specific work on trauma recovery groups (Mendelsohn, Herman, Schatzow, Coco, Kallivayalil & Levitan, 2011). "When dealing with trauma we are faced with two sides of the same coin: welcome remembrances and unwelcome reminders" (Malekoff, 2017, p. 373).

Research shows that the mutual aid group model is effective in healing survivors of trauma by instilling hope, increasing self-esteem, strengthening resilience, and promoting a sense of control over one's environment (Knight, 2017; Knight & Gitterman, 2014; Seebohm et al., 2013). These exemplars include mutual aid with trauma-specific groups affecting post 9/11 NYC residents (Chung, 2003), post-traumatic stress in complicated grief (Knight & Gitterman), mothers who are homeless and with a history of trauma (Knight), and adolescent girls who were human trafficked (Hickle & Roe-Sepowitz, 2014).

Model integration: the conceptual relationship between mutual aid dynamics and trauma-informed care

The rationale to integrate the mutual aid model and the trauma-informed care framework bears examination. For decades, mutual aid has been the quintessential model of group work – extending to both treatment and task groups of all sizes (Gitterman & Shulman, 2005; Shulman, 2015). The relevance of the model has increasingly become center stage since Schwartz's (1961) application to mutual aid in social work with groups. More recently, the "era of the brain" and insights into neurological research, including neuroplasticity, brought new understandings into trauma and treatment (Van der Kolk, 2014). Scholarship such as Harris and Fallot's (2001) trauma-informed care service delivery and the ACE study (Felitti et al., 1998) helped introduce the trauma-informed practice framework as a paradigm shift in mental health assessment and treatment.

To remain relevant, the mutual aid model must incorporate and integrate insights from trauma-informed practice. Consequently, a trauma-informed, mutual aid model of groupwork updates the mutual aid model with such trauma-informed principles including safety, trust, and empowerment. With the additional lens of historical trauma, the mutual aid model can be fully "trauma-informed" to groups. The evidence and broad application of SAMHSA's (2014a) conceptualization of trauma-informed care is applied to mutual aid. SAMHSA's refinements of "transparency," "peer support," "cultural, historical, and gender issues," and "mutuality" are useful concepts because they synchronize with mutual aid dynamics in the model integration.

This integration is also important because it more fully describes the benefits that groups provide members. For treatment groups, members come together and engage in groups for support, education, growth, socialization and therapy (Toseland & Rivas, 2017). The group offers members the space to voice and overcome loneliness, to gain insights, to become empowered, and to belong to a collective community that offers opportunity for healing and increased confidence. These benefits are incorporated into a trauma-informed formulation through the creation of a safe and supportive

atmosphere of trust in which peer support and a sense of solidarity exists. As this mutuality is realized in a trauma-informed group, members become comfortable to feel vulnerable and they can share – spontaneously or planned – their trauma narratives within the group. In turn, the group offers a sounding board, a holding space, and gentle, directed feedback and guidance for the members' journey through trauma and healing.

Mechanisms of integration

An integration is proposed based on mutual aid dynamics that generally serve as a catalyst to the generation of the trauma-informed practice components. In turn, the creation of a trauma-informed climate in the group further stimulates the creation of the mutual aid dynamics. Therefore, mutual aid and trauma-informed practice become conjointly reinforcing; mutual aid inspires a trauma-informed climate and a trauma-informed climate nurtures mutuality.

The mutual aid dynamics of sharing data, "all-in-the-same-boat" phenomenon, and discussing a taboo area are three mutual aid dynamics that cultivate the creation of trustworthiness, transparency, and safety in the group. From the initial moments of the group onset, members provide their names, why they are in the group, and whether they want to be in attendance. This initial round of sharing data begins to transform strangers into acquaintances. As the generation of data sharing occurs, members recognize that they may be in group for the same reason or may not want to participate in group at all. This "all-in-the-same-boat" phenomenon creates a beginning sense of safety among at least some of the members with each other. Equally important, the members begin to engage with the group leader, and this therapeutic alliance establishes safety as well. As members feel that they are heard and not alone, isolation can be reduced which clears the way for safety to appear. This also sets the stage for trust to appear as the therapeutic alliance between leader and member, and between member and member, begins. Additionally, the group leader sets a transparent stance with outlining group purpose, facilitating group rules, and inviting the group to contract for work.

With a group that is trauma-specific, the group is predicated on the discussion of a taboo area (e.g., abuse history). In this case, the beginning sharing of narratives of personal trauma and the courage it takes to share further establishes conditions of trust. Once they trust each other, members begin to feel safe and this increased trust and safety reinforces the presence of the mutual aid dynamics – which makes the group more cohesive. For other groups, that are trauma-informed but not trauma-specific, trauma may be slowly unveiled as trauma is not the focal issue in these groups. For example, in a group for caregivers for loved with ones with dementia, the members'

shared feelings of stress and resiliency may eventually evoke a planned or spontaneous sharing of a trauma narrative relating to a member's recollection of a domestic violence history at the hand of the beloved spouse for whom they serve as the caregiver.

The jockeying for power and control among members should be expected in group as members try to make sense of how the group will be of personal benefit to them. Here, members are testing the leader and each other. As conflict becomes resolved, the increase in understanding and acceptance of each other creates conditions for safety to be more firmly established. Concomitantly, trust also solidifies in this stage as member exchanges build trust's foundation. Though conflict appears and is difficult at times, its resolution generates trust as the group composition stabilizes and members realize that their collective investment in the group is secure. As the group resolves conflict over power and status, it reaches a stabilization point in preparation for mutual aid.

The dialectical perspective appears where the group begins to tolerate different perspectives among members, and new opinions are formed or revised based on such disagreement. The realization of this dynamic further reinforces a safe and trusting environment – disagreement can be accepted without the group disintegrating. The group's cohesion forms despite difference; this dynamic adds to the foundation of mutual aid.

Aligned with the universal perspective is attention to the trauma-informed insights from cultural, historical, and gender issues. Historical trauma impacts lived experiences of sexism, racism, classism, and the like; as members share these narratives, they identify how these oppressions are examples of the universal perspective and may have served to partially create the problems that group members individually and collectively experience. The discussion of the trauma-informed concept may catalyze the identification the universal perspective as oppression narratives are shared. Members of the group realize that many have one or more historical trauma experience in common that have served to create barriers to their self-actualization. This sociological perspective helps unify members and contributes to the necessary cohesion for mutual aid.

The bedrock of safety and trust in the group sets the foundation for the group to do its work. Genuine mutual support that members can provide to each other is on display in a mature group. As members bare their stories and seek solace, full caring and respect is realized. In a trauma-informed group, discussing a taboo area is apparent here, as hidden traumas may be revealed. Members need advice and individual problem solving via other members which is very useful in this stage. To practice how they might integrate new behaviors into their lives, rehearsal occurs with the use of role plays. When members doubt their ability to maintain their courage or solve their challenges, mutual demand is the gentle challenge in which members

encourage each other to stay the course and not waiver from their new or renewed sense of hope and liberation.

Mutual aid is characterized by trauma-informed principles of peer support, collaboration and mutuality, and empowerment, voice and choice. Mutual support is peer support. As members help one another with individual problem solving, and coupled with mutual support and mutual demand, collaboration is realized. The resultant cohesion that is formed allows for members to collaborate with each other in an enterprise of mutuality. Members' new or regained sense of insight and confidence empowers them and allows for the realization and sharing of new identities of liberation. This dynamic reflects members' empowerment, voice, and choice.

Once the group's goals have been accomplished, members help each other leave the group. The mutual strength and power of the group can catalyze the members to realize their "strength-in-numbers" and identify what type of change efforts they may collectively engage in outside of group. The "strength-in-numbers" change that can take place within an agency or community setting reflects increased collective voice, choice, and empowerment.

Further, as members leave group, as members transfer learning to their own lives, members gain an increased sense of empowerment. Members embody increased "voice" and "choice" – or confidence and sense of freedom – that begins to manifest in their daily lives. For this individual and collective transfer to occur, the group has created an emotional, supportive "anchor" that reflects the synthesis of mutual aid and trauma-informed care in group work. This is the power of such integration.

It is important to note that while the above description of the integration may unfold over the life cycle of a closed group, in practice, groups do not always neatly conform to theoretical phases of group work. In fact, even in a closed group, conflicts between members, and new disclosures of trauma narratives, may return the group to an earlier task of feeling included in group.

Distinction between trauma-informed group work and trauma-specific groups

Group work involves groups that are trauma-informed and groups that are trauma-specific; it is important to distinguish these two types. Trauma-informed groups require that the leader and the organization have full knowledge and comprehension of how trauma may impact the group members from the planning to the delivery of groups. Trauma-informed groups' central purpose does not focus on addressing and resolving trauma (e.g., support group for parents, social skills group for adolescents). In contrast, trauma-specific groups are those groups whose purposes explicitly focus on members' experience with trauma (e.g., therapy group for women who have been sexual assaulted, support group for veterans with PTSD group).

The role of the leader

In the treatment group, the group leader sets the culture of the group. Particularly at the beginning, members naturally look to and depend on the leader to begin the work of the group and promote member engagement. Even as the group matures into a more member-focused, democratic group, the leader plays an essential, though less explicitly visible, role in the group's progress toward mutuality. In a trauma-informed group, the facilitator follows group facilitation principles for member engagement and explicit goal completion and yet is available to identify and help members help themselves when a member may share an unexpected trauma narrative based on being triggered or otherwise catalyzed in the group. This dynamic indicates the deft balance and attention the leader provides to the work of the group on explicit group goals and the spontaneous sharing of trauma narratives.

Practicing from a mutual aid perspective, the leader promotes safety by overseeing the establishment of ground rules that include mutual respect. The trauma-informed leader closely monitors the group to ensure these ground rules are abided by, that no member is forced to disclose anything they would rather not share, and that members are poised to be supportive – and not critical – if and when a traumatic narrative is shared. The leader also establishes trust by conveying a warm and attentive demeanor, by active listening, by initiating democratic engagement among members, and by facilitating the growth of cohesion. These actions create the climate for discussion of trauma to occur in a trauma-informed group and reflect the necessary avoidance of re-traumatizing any members.

The leader fully respects diversity and addresses histories of oppression in the group. Suggesting that oppression narratives be named, the leader provides insight and liberation for members whose "problems" arise from historical trauma. The leader redirects member-leader interaction to member-member exchange to facilitate peer support. The leader helps members provide guidance to each other on how the members managed to name, vent, cry, seek support, heal, and grow from their respective traumas. Drawing on this culmination of supportive member-member exchange, collaboration is established and grows into a cohesive group. From this cohesion, the leader helps the group realize their individual and collective empowerment and their abilities to be liberated from any traumas they have experienced.

The role of the organization

The organization has an obligation to ensure the agency operates in a trauma-informed manner (SAMHSA, 2014b). This means the client's contact with the agency at all levels of the organization, from the initial inquiry for treatment to the end of the client's time with the organization, must

reflect this (Harris & Fallot, 2001). The organization facilitates this by training staff in trauma-informed principles and implementing those principles in the organizational culture, as well as creating policies and procedures for services that showcase these principles. The organizational culture should support the work of the direct practice staff, such as the group leader, to implement trauma-informed principles in their work with the clients.

In addition to the training of staff and supervising the implementation of trauma-informed principles, the organization provides this support by ensuring that the physical space for the groups is comfortable and safe. The waiting room for the members is arranged in a way that is comfortable for trauma survivors. This involves making sure the seating arrangement is comfortable and members do not feel too crowded, ensure that the seats are individual and not couches or double seats that force people to be in close physical proximity with each other. The outdoor environment should be considered as well, especially in regards to having a well-lit parking area for clients to come and go safely from the organization.

A trauma-informed organization is transparent about policies and procedures with group members. It encourages an atmosphere where these individuals can give voice to grievances or provide suggestions for improvement. The organization should ensure that services, such as translation services when requested, are provided in culturally relevant ways that are responsive to the needs of the group members. Overall, the organization's culture should promote the recovery and resiliency of group members and empower them to be the expert of their own lives.

Model application

The following is a description of a hypothetical group called "New Beginnings" for women who are newly divorced. This closed group takes place on a weekly basis for ten weeks in an outpatient counseling center. This is an example of a trauma-informed group rather than a trauma-specific group; with trauma-informed groups, all six principles can manifest – even in a single session. Though the group focuses on the emotional impact and next steps after divorce, the leader is ready to process any trauma that may emerge from group members.

Eight women in the group meet with the facilitator and begin to share their names, when they became divorced, and their goals for the group. The leader states "We are all invested in creating a safe environment where we are comfortable to share what we wish." While some of the members are very interested in the group, others state they are "just listening" as they are having second thoughts that they want to share with a group of strangers. Thus, members' goals range from "learning how to find new relationships" to "just wanting to listen to others" and "I don't have a goal." The leader thanks the members for sharing and states, "In time, we will be able to trust and rely

on each other for support." Safety and trust are in the process of being established. Members are beginning to feel a sense of commonality but the collective degree of genuine sharing and mutual aid are not present.

As the discussion continues, a collective awareness increases that as younger women, some felt societal pressure that forced them to marry. The group is split on whether they should get married again; this disagreement was able to be expressed and tolerated which honors the dialectical perspective. This shows that safety and trust have been firmly established for these expressions to be shared. One member who is lesbian believe that she needed to marry a man. Two members share histories of racism that prevented them from marrying interracially. The leader points out oppression narratives of heterosexism and racism, and the impact of these narratives on the barriers that the members were now seeking to conquer. The leader states, "We didn't deserve being told who we can marry but we can decide how we go forward with what we want."

Mutual aid is beginning to form now. One member shares she suffered domestic violence and is currently homeless and living in a shelter. This disclosure is fostered by the mutual aid in the group and the safety and trust that has been established. This leads to a second member recalling an abusive history as a child. The leader knows that mutual aid dynamics such as mutual support and discussing a taboo area would lead to members' empowerment within the group. A third member challenges that this group's purpose is to discuss divorce and not to discuss abuse as a child; the trauma-informed leader responds by stating, "I hear you; it is okay if members are reminded of things that may lead them to sharing of some painful stories. We owe them the honor of listening to them." The leader and other members congratulate the two members who disclosed abuse, with finding their voice and their choice, and for the member who is homeless, to determine that she would not return to the domestic violence situation. This is an example of how a group that is not trauma-specific can still be trauma-informed.

The member who was residing at a homeless shelter reports she would need to find another residence as her allowable time at the shelter is coming to an end. One of the other members offers a spare room for her to stay in temporarily. The member who is homeless is overjoyed and begins to cry; she states how embarrassed and ashamed she feels to be homeless. The leader facilitates peer support where the members provide individual problem-solving and empathy for this member to be heard and to begin to heal; collaboration, and therefore, cohesion, grow as a result of this dynamic.

At this point, the members are processing their emotions about the group and are happy that they can stay in touch with each other as ongoing supports. They are ready to apply what they learned in the group with respect to both their new identities as single women and their decisions about how they will think about future relationships. The members decide to meet outside of group and form a weekly "Ladies Night" for single women in

the community at a local coffeehouse where they can share poetry, music, and conversation in a safe and supportive atmosphere. This reflects the strength-in-numbers and empowerment and voice outside of the support group. The leader congratulates the group on their ability to organize and assist one another with healing from divorce as well as from their specific traumas they shared.

Model implications

Social work practice

The model can be applied to treatment groups as it opens the doors for leaders to move beyond the traditional mutual aid model to create group space that is open and responsive to underlying trauma that members may bring into the group. While the focus of the group remains the same, the group can create an environment where trauma disclosure is safe and respond appropriately to the disclosure without retraumatizing the group members For example, groups such as anger management/violence prevention groups can provide the platform where members may disclose abuse from parents that led them on a path of using violence for problem-solving. Therapy groups such as depression treatment group or substance use groups can allow members to disclose past or present traumas.

Social work education

Social work faculty can utilize this model in teaching a group work course to show the interplay of these two models for students. Field education may consider using this model in training field educators and field advisors who provide group supervision as students assume the internship role. Pedagogically, this model may provide insight in examining the social work classroom as a trauma-informed mutual aid group as social work students may be triggered themselves; of course, faculty need to maintain proper boundaries to ensure students – and themselves – stay in education roles.

Social work research

This model requires empirical review. Qualitative research may explore focus groups of practitioners, supervisors, educators, students, and/or group members to understand inductively the nature of trauma-informed, mutual aid groups. Quantitative research can test correlations between mutual aid and trauma-informed care as well as examine factors that predict an integrated model. The model also warrants scale development that can more fully test the validity of the model through factor analysis.

Theory-building

This integrated model warrants additional conceptualization. The role of the leader in planning, intervening, and assessing a trauma-informed, mutual aid group would be useful to outline. Developing the model for specific treatment group types (e.g., support, education, therapy) and membership (e.g., open/closed) would provide a blueprint for practice and research. Examining the model's insights for group therapy models (e.g., trauma-informed cognitive behavior therapy, narrative therapy) would help with cross-model integration including those models where "leader as expert" is reconciled with "leader as facilitator." Exploring trauma-informed task group application, such as committees and coalitions, where trauma can be addressed in the form of organizational trauma, vicarious traumatization, secondary traumatic stress, and historical trauma within a community, would be useful to explore as well.

Conclusion

This article expands on the literature of trauma-specific and mutual aid groups (Chung, 2003; Hickle & Roe-Sepowitz, 2014; Knight, 2017; Knight & Gitterman, 2014) by proposing an integrative model of trauma-informed care principles and the mutual aid model of groupwork. With this increased perspective, practitioners have a greater knowledge base that they can utilize to evaluate and to respond to treatment groups. The model prepares group leaders to apply TIC principles in mutual aid groups that, while not trauma-specific, may include members who share trauma narratives that need effective and supportive responses. Finally, the model provides social work practitioners and educators with practice insights they can utilize to move group work and the profession forward to help group members affected by trauma.

Disclosure statement

No potential conflict of interest was reported by the authors.

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