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Trauma & The Case for Utilizing NARM Therapy in Clinical Social Work: Implications for Practice, Compassion Fatigue, & Burnout

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Abstract

NeuroAffective Relational Model (NARM) therapy is a trauma informed therapeutic practice for treating developmental trauma by addressing attachment and interpersonal dynamics. This model is theoretically rooted in other clinical mental health therapy approaches, namely, Psychodynamic Psychotherapy, Attachment Theory, Cognitive Therapy, Gestalt Therapy, and Somatic Experiencing, and it incorporates self-regulation and awareness, bridging with relational approaches. As the research on developmental trauma grows, new research is needed to inform clinical social workers about NARM. In this paper the authors argue that NARM is a promising model that may prevent and mitigate secondary traumatic stress and burnout among social workers may use in trauma work with clients. A case vignette is presented demonstrating the application of the four pillars of the NARM model.

Keywords Secondary trauma · Compassion fatigue · Compassion satisfaction · Burnout · NARM · NeuroAffective Relational Model · Trauma · Training

This study investigates the use of NeuroAffective Relational Model (NARM) therapy in the practice of clinical social work as a tool for addressing developmental trauma in clients, and in doing so, it may prevent compassion fatigue and burnout in social workers. Social workers are frequently exposed to trauma, potentially leading to the development of second trauma (Bride, 2007; Ogińska-Bulik et al., 2022). This trauma can have an impact on the ability of practioners to effectively continue their work in the social work field (Branson, 2019; Sprang et al., 2019). Through an examination of the literature, a case is made for the further examination of NARM as a treatment for trauma, and as a preventative for secondary trauma in social work practitioners. A case vignette is included to demonstrate how NARM is used in the therapeutic relationship.

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Literature Review

Introduction to NARM

NARM therapy is a method for helping clients that have experienced developmental trauma (Heller & LaPierre, 2012). Developmental trauma, such as Complex-Post Traumatic Stress Disorder (C-PTSD) and attachment disorders, can be highly disruptive to overall functioning in adulthood, and more persistent than Post-Traumatic Stress Disorder (PTSD; World Health Organization, 2019). NARM is based on identifying and changing the adaptive patterns the client has developed due to developmental trauma (Heller & LaPierre, 2012). According to Heller and LaPierre (2012), the goal of NARM therapy is to help the client increase feelings of connection and create healthier personal relationships. They described NARM as a strengths-based therapy that draws on the client's available resources and current capacities to increase their ability to function.

The NARM Therapeutic Model

A foundational concept in NARM is that connection is our greatest longing and deepest fear (Heller & LaPierre, 2012). The NARM therapeutic model investigates the

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patterns that prevent clients from being true to themselves and connected with others using an exploration of identity, the body, and emotions (Heller & Kammer, 2022). NARM integrates top-down theory (cognitive) with a bottom-up orientation (somatic) incorporating interpersonal neurobiology in a mindfulness-based practice (Heller & Kammer, 2022). NARM is a therapeutic model based on organizing principles. The organizing principles of the NARM therapeutic model include that NARM is resource-oriented, non-reductionistic, psycho-biologically focused, present-moment focused, grounded in the here and now, containment-oriented, curiosity based, inquiry driven, client driven, and resource-oriented (Heller & Kammer, 2022). The NARM therapeutic model supports increased psychobiological capacity on all levels of the client experience (Heller & Kammer, 2022).

The concepts of curiosity and presence are central to the NARM therapeutic model and are present in every phase of NARM therapy. The NARM therapeutic model incorporates four pillars which frame all client work. Pillar one begins by clarifying the therapeutic contract (Heller & LaPierre, 2012). At this stage, the intention is set for the therapeutic process (Heller & Kammer, 2022). Learning what the client truly wants for themself, their heart's desire, in a way that is not goal driven or results oriented is a key element of this pillar (Heller & Kammer, 2022). Pillar two of the NARM clinical model is asking exploratory questions (Heller & LaPierre, 2012). This step involves inviting an inquiry-driven process of gathering information and inviting the client to reflect on their internal processes (Heller & LaPierre, 2012). Pillar three is reinforcing agency (Heller & LaPierre, 2012). This process includes reflecting on the client's relationship to organizing their internal and external experience (Heller & Kammer, 2022). Reinforcing client agency supports their capacity for awareness of their part in the challenges they face as an adult and encourages clients to function from their adult consciousness (Heller & Kammer, 2022). The fourth pillar of the NARM therapeutic model is reflecting psychobiological shifts (Heller & LaPierre, 2012). In this final pillar, the NARM Therapist tracks expressions of connection and disconnection in their clients, reflecting present experience of connection in the body on a physical, emotional, cognitive, and relational level (Heller & Kammer, 2022). This process allows old identities to be softened, while supporting integration and reorganization (Heller & Kammer, 2022).

The NARM therapeutic model utilizes a three-step emotional completion model that supports clients to identify their primary emotions, reflect on the intent of the emotion, and support a new relationship to unresolved emotional conflicts (Heller & Kammer, 2022). Step one is to identify the primary emotion which encourages client to psychobiologically take ownership of their emotions (Heller & Kammer, 2022). In step two, NARM supports clients to reflect on and understand the intention underlying their emotions (Heller & Kammer, 2022). Step three supports a new relationship with unresolved emotional conflicts while being present to and containing the energy in the emotions (Heller & Kammer, 2022).

Similarities and Differences in Therapy Modalities

NARM draws from several different therapeutic approaches: Psychodynamic Psychotherapy, Attachment Theory, Cognitive Therapy, Gestalt Therapy, and Somatic Experiencing (Heller & LaPierre, 2012). Heller and LaPierre (2012) explain that, like many therapeutic approaches, NARM seeks to understand how past trauma has affected current behavior. NARM therapy is intended to support the client to maintain *dual awareness*—while acknowledging the source of their trauma, the client focuses on how their patterns of behavior affect their life currently, rather than dwelling on the past.

Heller and LaPierre (2012) also detail the differences between NARM and other clinical mental health therapy approaches. They say that while Psychodynamic and Attachment approaches often encourage transference in the therapeutic relationship, NARM therapy encourages recreation of past relational dynamics only after the client has gained some control over their nervous system regulation so that they are not retraumatized. According to Heller and LaPierre, many approaches such as Gestalt therapy encourage reexperiencing past trauma to experience an emotional release, but NARM seeks to keep the client's awareness in the present. They explain that like Cognitive Therapy, NARM is present-focused, but NARM also includes body awareness in the therapeutic process. Heller and La Pierre say that a focus on nervous system regulation is a large part NARM therapy, and like Somatic Experiencing it advocates mindfulness of emotions and a gentle integration of the physical sensations they provoke into the client's awareness. However, they explain that NARM differs from Somatic Experiencing in that it has additional steps to address the effect of past trauma on the client's behavioral patterns. NARM's eclectic approach is intended to give therapists many tools for approaching different patterns of emotional dysregulation by helping clients develop both cognitive understanding and somatic awareness of these patterns (Heller & LaPierre, 2012).

Effectiveness

Though few studies have been performed into the effectiveness of NARM, similar therapies have been found to be successful in treating developmental trauma (Classen et al., 2021; Heeg, 2014; Kuhfuß et al., 2021).

Somatic Experiencing, a pioneering body-based therapy, was created to address the symptoms of trauma by allowing the traumatized patient to release energy from the fight-or-flight survival response that is trapped due to past thwarted survival response experiences (Ergos Institute and of Somatic Education, n.d.). Somatic Experiencing has been shown to be effective in reducing symptoms of Post-Traumatic Stress Syndrome (Kuhfuß et al., 2021). NARM adds treatment elements that are intended to address the behavioral patterns a client has developed due to the long-term nature of C-PTSD (Heller & LaPierre, 2012). Newer therapies for addressing trauma based around body awareness include the Comprehensive Resource Model (Hull & Corrigan, 2019) and Sensorimotor Psychotherapy (Fisher, 2019). Initial studies of these treatments have been promising but require more studies with larger and more diverse sample sizes to prove their effectiveness (Classen et al., 2021; Heeg, 2014).

A Phased Versus vs. A Modular Approach

Practitioners that work with clients that have a diagnosis of C-PTSD often use a phased approach to treatment (Corrigan et al., 2020). The phased approach involves three steps: 1) stabilization of symptoms, 2) processing of memories of the trauma, and 3) reintegration (Corrigan et al., 2020). NARM is consistent with this approach, beginning with stabilization through regulation of the nervous system before the client begins re-examining past experiences (Heller & LaPierre, 2012). Other phase-bases approaches such as Skills Training for Affective and Interpersonal Regulation (STAIR), may result in reduction in severity of the dissociative symptoms associated with childhood trauma, when compared to trauma-based treatment alone (van Vliet et al., 2023). The phase-based approach appears to be effective for the treatment of C-PTSD (Corrigan et al., 2020).

NARM Use by Mental Healthcare Providers

Mental health practitioners that work with clients that have experienced trauma are exposed to secondary trauma through their work (Sprang et al., 2019). The negative symptoms associated with secondary traumatic stress (STS) are like those of PTSD (Sprang & Steckler, 2023). Development of STS may cause fear, sleeplessness, avoidance of the source of trauma, and intrusive thoughts (Stamm, 2010). STS can have a significant impact on a social workers' personal and professional quality of life (Sprang et al., 2019). Prevention of STS results in better work performance, quality of care, and a longer career in social services (Branson, 2019).

Providers that work with traumatized clients report that having tools to recognize and treat the symptoms of trauma is beneficial to their practice (Kumar et al., 2022). Studies about the general effect of trauma-specific training on secondary trauma in any mental health practitioners have produced mixed results (Sutton et al., 2022), but initial studies of the effect of specific trauma treatment modalities have shown a positive effect on the well-being of mental health professionals (Aminihajibashi et al., 2022; Winblad et al., 2018). In a study of the effect of training in Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) on the well-being of child therapists, Aminihajibashi et al. (2022) attributed these improvements to increased feelings of self-efficacy in TF-CBT trained practitioners. Winblad et al. (2018) attributed improvements in well-being in providers trained in Somatic Experiencing to the ability of the practitioners to use the techniques they have learned to understand and address their own trauma.

NARM in Clinical Social Work

At the time of this study, NARM therapy had not been primarily investigated as a clinical intervention for social workers to use in their trauma work; however, because social workers are often exposed to secondary trauma in their work, they are vulnerable to secondary traumatic stress (Bride, 2007). Current NARM studies include various degree-disciplined mental health providers such as clinical social workers, licensed marriage and family therapists, psychologists, medical physicians, licensed professional counselors, and other identifying mental health providers (Gruber et al., n.d.; Vasquez, 2022). NARM is a trauma-informed therapy that may be used as a method for preventing the negative effects of exposure to secondary trauma in the field of social work. Social workers may be more likely than therapists to experience secondary trauma when working with victims of violence (Ogińska-Bulik et al., 2022). Because of this, more tools are needed to prepare social workers for the demands of working with clients who have experienced trauma. More study is needed into whether NARM may serve as an additional tool for social workers to use to protect themselves from the harmful effects of compassion fatigue and burnout.

NARM as a Protective Factor

Training in NARM may serve as a way for clinical social workers to protect themselves from secondary trauma, compassion fatigue, burnout, while promoting compassion satisfaction and professional quality of life. The ProQOL model for measuring professional quality of life is frequently used to examine the amount of compassion fatigue experienced by mental health practitioners (Stamm, 2010). In the ProQOL model, compassion fatigue is a measurement of two components: secondary traumatic stress (STS) and burnout. STS is defined as trauma developed from working

with people that have experienced it. Burnout is a feeling of hopelessness resulting from working as a helping professional. However, exposure to secondary trauma may also lead to the development of compassion satisfaction, which enables practitioners to feel that are that are serving their clients effectively and improves their professional quality of life (Stamm, 2010). Treatment modalities such as NARM, designed specifically to treat developmental trauma, can be used as a protective tool against STS and burnout. In a study of child therapists, Aminihajibashi et al. (2022) found that practitioners that had trained in TF-CBT experienced decreased burnout and increased compassion satisfaction. While more study is needed, NARM may serve as a tool for better professional quality of life in social workers.

Complex-PTSD/Developmental Trauma

According to the most recent edition of the World Health Organization's (2019) International Classification of Diseases and Related Health Problems (11th ed.; ICD-11), C-PTSD is now classified as a unique condition, separate from Post-Traumatic Stress Disorder. Both disorders develop, "following exposure to an extremely threatening or horrific event or series of events" (World Health Organization, 2019). The ICD-11 distinguishes C-PTSD as the result of repeated or persistent exposure to traumatic events rather than one-time exposure. According to the ICD-11, continued exposure to trauma results in an added cluster of symptoms: 1) feelings of low self-worth, 3) difficulty with emotional regulation, and 3) difficulty maintaining relationships. C-PTSD often results from trauma experienced during childhood because children are more likely than adults to be unable to cope with long-term exposure to traumatic experiences (World Health Organization, 2019). If the disturbances in self-organization that are symptomatic of C-PTSD are left unaddressed, they often persist into adulthood (Cloitre et al., 2019).

Developmental trauma can have a significant long-term impact on well-being and can be difficult to treat. The cumulative effect of trauma is demonstrated in a study by Copeland et al. (2018), who found that more traumatic experiences increase the likelihood of several negative outcomes in adulthood including impairment in social functioning, educational and financial attainment, health, and increased involvement with the criminal justice system. In their meta-analysis, Karatzias et al. (2019) found that treatments for PTSD such as Cognitive Behavioral Therapy, mindfulness, and Interpersonal Psychotherapy had positive outcomes for C-PTSD patients. However, they found that C-PTSD resulting from childhood abuse remained resistant to all the modalities examined. The persistent and damaging nature of developmental trauma warrants the examination of new potential treatments.

The Role of Attachment

Because attachment is achieved through secure and predictable relationships between children and their primary adult caregivers, attachment disruptions may result when the source of trauma is a parent or other adult caretaker (World Health Organization, 2019). Children that have experienced abuse from primary adult caregivers are more likely to develop C-PTSD than those that have experienced abuse from strangers (Cloitre et al., 2019). This highlights the importance of attachment, and the damage that can result from disruptions to the child-caretaker relationship. Secure attachment helps children learn to regulate their emotions (Forkey et al., 2021). Children that develop disorganized attachment because of parental abuse or neglect may exhibit erratic emotional responses in adulthood (World Health Organization, 2019). Adults with insecure attachment may have a more challenging time forming relationships (Forkey et al., 2021). Treatments aimed at resolving developmental trauma must address attachment disruption and its behavioral consequences.

There is an opportunity for clinical social workers to examine NARM as a trauma informed therapeutic practice with a benefit to clients and to providers. As a result, the authors of this study investigated the following questions:

1. What is NARM therapy? How is this approach used to target trauma?
2. Can this approach be used as a protective factor in compassion fatigue and burnout?
3. What is the trauma explored in this study, and how can NARM be utilized to intervene?
4. What is the effectiveness of NARM therapy in addressing trauma?

Case Vignette

A case vignette is presented based on de-identified client data; the client's name was changed in the vignette to protect client privacy. This vignette, a client case vignette from the researcher's own client work, explored the client presenting problems, applied the four NARM pillars, and summarized the core aspects of NARM's therapeutic approach.

Case Vignette Presentation

Sally is a 56-year-old single, white female professional who presented to therapy to work on developmental trauma.

Growing up she experienced chronic mis-attunement by her parents who never understood her or had the capacity to meet her needs. She describes her father as a malignant narcissist who was distant and cold and her mother as a perfectionist for whom nothing was ever good enough. Her mother detested any attempts at expressing her needs or requesting attention from her daughter. The world revolved around her mother who expressed chronic disapproval of her daughter. Sally experienced narcissistic abuse throughout her childhood, which led to bouts of depression throughout her adult life beginning in college.

She described a cycle of taking things personally, criticizing herself, and falling into a depression where it was difficult to get off the couch, sometimes for days. Sally had never been married. She longed for connection and a relationship, but it also felt unattainable to her. She did not feel attractive and did not think that men would be interested in her, despite being friendly, outgoing, and having a solid social circle. She felt alone, which was a familiar feeling from her childhood. She developed an internal critic that replaced the criticism her parents used to provide. She would become angry when people at work criticized her and when she responded she would beat herself up for days ruminating about the exchange. With aging parents, she was experiencing guilt about desiring boundaries and establishing a healthy distance from them. Sally saw Oprah appear on the TV show 60 Minutes and said that the conversation about developmental trauma could be a 'game changer'. Sally inquired about getting started with NARM therapy.

Case Vignette Analysis Using the NARM therapeutic model

Appropriateness for the NARM Therapeutic Model

During the consultation, NARM was identified as an appropriate therapeutic modality to address Sally's presenting problems due to NARM being specifically developed to address complex trauma, which Sally endorsed. In addition to Post-Traumatic Stress Disorder (PTSD) diagnostic criteria which includes a sense of threat, avoidance, and re-experiencing, Complex Post-Traumatic Stress Disorder (C-PTSD) diagnostic criteria adds three aspects of self-organization which are interpersonal disturbances, negative self-concept, and affect dysregulation (Cloitre et al., 2019). Sally endorsed interpersonal disturbances including persistent difficulties in sustaining relationships and a difficulty feeling close to others. Sally reported feeling different from the members of her family of origin and has been unable to maintain an intimate partnership. Sally also reported a negative self-concept. She did not believe men would be interested in her and did not believe she was attractive or deserving of the attention of others. In the affect dysregulation domain, Sally described heightened emotional reactivity, outbursts, and dissociative periods when under stress. She endorsed experiencing periods of anger and rage that would lead to emotional outbursts resulting in her experiencing emotional numbness and the lack of ability to feel positive emotions.

NARM Pillar 1: Establishing a Therapeutic Contract

After completing an intake, the NARM Therapist asked Sally, 'if you weren't taking things personally, criticizing yourself, and experiencing the bouts of depression that follow, what would be on the other side of that for you?' Sally explained that she would experience more peace and calm. The NARM Therapist asked Sally what she would say is her heart's desire. She replied to feel confident and happy and have a partner in her life she could count on, so she did not feel so alone. The NARM Therapist replied, 'I'm happy to work on what is getting in the way of you experiencing peace and calm, confidence and connection." The therapeutic contract was established. This contract was used as a thread to guide the NARM Therapeutic process.

When establishing a therapeutic contract, the quality of this phase is attunement (Heller & Kammer, 2022). The intention of the NARM Therapist was to help Sally clarify her intention and to get a felt sense of her distress (Heller & Kammer, 2022). The NARM Therapist noticed how it felt to be with Sally. The NARM emotional completion model step of identifying the primary emotion began during this pillar and continues into pillar 2 (Heller & Kammer, 2022). The emotions felt by the NARM Therapist in Sally's case were sadness, heaviness, feelings of rejection and not belonging.

NARM Pillar 2: Asking Exploratory Questions

The NARM Therapist began a relational inquiry into the patterns that were preventing Sally from being present to herself and others in her life (Heller & Kammer, 2022). An exploration began of how disconnection had resulted in dysregulation in her body (inflammation, migraines, chronic pain) and her mind (identity distortions such as no man would be interested in her) (Heller & Kammer, 2022). This process was driven by the NARM Therapist's inquiry to learn more about Sally's internal world (Heller & Kammer, 2022). This process offered an invitation for her to reflect on her own internal process (Heller & Kammer, 2022). The NARM Therapist created the space for Sally to be curious 'what if I considered the possibility that I'm ok as I am, not based on what I do or say or achieve, but just as I am?' This created a pathway to begin to move away from her own inner critic and begin the pathway to self-acceptance.

While asking exploratory questions, the quality of this phase is acceptance (Heller & Kammer, 2022). The NARM Therapist's intention was to make space for Sally's complexity (Heller & Kammer, 2022). Sally described several female friendships and participation in a variety of social activities outside of work. The NARM Therapist noticed when the impulse to rush, fix, label or take sides arose when working with Sally (Heller & Kammer, 2022). Once the NARM Therapist identified the default emotion of sadness in Sally and the primary emotion of anger, the next step in the NARM emotional completion model was to reflect on the emotion's intention (Heller & Kammer, 2022). In Sally's case, the intention of sadness was related to experiencing the failure of her parents to be able to meet her needs as a child. Since it wasn't safe for Sally to express anger at her parents, she rejected her basic needs and feelings, splitting off and shutting down her anger. Since Sally had lost connection to her anger, sadness had arisen as the default emotion in Sally. For Sally to experience completion and integration of her anger, the underlying sadness and grief of not having her needs met was addressed by the NARM Therapist. The NARM Therapist helped Sally to facilitate the grieving process of not having the relationship she had wanted with her parents. The process of grieving allowed Sally to reconnect to her heart and emotional completion became possible.

During a period of reflection and exploration, the NARM Therapist began to understand how Sally organized her inner experience. The NARM Therapist was able to clarify that Sally's core dilemma was if she can attune to her own needs or must she attune to everyone else's needs (Heller & Kammer, 2022). Sally had a survival need for attunement as a young child, however her needs were a threat (Heller & Kammer, 2022). As a result, she abandoned the awareness and expression of her needs to focus on her caregivers' needs (Heller & Kammer, 2022). Her core fear became if she expressed her needs, she will be rejected and abandoned (Heller & Kammer, 2022). The core expression that she compromised was having a right to get her needs met (Heller & Kammer, 2022). Growing up, Sally developed pride in not having needs and in being there for others (Heller & Kammer, 2022). She felt shame at experiencing longing, feeling needy, unfulfilled, and depressed (Heller & Kammer, 2022). Using the NARM emotional completion model, the NARM Therapist began to support Sally in having a new relationship with her unresolved emotional conflicts (Heller & Kammer, 2022).

NARM Pillar 3: Reinforcing Agency

As Sally became increasingly aware of the patterns that were getting in the way of her heart's desire to have connection and acceptance, the NARM Therapist supported a shift from the beliefs she held as a child which operate from the child consciousness into her adult consciousness (Heller & Kammer, 2022). Sally became more embodied. She began to experience an increased sense of clarity about herself and her world, a greater feeling of freedom from the patterns that previously ran her life, and belief that new ways of being in the world are possible for her (Heller & Kammer, 2022). Sally began to establish a comfortable distance from her parents. She began to feel that she could say no and set boundaries with them. As she changed, they began to change how they interacted with her. Sally began setting boundaries at work also. This resulted in a particularly difficult colleague resigning which created a much happier workplace for Sally. She established a greater work life balance and went on a vacation for the first time in seven years.

During this phase, the NARM Therapist used mindful interventions while holding the possibility of a new way for Sally to relate to herself and the world (Heller & Kammer, 2022). The NARM Therapist paid attention to a desire to become goal driven during this phase (Heller & Kammer, 2022). The NARM Therapist continued to support Sally's new relationship with her unresolved anger toward her parents for not being able to meet her needs and the grief process that was unfolding (Heller & Kammer, 2022).

NARM Pillar 4: Reflecting Psychobiological Shifts

The NARM Therapist reflected observations on all levels of the bio-psycho-social-spiritual domains to Sally, grounding her in the present experience of connection (Heller & Kammer, 2022). The NARM Therapist identified the psychobiological shifts as they were occurring in the present to support connection, disidentification, increased regulation (Heller & Kammer, 2022). Sally began to depersonalize the moods and behavior of others. She experienced greater connection to her colleagues, became less reactive, and began to feel a part of her social circles in a deeper way. Over time, the messages she told herself became more positive, she disidentified with the negative beliefs she held about herself, and her self-concept improved, along with her outlook about the possibilities of life.

During the integration phase, The NARM Therapist supported Sally's increased psychobiological capacity (Heller & Kammer, 2022). The NARM Therapist noticed their capacity to be present with Sally and be affected by the shifts Sally was experiencing (Heller & Kammer, 2022). Sally had come a long way with the support of the NARM Therapist walking her through the four pillars of NARM and the steps NARM emotional completion model. Sally had been able to grieve the loss of the parents she had hoped for, who would have been able to attune to her needs. As a result, she felt less sadness and had fewer

outbursts of anger. Sally felt more connected to her needs and felt more deserving of having her needs met. Toward the end of their work together, Sally began dating someone for the first time in over ten years, and she was open to the new connection.

Discussion

The objective of this research was to highlight NARM as a promising model for social workers to use in their trauma work and to underscore the potential of NARM as a preventive, or mitigator, of secondary traumatic stress and burnout among social workers. This study showed that the empirical evidence for NARM is limited but slowly growing, and it demonstrated how NARM eclectically draws on five evidenced based approaches to addressing trauma. This model extends beyond each of these five approaches by building on each of their strengths and limitations simultaneously by promoting cognitive development and somatic awareness in clients (Heller & LaPierre, 2012). The dual awareness of the here and now and concerning how clients' behavior patterns impact their lives is key as opposed to regressing solely to the past.

Cognitive stress and appraisal are central to how stress can impact a person after exposure to trauma (Lazarus, 2006). The transactional model of stress is the framework posited that stress was a dynamic interactive process between a person and their environment (Folkman & Lazarus, 1985). An individual's stress was not solely related to the existence of an environmental stressor, such as a client who has experienced developmental trauma or social worker who secondarily experienced their trauma, but it is also related to how the stressor, or trauma, is perceived by the individual. This perception is known as cognitive appraisal. This appraisal involves the coping resources and strategies an individual may use to manage the stressor (Freire et al., 2016; Lazarus, 2006).

Additionally, a person's thoughts and beliefs can result in maladaptive thought patterns (Padmanabhanunni & Pretorius, 2023), which is central to cognitive theory (Ehlers et al., 2005) while somatic experiencing is based on the premise that we have a core response network (ie., subcortical autonomic, limbic, motor and arousal systems), which if it becomes dysregulated, will need to be restored (Payne et al., 2015). A loss of agency has been explained has been attributed to being connected to trauma and PTSD (Adrien et al., 2024), which is what NARM targets in Pillar three. These models and theory can help explain what may cause and prevent STS and provide insights into how the NARM model may be theoretically helpful.

NARM as a Protective Factor

The literature shows the existence of STS among social workers. STS has been explained as being caused by repeatedly hearing about clients' traumatic experiences as well as some studies showing additional factors that are associated with developing STS in medical professionals (Bride et al., 2007; Ogińska-Bulik et al., 2021; Stamm, 1995). Previous research has noted mixed results on if this phenomenon was in existence and an occupational hazard (Elwood et al., 2011). Ogińska-Bulik et al. (2022) explained that symptoms of STS can appear suddenly may be the result of countertransference, which is the helplessness that a social worker might feel when working with clients who have experienced developmental traumas, PTSD, or C-PTSD. STS, also called vicarious trauma by Sabin-Farrell and Turpin (2003), may require treatment since the symptoms might emulate symptoms of PTSD; although this mimicking may not be clinically significant it may still be impactful to social workers quality of life and be positively impactful towards them being effective in their roles (Elwood et al., 2011; Ogińska-Bulik et al., 2022). Winblad et al. (2018) suggested that by engaging in a somatic approach to trauma work STS and burnout can be mitigated by increasing resilience. Resilience associated clinician factors have been named as: cognitive coping strategies, mindfulness, ability to access social support, and effectiveness of self-care (Windblad et al., 2018). This study argues that NARM's electric drawing on somatic experiencing strengthens its opportunity for client positive outcomes, and we argue that it also can be used to mitigate STS in social workers. An important factor in this is the finding that Ogińska-Bulik et al. (2022) found, which is that low empathy was a factor present in workers with STS. This low empathy may be described as compassion fatigue. However, Stamm (2010) said that this overall exposure to STS may be positive and could also lead compassion satisfaction and a feeling by workers that their clients are being helped (Stamm, 2010). These mixed findings suggest the eclectic nature of NARM, which integrates impactful techniques from other approaches to trauma, may make a positive difference for clients.

Smart et al. (2014) examined nurses' professional quality of life and found that compassion satisfaction was inversely related to STS. This is significant since Vasquez (2022) used an interpretive phenomenological approach to exploring NARM trained therapists, who were trauma therapists in the professions of Social Work, Professional Counseling, Psychology, or Marriage and Family Therapy, professional quality of life and found similar results that NARM model focused professional trauma training positively impacted profession quality of life (ie., high range results are over 42 and low range results defined as 22 or less) with results of study showing high compassion satisfaction among most of

the study participants ($\bar{x} = 41.69$), low STS ($\bar{x} = 18.15$), and low burnout ($\bar{x} = 18.62$). This may contribute to mitigating attrition in social workers as STS prevention can result in better work performance, quality of care, and a longer career in this field (Branson, 2019).

Case Vignette Reflections

The case vignette showed a client with a history of developmental trauma and attachment problems. Forkey et al. (2021) explained that adults with insecure attachment may have a more challenging time forming relationships, which can impact ability to maintain a social network. NARM's pillars were demonstrated, aligning with the model's aim to reinforce this client's agency and advance psychobiological shifts of support connection, disidentification, increased regulation were achieved (Heller & Kammer, 2022). Application of each pillar and knowledge of attachment and PTSD were essential. Also, progress was not immediate, as with many trauma-based interventions as research has shown it can take weekly sessions over a course of about 12 to 16 weeks until progress is made (Ehlers et al., 2013; Foa et al., 2005; Rothbaum et al., 2005). True to the model, connection was Sally's greatest longing and deepest fear as evidenced by her emotions of sadness, heaviness, endorsed feelings of rejection and sense of not belonging. NARM is client driven, and resource oriented as shown in this case with Sally help seeking, following up through emotional completion and the resulting increased psychobiological capacity (Heller & Kammer, 2022).

Mindfulness was introduced as part of pillar three in this case, according to the NARM model. This helped Sally to learn skills for nervous system self-regulation and prepare her to be able to work on past relational dynamics without being retraumatized. Kimbrough et al. (2010), Goldsmith et al. (2014), and Kim et al., (2010) found that mindfulness can be particularly impactful in the PTSD domains of re-experiencing, avoidance, numbing, and hyperarousal which was noted in this case study. This can happen by several pathways including through emotional regulation improvement, presence or "mindfulness," acceptance and tolerance of challenging experiences, and flexibility to shift perspective and attention (Cohen-Katz et al., 2005; Jimenez et al., 2010; Nyklíček & Kuijpers, 2008; Teper & Inzlicht, 2013). The focus on maladaptive thoughts, emotions, self-agency, and the physiological impacts was effective, thus the complimentary eclectic approach of NARM being argued as promising.

Limitations

Although there is promise with this approach to trauma work and there is promise in enhancing protective factors for social workers working with trauma clients, there is limited research investigating NARM. A general library search through a university library of databases yielded one empirical result, a qualitative dissertation by Vasquez (2022). The NARM Training Institute website cites Vasquez who utilized interpretive qualitative phenomenology to explore the lived experiences of NARM trained therapists of varying disciplines (N = 13), including social workers (n = 4) as it relates to their professional quality of life, and other articles relevant to NARM use, including a study by Gruber et al. (n.d.) utilizing descriptive statistics to analyze convenience sampled NARM therapists (N = 76) perceived effectiveness, and a study by Konnerman (n.d) who wrote about how NARM expands the therapeutic landscape. There was no evidence of Gruber et al.'s (n.d.) publication in a peer reviewed journal. This reaffirms a need for this call to social workers to engage in research about this model and to approach any use of this model in practice with caution. Because NARM draws eclectically on other well-known approaches, we believe that this model is an ethical model to use in practice.

NARM Training

Fall 2024 NARM basic level training to become "A NARM Informed Professional" requires 120 contact hours and 18 days of in person three-day training, therefore travel for some, and completion of four modules that can cost an application fee of $100 and $1499 tuition per module although students and interns can receive a 20% discount (NARM Training Institute, n.d.). There are additional supplemental learning opportunities through experiential learning including case consultations, study and practice groups, and other learning opportunities and Level Two training (NARM Training Institute, n.d.). This might be off-putting to some clinical social workers who may already have tremendous costs associated with continuing education and certification maintenance (Carnahan et al., 2016). There are free introductory NARM training courses available online that present an opportunity for clinical social workers to consider further immersion in this approach (NARM Training Institute, 2024). The free training is suggested for any clinical social workers seeking to trauma specific intervention training consider completing.

Future Study

Further study is needed to survey NARM training participants to gather more information about NARM impacts on STS and burnout. Using quasi-experimental and experimentally designed study designs to examine the effectiveness of NARM on clinical social work client outcomes is suggested for future study as well. Additionally,

future study exploring any benefits to completing the NARM free introductory training may be informative as well as researching how this training, combined with other STS prevention and response strategies, and burnout and self-care strategies is vital.

Conclusion

Helping professionals that work with traumatized clients are at risk of experiencing secondary trauma (Bride, 2007; Sprang et al., 2019). The symptoms of STS can be disruptive to both their personal and professional lives (Sprang et al., 2019). Therapists exposed to secondary trauma may experience compassion fatigue and burnout, which can lead to a high turnover in the profession (Branson, 2019). This places a burden on both agencies and clients who suffer when therapists leave. Training in trauma-informed treatments has been shown to act as a protective factor against secondary trauma (Aminihajibashi et al., 2022; Winblad et al., 2018). A NARM approach may be a viable intervention for clients seeking clinical social work services due to PTSD, C-PTSD, and developmental trauma. Overall, there is great opportunity for all social workers, regardless of age, licensure, and years of practice experience, to strengthen themselves against secondary trauma, to prevent burnout, impact their professional quality of life, and enhance client related outcomes.

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Declarations

Conflict of Interest All authors certify that they have no affiliations with or involvement in any organization or entity with any financial interest or non-financial interest in the subject matter or materials discussed in this manuscript. This research study was conducted retrospectively from data obtained by a previous study. We consulted the IRB of Our Lady of the Lake University who approved the study. Informed consent was obtained from all individual participants included in the study. The participants consented to the submission of their case reports to the journal.

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