MEANING MAKING: UNDERSTANDING PROFESSIONAL QUALITY OF LIFE FOR NEUROAFFECTIVE RELATIONAL MODEL TRAINED TRAUMA THERAPISTS

By

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Dissertation
Presented to the faculty of the Department
of Social Work
Our Lady of the Lake University,
in partial Fulfillment of the Requirements

for the degree of
Doctor of Philosophy in Social Work

Our Lady of the Lake University
San Antonio, Texas
March 23, 2022

ABSTRACT

Trauma therapists are routinely exposed to secondary trauma while performing their professional duties which can lead to burnout and secondary traumatic stress, the elements of compassion fatigue. Professional trauma training can support trauma therapists in developing compassion satisfaction, a protective factor in the sustainability of the profession, and reduce compassion fatigue. The purpose of this interpretative phenomenological study is to understand the lived experiences of NeuroAffective Relational Model (NARM) trained trauma therapists and how the NARM training has impacted their professional quality of life. The effect of the NARM training on professional quality of life, compassion satisfaction, and compassion fatigue was studied from the perspective of NARM Therapists using an interpretive phenomenological analysis research method. How NARM trained trauma therapists experience professional quality of life was identified.

Keywords: professional quality of life, compassion satisfaction, compassion fatigue, Neuro Affective Relational Model (NARM), developmental trauma

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CHAPTER ONE: INTRODUCTION

Trauma therapists are routinely exposed to secondary or vicarious trauma in their work with trauma survivors (Baird & Kracen, 2006; Bober & Regher, 2006; Craig & Sprang, 2010; Figley, 1995; Follette et al., 1994; Killian, 2008; Sloan et al.,1994; Sprang et al., 2007; Stamm, 1997, 1999, 2016; Street & Rivett, 1996; Thomas, 2013). Secondary trauma occurs when a helping professional repeatedly encounters the trauma their clients experience while executing their professional duties and develops symptoms that mirror that of their traumatized clients (Baird & Kracen, 2006). Exposure to secondary trauma, also called vicarious trauma, can have a significant and lasting impact on trauma therapists including burnout and secondary traumatic stress, the two elements of compassion fatigue, as well as compassion satisfaction (Baird & Kracen, 2006; Bober & Regehr, 2006; Cerney, 1995; Craig & Sprang, 2010; Elwood et al., 2011; Figley, 1995; Folette et al., 1994; Killian, 2008; Manning et al., 2016; Neuman & Gamble, 2005; Nishi et al., 2016; Ortlepp & Friedman, 2002; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995; Sodeke-Gregson et al., 2013; Sprang et al., 2007; Stamm, 1997, 1999, 2016; Steed & Downing, 1998; Street & Rivett, 1996; Thomas, 2013; Tominaga et al., 2020; Weiss et al., 1995).

Background of the Problem

Trauma therapists are undeniably impacted by their work with clients who have experienced trauma. This phenomenon is described in the literature as vicarious trauma, burnout, compassion fatigue, secondary traumatic stress, and countertransference. Sprang and colleagues (2007) found that, “Risking exposure to vicarious trauma is an inherent part of the process when working with traumatized persons” (p. 259). The negative

consequences of providing trauma therapy can have a profound effect on trauma therapists personally and professionally.

The extensive impact of trauma therapy work includes trauma therapists personally experiencing symptoms that mirror the symptoms of the post-traumatic stress disorder experienced by their clients. McCann & Pearlman (1990) identified, "The potential effects of working with trauma survivors are distinct from those of working with other difficult populations because the therapist is exposed to the emotionally shocking images of horror and suffering that are characteristic of serious traumas" (p. 134). Trauma therapists are at a significant risk of experiencing these detrimental results of their work due to repeated exposure to the traumatic experiences of their clients as retold to them in the execution of their professional duties.

In a study of 253 trauma therapists, 70% were at high risk of secondary traumatic stress (Sodeke-Gregson et al., 2013). Epidemiological evidence for compassion fatigue indicates that those who are treating trauma are at high risk for developing compassion fatigue (Craig & Sprang, 2010). In a study of 188 trauma therapists conducted by Sprang and colleagues (2007), 13% of providers were at high risk of compassion fatigue or burnout. In a 2020 study by Tominaga and colleagues, one-fifth of the 230 mental health clinicians studied reported clinically significant trauma symptoms two months following their trauma exposure. Tominaga and colleagues (2020) also found that training, knowledge, and preparedness on how to respond to trauma has been linked to positive psychological outcomes. Therapists with specialized trauma training reported higher levels of compassion satisfaction than therapists without trauma specific training (Tominaga et al., 2020). More research is warranted to develop a greater understanding of these phenomena (Tominaga et al., 2020).

Trauma therapy is a complex profession that can take an immense toll on the personal and professional lives of those who work with survivors of trauma. Being subjected to the vivid retelling of clients' often-horrific traumatic experiences places trauma therapists in a unique and vulnerable position to succumb to compassion fatigue, burnout, secondary traumatic stress, and vicarious trauma. This professional liability results in negative impacts for trauma therapists that can permeate all aspects of their lives.

Trauma therapy can also have a positive impact on therapists. In addition to the negative impact of trauma work are the gratifying outcomes of working with traumatized clients. Serving the most vulnerable clients can be rewarding for trauma therapists. Compassion satisfaction and vicarious posttraumatic growth are phenomena experienced by trauma therapists who find aspects of their work personally and professionally rewarding.

Therapists who report compassion satisfaction and vicarious posttraumatic growth experience satisfaction knowing that they have helped vulnerable clients and perhaps made a difference in their lives. Research suggests trauma therapists derive positive benefits from working with their clients who have experienced trauma (Stamm, 2010). These include the satisfaction that comes from being a helping professional and the feeling that your work makes a positive impact on the lives of others (Stamm, 2010). Both compassion satisfaction as well as vicarious posttraumatic growth are unexpected yet rewarding benefits of trauma work.

A substantial body of research has emerged since the mid- 1990s examining the impact of working with traumatized clients on trauma therapists (Stamm, 2010). The well-established concepts of compassion satisfaction, vicarious post traumatic growth,

vicarious trauma, burnout, compassion fatigue, secondary traumatic stress, and countertransference are documented throughout the literature. Significant in the research are recommendations for reducing compassion fatigue, burnout, and secondary traumatic stress (Baird & Kracen, 2006; Craig & Sprang, 2010; Elwood et al., 2011; Manning-Jones et al., 2016; Ortlepp & Friedman, 2002; Pearlman & Mac Ian, 1995; Sprang et al., 2007; Tominaga et al., 2019; Tominaga et al., 2020). Among these recommendations are trauma specific training.

Risk and Protective Factors

Many studies examine the various contributing protective and risk factors of compassion fatigue. The elements which might predict the development of secondary traumatic stress and burnout include high caseloads, large number of traumatized clients on a caseload, lack of professional support and training, lack of peer support/isolation, and personal trauma history (Killian, 2008). Protective factors include professional and social support, self-care, training and education, supervision and consultation, and manageable caseloads (Killian, 2008). Protective factors, such as specialized training in trauma therapy, can reduce the impact of secondary trauma on trauma therapists, prevent compassion fatigue, increase compassion satisfaction, and improve professional quality of life (Baird & Kracen, 2006; Craig & Sprang, 2010; Elwood et al., 2011; Manning-Jones et al., 2016; Ortlepp & Friedman, 2002; Pearlman & Mac Ian, 1995; Sprang et al., 2007; Tominaga et al., 2019; Tominaga et al., 2020).

Researchers overwhelmingly recommend further study to determine what specific factors can protect trauma therapists against the negative impacts of their profession. Extant literature recommendations encourage researchers to examine ways to reduce

compassion fatigue and increase compassion satisfaction among trauma therapists. Existing research clearly and definitively recommends training in general and trauma specific training in particular for trauma therapists, to combat the effects of the repeated exposure to secondary trauma that they face in their work (Baird & Kracen, 2006; Craig & Sprang, 2010; Elwood et al., 2011; Figley, 1995; Folette et al., 1994; Hesse, 2002; Killian, 2008; Larsen & Stamm, 2008; Orltepp & Friedman, 2002; Pearlman & Mac Ian, 1995; Pearlman & Skkavitne, 1995; Sprang et al., 2007; Steed & Downing, 1998; Street & Rivett, 1996; Tominaga et al., 2020; Winblad et al., 2018). Further research on the impact of specific interventions, such as trauma training, on trauma therapists is called for in recent literature (Sodeke-Gregson et al., 2013; Tominaga et al., 2020; Winblad et al., 2018). Further research is also recommended on the effectiveness of specific trauma trainings (Sodeke-Gregson et al., 2013).

The NeuroAffective Relational Model (NARM)

The NeuroAffective Relational Model (NARM) is a trauma specific training specially designed to support trauma therapists in their work with survivors of trauma (NARM Training Institute, 2021). NARM integrates both top-down (cognitive) and bottom-up (somatic) processing methods to address trauma (NARM Training Institute, 2021). This is unique to the NARM model, as other research-based methods to treat trauma are either a top-down cognitive based model, such as cognitive behavioral therapy and trauma-focused cognitive behavioral therapy, or a bottom up, somatic model such as Somatic Experiencing (SE), Eye Movement Desensitization and Reprocessing (EMDR), and the SE based Trauma Resiliency Model. The revolutionary integration of both a top-

down and bottom-up approach distinguishes NARM from other trauma therapy models and warrants study.

Baird and Kracen (2006) called for further study to evaluate innovative trainings that have been created to address the occupational hazard of secondary traumatic stress. In this research NARM, an innovative training created for the resolution of developmental trauma, will be examined through a trauma-informed framework to determine how the training impacts professional quality of life among NARM trained trauma therapists. Research shows that trauma specific trainings, such as NARM, cultivate the skills trauma therapists need to combat secondary traumatic stress, decrease compassion fatigue, and increase protective factors such as compassion satisfaction (Craig & Sprang, 2010; Ortlepp & Friedman, Sprang et al., 2017; Tominaga et al., 2019).

A significant gap in the research literature exists in the lack of study of the impact of specific trauma trainings on trauma therapists. Only one published study on the effects of a particular trauma specific training on professional quality of life, compassion fatigue, and compassion satisfaction among trauma therapists was identified. To date, no studies on the NeuroAffective Relational Model (NARM) have been published.

Current Study

A substantial gap in the literature exists in the study of the NARM model, which demonstrates significance in the ability to effectively address the diagnostic criteria from across symptom clusters of Complex Post Traumatic Stress Disorder and Developmental Trauma Disorder including Negative Self-Concept, Disturbance in Relationships & Affective Dysregulation (Gruber et al., n.d.). Results of existing research support the potential for NARM Therapy to effectively treat many characteristics of complex trauma

(Gruber et al., n.d.). With preliminary research demonstrating the effectiveness of the NARM model on complex trauma and existing literature demonstrating the need for trauma specific training to make trauma work sustainable for therapists, this study seeks to evaluate if the NARM model is a sustainable therapeutic intervention for use by trauma therapists by evaluating its impact on professional quality of life, compassion satisfaction, and compassion fatigue.

Existing research clearly and definitively recommends training in general and trauma specific training in particular for trauma therapists, to combat the effects of the repeated exposure to secondary trauma that they face in their work (Baird & Kracen, 2006; Craig & Sprang, 2010; Elwood et al., 2011; Figley, 1995; Folette et al., 1994; Hesse, 2002; Killian, 2008; Larsen & Stamm, 2008; Orltepp & Friedman, 2002; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995; Sprang et al., 2007; Steed & Downing, 1998; Street & Rivett, 1996; Tominaga et al., 2020; Winblad et al., 2018). Further research on the impact of specific interventions, such as trauma training, on trauma therapists is called for in recent literature (Sodeke-Gregson et al., 2013; Winblad et al., 2018). However, a significant gap in the research literature exists in the lack of study of the impact of specific trauma training on trauma therapists. One published study on the effects of a particular trauma specific training on professional quality of life, compassion fatigue, and compassion satisfaction among trauma therapists was identified.

This study will contribute to social work research as the first study on the impact of the NARM model on trauma therapists. This study will contribute to social work practice by understanding how trauma therapists who have been trained in the NARM model experience professional quality of life. This study will contribute to social work policy by helping to make the NARM model more accessible to therapists working in the

non-profit sector who are restricted by grantors to only use research-based models in their client work. This study will build upon existing research on the quality of life among trauma therapists that has been conducted investigating other trauma specific trainings such as the Somatic Experiencing study conducted by Winblad and colleagues (2018) by focusing specifically on professional quality of life as defined by the Professional Quality of Life model of Compassion Satisfaction and Compassion Fatigue developed by Stamm (2010).

The theory guiding this study is the Professional Quality of Life Theoretical Model of Compassion Satisfaction & Compassion Fatigue (see Appendix B). Stamm's (2010) Professional Quality of Life Theoretical Model of Compassion Satisfaction & Compassion Fatigue serves as the theoretical framework for the study. Twenty years of research investigating what constitutes professional quality of life contributed to the development of the theory of compassion satisfaction and compassion fatigue (Stamm, 2010). This extensive body of research informed the creation of a data informed theoretical compassion satisfaction and compassion fatigue model as shown in Appendix B (Stamm, 2010).

The purpose of this interpretative phenomenological analysis is to understand the lived experiences of NARM trained trauma therapists in the preeminent study of NARM therapists. This study will investigate how NARM trained trauma therapists experience professional quality of life. An understanding of the phenomenon of the professional quality of life of NARM trained trauma therapists is anticipated in this study. For the purposes of this study, professional quality of life consists of compassion satisfaction, compassion fatigue, burnout, and secondary traumatic stress (Stamm, 2010). This study

seeks to answer the following research question: how do NARM trained trauma therapists experience professional quality of life?

CHAPTER TWO: LITERATURE REVIEW

Historical Background

According to Stamm (1997), the expert on professional quality of life who developed the Pro-QOL scale to measure compassion fatigue and compassion satisfaction, “The great controversy about helping-induced trauma is not can it happen but what shall we call it?” (p. 1). Stamm (1997), “systemically reviewed 200 references from PILOTS, Psychlit, Medline, and Social Sciences Index and reports there is no routinely used term to designate exposure to another’s traumatic material by virtue of one’s role as a helper” (p. 1). The four most common terms used to describe this phenomenon are “compassion fatigue, countertransference, secondary traumatic stress, and vicarious traumatization” (Stamm, 1997, p. 1).

The first to report the impact of trauma on front line trauma workers in 1974, was Haley who wrote a seminal paper on the reaction of therapists to the horrors of war (Stamm, 1997). Dunning and Silva followed in their 1980 report on emergency service workers (Stamm, 1997). Hartsough and Myers continued in 1985 with their book *Disaster Work and Mental Health* along with Durham and colleagues, in their well-cited 1985 empirical study, *The psychological impact of disaster on rescue personnel* (Stamm, 1997).

The phenomenon as it relates to therapists was originally discussed as countertransference (Stamm, 1997). In 1990, McCann and Pearlman published a paper *Vicarious traumatization: A framework for understanding the psychological effects of working with victims*, recognizing the pervasive impact of trauma work in the lives of the

therapists that treat trauma survivors while highlighting that countertransference did not fully encompass the severity and pervasiveness of the impact on the therapist (Stamm, 1997). In 1991, Figley was the first to use the term compassion fatigue as it relates to PTSD in his book *Helping Traumatized Families* (Stamm, 1997). Figley went on to propose a new definition for PTSD in both the 1992 paper "Traumatic Stress Reactions and Disorders: Re-configuring PTSD," and in a presentation at the First World Conference of the International Society for Traumatic Stress held in Amsterdam in June 1992 where he, "argued that primary traumatic stress disorder should refer to those who were directly in harm's way while secondary traumatic stress disorder represents disorders displayed by supporters/helpers of those experiencing PTSD" (Stamm, 1997, p. 1). In 1994, Wilson and Lindy published their book *Countertransference in the treatment of PTSD* that framed therapist reactions to trauma exposure as countertransference (Stamm, 1997).

In the mid-1990s, much work was being published on this topic. According to Stamm (1997), "Wilson and Lindy's counter-transference text was published in 1994 and in 1995, three major texts were published, including edited volumes by Figley and Stamm and one written by Pearlman and Saakvitne, followed by Paton and Violanti in 1996" (p. 1). Stamm (1997) explains, "These three books show triadic cross-fertilization; each person's work appears in the other two books, yet each book chooses a different word to describe the effects of working with traumatized individuals" (p. 1) Figley and Stamm used secondary traumatic stress and compassion fatigue in their work, while Pearlman and Saakvitne used vicarious trauma and Paton and Violanti use burnout (Stamm, 1997).

Stamm (1997) believes the differences are elusive and academic. According to Stamm (1997), "Countertransference applies more to how our patients affect our work

with them, and CF/STS/VT is about how our patients affect our lives, our relationships with ourselves, and our social networks, as well as our work" (p. 1). As the subject expert, Stamm (1997) recommends "secondary traumatic stress (STS) as the broadest term, with other terms, such as compassion fatigue and vicarious traumatization, and even some forms of countertransference, serving as specific types of STS" (p. 2).

The major issues that impact this study include the differing results among previous studies regarding the impact of various factors on professional quality of life, compassion satisfaction, compassion fatigue, burnout, and secondary traumatic stress. Additionally, another factor that impacts this study are the various terms used to describe the impact of working with traumatized clients including secondary trauma and secondary traumatic stress, vicarious trauma, and vicarious traumatization. Researchers often uses these terms interchangeably, however, some authors indicate that these are separate and distinct terms.

The term vicarious traumatization and vicarious trauma were introduced by Pearlman & Saakvitne (1995) to describe a significant shift in the core belief system and world view of helping professionals working with traumatized clients because of secondary exposure to traumatic content. Secondary traumatic stress and secondary trauma was introduced by Figley (1995) and Stamm (1997) when describing the phenomenon of trauma workers who demonstrated the symptoms of PTSD without having experienced primary exposure to trauma. This study will use the terms secondary trauma and secondary traumatic stress as these are the terms used in the Professional Quality of Life model (Stamm, 2010) which is theoretically guiding this study. Finally, despite the number of studies calling for additional research in this area and the number of studies recommending trauma specific therapy training as a remedy to mitigate compassion fatigue, there is a lack of existing research on the impact of specific trauma

therapy trainings on professional quality of life.

Theoretical Framework

Professional Quality of Life Theoretical Model of Compassion Satisfaction & Compassion Fatigue

Professional quality of life theory (Stamm, 2002) is a theory that was developed following 20 years of substantial research on the topic between the mid-1990s to the early 2000s using data from over 3,000 National and International studies (Stamm, 2010). Professional quality of life is a combination of compassion satisfaction and compassion fatigue factors which includes concepts of burnout and secondary traumatic stress (Stamm, 2010). Trauma therapists are exposed to secondary traumatic stress through the routine exposure to traumatized clients in their work (Stamm, 2010). This repeated and chronic exposure to traumatic material can lead to burnout and eventually compassion fatigue among trauma therapists (Stamm, 2010).

Compassion satisfaction can be described as the positive benefits to helping people, while compassion fatigue can be considered the negative aspects of helping, or the consequences of working as a helping professional (Stamm, 2010). In the past 20 years, research investigating what constitutes Professional Quality of Life has led to the development of the theory of Compassion Satisfaction and Compassion Fatigue (Stamm, 2010). This extensive body of research has also led to the creation of a data informed theoretical Compassion Satisfaction and Compassion Fatigue model as shown in Appendix B (Stamm, 2010).

To develop this comprehensive theory of compassion satisfaction and compassion fatigue, primary data was gathered internationally from over 3,000 original sources (Stamm, 2010). This primary data was compared to secondary data through a

comprehensive literature review of over 2,017 research studies on the subject (Stamm, 2016). The findings were examined by trauma professionals and leading experts in the field to develop a theory that accurately expresses the complex dynamics of compassion satisfaction and compassion fatigue (Stamm, 2010).

While compassion fatigue is a more commonly known concept, compassion satisfaction and compassion fatigue theory explain that compassion satisfaction is also a significant component of professional quality of life (Stamm, 2010). Compassion satisfaction and compassion fatigue theory explains that, while often co-occurring, vicarious trauma or compassion fatigue are separate and distinct from Post-Traumatic Stress Disorder (PTSD) or secondary traumatic stress (Stamm, 2010). Unlike PTSD, compassion fatigue is not a diagnosis (Stamm, 2010). Compassion fatigue can be co-occurring with psychological disorders and these issues can be related to the experience of compassion fatigue, as in the case of burnout and depression (Stamm, 2010). People can experience compassion fatigue without developing a diagnosable disorder such as PTSD (Stamm, 2010).

Compassion satisfaction can be described as the positive benefits to helping people while compassion fatigue can be considered the challenging aspects of helping, or the consequences of working as a helping professional (Stamm, 2010). Compassion satisfaction describes the satisfaction trauma workers experience when caring for patients and feeling competent and supported by colleagues (Stamm, 2010). Burnout is associated with “feelings of exhaustion, frustration, anger and depression” (Stamm, 2010, p.12), while secondary traumatic stress is “a negative feeling driven by fear and work-related trauma, which can be a combination of both primary and secondary trauma” (Stamm, 2010, p.12). Both concepts together describe compassion fatigue, which is explained as the feelings of physical, emotional, and spiritual exhaustion from absorbing the problems

and suffering of others (Stamm, 2010).

Professional quality of life is comprised of compassion satisfaction and compassion fatigue (see Appendix A). Stamm (2010) defines compassion satisfaction as,

> the pleasure you derive from being able to do your work well, feeling like it is a pleasure to help others through your work, feeling positively about your colleagues or your ability to contribute to the work setting or even the greater good of society. (p. 12)

Compassion satisfaction includes the positive feelings derived from helping others through traumatic situations and can be a favorable result of trauma-focused work (Stamm, 2010). Compassion satisfaction is a protective factor that can help trauma therapists mitigate the impact of compassion fatigue and improve professional quality of life among trauma therapists.

Compassion fatigue is two dimensional. Burnout and secondary traumatic stress are the two elements that make up compassion fatigue. Secondary traumatic stress comes from work-related, secondary exposure to extremely stressful events. The symptoms of secondary traumatic stress may include, “being afraid, having difficulty sleeping, having images of the upsetting event pop into your mind, or avoiding things that remind you of the event” (Stamm, 2010, p. 17). This type of collateral damage puts trauma therapists at risk of not being able to successfully perform their job. For trauma therapists to adequately manage the secondary trauma they may experience when providing services to trauma survivors, they must proactively take steps to minimize the impact of secondary trauma.

Secondary trauma occurs when a helping professional who is exposed to the trauma their clients experience during routinely executing their professional duties and responsibilities develops symptoms that mirror that of their traumatized clients (Baird &

Kracen, 2006). According to Stamm (1999) and Figley (1995), secondary traumatic stress is a disorder that professionals who provide support to traumatized persons develop which mimics PTSD and occurs as a direct result of their exposure to the traumatic experiences of others. Baird and Kracen (2006) found that secondary traumatic stress disorder manifests itself through the symptoms of exhaustion, hypervigilance, avoidance and numbing and is often experienced by professionals serving clients who have experienced PTSD.

Secondary trauma can lead to burnout. According to Stamm (2010), "Burnout is associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively" (p. 13). The negative feelings associated with burnout accumulate over time; "they can reflect the feeling that your efforts make no difference, or they can be associated with a very high workload or a non-supportive work environment" (Stamm, 2010, p. 13). These factors are common in trauma work.

While most of the original research often cited in the areas of secondary trauma and compassion fatigue is from the early 1990s and before, Stamm (2010) found, in a comprehensive literature review of the subject, that a significant new body of work was developed in these areas from the mid-1990s to the early 2000s. Continued study and examination of the recent literature is recommended in this evolving field of research (Stamm, 2010). The literature highlights the importance of resiliency and transforming negative aspects into positive ones (Perlman & Carnigi, 2009; Stamm & Figley, 2009; Stamm, 2010; Stamm et al., 2010).

Attachment Theory

Studies of attachment theory have demonstrated the importance of a secure attachment between caregiver and child for healthy human development (Ainsworth & Bowlby, 1991). The foundation for healthy adulthood is profoundly predicated upon the

experiences of childhood. Hooper and colleagues (2012) explain, “Attachment theory, developed by John Bowlby, posits that the parent–child attachment bond that is formed during childhood is directly associated with mental and physical health, health-related behaviors and overall functioning in adulthood.” (p. 23). The ability to develop secure adult attachment relationships is created from an imprint established by the attachment relationships experienced in childhood.

Attachment theory explains that adult attachment behavior is based upon an internal working model solidified during adolescence that is a result of the childhood attachment relationship (Hooper et al., 2012). Hooper and colleagues (2012) describe, “These early experiences with a caregiver become psychologically internalized as mental representations or internal working models of future relationships” (p. 25). This internal working model forms the basis for the individual’s view of self, relationships with others, and the attachment expectations they have in adulthood, and is based upon experiencing a secure or insecure attachment in childhood. When there is a disruption in the healthy development of these key milestones for emotional health and well-being, the foundational criteria for developmental trauma are created.

Insecure attachment styles including insecure dismissing attachment, insecure preoccupied attachment, and insecure fearful attachment prevent individuals from experiencing wellness in adult relationships (Hooper et al., 2012). The extent of negative adult mental and physical health outcomes from adverse childhood experiences and the inability to form secure attachment in adult relationships due to childhood attachment disruptions are substantial examples of the impact of trauma across the lifespan. Insecure attachment leads to difficulty in establishing and maintaining supportive adult relationships, a hallmark of developmental trauma.

Attachment theory has established that attachment disruption and the

development of insecure attachment can create an imprint which is the basis for unhealthy patterns in adult relationships. The way the child sees the world, through the lens of insecure attachment, colors future relational patterns. Attachment theory can be effectively used as a theoretical framework to in the development of treatment modalities and interventions for adults with relational attachment disruptions and traumas, such as developmental trauma and complex post-traumatic stress disorder (Cassidy and Shaver, 2016).

With the central theme of attachment theory focusing on the attachment relationship, whether that be between a child and a caregiver, or a client and therapist, attachment theory offers a unique advantage in psychotherapy. According to Cassidy and Shaver (2016), "Attachment theory is a dominant construct in the theory and practice of psychotherapy today" (p. 760). As research on the prevalence of trauma and adverse childhood experiences has increased, a resurgence in the interest of attachment theory as it relates to the practice of psychotherapy has occurred. The specific relevance and clinical applicability of attachment theory to clients who have adverse childhood experiences, developmental trauma and complex post-traumatic stress disorder is undeniable.

Through the therapeutic bond that develops between a client and therapist, the opportunity for traumatized clients to have a curative attachment experience emerges. Cassidy and Shaver (2016) report, "It is the dynamic nature of attachment orientations that offers the promise of change through psychotherapy" (p. 762). Therapists with a theoretical orientation rooted in attachment theory are positively positioned to utilize the assessment tools found in attachment theory to identify their client's attachment style. Cassidy and Shaver (2016) describe, "Attachment theory would, of course, predict that the capacity to form a trusting relationship with a therapist will be determined, at least in

part, by the patient's attachment organization" (p. 764). An understanding of attachment theory assists the therapist in gaining a deeper understanding of their client, forming a therapeutic bond, understanding their attachment defenses and how they may present in the therapeutic relationship.

Knowledge of the impact of insecure attachment styles on adult relational and help-seeking behaviors can support the therapist in creating interventions to assist in the development of a more secure attachment relationship of the client to the therapist. According to Cassidy and Shaver (2016),

> Attachment theory would also predict- particularly for insecure individuals- that the vulnerability and therefore the threat inherent in forming a therapeutic relationship is likely to activate the attachment system in a variety of ways, revealing distinct patterns of defense and interpersonal relatedness. (p. 764)

Through establishing a more secure attachment relationship with the therapist, the therapist can begin to address the client's insecure attachment patterns, developmental trauma, and symptoms of complex post-traumatic stress disorder. Within the attachment relationship with a therapist knowledgeable in dynamics of attachment theory, a client's insecure attachment patterns and defensive strategies can safely emerge and be expressed, explored, and transformed, and more secure attachment patterns can begin to be developed.

Extensive research has been done on the outcomes of therapeutic interventions grounded in attachment theory (Cassidy & Shaver, 2016). Cassidy and Shaver (2016) report,

> In 2009, a study was conducted on the outcomes of an 8-week group treatment for Post-Traumatic Stress Disorder and described treatment outcomes as moderated by change in attachment orientation, such that the lessening of both attachment anxiety and attachment related avoidance over the course of treatment were

associated with decreases in overall symptomology. (p. 766)

Although the symptoms used to diagnose PTSD tend to apply more closely to clients who have experienced shock trauma, as compared to the new diagnosis of complex post-traumatic stress disorder, which differentiates itself from PTSD by utilizing additional diagnostic criteria more applicable to clients who have experienced developmental trauma, much of the diagnostic criteria overlaps (Cassidy & Shaver, 2016). The findings regarding the applicability of treatment interventions based in attachment theory in the PTSD study offer promise for the applicability of treatment interventions based in attachment theory to provide a decrease in overall symptomology for clients with complex PTSD as well (Cassidy & Shaver, 2016).

Additionally, research has been conducted regarding attachment theory and the ability of the client to establish a secure attachment with the therapist and experience therapeutic progress. Cassidy and Shaver (2016) indicate, “Two studies have linked secure attachment to the therapist to the capacity to explore significant issues in psychotherapy” (p. 767). Cassidy and Shaver (2016) report, “Research focused on the transformational moments within therapy have linked these moments in a meaningful way to attachment; for clinicians, it is within these shifts where attachment issues reveal themselves dramatically and where change is most likely to occur” (p. 767). The findings in the expansive research base regarding attachment theory lend support to the applicability of attachment theory to successful clinical interventions and positive therapeutic outcomes, particularly as they allow for a dynamic relational process to occur in the treatment.

Practice grounded in attachment theory provides the therapist the unique ability to assess a client’s attachment style and utilize that assessment in the development of clinical interventions that will activate the attachment system, triggering attachment

defenses to occur, creating transformational moments during which research shows change is most likely to occur (Cassidy & Shaver, 2016). Attachment theory helps the therapist to understand the defenses of each attachment style and therefore recognize when activation is occurring and respond appropriately. This ensures that the moments of activation are within the window of tolerance for the client where trauma resolution can happen within the context of a supportive secure attachment between the client and therapist (Cassidy & Shaver, 2016).

The therapeutic relationship has been demonstrated by research to be the vehicle through which healing can occur. Drawing upon attachment theory, the therapist can work with the client to establish a secure therapeutic bond that can be a curative experience for a client who has experienced attachment disruption. This curative experience is a parallel process reflective of the lived experience of healing attachment wounds from developmental trauma that the NARM therapist experiences during the NARM training.

Attachment theory informs the NARM model. NARM trained trauma therapists are required to engage in consultations, activities, and exercises throughout the training in which they gain the personal experience of the NARM therapy model. These personal experiences with the model help the NARM Therapist to deepen their understanding of NARM as well as engage in personal reflection about their own attachment wounds. Throughout the NARM training, the importance of the relational component of the NARM model is emphasized. For clients who have experienced adverse childhood experiences, developmental trauma, and for those who meet the criteria for diagnosis of the newly developed complex post-traumatic stress disorder, attachment theory presents an established theoretical framework, an expansive research base, and promising therapeutic interventions for the healing and resolution of trauma.

Trauma Theory

Adverse Childhood Experiences

The prevalence of childhood trauma in our society is staggering. Dr. Robert Block, former President of the American Academy of Pediatrics declared, "Adverse childhood experiences are the single greatest unaddressed public health threat facing our nation today" (Harris, 2014, 11:54). In the United States, Children's Protective Services investigated reports of child maltreatment in over 3.5 million children in 2018, an 8.4% increase over 2014 (U.S. Department of Health & Human Services, Administration for Children and Families, 2020). In a large-scale study of over 13,000 participants, the groundbreaking Adverse Childhood Experiences study established a relationship between adverse childhood experiences, such as child abuse and neglect, and increased negative adult health outcomes (Felitti et al., 1998). More than half of the respondents reported one adverse childhood experience, with one quarter reporting 2 or more, and one eighth reporting 4 or more adverse childhood experiences (Felitti et al., 1998). Exposure to adverse childhood experiences can result in serious mental and physical health problems, developmental trauma, and can now be clinically diagnosed as complex post-traumatic stress disorder (Felitti et al., 1998).

The impact of trauma can have devastating, life-long consequences on survivors. According to Monnat and Chandler (2015), "Children who are exposed to emotional, physical, or sexual abuse and other adverse conditions are at greater risk of several negative health outcomes in adulthood, including poor self-rated health, chronic diseases, functional limitations, premature mortality, and poor mental health" (p. 1). The widespread effects of trauma on both mental and physical health are clear and profound. Oral and colleagues (2016) explain, "Adverse childhood experiences are related to short- and long- term negative physical and mental health consequences among children and

adults" (p. 1). As demonstrated in the ACES study, both the direct experience of trauma and exposure to traumatic events put a child at risk. Adverse childhood experiences can impact the developing system to such an extent that it effects the child's ability to cope and can lead to physical symptoms and clinically significant, diagnosable mental health disorders. Experiencing traumatic events can have a profound impact on the well-being of survivors. Trauma can impact physical, mental, and emotional health and wellness.

Trauma can occur when a child is physically experiencing a traumatic event and when they are exposed to the threat of violence or violence in the home. Bellis and colleagues (2017) note,

> Such exposure can: alter early neurological development including both pleasure and reward centers and pre-frontal cortical impulse control; increase adolescent and adult health-harming behaviors, change hormonal and immunological systems contributing to chronic tissue inflammation and increased allostatic load; and increase risks of adults having poor social adjustment, reduced cognitive capacity and low mental well-being." (p. 168)

As a result of the increased visibility of the impact of trauma, the depth of research demonstrating the widespread extent of adverse childhood experiences, the significance of the mental and physical health consequences, and the maladaptive symptoms and behaviors that manifest because of exposure to trauma, it has been established that adverse childhood experiences can impact the child across the lifespan.

When a child is exposed to adverse childhood experiences, they are exponentially more likely to experience mental and physical health issues in adulthood. Felitti and colleagues (1998) report, "The seven categories of adverse childhood experiences were strongly interrelated and persons with multiple categories of childhood exposure were likely to have multiple health risk factors later in life" (p. 245). People who have four or

more adverse childhood experiences are at a statistically significant higher risk for alcoholism, drug abuse, depression, suicide attempt, smoking, poor self-rated health, more sexual partners, sexually transmitted disease, physical inactivity, severe obesity, ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease (Felitti et al., 1998). Felitti and colleagues (1998) describe, “Insofar as abuse and other potentially damaging childhood experiences contribute to the development of these risk factors, then these childhood exposures should be recognized as the basic causes of morbidity and mortality in adult life” (p. 246). In addition to the profound consequences on physical and mental health, adverse childhood experiences can also negatively impact the child’s ability to develop a healthy, secure attachment and set the stage for developmental trauma.

Complex Trauma

The need for treatment protocols specifically designed to address complex or developmental trauma has been established by the new diagnosis of Complex Trauma accepted by the World Health Organization, as well as diagnostic criteria published in the International Statistical Classification of Diseases and Related Health Problems (ICD-11) (Karatzias et al., 2016). Complex PTSD, also called developmental trauma, is a specific diagnosis with a unique set of symptoms that results from ongoing traumatic experiences, most commonly in childhood, and is different from post-traumatic stress disorder, which results from a specific traumatic event or cluster of traumatic events (Rosenfeld et al., 2018).

The prolonged exposure to trauma and the symptomatic expression of emotional and behavioral disturbances is distinct in developmental trauma as compared to shock trauma and requires treatment that specifically addresses complex trauma. Training in treatment models that have been specifically designed to address trauma protect trauma

therapists against secondary trauma. Models that are specifically designed to address and treat complex trauma help the trauma therapist to prevent the burnout that comes from trying to treat complex trauma with models that are designed to treat PTSD. While trauma models that treat PTSD are necessary, they do not address or effectively treat the dynamics found in survivors of complex trauma.

Judith Herman (1992), in an article titled *Complex Trauma*, was among the first to name and identify complex trauma, making a distinction from PTSD, explaining that prolonged trauma resulted in a disturbance in self-organization. Developmental trauma creates more complex outcomes in adulthood that cannot be explained by post-traumatic stress disorder or treated by traditional trauma interventions. With the growing research base of literature on complex trauma, the validation of a new complex post-traumatic stress disorder diagnosis, recognized by the World Health Organization, with diagnostic criteria published in the International Statistical Classification of Diseases and Related Health Problems (ICD-11), and an assessment tool endorsed for use in the diagnosis of complex post-traumatic stress disorder, a need has emerged for effective treatment modalities that have been specifically designed to address developmental trauma to be researched and evaluated (Karatzias et al., 2016).

The impact of trauma has been recognized and established as a diagnosable mental health condition for almost forty years. PTSD was first included as a diagnosis in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1980). The effect of prolonged exposure to trauma, as in cases of adverse childhood experiences such as child abuse and neglect, creates a profound and indelible impact on adult functioning. In the last decade, researchers have tried to recognize and differentiate the impact of prolonged developmental trauma with the proposal of a new diagnosis, Developmental Trauma Disorder (van der Kolk et al., 2009).

Developmental trauma disorder and complex PTSD were not included in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders, however, consideration for their inclusion was deliberated (American Psychiatric Association, 2013). Internationally, however, the movement toward the recognition and inclusion of developmental trauma is gaining traction. The World Health Organization has included complex post-traumatic stress disorder (C-PTSD) in the final draft of the 11th edition of the International Statistical Classification of Diseases and Related Health Problems (ICD-11), which was published in June 2018 and was submitted to the World Health Organization's World Health Assembly for official endorsement in 2019 (Rosenfeld et al., 2018). The World Health Organization also developed a self-report ICD-11 trauma questionnaire to measure C-PTSD (Rosenfeld et al., 2018).

The need for diagnosis and treatment of complex or developmental trauma has been recognized in the field, as the prolonged exposure to trauma and the symptomatic expression of emotional and behavioral disturbances is distinct in developmental trauma as compared to shock trauma. Rosenfeld and colleagues (2018) explain, “Complex post-traumatic stress disorder, or developmental post-traumatic stress disorder as it is also called, refers to the constellation of symptoms that may result from prolonged, chronic exposure to traumatic experiences, especially in childhood, as opposed to post-traumatic stress disorder which is more typically associated with a discrete traumatic incident or set of traumatic events” (p. 364). This new C-PTSD diagnosis defines what trauma therapists and researchers have been finding in their work with clients who have experienced complex trauma for the last several decades.

The new diagnosis of complex post-traumatic stress disorder has expanded the diagnostic criteria to account for, “a more frequent and a greater accumulation of different types of childhood traumatic experiences and poorer functional impairment”

(Karatzias et al., 2016, p. 2). Complex post-traumatic stress disorder includes:

> the core post-traumatic stress disorder symptoms that define post-traumatic stress disorder as a response characterized by some degree of fear or horror related to a specific traumatic event; re-experiencing of the trauma in the present, avoidance of traumatic reminders, and a persistent sense of threat that is manifested by increased arousal and hypervigilance, plus three additional symptoms that identify disturbances in self- organization; affective dysregulation, negative self-concept, and disturbances in relationships. (Karatzias et al., 2016, p. 3)

Research has begun to evaluate and substantiate the need for the diagnosis of complex post-traumatic stress disorder, to differentiate the results of developmental trauma from post-traumatic stress disorder. Karatzias and colleagues (2016) found, "Overall, the research evidence for the ICD-11 model of CPTSD is largely supportive as the findings from the mixture models support the qualitative distinction between PTSD and CPTSD" (p. 5). The International Statistical Classification of Diseases and Related Health Problems trauma questionnaire (ICD-TQ) is the recommended diagnostic measurement tool to evaluate and determine a diagnosis of C-PTSD.

The ICD-TQ is a 23-item self-report measure for the screening of ICD-11 PTSD and C-PTSD symptomatology. (Karatzias et al., 2016). To differentiate C-PTSD from a post-traumatic stress disorder diagnosis, the respondent is evaluated based upon their responses to questions regarding a disturbance in self-organization. The diagnosis is based upon a self-evaluation of symptoms in the previous month.

With the creation of diagnostic criteria and the ability to establish a diagnosis of C-PTSD, the need for treatment modalities appropriate to treat those newly diagnosed becomes necessary. Karatzias and colleagues (2016) suggest, "The high prevalence of

C-PTSD among the most traumatized highlights the potential benefit of identifying new interventions to aid recovery following this diagnosis" (p. 19). Many long-established theories, such as attachment theory have paved the way for the recognition and acknowledgement of the profound and unique impact of developmental trauma on the developing child and the impacts seen later in adult life.

Research has already begun to identify recommended treatment methods for C-PTSD. According to Cassidy and Shaver (2016), "In the growing clinical literature on the effects of early parent-child relationships, including troubled and abusive relationships, attachment theory is prominent" (p. x). In 2011, given the absence of treatment guidelines for C-PTSD, the International Society for Traumatic Stress Studies (ISTSS) surveyed expert clinicians regarding best practices for the treatment of C-PTSD (Cloitre et al., 2011). Common themes among recommended treatments included: establishing a collaborative client/therapist relationship, helping the client develop an observing ego, and emphasizing client areas of strength (Cloitre et al., 2011).

Additionally, recent research indicates that the development of self-compassion is important in resolving C-PTSD (Karatzias et al., 2018). Cassidy and Shaver (2016) report, "In 2001, the American Psychological Association Division 29 Task Force on Empirically Supported Treatments concluded that the therapy relationship makes substantial and consistent contributions to psychotherapy outcome independent of specific type of treatment" (p. 764). It is not surprising to note that the findings from both studies emphasize the importance of the therapeutic relationship in the healing process. Cassidy and Shaver (2016) explain, "This is entirely consistent with the belief held by most experienced therapists that the therapeutic relationship with a patient is essential to successful outcomes, and that the corrective emotional experience provided by the therapist is itself a potent agent for change" (p. 764).

This study is guided by Stamm's (2002) professional quality of life theory and informed by Attachment theory and Trauma theory. The professional quality of life theory specifically relates to the impact of trauma work on those who work with trauma survivors. Attachment theory informs NARM, which was designed to address developmental trauma, caused by attachment disruption or chronic mis- attunement. Finally, trauma theory guides the field of trauma therapy.

The professional quality of life theory posits that a trauma worker's professional quality of life is directly related to the impact of the exposure to trauma that they experience in their work (Stamm, 2010). Professional quality of life is composed of the relative compassion satisfaction, or the positive results or benefits one receives from helping others weighed against compassion fatigue, or the difficulties trauma workers experience in their professional work including burnout and secondary traumatic stress (Stamm, 2010). Trauma therapists are exposed to vicarious or secondary trauma in their work and are impacted by this exposure. Research has identified trauma specific training among factors that can support trauma therapists mitigate the impact of this exposure to secondary trauma in their work (Leitch et al., 2009; Rosner et al., 2020; Winblad et al., 2018).

Trauma Therapy Models

The American Psychological Association (APA) published guidelines for the effective treatment of clients who have experienced trauma and are exhibiting symptomology characteristic of PTSD (APA, 2019). Following a comprehensive systematic review, the Guideline Development Panel (GDP) of the APA strongly recommends the following therapy models for the treatment of PTSD: cognitive-behavioral therapy, cognitive processing therapy, cognitive therapy, and prolonged exposure therapy (APA, 2019). The GDP, "conditionally recommends the use of brief

eclectic therapy, eye movement desensitization and reprocessing (EMDR), and narrative exposure therapy" (APA, 2019, p. 596).

APA (2019) acknowledges that, "Funding for research can become circular and create systemic bias, such as additional funding directed to more closely examine particular facets of interventions already supported in the empirical literature, novel or other emerging treatments or innovations may not be adequately researched" (p. 605). GDP panel members recommend research in the areas of both treatment process and outcomes of therapy with trauma survivors (APA, 2019). The APA (2019) finds, "Emerging and novel treatment methods, in addition to established practices, warrant investigation to build on currently available findings" (p. 605). APA (2019) recommends that attention be paid to the research of additional treatments and methodological advances in trauma treatment. A gap exists in the study of somatic therapy models for trauma treatment, for which an emerging base of literature is beginning to become available.

Somatic Bottom-up Models. In a landmark study of the trauma-specific training Somatic Experiencing ® (SE), Winblad and colleagues (2018) investigated the impact of the SE training on quality of life among Somatic Experiencing practitioners (SEP). In this longitudinal study, Winblad and colleagues (2018) found health-related quality of life and social quality of life both increased significantly among practitioners who completed the SE trauma training. Somatic Experiencing ® is a somatic psychotherapy approach to trauma treatment that integrates a bottom up or body-based approach to trauma treatment.

Trauma therapy has begun incorporating somatic, body-based, or bottom-up interventions such as the Somatic Experiencing®/Trauma Resiliency Model™ (SE/TRM) where the "primary emphasis is on traumatic symptoms as patterns of dysregulation in the nervous system rather than on cognitions and emotions" (Leitch et al, 2009, p. 11).

Somatic models focus on “brain stem survival responses and dysregulation in the autonomic nervous system (ANS) rather than on neocortical cognition” (Leitch et al, 2009, p. 11).

A study was conducted to investigate the impact of the Somatic Experiencing®/Trauma Resiliency Model™ (SE/TRM), a bottom-up or body-based model among 142 front line Social Workers following Hurricanes Katrina and Rita (Leitch et al., 2009). SE/TRM treatment focuses on, “identifying the psychophysiological patterns that underlie a wide variety of traumatic responses” (Leitch et al, 2009). The focus of treatment is on “unlocking the somatized stress memories and movement impulses that remain bound in the body and restoring balance to the nervous system by working with small gradations of traumatic activation alternated with the use of somatic resources” (Leitch et al, 2009).

The therapist participants in this study who both experienced trauma and served traumatized clients following the hurricanes were trained in TRM and received TRM sessions. The 91 participants who received the treatment in this study showed statistically significant gains in resiliency and decreases in both PTSD symptoms and psychological distress compared with the control group (Leitch et al, 2009). Results suggest that TRM was “effective in attenuating the observed emergence of PTSD symptoms and promoted resiliency” (Leitch et al, 2009, p. 15).

Leitch and colleagues (2009) report that the most frequently used interventions with traumatized clients include cognitive behavioral therapy (CBT), a top-down model, and eye movement desensitization and reprocessing (EMDR), a bottom-up model. The authors report that “Knowledge of biological responses to fear and helplessness has been incorporated into trauma intervention strategies by such interventions as EMDR, CBT, and other exposure therapies” (Leitch et al, 2009, p. 11).

Leitch and colleagues (2009) report on the 1997 assessment of the benefits of EMDR by Grainger and colleagues stating, "Post Hurricane Andrew, recipients of EMDR, an intervention that uses bilateral stimulation linked with cognitions and emotions, had greater reductions in PTSD symptoms compared with a wait-listed control group" (p. 10). Shapiro (2014) found that out of the 29 randomized controlled trials that have been conducted on EMDR as a trauma treatment, "Twenty-four randomized controlled trials support the positive effects of EMDR therapy in the treatment of emotional trauma and other adverse life experiences relevant to clinical practice" (p. 71). Shapiro (2014) identified, "Seven of 10 studies reported EMDR therapy to be more rapid and/or more effective than trauma-focused cognitive behavioral therapy" (p. 71).
Shapiro's 2014 report indicates, "Twelve randomized studies of the eye movement component noted rapid decreases in negative emotions and/or vividness of disturbing images, with an additional 8 reporting a variety of other memory effects" (p. 71). EMDR therapy is a well-documented trauma therapy, endorsed by the APA that has been found to provide relief for trauma survivors.

Cognitive Top-down Models. According to Leitch and colleagues (2009), "The most widely practiced and studied form of treatment following trauma is CBT, which is a therapeutic intervention focused on helping individuals gain personal control over negative, internal thought processes" (p. 10). Leitch and colleagues (2009) report that according to Gibson's 2005 review of empirical studies, "CBT studies that use three to 10 session interventions have the greatest empirical support as measured by decreases in PTSD sequelae" (p. 10). Leitch and colleagues (2009) describe a 2005 meta-analysis of psychotherapy outcome studies on PTSD by Bradley and colleagues that found, "More than half the patients who completed treatment with various forms of CBT improved" (p. 10). Leitch and colleagues further describe Devilly and Spence's 1999 study of CBT and

EMDR interventions in adults who had experienced multiple traumas that found, "CBT to be more effective at reducing symptoms of PTSD" (Leitch et al, 2009, p. 10).

A specific form of Cognitive Behavioral Therapy used in trauma work is trauma focused cognitive behavioral therapy (TF-CBT). Rosner and colleagues (2020), discuss the importance of evidence-based therapy and report that trauma focused cognitive behavioral therapy (TF-CBT) is an evidence-based therapy with strong empirical support and medium to large effect sizes. Rosner and colleagues (2020) are investigating the influence of implementing TF-CBT on the professional quality of life of the therapists using the well- established and research based Professional Quality of Life (ProQOL-5) scale in a forthcoming study. The ProQOL-5 scale is based upon the professional quality of life theory (Stamm, 2010).

Existing research has identified trauma therapy methods that are effective in addressing symptoms of trauma in traumatized clients and have begun to study the impact of using these models on trauma therapists (Leitch et al., 2009; Rosner et al., 2020; Winblad et al., 2018). These research-based methods utilize either top-down (cognitive) or bottom-up (somatic) methods. The NARM model is unique by integrating both top-down and bottom-up methods to support both the clients with complex trauma and the trauma therapists who provide trauma therapy to survivors of complex trauma.

Top-down and Bottom-up: The NARM Model. The Neuro Affective Relational Model (NARM) was developed as a therapeutic model to address developmental trauma (Heller et al., 2012). Developmental trauma is trauma, such as abuse, neglect, or loss, that occurs during a child's developmental process, often disrupting the attachment bond. NARM integrates psychodynamic and cognitive psychotherapy models, somatic therapies, expressive therapies, gestalt therapy, somatic experiencing, ego psychology, object relations, self-psychology, cognitive therapy, attachment theory, relational theory,

and affective neuroscience (Heller & LaPierre, 2012).

Heller and LaPierre, (2012) found that, “NARM utilizes elements of all of the approaches mentioned in a system that introduces a significant and fundamental shift in how these theoretical elements are applied” (p. 27). The NARM model bridges traditional psychotherapy with somatic approaches within a context of relational practice (NARM Training Institute, 2020). The NARM Training Institute (2021) reports, “The NARM model is a developmentally oriented, neuro-scientifically-informed model that emerged out of psychotherapeutic orientations including Psychodynamic Psychotherapy, Attachment Theory, Cognitive Therapy, Gestalt Therapy, and Somatic Experiencing, as well as the work of Wilhelm Reich and Alexander Lowen” (para. 3).

The NARM model bridges traditional psychotherapy with somatic approaches within a context of relational practice (Heller et al., 2012; NARM Training Institute, 2020). The NARM Training Institute (2021) explains, “NARM offers a comprehensive theoretical and clinical model for addressing adverse childhood experiences (ACEs) and resolving complex trauma (CPTSD) that integrates a psychodynamic and body-centered approach” (para. 1). The approach of the NARM model, “works simultaneously with the physiology and the psychology of individuals who have experienced developmental trauma and focuses on the interplay between issues of identity and the capacity for connection and regulation” (NARM Training Institute, 2020, para. 5).

The NARM model provides a trauma-specific training specifically designed to support trauma therapists in their work with survivors of trauma (NARM Training Institute, 2021). The NARM model uses a somatic psychotherapy approach integrating both mind and body-based interventions (see Appendix C). The NARM model has a unique and exclusive focus on developmental trauma, a result of the wounds of attachment disruption.

The NARM model is a present moment, non-pathologizing, relational model that integrates both top down (cognitive) and bottom up (somatic) approaches (Heller et al., 2012). Top down and bottom-up processing is a concept from the fields of psychology and Neuroscience that describes how information is processed. Andrade and Walker (2020) explain, “Perception refers to the way sensory information is organized, interpreted, and consciously experienced and involves both bottom-up and top-down processing (para. 1). According to Andrade and Walker (2020), “Bottom-up processing refers to the fact that perceptions are built from sensory input” (para 1). Andrade and Walker (2020) describe, “How those sensations are interpreted is influenced by available knowledge, experiences, and thoughts, which is called top-down processing” (para. 1).

Through the five organizing principles of the NARM model, supporting connection and organization, exploring identity, supporting emotional completion, working in present time, and supporting re-regulation of all systems of the body, NARM therapists work with clients to restore the capacity for connection with others and a deeper connection with self (Heller et al., 2012). The NARM Training Institute (2020) reports, “The NARM approach works simultaneously with the physiology and the psychology of individuals who have experienced developmental trauma and focuses on the interplay between issues of identity and the capacity for connection and regulation” (para. 5). The NARM model is a non-regressive, resource-oriented model, grounded in a phenomenological approach that addresses identity and consciousness of self to support transformation (NARM Training Institute, 2020).

In an unpublished mixed methods study, the impact of the NARM model on the professional quality of life of trauma therapists (n=71) was examined (Vasquez, n.d.). Using the chi square goodness of fit test and residual analysis, the proportions of NARM Therapists to the population were compared on three levels; low, average, and high

among three sub scales of the professional quality of life scale; compassion satisfaction, burnout, and secondary traumatic stress (Vasquez, n.d.). Data provided by Stamm's (2010) ProQOL scale was used to establish percentiles of the existing population of those who work with traumatized clients who have completed the survey, which were expected at 25% of the population to fall into the low range, 50% of the population to fall into the average range, and 25% of the population to fall into the high range (Vasquez, n.d.). In the areas of compassion satisfaction, X2 (df=2) =55.72, $p < .01$, burnout, X2 (df=2) = 102.25, $p < .01$, and secondary traumatic stress, X2 (df=2) =96.17, $p < .01$, the relation between these variables were determined to be significantly significant (Vasquez, n.d.).

A residual analysis was conducted to reveal in what ways the two groups differ (Vasquez, n.d.). The researcher calculated residuals and adjusted residuals (Vasquez, n.d.). The results determined that NARM Therapists score higher in compassion satisfaction than the population who have completed the ProQOL (Vasquez, n.d.). In the areas of burnout and secondary traumatic stress, which when combined make up the component of compassion fatigue, NARM Therapists score lower than the population (Vasquez, n.d.).

Regarding compassion satisfaction, NARM Therapist scores deviate significantly in the negative direction in the low category, with no NARM Therapists reporting low compassion satisfaction (Vasquez, n.d.). In the average category, NARM Therapist scores were not significant, but very close to significant, with 32% of NARM Therapists reporting an average level of compassion satisfaction (Vasquez, n.d.). Among the high category, NARM Therapist scores deviate significantly in the positive direction, with 67.9% of NARM Therapists reporting a high level of compassion satisfaction (Vasquez, n.d.). The adjusted residual for the high compassion satisfaction score indicated that more

NARM Therapists scored high in compassion satisfaction than would be expected under the null hypothesis (Vasquez, n.d.).

In the area of burnout, NARM Therapist scores deviated significantly in the positive direction in the low category, with 84.9% of NARM Therapists scoring low in burnout (Vasquez, n.d.). Among the average and high categories in burnout, NARM Therapists scores deviate significantly in the negative direction, with 15.1% of NARM Therapists with an average burnout score, and no NARM Therapists with a high burnout score (Vasquez, n.d.). All three burnout categories were found to deviate significantly among NARM Therapists (Vasquez, n.d.). Significantly more NARM Therapists were found to have a low burnout score than the population (Vasquez, n.d.). The adjusted residual for the low burnout score indicated that more NARM Therapists are scored low in burnout than would be expected under the null hypothesis (Vasquez, n.d.).

Regarding secondary traumatic stress, NARM Therapist scores deviate significantly in the positive direction in the low category with 83% of NARM Therapists reporting low secondary traumatic stress (Vasquez, n.d.). Among the average and high categories of secondary traumatic stress, NARM Therapists scores deviate significantly in the negative direction with 17% of NARM Therapists reporting an average secondary traumatic stress score, and no NARM Therapists reporting a high secondary traumatic stress score (Vasquez, n.d.). Significantly more NARM Therapists scored low in secondary traumatic stress than the population (Vasquez, n.d.). The adjusted residual for the low secondary traumatic stress score indicated that more NARM Therapists are scored low in secondary traumatic stress than would be expected under the null hypothesis (Vasquez, n.d.).

The mixed methods study revealed four qualitative themes that represent the phenomenon of the impact of NARM on professional quality of life, compassion

satisfaction, and compassion fatigue from the perspective of NARM Therapists (Vasquez, n.d.). Less effort was identified as a key theme expressing the impact of NARM on professional quality of life, compassion satisfaction, and compassion fatigue from the perspective of NARM Therapists (Vasquez, n.d.). One study participant shared, “NARM is an amazing, respectful model and it supports agency of client and better self-awareness and boundaries as a helper” (Vasquez, n.d.). Another participant revealed, “Providing therapy with the NARM model uses less effort, which has changed me/my work dramatically” (Vasquez, n.d.). Using less effort describes that the trauma therapist feels they do not have to work as hard to achieve the same results, because the skills learned in the NARM training provide the structure for the trauma work to unfold more effortlessly (Vasquez, n.d.). Working within the NARM model, the therapist experiences less pressure to figure out what to do to help the client, and therefore expends less effort in the trauma work (Vasquez, n.d.).

Another theme that emerged that demonstrates the impact of the NARM model on professional quality of life, compassion satisfaction, and compassion fatigue from the perspective of NARM Therapists was improved boundaries (Vasquez, n.d.). A study participant explained, “I find it easier to have healthier boundaries with my clients, with my own energy, and in finding work/life balance (Vasquez, n.d.). I feel less triggered by my clients’ experiences and/or behaviors” (Vasquez, n.d.). The process of establishing healthy boundaries is supported by the NARM model 50/50 concept in which 50% of yourself remains connected to self and 50% is available to others (Vasquez, n.d.). Improved boundaries reinforce the establishing of a work life balance which in turn supports professional quality of life (Vasquez, n.d.).

NARM Therapists described increased energy as key to understanding the impact of the NARM model on professional quality of life, compassion satisfaction, and

compassion fatigue from the perspective of NARM Therapists (Vasquez, n.d.). One participant shared that, “Completing the NARM training has brought more energy to me and my work, more of a sense of connection within myself and to my clients, and more of a sense of optimism about my work” (Vasquez, n.d.). Another shared, “I feel more content and at ease in my work” (Vasquez, n.d.). A stronger connection to their own life force energy, the ability to sustain the difficult work of a trauma therapist, and the ability to care for others without feeling depleted resulted in the experience of increased energy levels (Vasquez, n.d.).

An additional theme that emerged that represents the impact of the NARM model on professional quality of life, compassion satisfaction, and compassion fatigue from the perspective of NARM Therapists is enhanced confidence (Vasquez, n.d.). A participant described it as, “NARM has provided me with a level of competency in which I feel confident doing the work I do - helping others, and there is a pleasure, a happiness that comes with doing what you love and doing it well!” (Vasquez, n.d.). The skills taught in the NARM training improve the therapists’ sense of being a competent clinician and improves confidence in their own professional skills and abilities (Vasquez, n.d.).

The theory that the NARM training serves to support the trauma therapists’ professional quality of life, compassion satisfaction, and compassion fatigue was supported by NARM Therapists during the quantitative questionnaire and reinforced by the qualitative strand (Vasquez, n.d.). The themes uncovered by the study as key to revealing how the NARM model supports trauma therapists’ professional quality of life, compassion satisfaction, and compassion fatigue from the perspective of NARM Therapists was that the NARM model supports professional quality of life through less therapist effort, improved boundaries, increased energy, and enhanced confidence (Vasquez, n.d.). Study participants shared descriptive and meaningful examples from

their client work to illustrate how they have witnessed the impact of the NARM model on professional quality of life, compassion satisfaction, and compassion fatigue (Vasquez, n.d.). The qualitative findings were compared alongside the quantitative results from the Professional Quality of Life survey and were almost exclusively supportive of the quantitative findings (Vasquez, n.d.).

The NARM Training. The Neuro Affective Relational Model (NARM) is, "an advanced clinical training for the healing of complex trauma for licensed psychotherapists, counselors, social workers & other licensed mental health professionals who work with complex trauma" (NARM Training Institute, 2021, para. 1). According to the NARM Training Institute (2021), "NARM addresses relational and attachment trauma by working with early, unconscious patterns of disconnection that deeply affect our identity, emotions, physiology, behavior and relationships" (para. 1). The NARM Training Institute (2021) explains, "Integrating a psychodynamic and body centered approach, NARM offers a comprehensive theoretical and clinical model for working with developmental trauma" (para. 1).

The NARM Training Institute (2021) reports, "NARM draws on psychodynamic models such as attachment and object relations theory, somatic models and character approaches, in addressing the link between psychological issues and the body" (para. 2). The NARM model addresses complex trauma using an innovative combination of cognitive psychotherapy and somatic psychology. According to the NARM Training Institute (2021), "Working relationally in the present moment, and within a context of interpersonal neurobiology, NARM offers a new approach of working relationally that is a resource-oriented, non-regressive, non-cathartic, and ultimately non-pathologizing model" (para. 2). The relational component of the NARM model is a central aspect of the approach. The NARM Training Institute (2021) describes, "Grounded in mindfulness and

contemplative spiritual practices, NARM supports a non-western orientation to the nature of personality” (para. 2). The NARM training prepares trauma therapists to support the holistic healing of trauma survivors. The NARM Training Institute (2021) describes, “Learning how to work simultaneously with these diverse elements is a radical shift that has profound clinical implications for healing complex trauma and supporting personal and relational growth” (para. 2). NARM Therapists are supported through the extensive and immersive training to develop, practice, and seamlessly integrate these skills into their work with trauma survivors.

The NARM Training Institute (2021) reports, The NARM Practitioner Training consists of “120 contact hours over a total of 18 days during the period of the training” (para. 4). The NARM Practitioner Training teaches:

> the different skills needed to work with developmental versus shock trauma: when and why shock trauma interventions may be contraindicated in working with developmental trauma; how to address the complex interplay between nervous system dysregulation and identity distortions, such as toxic shame and guilt, low self-esteem, chronic self-judgment, and other psychobiological symptoms; how to work moment-by-moment with early adaptive survival styles that, while once life-saving, distort clients’ current life experience; when to work ‘bottom-up’, when to work ‘top-down’, and how to work with both simultaneously to meet the special challenges of developmental trauma; how to support clients with a mindful and progressive process of disidentification from identity distortions; and a new, coherent theory for working with affect and emotions, which aims to support their psychobiological completion. (NARM Training Institute, 2021, para. 3)

Professional Quality of Life

Professional quality of life is comprised of compassion satisfaction and

compassion fatigue. Stamm (2010) defines compassion satisfaction as:

> the pleasure you derive from being able to do your work well, feeling like it is a pleasure to help others through your work, feeling positively about your colleagues or your ability to contribute to the work setting or even the greater good of society. (p. 12)

Compassion fatigue is two dimensional (see Appendix A). The first component of compassion fatigue includes “exhaustion, frustration, anger and depression typical of burnout” (Stamm, 2010, p. 12). The second component of compassion fatigue is secondary traumatic stress which “is a negative feeling driven by fear and work-related trauma, which can be a combination of both primary and secondary trauma” (Stamm, 2010, p. 12). The theory guiding this study is the Professional Quality of Life Theoretical Model of Compassion Satisfaction & Compassion Fatigue (see Appendix B). This study is also informed by attachment theory, which is the theory upon which the NARM model is structured, and trauma theory, which provides the understanding of developmental trauma and diagnostic criteria for complex post-traumatic stress disorder.

Professional quality of life is impacted by secondary traumatic stress and burnout that trauma therapists experience while conducting their work. According to Stamm (2010), “The negative effects of providing care are aggravated by the severity of the traumatic material to which the helper is exposed, such as direct contact with victims, particularly when the exposure is of a grotesque and graphic nature” (p. 8). Trauma therapists experience higher rates of secondary traumatic stress, burnout, and compassion fatigue because of the vicarious trauma they experience in the course of their professional duties.

Stamm (2010) reports, “The outcomes may include burnout, depression, increased use of substances, and symptoms of posttraumatic stress disorder” (p. 8-9). Trauma

therapists also experience compassion satisfaction. Trauma specific training can increase compassion satisfaction, decrease compassion fatigue, and improve professional quality of life among trauma therapists.

According to Stamm (2010), "from a research perspective, burnout is associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively" (p. 13). The negative feelings associated with burnout accumulate over time (Stamm, 2010). Stamm (2010) explains, "they can reflect the feeling that your efforts make no difference, or they can be associated with a very high workload or a non-supportive work environment" (p. 13). Burnout is one component of compassion fatigue. The other component of compassion fatigue is secondary traumatic stress (Stamm, 2010).

Secondary Traumatic Stress

Secondary traumatic stress is one of the two components that make up compassion fatigue along with burnout (Stamm, 2010). Secondary traumatic stress is related to vicarious trauma and occurs because of workplace exposure to the traumatic experiences of clients (Stamm, 2010). Trauma therapists often listen to clients retell stories about the traumatic things that they have experienced, which leads to what is commonly called vicarious trauma or secondary trauma. Performing front line work such as law enforcement, military, or disaster work involves primary exposure to trauma (Stamm, 2010). However, work that exposes one to the traumatic events experienced by others such as in a hospital emergency department or in child protective services investigations, is secondary exposure to trauma (Stamm, 2010).

Secondary trauma can lead to burnout among trauma therapists (Stamm, 2010). Exposure to secondary trauma can even lead to symptoms of post-traumatic stress disorder (PTSD) among those who provide therapy to trauma survivors. A study on secondary traumatic stress and vicarious trauma found that the amount of exposure to

traumatic material (including hours with traumatized clients, percentage of traumatized clients on caseload, and cumulative exposure) increases the likelihood of developing secondary traumatic stress (Baird & Kracen, 2006).

A significant amount of research has been conducted regarding the exposure to secondary trauma that trauma therapists inevitably face while performing the functions of their job. Sprang and colleagues (2007) identified that, “risking exposure to vicarious trauma is an inherent part of the process when working with traumatized persons” (p. 259). It is clearly demonstrated in the literature that therapists who work with clients that have experienced trauma are exposed to secondary trauma. The research also describes the consequences of exposure to secondary trauma for trauma therapists.

Secondary traumatic stress can have a profound impact on trauma therapists. Craig and Sprang (2010) uncovered that the empirical literature has extensively documented the consequences of exposure to clients who have experienced trauma on the mental health of the therapist. Sprang and colleagues (2007) discovered that “clients with trauma and loss issues suffer from severe symptoms that can exact a significant toll on clinicians who work with them over the long haul” (p. 273). The trauma experienced by the clients is relayed to the trauma therapist during the therapeutic process.

The consequences of exposure to that trauma are experienced directly by the trauma therapist. According to Craig and Sprang (2010), “For behavioral health professionals working with traumatized clients, continuous and prolonged exposure to the stress of working with the myriad of trauma-related stressors experienced by their clients can lead to various responses including burnout, compassion fatigue, and compassion satisfaction” (p. 319). These responses to trauma work contribute to the professional quality of life of the trauma therapist.

Compassion Satisfaction

Research has identified protective factors which assist trauma therapists in developing compassion satisfaction rather than compassion fatigue (Abu-Bader, 2002; Craig et al., 2010; Elwood et al., 2011; Manning-Jones et al., 2016; Nishi et al., 2016; Ortlepp & Friedman, 2002; Sprang et al., 2007; Tominaga et al., 2019; Tedeschi & Calhoun, 2004; Tedeschi et al., 2018). Compassion satisfaction is defined as the positive feelings derived from helping others through traumatic situations and can be a favorable result of trauma-focused work (Stamm, 2010). Compassion satisfaction is a protective factor that can help trauma therapists mitigate the impact of compassion fatigue.

Risk and Protective Factors

Existing research has identified specific factors that influence how exposure to secondary trauma impacts trauma therapists (Baird & Kracen, 2006; Cerney, 1995; Craig & Sprang, 2010; Figley, 1995; Hesse, 2002; Killian, 2008; Manning-Jones et al., 2016; Neuman & Gamble, 1995; Nishi et al., 2016; Orltepp & Friedman, 2002; Pearlman & Saakvitne, 1995; Sprang et al., 2007; Street & Rivett, 1996). Protective factors, such as specialized training in trauma therapy, can reduce the impact of secondary trauma on trauma therapists, prevent compassion fatigue, increase compassion satisfaction, and improve professional quality of life (Baird & Kracen, 2006; Craig & Sprang, 2010; Elwood et al., 2011; Manning-Jones et al., 2016; Ortlepp & Friedman, 2002; Pearlman & Mac Ian, 1995; Sprang et al., 2007; Tominaga et al., 2019; Tominaga et al., 2020). Therapists with special trauma training report significantly more compassion satisfaction and less burnout than those who did not have training (Craig & Sprang, 2010). Researchers recommend additional research to ascertain what impact different professional training may have on levels of compassion satisfaction, burnout, and secondary traumatic stress (Sodeke-Gregson, 2013).

Craig and Spring (2010) found, “For behavioral health professionals working with traumatized clients, continuous and prolonged exposure to the stress of working with the myriad of trauma-related stressors experienced by their clients can lead to various responses including burnout, compassion fatigue, and compassion satisfaction” (p. 319). Researchers identified protective factors, which contribute to trauma therapists developing compassion satisfaction rather than compassion fatigue (Abu-Bader, 2002; Craig et al., 2010; Elwood et al., 2011; Manning-Jones et al., 2016; Nishi et al., 2016; Ortlepp & Friedman, 2002; Sprang et al., 2007; Tominaga et al., 2019; Tedeschi & Calhoun, 2004; Tedeschi et al., 2018).

Protective factors such as compassion satisfaction can be cultivated to support trauma therapists in enhancing their ability to sustain the difficult but important work of providing therapy to trauma survivors. These protective factors can provide therapists with a valuable skill set that shields them from secondary trauma and the symptoms that exposure to secondary trauma can cause in trauma therapists. Trauma specific training can help bolster trauma therapists from the inherent risks associated with their profession such as burnout, compassion fatigue, and PTSD.

Sprang and colleagues (2007) found that protective factors, including specialized training for trauma therapists, enhance compassion satisfaction, prevent against compassion fatigue and burnout among trauma therapists, and protect against the effects of trauma exposure. Ortlepp and Friedman (2002) described that specialized training can provide a protective function for trauma therapists. Abu-Bader (2002) echoed this in a study conducted among social workers, finding that education and training can counteract burnout. Tominaga and colleagues (2019) identified that preparation, training, and knowledge reduced burnout and increased satisfaction in clinicians exposed to trauma.

Sprang and colleagues (2007) discovered that specialized trauma training

prepared therapists to help clients in the resolution of trauma by providing specific techniques, resources, more effective assessment, and treatment skills to use when working with traumatized clients, which resulted in decreased burnout, reduced compassion fatigue, enhanced treatment outcomes, improved self-efficacy, and higher levels of compassion satisfaction than therapists without trauma specific training. Tominaga and colleagues (2019) agree that training, knowledge, and preparation about how to respond to trauma survivors is associated with positive psychological outcomes among those who respond to trauma survivors. Craig and Sprang (2010) report, "The utilization of evidence-based practices predicted statistically significant decreases in compassion fatigue and burnout and increases in compassion satisfaction" (p. 319). The literature demonstrates that education and training in practices specifically developed to address the unique needs of trauma survivors protect trauma therapists from secondary traumatic stress and trauma fatigue, while improving the satisfaction that can be derived from working with clients in the resolution of trauma.

Craig and Sprang (2010) found that having no trauma training is a significant factor in predicting burnout. Individuals with special training in trauma treatment reported significantly more compassion satisfaction than did those without special trauma training (Craig & Sprang, 2010). In addition, Craig and Sprang (2010) found individuals with special training in trauma reported significantly less burnout than did those without special trauma training. Craig and Sprang (2010) suggested that participating in trauma training may protect against the debilitating effects of burnout. Trauma specific training is an adaptive strategy to address burnout and professional development benefits practitioners beyond acquiring knowledge (Craig & Sprang, 2010).

Pearlman and Saakvitne (1995) state that they cannot over emphasize the value of trauma-specific professional education and training. Pearlman and Saakvitne (1995)

recommend that clinicians who work with trauma survivors to obtain as much training as they need to be comfortable with the wide range of issues that clients who have experienced trauma bring to treatment. Pearlman and Saakvitne (1995) highlight that appropriate training provides the theoretical framework for understanding and treating trauma survivors and may prevent vicarious traumatization. Pearlman and Saakvitne (1995) found that training provides a theoretical grounding in the principles and techniques of psychotherapy. Inadequate training in psychotherapy in general and trauma therapy specifically contributes to vicarious traumatization (Pearlman & Saakvatne, 1995). Pearlman and Saakvitne (1995) recommend attending workshops and professional development, such as continuing education, for therapists to combat the effects of working with traumatized clients.

Sprang and colleagues (2007) found that specialized trauma training enhanced compassion satisfaction and reduce levels of compassion fatigue and burnout among trauma therapists. According to Sprang and colleagues (2007), "Specialized training enhanced clinician self-efficacy through cultivation of more effective assessment and treatment skills; these clinicians might have experienced treatment outcomes that were superior to their counterparts with less expertise in trauma work" (p. 272). Training experiences protect against compassion fatigue and burnout (Sprang et al., 2007). Trauma therapists with specialized trauma training report higher levels of compassion satisfaction than those who have not pursued a specialty in trauma through training (Sprang et al., 2007). Sprang and colleagues (2007) recommend interventions to assist clinicians working with traumatized clients including specialized trauma training, incentivizing training, and continuing education opportunities, educating clinicians about risk and protective factors, providing resources to enhance protection, capacity

management and caseload mix development.

Hesse (2002) recommends professional training and development to help process the effects of daily work for preventing and coping with secondary trauma and to help process the effects of the daily work of trauma therapists. Individual coping and prevention strategies recommended by Hesse (2002) include:

> a balance of work and play, physical and psychological self-care, making adequate time for rest and relaxation, eating right and exercising, taking time for self-reflection and creative expression, such as writing, drawing, painting, sculpting, dancing, or cooking, regular contact with nature, including taking trips to the park, hiking, boating, camping, or even simply caring for pets or plants, spirituality, meditation and yoga, becoming a part of a religious group, participating in community activities or revitalization projects, spending time with friends and family, spending time alone, praising yourself, allowing yourself to cry, finding things to laugh about, seeking personal psychotherapy. (p. 303)

Strategies Hesse (2002) recommends in the workplace to improve professional quality of life include:

> recognizing that secondary trauma is a normal part of doing trauma work, limiting exposure to traumatized clients, leaving as close as possible to the agreed upon time, taking regular breaks, taking a full hour lunch, taking regular vacations, know their limits, maintaining a realistic view of which goals are achievable, maintaining professional connection, professional training or development, staff or peer support groups, supervision and consultation, membership and participation in professional affiliations or associations, regular and adequate supervision, group supervision, having other trauma therapists and colleagues to speak with informally. (p. 304-305)

Organizational methods recommended by Hesse (2002) include:

> having understanding and supportive supervisors, administrators who recognize and accept that secondary trauma exists among their workers, providing therapists with safe, private, and comfortable space in which to have sessions, decorate or allow their staff or clients to decorate the common areas of the office in a way that is safe, attractive, and comforting, provide adequate benefits, staff development opportunities, the chance to express themselves in staff meetings, implementing an open door policy in which administrators are accessible to staff, celebrating staff birthdays, taking some time out of the day every month to eat some cake and socialize with other staff, creating a climate that is warm, friendly, and supportive. (p. 305-306)

Killian (2008) found that, "primary and secondary exposure to trauma can impinge on helping professionals' well-being and compassion, but specific identified practices/strategies may help ameliorate the effects of personal and professional traumatic events such that they do not impinge on the quality of therapy and do not precipitate burnout" (p. 37). According to Killian (2008), risk factors to developing work stress and compassion fatigue include, "high caseload demands and/or workaholism, personal history of trauma, lack of regular access to supervision, lack of a supportive work environment, lack of supportive social network, social isolation, worldview (overabundance of optimism, or cynicism, etc.), and the lack of ability to recognize and meet one's own needs (i.e., self-awareness)" (p. 36). Protective factors found by Killian (2008) include self-care, exercise, spirituality, peer support, continuing education, assessing new information and techniques, debriefing with supervisors, consultants, and colleagues.

Existing research literature has identified factors that can support compassion

satisfaction and reduce compassion fatigue (Baird & Kracen, 2006; Cerney, 1995; Craig & Sprang, 2010; Figley, 1995; Hesse, 2002; Killian, 2008; Manning-Jones et al., 2016; Ortlepp & Friedman, 2002; Pearlman & Saakvitne, 1995; Sprang et al., 2007). Craig and Sprang (2010) report factors that increase the risk of developing compassion fatigue include female gender, age, increased exposure to traumatized clients, length of time providing treatment, occupational stress, and personal trauma history. The factors shown to prevent compassion fatigue include access to clinical supervision, training, perceived coping ability, emotional separation, experience, self-care strategies and support (Craig & Sprang, 2010). The factors impacting professional quality of life can be categorized as either internal factors or external factors. Internal factors are things within the control of the therapist, while external factors are outside the influence of the individual, and are often things provided by the employer, agency, or setting the therapist works in. Both internal and external factors play a significant role in how trauma therapists experience this exposure and can either protect the trauma therapist or leave them more vulnerable.

Internal Factors

Internal factors that impact the development of compassion fatigue or compassion satisfaction among trauma therapists reported in the research literature include personal trauma history, gender, age, years of experience, self-care, perceived coping ability, self-awareness (the ability to recognize and meet one's own needs), sense of self, self-respect, self-efficacy, self-esteem, sense of coherence, connection or over-identification with clients, perceived effectiveness in their role, work-life balance, ideals, worldview (optimism/cynicism), knowledge of the risks associated with trauma work, countertransference, transference, therapeutic realism, leisure and relaxation, humor and laughter, and maintaining physical and mental health (Baird & Kracen, 2006; Cerney, 1995; Craig & Sprang, 2010; Figley, 1995; Hesse, 2002; Killian, 2008; Manning-Jones,

de Terte & Stephens, 2016; Ortlepp & Friedman, 2002; Pearlman & Saakvitne, 1995; Sprang et al., 2007).

External Factors

External factors are presented in the research literature as contributing factors to professional quality of life. Existing research found that the external factors that can impact compassion satisfaction or compassion fatigue among trauma therapists include supervision, training and continuing education, evidence-based practice, caseload, percentage of traumatized clients on caseload, peer support, membership and participation in professional affiliations or associations, occupational stress, work setting, supportive work environment, supportive social network, long work hours, autonomy and control (Baird & Kracen, 2006; Cerney, 1995; Craig & Sprang, 2010; Figley, 1995; Hesse, 2002; Killian, 2008; Manning-Jones et al., 2016; Ortlepp & Friedman, 2002; Pearlman & Saakvitne, 1995; Sprang et al., 2007).

The common thread tying the existing literature together is the relationship to the central theme of this study, which is the impact of trauma on professional quality of life for front line trauma workers and trauma therapists. Additionally, the theme that weaves through many of these studies is the acknowledgement that specific factors can impact professional quality of life, reducing compassion fatigue, burnout, and secondary traumatic stress, and increasing compassion satisfaction. Many studies have examined these factors and a review of existing literature identifies the categories of internal and external factors impacting professional quality of life.

There are factors that an individual can control that can reduce compassion fatigue and increase compassion satisfaction such as self-care and work-life balance. Alternately, there are factors that are beyond the control of the individual that agencies and supervisors can impact such as supervision and caseload. The subject of this study,

trauma specific training, falls generally in the literature under an external factor, as the trauma specific training is a factor outside of the individual that can be accessed to improve professional quality of life. Further, employers typically provide employee training, control access to time off to attend training, and often pay for employees to participate in continuing education by way of covering the costs of the training or paying the employee salary while attending the training, mileage to attend the training, or per diem while at the training.

To improve upon the limitations noted in earlier studies, this study includes the collection of demographic data and data analysis broken down by age, gender, experience, race, ethnicity, culture, license type, length of time as a therapist, and other trauma trainings attended. This study also incorporates all aspects of professional quality of life including compassion satisfaction, compassion fatigue, burnout, and secondary traumatic stress in the design.

Baird and Kracen (2006) called for further study to evaluate innovative trainings that have been created to address the occupational hazard of secondary traumatic stress. In this research the NARM model, an innovative training created for the resolution of developmental trauma, will be studied through a trauma-informed framework to determine how the training impacts professional quality of life. The research shows that trauma specific trainings cultivate the skills trauma therapists need to combat secondary traumatic stress, decrease compassion fatigue, and burnout as well as increase protective factors such as compassion satisfaction (Baird & Kracen, 2006; Craig & Sprang, 2010; Elwood et al., 2011; Manning-Jones et al., 2016; Ortlepp & Friedman, 2002; Pearlman & Mac Ian, 1995; Sprang et al., 2007; Tominaga et al., 2019; Tominaga et al., 2020). The research question that will guide this study is: How do trauma therapists who have been trained in NARM experience professional quality of life?

CHAPTER THREE: METHODOLOGY

Interpretive Phenomenological Analysis

IPA is a research method that was developed in the mid-1990s that is rapidly becoming a leading figure in qualitative research (Hefferon & Gil-Rodriguez, 2011). Reid and colleagues (2015) conducted a comprehensive literature review that identified 65 peer- reviewed papers from 1996 to June 2004 that all used IPA, confirming the increasing popularity of this method. Reid and colleagues (2015) coalesce the way that IPA approaches research design as,

> the outcome of all these analytic and evaluative processes in IPA is a set of themes, often organized into some form of structure (a coding overview, table of themes, hierarchy, or model). These themes generally provide the topic and focus for the analytic commentary in presentations and published IPA reports. They represent commonalities across the participants' accounts but should also attempt to accommodate the variations within the data set. This balance is reflected in a range of flexible and creative approaches to writing
> up the analysis. (p. 23)

IPA is comprised of influences from three areas of study; phenomenology, hermeneutics, and idiography (Charlick et al., 2016). Phenomenology aims to fully describe a lived experience (Charlick et al., 2016). Elements of both descriptive and interpretive phenomenology inform the IPA model (Charlick et al., 2016). Descriptive phenomenology serves to describe a lived experience, while interpretive phenomenology both describes and interprets the meaning of the lived experience (Charlick et al., 2016). Hermeneutics is an interpretive theory that aims to provide guidance for the interpretation

of text (Charlick et al., 2016). Idiography emphasizes that the focus of the research is on the individual (Charlick et al., 2016). Idiography focuses on analytic depth and the unique perspective of the specific subjects under investigation (Charlick et al., 2016).

This study utilized the Interpretive Phenomenological Analysis (IPA) research method to describe the participants' lived experience of the phenomenon of the professional quality of life of NARM trained trauma therapists. IPA is an ideographic qualitative research method used to deepen the understanding the phenomena being studied (Alase, 2017). IPA looks to "explore, describe, interpret, and make sense of the participants' sense-making of their experiences" (Tuffour, 2017, p. 3).

In IPA the focus is depth not breadth or generalizability (Smith & Osbourne, 2012). IPA utilizes fewer participants and shorter interview guides to identify a smaller number of themes. The deeper dive approach of IPA provides for a more thorough, nuanced, and detailed understanding of the phenomenon participants share as well as their individual experiences.

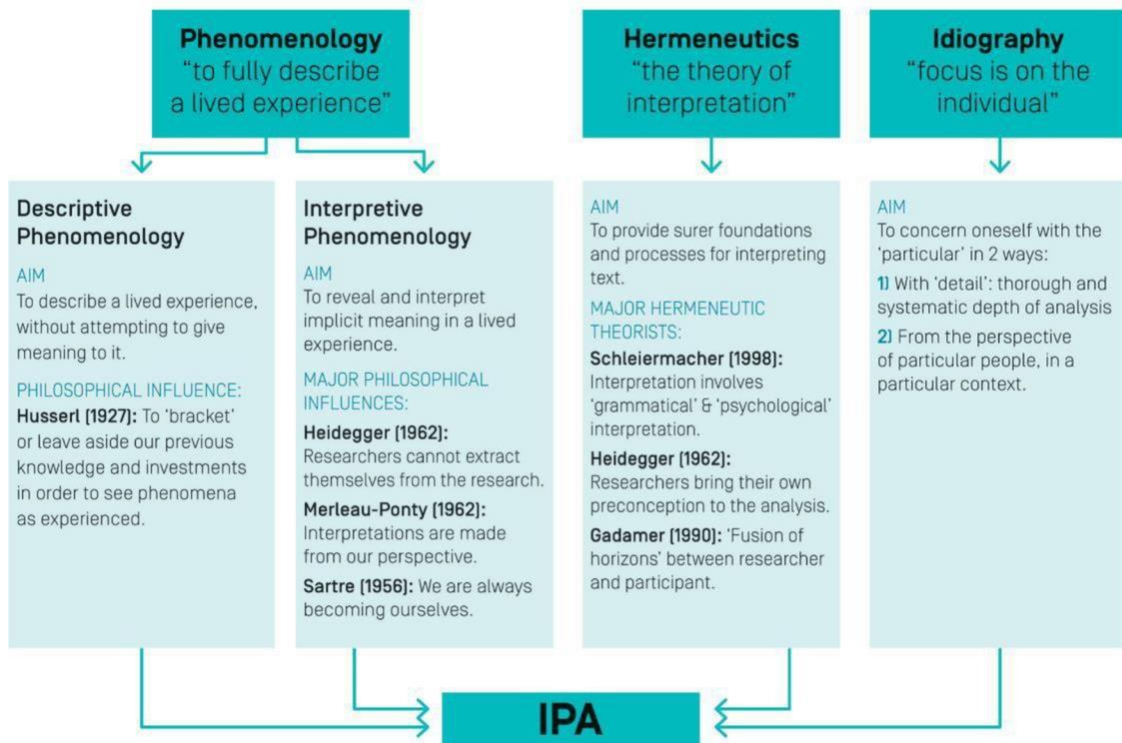
IPA assumes that participants seek to interpret their experiences into some form that is understandable to them (Brocki & Wearden, 2006). As a result of this tenet, the interview may be seen as a process by which the participant describes their life world and to an extent will be creating it through language (Brocki & Wearden, 2006). IPA has a theoretical commitment to the person as a cognitive, linguistic, affective, and physical being and assumes a chain of connection between people's talk and their thinking and emotional state (Smith & Osborn, 2012).

In the IPA tradition, the researcher must have a true and deep understanding of the participants' lived experiences for the stories of the participants to make-sense interpretively (Alase, 2017). IPA is a phenomenological approach that, "attempts to explore personal experience and is concerned with an individual's personal perception

or account of an object or event" (Smith & Osbourne, 2012, p. 53). The perceptions of the interview participants are identified through the process of IPA data collection and analysis.

Figure 1

The three influences of IPA



Note. From "Making Sense of Participant Experiences: Interpretative Phenomenological Analysis in Midwifery Research," by Charlick, S., Pincombe, J., McKellar, L., & Fielder, A., 2016, *International Journal of Doctoral Studies*, *11*, p. 205-216 (http://www.informingscience.org/Publications/3486). Copyright 2016 by Informing Science Institute.

Research Design

This study will utilize the Interpretive Phenomenological Analysis (IPA) research method to describe the participants' lived experience of the phenomenon of the professional quality of life of NARM trained trauma therapists. This study aims to

develop a cohesive description of the common experiences of NARM trained therapists (Creswell & Poth, 2018). IPA was selected because according to Alese (2017), it is

> interpretative, interpersonal, and interactive in nature, endowed with features that help equip its studies and researchers with rich abundance of data insight, holistic flavor to the stories that are being explored, all the necessary tools and mechanisms needed to conduct a rich and thick, descriptive research study. (p. 13)

Through use of the IPA research design, the interviewer delved into the lived experience of the participants. The interviewer and participant worked together in the process of identifying and interpreting the relevant meanings describing the phenomenon (Reid et al., 2005). The researcher became a part of the research process by bringing themselves and their subjective point of view into the process of reflecting upon and interpreting the data to reveal the participant's lived experience of the phenomenon (Reid et al., 2005). Acknowledgement of the role of the researcher and the impact of the interaction between the interviewer and the participant is a fundamental element of IPA research.

This design allowed the researcher to gain the perspective of NARM Therapists about how NARM trained trauma therapists experience professional quality of life. After completion of the interviews, the researcher transcribed the interviews. The researcher identified themes from the interview transcriptions and selected quotes that expressed the identified themes to tell the story of the participants. These themes and quotes were used to give voice to the NARM trained trauma therapists as they related their experiences with the NARM model from the point of view of an insider deeply familiar with the phenomenon of the quality of life of NARM trained trauma therapists being studied.

Data sourcing from the bottom up paired with the repetition of the researcher's emersion into the data resulted in the development of an insider perspective on the

phenomenon (Reid et al., 2005). The researcher interpreted the data from this perspective and supports the interpretation using examples and quotes from the participants (Reid et al, 2005). The use of quotes from the participants in their own words allowed the themes to be described directly by the insiders to the phenomenon who are experts in the subject with firsthand experience.

Quotes that represent the core of the identified themes were selected to tell the story of the participants in their own voice using their own words. As Brocki and Wearden (2014) instruct, "Extracts may be selected as exemplars of a theme with those presented representing the most articulate expression of that theme" (p. 30). Using identified themes and quotes that bring these themes to life, the researcher conveyed the lived experience of the participants' description of their encounter with the phenomenon. Brocki and Wearden (2014) found, "The inductive nature of IPA allows authors to discuss their analysis in the light of varied existing psychological theories, models or approaches" (p. 26). Through the framework of IPA, the researcher discussed the identified themes as they relate to the therapeutic model under investigation as well as guiding psychological theories underpinning the model.

The framework for IPA research adhered to in this study included sensitivity to context, commitment and rigor, transparency and coherence, impact, and importance (Yardley, 2008). This model supports evaluation of the quality of the study and demonstrates validity in IPA research. Sensitivity to context was approached through familiarity with the model and participants, deep exploration of related literature on professional quality of life, as well as development of the interview guide in consultation with a subject expert (see appendix D).

Commitment and rigor were addressed by in depth study of and close adherence to the theory and method of IPA. The researcher engaged intensively with the

phenomenon and selected a purposive, homogenous sample of NARM Therapists, reflecting the ideographic nature of the IPA model. Rigor was further demonstrated by the multiple processes of reading and re-reading the transcript, thorough analysis, and interpretation to reveal the phenomenon from the descriptive accounts of the interview participants, told through the participant's narrative using their own words.

Theory triangulation was implemented by means of combining the three theories guiding this research, professional quality of life theory, trauma theory, and attachment theory, to interpret the phenomenon, to help ensure that fundamental biases were overcome, to increase validity and reliability of the research findings (Noble & Heale, 2019). Reid and colleagues (2005) describe, "A number of further methodological features of IPA, such as 'transparency' of the results and 'reflexivity' in the interpretation processes, provide good benchmarks for ascertaining whether the qualitative 'good practice' guidelines set down by Elliot and colleagues. (1999) have been adhered to" (p. 23).

The IPA method is inherently subjective. The data analysis plan relied upon the reflections and coding of one researcher to identify themes. IPA does not use intercoder agreement to identify themes, rather the primary researcher consulted with an experienced IPA researcher to reflect on the process of coding and thematic identification to strengthen the credibility of emerging themes (Reid et al., 2005). Cross-validation to strengthen the credibility of emerging themes (Reid et al., 2005). Cross-validation procedures in the IPA tradition included utilizing independent audits of the analysis in addition to or instead of analysis conducted by more than one researcher, which is a form of triangulation (Reid et al., 2005). The transparency of the study design honored the IPA method by describing the steps of the researcher's process. This study maintained an epistemological commitment to the method and its acknowledgment of reflexivity.

The advantages of IPA include, "its emphasis on the convergence and divergence of experiences, its mission to examine the phenomenon in a detailed way using a nuanced analysis of the lived experience of a small group of participants" (Tuffour, 2017, p.1). IPA uses a structured approach to achieve its two goals of first deeply understanding how someone makes sense of their experience as well and then gaining an even deeper understanding of their experience by providing a detailed account of their experience (Tuffour, 2017).

Measures were taken to protect study participants by informing the participants that their participation was optional, they would not be penalized in any way for declining participation, and they were not obligated to answer any or all questions. Informed consent was completed by participants prior to the start of the semi-structured interview. The researcher notified participants that the interview would be recorded and transcribed verbatim by the researcher. The interviews were recorded to obtain complete data for transcription. Ten questions (see Appendix D) were asked in the 60-minute time frame allotted for each interview. Interview questions were created to understand the experience of participants before and after the NARM training, to collect data on how the NARM training impacted their work, their relationship to their work, and the sustainability of their work. The researcher took detailed field notes during and immediately following the interviews.

Participants

This Interpretive Phenomenological Analysis (IPA) study explored the experience of NARM trained trauma therapists. According to Reid and colleagues (2005), in the IPA tradition, "Participants are experts on their own experiences and can offer researchers an understanding of their thoughts, commitments and feelings through telling their own stories, in their own words, and in as much detail as possible" (p. 20). The study

participants completed the NARM Professional Training in the United States in the last five years. Study participants were trauma therapists in the professions of Social Work, Professional Counseling, Psychology, or Marriage and Family Therapy. The researcher anticipated a variety of gender, age, race, ethnicity, education, and training among the respondents and requested to collect demographic information during the interview.

The researcher utilized a convenience method for the sample selection of participants. The purposive sampling method used in this study was informed by phenomenological research design, in which "Samples are selected purposively (rather than through probability methods) because they can offer a research project insight into a particular experience" (Smith et al., 2009, p. 48).

IPA research focuses on the subjective lived experience of the participants (Hefferon & Gil-Rodriguez, 2011). According to Reid and. colleagues (2005), "Participants are recruited because of their expertise in the phenomenon being explored" (p. 20). The participants in this study have completed the NARM training, are trauma therapists, and are experts in the phenomenon of the NARM model of therapy for the resolution of developmental trauma.

According to Alase (2017), "As a result of the homogeneity of the research participants and the size of the sample pool, it is anticipated that IPA research studies will be rich and descriptively deep in the analytical process" (p.13). IPA recommends smaller samples, reflecting the importance of ideography to the method (Hefferon & Gil-Rodriguez, 2011). Four to ten participants are recommended for doctoral IPA research (Smith et al, 2009). Reid and colleagues (2005) explain, "Fewer participants examined at a greater depth is always preferable to a broader, shallow, and simply descriptive analysis of many individuals" (p. 21). A key component in the IPA research tradition is the philosophy that less is more in the areas of participants, number of questions asked, and

number of themes analyzed (Hefferon & Gil-Rodriguez, 2011).

Participants who completed the NARM Therapist training were invited by e-mail to participate in an interview for the purposes of conducting a research study on how trauma therapists who have been trained in NARM experience professional quality of life. Members of the possible sample pool of NARM Therapists in the United States with two or more years of experience using the NARM model were invited to participate in this voluntary research study via the NARM Training Institute with exclusionary criteria consisting of the requirement to be a trauma therapist who completed the NARM training, practicing in the United States with two or more years of experience using the NARM model, an e-mail account, computer, and internet access. No incentives were provided for participating and no consequences were extended for not participating.

This study commenced after receiving Institutional Review Board approval to provide full protection and consideration for human subjects. The researcher was granted permission to conduct the study by the NARM Training Institute. The NARM Training Institute agreed to allow the researcher access to recruit study participants who have completed the NARM Practitioner Training. Documentation of this permission was submitted to the IRB on NARM Training Institute letterhead.

Measures

The researcher utilized a semi-structured interview guide (see Appendix D) that included an open-ended question formula (Creswell, 2003). The interview questions in this research study inquired what the participants have experienced and how they have experienced it, to arrive at the essence of their experience (Creswell & Poth, 2018). The questions were developed based upon the researcher's professional knowledge of the NARM model and in consultation with a subject expert. The research design "used open-ended questions without reference to the literature or theory unless otherwise indicated by

a qualitative strategy of inquiry” (Creswell, 2003, p. 107). The open-ended questions in this study asked NARM practitioners about their experiences as a trauma therapist, their training experiences, and their experiences of professional quality of life (see Appendix D). For this qualitative study, the researcher interviewed 13 NARM trained therapists until saturation was reached using a semi structured interview guide to investigate how trauma therapists who have been trained in NARM experience professional quality of life.

ProQOL 5

The Professional Quality of Life Scale (ProQOL 5), an Internationally recognized and well-established measure of the impact of working with people who have experienced trauma, was utilized in this study to compare the established ProQOL scale means to the results of NARM Trained therapists (Stamm, 2010). This was implemented to establish how NARM Therapists scored in the three domains of professional quality of life.

A qualtrics survey was administered that incorporated thirty questions from the research based ProQOL 5 (see Appendix F), “the most commonly used measure of the positive and negative effects of working with people who have experienced extremely stressful events” (Stamm, 2010, p. 12). The ProQOL 5 means are produced from a data bank of 1,289 cases created from multiple studies (Stamm, 2010, p. 19). “Of the 100 papers in the PILOTS database (the Published Literature in Posttraumatic Stress Disorder), 46 used a version of the ProQOL” (Stamm, 2010, p. 12). "There is good construct validity with over 200 published papers and more than 100,000 articles on the internet, nearly half of have utilized the ProQOL” (Stamm, 2010). Cronbach’s Alpha scale reliability for the three ProQOL 5 dimensions are .88 for compassion satisfaction, .81 for secondary traumatic stress, and .75 for burnout (Stamm, 2010).

According to Stamm (2010):

> The three scales measure separate constructs. The Compassion Fatigue scale is distinct. The inter-scale correlations show 2% shared variance (r=-.23; co-σ = 5%; n=1187) with Secondary Traumatic Stress and 5% shared variance (r=.-.14; co-σ = 2%; n=1187) with Burnout. While there is shared variance between Burnout and Secondary Traumatic Stress the two scales measure different constructs with the shared variance likely reflecting the distress that is common to both conditions. The shared variance between these two scales is 34% (r=.58; co-σ = 34%; n=1187). The scales both measure negative affect but are clearly different; the BO scale does not address fear while the STS scale does. (p. 13)

Data Collection

An informed consent form was signed by participants prior to the start of the semi-structured interview. Reid and colleagues (2005) explain, "The chosen method for much qualitative data collection is a semi-structured interview" (p. 22). Fifteen total questions were asked in this semi-structured interview, seven central and eight demographic questions (see Appendix D). The ten central qualitative interview questions were: 1) Describe your work as a trauma therapist since completing the NARM training; 2) How do you feel about being a NARM trained trauma therapist?; 3) Tell me any positive aspects of your work as a NARM trained trauma therapist; 4) Tell me a professional success story; 5) Describe some of the beliefs you have about your work as a NARM trained trauma therapist; 6) Tell me about any difficult aspects of working with trauma survivors; 7) Describe any ways that working with trauma survivors has affected you; 8) Tell me about working with challenging clients before and after becoming a NARM trained trauma therapist; 9)

Tell me about any consequences of working with trauma survivors that you've experienced personally; 10) Describe any differences in how your work impacts you since becoming a NARM trained trauma therapist.

The demographic questions found in the quantitative survey (see Appendix E) inquired about participant gender, race, ethnicity, age, education, training, and experience. Participant responses were transcribed in preparation for data analysis. The demographic questions and the ProQOL5 measure were completed via Qualtrics survey.

Data Analysis

The data analysis process in this study was based upon recommendations from existing literature in the field of IPA. Reid and colleagues (2005) describe, "A successful analysis is: interpretative (and thus subjective) so the results are not given the status of facts; transparent (grounded in example from the data) and plausible (to participants, co- analysts, supervisors, and general readers)" (p. 20). Data analysis in IPA focuses on, "the exploration of participants' experience, understandings, perceptions and views" (Brocki & Wearden, 2014, p. 3). According to Reid and colleagues (2005), "analyses usually maintain some level of focus on what is distinct (i.e., idiographic study of persons), but will also attempt to balance this against an account of what is shared (i.e., commonalities across a group of participants)" (p. 20). The overarching themes uncovered in an IPA study represent the commonalities of the participant experience with the phenomenon, while the participant quotes highlight the uniqueness of the individual experience.

The interviews were transcribed, coded, and prepared for thematic analysis using the approaches outlined by Van Manen (1990). Brocki and Wearden (2014) report, "IPA requires close interaction between analyst and text: the analyst seeks to comprehend the presented account whilst concurrently making use of his or her own interpretative

resources" (p. 24). This analysis involved remaining open to the phenomenon revealing itself through all available means including the audio recording of the interviews, the transcript, field notes, and reflections on the interaction between the researcher, participants, and the phenomenon. Reid and colleagues (2005) explain, "IPA researchers reduce the complexity of experiential data through rigorous and systematic analysis that relies on the process of people making sense of the world and their experiences, firstly for the participant, and secondly for the analyst" (p. 20).

The phenomenon was uncovered through extensive review of the interview transcripts, thorough analysis, and reflective interpretation by the researcher to identify themes. Brocki and Wearden (2014) describe, "In IPA, the analysis is based on a careful reading of the participants' account" (p. 34). The data analysis process will begin with the researcher becoming thoroughly acquainted with and reflecting on the interview transcripts by sitting with the content and deeply considering what is being said. Biggerstaff and Thompson (2008) found, "IPA analysis revolves around the close reading and re-reading of the text and the researcher makes notes of any thoughts, observations and reflections that occur while reading the transcript or other text" (p. 177).

Reading and reviewing field notes supplemented the transcript review in the researcher's quest for themes. The process described by Biggerstaff and Thompson (2008) explains, "The transcripts were analyzed in conjunction with the original recordings and interview themes are identified" (p. 177). Only after the researcher become immersed in the field notes and transcripts did themes begin to emerge and be documented.

The researcher drew upon the guidance of Van Manen (1990) identifying themes, while acknowledging that the process is subjective and involves making judgement calls that are unique to each researcher, with none being more valid than another. The

researcher worked intimately with the text to uncover an interpretation that revealed the themes expressed by the participants and described the core of the phenomenon under investigation in this study.

A potential limitation in this study was that the researcher is a NARM trained therapist, and former NARM trainer, which could impact what participants shared in the interviews. This potential bias was mitigated by the researcher strictly adhering to the IPA model. IPA acknowledges that the research is an interaction between the researcher and the participants. Brocki and Wearden (2014) describe,

> Whilst the researcher attempts to access the participant's personal world insofar as this is feasible, IPA acknowledges that access depends on and is complicated by the researcher's own conceptions… required in order to make sense of that other personal world through a process of interpretative activity" (p. 4).

This approach to research acknowledges that it incorporates "the joint reflections of both participant and researcher to form the analytic account produced" (Brocki & Wearden, 2014, p. 4). According to Reid and colleagues (2005), "Researchers should reflect upon their role in the interpretative and collaborative nature of the IPA interview, data analysis and subsequent publication" (p. 20). IPA acknowledges that interviews are not a neutral means of data collection (Reid et al., 2005). Researchers are an acknowledged part of the research process in IPA. This study addressed this issue directly using reflexivity and bracketing to acknowledge the role of the researcher in the study and minimize the involvement of the researcher's pre-existing beliefs and goals for the study prior to data analysis.

IPA researchers develop an understanding of the participants' experiences of a phenomenon. Tuffour (2017) explains the position of the phenomenological theorist, "Husserl believed that this could be achieved by consciously setting aside our previous

knowledge and to detach ourselves from prejudices, prior understandings and our own history, therefore, thoughtful focus and the careful examination of experience in the way it occurs to the participants is essential" (p. 3). Concerted efforts that are grounded in the literature were taken to account for researcher bias. Brocki and Wearden (2014) describe that, "the inclusion of verbatim extracts in the analysis certainly helps the reader to trace the analytic process, perhaps including more acknowledgement of analysts' preconceptions and beliefs and reflexivity might increase transparency and even enhance the account's rhetorical power" (p. 40). The data analysis plan provided for efforts to minimize researcher bias in the process of identifying themes and methods to verify that researcher interpretations are grounded in the data to improve the accuracy of theme identification. This was supported by the ease of data organization in NVivo software. NVivo 12 was selected for data analysis in this study because it facilitates efficiency, accuracy, and data organization, and assisted the researcher in examining relationships in the data.

The selection process in the data analysis plan was based on the recommendations from existing literature. Brocki and Wearden (2014) explain, "IPA researchers should take particular care in their production of lists of themes to ensure that each theme is actually represented in the transcripts" (p. 28). Prevalence and frequency are considerations in IPA but are not the only selection criteria for themes in IPA. Brocki and Wearden (2014) describe,

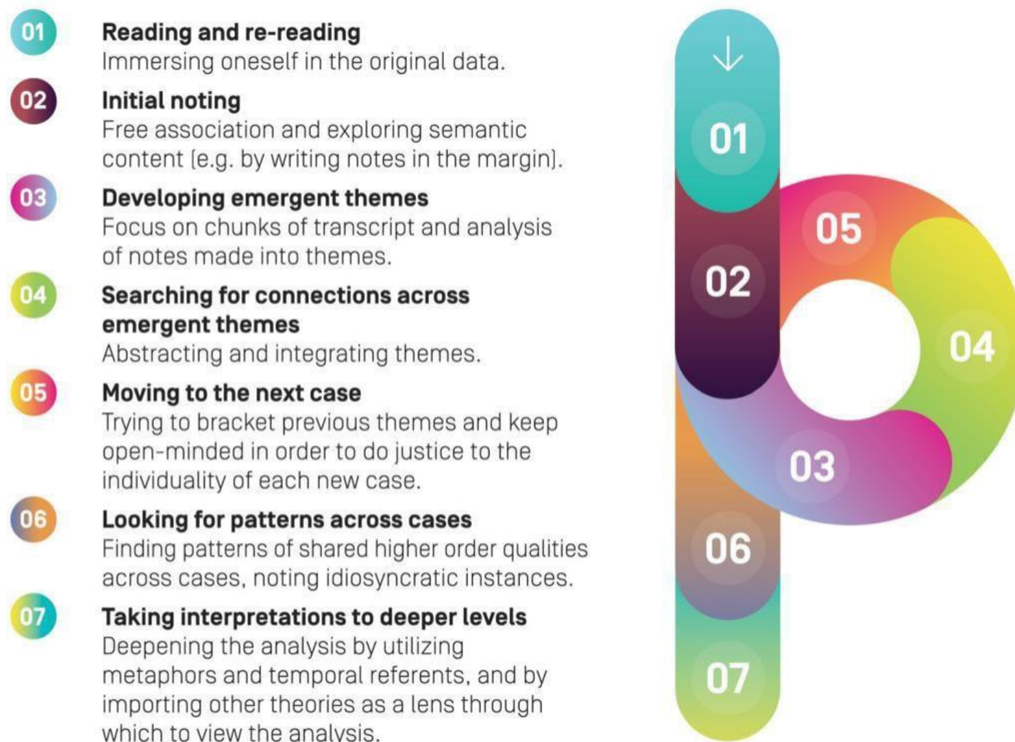
> Other factors including the articulacy and immediacy with which passages exemplify themes (perhaps the eloquence with which one participant summarizes the point may best sum up what many others sought to say in more words and less concisely) and the manner in which the theme assists in the explanation of other aspects of the account are also important considerations. (p. 28)

This data analysis plan incorporated a seven-step method described to identify the core themes and excerpts that best convey the experience of the participants in relation to the phenomenon (see Figure 2). Using the framework for IPA research as a guidebook to support validity and rigor, the seven data analysis steps outlined in IPA were followed and repeated until themes naturally arose from the text. These seven steps support the researcher in their ability to make sense of the experience of the study participants as well as gain a deeper understanding of the phenomenon under investigation in the study.

Charlick and colleagues (2016) outline the seven steps for data analysis in the IPA model (see Figure 2). The first step involved the researcher immersing themselves in reading and re-reading the data (Charlick et al., 2016). The second step included initial noting by which the researcher makes notes in the margins of the transcripts through the process of free association (Charlick et al., 2016). The third step was to develop emerging themes through the analysis of the transcript and notes (Charlick et al., 2016). In the fourth step, the researcher looked for connections among the emerging themes (Charlick et al., 2016). The fifth step moved the researcher to the next case under investigation while bracketing existing themes to see each new case in its own light (Charlick et al., 2016). In the sixth step, the researcher looked for patterns across cases while noting individual differences (Charlick et al., 2016). Finally, the seventh step deepened the interpretation using theories as a lens for analysis (Charlick et al., 2016). In addition to the seven steps of IPA data analysis, there are three stages in the IPA data analysis method.

Figure 2

The seven-steps of IPA data analysis



Note. From "Making Sense of Participant Experiences: Interpretative Phenomenological Analysis in Midwifery Research," by Charlick, S., Pincombe, J., McKellar, L., & Fielder, A., 2016, *International Journal of Doctoral Studies*, *11*, p. 205-216 (http://www.informingscience.org/Publications/3486). Copyright 2016 by Informing Science Institute.

The data analysis method used in IPA is, "a cyclical process where the researcher proceeds through several iterative stages: Stage 1: first encounter with the text; Stage 2: preliminary themes identified; Stage 3: grouping themes together as clusters; Stage 4: tabulating themes in a summary table" (Biggerstaff & Thompson, 2008, p. 5). These steps were followed in the data analysis method for this research study. Brocki and Wearden (2014) recommend that researchers "first categorize each transcript into broad themes, working back from these into more specific themes" (p. 28). The researcher

engaged with the interview transcripts until core themes emerged. Biggerstaff and Thompson (2008) instruct, “The researcher moves on to re-read the text and identify themes that best capture the essential qualities of that interview” (p. 5).

Once themes were identified, the researcher grouped related themes together. According to Biggerstaff and Thompson (2008), “The third stage involved attempting to provide an overall structure to the analysis by relating the identified themes into 'clusters' or concepts. The aim, at this stage, was to arrive at a group of themes and to identify super-ordinate categories that suggest a hierarchical relationship between them” (p. 10). After the relationships among themes were identified, the organized themes were arranged and presented using tables and visual aids. Biggerstaff and Thompson (2008) describe, “The fourth stage is to develop a 'master' list, or table, of themes. It is important to locate these themes in an ordered system that identifies the main features and concerns identified by the research participant” (p. 5).

At this stage, models that provide a visual description of the themes identified in this study were developed. Biggerstaff and Thompson (2008) explain, “These are usually produced as a table with evidence from the interview, using a quotation which, the analyst feels, best captures the essence of the person's thoughts, and their emotions about the experience of the phenomenon being explored” (p. 5). Through this data analysis plan, the final product revealed the themes that represent the core of the phenomenon of the quality of life of NARM trained trauma therapists.

Procedures

After securing IRB approval, the researcher solicited participants for this research study via e-mail (see Appendix F), which was sent to trauma therapists in the United States who have completed the NARM training. A purposive, convenience sample of 13 participants was selected to participate in this study from the respondents in the United

States who are trauma therapists who have completed the NARM training and have two or more years of experience using the NARM Model. The researcher interviewed the NARM Therapist participants using a semi-structured interview guide (see Appendix D) and an open-ended question formula. The researcher provided the definition for professional quality of life to the participants.

The interviews inquired about the lived experience of how trauma therapists who were trained in NARM experience professional quality of life. Reid and colleagues (2005) describe why interviews are the chosen research method in the IPA tradition, "One-to-one interviews are easily managed; allow rapport to be developed; allow participants to think, speak and be heard; and are well suited to in-depth and personal discussion" (p. 22). This interviewing strategy encouraged respondents to isolate their experience of the phenomenon of the quality of life of NARM trained trauma therapists. The interviews were analyzed using NVivo 12 software, coded, and prepared for thematic analysis using the approaches outlined by Van Manen (1990).

CHAPTER FOUR: RESULTS

This chapter presents the results of this study. The results begin with an overview of the sample investigated in this study. Commitment, rigor, and transparency are described. Finally, the data is presented in the themes that emerged through the study.

Sample

The phenomenological research tradition recommends a participant group of between 2 and 25 members who are representative of the homogeneity that exists among the participants' sample pool to truly understand the subject matter (Alase, 2017). The purposive sampling method used in this study was informed by phenomenological research design where, "Samples are selected purposively (rather than through probability methods) because they can offer a research project insight into a particular experience" (Smith, et al., 2009, p. 48). The participant sample size of 13 was sufficient according to the tenets of IPA.

Participants who completed the NARM Therapist training were invited to participate in an interview on how completing the NARM training impacts their professional quality of life, compassion satisfaction, and compassion fatigue. Licensed NARM Therapists, with a minimum of two years of experience, were invited to participate in this voluntary research study with no exclusionary criteria, no incentives for participating, and no consequences for not participating.

The 13 participants for this study were Licensed Therapists consisting of four Social Workers, four Professional Counselors, three Marriage and Family Therapists, and two Psychologists who completed the 150-hour NARM training. Participants ranged from 31-70 years old with one participant between 31-40 years old, six participants between 41-50, four participants 51-60, and two participants 61-70 years old. Three participants were from the West coast, four were from the Southwest, and six were from

the Midwest. Eleven participants identify as Caucasian, one Southern European/ Ashkanazy, and one participant reported race as other, unspecified. Two of the participants were male and 11 were female.

Table 1

Demographics

Characteristics	*n* = 13	%
Race/Ethnicity		
Caucasian (not Hispanic)	11	84.6
Southern European/Ashkanazy	1	7.6
Other (not specified)	1	7.6
Age		
31-40	1	7.6
41-50	6	46.2
51-60	4	30.7
61-70	2	15.3
Gender		
Male	2	15.3
Female	11	84.6
Region		
West coast	3	23.1
Southwest	4	30.7
Midwest	6	46.2
Years of Experience		
1-10	3	23.1
11-20	8	61.5
21-30	1	7.6
31-40	1	7.6

Participants' years of experience as a trauma therapist range from 6 to 37 years of experience. Participants' years of experience as a NARM Therapist range from 2 to 8 years of experience. Ten participants were also trained in Somatic Experiencing (SE), four were trained in Eye Movement Desensitization Reprocessing (EMDR), two were trained in Trauma Focused Cognitive Behavioral Therapy (TF-CBT), one was trained in HeartMath, one was trained in Neurofeedback, one was trained in Cognitive Behavioral Therapy (CBT), one was trained in Psychological Approach to Couple Therapy (PACT), one was trained in Daring Way, one was trained in Sensorimotor psychotherapy, and one participant was not trained in any other models. While data concerning the demographics

of NARM training participants as a whole is unavailable, the breakdown among participants in the areas of profession, age, and gender appears to closely mirror that of NARM Therapists, which is a primarily female, diverse representation from across the Psychotherapy professions.

In the IPA tradition, the researcher must have a true and deep understanding of the participants' lived experiences for the stories of the participants to make-sense interpretively (Alase, 2017). As a NARM Therapist and trainer, the researcher is familiar with the NARM model and has a unique perspective of and insight into the experiences of the participants in this study. IPA is a phenomenological approach that, "attempts to explore personal experience and is concerned with an individual's personal perception or account of an object or event" (Smith and Osbourne, 2012, p. 53). The perceptions of the interview participants were identified through the process of IPA data collection and analysis.

Commitment, Rigor, and Transparency

The framework for IPA research adhered to in this study included sensitivity to context, commitment and rigor, transparency and coherence, impact, and importance (Yardley, 2008). This model supports evaluation of the quality of the study and demonstrates validity in IPA research. Sensitivity to context was approached through familiarity with the model and group participants, deep exploration of related literature on professional quality of life, as well as development of the interview guide in consultation with subject experts.

Commitment and rigor were addressed by in depth study of and close adherence to the theory and method of IPA. The researcher engaged intensively with the phenomenon and selected a purposive, homogenous sample of NARM Therapists, reflecting the ideographic nature of the IPA model. Rigor was demonstrated by the

multiple processes of reading and re-reading the transcript, thorough analysis, and interpretation to reveal the phenomenon from the descriptive accounts of the interview participants, told through the participant's narrative using their own words.

The transparency of the study honored the IPA method by describing the steps of the researcher's process. This study has maintained an epistemological commitment to the method and its acknowledgment of reflexivity. Measures were taken to protect study participants by informing the participants that their participation was optional, they would not be penalized in any way for declining participation, and they were not obligated to answer any questions at all. Participants were provided and signed an informed consent form prior to the interview.

Themes

The study revealed four themes that represent the phenomenon of the impact of NARM on professional quality of life, compassion satisfaction, and compassion fatigue from the perspective of NARM therapists (as shown in Appendix H). These themes represent the elements of the NARM model that NARM trained trauma therapists reported most support their professional quality of life.

Theme One: More Effective Work

More effective work was identified as a key theme expressing the impact of NARM on professional quality of life, compassion satisfaction, and compassion fatigue from the perspective of NARM Therapists. One study participant shared, "I've worked with a lot of clients who in one session, say that in this session, they've had more change than in 15 years of doing talk therapy previously." Another participant described, "NARM really deepens my ability to do much more effective work." The theme of more effective work expresses the therapists' experience of the effectiveness of their therapeutic work when using the NARM model with clients. NARM therapists in this study overwhelmingly

expressed that their clinical work was more effective when using the NARM model.

> I have a client who maybe I've been working with for about a year, maybe a little less than a year and what I've noticed with this client is that they have increased capacity to be more connected to themselves. You know, when we first started working together, they had a lot of judgments around tearfulness and grief and saw that that would be—or perceive those emotions as weak. And now they're really comfortable, they can access those emotions with much less judgment than they had before. I had a session with them yesterday and they had said to me that in 30 years of therapy, they had never had a therapist support them to feel their anger and their grief up until our work together. And they notice such a shift within their life because of that.

Another participant shared how NARM has increased their effectiveness as a trauma therapist and how that has impacted both them and their clients,

> Before the NARM training, I had a lot of compassion fatigue, I would feel exhausted after a day's work, a week's work. I would carry thoughts of my clients all week, and you're just wondering how that they're doing. I sometimes had reoccurring thoughts of the trauma that they experienced. And I had concerns if I was helping them enough, second guessing my capacity to support them through the work that they were doing – second guessing is a little bit strong, but always wondering if I should be taking other trainings, what other trainings could I get. I knew I was helping them to some degree but wondering what I could do better, or how I could work harder. And since the NARM training, I have way less of all of that. I actually don't carry thoughts or worries about my clients after the session. I know that the work is effective, it feels really satisfying.

Other study participants summarized the effectiveness of the work reporting, "My

experience is that NARM gets to the core a lot quicker" and "Not only is the modality effective, but it also supports me in being able to do the work and sustain it" and "I feel like the work I'm doing is effective, it gives me a certain degree of job satisfaction that I didn't have in all my other trainings" and simply, "I feel like the work I'm doing is effective." One participant explained,

> I think I've become more effective as a therapist as a result of NARM. I think my clients have derived more benefit from working with me as a result of it. It's also helps with my professional persona, because I've become known as a NARM therapist, and it seems like NARM is a model that has become popular and so more clients are finding me, so my practice has expanded and that's been welcomed... But yeah, it's nice to know that clients want to work with me, it's also good for my self-esteem, it reinforces my sense that I'm making a positive contribution, and it's motivating.

Study participants described both their own experience of increased effectiveness as a therapist, and their experience of witnessing the effectiveness of the NARM model with their clients. One study participant explained their experience of the effectiveness of their NARM work with clients,

> I feel like NARM, for me, gives me a framework and it feels both more organizing for myself, in terms of what I'm doing amidst to trauma, because trauma is so disorganizing, so it's really organizing for me as a therapist, and I'm just seeing it be effective. I'm understanding things with clients differently and I'm seeing it be effective with them.

Another study participant explained their own experience of increased effectiveness, "NARM allowed me to feel more confident and believe that I can be effective in supporting people and working on healing their developmental trauma." Increased effectiveness as a NARM trained trauma therapist was the most significant

finding impacting professional quality of life expressed by NARM trained trauma therapists in this study.

Theme Two: Enjoying their Work

Another theme that emerged, which demonstrates the impact of NARM on professional quality of life from the perspective of NARM Therapists, is the theme of NARM trained trauma therapists enjoying their work. A study participant explained, "I really enjoy it when I see NARM clients on my schedule, I'm very excited." Enjoying the work reflects the way NARM trained trauma therapists experience their work when using the NARM model. Another participant reflected, "I feel more joy in the work and in my life personally." The second most significant theme among NARM Therapists when discussing their professional quality of life since becoming a NARM Therapist, is that they enjoy their work since completing the NARM training. One study participant described,

> It invigorates me more, it uplifts…. I find it more exciting and uplifting and invigorating, because I'm not walking away from a session with this big brick on my back, like, 'Oh, my God, what am I going to do,' So it's more fun. I know there are several people in the NARM community that I really, really look up to. And their case loads are really big, and you can tell their life force is fully intact, because they're not exhausted by this work. They're just freed up.

Another study participant explained,

> I think before being trained in NARM I felt such a personal responsibility to fix people that I was burning myself out. Actually, yeah, as I think about it—I've been trained in NARM for so long, I forget who I was before now. But as I reflect back, I remember thinking, like, I picked the wrong profession, or this might not be for me, and because I was so exhausted trying to fix people. And I think after NARM, I actually really enjoy the work now.

Another study participant related their enjoyment of the work stating,

> My work is much more fulfilling and satisfying, being a NARM-trained therapist, it's deeply satisfying to know that I have supported someone or helped someone in a way that has the capacity to change their lives. You know, sometimes I feel like I would do this for free. I mean, it's so much fun, and then they pay me at the end. I think it's just— I can't believe it that I actually have come to a career and a modality that is so deeply satisfying that it doesn't even feel like work a lot of the time.

The impact that NARM has on trauma therapists' enjoyment of their work was a significant factor that impacted professional quality of life as reported by the NARM trained trauma therapists.

Theme Three: Support for Therapists

The support that NARM provides for the therapist was an additional theme that NARM Therapists described as key to understanding the impact of NARM on professional quality of life from the perspective of NARM Therapists. One participant shared how they have felt supported as a NARM trained trauma therapist,

> I've remained engaged in the community, and so there's a lot of intentional ways the NARM community and Institute has created support for those in this noticed is that, you know, there's ways to stay engaged, such as the inner circle, the podcast, the consultation groups, the continued training, and it just seems like they are relational to me, that's how I take them in. I know not everyone will have the same experience. They don't feel corporate, they feel more like connecting, and it feels to me like there's an intention to set up community, and I really value that.

Another participant explained more about how NARM supports therapists, which in turn supports their professional quality of life,

> The NARM Training Institute is kind of fashioned after these early psychoanalytic institutes that were created in Europe and then came over to the United States. And the idea of them at the time—it was a new science, I mean, psychotherapy was a new thing and so people would come together in these societies or these Institutes—they use to call them societies—and there were a few different levels of what they would do. So one of them was just to support each other; people were going off and doing this work and just having a place to come back and share it with each other and learn from each other, and support each other. It was really important at the early stages of developing psychoanalysis. So that was one piece of it and the other piece is training, they would come together to do training from more senior trainers, they get ongoing consultation. In those days, we don't do this now, but in those days, they would also be doing ongoing therapy from some of the trainers as well, because at that point, psychoanalysis, they realized how important it was for the therapist to also undergo their own psychoanalysis. So, it also was a social kind of, they would have social events, they would bring in lectures, all that kind of stuff. So that is the idea, it's part of the mission of the NARM Training Institute to…. We're all on these islands nowadays, like the United States is so fragmented, and there's just not a lot of support. And I think that's why people come to these trainings and feel so supported and excited about it because we're coming together to support each other in a different way.

A participant summarized how NARM has been supportive of their professional quality of life, "There's no way I could have worked with this population, and the number of people I'm working with prior to NARM. So, not only is the modality effective, but it also supports me in being able to do the work and sustain it." Another

participant described how NARM has provided support for their professional quality of life as a trauma therapist,

> Prior to working through the NARM model, I had so much compassion fatigue, it was pretty significant, enough that I wanted to leave the field at one point, and I think I probably had some vicarious trauma quite honestly, and doing my own work, and working through the NARM lens, that's not there anymore. And that is really powerful, I don't have to tell you or anyone, working with trauma is a difficult choice, and using NARM has allowed me to really stay in it without being in it in a way that's impacting my myself and my ability to be there and be present.

Another therapist explained, "I believe NARM is not only a model for helping other people heal, but I think there's an emphasis on supporting the therapist. I don't know how you can support healing if the emphasis isn't on both the therapist and the client." Another therapist described the impact of NARM on their professional quality of life, "I was able to learn NARM because they have a sophisticated training program in terms of the experientials and the case consultations, and having that as a support, it's like that supportive system helps me be more supportive with clients and feel less burdened." The support NARM provides for therapists was a significant factor expressed by NARM trained trauma therapists as impactful to their experience of professional quality of life.

Theme Four: Increased Confidence

Another theme that emerged was the increased confidence NARM trained trauma therapists experience in their work which supports their professional quality of life. A participant described it as,

> I feel a sense of freedom. I feel like I have been given a lens and tools and

> interventions and a way of being that allows me to just provide something to the person in front of me that really feels different than any other modality I've ever been trained in or used or use. Honestly, I feel like I've been given the keys to the kingdom, like, I've got just even the contracting and the consent and the intentionality. It's hard to put into words how much... I feel empowered, I feel like, honestly, it's brought my own sense of agency more online, like, I got this because especially with the complex PTSD, and the tangential, and now I've got the contract and I can always bring them back to you know, our patients and clients and even my virtual private practice, it's like, the level of disorganization is high so I've got this thread now I can use to keep us on track and it's allowed more spaciousness and confidence in my ability. NARM, you know, just the curiosity and inquiry, slowing everything down, you know, and it's just been a freeing way to approach this field and the craft in a different way, a more spacious way.

Increased confidence represents the way that NARM trained trauma therapists feel better prepared and able to address the complex needs of the trauma survivors they serve in their practice using the NARM model. One study participant described,

> I feel more confident in my ability to manage unpredictable situations and just kind of show up as who I am, and just feel confidence that I can handle this and I know how to ask for help if I need to. And I think before, I would maybe just try to solve things by myself, and like internally process them and come up with a solution, but now I'm better at delegating and asking for support and being vulnerable in professional settings, which I was probably less comfortable with before. I mean, I would always be authentic and I'm good at being vulnerable if I feel like I'm in control. But now I feel like I can just show up not being in control

> and being vulnerable and ask for support. I think that's pretty powerful because I don't need to figure it all out on my own. And I think that's the essence of being in relationship is that you aren't alone. Or you don't need to be alone if you don't want to be. And so I think I just feel more settled and confident in the different roles that I have in my professional life and personal life. And I think that is due to a lot of the work I've done with NARM in my own consultations and learning and just practicing the model and my own self exploration and curiosity.

Another participant explained,

> It's been really beneficial. So, certainly, my confidence has increased significantly, maybe even dramatically as a therapist. Like I said, I think it is a coherent model and I think there's a cogency that comes with the language of it, that allows me to dialogue with other therapists, both within the NARM community and outside of it in a way where I can articulate a stance and it feels pretty internally organized.

Other study participants related, "It just allowed me to feel more confident and believe that I can be effective in supporting people and working on healing their developmental trauma", "After becoming a NARM-trained therapist, I just feel so much more confident and competent", "Since the NARM training, I noticed that I feel a lot more confident", "It really helped me a lot to feel much more confident and comfortable in working with complex trauma" and "Yeah, confidence, I feel a lot more confident." Another participant described the impact NARM has had on their confidence professionally, "It gives me more of an informed understanding of why I'm using the interventions that I'm using. I'm not just pulling them randomly to do something for the client, they're coming from a place where I feel pretty confident why I'm using them, because I've really spent time being connected to myself throughout the process." NARM

trained trauma therapists expressed that they experienced an increased confidence in their professional abilities following the NARM training. This increased confidence positively impacted their professional quality of life.

The theory that the NARM training serves to support the trauma therapists' professional quality of life, compassion satisfaction, and compassion fatigue was supported by NARM Therapists during the interviews. Using the framework for IPA research as a guidebook to support validity and rigor, the steps outlined in IPA were followed and repeated until four themes naturally arose from the text. The researcher used the words of the participants to illustrate how the themes organically expressed themselves in the study. The themes uncovered by the study are key to revealing how NARM supports trauma therapists' professional quality of life, compassion satisfaction, and compassion fatigue from the perspective of NARM Therapists were increased confidence, support for the therapist, more effective work, and more effective work. Study participants shared descriptive and meaningful examples from their client work to illustrate how they have witnessed the impact of NARM on professional quality of life, compassion satisfaction, and compassion fatigue.

ProQOL 5

Using the ProQOL 5 measure (see Appendix F), NARM Therapists scores were assessed in three categories; low, average, and high among three areas; compassion satisfaction, burnout, and secondary traumatic stress. Burnout and secondary traumatic stress together make up compassion fatigue. Data provided by ProQOL was used to define the range of scores that fall in the low, medium, and high range.

These ranges are based upon over 1,200 responses of those who work with traumatized clients who have completed the survey, which were expected at 25% of the population to fall into the low range, 50% of the population to fall into the average range,

and 25% of the population to fall into the high range (Stamm, 2010). Across all domains, a score of 22 or less falls within the low range, while a score between 23-41 falls in the moderate range, and a score of 42 or higher falls within the high range (Stamm, 2010).

Compassion Satisfaction

Among the NARM trained trauma therapists in this study, the mean ProQOL 5 score in the compassion satisfaction domain was 41.69. In the compassion satisfaction domain, eight respondents scored high, five scored moderate, and zero scored low. The NARM trained trauma therapists in this study fell in the high compassion satisfaction range.

Burnout

Among the NARM trained trauma therapists in this study, the mean ProQOL 5 score in the burnout domain was 18.62. In the compassion satisfaction domain, zero respondents scored high, two scored moderate, and eleven scored low. The NARM trained trauma therapists in this study fell in the low burnout range.

Secondary Traumatic Stress

Among the NARM trained trauma therapists in this study, the mean ProQOL 5 score in the secondary traumatic stress domain was 18.15. In the secondary traumatic stress domain, zero respondents scored high, three scored moderate, and ten scored low. The NARM trained trauma therapists in this study fell in the low secondary traumatic stress range.

Collectively, the NARM trained trauma therapists who participated in this study fell in the high compassion satisfaction, moderate to low burnout and secondary traumatic stress category. According to Stamm (2010),

> This is the most positive result. This result represents a person who receives positive reinforcement from their work. They carry no significant concerns about

being “bogged down” or inability to be efficacious in their work—either as an individual or within their organization. They do not suffer any noteworthy fears resulting from their work. These persons may benefit from engagement, opportunities for continuing education, and other opportunities to grow in their position. They are likely good influences on their colleagues and their organization. They are probably liked by their patients, who seek out their assistance. (p. 22)

CHAPTER FIVE: DISCUSSION, IMPLICATIONS & CONCLUSION

Summary

In this Interpretative Phenomenological Analysis, 13 NARM trained trauma therapists participated in individual interviews to investigate how NARM trained trauma therapists experience professional quality of life. Professional quality of life is comprised of compassion satisfaction and compassion fatigue, which includes burnout and secondary traumatic stress (Stamm, 2010). The literature suggests that routine exposure to the secondary trauma that trauma therapists experience in their daily work results in burnout and secondary traumatic stress, the two elements of compassion fatigue, as well as compassion satisfaction (Baird & Kracen, 2006; Bober & Regehr, 2006; Cerney, 1995; Craig & Sprang, 2010; Elwood et al., 2011; Figley, 1995; Folette et al., 1994; Killian, 2008; Manning et al., 2016; Neuman & Gamble, 2005; Nishi et al., 2016; Ortlepp & Friedman, 2002; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995; Sodeke-Gregson et al., 2013; Sprang et al., 2007; Stamm, 1997, 1999, 2016; Steed & Downing, 1998; Street & Rivett, 1996; Thomas, 2013; Tominaga et al., 2020; Weiss et al., 1995).

Recommendations to reduce the impact of trauma therapy work on trauma therapists' professional quality of life have been identified in the literature (Baird & Kracen, 2006; Craig & Sprang, 2010; Elwood et al., 2011; Manning-Jones et al., 2016; Ortlepp & Friedman, 2002; Pearlman & Mac Ian, 1995; Sprang et al., 2007; Tominaga et al., 2019; Tominaga et al., 2020). Significant among these research-based recommendations to support the professional quality of life among trauma therapists are training in general, and trauma specific professional training specifically (Baird & Kracen, 2006; Craig & Sprang, 2010; Elwood et al., 2011; Figley, 1995; Folette et al., 1994; Hesse, 2002; Killian, 2008; Larsen & Stamm, 2008; Orltepp & Friedman, 2002; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995; Sprang et al., 2007; Steed &

Downing, 1998; Street & Rivett, 1996; Tominaga et al., 2020; Winblad et al., 2018). Despite the extensive literature supporting the protective effects of trauma specific training on trauma therapists, scant research exists that investigates specific trauma trainings to determine how they uniquely impact trauma therapists' professional quality of life (Leitch et al., 2009; Rosner et al., 2020; Winblad et al., 2018). This is the premiere study investigating how trauma therapists who have completed the trauma specific NARM professional trauma therapist training experience professional quality of life.

Discussion

The Lived Experiences of NARM Trauma Therapists

This study used IPA to understand the phenomenon of how NARM trained trauma therapists experience professional quality of life. Out of this analysis, four themes emerged. This investigation revealed that NARM trained trauma therapists experience professional quality of life in four unique ways that consistently arose from interviews with NARM trained trauma therapists in this study. NARM trained trauma therapists engage in more effective work after completing the NARM training. Trauma therapists who have completed the NARM training report enjoying their work. NARM trained trauma therapists explain support for therapists as a key factor in their professional quality of life. Trauma therapists describe increased confidence after completing the NARM training, which enhances their experience of professional quality of life. These four themes emerged as central to the experience of professional quality of life among NARM trained trauma therapists.

The Role of the Theoretical Model of Compassion Satisfaction & Compassion Fatigue

The Theoretical Model of Compassion Satisfaction and Compassion Fatigue (Stamm, 2010) guided this study. This theoretical model explains how trauma therapy

work impacts the professional quality of life among those who work directly with trauma survivors and results in both compassion satisfaction and compassion fatigue (Stamm, 2010). Compassion satisfaction describes the positive impacts of trauma work, which include the feelings of making a difference in your work as a helping professional and contributing to both individuals and society in an effective and supportive way (Stamm, 2010). Compassion fatigue explains the two components of trauma work that negatively impact those who work with trauma survivors. The two components of compassion fatigue are burnout and secondary traumatic stress (Stamm, 2010). These factors describe how trauma workers take on the experiences of the trauma survivors they work with because of the repeated exposure to secondary trauma in their work and as a result are not able to effectively execute their role and responsibilities (Stamm, 2010).

In this study, NARM trained trauma therapists completed the ProQOL 5 measure (Stamm, 2010) to determine their professional quality of life, as well as participated in an individual interview, which inquired about their professional quality of life, both based on the Theoretical Model of Compassion Satisfaction and Compassion Fatigue (Stamm, 2010). Results revealed that the responses and accompanying scores of NARM trained trauma therapists in this study indicate high compassion satisfaction and low compassion fatigue. NARM trained trauma therapists in this study reported low burnout and secondary traumatic stress, and high compassion satisfaction and professional quality of life. These significant findings were demonstrated by NARM trained trauma therapists' increased confidence in their work, more effective work, greater enjoyment of their work, as well as feeling supported in their work as a NARM trained trauma therapist.

Trauma Theory and Secondary Trauma

The understanding of complex trauma has been evolving since the seminal work of Judith Hermann (1994) was first published almost thirty years ago. Advances in

trauma theory have identified that distinct criterion exist, which differentiate Complex Post Traumatic Stress Disorder (C-PTSD) from Post-Traumatic Stress Disorder (PTSD). These criteria have been recognized by the World Health Organization and elucidated by diagnostic criteria published in the International Statistical Classification of Diseases and Related Health Problems (ICD-11).

The groundbreaking work and research in the field of trauma by Dr. Daniel Siegel, Dr. Bessel Van der Kolk, Dr. Peter Levine, and Dr. Lawrence Heller have expanded the understanding of trauma immensely. The complex post-traumatic stress disorder diagnosis and the assessment tool endorsed for use in the diagnosis of complex post-traumatic stress disorder have legitimized the field of complex trauma. The need for research and evaluation of treatment modalities specifically designed to address developmental trauma has been established (Karatzias et al., 2016).

NARM is a trauma specific training that prepares trauma therapists to provide effective psychotherapy services to survivors of complex trauma. Using treatment modalities that are effective in the treatment of PTSD when treating C-PTSD ignores the components that make C-PTSD a separate and unique diagnosis. Failure to address these criteria in the treatment plan contributes to the lack of effectiveness in the treatment, prolonging the therapists' exposure to secondary trauma, and leading to increased compassion fatigue and decreased compassion satisfaction. The NARM training educates trauma therapists on the intricacies of complex trauma and provides a therapeutic model, which has been specifically designed to address complex trauma.

The impact of training and education specifically developed to address complex trauma is evident in the NARM trained trauma therapists studied in this research. NARM trained trauma therapists are less impacted by exposure to secondary trauma in their work, experience less burnout, and have greater satisfaction in their work. They describe

their work as enjoyable and effective. They discuss feeling confident and supported in their work. They relate a greater professional quality of life than they had prior to participating in the NARM training. The deeper understanding of the dynamics in complex trauma they receive in the NARM training and the skills they develop for addressing complex trauma while using the NARM model serve to support them in their work with trauma survivors.

Professional Training

Many factors that impact professional quality of life have been identified in the literature (Baird & Kracen, 2006; Cerney, 1995; Craig & Sprang, 2010; Figley, 1995; Hesse, 2002; Killian, 2008; Manning-Jones et al., 2016; Ortlepp & Friedman, 2002; Pearlman & Saakvitne, 1995; Sprang et al., 2007). Both internal and external factors have been found to contribute to the professional quality of life of those who work with trauma survivors. Professional training has been identified as an external factor, which contributes to professional quality of life among trauma therapists (Baird & Kracen, 2006; Craig & Sprang, 2010; Elwood et al., 2011; Manning-Jones et al., 2016; Ortlepp & Friedman, 2002; Pearlman & Mac Ian, 1995; Sprang et al., 2007; Tominaga et al., 2019; Tominaga et al., 2020). While professional training is robustly recommended in the literature, limited research has been conducted on specific trauma trainings to determine how a specific training impacts professional quality of life.

In this study, trauma therapists who completed the NARM trauma training were examined. This study supports findings in existing literature that indicate professional training supports professional quality of life among those who work with trauma survivors. NARM trained trauma therapists in this study received the most positive result possible on the ProQOL 5 measure, an optimal professional quality of life score. NARM trained trauma therapist participants in this study scored in the low burnout, low

secondary traumatic stress, and high compassion satisfaction ranges. Trauma therapists in this study identified increased confidence, more effective work, greater enjoyment of their work, and feeling supported after completing the NARM trauma training as the key elements of their improved professional quality of life.

Limitations

Interpretative Phenomenological Analysis was the research method used to deepen the understanding the phenomena of professional quality of life among NARM trained trauma therapists in this study. IPA utilizes fewer participants and short interview schedules to uncover a smaller number of themes. The focus of IPA research is on depth rather than breadth or generalizability.

A limitation in this study was that the researcher was a NARM Therapist and NARM co-training assistant, which could potentially impact what participants shared in the interviews. Another limitation was limited diversity among participants in terms of gender, race, and ethnicity. Additionally, a limitation was that due to the geographic location of participants across the United States, as well as social distancing restrictions resulting from the Covid-19 global pandemic, all interviews were conducted remotely.

Social Work Implications

While not every social worker becomes a trauma therapist, clients who have experienced trauma are found in nearly every practice setting across the field of social work. Social workers are not typically required in graduate school to take a specific class on how to work effectively with clients who have experienced trauma. As a result, social workers often lack the specific training necessary to work with trauma survivors in an effective and sustainable way.

Working with trauma survivors exposes social workers to secondary trauma. While self-care is stressed in most social work programs, many programs do not

specifically prepare social workers to know how to recognize or address the secondary traumatic stress and burnout that can come from repeated exposure to secondary trauma. Many social workers who work with trauma survivors suffer from compassion fatigue, burnout, and secondary traumatic stress yet do not know what to do to address it or prevent it. The results of this study support the NARM training as a method of improving professional quality of life, reducing compassion fatigue, burnout, and secondary traumatic stress, and improving compassion satisfaction.

Implications for social work practice include the reduction of burnout and lower secondary traumatic stress among social workers who work with trauma survivors that complete the NARM training. Additional implications to the profession may include increased compassion satisfaction and improved professional quality of life among NARM trained social workers who work with trauma survivors. Social workers who become trained in the NARM model are more likely to stay in their position longer, thus reducing turnover and increasing retention because of having the skills necessary to work with clients who have suffered complex trauma.

NARM trained social workers are taught how to properly assess clients who have experienced trauma and to identify clients who have experienced shock trauma from those who have experienced developmental trauma. Social workers who have been trained in the NARM model learn how to appropriately diagnose clients with C-PTSD because of the thorough understanding of complex trauma gained in the NARM training. NARM trained social workers learn skills to support complex trauma survivors by developing an appropriate treatment plan and achievable goals for treatment.

Recommendations for Future Research

The limited existing research on the impact of specific trauma trainings on professional quality of life has left a substantial gap in the literature on professional

quality of life among trauma therapists. Studies that continue to investigate how specific trauma trainings impact trauma therapists' professional quality of life are needed to close this gap, add specificity, and provide guidance for trauma therapists looking to implement the recommendation of existing findings that indicate training improves professional quality of life. While the literature clearly recommends training to improve the professional quality of life of trauma therapists, it does not provide any information on which types of training provide this critical benefit to trauma therapists, if a particular type of training will produce a more profound improvement on professional quality of life than another, or if all trauma trainings will have a similar impact on professional quality of life.

Recommendations for future research include the need for a study to investigate the professional quality of life among trauma therapists who have been trained in various Somatic Psychotherapy approaches such as NARM, SE, and EMDR and provide a comparison trauma therapists can use when determining which trainings or combination of trainings to pursue to enhance their professional quality of life. A study that will examine the professional quality of life among trauma therapists who utilize bottom-up therapies when working with trauma survivors as they compare to trauma therapists who implement top-down approaches such as CBT is recommended to understand the impact of somatic therapy as compared to cognitive therapy models on professional quality of life. A longitudinal study that investigates the impact of participating in the NARM training on professional quality of life beginning pre-training to establish a baseline and taking another measure following the conclusion of each of the four modules of the NARM training and again after the participants have had time to implement the model in their practice is also recommended. Finally, a mixed methods study of NARM trained trauma therapists is recommended to understand in greater depth what factors in addition

to completing the NARM training support or diminish professional quality of life.

Conclusion

The responses of participants and their accompanying scores at the time of this study indicate that trauma therapists who completed the NARM training reported low burnout, low secondary traumatic stress, high compassion satisfaction, and professional quality of life. Participants in this study indicate that completing the NARM training has resulted in greater confidence, more effective work, greater enjoyment of their work, and feeling supported professionally. These key elements are central to their experience of professional quality of life. This study supports the multitude of existing research that recommends training as a supportive and protective factor to improve trauma therapist professional quality of life (Baird & Kracen, 2006; Craig & Sprang, 2010; Elwood et al., 2011; Manning-Jones et al., 2016; Ortlepp & Friedman, 2002; Pearlman & Mac Ian, 1995; Sprang et al., 2007; Tominaga et al., 2019; Tominaga et al., 2020).

The results of this study also support the findings of the limited existing studies that examine the impact of specific trainings on trauma therapists' professional quality of life (Leitch et al., 2009; Rosner et al., 2020; Winblad et al., 2018). Supporting the results of the study conducted by Winblad and colleagues (2018) on the professional quality of life of therapists who completed the trauma specific SE training, this study confirms that the trauma specific training NARM may also benefit the professional quality of life of trauma therapists who complete the training. The results of this study also support the results of the study by Leitch and colleagues (2009) that showed statistically significant gains in resiliency and decreases in both PTSD symptoms and psychological distress among trauma workers trained in the Trauma Resiliency Model. Finally, the results of this study support initial findings in the study underway by Rosner and colleagues (2020) who are investigating the influence of implementing TF-CBT on the professional quality

of life of the therapists using the well-established and research based Professional Quality of Life (ProQOL-5) scale.

The results of this study align with the theories used to design the study. Attachment theory discusses the significance of the attachment relationship between the therapist and client. A key component of the NARM model centers around the relational aspect of NARM therapy, as it is a relational model. This study indicates that NARM therapists feel supported in their work, which by design, can be attributed to the relational components of the model.

The results of this study also align with trauma theory, which contributed to the design of the study. Trauma theory identified the distinct ways in which complex trauma is different from shock trauma. Trauma therapy models which attempt to treat C-PTSD with modalities designed to treat PTSD have been unsuccessful at addressing the disturbances of self-organization that differentiate C-PTSD from PTSD, which are emotional dysregulation, interpersonal difficulties, and negative self-concept as outlined in the ICD-11 which was published by the World Health Organization in 2019 (Karatzias et al., 2016). The results of this study found that trauma therapists trained in the NARM model, which was explicitly created to address complex trauma, experience their work as more effective and enjoyable. Engaging in more effective and enjoyable work may contribute to the professional quality of life among the trauma therapists who participated in this study.

The results of this study also align with the tenets of the Professional Quality of Life Theoretical Model of Compassion Satisfaction & Compassion Fatigue which guided this study. Therapists who work with clients who have experienced trauma are exposed to secondary trauma which can lead to burnout. Many of the participants in this study referred to their own experiences of burnout and secondary traumatic stress prior to taking the NARM training, even citing it as a reason for initially seeking out the training.

The results of this study contrast the effects of exposure to secondary trauma and the impact of burnout on participants' work before and after the study with participants describing enjoying their work after the NARM training as well as have increased confidence in the work they do, feeling supported by NARM, and engaging in more effective work since completing the NARM training.

The responses of participants and their accompanying scores at the time of the study indicate that they are experiencing professional quality of life. NARM trained trauma therapists are uniquely prepared by the NARM professional trauma training with an understanding of the dynamics of complex trauma and how to address the specific needs of complex trauma survivors. It could be concluded that previous education and training had not adequately prepared them for work with this population. The NARM training provides NARM trained trauma therapists the education, skills, and training needed to be better prepared for their work with trauma survivors. It could be further concluded that NARM provides the elements necessary for trauma therapists to be able to work with complex trauma survivors in a way that is enjoyable, effective, and may be more sustainable.

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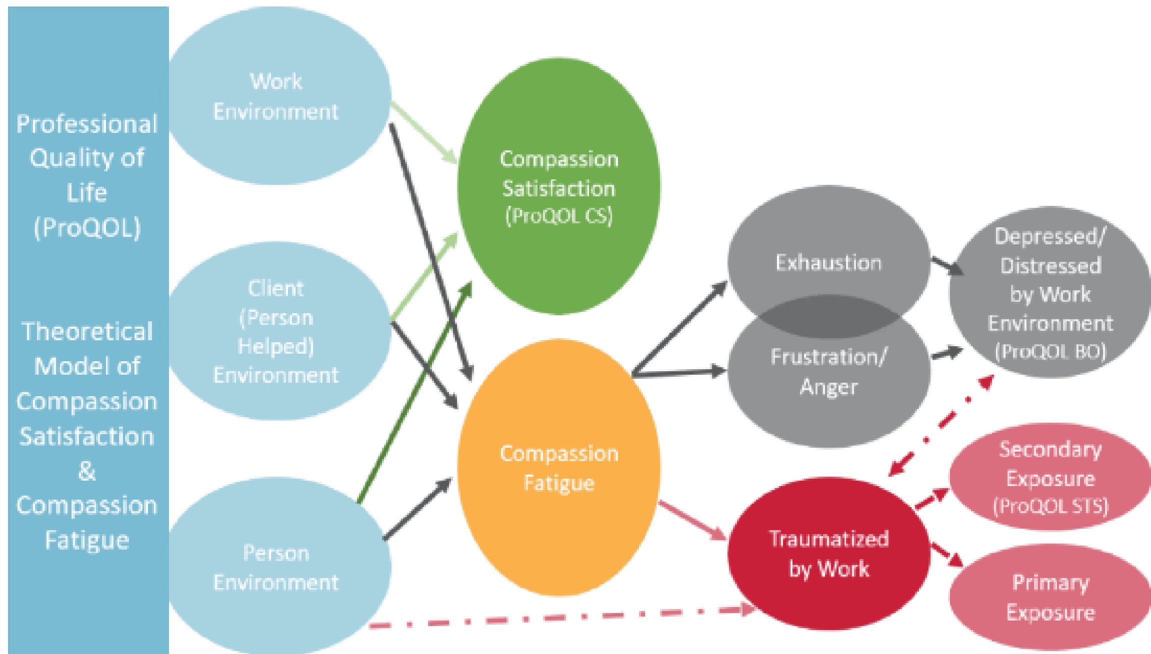
APPENDICES

Appendix A: Diagram of Professional Quality of Life

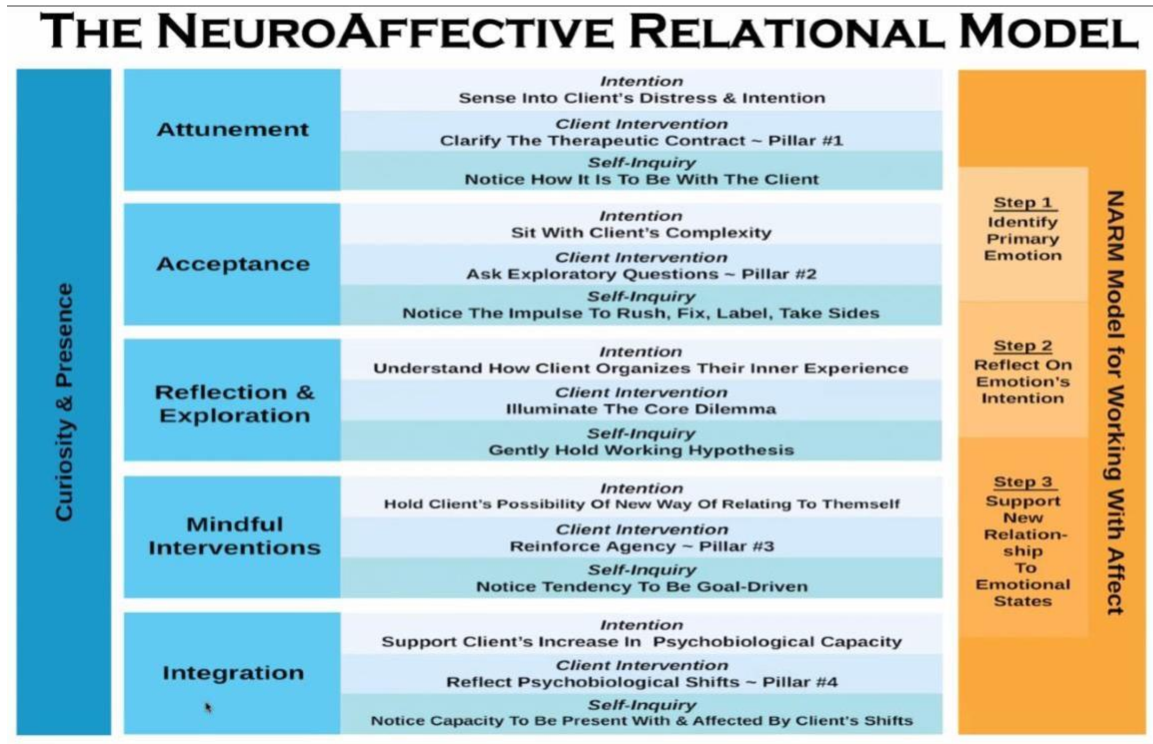
Reprinted from *Professional Quality of Life Measure*, by B.H. Stamm, 2010. https://proqol.org/Compassion_Satisfaction.html.

Appendix B: Theoretical Path Analysis



Reprinted from *Professional Quality of Life Measure*, by B.H. Stamm, 2010.
https://proqol.org/Full_CS-CF_Model.html

Appendix C: The NeuroAffective Relational Model



Reprinted from *NARM Training Manual*, by L. Heller & B. Kammer, 2020.

Appendix D: The Semi-Structured Interview Guide

1) Describe your work as a trauma therapist since completing the NARM training.

(I'm going to ask you some questions about both any positive and any negative aspects of being a trauma therapist. I don't want to assume anything about your experiences so if you have not experienced something, please feel free to let me know.)

2) How do you feel about being a NARM trained trauma therapist?

3) Tell me any positive aspects of your work as a NARM trained trauma therapist.

4) Tell me a professional success story.

5) Describe some of the beliefs you have about your work as a NARM trained trauma therapist.

6) Tell me about any difficult aspects of working with trauma survivors.

7) Describe any ways that working with trauma survivors has affected you.

8) Tell me about working with challenging clients before and after becoming a NARM trained trauma therapist.

9) Tell me about any consequences of working with trauma survivors that you've experienced personally.

10) Describe any differences in how your work impacts you since becoming a NARM trained trauma therapist.

Appendix E: Quantitative Survey Questions

1) What professional license(s) do you hold?
    a) LMSW/LSW
    b) LCSW
    c) LCSW-S
    d) LPC
    e) LPC-I
    f) LMFT
    g) None
    h) Other: ___________

2) How many years have you been a NARM Therapist?_________years

3) How long have you been a trauma therapist?________years

4) What other trauma models are you certified in? (Check all that apply)
    a) Somatic Experiencing
    b) Somatic Experiencing®/Trauma Resiliency Model™ (SE/TRM)
    c) EMDR
    d) TF-CBT
    e) Cognitive Behavioral Therapy (CBT)
    f) Cognitive Processing Therapy (CPT)
    g) Cognitive Therapy
    h) Prolonged Exposure Therapy
    i) Brief Eclectic Therapy
    j) Narrative Exposure Therapy
    k) None
    l) Other: ___________

5) What gender do you identify with?
    a) Male
    b) Female
    c) Transgender
    d) Non-binary
    e) Other: _____________

6) How do you describe your race/ethnicity?
    a) Caucasian/white
    b) African American/black
    c) Hispanic/Latino
    d) Asian
    e) Multi-racial
    f) Other: __________

7) What is your age? _______

8) What is your highest level of education
   a) Some high school
   b) High school
   c) Some college
   d) Bachelors degree
   e) Masters degree
   f) Doctorate
   g) PhD
   h) Technical or vocational certificate

9) What field is your highest degree in?
   a) Social Work
   b) Counseling
   c) Psychology
   d) Marriage and Family Therapy
   e) Other ____________________

10) What city and state do you live in? ____________________

Appendix F: ProQOL 5

PROFESSIONAL QUALITY OF LIFE SCALE (PROQOL)

COMPASSION SATISFACTION AND COMPASSION FATIGUE
(PROQOL) VERSION 5 (2009)

When you *[help]* people you have direct contact with their lives. As you may have found, your compassion for those you *[help]* can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *last 30 days*.

1=Never	2=Rarely	3=Sometimes	4=Often	5=Very Often

______ 1. I am happy.
______ 2. I am preoccupied with more than one person I *[help]*.
______ 3. I get satisfaction from being able to *[help]* people.
______ 4. I feel connected to others.
______ 5. I jump or am startled by unexpected sounds.
______ 6. I feel invigorated after working with those I *[help]*.
______ 7. I find it difficult to separate my personal life from my life as a *[helper]*.
______ 8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I *[help]*.
______ 9. I think that I might have been affected by the traumatic stress of those I *[help]*.
______ 10. I feel trapped by my job as a *[helper]*.
______ 11. Because of my *[helping]*, I have felt "on edge" about various things.
______ 12. I like my work as a *[helper]*.
______ 13. I feel depressed because of the traumatic experiences of the people I *[help]*.
______ 14. I feel as though I am experiencing the trauma of someone I have *[helped]*.
______ 15. I have beliefs that sustain me.
______ 16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.
______ 17. I am the person I always wanted to be.
______ 18. My work makes me feel satisfied.
______ 19. I feel worn out because of my work as a *[helper]*.
______ 20. I have happy thoughts and feelings about those I *[help]* and how I could help them.
______ 21. I feel overwhelmed because my case [work] load seems endless.
______ 22. I believe I can make a difference through my work.
______ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.
______ 24. I am proud of what I can do to *[help]*.
______ 25. As a result of my *[helping]*, I have intrusive, frightening thoughts.
______ 26. I feel "bogged down" by the system.
______ 27. I have thoughts that I am a "success" as a *[helper]*.
______ 28. I can't recall important parts of my work with trauma victims.
______ 29. I am a very caring person.
______ 30. I am happy that I chose to do this work.

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Appendix G: Participant Recruitment E-mail

You are receiving this e-mail because you have completed the NARM Practitioner Training. NARM Therapist Jennifer Vasquez, LCSW-S is seeking participants for a research study for her dissertation. This study aims to explore the experience of NARM trained trauma therapists. The study seeks to understand the phenomenon of the quality of life of NARM trained trauma therapists. The study will inquire about trauma therapists' experience through one virtual interview.

Interested participants must be trauma therapists who have completed the NARM Practitioner Training and have 2 years of experience working with the NARM model.

Participants will be asked to complete a consent to participate in the study, complete an online survey with 10 demographic questions and 30 questions about your professional quality of life, and attend one interview as part of the study during which you will be asked questions about your experience with the NARM model. It is anticipated that this interview will last between 60-90 minutes. This interview will be recorded and transcribed. All participants' information including recordings and transcriptions will be stored in a secure location to assure confidentiality. Participation in this study is voluntary. Participants can withdraw from this study at any time without penalty.

If you are interested in participating in this research study, please e-mail Jennifer Vasquez at javasquez19fl@ollusa.edu to schedule the interview.

If you have questions about this research, please contact Jennifer Vasquez at javasquez19fl@ollusa.edu.

The supervising professor of this research study is Dr. Alicia Hawley-Bernardez who can be contacted at achawley-berna@ollusa.edu.

If you experience any adverse psychological effects of participating in this research study, you can find support available at:

https://directory.narmtraining.com/

https://www.psychologytoday.com/us

https://directory.traumahealing.org/

Thank you,

Jennifer Vasquez, LCSW-S

Our Lady of the Lake University, Worden School of Social Work

This project was approved by the OLLU IRB on 7/23/21. Pertinent questions or concerns about the research, research participants' rights, and/or research-related injuries to participants should be directed to the IRB (irb@ollusa.edu)

Appendix H: IRB Approval Letter

OUR LADY OF THE LAKE UNIVERSITY

NOTICE OF APPROVAL

Approved: ☐ at a Convened Meeting ☒ by Expedited Review and Approval

Approval Date: 07/23/2021 Expiration Date: 07/22/2022

PI Name: Jennifer Vasquez Bernardez Faculty Advisor: Dr. Alicia Hawley-

Title of Study: MEANING MAKING: UNDERSTANDING PROFESSIONAL QUALITY OF LIFE FOR NEURO-AFFECTIVE RELATIONAL MODEL TRAINED TRAUMA THERAPISTS. **If applicable please contact your advisor for further instructions.**

Provisions:
Upon receipt of this letter, and subject to any provisions listed above, you may now begin this research. This approval, contingent upon compliance with the following stipulations, will expire as noted above.

CHANGES – The PI must receive approval from the IRB before initiating any changes, including those required by the sponsor, which would affect human subjects. Such changes include changes in methods or procedures, numbers or kinds of human subjects, or revisions to the informed consent document or process. In addition, co-investigators must also receive approval from the IRB. In addition, the PI will notify the IRB as to the disposition of the research upon leaving the institution.

UNANTICIPATED RISK OR HARM, OR ADVERSE DRUG REACTIONS – The PI will immediately inform the IRB of any unanticipated problems involving risks to subjects or others, of any serious harm to subjects, and of any adverse drug reactions. For applicable research, this notification may be accomplished by sending copies of reports filed with the sponsor/the FDA.

RECORDS – The PI will maintain adequate records, including signed consent documents if required in a manner which ensures confidentiality. With the exception of review by such Federal agencies as HHS or the FDA, IRB policy relating to maintenance of subject confidentiality will be followed during any monitoring/verification of data by an outside agency or sponsor. Such records may also be used during any necessary internal investigation.

SUBSEQUENT REVIEW – The PI will respond promptly to IRB review requests, which will occur once a year until the expiration date noted above. Approved protocols are subject to monitoring by the IRB. The IRB has the authority to inspect any research records and practices associated with this protocol at any time. If you have questions about IRB procedures or monitoring or need assistance from the Board, please contact the Board at IRB@ollusa.edu or (210) 434-6711 extension 2402.

Copy: ☒ _OLLU IRB

IRB

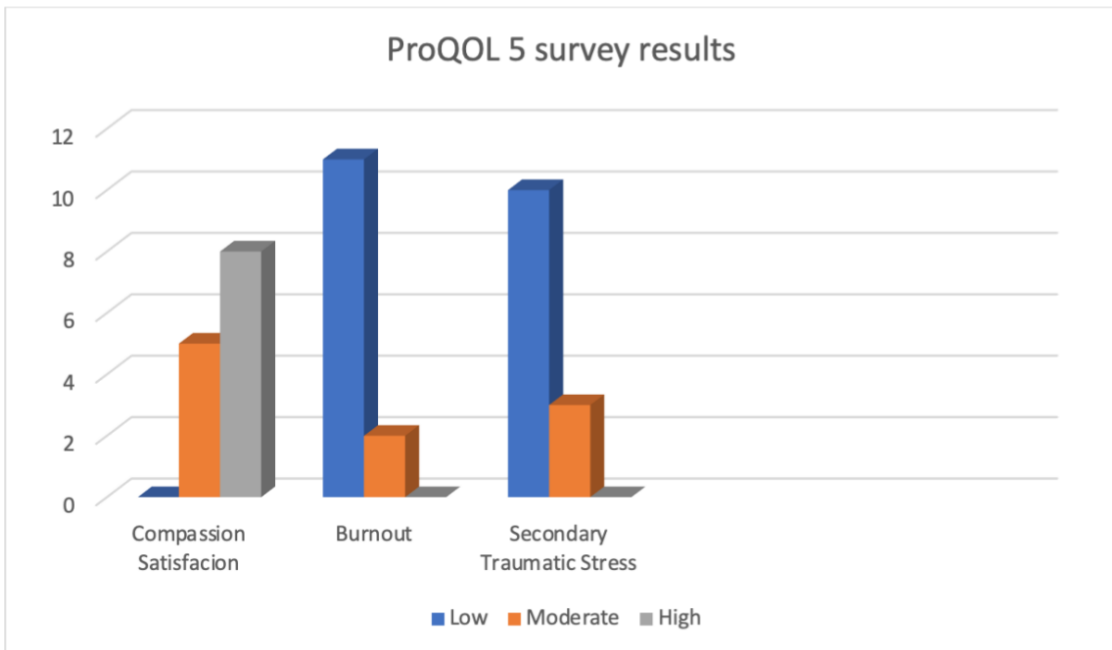
Chair

Appendix I: Table of Themes

Emergent themes	Original transcript
More Effective Work	"I've worked with a lot of clients who in one session, say that in this session, they've had more change than in 15 years of doing talk therapy previously." "NARM really deepens my ability to do much more effective work." "I feel like the work I'm doing is effective, it gives me a certain degree of job satisfaction that I didn't have in all my other trainings"
Enjoying their Work	"I really enjoy it when I see NARM clients on my schedule, I'm very excited." "My work is much more fulfilling and satisfying, being a NARM-trained therapist, it's deeply satisfying to know that I have supported someone or helped someone in a way that has the capacity to change their lives. You know, sometimes I feel like I would do this for free. I mean, it's so much fun, and then they pay me at the end. I think it's just— I can't believe it that I actually have come to a career and a modality that is so deeply satisfying that it doesn't even feel like work a lot of the time." "I think before being trained in NARM I felt such a personal responsibility to fix people that I was burning myself out. Actually, yeah, as I think about it—I've been trained in NARM for so long, I forget who I was before now. But as I reflect back, I remember thinking, like, I picked the wrong profession, or this might not be for me, and because I was so exhausted trying to fix people. And I think after NARM, I actually really enjoy the work now."
Support for the Therapist	"There's no way I could have worked with this population, and the number of people I'm working with prior to NARM. So, not only is the modality effective, but it also supports me in being able to do the work and sustain it." "I believe NARM is not only a model for helping other people heal, but I think there's an emphasis on supporting the therapist. I don't know how you can support healing if the emphasis isn't on both the therapist and the client." "I've remained engaged in the community, and so there's a lot of intentional ways the NARM community and Institute has created support for those in this community and so it seems different than other trainings, in my opinion, what I've noticed is that, you know, there's ways to stay engaged, such as the inner circle, the podcast,

	the consultation groups, the continued training, and it just seems like they are relational to me, that's how I take them in. I know not everyone will have the same experience. They don't feel corporate, they feel more like connecting, and it feels to me like there's an intention to set up community, and I really value that."
Increased Confidence	"It's been really beneficial. So, certainly, my confidence has increased significantly, maybe even dramatically as a therapist." "It just allowed me to feel more confident and believe that I can be effective in supporting people and working on healing their developmental trauma." "After becoming a NARM-trained therapist, I just feel so much more confident and competent." "Since the NARM training, I noticed that I feel a lot more confident." "It really helped me a lot to feel much more confident and comfortable in working with complex trauma."

Appendix J: ProQOL 5 Survey Results



Appendix K: Glossary

Burnout: Burnout is associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively. These negative feelings usually have a gradual onset. They can reflect the feeling that your efforts make no difference, or they can be associated with a very high workload or a non-supportive work environment (ProQOL, 2021).

Complex trauma: Complex trauma describes both children's exposure to multiple traumatic events—often of an invasive, interpersonal nature—and the wide-ranging, long-term effects of this exposure. These events are severe and pervasive, such as abuse or profound neglect. They usually occur early in life and can disrupt many aspects of the child's development and the formation of a sense of self. Since these events often occur with a caregiver, they interfere with the child's ability to form a secure attachment. Many aspects of a child's healthy physical and mental development rely on this primary source of safety and stability (NCTSN, 2021).

Complex Post Traumatic Stress disorder (C-PTSD): The diagnosis Complex PTSD describes the symptoms of long-term trauma. Such symptoms include Behavioral difficulties (impulsivity, aggressiveness, sexual acting out, alcohol/drug misuse and self-destructive behavior); Emotional difficulties (affect lability, rage, depression, and panic); Cognitive difficulties (dissociation and pathological changes in personal identity); Interpersonal difficulties (chaotic personal relationships); Somatization (resulting in many visits to medical practitioners) (Herman, 1988).

Compassion fatigue: Compassion fatigue is the negative aspect of our work as helpers. There are two parts. The first part concerns things such as exhaustion, frustration, anger and depression typical of burnout. Secondary Traumatic Stress is a negative feeling driven by fear and work-related trauma. It is important to remember that some trauma at work can be direct (primary) trauma. In other cases, work-related trauma be a combination of both primary and secondary trauma. Compassion fatigue is the negative aspect of helping those who experience traumatic stress and suffering (ProQOL, 2021).

Compassion satisfaction: Compassion satisfaction is about the pleasure you derive from being able to do your work. For example, you may feel like it is a pleasure to help others through what you do at work. You may feel positively about your colleagues or your ability to contribute to the work setting or even the greater good of society through your work with people who need care (ProQOL, 2021).

Developmental trauma: Developmental Trauma is a term used to describe childhood trauma such as chronic abuse, neglect or other harsh adversity in their own homes. When a child is exposed to overwhelming stress and their caregiver does not help reduce this stress, or is the cause of the stress, the child experiences developmental trauma (van der Kolk et al., 2009).

Professional quality of life: Professional quality of life is the quality one feels in relation to their work as a helper. Both the positive and negative aspects of doing your work

influence your professional quality of life. People who work helping others may respond to individual, community, national, and even international crises. They may be health care professionals, social service workers, teachers, attorneys, police officers, firefighters, clergy, transportation staff, disaster responders, and others. Understanding the positive and negative aspects of helping those who experience trauma and suffering can improve your ability to help them and your ability to keep your own balance (ProQOL, 2021).

Secondary traumatic stress: Secondary traumatic stress is an element of compassion fatigue (CF). It is related to Vicarious Trauma (VT). STS is about your work-related, secondary exposure to extremely stressful events. For example, you may repeatedly hear stories about the traumatic things that happen to other people, commonly called VT. If your work puts you directly in the path of danger, such as being a soldier or humanitarian aid worker, this is not secondary exposure; your exposure is primary. However, if you are exposed to others traumatic events as a result of your work, such as in an emergency room or working with child protective services, this is secondary exposure. The symptoms of STS are usually rapid in onset and associated with a particular event. They may include being afraid, having difficulty sleeping, having images of the upsetting event pop into your mind, or avoiding things that remind you of the event (Stamm, 2021).

Vicarious trauma: Vicarious trauma is the emotional residue of exposure that counselors have from working with people as they are hearing their trauma stories and become witnesses to the pain, fear, and terror that trauma survivors have endured. It is a state of tension and preoccupation of the stories/trauma experiences described by clients. (American Counseling Association, 2021).