Trauma-informed interventions in social work: ethical grounding, philosophical reflections, and interdisciplinary practices

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Abstract: The article discusses philosophical counselling as a tool for developing personal resilience and examines its impact on coping with life challenges. In recent decades, people have faced numerous global changes, including pandemics, natural disasters, and economic shifts, making the issue of personal resilience more critical than ever. Personal resilience is defined as the ability to cope, recover, and grow from crises, consisting of cognitive, emotional, and behavioral components. The paper presents philosophical counselling as a unique approach to enhancing personal resilience, differing from other therapeutic approaches such as psychotherapy. Philosophical counselling focuses on the analysis of ethical and moral issues, aiming to empower self-awareness and foster critical thinking and mental flexibility. The article explores key philosophical approaches, such as Stoicism, Socratic philosophy, and Existentialism, which reinforce a sense of self-control, finding meaning in life, and mental adaptability. This study examines the impact of a philosophical counselling

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workshop on three dimensions of personal resilience: comprehensibility, manageability, and meaningfulness. The findings show significant improvement in these areas, particularly in the manageability dimension. The results support the notion that philosophical counselling can contribute to strengthening personal resilience, primarily by enhancing the ability to understand life situations and give them meaning. Trauma-informed care is a vital paradigm of modern social work, which enforces the imperatives of ethical practice, context-awareness, and human-oriented interventions. In this paper, five trauma-informed interventions—The Sanctuary Model, the ARC Framework, Narrative Exposure Therapy, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), and Somatic Experiencing—are examined interdisciplinary in a synthesis of counseling theory, ethics, and philosophy. Each intervention is discussed regarding its theoretical framework, practical application, ethical concerns, and philosophical implications. Through the blending of practice and reflection, this paper encourages a paradigm of trauma-informed practice that respects client self-determination, promotes safety, and resists pathologizing narratives. The paper also suggests the importance of cultural awareness, ethical responsibility, and systemic awareness in the processing of individual and collective trauma. Implications for social work education, policy, and practice are discussed, including the importance of interdisciplinary dialogue and reflective practice in the facilitation of trauma-informed practice.

Key-words: trauma-informed care; social work interventions; counseling ethics; narrative therapy; phenomenology of trauma; somatic interventions; ARC framework; interdisciplinary practice; Sanctuary model; ethical reflexivity;

Introduction

In the practice of social work today, trauma is no longer a secondary concern but an organizing principle for understanding the life of clients and creating responsive intervention. The prevalence of complex trauma across the lifespan, particularly in vulnerable and marginalized populations, calls for a shift from traditional deficit-based practice to the

principles of trauma-informed practice (Levenson, 2017; Joseph & Murphy, 2014). Social workers are finding themselves more and more working with clients who have been affected by interpersonal violence, systemic oppression, migration, poverty, or childhood trauma, which can cause profound psychological distress. Trauma-informed social work is therefore not just a specialized niche; it's an underlying stance that shapes ethical, philosophical, and relational dimensions of practice (Bent-Goodley, 2019). The ethical responsibility to trauma-informed care is based on the profession's core values: respect for human dignity, self-determination, and justice. Trauma-informed practice challenges the traditional expert-client roles, requiring instead collaborative, safety-oriented, and empowering relationships (Knight, 2015). It also emphasizes the practitioner's responsibility to avoid re-traumatization and to engage their own affective responses to trauma work reflectively (Cunningham, 2003; Ben-Porat & Itzhaky, 2015). The literature here indicates the risk of secondary traumatization and burnout for trauma social workers, and it emphasizes the importance of ethical supervision, organizational learning, and backup systems (Ben-Porat, 2017; Vîşcu & Rad, 2024a; 2025a).

The utility of trauma-informed care does not stop within the clinical sphere, but expands to interdisciplinary practice areas such as counseling, ethics, and philosophy. Philosophical theories such as phenomenology and hermeneutics influence our understanding of the subjective nature of trauma, while ethical theories—such as care ethics or virtue ethics—shed light on the moral demands placed on practitioners working in high-emotional-stakes environments. Trauma is not only a psychological condition but an embodied, lived, and socially mediated phenomenon that necessitates integrative responses (Strand et al., 2014; Knight, 2015). The convergence of trauma with systemic injustice, ethical complexity, and relational interdependence calls for a multidimensional perspective, best articulated within interdisciplinary research paradigms such as those fostered by counseling ethics and philosophical reflection (Runcan et al., 2025; Vîşcu & Marici, 2025). Recent arguments have been presented concerning the role of process models and reflective supervision in sustaining social workers' well-being as well as trauma-informed care quality (Vîşcu & Rad, 2024b; Vîşcu et al., 2025). Organizational models centered on learning, ethical duty, and supervision were identified as resistant to vicarious trauma and supporting resilience (Vîşcu & Rad,

2025b; Vîşcu et al., 2025). These are not merely administrative niceties but ethical requirements in trauma-informed care systems. Last but not least, trauma-informed social work is a practice methodology and an ethical-philosophical position—one that cuts across psychology, counseling, social policy, and moral reasoning. By situating trauma in broader contexts of meaning-making, relational processes, and organizational culture, practitioners can move toward a more empathic, evidence-based, and ethically reflective model of care.

Theoretical and ethical foundations

Trauma-informed practice is guided by a philosophy that is not only focused on clinical effectiveness but also ethical practice and philosophical insight. Far beyond a checklist of procedural guidelines, trauma-informed practice integrates an in-depth understanding of the widespread impact of trauma with a deliberate commitment to healing relationship-based, organizational, and professional ethics (Kimberly & Parsons, 2017; Knight, 2019). Core values—safety, trustworthiness, choice, collaboration, and empowerment—are the foundation of this approach, simultaneously clinical requirements and ethical demands (Mersky et al., 2019).

Physical and emotional safety is critical in creating spaces where clients can begin the healing process. Trustworthiness and transparency foster accountability and dependability on the part of the social worker. Choice respects client autonomy, particularly vital for survivors of trauma whose agency may have been compromised. Collaboration acknowledges the built-in power inequality of social work, whereas empowerment is strengths-focused, resilience-promoting support (Knight, 2019; Jirek, 2017). They are not operation principles alone; they are signs of a highly humanistic and ethical way with others, especially those who have endured the impact of trauma (Ross et al., 2023).

Trauma-informed social work, ethically, employs a number of moral styles. Deontological ethics, which are based on duty and general moral obligations, steer the professional practice of social workers towards justice and non-maleficence. Ethics of care, however, emphasize relationally, empathy, and sensitivity to other persons' vulnerability—features particularly important in working with survivors of trauma (Wilkin & Hillock, 2014). Social justice demands that practitioners not just

attend to healing at the level of the individual but also at the level of structural trauma wrought by colonization, systemic oppression, and intergenerational violence (Masson & Smith, 2019; Suarez, 2016). Ethical trauma-informed practice must thus balance attention to micro-level interpersonal relationships with attention to macro-level sociopolitical forces. The philosophical foundations of trauma-informed social work enrich and deepen it. Phenomenology, both as worldview and as approach, offers tools for working with survivors of trauma on their own terms without robbing them of symptomology or diagnosis. It encourages a "being-with" practice, based on openness to clients' subjective worlds (Pascal, 2010; Welch, 1999). Hermeneutics supports this by highlighting the importance of narrative, interpretation, and meaning in therapy (Newberry-Koroluk, 2014). As Jirek (2017) notes, the narrative reconstruction can be a powerful process of post-traumatic growth, in which survivors reconstruct their life narratives and identity through dialogical exchange. Furthermore, existentialist philosophy introduces a conceptualization of trauma as a confrontation with profound human questions—meaning, freedom, death, loneliness. Existentialist social work recognizes clients as more than cases but as human beings searching for meaning amidst despair (Nilsson, 2018; Thompson, 2017; Dixon, 2010). This perspective prepares practitioners to accompany clients in despair and uncertainty, recognizing their strength without avoiding their suffering. In its integration of these frameworks, trauma-informed practice is not merely an approach to intervention, but a moral-epistemological positionality toward practice—a one that welcomes social workers into ethical self-awareness, philosophical sophistication, and unyielding respect for the dignity and intricacy of human existence. The intersection of phenomenology, care ethics, social justice, and existential philosophy within trauma-informed care offers a uniquely interdisciplinary foundation, situating social work as at once clinical and moral work.

Methodological framework

The selection of trauma-informed models in this paper is both clinically appropriate and ethically-philosophically sound with contemporary social work practice. The five models to be discussed here—The Sanctuary Model, the ARC Framework, Narrative Exposure Therapy,

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), and Somatic Experiencing—were specifically chosen based on their interdisciplinary, empirical origins, and translatability across populations and settings. All interventions speak to trauma not just as a clinical presentation but as a relational, embodied, and socially situated phenomenon, in keeping with the ethical and philosophical underpinnings delineated earlier.

The Sanctuary Model, through its organizational focus, demonstrates how trauma-informed moves beyond individual interaction to reshape institutional culture care. Similarly, the ARC Framework is both relationally oriented and developmentally sensitive, offering an adaptive model for working with children and adolescents who have endured chronic adversity. Narrative Exposure Therapy is testimony- and meaning-making-oriented, highly congruent with hermeneutic and phenomenological traditions. TF-CBT remains one of the well-supported treatments for trauma, with inherent developmental level sensitivity, caregiver involvement, and cognitive restructuring. Lastly, Somatic Experiencing is an important step toward body-centered interventions, concentrating on autonomic regulation and embodied trauma—areas far too often neglected in mainstream talk therapies. These treatments were selected not only for their empirical evidence, but because they form an ethical practice consistent with the values of trauma-informed care: safety, trust, collaboration, empowerment, and cultural humility. Accordingly, their selection is justified on a combination of clinical effectiveness, theoretical coherence, and ethical congruence.

The critical approach applied to these interventions is explicitly interdisciplinary. It is informed by the ethics of care, which prioritizes relational responsibility, attention to vulnerability, and contextual judgment over ethics. This model rejects abstract, Universalist ethics for a rich appreciation of interpersonal complexity—something that is particularly required in trauma work, where power imbalance, trust damage, and emotional vulnerability are all pervasive (Wilkin & Hillock, 2014; Ross et al., 2023). Furthermore, the values of client autonomy underpin the evaluative principles. Trauma also consists of helplessness, coercion, and damaged agency. Interventions, consequently, not only should not reestablish these processes but must have to re-reclaim the client's agency and authorship. Theories like TF-CBT and Narrative Exposure Therapy, for example, embed decision-making, pacing, and

narrative creation in the process of treatment, validating agency and engagement (Jirek, 2017; Knight, 2019). Cultural competence is also a non-negotiable component of the model. Trauma does not exist in isolation; it is experienced, controlled, and recovered through culturally mediated frames. Interventions must be attuned to local values, collective narratives, and historical traumas (Suarez, 2016; Masson & Smith, 2019). The models that have been discussed vary in their flexibility, but all offer the potential for cultural adaptation when done with humility and awareness. Briefly, then, the methodological decision here is a reflective blend of evidence-based practice and ethically discriminate judgment. It requires trauma-informed care to be not just clinically effective but also morally attentive, relationally astute, and culturally astute, being an exemplification of the very values it espouses.

Five trauma-informed interventions in social work practice

Trauma-informed interventions vary in modality, scope, and orientation but share a common dedication to creating safety, empowerment, and resilience. The following five approaches—each originating from diverse theoretical paradigms—illustrate how social work can operationalize trauma-informed principles in practice while being ethically aware and culturally responsive.

A. Sanctuary Model

The Sanctuary Model, developed by Sandra Bloom and her collaborators, is a well-developed trauma-informed organizational change model, originally designed for mental health and social service organizations. Based on trauma theory and systems theory, the model contends that trauma is not solely an intra-psychic phenomenon (confined to the individual psyche) but is also significantly institutional and systemic, manifesting through organizational practices, relational dynamics, and institutional cultures (Bloom & Sreedhar, 2008; Bloom, 2013). As a result, the model perceives organizations as living systems wherein all of the components—leadership, staff relationships, policies, and routines—are involved either in the ongoing perpetration of trauma or the promotion of healing and recovery. Essentially, the Sanctuary Model establishes a paradigm shift in how institutions acknowledge and react to client and

staff experiences of trauma. It offers a model based on seven primary commitments: non-violence, emotional intelligence, inquiry and social learning, shared governance, open communication, social responsibility, and growth and change (Bloom et al., 2003). The commitments are not stand-alone values but are interdependent principles whose aim is to dismantle authoritarian hierarchies, facilitate inclusive decision-making, and institutionalize reflective practice into the framework of daily activity (Clarke, 2013). The implementation process is cultural and structural. It requires system-wide integration of trauma-awareness into all levels of organizational functioning, including staff recruitment, supervision, communication styles, and discipline. For example, staff are taught about the impact of trauma not only on clients but also on themselves and their colleagues, thereby avoiding burnout and vicarious traumatization (Esaki et al., 2014). Decision-making is made more transparent and participatory, and reflective arenas are institutionalized to facilitate continued learning and adaptation (Galvin et al., 2021). Interestingly, the Sanctuary Model is applied to indirect care staff as well, with the belief that all staff—not only clinicians—affect the organizational climate and client outcomes.

Ethically, the model resonates profoundly within the ethics of care, most specifically in its emphasis on relational responsibility, mutual respect, and safety. By addressing power imbalances within organizations, the Sanctuary Model establishes psychological safety in order for staff and clients alike to be seen, heard, and valued (Bloom, 2018). The ethical dimension of the model is particularly evident in settings such as child welfare and anti-trafficking, where moral injury, exploitation, and dehumanization by systems are the norm. In these situations, Sanctuary supports the creation of moral systems—those organizational cultures that prioritize dignity, rights, and collective well-being (Bloom, 2018).

Outcomes associated with the use of the Sanctuary Model include improved staff cohesion, client engagement, and reductions in behavioral incidents, particularly in residential and out-of-home care settings. A growing body of literature attests to its positive impact on trauma recovery, organizational resilience, and workplace culture (Galvin et al., 2021; Bloom, 2013). Nonetheless, execution remains resource-intensive and complex, often requiring years of consistent training, leadership buy-in, and cultural realignment. Among the primary challenges is resistance to change, especially in organizations with rigid hierarchies or punitive

disciplinary cultures (Galvin et al., 2021). Additionally, sustainability is undermined without continued reflection, reinforcement, and institutional commitment. Overall, the Sanctuary Model is more than a clinical intervention; it is a wide-ranging, ethically grounded blueprint for trauma-informed system change. It asks organizations to model the same principles they advocate for their clients—non-violence, respect, empowerment, and relational accountability—and in doing so, is a model of trauma-informed ethics-in-action.

B. ARC Framework (Attachment, Self-Regulation, and Competency)

The ARC Framework, developed by Blaustein, Kinniburgh, and others, is a trauma-informed, developmental-relational model specifically for the treatment of children and adolescents with complex trauma. Developed from attachment theory, neurodevelopmental science, and ecological systems theory, the model was designed to treat the pervasive disruptions in development caused by chronic, interpersonal trauma, especially when exposure occurs early in life (Hodgdon et al., 2013; Arvidson et al., 2011). ARC relies on three core domains of intervention—Attachment, Self-Regulation, and Competency—each supporting a primary area of developmental functioning most often disrupted in traumatized children (Grant, 2013; Hodgdon et al., 2016). The attachment domain is focused on the development of caregiver-child relationships, enhanced attunement, and improved emotional availability in caregiving systems. Self-regulation strategies target emotional and behavioral modulation and enable adolescents to develop awareness of their internal states and build strategies for calming and focusing. The competency domain targets developing skills in executive functioning, problem-solving, identity formation, and relational engagement to foster adaptive living in life domains. A characteristic of ARC is its flex and grow ability. The model has been successfully translated to several environments—residential treatment centers, community, and juvenile justice system settings—with modifications appropriate to setting and population (Fehrenbach et al., 2022; Collin-Vézina et al., 2019). Its modular design allows clinicians to address domains in a manner that focuses on areas according to client readiness and available organizational capability, providing for feasibility within systems with varying degrees of awareness of trauma and clinical expertise. Morally, ARC is deeply rooted in the care ethics, specifically

honoring developmental timing, relational safety, and responsiveness to vulnerability. Rather than requiring static, manualized treatment protocols, ARC calls upon clinicians to engage with the evolving needs of the child in the environmental context, thereby avoiding retraumatization and over-pathologization. The model underscores the co-regulatory role of caregivers and service providers so as to allow a relational, collaborative, and strengths-based model of healing (Hodgdon et al., 2016). Furthermore, ARC is particularly culturally and contextually sensitive. Arvidson et al. (2011) identify the need for cultural adaptation when applying ARC to multicultural populations, referencing how trauma, attachment, and self-regulation narratives are influenced by socio-cultural norms. The emphasis of the framework on caregiver involvement also supports community integration and family-based care, recognizing that recovery from trauma cannot be accomplished outside of broader social systems.

Empirical studies indicated ARC implementation was linked to favorable outcomes, including better emotional regulation, interpersonal adjustment, resilience, and placement stability (Hodgdon et al., 2013; Hodgdon et al., 2016). Adolescent participants of ARC-based treatment exhibit fewer incidents of behavior, improved relational trust, which means its capacity for reparation of impaired attachment systems and the promotion of developmental abilities needed for sustainable recovery. Despite such strengths, challenges persist. Effective implementation of ARC requires rigorous training, clinical supervision, and organizational commitment, which are difficult to sustain in under-resourced or turnover-prone environments (Fehrenbach et al., 2022). Variability in fidelity and practitioner readiness can affect outcomes and thus ongoing evaluation and reflective practice are essential. Briefly, the ARC Framework is an ethically responsive, trauma-informed, and developmentally sensitive intervention that promotes healing in youth with chronic adversity. Its philosophical grounding in relationally and its ethical emphasis on attunement and empowerment serve to make it an exemplary social work practice for trauma-informed social work in diverse settings.

C. Narrative Exposure Therapy (NET)

Narrative Exposure Therapy (NET) is a short-term, structured, trauma-focused intervention that integrates cognitive-behavioral theory

with hermeneutic and narrative theory, offering an innovative treatment for the psychological and existential consequences of repetitive and complex trauma. Designed for survivors of collective violence and mass trauma, NET relies on the assumption that traumatic experiences are often retained in fragmented and disorganized memory systems, in a way that they generate hyper arousal, avoidance, and intrusive symptoms (Elbert et al., 2022; Robjant & Fazel, 2010). The goal of treatment is to enable clients to reconstruct coherent autobiographical narratives, thereby contextualizing traumatic memories within the broader course of their life story. The treatment involves the development of a chronological narrative, or "lifeline," which maps significant life events—both traumatic and positive—onto a physical or visual timeline. Clients are asked by trained therapists to revisit and recount in detail each traumatic memory and to place those events in an ordered autobiographical context (Schauer et al., 2025; McPherson, 2012). This reconstructed story is not a simple act of storytelling but a deliberate integration of memory, meaning, and identity, reducing the fragmentation and emotional deregulation so typical of post-traumatic stress.

NET has also been adapted for a wide range of populations, including refugees, asylum seekers, survivors of war, children exposed to domestic violence, and survivors of natural disasters and political persecution (Gwozdziewycz & Mehl-Madrona, 2013; Ryan, 2023). An example of an adaptation is KIDNET, which was developed for use with children and adolescents and continues to follow the basic tenets of NET but adapts content and language for developmental appropriateness (Schauer et al., 2025). NET's most important contribution is likely its ethical emphasis on restoring narrative control and voice, squarely aligned with trauma-informed values of empowerment, choice, and dignity. The intervention affirms the client's agency and role as narrator of their experience, undoing the dehumanization and silencing that are part of so many traumatic experiences (Burack-Weiss et al., 2017). The act of observing one's own story—in the context of a safe and affirming therapeutic relationship—carries both psychological and existential value, promoting integration, post-traumatic growth, and renewed meaning. However, ethical use requires complex clinical judgment. Therapists must assess client readiness for narrative exposure and proceed with sensitivity to avoid traumatization. Careful pacing, grounding, and sensitivity to

cultural and contextual factors are necessary, particularly for individuals whose trauma is embedded in collective or intergenerational experiences (McPherson, 2012; Ryan, 2023). Furthermore, therapists must be adequately trained to carry out the process with competence, empathy, and cross-cultural sensitivity. The effectiveness of NET is supported by a growing body of empirical evidence. Systematic reviews and meta-analyses attest to its effectiveness in significantly reducing symptoms of post-traumatic stress disorder (PTSD), especially in populations traumatized by war, displacement, and human rights violations (Grech & Grech, 2020; Gwozdziewycz & Mehl-Madrona, 2013). Studies also revealed that NET is not only successful in reducing symptoms but also encourages social functioning, emotional control, and self-insight (Elbert et al., 2022).

Yet, there remain challenges. Access to NET-trained therapists is limited in most regions, particularly in low-resource or conflict-affected regions. Additionally, the cultural adaptation of life narratives—particularly in collectivist or oral traditions—may entail revision of the standard NET protocol in order to attain relevance and resonance (Burack-Weiss et al., 2017). Additional research is also required into the ways that NET can be integrated into broader systems of care, including child protection, refugee services, and community mental health programs.

In conclusion, NET is an ethically grounded, trauma-informed, and narrative-based intervention that empowers clients through framed storytelling and meaning-making. Its consonance with hermeneutic and cognitive-behavioral theory makes it especially applicable in interdisciplinary trauma care, where healing is understood not only in terms of symptom reduction but also narrative repossession and existential rehabilitation.

D. Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is the widely recognized, manualized, evidence-supported treatment protocol for working with children and adolescents and their caregivers suffering from severe emotional and behavioral distress in the wake of trauma exposure. Cohen, Mannarino, and Deblinger originated TF-CBT. It stems from the theory underlying cognitive-behavioral therapy (CBT), supported by developmentally adaptive psycho-education, affect modulation tactics, and ordered exposure practice (Mannarino et al., 2014; Cohen et al., 2000).

TF-CBT is structured around several core components, all of which are denoted by the acronym PRACTICE: Psycho-education, Parenting skills, Relaxation, Affective expression and modulation, Cognitive coping, Trauma narrative and processing, In vivo mastery of trauma reminders, conjoint child-parent sessions, and Enhancing safety and future development (Deblinger et al., 2011; Cohen & Mannarino, 2015). This modular structure enables clinicians to adapt the intervention to the level of the child's development and the history of trauma, all while ensuring flexibility without compromising fidelity to the model's fundamental structure. Implementation of TF-CBT has been demonstrated to be effective in a range of clinical and community-based settings, and the model has been adapted for individual, family, and group modalities (Deblinger et al., 2016). It is used with children exposed to a broad range of different types of traumas, including sexual abuse, physical abuse, domestic violence, natural disasters, and traumatic loss. Active involvement of caregivers throughout the treatment is one of the central features of TF-CBT and has been shown to be linked with improved child outcomes and more secure relational relationships, especially where there has been attachment disruption or intergenerational trauma (Cohen & Mannarino, 2015). Ethically, TF-CBT is designed to enable client autonomy, informed consent, and emotional pacing—principles that are cornerstones of trauma-informed care. The model interweaves structured intervention with client-driven flexibility, as opposed to overwhelming or traumatizing children with premature exposure to painful memories (Allen & Johnson, 2012). The co-authoring of the story of trauma serves both therapeutic and ethical goals, enabling children to gain a sense of control over naming their experience, re-writing their self, and assimilating trauma into a broader story of life. TF-CBT is among the strongest evidence-based treatments for trauma, with overwhelming evidence proving that it can significantly reduce PTSD symptoms, depression, anxiety, and behavior problems among children (Seidler & Wagner, 2006; de Arellano et al., 2014). TF-CBT is supported by numerous randomized controlled trials and meta-analyses proving its effectiveness for diverse populations ranging from low-income families to racially diverse groups as well as for child welfare-entangled youths. Despite its strength, TF-CBT also has limitations. One of the key concerns is the model's demands for fidelity, which, while essential to guaranteeing

consistency of results, may restrict cultural sensitivity and practitioner flexibility to multifaceted contextual and individual factors (Webb et al., 2014). In such settings with high caseload or limited resources, implementation of the complete PRACTICE components could be difficult, particularly where caregivers are not available or encountering such conditions as poverty, mental illness, or substance abuse (Allen & Johnson, 2012). In addition, while TF-CBT has been successfully adapted to group-based models to promote access, concerns remain regarding psychological safety and individualized treatment in groups—especially among youth with complex trauma histories (Deblinger et al., 2016). With the model expanding internationally, more research is needed to explore cross-cultural applications, local adaptation processes, and the integration of non-Western epistemologies into healing from trauma. In summary, TF-CBT is a foundation of trauma-sensitive clinical practice that bridges cognitive-behavioral processes with moral imperatives such as safety, collaboration, empowerment, and cultural responsiveness. Its strength is its flexible structure—offering a research-tested protocol that serves as the anchor for the child's personalized needs, voice, and developmental trajectory. As trauma-sensitive care expands, TF-CBT will remain a priceless resource, if it is practiced with reflective practice, contextual awareness, and ethical integrity.

E. Somatic Experiencing

Somatic Experiencing (SE) developed by Peter Levine is body-oriented trauma treatment that deviates from normative psychotherapeutic approaches in the sense that it is not interested in cognitive processing or verbal remembering, but in the neurophysiological regulation of trauma. In essence, SE conceives of trauma as an autonomic nervous system deregulation rather than a purely psychological or cognitive disturbance. In this model, traumatic memories overfull the body's usual functioning to regulate arousal, leaving the nervous system "stuck" in a constant state of fight, flight, or freeze (Brom et al., 2017; Kuhfuß et al., 2021). Practically, SE causes clients to develop interceptive awareness—the capacity to perceive internal bodily sensations—and gradually discharge stored survival energy in the form of titration. This involves gradual re-exposure to traumatic activation in manageable doses, facilitated by body tracking, sensory anchoring, and mindfulness

interventions (Leitch et al., 2009). Non-verbal approaches by SE make it particularly apt for clients who cannot access or verbalize trauma stories, like children, dissociative clients, or collective and preverbal trauma victims (Özel, 2024; Ranson, 2015). The phenomenological foundation of SE emphasizes presence, embodiment, and lived experience. Rather than employing the body as an object to be controlled or suppressed, SE invites clients to listen to the body's wisdom, establishing a permission and respect relationship between therapist and client. This emphasis on bodily dignity, agency, and consent is in keeping with trauma-informed ethics, particularly when bodily autonomy has been violated (Levit, 2018). By operating below the threshold of conscious narrative, SE makes contact with somatic memory of the trauma so that resolution occurs at the level at which it is likely to be encoded. Ethically, SE's approach shows a high degree of sensitivity to risks of traumatization. Clinicians learn to monitor subtle cues of activation and to prevent overwhelming the client's system. The pacing is considerate of the client's window of tolerance and facilitates gradual re-entry into the body in a safe, graded manner. Such somatic pacing can be especially crucial in populations whose trauma included chronic immobilization or invasion of the body—torture, abuse, medical trauma survivors, for instance. Although continuing to develop its empirical base, mounting evidence verifies SE's effectiveness. A randomized controlled trial conducted by Brom et al. (2017) demonstrated significant symptom reduction in PTSD among SE participants, whereas Leitch et al. (2009) observed improvement among disaster-affected social service workers following Hurricanes Katrina and Rita. Kuhfuß et al. (2021) note in their scoping review that SE has the potential not only to target symptoms of trauma but also broader outcomes such as affect regulation, interpersonal functioning, and overall well-being. However, there are obstacles. SE is extremely intensive training involving prolonged, multi-level education that can be costly and time-consuming. As such, access to SE-trained clinicians is unequal, particularly in underserved or rural populations. Moreover, since SE is founded on a comparatively new paradigm, it is sometimes met with resistance within those systems for which manualized or evidence-based practice is valued, although there is a growing body of qualitative and quantitative evidence (Kuhfuß et al., 2021; Levit, 2018). Aside from that, cultural application of SE principles is also an area requiring ongoing

exploration. The model highlights universal neurobiology regarding trauma, but the development of bodily awareness and its formulation can appear astonishingly different across different contexts. Maintaining somatic treatments in a respectful acknowledgment of differences in body knowledge and performed in a culturally modest fashion is still a persistent issue—a required ethical imperative. Lastly, Somatic Experiencing is a valuable contribution to trauma-informed social work, and it is a modality that honors the body as the central feature of both trauma and healing. With its emphasis on regulation, presence, and consent, SE provides a path of healing that is not based on re-telling trauma but on restoring body safety. As trauma-informed practice becomes increasingly integrative, interdisciplinary, SE is a powerful reminder that the body is not only a site of injury—but also an essential source of healing.

Comparative reflections

The five trauma-informed interventions discussed—The Sanctuary Model, ARC Framework, Narrative Exposure Therapy (NET), Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), and Somatic Experiencing (SE)—offer diverse yet complementary paths to addressing the complex needs of individuals impacted by trauma. While each model is embedded in a distinct theoretical tradition and approach to application, all reflect the basic tenets of trauma-informed care, including safety, trust, empowerment, collaboration, and respect for the client's lived experience.

A common region of convergence among these interventions is their emphasis on the restoration of agency and re-establishing relational trust. Whether through narrative reconstruction (NET), co-regulation and developmental attunement (ARC), organizational culture change (Sanctuary), cognitive restructuring (TF-CBT), or somatic integration (SE), each of these models recognizes trauma as a disruption not only of individual functioning but of intersubjective and systemic relationships. These interventions also overlap in their commitment to minimizing re-traumatization, creating predictability, and pacing therapeutic exposure—elements essential to ethical trauma practice. However, there are considerable dissimilarities in how these models think about trauma and healing. TF-CBT and ARC, for instance, are more structured and manualized, grounded in behavioral and developmental frameworks,

whereas NET and SE are more experiential, narrative, or somatically focused, emphasizing meaning-making and embodied regulation. The Sanctuary Model, in contrast, is at an organizational level, trauma in institutions as systems, rather than individual clinical intervention. These differences reflect broader social work discussions about the balance between evidence-based protocols and context-responsive, relationally focused approaches (Hugman, 2009; Baldwin, 2016). Ethical issues of trauma-informed interventions are multifaceted. Among the foremost concerns is the risk of re-traumatization, particularly with exposure-based or narrative therapies such as NET and TF-CBT. While structured recall can facilitate integration and healing, it can also be overwhelming to clients if the timing is unfavorable or if not coupled with sufficient support. Therapists must maintain ongoing ethical attention, as guided by the client's pacing, readiness, and capacity to tolerate distress. Similarly, informed consent is challenging in vulnerable populations—such as children, individuals with cognitive disability, or clients in child protection or criminal justice systems—where power dynamics can undermine autonomy. In such cases, the therapist must negotiate professional responsibility, legal mandates, and client self-determination (Parton, 2014; Hugman, 2009). ARC and Sanctuary programs solve this by promoting relational authority rather than hierarchical control, embedding ethical sensitivity in systemic practice. Another layer of complexity is cultural and contextual variables. Trauma is not culturally neutral, and interventions are not always transferable. What "healing" is can differ among communities, guided by shared narratives, religious worldviews, historical injustices, and indigenous coping strategies (Haug, 2005). For example, NET's life-narrative framework would need adjustment in oral cultures or collectivist societies where trauma is understood communally, rather than individually. In the same way, somatic practices like SE may interfere with cultural norms regarding body awareness or emotional expression. Also, interventions developed in high-resource settings can prove difficult to implement in under-resourced or over-stretched systems, where staff training, clinical supervision, and reflective practice are limited. This creates a tension between global standards of trauma intervention and local feasibility, echoing long-standing critiques in international social work of the exportation of Western models without adequate contextualization (Haug, 2005;

Baldwin, 2016). To apply trauma-informed interventions both ethically and effectively, then, practitioners are required to engage in critical reflection—a proficiency emphasized in contemporary social work education and practice standards (Staempfli et al., 2015). Critical reflection allows social workers to question assumptions, be responsive to ethical dilemmas in a flexible manner, and adapt interventions in ways that are both empirically driven and culturally sensitive. While varying in scope, approach, and theoretical orientation, every one of the five trauma-informed models examined here offers valuable contributions to social work trauma care. Their ethical application demands contextual sensitivity, reflective practice, and a commitment to justice, especially when practiced across cultural, institutional, and systemic boundaries.

Implications for Social Work Practice

The integration of trauma-informed interventions into contemporary social work practice necessitates an ethical, systemic transformation of policy, education, supervision, and service delivery. Five models addressed in this paper—Sanctuary, ARC, NET, TF-CBT, and SE—provide a multi-dimensional framework for individual and collective recovery. Their use, however, is not a clinical choice but entails structural and cultural transformation of the institutions and systems within which social work is practiced. Trauma-informed practice must become embedded in robust policy frameworks with a focus that positions trauma responsiveness at the center of child welfare, mental health, criminal justice, education, and social protection systems. Compulsory social worker training, funding trauma-specialized services, and regulatory specifications promoting safety, trust, and non-violence are all examples of this. As Rad, Runcan, and Kiss (2025) exemplify in their bibliometric synthesis, the rise of trauma-informed discourse among forensic social work reflects an emerging global recognition of trauma's widespread influence on marginal groups. Policy needs to support trauma-sensitive environments in prisons, probation, and restorative justice—where institutional trauma and systematic violence intersect (Vlai & Rad, 2025). Furthermore, policies have to take cumulative trauma into consideration in rural, marginalized, and institutionally disadvantaged communities where intergenerational and historical adversity goes unseen or goes

untreated (Gavrilă-Ardelean, 2014). Policy institutionalized must embrace the moral call of prevention and early intervention, particularly for youth in family-home type care or in protective custody. Communication, socialization, and trust at the relational level must take top priority in care environments that are residential to preclude further hurt and isolation of children, maintains Gavrilă-Ardelean (2017). Trauma-informed standards folded into accreditation procedures for child and youth care residential homes is an actionable policy mandate. Trauma-informed practice is successful not only due to well-designed interventions but also due to the reflectivity and preparedness of social workers. Practitioners require training that goes beyond theoretical education into embodied, relational, and contextually responsive skills. Due to the emotional intensity of trauma work, clinical supervision must be reconceptualized as a reflective, safety-focused, and developmental process. Dughi (2025) emphasizes the importance of studying historical trauma and collective pain as part of social work education, particularly in societies that are marked by oppression, migration, and violence. Curriculum training should not only comprise empirically based approaches like TF-CBT and ARC, but also critical theory, cultural humility, and somatic, in order to ready practitioners for the subtleties of trauma at the individual and systems level. Supervision systems also need to address vicarious trauma, compassion fatigue, and burnout, all of which are common among those who work with secondary trauma, particularly in under-resourced environments. A trauma-informed supervision model prioritizes safety, self-regulation, and mutual responsibility—consistent with the Sanctuary Model's emphasis on learning-oriented, non-hierarchical organizational cultures. Along with direct clinical intervention, trauma-informed social work must also confront systemic trauma—that is, the internalized injury of poverty, racism, colonialism, institutional violence, and historical injustice. As Dughi (2025) and Costin (2025) note, trauma often transcends individual pathology, as a collective experience based on cultural memory, social institutions, and intergenerational narratives. A trauma-informed systemic care, therefore, requires multi-level interventions of community healing, collective testimony, and culturally based practices of resilience. For example, restorative justice models offer promising alternatives for addressing harm in criminal justice systems while allowing for reparation and healing and without recycling punitive cycles (Vlai & Rad, 2025).

Similarly, culturally embedded rural development and traditional village life practices as documented by Gavrilă-Ardelean (2014) could be the untapped potential to re-embed individuals in meaning, identity, and community affiliation. Lastly, trauma-informed social work practice must move towards collective care practice—one that addresses trauma as a personal and communal wound, and one that is committed to healing through relational, ethical, and socially just practice. This will require long-term investment in practitioners' well-being, policy innovation, cultural competency, and inter-professional collaboration.

Conclusions

This article has explored five trauma-informed interventions—The Sanctuary Model, ARC Framework, Narrative Exposure Therapy (NET), Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), and Somatic Experiencing (SE)—from the combined lenses of theory, ethics, and interdisciplinary social work practice. While each model presents a distinct way of healing trauma, they all resonate with a shared commitment to the re-establishment of safety, relational trust, and client agency that are at the core of effective and ethical care.

Trans diagnostically and across settings, trauma-informed work represents not just best practices but also a values-based and philosophical stance: one that recognizes trauma as an intensely human event that requires care, relational presence, and attention to systems-level dynamics. This method demands more than technical expertise—it demands that practitioners assume an ethic of care, practice critical reflection, and embody principles of justice, dignity, and empowerment. Trauma-informed care, in this way, is greater than a treatment model—it is a revolutionary ethos that transforms social work's very definition of suffering, healing, and professional obligation.

Philosophically, the convergence of phenomenology, existentialism, and hermeneutics in trauma-informed practice attests to the importance of meaning-making, embodiment, and narrative in recovery. Trauma is not just something that has happened to individuals; it is an event that disrupts time, identity, and relation. Interventions thus must take on the whole spectrum of trauma's effects—psychological, physiological, relational, and structural.

In the future, the promise of trauma-informed social work lies in its capacity to be both a responsive and reflective profession. This includes:

- Developing culturally grounded and community-generated extensions of existing models;
- Expanding the scope of somatic and body-based approaches, especially for populations with limited verbal processing capacity;
- Consolidating organizational and policy-level applications of trauma-informed principles in health care, education, child welfare, and justice systems;
- Increasing training and supervisory infrastructures to support practitioner well-being and ethical practice;
- And investment in research bridging theory and practice, including inter-disciplinary examination of the ethical and philosophical foundations of trauma care.

Last but not least, trauma-informed social work is a call to rethink helping relationships not merely as fields of service provision, but as places of ethical encounter, common humanity, and shared healing. In the face of a world beset with rising uncertainty, violence, and structural inequality, trauma-informed care is not only a model of personal resilience, but a blueprint for social change.

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