Introduction

Sara, a 26-year-old woman, was the client (not her real name). Sara moved to Australia with her parents when she was 12. Sara was new to the agency and dealing with a terrible occurrence six months prior. Sara was raped after a night out with pals. She recalls being drugged in a club and waking up the next morning in a lodge room in the same club, her clothing shredded and sexually tortured. Sara has been struggling with the day's events ever since. She had to return to Adelaide and abandon her job in Port Lincoln. Sara is fearful, easily startled, and always on guard. She drinks too much to forget her worries and sometimes drives her car first. She is overcome with remorse and blames herself for coming to the club and getting high. Her nervousness prevents her from sleeping and focusing.

Buchanan and Jamieson (2016) describe sexual abuse as any act directed at another person through compulsion, and they acknowledge that sexual abuses disproportionately harm women. The perpetrator of sexual assault is usually perceived as an attack on the survivor's autonomy and self-worth. According to Haskell & Randall (2019), sexual assault is one of the most traumatising experiences for women. The impact of a sexual assault is determined by various aspects, including the level of physical injury, the length of time it lasts, and the reaction of family and friends. Victims may experience the impact of a sexual assault physically and mentally in both the short and long term (Chivers-Wilson, 2006).

At this first session, my goal as the social worker was to establish safety and stability with the client. A key principle for trauma-informed practice is establishing safety. Trauma informed care (TIC), according to its proponents, aims to provide clients with a secure atmosphere that encourages trust, choice, cooperation, and empowerment across therapy modalities so that they may develop healthy connections with others (Elliott et al., 2005). Social workers are aware that trauma is frequent and that it may have an impact on a person's psychosocial development as well as their ability to cope in the long term (Levenson, 2017).

Working with clients, social workers emphasise strengths rather than pathologies, and they focus on developing healthy abilities rather than merely managing symptoms while they are working with them.

Herman (2015), in his phased-based approach to trauma recovery, argues that the first step of healing is ensuring client safety. An experience that causes detachment and disempowerment is at the root of its effects, and the purpose of any therapy is to re-establish connection and empower the client so that he or she can respond more effectively to future irritants. In order for a client to restore social engagement capacities after a traumatic event has occurred, certain faculties such as autonomy, trust, identity, intimacy, and competency must be re-established and strengthened. The first concept of rehabilitation is empowerment, which is giving the client the ability to make decisions about his or her own recovery (Herman, 2015). Another important element of rehabilitation is regaining control over one's life by diminishing feelings of helplessness, isolation, and harmful behaviour. Another idea is partnership, in which the client benefits from the abilities and expertise of the counsellor while the counsellor avoids abusing his or her position of authority.

According to Herman (2015), rehabilitation occurs through three stages, beginning with safety, progressing through remembering and grieving, and finally reconnecting with regular life. Choosing the right strategy to treatment depends on the stage. A therapeutic technique that is effective in one stage may be damaging in another step. A phased approach is preferable or suited for traumatised patients because appropriate techniques may be employed in each step for maximum efficacy, as opposed to a trauma-focused strategy that is applied immediately after the traumatic event. When it comes to treating post-traumatic stress disorder (PTSD), a research by Van Vliet et al. (2021) found that a phased strategy is preferable to a trauma-focused approach. Furthermore, a phased-based approach focuses more on the therapeutic alliance, interaction, cooperation, and communication between the therapist and the client, as

well as on problems of trust and power dynamics within the therapeutic alliance and the therapeutic relationship (de Boer et al., 2021).

In the case of Sara, the session focused on the first phase which is to establish safety. Establishing safety is significant in that no other therapeutic work can be successful if the safety of the client is not secured adequately. Establishing safety can take days or months. Sara feels unsafe and is always on guard and has severe anxiety issues and blames herself for what happened. To initiate the establishment of safety on the first day, I was determined to ensure Sara felt comfortable and safe physically. Following the recommendations of WHO (2010), I ensured the meeting room was private away from prying eyes and ears. This is significant in ensuring the clients privacy and confidentiality are maintained which is a main way to establish trust. When the client arrived, I greeted her appropriately and showed her to the meeting room which had several comfortable chairs in different areas. I let the client choose where she to sit and where I would sit. This was meant to establish an appropriate space for Sara's safety concerns. I let her scan through the room for a few minutes and then inquired whether she felt safe in the room or we could go to another room.

Additionally, the polyvagal theory's notions that many of the difficulties encountered by human beings may be explained by an autonomic reaction in their bodies to what is happening in their environment were explored. According to Polyvagal theory, the nervous system is divided into three distinct systems: ventral, sympathetic, and dorsal. The hypothesis highlights the cooperative nature of the sympathetic and parasympathetic nervous systems in responding to danger and returning to a calm state once the danger has gone. When these two functions are out of sync, the body is unable to achieve rest (Dykema, 2006). The ventral system assists clients in navigating relationships, and activating this system enables clients to develop more adaptable coping mechanisms (Porges, 2009). The sympathetic nervous system governs the aggressive defence mechanism and the flight or fight response to vexing

conditions. The dorsal system is a withdrawal-based passive defence system. When a traumatic event happens, it has the potential to shut down the systems hierarchically, and when the dorsal system takes control, a dysregulated condition ensues.

In this approach, polyvagal-informed treatment focuses on assisting the client in identifying and overcoming obstacles that prevent them from reaching a balanced state in which the ventral vagal system is in charge. Individuals may only begin their journey back to peace and connection when they are able to recognise their placement on the polyvagal map (Porges, 2017). My focus in the case of Sara was to help her regain a connection with her nervous system and get control over her reaction.

In terms of communication, I used both verbal and nonverbal safety indicators to keep to signal safety to Sara. With Sara, I focused on indicators of safety that might be used to help in the regulation of a situation or event. Prior to anything else, I focused on creating direct eye contact with Sara and looked for evidence of spontaneity in her eyes, which would indicate that she was comfortable and capable of collaborating. The orbicularis oculi muscle, which is part of the social engagement system, is responsible for controlling the movement of the eyes. Given Sara's sense of danger and worry, it was important for me to develop a functional connection with her right away. First and foremost, it was important for me to determine whether Sara felt comfortable and was open to human connection before I attempted to develop a relationship with her.

Prosody was another notion from polyvagal theory that I used to aid with co-regulation, in which I vocalised with attractive articulation and speed in order to help with co-regulation. I paused sequentially to allow Sara to understand and process information and I also took time to listen to what she had to say without interruption. Porges (2011) asserted that listening to warm and melodious tones causes the muscles in the ears to relax, which in turn causes the muscles in the eyes and face to relax as a result. This modifies the middle-ear muscles, allowing

the human voice to be distinguished more effectively from background noise. A deep, resonant tone, on the other hand, may elicit a stress reaction in the client, which will be detrimental to their health. In Sara's instance, I concentrated on using phrases that were soothing and comforting. Also, I attempted to assist Sara in feeling more serene and being able to think more clearly by asking her to select one thing in the room that she could focus on for a few minutes.

Another consideration was the fact that Sara is always on the lookout for signs of danger and is bombarded with signals of defence. As a result, I was quite conscious of my own responses as well as my body language. I concentrated on demonstrating compassion by keeping calm, paying attention to my breathing, and being mindful of my surroundings. Due to Sara's vulnerability to being startled by disturbance outside, I maintained constant awareness of the surroundings to ensure she was secure, peaceful, and favourable to learning.

References

Buchanan, F. & Jamieson, L. (2016). Rape and Sexual Assault, in Wendt & Moulding, (eds) *Contemporary Feminisms in Social Work Practice*. Routledge.

Chivers-Wilson, K. A. (2006). Sexual Assault and Posttraumatic Stress Disorder: A Review of the Biological, Psychological and Sociological Factors and Treatments. *McGill Journal of Medicine, 9*(2), 111-118. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2323517/

de Boer, K., Gnatt, I., Mackelprang, J. L., Williamson, D., Eckel, D., & Nedeljkovic, M. (2021). Phase-based approaches for treating complex trauma: a critical evaluation and case for implementation in the Australian context. *Australian Psychologist*, *56*(6), 437-445. https://doi.org/10.1080/00050067.2021.1968274

Dykema, R. (2006). 'Don't talk to me now, I'm scanning for danger.''How your nervous system sabotages your ability to relate: An interview with Stephen Porges about his polyvagal theory. *NEXUS, March/April*.

Elliott, D. E., Bjelajac, P., Fallot, R. D., Markoff, L. S., & Reed, B. G. (2005). Trauma-informed or trauma-denied: Principles and implementation of trauma-informed services for women. *Journal of community psychology*, *33*(4), 461-477. https://doi.org/10.1002/jcop.20063

Haskell, L., & Randall, M. (2019). *The impact of trauma on adult sexual assault victims*. Justice Canada.

Herman, J (2015) *Trauma and Recovery : The Aftermath of Violence--From Domestic Abuse to Political Terror*, Basic Books

Levenson, J. (2017). Trauma-informed social work practice. *Social work*, *62*(2), 105-113. https://doi.org/10.1093/sw/swx001

Porges, S. (2009). Reciprocal influences between the body and brain in the perception and expression of affect: A polyvagal perspective. In D. Fosha, D.J. Siegel and M. Solomon (Eds.), *The Healing Power of Emotions: Affective Neuroscience, Development and Clinical Practice*, (p.27–55). W.W. Norton and Company, New York

Porges, S. W. (2017). *The pocket guide to the polyvagal theory: The transformative power of feeling safe*. WW Norton & Co.

Porges, S.W. (2011). *The Polyvagal Theory: Neurophysiological Foundations of Emotions, Attachment, Communication, Self-regulation.* New York: W.W. Norton & Co.

Van Vliet, N., Huntjens, R., Van Dijk, M., Bachrach, N., Meewisse, M., & De Jongh, A. (2021). Phase-based treatment versus immediate trauma-focused treatment for post-traumatic stress disorder due to childhood abuse: Randomised clinical trial. *BJPsych Open, 7*(6), E211. https://doi.org/10.1192/bjo.2021.1057

World Health Organization. Department of Making Pregnancy Safer, & World Health Organization. (2010). *Counselling for maternal and newborn health care: A handbook for building skills*. World Health Organization.