# INTRODUCTION TO TRAUMA AND TRAUMA-INFORMED PRACTICES



As a peer supporter, many of the women you work with will have experienced some form of violence or trauma in their lives. Perhaps you have experienced trauma in your own life. Whether you work in a mental health or substance abuse program, a homeless shelter, a correctional institute, a domestic violence shelter, an independent peer-run program, or any other setting, your relationships with the people you support may be profoundly affected by trauma. In this chapter, we will provide basic information on sources and impacts of trauma and will describe how behavioral health, human services, and other systems are becoming "trauma-informed." This chapter will introduce some of the concepts that will be explored in more depth later in the guide.

## WHAT IS TRAUMA?

Trauma occurs when an external threat overwhelms a person's coping resources. It can result in specific signs of psychological or emotional distress, or it can affect many aspects of the person's life over a period of time. Sometimes people aren't even aware that the challenges they face are related to trauma that occurred earlier in life. Trauma is unique to each individual—the most violent events are not always the events that have the deepest impact. Trauma can happen to anyone, but some groups are particularly vulnerable due to their circumstances, including women and children, people with disabilities, and people who are homeless or living in institutions.

### Sources of Trauma

Trauma can result from a wide variety of events:

- Emotional, physical, or sexual abuse in childhood
- Abandonment or neglect (especially for small children)
- Sexual assault
- Domestic violence
- Experiencing or witnessing violent crime
- Institutional abuse
- Cultural dislocation or sudden loss
- Terrorism, war
- Historical violence against a specific group (as in slavery or genocide)
- Natural disasters
- Grief
- Chronic stressors like racism and poverty
- Accidents
- Medical procedures
- Any situation where one person misuses power over another

Interpersonal violence is a major source of trauma in the United States, particularly for women. While men are most likely to experience violence from strangers, women and girls are most likely to be hurt by people they know. For women in the military, the greatest risk of harm is from fellow soldiers; for adolescent girls, it is from the people they love.

**INTERPERSONAL VIOLENCE IN THE UNITED STATES**

**More than 3 million children witness domestic violence every year.**

**Every 35 seconds, a child is abused or neglected.**

**One in three girls and one in five boys are sexually abused by age 18.**

**One child dies from violence every three hours.**

**1.5 million women and 835,000 men are raped or physically assaulted by an intimate partner every year.**

**www.witnessjustice.org**

## What to Look For

Some common signs of trauma include:

- Flashbacks or frequent nightmares
- Being very sensitive to noise or to being touched
- Always expecting something bad to happen
- Not remembering periods of your life
- Feeling numb
- Finding yourself in situations where others abuse or take advantage of you
- Lack of concentration, irritability, sleep problems
- Excessive watchfulness, anxiety, anger, shame, or sadness

Some people don't openly display signs of emotional distress. People cope using whatever coping skills and resources they have available to them. Some may keep to themselves, some focus intently on work, while others may use substances or take risks. Every person expresses their pain differently, so it's important to *always* stay open to the possibility that the women you support have experienced trauma.

All forms of violence can be traumatizing, but the earlier in life the trauma occurs, the more severe the long-term consequences may be. Deliberate violence is particularly damaging, especially when it is inflicted by trusted caregivers. Examples of such "betrayal trauma" include incest, child sexual abuse by clergy, and abuse by professional caregivers. Secrecy also intensifies trauma. Often perpetrators will threaten victims in order to keep them from revealing what happened. In other cases, victims will remain silent due to self-blame and shame. When violence is compounded by betrayal, silence, blame, or shame, it can have lasting effects on the ability to trust others and to form intimate relationships—and can directly affect your work as a peer supporter. Helping women to regain their own voice is often the first step in establishing a trusting relationship.

It is important to remember that many of the women you work with may have experienced multiple forms of violence over their lifetime, even though they might not talk about it. For example, you might work with a woman who experienced poverty and racism as a child; grew up in foster homes; lost family, friends, home and job during Hurricane Katrina; and became involved with an abusive partner. Or perhaps you work with a woman who has been put in restraints many times during her multiple hospitalizations and, upon further exploration, she reveals that she is an incest survivor and that she was raped by a fellow soldier when she enlisted to get away from home. Remembering the long road that each woman has already walked can help you focus on the strength and courage it has taken her to survive.

## WHAT IMPACT DOES TRAUMA HAVE?

Scientific findings confirm that trauma affects the mind and body and can have a lasting impact. One study looked at the "adverse childhood experiences" (ACEs) of about 17,000 people enrolled in an HMO, correlating their "ACE score" with a range of medical and social problems.[1] The relationships are staggering. People with high ACE scores are *much* more likely to develop mental health problems, abuse substances, have chronic physical illnesses, and die early. Women are significantly more likely than men to have high ACE scores.

### THE IMPACT OF ADVERSE CHILDHOOD EVENTS (ACES) ON WOMEN

**Women are 50% more likely than men to have an ACE score of 5 or more.**

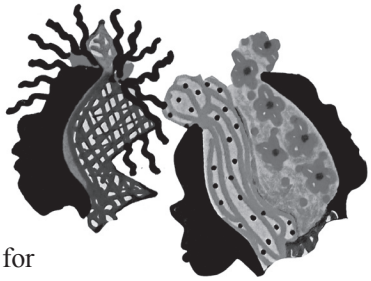
**54% of depression in women can be attributed to childhood abuse.**

**Women with an ACE score of 4 or more are almost nine times more likely to become victims of rape and five times more likely to become victims of domestic violence than women with a score of zero.**

**Two-thirds of all suicide attempts are attributable to ACEs; women are three times more likely to attempt suicide than men across the lifespan.**

**http://www.acestudy.org/**

[1] *Felitti, V.J. & Anda, R.F. (2010). The relationship of adverse childhood experiences to adult medical disease, psychiatric disorders, and sexual behavior: Implications for healthcare. In R. Lanius & E. Vermetten (Eds.), The Hidden Epidemic: The Impact of Early Life Trauma on Health and Disease. Cambridge University Press.*



Adverse events can impact people in two ways. First, trauma affects the developing brain and body and alters the body's natural stress response mechanisms. Second, trauma increases health risk behaviors such as smoking, drinking, over-eating, and engaging in risky sex—things that trauma survivors sometimes do to cope. Recognizing these behaviors as coping responses rather than "bad choices" is essential to an effective peer support relationship.

Over time, trauma can alter everything about a person's life and behavior. Because it shatters trust and safety and leaves people feeling powerless, trauma can lead to profound disconnection from others. Survivors may always be on guard or feel overwhelming despair. Coping mechanisms can become habits that are hard to quit. Trauma can lead to problems at home, at school, or at work. People may unknowingly re-enact their trauma in different ways. As a peer supporter, your job is to help people connect to their own strengths, to talk about trauma and its impact in ways that acknowledge and respect the person's coping strategies, and to support people in naming their own experience. It is also critical to understand trauma so that you can help ensure that the people you work with are not unintentionally "re-traumatized." Re-traumatization happens when something in the environment recreates an aspect of a previous traumatic situation and triggers a trauma response. Groups, organizations, and even societies can also be traumatized, so it is also important to apply these concepts to the larger settings in which you work.

## WHAT HELPS? FACTORS THAT FOSTER TRAUMA HEALING

Over the past twenty years, the field has learned a great deal about healing from violence and trauma. A national dialogue about women, violence and trauma was stimulated by a series of national conferences[2] and the Women Co-Occurring Disorders and Violence Study (WCDVS), a five-year Substance Abuse and Mental Health Services Administration (SAMHSA)-funded research study co-sponsored by all three SAMHSA Centers (the Center for Mental Health Services, the Center for Substance Abuse Prevention, and the Center for Substance Abuse Treatment).[3] The study explored the interrelation among violence, trauma, and co-occurring mental health and substance use disorders among women, provided recommendations for trauma-integrated services for these women, and sparked the development of guiding principles for positive change.

These efforts emphasized peer support, the re-traumatization that too often happens within service systems, and the importance of focusing on gender. The women survivors who participated in the conferences and the research study demonstrated clearly the power of finding and using one's voice, especially when the experience of trauma has been wrapped in secrecy and silence.[4] Their participation has helped the trauma field to understand how important it is for people who have experienced trauma to determine the course of their own lives. It is also vital that they participate in every aspect of service planning, delivery, and evaluation and that they have the opportunity to develop peer-run services.[5]

### Recovery, Resilience, and Post-Traumatic Growth

The most important message you can convey as a peer supporter is that *healing is possible*. The women you support have faced great challenges and survived. It's a tribute to their strength that they've made the courageous choices to get to where they are today.

Research shows that people are extremely resilient. They can recover from even severe and repeated trauma, and can grow stronger in unexpected ways. Just like a broken bone, a person can become "stronger at the broken places." Often people move through predictable stages of safety, remembrance and mourning, and reconnection with others.[6] Grieving is often a major component of healing. This guide includes personal stories and suggestions for healing techniques that the women you support may want to try, but it is critical to remember that each woman's journey is different.

[2] *Dare to Vision (1995), Dare to Act (2004), and Dare to Transform (2008).*

[3] *The Women, Co-Occurring Disorders, and Violence Study (1998-2003).*

[4] *Mockus, S., Mars, L.C., et al (2005). Developing consumer/survivor/recovering voice and its impact on services and research: Our experience with the SAMHSA Women, Co-Occurring Disorders and Violence Study. Journal of Community Psychology, 33(4), 515-525.*

[5] *Prescott, L. et al. (1998). Women Emerging in the Wake of Violence. Culver City, CA: Prototypes Systems Change Center.*

[6] *Herman, J. (1992). Trauma and Recovery. New York, NY: Basic Books.*

There are many resources available that describe trauma recovery and that outline strategies to promote healing and post-traumatic growth. A few are listed in the resource section. As a peer supporter, one of the most important things you can do is to remind people that healing from trauma, like healing from a physical injury, is a natural human process.[7] After violence occurs, a self-healing process is activated. The will to survive is triggered, and often the individual tries to make meaning of the experience. It is critical for helpers to support the self-healing process rather than undermine it. Skills for supporting self-healing from trauma will be described in later chapters.

## Trauma-Specific Services and Trauma-Informed Practices

One important distinction is between "trauma-specific" interventions and "trauma-informed" practices, services, and supports.[8] Trauma-specific interventions are designed to treat the specific signs of trauma. Many have demonstrated positive outcomes.[9] Trauma-specific services include integrated models for trauma and substance abuse treatment, manualized group counseling models, cognitive behavioral therapies, prolonged exposure therapy, body-based interventions, eye movement desensitization and reprocessing (EMDR), and many others.

In contrast, trauma-informed practices provide a new paradigm for organizing services and supports that recognizes the central role that trauma plays in people's lives and shifts the focus from "what is wrong with you?" to "what happened to you?" Trauma-informed practices can be implemented anywhere—in educational settings, in job programs, in housing, in justice systems, and, of course, in peer support. Trauma-informed services seek to understand what happened to an individual and the meaning she makes of those experiences. In a trauma-informed program, everyone is educated about trauma and its consequences, and about the importance of women's voices and choices in the services and supports they receive. People are alert for ways to make their environment more healing and less re-traumatizing for both clients and staff. They understand that when you have been traumatized, regaining control over the environment is the number one priority, so they emphasize safety, choice, trustworthiness, collaboration, and empowerment.[10] Trauma-informed services support resilience, self-care, and self-healing. Violence and healing both occur in a cultural context, so trauma-informed programs also respect and include culturally specific healing modalities.

Because violence and trauma are so common, peer supporters should assume that every woman they see may have experienced some form of trauma. How you engage people, how you empower them to tell their stories in their own words, and how you work with their existing strengths and coping strategies are critical skills of trauma-informed peer support, and will be discussed in detail later.

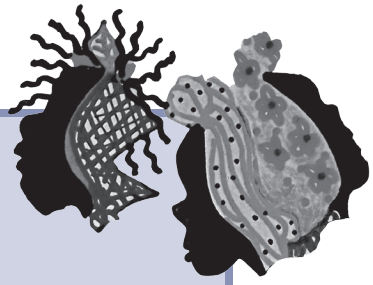
> Trauma-informed services don't ask, "What's wrong with you?"
>
> They ask, "What happened to you?"
>
> *– Sandra Bloom*

[7] *Mollica, R.F. (2006). Healing Invisible Wounds. New York, NY: Harcourt Press.*

[8] *Distinction first made by Roger Fallot and Maxine Harris.*

[9] *Jennings, A. (2008). Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services. The Substance Abuse and Mental Health Services Administration's National Center on Trauma-Informed Care.*

[10] *Fallot, R.D. & Harris, M. (2008). Trauma-informed services. In Reyes, G., Elhai, J.D., & Ford, J.D. (Eds.), The Encyclopedia of Psychological Trauma (pp. 660-662). Hoboken, NJ: John Wiley.*



## CHAPTER SUMMARY: KEY POINTS

- Trauma occurs when external events overwhelm a person's coping responses.
- Trauma is widespread. You can assume that many of the people you support have trauma histories, and that many have experienced multiple sources of trauma.
- The earlier in life trauma occurs, the more damaging the consequences are likely to be.
- Being betrayed by trusted caregivers, being silenced, or feeling blame or shame may intensify the impact of the trauma.
- Trauma can affect every aspect of a person's life over time.
- Trauma-informed practices shift the focus from "what is wrong with you?" to "what happened to you?"
- Trauma-informed practices emphasize voice, choice, safety, trustworthiness, collaboration, and empowerment.
- Healing is possible.
- It is essential for peer supporters to understand trauma in order to support healing and to avoid re-traumatization.

## RESOURCES


Bloom, S.L. & Reichert, M. (1998). *Bearing Witness: Violence and Collective Responsibility*. New York, NY: Haworth Press.

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Mockus, S., Mars, L.C., et al (2005). Developing consumer/survivor/recovering voice and its impact on services and research: Our experience with the SAMHSA Women, Co-Occurring Disorders and Violence Study. *Journal of Community Psychology*, 33(4), 515-525.

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Substance Abuse and Mental Health Services Administration. (2003). *Helping Yourself Heal: A Recovering Woman's Guide to Coping with Childhood Abuse Issues*. U.S. Department of Health and Human Services Publication # (SMA) 03-3789.

Vesey, B. & Heckman, J., with Mazelis, R., Markoff, L., & Russell, L. (2006). *It's My Time to Live: Journeys to Healing and Recovery*. Substance Abuse and Mental Health Services Administration/Center for Mental Health Services.

The Anna Institute, **http://annafoundation.org/**

The Adverse Childhood Experience (ACE) Study, **http://www.acestudy.org/**

The National Center on Trauma Informed Care, **http://www.samhsa.gov/nctic/**

The Salasin Project, **http://wmtcinfo.org/~wmtc/typolight/index.php/salasin-project.html**

The Transformation Center, **http://transformation-center.org/resources/education/trauma/info.shtml**

CHAPTER 2

# AM I A TRAUMA SURVIVOR?

This manual is designed to help you provide trauma-informed peer support. But what if the women you work with don't identify or even recognize themselves as "trauma survivors?" In this chapter, you will have a chance to think about how people come to recognize the impact of trauma on themselves and others. By examining potential sources of trauma in your own life, you will become aware of the ways in which the women you work with might have been affected by trauma, whether or not they talk about it.

## IDENTIFYING AS A TRAUMA SURVIVOR

Everyone experiences pain and suffering, so how do you know if you have been traumatized? Often, when a person is experiencing violence—especially as a child—they have no way of knowing that it isn't normal. An abused child may grow up believing that the world is a hurtful place, that they are unworthy and deserve whatever they get. They may feel uncertain of themselves and look to others to define what is "normal." It may take a long time for them to realize that they have a right to be safe and happy, and even longer to develop the skills of self-care.

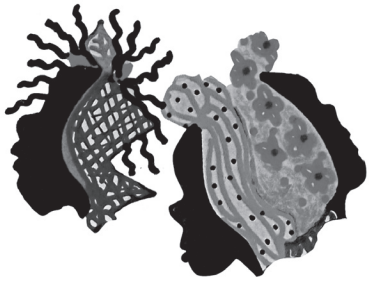
Even adults can have a hard time recognizing abuse and trauma. Many women who experience date rape, for example, are unsure how to categorize their experience. They might think because it wasn't a stranger and he didn't hold a gun to their heads, that somehow it didn't "count" as rape. Or they might blame themselves for accepting the date. Women who experience violence at the hands of an intimate partner may see such events as an expected part of their relationship. Others may see certain types of violence as an unavoidable part of life in their family or neighborhood, something to be endured and not discussed. Sometimes women only begin to see themselves as abuse survivors when they get a chance to share their stories with other women.

Even when women recognize that the violence they experienced was wrong and was not their fault, they may find it very hard to talk about—especially if they have been silenced, blamed, or shamed in the past for speaking out. There may be cultural differences in how violence is defined and talked about. It is important to pay attention to how the women you support describe themselves, and to respect the language they use. There are different views and core values about self-identity, and some of these are culturally based. For example, one woman who has experienced violence may describe herself as an Asian woman, a parent, a daughter, and an advocate. When she shares her journey of healing from violence and emotional distress, she may not use terms like "trauma survivor," not out of shame, but because these terms do not hold meaning for her. As peer supporters, we need to be clear about how we self-identify, so that we can be aware of when our views and experiences may be influencing how we understand the women we support. Specific strategies for holding a conversation about trauma will be discussed in later chapters, but it is important to remember that defining one's own experience in one's own terms is essential to healing.

### CHOOSING STRENGTH

**Someone from the Women's Building came around asking if we wanted to go to a meeting, just for women, to talk about violence in our neighborhood. The first night seven women came. The group leader talked a lot about violence and how something that happened way back when I was little can still bother me. I guess I was surprised. Where I live somebody gets beat up almost every day. I didn't say much. They asked if we would come back again. I guess so. But like K. said: "If coming here makes me feel better and stronger when I leave, then I will come back. I can't have pity. No feeling sorry for me. Don't even look at me with sad eyes. I have to go back out there and be a strong woman. Take care of my kids and be strong."**

***– Participant in Sister to Sister peer support group, quoted by Cathy Cave***



Words do matter, and words that describe our identity matter a great deal. Many of the women you work with have received a psychiatric diagnosis at one time or another. For some, that diagnosis may be helpful, even comforting. For others, it is harmful and disturbing. The same thing holds true for people who have experienced violence and trauma in their lives. How they choose to talk about it—or if they choose to talk at all—is a very personal matter. It is important that peer supporters make it safe for women to share their experiences.

"Coming out" as a trauma survivor may have a profound effect on a woman's identity. For example, women refugees coming to the U. S. after the war in Kosovo often defined themselves as "freedom fighters" injured in the struggle for liberation rather than as "rape survivors," although most had been brutally raped and beaten by their captors. This had cultural significance for them as Muslim women and personal significance, giving a sense of meaning and purpose to their experience. Often, simply using the term "survivor" rather than "victim" can make a difference in the way people think and feel about what happened to them and how they envision the future. On the other hand, sometimes a woman chooses to use the term "victim"—for example, to emphasize that she was both powerless and blameless.

As a peer supporter, you play an important role in ensuring that people can choose the words they want to use to define and describe their experience and their identity and helping other people in the system respect those choices. But it is also your responsibility to give people space to look at what has happened to them throughout their lives and to begin to think about how those events might have impacted them.

### TRACING TRAUMA IN YOUR LIFE AND THE LIVES OF YOUR PEERS

**Take a few minutes to review the possible sources of trauma in your own life. Notice if there are potential sources of trauma that you have never considered before.**

**Historical trauma.** We usually think of historical trauma as resulting from mass acts of violence against an entire group: slavery, or the genocide of Native Americans, or the Holocaust, or the internment of Japanese Americans during World War II. But it can also occur in more individual ways. If your parents or grandparents were immigrants, belonged to a religious group that was persecuted, or came from households that used extremely harsh physical discipline, you may feel the impact of the violence and trauma they faced even though you never directly experienced it. Think about your own family tree. Do you think you might have patterns of historical trauma in your family? Have you ever discussed it with anyone?

**Social violence.** Social violence such as ongoing poverty, racism, dislocation, or living in severely polluted or degraded environments can also have a traumatic impact over time. Have you ever experienced the impact of social violence? If so, do you think that it might have affected the way you think, feel, or act?

**Childhood trauma.** Children may be traumatized through emotional, physical, or sexual abuse; witnessing domestic violence; incarceration of a family member; family separation; physical or emotional neglect; gang violence; bullying (including cyber-bullying or "sexting"); or witnessing violence in the streets. Think about your own childhood. How many different types of childhood trauma did you experience? At the time, what did you think or feel about these events? Have you ever thought about the impact that these experiences might have had on you as an adult?

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**Interpersonal violence.** Adults, especially women, experience interpersonal violence in many forms, including domestic violence, rape and sexual assault, sexual harassment, workplace bullying, and experiencing or witnessing violent crime. Have you ever experienced interpersonal violence? Have you had an experience where you felt shamed or fearful or coerced into doing something you didn't want to do, but weren't quite sure if it "counted" as abuse?

**Institutional trauma.** Institutional procedures such as forced medication, involuntary commitment, transportation by law enforcement, and seclusion and restraint are often traumatizing. Medical interventions and certain aspects of routine institutional care, such as inflexible rules, authoritarian staff, and even the use of certain words or labels may be traumatic in less obvious ways. Think about your experience with institutions. Did anything ever happen that felt abusive? At the time, did you consider yourself as surviving a traumatic experience? Did the staff? Would you consider them traumatic now?

**Other traumatic events.** Natural disasters like Hurricanes Katrina and Rita, acts of terrorism like 9/11, and wars can affect us—even if we are not immediately present. Groups and organizations can also be traumatized by events such as a death or staff injury or even an unexpected layoff or reorganization. Have you ever experienced trauma from a natural disaster or war, either directly or indirectly? Has a group or organization you were a part of ever experienced a severe shock that affected you deeply? Have you ever thought about how these events affect your life?

**Do you consider yourself a "trauma survivor?" Why or why not? What about the people you work with? Do you think they consider themselves trauma survivors? Why or why not?**

## THE POWER OF LABELS

**In the following excerpt by Pat Deegan, she refers to herself, or is referred to by others, as "a schizophrenic," "multiple personality disorder," "an abuse survivor," and "chronically mentally ill." Consider the implications of each of these labels for Pat and for staff working in the system.**

**Before We Dare to Vision, We Must be Willing to See**
***by Patricia E. Deegan, PhD***

. . . Stay with me. See with me. It is breakfast time. The same 6-year old girl is in the kitchen. Her mother is in a quiet but dangerous fury at this early hour. There is cereal on the table, some bowls and spoons strewn about. The other kids, dad, and grandma are in and out of the kitchen in the morning hustle to get off to work and school. The mother takes a bottle out of the cabinet. The 6-year–old child knows the bottle well. The mother removes a large pink pill from the bottle. The girl begins to feel ice cold in terror. A nausea grips her innards. The pink pills are amphetamines. Adult dosages of amphetamines. The mother places one pink pill on the table. It seems so big. The mother is afraid that someday the child may become fat. The mother is obsessed with this fear. She turns to the 6-year-old girl. "Here, take this." The child's eyes fill with tears. A hushed, whispered plea—"Please, not today. Please mommy, not today." The words fall on deaf ears. No one hears. No one helps.

"Take the pill. It's for your own good. I love you. You don't want to get fat, do you. I love you. Take the pill. Here, try this . . . " She takes a spoon and shows the 6-year-old how she will crush up the pill and make the big pill "go away" by mixing the powdered amphetamine in a small glass of milk. But the 6-year-old child already knows this trick—the milk is scary. "Drink it," comes the command. Every fiber in her body

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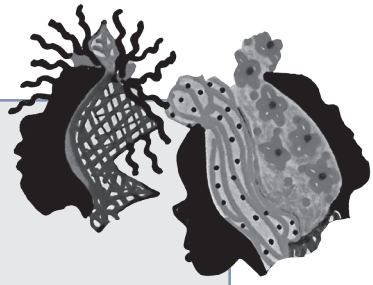

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screams against the order but she obeys. There is no choice. The liquid amphetamine slides down her throat and enters her stomach. Mommy is happy.

Everyone sits down and eats some cereal. Except for me, the 6-year-old girl. I go into an alcove in the living room. It's small place with walls that are close enough to hold me in. And soon I begin to feel the rushes of adrenaline inside my body. I begin to whine quietly to myself. I pace around and around in a small circle. My heart begins pounding. I shake my hands in some spastic rhythm to somehow get the terror out. The drug is roaring through my body now. I feel like I am dying and I don't know if it will ever end. But I remain quiet, too afraid of what will happen if I make a noise, going around and around, shaking and heart pounding until my body quakes. And then I feel my body get so huge and it feels just like my skin has disappeared and nothing is there to hold me together and my skin just evaporates so that I no longer have an inside or an outside and I just come apart. I just disintegrate. I'm gone . . .

I was forcibly drugged with adult doses of amphetamines between the ages of 6 and 16. The "breakfast scene" as I described it happened more times than I can count. I was scared and no one soothed me. I was a child and no one protected me. I was visible but no one around me was willing to see or to say what was happening . . . And then I broke. When I was 17 and a senior in high school, I just broke—snapped into a thousand pieces that did not come back together again . . .

Come, dare to see with me: a female nurse approaching me with two cups of liquid. In one cup was clear liquid Thorazine and in the other orange juice. She poured the clear liquid into the cup with the orange juice. She told me to drink it. She said it was medicine and that it was good for me and that the orange juice would make it taste better. And I stiffened, and felt the cold chill and the nausea grip my bowels.

But I did not resist. I knew all about this. I drank the "orange juice." The nurse was very happy that I drank it. That was on a Friday afternoon. I did not return to consciousness until Sunday evening when they roused me from my drug-induced coma. And when I woke up I found I was gone. I was gone again. I drooled and choked and walked like a zombie and passed out and I could feel nothing and think nothing and say nothing . . .

There seems to be a two-tiered caste system and service delivery system developing in the mental health arena. One set of services is for people we once called the "chronically mentally ill" and who we now refer to as the "the severely and persistently mentally ill." The second tier in this emerging caste system is the proliferation of specialized service, often in private hospitals, for survivors of abuse.

I have experienced this emerging trend on a firsthand basis. Between the ages of 17 and 39 I was labeled and treated as "a schizophrenic." When they said I was "a schizophrenic," the first thing I always got offered was drugs . . . But then after 16 years of being labeled "a schizophrenic" I got a new diagnosis during a hospitalization in 1988. Now I am labeled as having multiple personality disorder. And the change in how I am perceived by mental health professionals is extraordinary! Now everyone wants to know what my voices are saying! Now there are no particular drugs people think I should take. Now all the clinicians agree the treatment of choice for me is insight-oriented, long-term psychotherapy. . . . Of course the irony is that I have been the same person all along, no matter what diagnosis I carried.

Excerpted from keynote address, Dare to Vision Conference, July 14-16, 1994, Arlington, VA. Reprinted with the author's permission. For more by Pat Deegan, see:

**http://www.patdeegan.com/**

## CHAPTER SUMMARY: KEY POINTS

- Children who are abused may grow up believing the world is a hurtful place. It may take time for them to realize they have a right to be safe and happy, and to identify the impact of trauma on their lives.
- Adults may also blame themselves for the things that happen to them or minimize the impact of violence they have experienced.
- Even women who recognize the impact of trauma on their lives may find it difficult to talk about.
- Defining one's own experience in one's own terms is essential to healing. Women from different cultures may use different words and frameworks for talking about violence.
- Peer supporters play an important role in ensuring that people can choose the words they want to use to describe their experience and help other people respect those choices.

## RESOURCES


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Pat Deegan, **http://www.patdeegan.com/**


# PEER SUPPORT FUNDAMENTALS



Peer support does not adhere to any one "program model." Rather, it is a dynamic and flexible approach to connection and mutual understanding based on a set of core values and principles. This chapter will present information on the fundamentals of peer support that have been developed over the years by people who have worked in peer support roles, conducted research on the topic, and have reflected upon and written about it.[1,2,3,4] These ideas can be applied to any setting or activity. Understanding the fundamentals will help you use the strategies presented in later chapters to apply these principles to peer support relationships with women who are trauma survivors. The chapter also suggests books, articles, and websites that provide additional information.

## What is Peer Support?

Peer support is a way for people from diverse backgrounds who share experiences in common to come together to build relationships in which they share their strengths and support each other's healing and growth. It does not focus on diagnoses or deficits, but is rooted in compassion for oneself and others. Through peer support, we can challenge ourselves and each other to grow beyond our current circumstances and build the lives we want and deserve. Peer support promotes healing through taking action and by building relationships among a community of equals. It is not about "helping" others in a hierarchical way, but about learning from one another and building connections.

### A NATURAL HUMAN RESPONSE TO SHARED ADVERSITY

**Most people who've been through hard times empathize with and have an urge to reach out to others who struggle with problems that feel similar to their own. For example, an older woman with children shares her experiences with an overwhelmed new mother. A widow offers tea and words of comfort to a woman whose husband has recently died. The desire for peer support relationships can be seen as a natural human response to shared struggles.**

A "peer" is an equal, someone who has faced similar circumstances, such as people who have survived cancer, widows, or women who parent adolescents. In peer support, the people involved have had some sort of similar experience, such as being given a psychiatric diagnosis and receiving behavioral health services.

That is one of the key differences between peer support and professional services and treatment. "Support" is another way of expressing the kind of understanding and encouragement toward growth that people who struggle with similar issues can offer one another.

Peer support can take many forms. In the 1930s, the twelve-step model emerged to provide mutual emotional, social, and informational support for people struggling with alcohol dependency. Today, twelve-step programs are the most widely available mutual support groups for people in addiction and substance abuse recovery, although other models for peer support have emerged, including Women for Sobriety (WFS), SMART Recovery (Self-Management and Recovery Training), and Secular Organizations for Sobriety/Save Our Selves (SOS).[5]

[1] *Campbell, J. & Leaver, J. (2003). Emerging New Practices in Organized Peer Support. Report to the National Technical Assistance Center for State Mental Health Planning (NTAC), National Association of State Mental Health Program Directors (NASMHPD). Alexandria, VA.*

[2] *Campbell, J. (2005). Historical and Philosophical Development of Peer Run Programs. In Clay, S. (Ed.), On Our Own Together: Peer Programs for People with Mental Illness (17-64). Nashville, TN: Vanderbilt University Press.*

[3] *Solomon, P. (2004). Peer support/peer provided services: Underlying process, benefits and critical ingredients. Psychiatric Rehabilitation Journal 27, 392-401.*

[4] *Mead, S., Hilton, D., & Curtis, L. (2001). Peer support: A theoretical perspective. Psychiatric Rehabilitation Journal 25, 134-141.*

[5] *Substance Abuse Fact Sheet in Brief, Spring 2008, 5:1. "An Introduction to Mutual Support Groups for Alcohol and Drug Abuse" http://kap.samhsa.gov/products/brochures/pdfs/saib_spring08_v5i1.pdf*

### ROOTS OF PEER SUPPORT: THE FEMINIST PRACTICE OF CONSCIOUSNESS-RAISING

Consciousness-raising is a group process rooted in feminism in which people with a common problem share and explore their experiences in order to draw connections between the personal and the political.

In the 1970s, former mental patients used consciousness-raising as a tool to understand their experiences in a social and political context. This helped people realize that many of their issues were not individual problems related to their diagnoses, but the result of patterns of discrimination and oppression. Ex-patients learned that their feelings of isolation, inadequacy, and powerlessness were the result of real practices within the mental health system and real discrimination in the community, not by-products of their "illnesses."

Consciousness-raising also helped people to recognize their own internalized stigma—their unconscious agreement with society's negative stereotypes of "mental patients"—and to develop new, more empowering beliefs about their ability to regain control of their lives.

In mental health, peer support in its modern form began in the early 1970s among former mental patients who were angry about the involuntary treatment they had received in state hospitals and other institutions. Some of these people found each other and came together in groups to share their outrage, support each other's healing, and demand changes in the system. In those days, peer support—more commonly called "self-help" at the time—was a communal activity. No one was paid, and people supported each other as they became activists and advocates for positive change.

In the decades since, peer support has developed in a number of different ways, many of which bear little resemblance to the peer support groups of the 1970s. Today, as a peer supporter, you may work in a paid or volunteer job in mainstream behavioral health programs such as outpatient clinics, inpatient units, or emergency rooms. You might work in other service systems, such as a homeless service program, the justice system, or a domestic violence shelter. Maybe you are involved as a staff or volunteer in a peer-run program. Or perhaps you are a member of a free-standing, independent support group that maintains many of the qualities of peer support from the early days of the ex-patients' movement. You may have had formal training by a peer-run organization or a state-certified program, or maybe you learned about peer support through reading articles and websites or through participating in a peer support group.

Some organizations—mainly programs that hire Medicaid-reimbursable peer specialists—define peer support as a "helping relationship," similar to the hierarchical roles of other behavioral health professions. But in this guide, we define peer support as an activity based on mutual relationships that incorporate the principles described below.

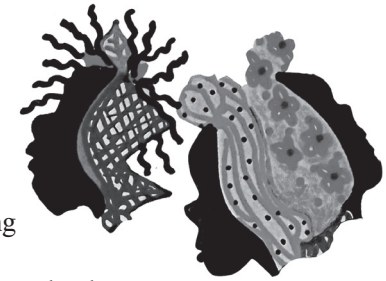
## Principles of Peer Support[6]

While peer support can be practiced in different settings and through a variety of activities, there are some important underlying values that make peer support unique and valuable. As we discussed earlier, these principles have been developed by consensus over the years by people who have been directly involved in peer support as participants, researchers, and writers.

**Peer support is voluntary.** The most basic value of peer support is that people freely choose to participate. It is for people who want to be involved, not people who have been told they need it or who are pressured to attend. The voluntary nature of peer support makes it easier for us to build trust and connections with one another.

**Peer support is non-judgmental.** In peer support, we meet people who have experiences, beliefs, or ways of living their lives that may be different from our own, despite the things we have in common. Being non-judgmental means approaching each person with openness, curiosity, and genuine interest.

[6] *Many of the ideas in this section are adapted from an unpublished manuscript by Shery Mead, Darby Penney, and Laura Prescott and are heavily influenced by Shery Mead's work on intentional peer support (see Resource section at the end of this chapter).*



**Peer support is empathetic.** Sometimes people call this "putting yourself in the other person's shoes." It means that we each make a genuine effort to imagine how the other person feels, what might have led to those feelings, and how we would want someone to respond to us in that situation.

**Peer support is respectful.** Everyone is seen as having something important and unique to contribute. We value everyone who wants to be a part of the group and treat each other with kindness, warmth, and dignity. We accept each other and are open to sharing with people from many ethnicities and cultures, educational levels, and religions. We honor and make room for everyone's opinions and see each other as equally capable of contributing to the group.

### RESEARCH SHOWS PEER SUPPORT'S EFFECTIVENESS

**Research on peer support has consistently shown that people benefit by participating. Ed Knight, a researcher with mental health and substance abuse histories, reviewed the findings of six peer support studies. He reported that people with serious psychiatric diagnoses get great benefit from being part of peer support activities. Emotional distress and substance use problems decrease. Participants do not have as many crises and are hospitalized less often. Peer support participants feel better about themselves and have more social skills and broader networks of friends.**

**Other studies have had similar results. These include improvements in:**

- **Self-esteem**
- **Hopefulness**
- **Inner strength**

**Participants also report greater awareness of their rights and social justice issues and greater feelings of empowerment.**

**Jean Campbell summarized the "Emerging Research Base of Peer-Run Support Programs" at :**

**http://www.power2u.org/emerging_research_base.html**

**Peer support requires honest and direct communication.** Each of us says what is on our mind in a respectful way. Learning how to speak honestly but with compassion about difficult issues can be the most challenging part of developing relationships with our peers. Combining directness with caring requires that we move beyond our fear of hurting other people or making them angry and have honest conversations with the people we need to address.

**Peer support involves mutual responsibility.** We each take responsibility for voicing our own needs and feelings. Each of us needs to understand that we are not there to take care of the other, but that each participant is responsible for making sure that everyone is heard.

**Peer support is about sharing power.** No one is in charge and everyone is equally responsible. Sharing power may be a new idea. If we have been in service systems for a long time, we may have gotten used to being told what to do. Sometimes when people suddenly have the freedom to make decisions, they may act like the people who used to make decisions for them. Some people may be more assertive than others and it is important that they allow people who are quieter and less assertive to be involved in decisions. When power is shared successfully, people give and take the lead in discussions, everyone is offered a chance to speak, and decisions are made by the group.

**Peer support is reciprocal.** Every person both gives and receives in a fluid, constantly changing dynamic. This is very different from what we are used to in treatment programs, where we are usually seen as people who need help and the staff are the people who give help. In peer support, we are aware that each of us has things to teach and things to learn. This is true whether you are a paid peer supporter or part of an informal group.

## Types of Peer Support Activities

**Formal support groups** are structured groups in which people who share a common experience meet at a regularly scheduled time to give each other support by sharing ideas through discussion and conversation. Usually the conversation focuses on an agreed-upon topic or question and the discussion is moderated by a facilitator to ensure that the conversation stays on track and everyone has a chance to be heard. Support groups can take many shapes depending on what works best for the people involved. Groups may follow

an existing format, such as those used by 12-step programs, Recovery International, Double Trouble, or other organized models. Peer support groups may be focused on a particular issue or group of people, such as women who are trauma survivors. Members may decide that the group will be ongoing and open-ended, or that it may end after a certain number of meetings.

**Activity-focused peer support.** Another way to organize peer support is around a specific activity. Some people just don't like sitting around and talking—they'd rather be doing something. This could be a one-time event, like going with a group to a film that has a positive message about recovery. Or it could be an ongoing activity like a softball team of women trauma survivors that plays in a neighborhood league. Other possibilities include arts and creative expression or volunteering together to work on community service projects. Doing things with others helps develop a common purpose, a group identity, and a sense of belonging.

**Educational activities.** Learning new things with one's peers can be exciting and less intimidating than trying to learn on one's own. When people start thinking about what they want their lives to become, instead of just talking about what went wrong in the past, they can learn and create things together that they might not be able to accomplish alone. They can create what's called a "learning community" of people who teach and learn together about topics that interest them, without formal teacher/student relationships. Most educational activities grow out of people's own interests or their need to learn something new to help them deal with a current issue they face. Some examples might be people who form a study group to prepare for the GED exam, people with diabetes and other health issues learning together how to prepare healthy meals, or women trauma survivors starting a book club to read and discuss trauma recovery materials.

**Informal and one-on-one peer support.** Some people are not joiners and just don't feel at home in groups. Peer support can happen in many different settings and doesn't have to be highly structured. People can support each other in pairs or in ad hoc small groups. Peer support can happen casually on the phone or in person, through email, on the street, or in a park or coffee shop. One-on-one peer support can also happen in a planned way in peer-run programs or with peer support staff in mainstream programs.

**Advocacy** is a positive way to put peer support into action. It's about a group deciding what they want, what changes are required to attain their goal, and communicating effectively with the right people to make this happen. Working together to solve a common problem helps build connections among people and improves their confidence in their ability to make their lives better. By taking action together, people move away from feeling helpless as they recognize the possibilities for making positive change together. Even when advocacy doesn't result in all the changes people want, they develop a sense of strength and purpose that can make them feel empowered and hopeful about the

### ROOTS OF PEER SUPPORT: 12-STEP PROGRAMS

**The 12-step movement was launched when one alcoholic turned to another for help in 1935. Two men, Bill W. and Dr. Bob, began informally working with others to quit drinking and stay sober through self-help techniques based on spirituality. In 1939, Bill W. wrote a book, Alcoholics Anonymous, based on the 12 principles that he and Br. Bob developed for their 12-step recovery program.**

**Alcoholics Anonymous (AA) is "a fellowship of men and women who share their experience, strength and hope with each other so that they may solve their common problem and help others to recover from alcoholism." Narcotics Anonymous (NA), founded later, is based on the same principles. AA/NA believes that drinkers/drug users must stop drinking/using completely, admit they are powerless over addiction, and rely on a higher power for help. Members also believe that alcoholism and addiction are diseases. Anonymity, group unity, and shared responsibility for leadership are important features of 12-step recovery groups.**

**Bill W. and other AA pioneers spread a radical new philosophy. It taught that people do not have to rely on "experts" to change their lives, but can do so with the support of people who share their experience.**

future. Many people have had experiences in their lives or in service systems where their wishes have been ignored, they haven't felt listened to, or where they have had things done to them, rather than with them. As advocates, they can support each other as they learn how to make their voices heard, make sure their rights are protected, and get supports and services that work for them on their terms.

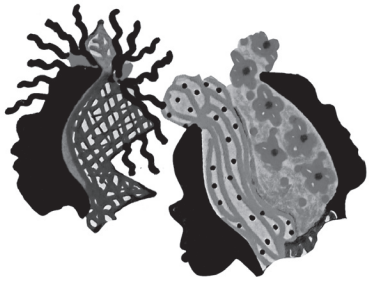
## Where Does Peer Support Take Place?

Peer support can be practiced in a variety of settings, each presenting particular challenges and opportunities. Some of the common locations and situations where peer support happens include:

**Independent, unincorporated peer support groups.** These are voluntary groups developed by people to meet their own self-defined peer support needs. Usually, such groups are not funded by government, although they may raise funds to cover the costs of their activities. This kind of group is not explicitly part of a service system, even though its members may have met each other through programs. Groups may meet in members' homes or in free community spaces such as churches or libraries.

**Peer-run programs.** These are incorporated not-for-profit organizations that are run by people who have used behavioral health services, and are governed by a majority peer board. They may receive government funding and/or private funding. Common types of peer-run programs include peer support centers, drop-in centers, warmlines, housing programs, employment programs, and crisis alternatives.

**Peer support staff working in mainstream behavioral health programs.** In many states, people are hired into positions called peer specialists (or similar titles) which may or may not require a state certification. Typically, people in these positions provide peer support services in inpatient units, emergency rooms, and a variety of community-based programs. People working as paid staff in traditional programs may face particular challenges in adhering to the values of peer support, as agencies that work from a medical model may not recognize the impact of trauma and may not understand the unique role of peer support. Ideally, the role should be to facilitate the development of peer support relationships and communities rather than to act in a hierarchy-based "expert" role.



**Internet peer support.** Meeting people in person can be hard. Some people live in rural areas where travel is expensive or public transportation is lacking. Others may feel socially awkward after years of isolation in systems or because of the side effects of medication. People may be trying to re-learn how to socialize without using alcohol or drugs to numb their sense of insecurity in social situations. The Internet provides opportunities for peer support through social networking sites like Facebook, through blogs and websites, and through online discussion groups. Using these tools, it's possible to safely meet new people who want to share information on vital issues and to build virtual online communities of support.

### PEER RECOVERY CENTERS

Across the United States, more than 30 Peer Recovery Centers have been established with funding from SAMHSA's Recovery Community Support Program to promote sustained recovery from alcohol and drug use disorders. Many who use these peer-to-peer services are trauma survivors.

The RECOVER Project in Western Massachusetts is a large, welcoming space in Greenfield offering peer-led activities including art classes, free yoga and reiki, sober social events, leadership training, and mentoring. The RECOVER Project uses a participatory process to ensure that decisions are made by the recovery community as a whole. Creating a trauma-informed center was a central goal, supporting their efforts to "provide support, services and solace to families and individuals who are living in fear" and to "create conditions where every member can achieve a full and satisfying life free of violence and its consequences."

The RECOVER Project has developed a manual, *How to Build Your Own Peer-to-Peer Recovery Center From the Ground Up!* Available for download at:

**http://www.recoverproject.org/**

## CHAPTER SUMMARY: KEY POINTS

- Peer support is a flexible approach that people who share common experiences can use to build relationships that support each other's growth and healing and open up new ways of understanding oneself and others.
- The core values of peer support focus on mutuality, reciprocity, being non-judgmental, and sharing power in non-hierarchical ways.
- Peer support can take different forms and can take place in a wide variety of settings.
- In peer support, we support and challenge each other as we develop new ways to interpret and make meaning of our life experiences, our relationships, and our futures.

## RESOURCES


Campbell, J. (2005). *Emerging Research Base of Peer-Run Support Programs.* Available at **http://www.power2u.org/emerging_research_base.html**

Campbell, J. & Leaver, J. (2003). *Emerging New Practices in Organized Peer Support: Report to the National Technical Assistance Center for State Mental Health Planning*. Alexandria, VA: National Association of State Mental Health Program Directors (NASMHPD). **http://www.consumerstar.org/pubs/Emerging%20New%20Practices%20in%20Oraganized%20Peer%20Support.pdf**

Kalinowski, C., & Penney, D. (1998). Empowerment and women's mental health services. In B. Levin, A.K. Blanch, A. Jennings (Eds.), *Women's Mental Health Services: A Public Health Perspective*. Thousand Oaks, CA: Sage Publications.

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Mead, S. (2001). *Peer Support and a Socio-Political Response to Trauma and Abuse*. Available at **http://www.mentalhealthpeers.com/pdfs/PeerSupportSocioPoliticalResponse.pdf**

Mead, S., Hilton, D., & Curtis, L. (2001). Peer support: A theoretical perspective. *Psychiatric Rehabilitation Journal* 25, 134-141.

National Empowerment Center, **http://www.power2u.org/consumerrun-statewide.html**

National Mental Health Consumers Self-Help Clearinghouse, **http://www.mhselfhelp.org**

Recover Project, **http://www.recoverproject.org/**

The Substance Abuse and Mental Health Services Administration's Recovery Community Services Program (RCSP), **http://www.samhsa.gov/grants/2011/ti_11_004.aspx**

Starting and Maintaining Support Groups Library, **http://www.ccsr.wichita.edu/selfhelpgroupsupport_starting.htm**

Zinman, S., Harp, H., & Budd, S. (1987). *Reaching Across: Mental Health Clients Helping Each Other*. Sacramento, CA: California Network of Mental Health Clients.

Since both men and women experience trauma, why create a manual that focuses on women? While men experience high rates of trauma, we saw in Chapter 1 that women are more likely to experience violence at the hands of people they know and trust, while men are more likely to experience violence from strangers. These differences have a profound impact on how women and men understand their trauma experiences, and on peer support relationships. When services are "gender-neutral" and fail to recognize the unique issues related to betrayal, trust, safety, and shame—and their impact on engagement, connection, and relationships—women who have experienced trauma may find it impossible to heal. Although you may not be in a position to provide gender-specific peer support, it is important to consider gender-specific needs.

But there are other reasons, too. Throughout history, women's experience has been invisible, ignored, or discounted. Women are socialized to take on certain roles, and if they don't follow the rules, they may be treated as sick or criminal. Understanding this will help you better support the women you work with. This chapter will provide an overview of how gender role socialization contributes to violence and trauma, how social norms and institutions affect women survivors, and how gender may affect peer support relationships. It will also set the stage for gender-based tools and techniques described in later chapters.

## The Invisibility of Women

Historically, women were considered to be the property of men and were believed to be physically, mentally, emotionally, and spiritually weaker than men. The notion of women's bodies as men's property was established in the Code of Hammurabi in 1800 BC, codified in English Law in 1769, and adopted by the United States in 1776. It was not until 1962 that a U.S. court first ruled that men do not have a right to beat their wives, and not until the 1980s that U.S. courts ruled that men do not have a right to rape their wives.

Until relatively recently, women have been socially, as well as legally, "invisible." Girls still grow up in a society where political and economic power rests primarily with men, media and popular culture objectify women, and violence against women is common. Until the early 1990s, women were routinely excluded from clinical medical research trials and were overlooked in many systems—for example, in employment, jails, and homeless shelters. As a result, many systems are basically designed for men, with women and children added as an afterthought. Gender-related issues are often overlooked. For example, many mental health programs do not routinely ask the women they serve about possible domestic violence or about whether they have children. As a peer supporter, you may encounter women who are struggling to get their basic needs met. You can support them with understanding, information, and advocacy.

### INVISIBLE NO LONGER

**In 2007, women represented 65% of the sheltered homeless population.**

**Women with children who have sole economic responsibility for their families is one of the fastest growing sectors of homelessness.**

**Over 90% of homeless mothers have been seriously physically or sexually assaulted.**

***– From Laura Prescott, A Long Journey Home, 2008***

**Women make up 17% of the total population of offenders in the justice system. They are more likely than male offenders and women in the general population to experience physical or sexual assault.**

**Many of the 3,000 jails across the country are too small to have separate facilities for men and women.**

**Girls are the fastest growing population in the juvenile justice system. Traditional justice practices may backfire with the very high percentage of girls who are abuse survivors.**

***– From Women and Trauma: Report of the Federal Partners Committee on Women and Trauma, 2011***