TRAUMA-INFORMED PEER SUPPORT ACROSS THE LIFESPAN

As a peer supporter, you are likely to encounter women from across the lifespan—from adolescents to elders. While the basic principles of trauma-informed peer support remain the same, the experiences of youth and older women may differ significantly. Women of different ages are vulnerable to different forms of trauma and their trauma histories may affect them in different ways. Their experiences and needs may also be affected by the defining events and prevailing norms of their generation. Regardless of your own age, it is helpful to be alert to ways in which your relationships can be affected by age. This chapter provides an overview of developmental, generational, and inter-generational issues, as well as suggestions for specific peer support strategies for working with women across the lifespan.

Developmental Issues

The impact of violence is determined in part by the developmental stage at which it occurs. Unfortunately, violence against children in our society is extremely common. A recent survey showed that 60% of all children 17 years or younger experience some form of direct or indirect (witnessed) violence in a given year.[1] Children who experience trauma at a very young age, when the primary developmental task is to develop trust, may have their sense of safety shattered or develop problems with attachment. Adolescent girls who are raped may come to fear or avoid intimate relationships. For women who are trauma survivors, the violence they experienced may become the pivotal point in their lives, around which the rest of their lives are organized. Or, it may be forgotten or repressed, only to reappear later in life when new challenges emerge. Older women who experience trauma may find that it compounds a sense of isolation and powerlessness.

Younger Women

For adolescents and young women, the development of sexual identity and the formation of intimate relationships are two critically important developmental milestones. Childhood abuse, especially sexual abuse, may be a barrier to developing intimate relationships. This period of development is also fraught with the possibility of violence and trauma (see sidebar). Girls who have experienced childhood abuse are particularly vulnerable. Adolescent girls need to be informed about dating violence, date rape, and abusive power tactics in relationships. They also need to understand the role of alcohol and other substances in interpersonal violence, particularly since trauma survivors often turn to substances as a tool for coping with the consequences of their abuse. For example, a high percentage of rape victims are intoxicated at the time of assault; many perpetrators use alcohol or drugs to incapacitate their victims.[2] Many helpful resources are available online, including documents like a "Dating Bill of Rights" and guidelines for dating safety *(see, for example, the National Center for Victims of Crime).*

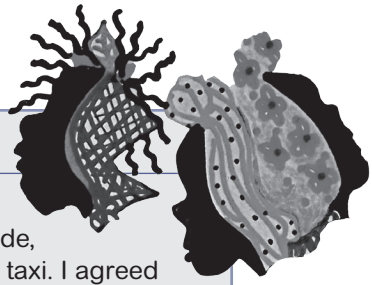
GIRLS ARE AT RISK

- **One in three high school girls will be involved in an abusive relationship.**
- **Forty percent of girls ages 14 to 17 know someone their age that has been hit or beaten by a boyfriend.**
- **Teen dating violence most often takes place in the home of one of the partners.**
- **In 1995, 7 percent of all murder victims were young women who were killed by their boyfriends.**
- **One of five college females will experience some form of dating violence.**
- **In a survey of 500 women ages 15 to 24, all participants had experienced violence in a dating relationship.**
- **One study found that 38 percent of date rape victims were women aged 14 to 17.**
- **More than 4 in 10 incidents of domestic violence involves non-married persons.**
- **Teens identifying as gay, lesbian, or bisexual experience the same rates of dating violence as youth involved in opposite sex dating.**

– Bureau of Justice Statistics Special Report: Intimate Partner Violence, May 2000

[1] *Children's Exposure to Violence: A Comprehensive National Survey. (2009). Available at https://www.ncjrs.gov/ pdffiles1/ ojjdp/227744.pdf.*

[2] *Dawgert, S. (2009). Substance Use and Sexual Violence: Building Prevention and Intervention Responses. The Pennsylvania Coalition Against Rape.*



CAROLINE'S STORY

In January 2006, I was sexually assaulted on my way home from the nightclub HOME in the Meat Packing District of NYC. As I left the club, several limousines were parked outside, and one of the drivers called to me and offered to drive me home for the same cost as a taxi. I agreed and proceeded to enter the cab of the limousine. I believe I was visibly intoxicated. The driver drove to a remote street, got out of the car, entered the back of the limousine, and locked the door. He offered me a joint, which I declined. He smoked part of the joint then he pulled my dress up and yanked down my underwear and proceeded to rape me. I felt trapped and helpless; I couldn't move or scream. I panicked and froze in place while he assaulted me. I could do nothing to protect myself. While I did not protest, this was not consensual sex. The next thing I can remember is walking back to The Four Seasons Hotel, where I was staying, having been dropped off several blocks away.

I did not report the sexual assault at the time because I was embarrassed at having been intoxicated, and I knew the police would just laugh at me like I was some young drunk girl. I also felt at the time that it was my fault for being intoxicated and making a stupid decision. But, looking back, I definitely think the driver was targeting intoxicated women coming out of the club, which is, quite frankly, disgusting. Since then I've been through treatment for my drinking and have accepted that I am an alcoholic. And I've met countless women who have experienced similar acts of sexual violence. It is unfortunate that while we are in our active addictions, we cannot see that these experiences aren't our fault, that we are disproportionately targeted by perpetrators of sexual assault. But in recovery, we have the opportunity to begin to believe that it wasn't our fault and to heal.

– From Dawgert (2009)

Girls and young women who are lesbian, bisexual, transgendered, intersex, or who are questioning their sexuality may face additional social discrimination and exclusion, or may be targeted for violence. Well-intentioned efforts to address trauma and prevent sexual violence—like separating residential units, showers, or bathrooms by gender—may overlook the possibility of same-sex violence. Young women who have been diagnosed with psychiatric or substance abuse disorders, or who have been in the foster care or juvenile justice systems, may face overwhelming isolation and multiple sources of discrimination. For girls with these experiences, peer support is particularly crucial.

Young women are also vulnerable to other forms of interpersonal violence, such as bullying. While the stereotype of a bully is a larger boy, girls with trauma histories may end up either being bullied or bullying others. Peers who are supporting young women should be familiar with the many resources available on girls and bullying.[3]

Young women also face the formidable challenge of becoming more independent by leaving home to attend college or to begin a job and a career, entering new environments where power dynamics need to be negotiated. If the women you work with are moving into the world of work—whatever their age—they might want to consider the "triggers" that they may encounter. For example, a boss, a room, or a smell can unintentionally bring back memories of trauma and abuse which occurred at the hands of an older person in a position of power.

Additional challenges for young women may arise in partnering. Making a life commitment to a partner may be difficult for a woman whose ability to trust and form intimate relationships has been affected by trauma. If one of her parents was abusive, she may find herself being triggered by her in-laws or other new parental figures. If they resemble her abuser in any way, the possibility for re-traumatization is high.

For some sexual abuse survivors, getting pregnant, giving birth, and raising children may be both the biggest challenge and the biggest blessing of their lives. Every aspect of gynecological care and parenting may be re-traumatizing, from pelvic exams to delivery to breastfeeding. Women who grew up in families or communities where abuse occurred may be highly motivated to break the intergenerational cycle of violence, but they may need help in doing it. Trauma survivors may not have had good role models for effective parenting and may need to learn the basics of how to support and nurture their children. They may have difficulty bonding, even with their own child. They may have trouble with certain aspects of child

[3] *See, for example, the National Crime Prevention Council's website: http://www.ncpc.org/topics/bullying/girls-and-bullying*

rearing, such as discipline; being firm and setting limits can easily remind a trauma survivor of "discipline" that was abusive. And they may be so fearful of losing their children that they avoid reaching out for help, especially if their own childhood included separation or abandonment. Finally, it is not unusual for a child's behavior to bring back memories of long-forgotten or repressed abuse, especially as the child approaches the age at which the abuse happened.

Despite these challenges, raising healthy and happy children can be a deeply healing and rewarding experience. Unfortunately, too many trauma survivors lose custody of their children due to lawyers and courts that are not trauma-informed. If the women you support have children—or want children—there are many resources available that can help them to be the best parents possible. For example, the nationally recognized TAMAR (Trauma, Addictions, Mental Health, and Recovery) program provides information on trauma, the development of coping skills, pregnancy and STDs, sexuality, and role loss and parenting issues.

Other women may be unable to have children due to the trauma they experienced, which may cause deep grief and mourning. As a peer supporter, you can be there as a witness to the grief and to help women find ways to move forward despite their loss. For example, you may be able to help find other ways to be an important adult in the lives of children, for instance as an aunt, a godmother, or caregiver for a friend's children.

Women at Mid-life

Mid-life—generally considered the period between 40 and 60—is a time when many women come into their own, feeling grounded, independent, and satisfied with what they have.[4] However, while some women experience a new sense of adventure, for others, especially those with few resources, mid-life may be a tumultuous period. It is a time of personal reassessment, shifting relationships, and physical changes. Parents may die or become dependent, children may leave home, and intimate relationships may come to an end. All of these events can have particular impact on women with trauma histories.

Health problems that women were able to ignore in youth may now demand attention. Many sexual abuse survivors avoid routine preventive services, such as gynecological and dental care, and women in mid-life may find themselves facing invasive exams (for example, mammograms, colonoscopies, and rectal exams).

Respiratory problems and chronic pain—both related to adverse childhood events—may also become harder to ignore as aging occurs. As a peer supporter, you may want to help the women you support find health care providers who are trauma-informed, or role-play ways of minimizing the re-traumatization of a physical exam.

Women who enter peer support in mid-life may also be in the process of reviewing their lives for the first time in decades. They may voice a sense of disappointment, loss, or grief over years spent abusing substances, in institutions, or in destructive

DOING A LIFE REVIEW

A "life review" is one way to put experiences in perspective. It can help people to examine the trauma that has occurred over their lives and to reassess or reshape its meaning. The following questions can be used to start the conversation.

HAVE YOU LIVED A GOOD LIFE? DO YOU CONSIDER YOURSELF A GOOD PERSON?

What things did you consider in answering these questions?

Is this list different that it would have been when you were younger?

WHERE DO YOUR VIEWS COME FROM?

Think about the negative things that happened in your life. Did anything good come out of them?

Is there anything in your life about which you have felt ashamed, embarrassed, or guilty? Have your feelings about these events changed over time?

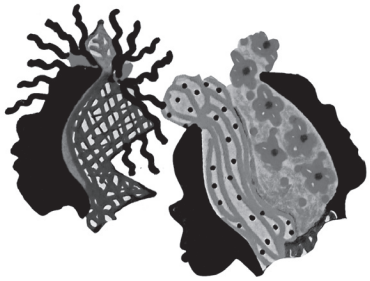
WHAT THINGS ARE YOU MOST PROUD OF?

Are there any things you would like to do that would make your life feel more complete?

WHAT NEW DIRECTIONS MIGHT YOU TAKE FROM HERE?

(Adapted in part from Judith Lyons, 2008)

[4] *Hunter, S., Sundel, S.S., & Sundel, M. (2002). Women at Midlife: Life Experiences and Implications for the Helping Professions. Washington, DC: National Association of Social Workers Press.*



relationships. Both situational and hormonal changes may trigger the emergence of old memories. However, the remembrance of old traumas can be healing, if it is done in a spirit of reflection; taking stock of one's life; and developing new directions, relationships, and activities. A peer supporter can help by encouraging women to focus on their strengths and survival skills. The sidebar on "doing a life review" illustrates one possible set of questions to start the discussion.

Elders

With age often come experience and wisdom, and many women find themselves enjoying new freedom as family and work responsibilities diminish. Others may face new struggles, such as living on a fixed income, being alone, or raising grandchildren whose own parents are not in a position to parent. As we age, coping strategies that worked in the past may not work as well anymore. Developmental milestones or the circumstances we find ourselves in as we get older may remind us of traumas that we thought had long been put to rest. Elders are also at risk for abuse at the hands of family members or caretakers. Peer supporters need to be alert to the signs of elder abuse and be prepared to intervene, if necessary.[5] These life changes can provide challenges to peer support relationships, but they can also provide new opportunities for healing.

Slowing down is a natural part of the aging process. For trauma survivors who have used active physical coping strategies, like physical exercise or staying busy at all costs, new physical limitations may unleash old trauma responses. Some trauma survivors literally work themselves to exhaustion in order to sleep through the night, and slowing down may cause sleep disturbances or intrusive nightmares. Even retirement can be a problem, as newfound leisure time allows old thoughts and memories to surface.[6]

The aging process may recreate conditions that surrounded the original trauma, such as dependency, isolation, or weakness. Women institutionalized in nursing homes may be re-traumatized by rigid rules and hierarchical structures, especially if their original trauma occurred in an institutional setting. The onset of dementia can also contribute to this process. Sometimes, traumas that were long forgotten or repressed come to consciousness for the first time as people begin living more and more in the past. It is important to honor these revelations and not dismiss them as a product of a failing memory.

Aging may also bring significant changes in family relationships and responsibilities. When a woman becomes a grandmother or a great-grandmother, or as she begins to prepare for the last stages of her life, there is a natural tendency to look back and consider her legacy. She may become acutely aware of how her own actions and experiences have affected her children and grandchildren. In whatever ways the women you work with approach the process of aging, it is likely to be both a challenge and an opportunity for healing.

Generational Issues

Has anyone ever asked you where you were when JFK or MLK was assassinated? Or when the Berlin wall came down? Or on 9/11? Are there particular personal or social milestones that you use to measure your life? It is common for people to divide their lives into periods marked by major events. To understand the women you work with, it is important to understand the historical circumstances in which their lives unfolded.

An obvious generational difference between women who grew up in the 1930s-1960s and those who grew up after that is the status of women in society and the accepted norms of behavior for women and children. Earlier generations often believed that one should tolerate whatever your parents did to you, that protecting the family's reputation was of primary concern, that women belonged in the home, and that children should "be seen and not heard."

For example, the generation that grew up during the Great Depression may harbor deep fears about having enough to eat. They lived through the Holocaust and internment camps and the McCarthy years and the Cuban missile crisis. And although they may have experienced domestic violence when their husbands returned from WWII or Korea, war was seen as heroic—and it was fought, of course, by men. They may be uncomfortable with technology and with globalization and feel powerless as the world changes around them.

In contrast, women born in the United States since the 1970s grew up in an interconnected global economy where events that happen on the other side

[5] *National Center on Elder Abuse, http://www.ncea.aoa.gov/ncearoot/_Main_Site/_About/_What_We_Do.aspx*

[6] *Lyons, J.A. (2008). Using a life span model to promote recovery and growth in traumatized veterans. In S. Joseph and P.A. Linley (Eds.), Trauma, Recovery, and Growth: Positive Psychological Perspectives on Posttraumatic Stress. New York, NY: John Wiley and Sons.*

IMPACT OF DEPLOYMENT

I returned from a year in Afghanistan to unexpected challenges. Being overseas in a war zone is incredibly stressful. At times I slept only three hours a day and I was always waiting for the next issue to arise, or crisis to happen. What I missed most was privacy—being able to find a quiet spot to be alone—and the feeling that the day is over, now I can relax.

When I deployed, my daughter was two and a half and in diapers. When I returned, I had missed a whole year of her life. She was potty trained, but I didn't know how to respond to her signals. I didn't know so much about her daily life—which clothes she liked to wear or which sippy cups leaked in the lunchbox. She would sometimes have complete meltdowns because I didn't know the basic stuff she thought I should know. And she didn't respond to me as a parent—I'd tell her to do something and she'd just wait until her father told her to do it. People in the community sometimes thought I was her babysitter and not her mother, or they completely misunderstood what it was like over there. Although I didn't experience MST or PTSD, it's been extremely challenging to reconnect with my daughter and my husband and my community.

– Jordanna Mallach

of the globe have consequences here. They grew up in a world where women's rights were already established, at least on paper. And while they grew up in a society of plenty, the chasm between the rich and the poor, between the privileged and those who are marginalized, widened steadily during their lifetimes. This created new distinctions between the haves and the have-nots. For example, those who cannot afford computers or smart phones, or who live in rural areas where internet access is limited, do not have access to the benefits these new technologies can offer.

Young women who can afford these devices may be comfortable with technology, although it opens them up to new forms of violence, such as cyber-bullying and sexting. They are used to being connected with friends at all times, even over huge distances. The Vietnam War was probably over before they were born and, for the most recent generations, wars are fought by women as well as men. Their formative years may have been shaped by school shootings, the events of 9/11, the "war on terror," and the devastation of Hurricanes Katrina and Rita, as well as other major disasters at home and across the globe.

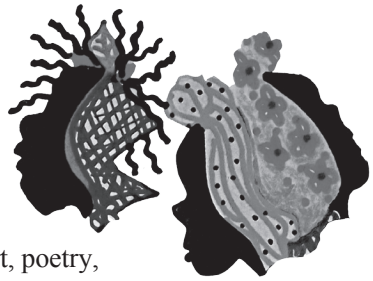
Obviously, the issues that arise in peer support relationships will be profoundly affected by these differences. Younger women may have had traumatic experiences that are completely outside the understanding of older women, and vice versa. The experience of women soldiers is a good example. Some of the younger women you work with might be veterans, and some might have served on combat missions, a situation essentially unheard of in earlier generations. The number of women in the military has steadily increased over the past two decades and women now make up 15% of the armed services.

Since 2001, more than half of female service members have been deployed, 85% of them to a combat zone. During the same period, over 21% of all female VA hospital patients screened positive for Military Sexual Trauma (MST), defined as "psychological trauma resulting from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment that occurred while a Veteran was serving on active duty."[7] A woman who experiences sexual assault in the military faces particular challenges, since the perpetrator is often in her own unit. She may hesitate to report the assault or seek help if the perpetrator is of a higher rank and or is otherwise in a position to affect her career. War trauma often compounds other forms of trauma. Women veterans are nine times more likely to be diagnosed with Post Traumatic Stress Disorder (PTSD) if they have a history of military sexual trauma, seven times more likely if they have a history of childhood sexual assault, and five times more likely with a history of civilian sexual assault.[8]

Military culture is very different from civilian life, and women veterans may experience a difficult readjustment period after discharge. Soldiers often benefit from a high level of interpersonal support and camaraderie with unit members, and may feel acute social isolation on returning to civilian life. The

[7] *Department of Defense FY 2009 Annual Report on Sexual Assault in the Military. http://www.sapr.mil/media/pdf/reports/fy09 annual report.pdf*

[8] *Department of Defense FY 2009 Annual Report on Sexual Assault in the Military. http://www.sapr.mil/media/pdf/reports/fy09_annual_report.pdf*



structure of military life may also make civilian life seem chaotic and unpredictable. Women who have left young children at home during deployment may find they have missed major phases of their child's development or that their child no longer relates to them as a parental figure. Women who return from deployment are also at risk for losing their children for a variety of reasons, including homelessness, unemployment, substance abuse, or marital strife. These reintegration issues can be compounded by trauma. As a peer supporter, you need to be aware of the possibility that military life may be part of the experience of the younger women you support.

Strategies for Peer Support

Being aware of lifespan issues will broaden the way you think about peer support. Many young people with trauma histories are gathering in their own groups and forming their own organizations, determined to create their own identities. Although they may never label themselves as trauma survivors, they use performance art, poetry, music, and political analysis as healing tools (see, for example, We Got Issues!). Other young women are using open mike nights at local hangouts to do spoken word performances. By working with young women in settings of their own choice, you can support them in creating the lives they want.

Older women may prefer not to talk directly about their trauma histories because their generation was raised not to discuss personal matters in public. Instead, they may find support in simply gathering to do something together, for example, book clubs or community service activities. Some older women may take in younger family members whose own parents are not

INTERGENERATIONAL HEALING: ONE FAMILY'S JOURNEY

Usually, healing is assumed to be an individual process. But trauma ripples out, affecting a widening circle of people. What if there was a way to go back in time and heal some of the "collateral damage" caused by trauma?

Ann Jennings is a mother of five and a grandmother of eight. Her third daughter, Anna, was severely sexually abused as a young child, starting at the age of 3. Anna's abuse was unseen, ignored, and discounted by the many systems she came into contact with. She committed suicide at the age of 32 in the back ward of a state hospital. Anna's story is powerful and has been a force for change in the mental health system. But what happened to Anna's siblings? What did they experience during the 29 years of Anna's life after the abuse began?

Ann recently began a process of intergenerational healing with her other four children, now grown with families of their own. She started by asking each child's permission to raise the issues. She then interviewed each of them, using the following four questions:

1) What was it like growing up in our family?

2) What was it like having Anna as your sister?

3) What was it like for you when Anna took her life?

4) How does this impact your life today?

Ann taped the interviews to ensure that her own memories and feelings did not distort what she heard from her children. She then asked permission to transcribe the interviews. One person said no, preferring to keep the process private for now. The others gave permission and also decided to share their recorded interviews with each other. Their conversations—still ongoing—are supporting and enhancing their own individual journeys.

The interviewing process also took Ann to new levels of understanding about her family of origin. She began to see patterns from her own childhood that had affected her and her eight brothers and sisters, and she began conversations with several of them. Revisiting her own childhood has helped her to understand herself better—if not yet to completely forgive herself—for unconsciously carrying these patterns into the raising of her own children. It has also deepened her relationship with several of her siblings.

During this process, Ann realized how important it was to seek help and support for herself. She sought out and engaged in a body-based healing process. She states: "So much of this is unconscious and is stored in my body. I just can't say it, or even get to it, in words. Regaining my body memories brings back aspects of my childhood that were long buried, and has been tremendously healing."

able to raise them, and pass on their years of wisdom by teaching them to protect themselves and preparing them to survive in their neighborhoods. Elders may also use political organizing as a tool for healing themselves and the world *(e.g., the Raging Grannies, http://www.raginggrannies.org).* Helping to connect the women you support with groups like this can be a wonderful step towards meaningful community life and personal healing.

CHAPTER SUMMARY: KEY POINTS

- Women of different ages are vulnerable to different forms and manifestations of trauma.
- Children who experience abuse or neglect at a very young age may have their sense of safety shattered or have attachment problems.
- Teenage girls who are raped may come to fear or avoid intimate relationships.
- In mid-life, health problems may emerge for trauma survivors who have avoided routine preventive care.
- Elders may face the re-emergence of trauma issues that they have not thought about for years.
- Some of the younger women you work with might be veterans, and some might have served on combat missions, a situation essentially unheard of in earlier generations.
- Being aware of lifespan issues can help broaden the way you think about peer support.

Resources

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National Center for Victims of Crime, **http://www.ncvc.org**

Department of Veterans Affairs National Center on PTSD, **http://www.ptsd.va.gov/public/pages/traumatic-stress-female-vets.asp**

Grace after Fire, an online social network for female veterans, **http://garden.graceafterfire.org**

Defense Center for Excellence, **http://www.afterdeployment.org**

TRAUMA AND PEER SUPPORT RELATIONSHIPS

As a result of trauma, the women you work with may not believe that they have the ability to do more for themselves than what they are currently doing. This chapter will help you recognize ways in which peer support relationships may inadvertently reinforce a survivor's experience of trauma and how the principles of peer support can address these challenges to healing. By emphasizing authentic, mutual relationships and by using simple, non-clinical language, you will be better prepared to connect with the women you support, even if your experiences are very different.

Reconnecting with Self and Others in Peer Support Relationships

Violence and abuse can lead to disconnection from self and others. Peer support emphasizes reconnection. You may wonder how to be of assistance in the presence of helplessness, hopelessness, grief, rage, despair, distrust, and/or sense of disability. It is important to recognize that it is not up to you to empower women to claim their own lives. As a peer supporter, your role is to develop relationships that allow women to use their own voices and to name their own experiences in order to reclaim power and control over their own lives. It is crucial that peer supporters examine their own ways of interacting to make sure their actions do not create barriers to survivors' growth and healing.

The Need for Reconnection

Meaningful relationships can help people heal. But, as we discussed in Chapter 1, women and girls are most likely to be hurt by someone they know. This means that it may be very hard for women who are trauma survivors to form those essential connections. They may find it difficult to trust you or to trust that others are not out to hurt or betray them. Particularly when trauma has been a pervasive, ongoing part of her life, a woman may feel at the mercy of others and that she has little opportunity to say what she wants and to act on her own needs.

Women raised in homes where women are not respected may feel that they are inferior and may look to you for direction and to make important decisions. They may not understand that relationships are built on give and take and may feel that they have nothing to offer. Or a woman may have developed styles of relating that further isolate her; for example, she may be overly aggressive or hostile, which can make connecting difficult.

Because many trauma survivors have spent time in programs, institutions, communities, or families where they were given few options and had little control over their lives, they may have learned to be dependent and helpless as a way to respond to threat. Or they may have learned that the only way to survive is to fight. In response to trauma, some women disengage or retreat from the present and create their own reality.

You may be familiar with the three responses to danger referred to as fight, flight, or freeze. These are natural responses to any perceived or real threat that allow for optimal use of the body's resources for self-protection. For example, in a fight or flee response, adrenalin courses through your body while oxygen rushes to your limbs, providing extra energy to run for your life or stand and fight. The freeze response allows both your mind and/or body to shut down, perhaps to lie still until danger passes, or to "zone out," or "disappear." These responses can be misinterpreted and labeled in ways that often lead to negative or punitive reactions to women who are simply struggling for control over their bodies, minds, and selves.

As a result of their responses to trauma, survivors often find themselves involved with behavioral health, criminal justice, child welfare, or homeless services. When staff in these organizations are not aware of the impact of trauma, they may use power and control in ways that make a trauma survivor's sense of powerlessness even more intense. While staff may believe they are doing something for the individual's own good, they may actually be doing harm, as this reinforces a survivor's experience of powerlessness. Practices that are meant to help but which do not take trauma into account run the risk of re-traumatizing women who are already trauma survivors, or causing traumatic response in women who have not previously experienced trauma. In Chapter 1, we saw that re-traumatization happens when something in the environment recreates an aspect of a previous traumatic situation and triggers a trauma response.

Consider this example:

The Emergency Department of a busy hospital has a policy requiring nursing staff to confiscate the clothes of people who are admitted for self-injury or suicidal feelings. The policy was developed to protect patients by ensuring that they do not have a concealed weapon. Brenda is a woman who experienced a rape some time ago but never reported it. She is admitted for self-injury and is asked to take off her clothes, but refuses. Brenda is held down by a male security guard while a nurse removes her clothes. This practice—intended to protect her—has instead re-traumatized her. The forced disrobing in the presence of a male staff and the experience of being held down against her will mirror her past assault experience. Brenda's heart starts pumping, she can't think clearly, her breathing gets shallow, and her fight, flight, or freeze response kicks in.

The ER staff may not recognize Brenda's reaction as trauma-induced. If she is too disruptive, she may find herself in chemical or physical restraints, or in a police car upon discharge, bewildered by what just happened. If she dissociates to protect herself (consciously or unconsciously) from the perceived assault, she may be labeled with an even more disabling diagnosis, without her trauma experience ever coming to light.

Not only has she just re-experienced the rage, helplessness, and humiliation of the original assault, but now Brenda must also contend with the impact of the current event. Since re-traumatization erodes one's natural coping resources and resiliency, it is essential that supporters recognize where and when power imbalances occur.

In Chapter 10, we will discuss in more detail the challenges facing peer supporters who work in organizations that are not trauma-informed and some strategies that can be used to work toward resolution of these issues.

Re-traumatization in Peer Support Relationships

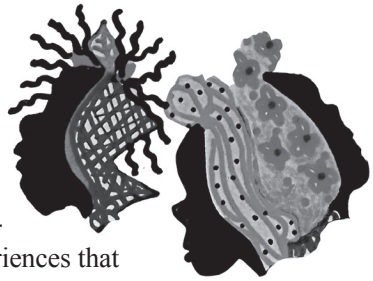
As we have seen, deliberate abuse of power is damaging, but what if peer supporters are not aware of the power they have and how women they support may experience these power differences? In Chapter 1, we saw that sources of interpersonal trauma include any situation in which one person misuses power over another. If you provide peer support as staff of a program, many practices that your organization considers "business as usual" may actually create power imbalances that can reinforce survivors' feelings of powerlessness. These power differences challenge the peer support principle of mutuality.

Because there may be tasks required of you as peer support staff that have the potential to cause power imbalances, being sensitive to how these activities may impact women who have had little power in their lives is crucial. Being trauma-informed means recognizing and then adjusting or modifying current practices in light of your understanding of trauma and its devastating consequences.

It is important to recognize that you may not be able to change some requirements of your job, such as writing progress notes, but you can, for example, write the progress notes collaboratively with the women you are supporting. It is important to recognize where potential power imbalances occur so that these can be addressed with the women you support.

Principles of Peer Support in Action

Being trauma-informed means recognizing some of the ways that "helping" may reinforce helplessness and shame, further eroding women's sense of self and their ability to direct their own lives. It means recognizing things you may be doing in your relationships that keep women in dependent roles, elicit anger and frustration, or bring on the survival responses of fight, flight, and/or freeze. "Helping" can also send the mistaken idea that one person—the helper— is more "recovered" than the person who is being "helped." The roles of helper/helpee can become fixed, especially for peer supporters who work as paid staff, causing both people to get stuck in roles that limit growth and exploration.[1]



Peer support relationships, with their emphasis on mutuality, provide an opportunity to shift the focus from problems and problem-solving to learning about the experiences that have shaped each other's lives. In the process of learning rather than helping, peer supporters and the women they engage will discover a larger, richer context for understanding and appreciating each other.

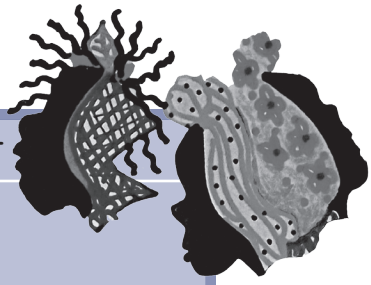
[1] *Mead, Shery (2005, 2007, 2008). Intentional Peer Support: An Alternative Approach. Available at http://www.mentalhealthpeers.com*

CHARACTERISTICS OF TRAUMATIC RELATIONSHIPS	HOW PEER STAFF MAY REINFORCE TRAUMA
• Impose authority	• Tell her that she needs to take her meds
• Invalidate personal reality	• Interrupt her to take a call or answer email
• Take away voice	• Dismiss her distress since she has a diagnosis of borderline personality or assume her reactions are paranoid or delusional
• Communicate worthlessness	• Write your opinions of her progress in daily notes
• Humiliate and shame	• Enter a "staff-only" area with a card key
• Create mistrust and alienation	• Walk into the "staff" bathroom rather than the "client" bathroom
• Take away power and control over what is happening	• Tell her you are only there to help and she needs to stop fighting you; discuss her when she is not present
• Use power to control or intimidate	• Lock a door; create program schedules without her input
• Include the experience of being dominated, controlled, or manipulated	• Wear keys to parts of the building attached to a belt loop or arm loop
• Violate personal boundaries and sense of safety	• Decide who gets to talk next in a group
• Involve coercion	• Press her for personal information
	• Grant privileges based on compliance

Trauma-informed peer support provides a lens for understanding the larger context of women's lives. While "helping" relationships that are not trauma-informed are often based on the assumption that the problem originates in the person, trauma-informed relationships take into account the ways that trauma may have shaped a woman's experience in the present. Her current environment—her family, community, program, or relationships—plays a huge role in her experience of self and her relationships to others. The way that people participate in the present has everything to do with their past experience.

The shift to practices that are trauma-informed is often illustrated by systems moving from asking the question: "What is wrong with you?" to asking the question: "What happened to you?" It is also important to ask about the meaning these events have for the women who experienced them. The table below shows how each question impacts women's relationships to services and supports. In settings that are not trauma-informed, the focus is on trying to stop women's distressing behaviors, thoughts, and feelings. In trauma-informed environments, the impact of a woman's trauma history provides a context for understanding her distressing thoughts, feelings, and behaviors.

PROGRAM THAT IS *NOT* TRAUMA-INFORMED ASKS "WHAT IS WRONG WITH YOU?"	TRAUMA-INFORMED PROGRAM ASKS "WHAT HAPPENED TO YOU?"
Examples: • "I am hearing voices." • "I want to hurt myself." • "I'm depressed/can't stop crying." • "I feel like dying." • "I feel like hurting someone." • "I can't manage my anger. I'm in trouble with the law." • "I keep using even though I can't pay my rent now."	**Examples:** • "I was raped, so now I'm scared and afraid to leave my house and go to work." • "I don't think I've ever felt like someone cared." • "My partner of thirty years died suddenly. I'm all alone now." • "I was called crazy and locked up while I was a teenager, so I don't know how to make friends." • "I was sentenced to prison and lost custody of my child, so now I can't keep her safe." • "After I was diagnosed, all my dreams and hopes died."
What does "help" look like? • Focus is on her "needs" as defined by staff: "She needs to stop hearing voices." • The "helper" decides what "help" looks like. • Relationships are based on problem-solving and resource coordination, not on creating meaningful connections. • Safety is defined as risk management. • Common experience between peer staff and clients may be assumed and defined by the setting; i.e., common experience in a clinic is based on "illness" and coping with "illness."	**What does "help" look like?** • Creating and sustaining a sense of trust and safety in relationships. • Safety is mutually defined by both people. • Collaboration and shared decision-making. • Understanding and acceptance of big feelings. • Crisis becomes an opportunity for growth. • Authentic relationships are emphasized, rather than common experience. Everyone recognizes that people rarely have the same experience or make the same meaning out of similar events.



IMPACT OF TRAUMA	PRINCIPLES OF PEER SUPPORT
• Invalidates personal reality	• Non-judgmental
• Creates mistrust and alienation	• Empathetic
• Loss of power and control	• Respectful
• Feelings of helplessness and hopelessness	• Honest and direct communication
• Feelings of voicelessness	• Mutual responsibility
• Being dominated, controlled, or manipulated	• Power is shared
• Violates personal boundaries and sense of safety	• Relationships are reciprocal

Peers involved in trauma-informed relationships report that using the principles of peer support in conjunction with the trauma-informed question "What happened to you?" helps them think through their relationships with women survivors. In the chart above, the column on the left lists some of the ways trauma impacts women. The column on the right lists principles of peer support. One way to read this information is to think about how the principle in the column on the right might help women heal from the trauma experiences listed in the left column. For example, if a woman has been told, "You are so stupid you will never get a GED," she may adopt her persecutor's belief. A peer supporter who is non-judgmental would NOT say, "You're right, after so many years out of school, you probably won't be able to pass your GED." Instead, she might say, "I don't know if you can pass, but I am excited for you about the journey ahead. Would you like my support?"

The principles of peer support directly influence healing relationships by contradicting many of the destructive messages that women have internalized about who they are. Putting these principles into action creates opportunities for women to re-evaluate themselves and their relationships with others.

What is "Common Experience" in Peer Support?

In Chapter 3, we defined peer support as "people who share similar experiences coming together to offer each other encouragement and hope." But what if trauma does not describe what went on in your own life? What if you are a man trying to support a woman? What if you are trying to support a woman who does not share your values, your heritage, or something that is essential to how you view yourself and your world? If you feel like your experience is fundamentally different, how can you find commonality in peer support?

It is easy to make the mistake of basing relationships with women survivors on the trauma-uninformed question "What is wrong with you?" This is especially true if you work in a system that reinforces deficit-based relationships. For example, relationships based on a label of "mental illness" or on the experience of incarceration or homelessness or substance use: "You and I share the lived experience of addiction." This is only part of the picture; these experiences alone do not define you or the women you support. Basing peer relationships only on these factors may keep the relationship on superficial ground. This narrow definition of common experience can increase the likelihood of disconnection by excluding anyone who does not share exactly the same experience. Assuming common experience based solely on labels might push people away if you believe that others will respond to situations in the same way that you did or that they should do what you did in order to recover.

EXPLORING THE IDEA OF "COMMON EXPERIENCE" IN PEER SUPPORT: AN EXERCISE

Tammy works as a peer supporter in an outpatient clinic. She believes that her sobriety began once she accepted that she was an alcoholic. In college, she had used alcohol to help deal with her shyness, but then used it to cope with anything that made her anxious or uncomfortable. Her alcohol use led to her expulsion from school. She "hit bottom" and entered a residential treatment program. She is proud that she was able to get sober and stay sober one day at a time for the past three years. On her job, she feels that she has a lot to give to other women struggling with addiction.

Lila was referred to the clinic by her physician, who recognized her alcohol issues. She once worked with her husband at the Twin Towers in New York. Due to a bad cold on September 11, she decided to stay home. Like many others, Lila's life changed forever that day. She felt guilty that her husband died and she had not. Once a social drinker, she now found herself drinking every night just to go to sleep and stop the nightmares. Instead of helping, the alcohol made things worse. She no longer wanted to be around her friends or her husband's family. She lost her job and sometimes thought about killing herself. Ten years later, she still feels numb and disconnected. Her only emotion is anger.

If Tammy is not aware of the impact of trauma and defines her connection to Lila on the basis of addiction, she might miss some important opportunities for connection. The conversation might go something like this:

Tammy: I understand you've gone through a lot and I'm really sorry, but you've got to take control of your life. You need to start living one day at a time. You can't change the past. It's gone. I've been there. I can help you.

Lila: I don't know why I even thought you people would have a clue. You have no idea what I've been through. You're like everyone else, just telling me to move on, let go, get a life.

Instead, assume that Tammy is aware of the impact of trauma, even though she has not had that experience. She understands the principles of peer support: mutuality, respect, and shared power. She thinks about "common experience" from a broader perspective than their shared experience with alcohol abuse.

Tammy: I know I can't even imagine what you've been through, Lila. I'm just so glad you made it here.

Lila: Thanks. You're the first person who hasn't told me to move on and forget the past. Or pity me or try to take care of me, or start talking non-stop about your own stuff.

Tammy: It takes a lot of strength for women like us to survive.

Lila: So you've been there too?

Tammy: I don't know what being there means for you but, for me, I was incredibly angry with myself. My addiction cost me college and stability and my family. I hated myself.

Lila: Me too. I hate myself, Tammy. I get so mad at the universe, I stay alive out of spite.

Tammy: That anger sounds pretty powerful, and pretty helpful. When I think about it, my own anger kept me alive, too.

Lila: Maybe anger is something I can use….to make some changes, I don't know….

Tammy: I wonder what other sources of power our anger might reveal. Can we keep talking?

Lila: Yes, OK.

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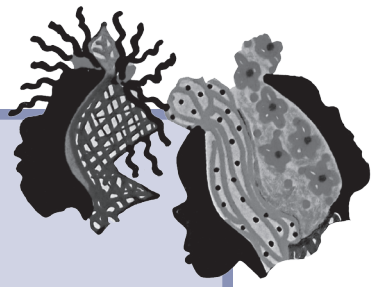

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How did Tammy create a connection with Lila, whose own experience is very different from hers?

- She expressed care and sadness rather than judging Lila and telling her what she should do.
- She created a two-way relationship by being open to learning from Lila.
- She found connection through their shared feelings of anger.
- Tammy and Lila got to look at their experiences with anger in very different ways.
- Tammy did not assume that what worked for her recovery would work for Lila.

MALE PEER SUPPORTERS WORKING WITH WOMEN SURVIVORS: AN INTERVIEW WITH MIKE SKINNER

Q: Tell me a little bit about your work.

A: I'm a musician and a public speaker, and I've done mental health advocacy and one-on-one support. I started a nonprofit, The Surviving Spirit, and I'm in touch with people every day through that connection and our newsletter. I started years ago as a volunteer with the New Hampshire Incest Survivors Center.

Q: What's the most important thing for men working with women trauma survivors to remember?

A: I learned that when I was willing to be open about my experience, people would start to share their own. People need to remember that they can be triggers for each other—men or women. At the Incest Survivors Center, I noticed that one woman was shying away from me, keeping me at arm's length. Then we did an art event, and she brought some of her artwork. She had painted the man who had assaulted her, and he looked a lot like me—tall, with a beard. That was a great learning experience.

Q: Have women ever gotten angry at you for being a man working with women?

A: Oh yes! I'm a tall man, and my size can intimidate people. I have had a lot of anger thrown at me. I try to be gentle in response, to say, "I understand that you are fearful, please know that my own childhood was full of trauma by both males and females. I am trying really hard not to shut women out of my life." Most of the time that message gets through. I see their expression soften, and we can have a dialogue. I try never to say, "I feel what you are feeling." People's experiences are unique, and I can't feel their feelings. But I point out that I still feel fear and shame, and that's why I sometimes isolate myself.

Q: What other suggestions do you have for men working with women trauma survivors?

A: "Learn to listen and listen to learn." We are all human; we all like to start yakking away. But we need to learn to be silent and NOT interject, especially when a trauma survivor starts to open up. Learn to stay with silence when it comes; be patient, even if it seems like forever. It is important to validate someone's story. I have witnessed people who have been invalidated, not only by treatment providers, family members, and friends, but by their peers, even those trained as peer support specialists. We mustn't shut people off with denial, avoidance, and silencing. Peers should make sure they have done their own healing work; too many have not. One of the most powerful healing tools we have is the ability to share our experience and have it heard. For many, this may be the first time that they open up to someone.

Q: Are there any final thoughts you'd like to leave us with?

A: I believe we need to be working together, men and women, to solve these issues. Many of us were young people when we were abused, and our abusers were adults. Now we have grown up and we will have much more power if we work together. Of course, there are men and women who are angry at each other, and there are times when men need to be with just men and women need to be with just women. But it's unfortunate if we create gender silos. I hope we have a paradigm shift so that we can join forces.

The Language of Peer Support

Every service system has its own way of talking about people who come into contact with it. For women with psychiatric diagnoses who have experienced violence, diagnostic and clinical language limits their ability to communicate who they are, what their lives have been about, and what they feel, think, and perceive as a result of their experiences.

Women who have been in the system for a long time may come to view all their experiences through the lens of "illness." If you have been in the system, you may understand how easily one can learn to refer to intense feelings as "relapse," or talk about "being depressed" rather than sad or grieving. Relationships may revolve around "maintaining wellness" rather than taking risks and exploring new ways of living. Being constantly on the lookout for any feeling, perception, or thought that is out of the ordinary, too big, or too scary can set people up to be constantly on guard for signs of returning "symptoms." Instead of being able to tolerate discomfort as a natural consequence of growth and change, peer relationships can get bogged down with things like "contracting" around "safety," or helping each other identify potential signs of returning "instability." [2]

The language used by systems has several purposes. One is to identify and categorize the "problem" in order to determine a strategy to deal with it, often a "treatment plan" or a "risk management plan." In contrast, everyday language is what people use to describe experiences that are part of the human condition. Using everyday language instead of "symptom-speak" lets people relate to and connect with someone's situation, perspective, and feelings beyond the experience of "illness" or "problem behavior." This is not to say that people do not experience what they may call "symptoms," but to suggest that peer support relationships help us reconsider how women have been taught to name their experience of distress.

[2] *Mead, S. & Hilton, D. (undated). Crisis and Connection. Available at http://www.mentalhealthpeers.com*

The shared experience of peer support is often revealed when peer supporters move away from the language of service systems and begin to use the language of everyday life: "I am so bleeping mad!" instead of "I must be getting manic" or "I should take a PRN." This creates opportunities for connection based on what our lives are about, not merely what our problems are: "Why are you mad?" rather than "I'll let your doctor know you need a PRN," becomes the natural response to someone who expresses anger.

Everyday language:

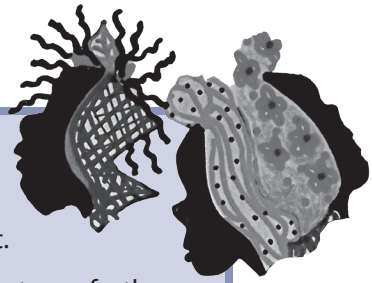
- Has a non-clinical focus.
- Creates the type of relationships we have in the community rather than service relationships or "helping" relationships.
- Provides a context for understanding what is going on for the person.
- Supports individuals to move beyond the identity of "mental patient," "addict," or "inmate."
- Allows us to make meaning out of our experiences and to have that meaning understood by others.

CLINICAL LANGUAGE

Diagnostic and clinical language tends to be problem-focused and deficit-based. It typically describes what is "wrong" with the person and what needs to happen to solve the problem. Trauma-informed peer support uses the language of human experience, asking instead, "What happened to you?" so that women are invited to talk about the totality of their experience.

How would your own life story change if you could only tell it using clinical language? How would your description of mental health challenges and recovery change if there was no clinical, diagnostic language?

Think back to a critical time in your life and describe it using everyday language. What have you learned as a result of what has taken place in your life?



CHAPTER SUMMARY: KEY POINTS

- Trauma is a disconnecting experience. Peer support offers survivors a way to reconnect.
- Survival responses are often misinterpreted in treatment settings and result in labels that may further incapacitate women who are trying to cope.
- It is critical to pay attention to power differences in peer support relationships, as these differences can reinforce women's sense of being "less than" or cause re-traumatization.
- The principles of trauma-informed peer support contradict many of the negative messages women have received about who they are and what they are capable of.
- Common experience in peer support can be understood as the formation of authentic relationships where shared experience is explored rather than assumed.
- The language of peer support is the language of human experience rather than clinical language. This allows women to explore the totality of their lives in the healing journey.

Resources

Copeland, M. E. & Mead, S. (2004). *Wellness Recovery Action Plan and Peer Support: Personal, Group and Program Development.* Peach Press. Available by order at **http://www.mentalhealthpeers.com** or **http://www.mentalhealthrecovery.com**

Emotional CPR, **http://www.emotional-cpr.org**

Estes, Clarissa Pinkola (2003). *Women Who Run with the Wolves: Myths and Stories of the Wild Woman Archetype*. New York, NY: Random House.

Sharma, Kriti. *Moral Revolution! Creating New Values, Undermining Oppression, and Connecting Across Difference.*

Mead, Shery & MacNeil, Cheryl (2004). *Peer Support: What Makes It Unique?* Available as a free download at **http://www.mentalhealthpeers.com/booksarticles.html/**