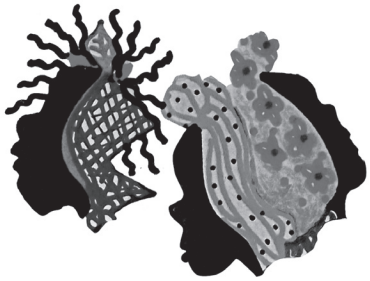
ENGAGING WOMEN IN TRAUMA-INFORMED PEER SUPPORT:

A Guidebook

by Andrea Blanch, Beth Filson, and Darby Penney
with contributions from Cathy Cave

We Are All Here by Sharon Wise

DRAFT



ENGAGING WOMEN IN TRAUMA-INFORMED PEER SUPPORT:

A Guidebook

by Andrea Blanch, Beth Filson, and Darby Penney
with contributions from Cathy Cave

April 2012

Acknowledgements

This technical assistance document was developed by the National Association of State Mental Health Program Directors (NASMHPD) and Advocates for Human Potential, Inc. (AHP) under contract number HHSS2832007000201 for the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS). Its content is solely the responsibility of the author(s) and does not necessarily represent the position of NASMHPD, AHP or SAMHSA.

Dedication

This guide is dedicated to the women survivors who participated in SAMHSA's Women, Co-Occurring Disorders and Violence Study (WCDVS), the first of its kind in the nation. Consumers/Survivors/Recovering Women (C/S/Rs were integrated as leaders in substantive and meaningful ways, including in the design of the research and evaluation methodologies; in peer support and service interventions; and in the Leadership Academy and the Trauma Studies Seminar program. For the first time, women who had experienced violence and abuse were incorporated as instruments of teaching and learning in the fields of mental health, substance abuse, and trauma services and studies.

TABLE OF CONTENTS

INTRODUCTION 1

SECTION I. FUNDAMENTALS 3

Chapter 1. Introduction to Trauma and Trauma-Informed Practices. 3

Chapter 2. Am I a Trauma Survivor? 8

Chapter 3. Peer Support Fundamentals 13

Chapter 4. Gender Politics and the Criminalization of Women 19

SECTION II. CULTURAL CONSIDERATIONS 25

Chapter 5. Culture and Trauma 25

Chapter 6. Religion, Spirituality, and Trauma 33

Chapter 7. Trauma-Informed Peer Support Across the Lifespan 39

SECTION III. MOVING INTO ACTION. 47

Chapter 8. Trauma and Peer Support Relationships. 47

Chapter 9. Self-Awareness and Self-Care 56

Chapter 10. Organizational Context: Working in Systems 62

Chapter 11. Trauma-Informed Storytelling and Other Healing Practices. 70

Chapter 12. Self-Inflicted Violence and Peer Support 77

Chapter 13. Reclaiming Power Through Social Action 86

INTRODUCTION

This guide was created for a very specific purpose: to help make trauma-informed peer support available to women who are trauma survivors and who receive or have received mental health and/or substance abuse services. It is designed as a resource for peer supporters in these or other settings who want to learn how to integrate trauma-informed principles into their relationships with the women they support or into the peer support groups they are members of. The goal is to provide peer supporters—both male and female—with the understanding, tools, and resources needed to engage in culturally responsive, trauma-informed peer support relationships with women trauma survivors.

As a peer supporter, you may work or participate in a variety of roles and settings. For example, you may offer peer support services as paid staff or as a volunteer in mainstream behavioral health programs, or in independent peer-run programs. You might also be a member of a voluntary mutual support group organized by people who have received services. Perhaps you work in the homeless services system, in the justice system, or in the veteran's service system. In whatever way you are involved in peer support with women who have received mental health and/or substance abuse services, this guide was written for you.

The guide is organized in three sections: **Fundamentals, Cultural Considerations,** and **Moving Into Action**. The first section provides basic information on topics related to trauma, trauma-informed services and supports, peer support, and the social and cultural factors that affect women trauma survivors. The second section discusses cultural considerations for working with women who are trauma survivors, including race, ethnicity, spiritual and religious factors, and age and generational concerns. The third section focuses on concrete ways to bring an understanding of these issues into active peer support relationships with women trauma survivors. All sections offer exercises you can do by yourself or with a group, and point you to books, articles, and websites that you can use to explore each topic more deeply.

FUNDAMENTALS

In this section, you will be introduced to important information about trauma, the principles of trauma-informed practices, and the ways in which trauma and trauma-informed services and supports can impact women's lives. You will learn about some basic values and principles of peer support that are grounded in the experience, research, reflection, and writing of people who have been involved with peer support. This section also provides information about gender politics and the criminalization of women in the context of trauma. Cultural considerations that impact peer support work with women trauma survivors are discussed. The goal of this section is to provide you with basic information and resources that will help prepare you to apply a trauma-informed philosophy to your day-to-day peer support work with women who are trauma survivors.

CULTURAL CONSIDERATIONS

Race, ethnicity, language and other cultural considerations that impact peer support work with women who are trauma survivors are examined in this section. There is a focus on cultural biases and historical trauma experienced by many ethnic groups, as well as spirituality and religion. The impact of trauma across the lifespan is also discussed.

MOVING INTO ACTION

The chapters in this section focus on tangible ways that you can apply your understanding of trauma, trauma-informed practices, peer support, and the particular issues facing women who have histories of trauma and who have used behavioral health services. This section shows how peer support is rooted in mutual relationships. The value of self-awareness and self-care for all participants in peer support is described. You will learn about the importance of shared values, a common language, and taking a culturally sensitive, non-clinical approach to peer support. Specific skills that will enable you to engage women trauma survivors in a meaningful way are explored. Crucial information is presented to help you work successfully as a peer supporter within organizations that are not yet trauma-informed. Information is presented about the causes of self-inflicted violence and how to work respectfully with women who self-injure. The role of religion and spirituality in the lives of women trauma

survivors is explored, as well as a discussion about how trauma affects women across the lifespan. There is a discussion of how trauma survivors can become involved in social action and reclaim their power by working for positive change as part of the healing process. Each chapter includes a list of print and electronic resources that may be used to explore the subject area of the chapter more extensively, and many chapters include exercises or illustrative stories.

A Note About Language

An important message within this guide is that women have the right to define themselves and their experiences in ways that have meaning for them. To that end, we have tried to avoid diagnostic and illness labels (except when quoting material), as well as jargon specific to the behavioral health system. Instead, we have tried to use descriptive, non-judgmental terms, such as "women who have experienced violence" and "women who are trauma survivors," while recognizing that some women may not find these terms personally useful, either. In the end, it's important that peer supporters recognize and support each woman's way of naming her experiences and talking about herself as part of the healing process.

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 symptoms 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

Three-ten 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 psychiatric symptoms, 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.

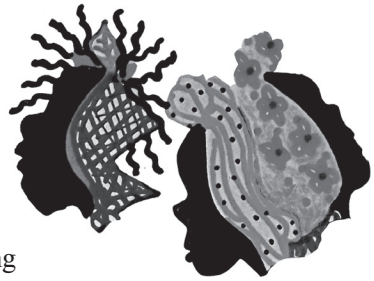
54% of depression in women can be attributed to childhood abuse.

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 counseling" 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 with the lived experience of 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 they have made 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 symptoms 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 has 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.

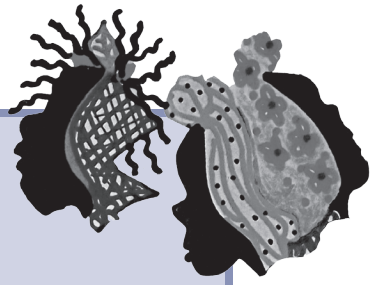
> Trauma-informed services don't ask, "What's wrong with you?"
>
> They ask, "What happened to you?"
>
> *– Sandra Bloom*

[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.

Harris, M. & Fallot, R. (Eds.) (2001). *Using Trauma Theory to Design Service Systems*. San Francisco, CA: Jossey Bass.

Jennings, A. (1998). On being invisible in the mental health system. In B. L. Levin, A. K. Blanch, and A. Jennings (Eds.), *Women's Mental Health Services*. Thousand Oaks, CA: Sage.

Joseph, S. & Linley, P.A. (Eds.) (2008). *Trauma, Recovery and Growth*. New York, NY: John Wiley & Sons.

Levine, P.A. & Frederick, A. (1997). *Waking the Tiger: Healing Trauma: The Innate Capacity to Transform Overwhelming Experiences*. Berkeley, CA: North Atlantic Books.

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.

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

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

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.

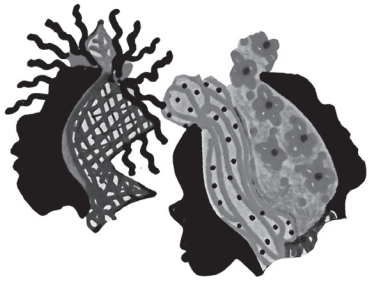
Even adults can have a hard time recognizing abuse and trauma. Many women who experience date rape, for example, are unsure how to categorize their experience. They might think because it wasn't a stranger and he didn't hold a gun to their heads, that somehow it didn't "count" as rape. Or they might 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?

Continued on page 10

Continued from page 10

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 inter**ven**tions 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

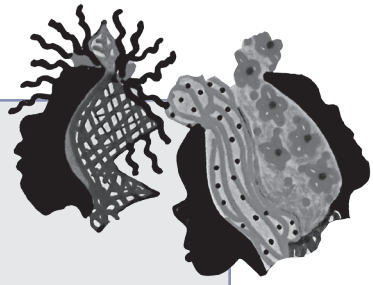
In the following excerpt by Pat Deegan, she refers to herself, or is referred to by others, as "a schizophrenic," "multiple personality disorder," "an abuse survivor," and "chronically mentally ill." Consider the implications of each of these labels for Pat and for staff working in the system.

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

Continued on page 11



Continued from page 10

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 zlabeled 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

Cape, A.L. and Clay, S. (2003). *Triad Peer Specialist Training Manual.* Tampa, FL: University of South Florida.

Deegan, P. (1994). *Before we dare to vision, we must be willing to see.* Keynote presentation at Dare to Vision Conference, July 14-16, 1994, Arlington, VA.

Wilkerson, J.L. (2002). *The Essence of Being Real: Relational Peer Support for Men and Women Who Have Experienced Trauma.* Baltimore, MD: Sidran Press.

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 (peer) 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 freestanding, 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.

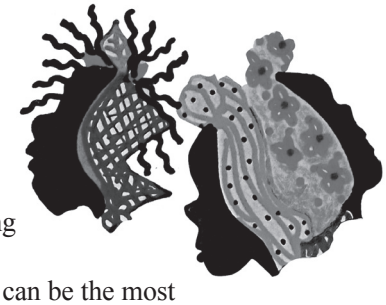
Principles of Peer Support[6]

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.

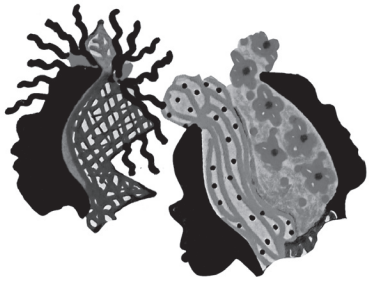
Where Does Peer Support Take Place?

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).

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.

Harp, H. & Zinman, S. (1994). *Reaching Across II: Maintaining our roots/ The Challenge of Growth*. Sacramento, CA: California Network of Mental Health Clients.

Mead, S. (undated). *Trauma Informed Peer Support.* Available at **http://www.familymentalhealthrecovery.org/conference/handouts/Workshop%209/Trauma%20informed%20Peer%20Support.pdf.**

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, 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

WOULD YOU KNOW WHAT TO LOOK FOR?

Lara is 37 years old and has been hospitalized many times with diagnoses of an eating disorder and major depression. She lives with her boyfriend, whom she met in the state hospital several years ago. Lara has one child, but she lost custody of her child 13 years ago.

Lara came to the peer center after being discharged from the state hospital. She was hospitalized five days earlier when her boyfriend called 911 after an apparent overdose of her medication. Lara has overdosed many times before, always saying that it was the only way to get out of the apartment. It has been repeatedly noted in her records that she is "manipulative" and stages minor overdoses to get attention. The peer supporter knows about the impact of trauma, and gave Lara an opportunity to talk about her childhood. Lara described early sexual abuse and a gang rape at age 14. They decided to work together on the impact of Lara's trauma history on her feelings and behaviors. Several months later, Lara was back in the hospital with another overdose.

While the peer supporter acted with sensitivity about Lara's trauma history, she hadn't thought much about her boyfriend. In fact, Lara was being abused by her boyfriend. He sometimes became highly suspicious and jealous, and to protect his "rights" to Lara he would lock her in the apartment with no phone and no way to get out. Lara knew that if he found her after an apparent overdose he would call 911 to "save" her. Because of her trauma history, Lara didn't understand that relationships could be safe. She didn't mention the problem with her boyfriend because she feared losing both her relationship and her place to live. After contacting the local domestic violence shelter, Lara began working on a safety plan, housing options, and began rethinking her options for relationships.

DISCUSSION QUESTIONS:

Would you have realized that Lara was being abused by her boyfriend? Why or why not?

Why do you think that domestic violence is sometimes overlooked by mental health providers?

Domestic violence is a reality for many women, with or without psychiatric diagnoses. To learn more, see the Domestic Violence and Mental Health Policy Initiative,

www.dvmhpi.org.

GENDER ROLE SOCIALIZATION AND VIOLENCE

Despite the advances made by women during the 20th century, our society is still fundamentally male-dominated, and many Americans embrace socialization practices based on physical dominance. The majority of Americans endorse spanking or other forms of physical discipline;[1] corporal punishment in schools is still allowed in 19 states and is used routinely in eight states.[2] While corporal punishment remains controversial, there is little doubt that if it is experienced as shameful, unwarranted, or abusive, it can have lasting psychological consequences.

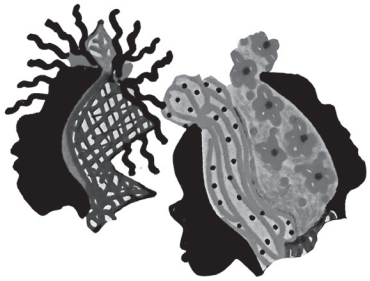
For girls, learning to be compliant through physical force is coupled with mixed messages that increase vulnerability to abuse as adults: "be equal, but learn to submit; be peaceful, but expect to be the object of violence; be powerful, but expect the most important leadership positions to go to men."[3] For boys, being physically dominated while being socialized to be powerful may create a vicious cycle of powerlessness, denial, shame, and vulnerability that may be dealt with through domination of others. In this way, both women and men may have been conditioned to live out patterns of abuse.

These dynamics create a backdrop for interactions among one's peers. In whatever setting you work, both men and women may act from a sense of "victimhood" related to their past experiences. Gender-related violence—sexual assault, domestic violence, sexual harassment—may be a part of their lives, and may even occur within peer relationships. In addition, the behavioral health system may unintentionally contribute to a failure to recognize these behaviors.

[1] *National Association of Pediatric Nurse Practitioners (2011) NAPNAP Position Statement on Corporal Punishment.*

[2] *World Corporal Punishment Research, www.corpun.com.*

[3] *Wineman, S. (2003.) Power-Under: Trauma and Nonviolent Social Change, p.125. Available at http://gis.net/~swineman/*



Because the system is so focused on diagnosis and illness, behavior is often assessed in terms of "mental illness." So, in a psychiatric setting, an incident that might quickly be identified as domestic violence anywhere else may be written off as a symptom of "mental illness." For instance, a woman's report of being stalked or harassed may be misconstrued as paranoia. As a peer supporter, it is crucial that you become familiar with the dynamics of gender-related violence, the signs to watch for, and ways to intervene to ensure safety.

SOCIAL CONSTRUCTIONS OF WOMEN'S EXPERIENCE

Women are socialized to defer to power, and if they do not comply with these expectations, their behavior may be labeled as deviant. This is a common process—the man who demands his own way is often described as "a strong leader," but the woman who does the same thing is called "aggressive." The process of constructing women's experience as sick, crazy, or criminal is institutionalized in both medical and legal institutions.

The Medicalization of Trauma

The history of psychiatry is full of examples of women being portrayed as over-emotional and prone to imagined conditions, starting with the diagnosis of "hysteria" used for women in the 19th century. Currently, women are far more frequently prescribed drugs for anxiety, stress, or normal life changes (such as childbirth or menopause) than men. In the 1960s and 70s, there was a national scandal about the over-prescription of addictive drugs to women, many of whom were living in intolerable or abusive situations. While the most damaging drugs were removed from the market or more carefully controlled, the tendency to "medicalize" women's problems rather than to deal with the underlying causes has not changed.

For women with severe abuse histories, the process of medicalization can be life-destroying. Survivors of violence usually try to make sense of their experience, "reconstructing" their self-identity to incorporate their experience. If people around them refuse to acknowledge or condemn the abuse, the survivor may come to the same conclusion. For instance, she may come to believe that "it didn't happen" or "it happened, but it wasn't important and has no consequences" or "I provoked (and deserved) it — it wasn't abusive."[4] The survivor may repress and deny the trauma in order to survive. And if she does that, what other explanation for her distress is there, other than that she must be "crazy?"

The Criminalization of Women Trauma Survivors

The number of women in the criminal justice system has increased dramatically since 1980. Many enter the justice system because of domestic violence or the criminal activity of their male partners. According to a Howard University Law School professor: "A woman may be married to a man who deals drugs and the woman has only a very basic low-level involvement. She may answer the phone and take messages... and yet, with drug laws the way they are now, she gets charged with conspiracy for the total amount of the drugs."[5] Incarceration reflects social patterns of racism; women of color are disproportionately incarcerated, while white women are disproportionately given probation.

PATHWAYS FROM VICTIM TO CRIMINAL

Girls run away from home to escape violence and end up in juvenile justice.

Women end up homeless due to violence, are picked up by police, and charged with petty crime.

Women use drugs to cope with pain and end up in the justice system.

Violence impoverishes women, causes loss of job and benefits, and women turn to crime to survive.

Women are arrested for defending themselves or their children from violence.

Once in the legal system, women are not taken seriously as victims and have a harder time getting released.

– From Mary Gilfus, 2002

[4] *Carmen, E. & Reiker, P. (1989). The victim-to-patient process: Clinical perspectives. In Dare to Vision, proceedings of a conference held July 14-16, 1994, in Arlington, VA. Holyoke, MA: HRA, p. 47.*

[5] *Torian, S. (2001). Criminalization of women. Southern Changes, 22(3), 24-25.*

Women may also end up being "criminalized" as they attempt to escape from domestic violence. As shown in the sidebar, there are multiple pathways through which women and girls who are being abused end up in the justice system, where they are most often treated as criminals rather than victims.[6] And of course, incarceration itself can be fundamentally traumatizing.

The legal system offers little help to women with psychiatric diagnoses. Once diagnosed with a mental illness, women's trauma histories are persistently discounted or ignored within the legal system. In fact, for women with a diagnosis of borderline personality disorder, the impact of the law is "pervasive and almost wholly negative."[7] About 76% of all people who receive this diagnosis are women, and a very high percentage of them are sexual abuse survivors. Women who are diagnosed as "borderlines" often behave exactly as you would expect, trying to gain control back over themselves and others, and angrily confronting people in authority. But rather than recognizing their history and providing supports, the legal system may deem them "not disabled enough" to receive benefits, but far too troubled to be able to care for their own children or even themselves.

Implications for Peer Support

Many of these issues will surface again in later chapters, which are designed to help you develop the specific skills you need to work with women in peer support relationships. It is critical that you develop the ability to look through a "gender lens," since so many aspects of experience depend on gender identity. Using a gender lens will help you to create a safer environment, recognize potentially abusive interactions, and develop services and supports that are more responsive to the needs and histories of both men and women.

[6] *Gilfus, M.E. (2002). Women's Experiences of Abuse as a Risk Factor for Incarceration. Harrisburg, PA: VAWnet, a project of the National Resource Center on Domestic Violence/Pennsylvania Coalition Against Domestic Violence. Available at http://www.vawnet.org.*

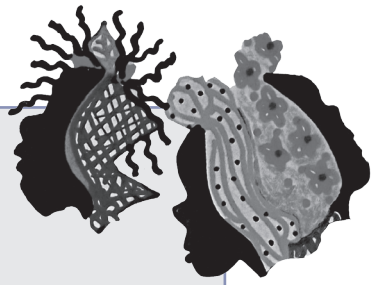
[7] *Stefan, S. (1998). Impact of the law on women with diagnoses of borderline personality disorder related to childhood sexual abuse. In B. Levin, A. Blanch, & A. Jennings (Eds.), Women's Mental Health Services (240). Thousand Oaks, CA: Sage.*

TONIER'S STORY

At age 9, I believed I would amount to nothing. My mother was an alcoholic. I had 8 brothers and sisters. My mother "entertained" all the time, and when she stopped singing and laughing, I knew I would hear the footsteps coming to my door. There were a lot of sexual assaults, a lot of abuse. Sometimes I couldn't go to school, but no one asked me why. I also started drinking at age 9. When I started to drink, my mother would slap me down, but when the men came, it didn't feel as painful, so I drank.

Eventually someone noticed and they sent out a social worker. She removed us from the family immediately, and put us in foster care. I was given back to my mother, but she needed a place to live, and she had an alcoholic friend of hers who she thought was pretty cute. So I married him, and she moved in. I was pregnant, and every day he beat me. Then I started using crack cocaine, and I didn't have to feel. I thought I never had to feel anything ever again. But unfortunately, the cocaine introduced me to the criminal justice system. I stand before you with 86 arrests and 66 convictions. They told me I was going to spend the rest of my life in and out of prison or on the streets. They kept calling me crazy and I didn't know why.

Continued on page 23



Continued from page 22

I was a "repeat offender" and every time I was arrested it got worse. I was raped so many times I can't count them, but they assigned me a male counselor. I was alone with this man, sharing the things that had happened to me, and how despite it all I had graduated the program, and he raped me. And he told me, no sense telling anyone about it, you're just a convict, a prostitute. He has since been held accountable for his actions, but given my history, maybe a male counselor wasn't the best thing for me.

One of the worst things was being put into seclusion or restraint. I don't care if the room is padded or not, it triggers my issues with my mother. My survival mode kicks in. One time I pushed a tray out my face, and someone got hit with the tray. So they call a code, and then I'm down on the ground being restrained. Restraining a rape victim? Doing more harm, causing more trauma.

I lived under a bridge for 19 years. But then I ended up in the Maryland Correctional Institution for Women, and I got into this program. The first thing they told me was that what had happened to me wasn't my fault. And you know what? After years of everyone telling me that I deserved everything I got, I believed them, and my thought process changed. One of the best things I did was to take a course on how to be a mother. I had lost 4 kids to the system, I knew how to do that, but I didn't know how to take care of a kid. I had been told that when they cry, they're attention seeking. When you come from abuse, sometimes it takes real work not to be abusive. And I didn't want that for my daughter.

Today I'm a homeowner. My daughter goes to a private school. Treating my trauma, you kept me out of your system, and I'm grateful. You also helped me to break that intergenerational curse I had in my family. My daughter will never know what I felt. She doesn't know what it's like to live in the projects, to be hungry. All she knows is that my mom loves me, feeds me. What if, at age 9, someone had recognized my trauma? Isn't it possible that I could have become the woman I am today without the substance abuse, the homelessness, the psychiatric diagnoses? And I have one last question. When I was in prison—83 times in and out—when you looked across your desk and saw me, would you have seen the woman I am today? Would you have been able to see a woman who would be speaking to all of you at a federal roundtable meeting? Do you truly believe in the people you serve? Treat the trauma. You're going to get different results. I promise you. I am the evidence.

CHAPTER SUMMARY: KEY POINTS

- Throughout history, women have been considered the property of men. Women's rights to control their own lives have only been established within the last 50 years.
- When women do not conform to societal expectations, they may be labeled as crazy or criminal.
- Socialization practices based on physical dominance set the stage for both women and men to live out patterns of abuse.
- Gender-related issues, such as women's health, parenting, and domestic violence, are sometimes overlooked by social service systems.
- Women often enter the criminal justice system as a result of actions they take to escape from violence, or as a result of the behaviors of their husbands or boyfriends.
- The legal system offers little protection to women who have been diagnosed with mental illnesses, many of whom are trauma survivors.

Resources

Balfour, G. & Comack, E. (Eds.). *Criminalizing Women. Gender (In) justice in Neoliberal Times.* Toronto, Ontario: Brunswick Books.

Bloom, B., Owen, B., & Covington, S. (2000). *Gender-Responsive Strategies: Research, Practice and Guiding Principles for Women Offenders.* U.S. Department of Justice, National Institute of Corrections.

Cain, Tonier. *Healing Neen*. Videotape available from the National Center on Trauma Informed Care.

Covington, S. (1998). *The Relational Theory of Women's Psychological Development: Implications for the Criminal Justice System.* Paper presented at the 50th Annual Meeting of the American Society of Criminology, November 11-14, 1998, Washington, DC.

Frohman, S. & Neal, C. (2005). *The probation response to supervision of women who are abused.* Violence Against Women Online Resources. Available at **http://www.mincava.umn.edu/documents/commissioned/probationanddv/probationanddv.html.**

Gilfus, M. (2002) *Women's Experiences of Abuse as a Risk Factor for Incarceration.* Harrisburg, PA: VAWnet, a project of the National Resource Center on Domestic Violence/Pennsylvania Coalition Against Domestic Violence. Available at **http://www.vawnet.org.**

Miller, A. (1983). *For Your Own Good.* New York, NY: Farrar, Straus, Giroux.

Prescott, L. et al (2008). *A Long Journey Home. A Guide for Creating Trauma-Informed Services for Mothers and Children Experiencing Homelessness.* Rockville, MD: The Substance Abuse and Mental Health Services Administration/Center for Mental Health Services, the Daniels Fund, the National Child Traumatic Stress Network and the Kellogg Foundation. Available at **www.homeless.samhsa.gov.**

Stefan, S. (1998). Impact of the law on women with diagnoses of borderline personality disorder related to childhood sexual abuse. In B. Levin, A. Blanch, & A. Jennings (Eds.), *Women's Mental Health Services.* Thousand Oaks, CA: Sage.

Torian, S. (2001). Criminalization of women. *Southern Changes,* 22(3), 24-25.

Warshaw C., Pease T., Markham D., Sajdak L., & Gibson J. *Access to Advocacy: Serving Women with Psychiatric Disabilities in Domestic Violence Settings: A Curriculum for Domestic Violence Advocates.* Washington, DC: U.S. Department of Justice Office of Violence Against Women.

Women and Trauma. Report of the Federal Partners Committee on Women and Trauma (June, 2011).

Domestic Violence and Mental Health Policy Initiative, **www.dvmhpi.org**

GAINS Center, **www.gainscenter.samhsa.gov/html/**

CULTURE AND TRAUMA

Trauma always happens within a context, and so does healing. To understand the impact of trauma means being acutely sensitive to the environment—to the conditions under which people grew up, to how they live today, and to the journeys they have taken along the way. This chapter provides basic information about how cultural considerations impact the meaning we make of our experiences and can affect both the experience of trauma and the development of peer support relationships.[1] We hope to help you become aware of ways in which your own cultural experience may affect your attitudes and behaviors towards others. We will also explore how assumptions about others can affect peer support, and how services sometimes fail women of color, refugees and immigrants, people who live in rural areas, and women viewed as "different" because of sexual orientation, religion, or other cultural factors.

Racism and Cultural Biases

Culture affects every aspect of a woman's life and identity. Culture determines views about seeking help: where to go, who to see, what is helpful. The assumptions made about culture can become barriers to working effectively in peer support relationships. For example, race can be the most recognizable aspect of a woman's cultural heritage and can set the stage for how people work together, but many times the assumptions we make about race are wrong.

> We don't see things as they are, we see things as we are.
>
> *– Anais Nin*

As a peer supporter, it is important to look at your own attitudes and behaviors. We all have stereotypes and misinformation about groups different from our own. It is common for these stereotypes to influence the work we do and the judgments we make about people.

IN THIS GUIDE, WE USE THE FOLLOWING DEFINITION OF "CULTURE:"

"The shared values, traditions, arts, history, folklore, and institutions of a group of people that are unified by race, ethnicity, nationality, language, religious beliefs, spirituality, socioeconomic status, social class, sexual orientation, politics, gender, age, disability, or any other cohesive group variable."

– N.N. Singh, 1995

If asked, most people would not identify themselves as racist or as participants in discrimination. However, they may tolerate existing disparities or be passive when witnessing injustice. Recent research suggests that about 85% of European Americans hold unconscious "aversive biases" toward people of color, even though they do not hold overtly prejudiced beliefs.[2] These unconscious beliefs and feelings may affect your relationships and interactions with your peers, who may pick up these feelings even if you don't!

Similarly, in the United States, European Americans and men experience "white privilege" and "male privilege"— benefits and advantages that result strictly from their social status. In her article, "White Privilege: Unpacking the Invisible Knapsack," Peggy McIntosh identifies over twenty ways in which she has benefited from white privilege. Regardless of your cultural background, you may have benefited from an education, from having a steady job, or from having other forms of advantage. People who have always been in a favored position—whether it comes from gender, race, education, money, high-status jobs, or position within a group—may assume that they can do what they want without interference, and that the systems, structures, and rules of society are there to support them. Most people have some mix of privilege and disadvantage.

[1] *Many of the concepts in this chapter are drawn from work by Cathy Cave of Advocates for Human Potential. Inc.. Some of her work can be found at http://www.unlimitedmindfulness.com/.*

[2] *Brown, L.S. (2009). Cultural competence. In C.A. Cortois & J.D. Ford (Eds.), Treating Complex Traumatic Stress Disorders. An Evidence Based Guide. New York, NY: Guilford Press.*

LAVERNE'S STORY

I am sure that the constant bullying I experienced in elementary and junior high school had something to do with the onset of my depression. I was part of the first group of African American students to be "bussed out" to predominantly white schools. I was placed in classes for the intellectually gifted and was almost always the only brown face in the class. I felt so isolated. The white kids did not want to sit next to me and often made remarks about the color of my skin while the African American students called me an "Oreo." I was frequently harassed and beat up on the bus. Things got so bad that at the age of 8, my parents and I decided it would be safer for me to take public transportation to and from school. This only added to my isolation and increased the bullying. I became increasingly isolated, and I don't think that my parents or the schools knew how to support me. I gave up trying to get protection from the bullying and retreated into my own little world. I think that's when I first started to think that the world would be better off without me, and starting thinking the dark thoughts that would become full blown depression in college. Healing from bullying has been an ongoing process. I still sometimes feel out of place, regardless of where I am or who I am with. Reading about others who have overcome adversity and writing poetry were very healing. I learned that I was not alone and that there were other ways to connect with my thoughts and feelings. Finding a peer group has also been important. The unconditional love and support I get from my peers has made me feel more accepted. They reach out to me even before those dark periods come—several peers just check in knowing that I am very unlikely to check in with them when I get down.

- LaVerne Miller, Esq.

Often, because people have grown up with certain advantages, they forget that they have them.[3] Our position—in groups and in society—can create "filters" that determine how we see the world.

Acknowledging your own advantages and recognizing racial or other cultural biases may be difficult or feel shameful, but having honest conversations about these issues can help you to build effective peer support relationships. This is particularly important when working with trauma survivors, who are often skillful at detecting dishonesty and who have good reason to be attuned to issues of power and authority. Also, it is essential that you recognize any areas that create a sense of powerlessness in you, whether they are related to trauma or to discrimination. Topics that touch on your own history with oppression can be particularly challenging.

As a peer supporter, failure to recognize when you are acting from a position of power, or feeling powerless even though you have authority, can make you ineffective and may cause you to do harm to others in your peer support relationships. Your anger, frustration, or hurt may affect your ability to think clearly, stay respectful towards others, and act within the guiding principles of peer support. It is important to be able to say, "I can't do this right now," and just as important to return when you can to discuss the challenge.

Community Perspectives

We know from the research discussed in Chapter 1 that the impact of trauma and toxic stress accumulate over time, affecting every aspect of an individual's life. Violence and trauma have similar effects on communities. In order to understand the experience of the women you support, it is critical to understand the communities they grew up in, as well as the communities they currently call home.

Historical Trauma

Maria Yellow Horse Brave Heart, a pioneer in the field, defines historical trauma as: "Cumulative emotional and psychological wounding over the lifespan and across generations, emanating from massive group trauma." As a peer supporter, it is important to recognize that the people you work with may carry deep wounds from things that happened to their people, rather than or in addition to what happened to them as individuals.

[3] *Robinson, M. Frost, D., Buccigrossi, J., & Pfeffer, C. (2003). Gender, Power and Privilege. Rochester, NY: wetWare, Inc.*

Many groups have a legacy of historical trauma. In addition to Native Americans, families of Holocaust survivors, and descendants of enslaved Africans, many cultural groups carry historical trauma—either from violence in their home countries or from what happened to them when they arrived here. For example, there are 24 Asian and 19 Pacific Islander ethnic groups in the United States, each with a unique history. Southeast Asians often arrived as refugees; Japanese-Americans may have been incarcerated in internment camps during World War II; Hawaiians and Pacific Islanders were colonized by the United States. Similarly, Latinos/Latinas in the United States trace their origins to 20 Latin American and Caribbean countries, Spain, and Portugal; their presence predates the Pilgrims and their history is replete with oppression and trauma. Members of many religious groups have also suffered persecution. Historical trauma, coupled with present-day racism, creates the context for many groups.

Historical trauma has a particularly devastating impact on women and children. Historical trauma, racism, and poverty combine to create health disparities and may contribute to high rates of interpersonal violence. For example, American Indian/Alaska Native women experience intimate partner violence at twice the rate of any other group, they are raped or sexually assaulted 2.5 times as often as others, and the suicide rate among children and youth is almost 300% higher than that of whites.[4]

Some people assume that the impact of historical trauma is largely in the past. But reactions to trauma and violence often become embedded in social behavior, while their original context may be forgotten. A parent who uses harsh child-rearing practices may be unaware that she is acting from a historical legacy, either from her culture or from her family. Similarly, "helping systems" that may seem benign to the dominant group may be deeply re-traumatizing to groups that have been persecuted in the past.

Gender, Culture, and Sexual Orientation

Women often face "multiple oppressions," such as gender discrimination compounded by discrimination due to their racial or ethnic group, religion, sexual orientation, poverty, as well as living with ongoing violence. While many of us may think of extreme violence as an aberration, for some women, violence is the norm. Hate crimes, racial profiling, and gender-based violence are still far too common. If the people you work with seem to be in a constant state of hyper-vigilance, remember that they may live in a state of chronic stress, which is itself a profound source of trauma.

Refugees, immigrants, and others who have been displaced face the additional stress of cultural dislocation, which can be severe. Women and girls from countries involved in war are likely to have significant violence in their backgrounds. Women and children now make up over 80% of all war casualties. Women are at high risk for torture, rape, and gender-based violence during war, migration, or in refugee settings. They may have experienced violence and trauma in their home countries, and the violence

HISTORICAL TRAUMA IN AMERICAN INDIAN/ ALASKAN NATIVE COMMUNITIES

This agency forbade the speaking of Indian languages, prohibited the conduct of traditional religious activities, outlawed traditional government, and made Indian people ashamed of who they were. Worst of all, the Bureau of Indian Affairs committed these acts against the children entrusted to its boarding schools, brutalizing them emotionally, psychologically, physically, and spiritually . . . The trauma of shame, fear, and anger has passed from one generation to the next, and manifests itself in the rampant alcoholism, drug abuse, and domestic violence that plague Indian country . . . Poverty, ignorance, and disease have been the product of this agency's work. And so today I stand before you as the leader of an institution that in the past has committed acts so terrible that they infect, diminish, and destroy the lives of Indian people decades later, generations later. These things occurred despite the efforts of many good people with good hearts who sought to prevent them. These wrongs must be acknowledged if the healing is to begin.

– Kevin Gover, Asst. Secretary for Indian Affairs, Dept. of Interior, on the 175th anniversary of the founding of the Bureau of Indian Affairs, Sept. 8, 2000

[4] *Substance Abuse and Mental Health Services Administration (SAMHSA) (2009). American Indian/Alaska Native Communities' Trauma Informed Care Work Group Report.*

often does not end at resettlement.[5] For some refugee women, the stress of being in a new country—and not knowing if they might at any moment be sent back—is more traumatic than the violence they originally fled.

However, it is important not to assume that women are always victims. Many women overcome the most severe forms of violence and trauma with courage and strength, going on to become leaders in their communities. Sometimes women are reluctant to disclose the violence in their background because they fear that their identity will be overwhelmed by a pervading sense of "victimhood." As a peer supporter, you can help overcome this fear by consistently responding to and acknowledging the personal strengths and the cultural identity of the women you support.

As a person, I have membership in many cultural groups, and while none is more important than another, because they all contribute to the whole, one may have greater momentary significance in my healing and recovery. One identifier does not overpower or negate the existence of other cultural connections and no one else can determine the value of my connections. I am always African American, always a woman, always a survivor, always a parent, always a partner, always spiritual.

– Cathy Cave

Unfounded fear and misinformation about sexual orientation is another source of potentially traumatizing discrimination, overt hostility, and violence. The Urban Justice Center reports that 30% of lesbian, gay, bisexual, transgender, queer or questioning, intersex, and two-spirited (LGBTQI2S) youth experience abuse or neglect from their families of origin; almost that many are forced to leave their families; and 100% of LGBTQI2S youth in NYC group homes report being verbally harassed.[6] LGBTQI2S youth may also engage in high-risk behaviors known to be associated with trauma: They are twice as likely as straight youth to report binging on alcohol, smoking cigarettes, or using marijuana. They also are three times more likely to try other drugs (cocaine, inhalants, hallucinogens, depressants, stimulants), to have eating disorders, or to attempt suicide. Unlike many other cultural groups, LGBTQI2S women also risk losing contact with their family and support systems when they "come out." For a woman of color, there will likely be support from her community to address race-based violence. But if she is a lesbian, she may quickly lose that support, leaving her isolated. For peer supporters, it is important to consider these aspects of oppression and talk with each woman about her experiences.

Culturally Relevant Healing and Support

Cultural competence involves using information from and about individuals and groups to transform our skills and behaviors to match the health beliefs and practices of the people we support.[7] One of the most basic ways of providing culturally responsive healing and support is to ensure that the individual can interact in their language of choice. People have a legal right to an interpreter provided at no charge—a right that sometimes gets forgotten in peer support environments.[8] It is important to be sure women know they have that right and to make it possible for them to participate in their own language. The United States Department of Health and Human Services' Office for Minority Health's Culturally and Linguistically Appropriate Services Standards and the website for the National Center for Cultural Competence can be helpful.

There are an infinite number of cultural considerations that can affect an individual's identity and outlook. It may be where she is from that is most important: rural or urban, north or south, east coast or west coast. It may be her spirituality, values about education, or her ability to parent children. It could be that what is important today may be more or less important next time you meet. One vital thing you can do as a peer supporter is to assume nothing and to create space in your conversations for each woman to explore and define her own cultural identity.

[5] *Blanch, A.K. (2010). Understanding refugee trauma; and, Innovative program approaches to refugee trauma. Chapters in S.A. Estrine, H.G. Arthur, R.T. Hettenbach, & M.G. Messiana (Eds.), Service Delivery for Vulnerable Populations: New Directions in Behavioral Health. New York, NY: Springer Publishing.*

[6] *Urban Justice Center (2001). Justice for All? A report on LGBTQ youth in the NY Juvenile Justice System. New York, NY. Available at www.urbanjustice.org.*

[7] *Davis, King (1998). Race, health status and managed health care. In Brisbane, F. L. & Epstein, L. G. (Eds.), Special Collaborative Edition CSAP Cultural Competence Series (7) (145-163). Rockville, MD: SAMHSA, Center for Substance Abuse Prevention.*

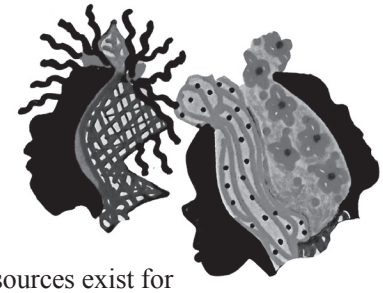
[8] *National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care, http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15*

It is important for peer supporters to stay open and curious about someone else's culture and experiences and to develop a habit to "check in" about cultural considerations regularly as part of developing peer support relationships. Staying curious allows for exploration of what has happened, what it means to the individual's grieving, and what healing approaches make the most sense. Any "facts" you think you know about a cultural group should be checked with the person you are working with to see if they apply to her life. Most people are happy to tell you about their cultural experiences, beliefs, and values when you become a trusted support.

For example, in some cultures, the good of the family or the community is considered a higher value than the good of the individual. For people whose culture values individual empowerment, it may be challenging to remain nonjudgmental and supportive when women embrace values that appear not to be in their individual best interest. Finding a way to honor and respect the women you support, despite apparent differences, is fundamental to your role.

As a peer supporter, it is also part of your role to help women connect to culturally relevant supports and healing resources in the community. In your community, you may find resources that attract specific groups. For example, perhaps there is a women's center, a community center that provides services for women and their children, or maybe a housing program for people who are homeless that offers a monthly Native American Healing Circle. Several of the Peer Recovery Centers mentioned in Chapter 3 serve a majority of people of color. These programs often incorporate healing rituals and social norms that are important to the community, like hospitality and authenticity. One program described their emphasis on learning how to be honest with each other, noting that "truth telling" might not have been the norm for some people during the time when they were actively misusing substances.

In remote rural areas, community resources may be scarce and hard to access. Women may live in isolated settings without access to transportation or to the Internet, confidentiality and anonymity may be difficult to maintain, and the impact of labeling may be magnified. Often, the general healthcare practitioner plays a key role as confessor, counselor, and problem-solver. Faith communities may play a significant role in organizing social, as well as spiritual, activities. In these situations, it is particularly important to offer opportunities for people to come together through safe, less stigmatizing activities such as art, writing, wellness, or children.



In some communities, specific resources exist for refugees and immigrants. There are close to a hundred ethnic community-based organizations called Mutual Assistance Associations (MAAs), in 25 states. MAAs are self-help groups that assist refugees in a variety of ways, providing cultural preservation and social activities, religious services, resettlement and social services, business and economic development, and advocacy and political action.[9] All build on a mutual support model, connecting people with their peers, sharing resources and information, and encouraging integration and self-sufficiency.

NEW YORK ASIAN WOMEN'S CENTER (NYAWC)

NYAWC was founded in 1982 by a group of volunteers from the Asian community who recognized that Asian immigrant women had nowhere to turn when faced with domestic violence. They work to overcome violence and trauma by empowering women to govern their own lives. Currently NYAWC includes a multilingual hotline (with 11 different languages), shelter services, advocacy, a children's program, and public awareness.

One special focus is on helping survivors of human trafficking to regain their freedom and recover from trauma. Project Free coordinates with law enforcement and legal services and provides emergency shelter, trauma counseling, and case management.

Human trafficking—modern day slavery—is the fastest-growing criminal industry in the world. An estimated 17,500 foreign nationals are trafficked annually in the United States, many of them forced into the sex trade. The majority of victims of human trafficking are women and young girls from Central American and Asian countries.

For more information, see: www.nyawc.org.

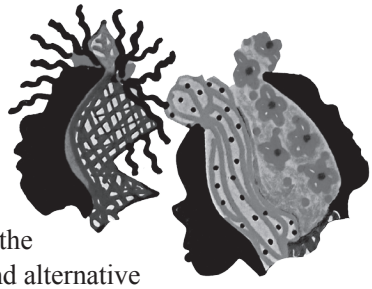
[9] *Ranard, D.A. (1990). Mutual assistance association: Refugee self-help groups play key role. In America: Perspective on Refugee Resettlement, March, 1990.*

In many communities, cultural healers are highly valued: shamans, natural healers, herbalists, medicine men, "curanderos" (folk healers), or others to whom people turn in the context of their own culture for help and healing. Music, dance, storytelling, and art may be deeply healing, helping people to reconnect with their own cultural traditions. You can also add a cultural dimension by encouraging the women you work with to learn more about their own history. Maria Yellow Horse Brave Heart and the Takini Network[10] have developed an intervention to heal historical trauma by working through four stages: 1) Confronting the trauma and embracing history, 2) Understanding the trauma, 3) Releasing the pain, and 4) Transcending the trauma. In this model, understanding one's history is a key to healing, because it helps people to become aware of

[10] *Brave Heart, M.Y.H. (2005). From intergenerational trauma to intergenerational healing. Keynote address at the Fifth Annual White Bison Wellbriety Conference, Denver, CO, April 22, 2005.*

COMMON CULTURAL MISTAKES ABOUT TRAUMA	MORE CULTURALLY SENSITIVE APPROACH
Assuming everyone who has experienced violence needs professional help	Assuming people are resilient and giving them many opportunities to tell you if they need help
Focusing on the most extreme instances of violence as the most damaging	Allowing the individual to define what aspects of her experience have been most traumatic and recognizing that this may change over time
Assuming that violence is unusual, an aberration, and generally perpetrated by individuals	Recognizing that violence is perpetrated by groups and institutions, not only individuals, and may be so common that people become desensitized to it
Applying norms and standards of behavior without considering political and social context	Recognizing that political and social oppression may affect priorities and values; allowing the individual to define the meaning of what she has experienced
Relying on DSM diagnoses or lists of trauma "symptoms"	Recognizing that trauma responses are varied and that different cultures express grief and loss and understand trauma differently; learning how this person and her culture expresses distress
Assuming that one woman's story represents the "typical" story for the group	Recognizing that "one woman's story is just one woman's story"
Inadvertently highlighting the stories of women that fit cultural stereotypes	Providing opportunities for many women to share their stories, and noticing what is unique; making sure many points of view are represented
Assuming that if people speak English, you don't have to worry about an interpreter or translated documents	Recognizing that some topics are very difficult to talk about in anything other than your first language; knowing and acting within the law about provision of language assistance services
Assuming that people always (or never) want to tell their stories and that if people want help they will ask for it	Being aware that self-disclosure and help-seeking vary widely across cultures and may be dependent upon whether a woman feels safe with you; learning from each woman what her cultural norms and expectations are

unconscious sources of grief and anger. This model also encourages the use of traditional mourning and grieving ceremonies. The western concept of "trauma" may not make sense in all cultures, but every culture has ways of handling loss and suffering. Reclaiming these rituals and ceremonies can be deeply healing.



Common Cultural Mistakes in the Trauma Field

Below is a chart showing some of the most common cultural mistakes and alternative responses to the same situation. Read through the chart and consider how you can make your own peer support relationships more culturally sensitive. Notice that using these "alternative" responses can help you be more trauma-informed in your interactions with all the people you work with, not just those from other cultures.

GRANDMA ETTA'S STORY

As a child, I frequently dodged the bricks thrown by my elderly great-grandmother, a small, dark, wiry woman, as she guarded her front porch. By professional standards, Grandma Etta was probably mentally ill, suffering from extreme paranoia and an intense hatred of white people. On the days that I could get close to her, I could hear her muttering about blue-eyed devils, and her favor target of attack was a blond-haired, blue-eyed teacher who frequented my family's restaurant, which unfortunately was attached to her house. In her mid-seventies, my great-grandmother was moved to a nursing home after it was determined that she was completely blind (and probably had been for some time). She died less than two weeks after being admitted to the nursing home. Her death did not surprise me because I could not imagine her being contained in any space that she did not control.

I was young then, wrapped up in my own life and struggling with the embarrassment I felt when people made fun of Grandma Etta by calling her "crazy." It was years later that I began to look through boxes of family pictures and see the world of rural Missouri where she grew up. I really thought about the fairness of my grandmother's skin and wondered if there was some connection with my great-grandmother's hatred of "blue-eyed devils." I visited her hometown many years later—afraid to get out of my car in this rural, white world—and wondered how her "paranoia" may have kept her safe in this hostile territory.

I start with my grandmother's story because it reminds me of the importance of understanding a person's history before judging behavior. Context is everything, and that is a poorly understood principle in the history of psychiatric treatment. Grandma Etta escaped the oppression of a psychiatric label and the treatments that are frequently imposed after the labeling process. Other members of my family, myself included, were not so lucky. I offer libations to Grandma Etta for escaping the bonds of psychiatric labeling and to my sister, Michelle Yvette Jackson, who was not so lucky and who committed suicide in June 1984 after a four-year struggle with depression and life.

– *Vanessa Jackson, Introduction to In Our Own Voice: African American Stories of Oppression, Survival and Recovery in Mental Health Systems*

Discussion Question

1. **Discuss the various forms of trauma that occur in this story. How many of them were labeled as trauma?**
2. **Do you think Grandma Etta was paranoid? Mentally ill? Why do you think she might have hated the "blue-eyed devils" so much?**
3. **How did Grandma Etta's experience affect her children, grandchildren, and great-grandchildren?**

CHAPTER SUMMARY: KEY POINTS

- Culture affects every aspect of a woman's life and identity, shapes how she makes meaning of her experiences, and often determines her view about seeking help: where to go, who to see, what is helpful.
- Acknowledging your own racial or cultural biases and having honest conversations about these issues is particularly important when working with trauma survivors.
- Historical trauma, coupled with ongoing racism and poverty, has a devastating impact on women and children.
- Women often face "multiple oppressions:" gender bias compounded by discrimination due to their racial or ethnic group, religion, sexual orientation, poverty, or conditions of ongoing violence.
- One important thing you can do as a peer supporter is to assume nothing and to create space in your conversations for each woman to explore and define her own cultural identity.
- As a peer supporter, it is also part of your job to connect the women you support to culturally relevant supports and healing resources in the community.

RESOURCES

Blanch, A.K. (2010). Understanding refugee trauma; and Innovative program approaches to refugee trauma. Chapters in S.A. Estrine, H.G. Arthur, R.T. Hettenbach, & M.G. Messiana (Eds.), *Service Delivery for Vulnerable Populations: New Directions in Behavioral Health.* New York, NY: Springer Publishing.

Jackson, V. (Undated). *In Our Own Voice: African American Stories of Oppression, Survival and Recovery in Mental Health Systems.* **Contact: healingcircles@hotmail.com.**

Mathis, D. (2002). *Yet a Stranger: Why Black Americans Still Don't Feel at Home.* New York, NY: Warner Books.

McIntosh, P. (1989). White Privilege: Unpacking the Invisible Knapsack. *Peace and Freedom Magazine,* July/August: 10-12: Women's International League for Peace and Freedom, Philadelphia. Available at **http://www.antiracistalliance.com/Unpacking.html.**

Mollica, R.F. (2006). *Healing Invisible Wounds.* New York, NY: Harcourt, Inc.

National Center for Cultural Competence, **http://nccc.georgetown.edu/**

National Child Traumatic Stress Network (2007). Preliminary Adaptations for Working with Traumatized Latino/Hispanic Children and Their Families. *Culture and Trauma Brief,* 2(3), 1-8. Available at www.NCTSN.org.

Office of Minority Health, Department of Health and Human Services, **http://minorityhealth.hhs.gov/**

Project SOAR's Guide to Ethnic Community-Based Organizations, **www.ethniccommunities.org**

Substance Abuse and Mental Health Services Administration (2009). American Indian/Alaska Native Communities' *Trauma Informed Care Work Group Report.*

Southerners on New Ground, **http://www.southernersonnewground.org/**

The Male Privilege Checklist, **http://sap.mit.edu/content/pdf/male_privilege.pd**

RELIGION, SPIRITUALITY, AND TRAUMA

Spirituality is likely to be important to many of the women you work with. Some people talk about the importance of spirituality in their recovery, while for others religion is a source of turmoil. Some are confused about the distinction between spiritual experiences and what some clinicians call "symptoms of religiosity." Some don't embrace a formal religion or consider themselves to be particularly "spiritual," but wonder what it has to offer. Others might describe themselves as spiritual but not religious, and find spiritual connection through art or nature. Still others find that spirituality or religion plays no role in their lives of beliefs.

In this chapter, "religion" refers to an organized faith tradition with accepted theology, practices, and structure, while "spirituality" refers to an individual's sense of connection with the wholeness of the universe. While there is some overlap between the two, there are also differences. Many people are not sure how to talk about religious issues, or are concerned that it might be a violation of the separation of church and state to bring the subject up in a public setting. Discussing religion requires considerable sensitivity, especially for people who have experienced religious abuse or for whom religion is a defining aspect in how they understand their experiences. This chapter will provide information, tools, and resources to help you address issues of religion and spirituality in peer support contexts.

Why is this Subject Important?

Chances are good that many of the women you work with have an active religious or spiritual life. According to the Pew Foundation, 87% of people in the United States define themselves as "religious" and 57% regularly attend a worship service.[1] While most are Christian, roughly 44% have changed affiliation at least once. People who describe themselves as "spiritual, but unaffiliated" are the fastest growing group, especially among youth. For many people, religion or their own inner spiritual beliefs guide every aspect of their life.

[1] *Pew Forum on Religion & Public Life. U.S. Religious Landscape Survey: Summary of Key Findings. http://religions.pewforum.org/pdf/report-religious-landscape-study-key-findings.pdf.*

SPIRITUALITY AND TRAUMA HEALING

As a very young child, I was quite ill and suffered from what I now know was medical trauma. I also grew up in a home with a parent who had a severe mental illness. These experiences were at the core of many traumatic events that continued to occur over time. When I reflect back on my life there were many things that contributed and detracted from my healing process. In my early adolescence, I was asking hard questions of my religious community. I wanted to know why things were so hard for me, why God could let me live in so much pain. I prayed for faith, for peace, for healing. I had conversion experiences and still the pain didn't go away. I would have profound moments of connection with God and no way to sustain them, no matter how hard I prayed or how "good" I was. I searched in all types of spiritual communities. I began to experience peace only when I finally understood that it wasn't religion that would save me but the spiritual quest of knowing and loving myself. I wanted the church to have answers, but I found that the answers were inside. Spiritual teachings were a way for me to get to know myself and to become comfortable in the universe. Through connections with other people and nature I found the connection to myself. As I began daily prayer and meditation, I began to make meaning of the things that had happened to me. Having a connection to my spiritual self has helped me bring all the parts of my life together; my willingness to learn to love myself has been the glue that holds it all together. Spirituality has helped me reframe my life from living through the lens of grief and loss to one of wonder and awe at the power of the human spirit, including mine.

– Cheryl Sharp

There is a long tradition of using religious and spiritual practices in recovery. In a recent survey of alternative recovery practices, the four most frequently reported practices were meditation (73%), massage (48%), yoga (33%), and prayer (28%).[2] Many of these practices were originally associated with religious traditions. For example, many meditation techniques were developed by Buddhist monks, and yoga is an ancient Hindu practice. In recent years, these practices have been separated from their religious origins, and have been renamed "alternative coping strategies" or "relaxation exercises." While they do affect the physical body, their original intention was to help people connect with the divine. People who are interested in these techniques should have the choice of pursuing them as independent coping strategies or studying them in the context of their associated traditions.

Religious communities can be a major source of community support. There are over 300,000 religious congregations in the United States, making them the most widespread of all social institutions. In fact, Americans are far more likely to turn to religious leaders than to behavioral health professionals for help in times of trouble.[3] Because they are embedded in mainstream society, faith communities can play a significant role in helping women transition out of institutions. For example, they are often very effective in helping women reintegrate into the community after being incarcerated in jail or prison.[4]

On the other hand, many people have been traumatized by religion, and religious communities have sometimes been damaging to people in recovery. There are often mixed messages about acceptance. For example, some religious communities proclaim that everyone is welcome, but shun those who are lesbian, gay, bisexual, or transgendered unless they change their identity and their behavior. Some churches have judged those perceived to have "mental illness" as being possessed by evil. Misunderstanding and discrimination against people who are different persists in many religious traditions.

[2] *Russinova, Z. & Cash, D. (2007). Personal perspectives about the meaning of religion and spirituality among persons with serious mental illnesses. Psychiatric Rehabilitation Journal, 20(4), 271-284.*

[3] *Blanch, A. (2007). Integrating religion and spirituality in mental health: The promise and the challenge. Psychiatric Rehabilitation Journal, 30(4), 251-260.*

[4] *Holmes,D.R. (2009). The role of religious services in the Oregon accountability mode. Corrections Today, April 2009.*

EXPLORING YOUR RELIGIOUS IDENTITY

Do you consider yourself religious or spiritual?

Do you have beliefs or practices that help you cope?

Do you remember your religious upbringing as primarily positive or negative? How has that experience affected you as an adult?

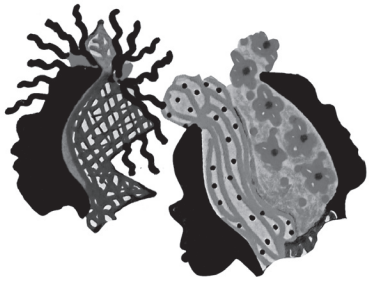
Has your religious or spiritual identity changed during the course of your lifetime?

Do you have strong religious beliefs that might make it difficult for you to accept the religious or spiritual experience of others?

Do you have strong religious beliefs that might make it difficult for you to accept the identities of others, such as atheists or LGBTQI2S individuals?

People with psychiatric histories have written extensively about the beneficial impact of religious practices, and some see healing as a spiritual journey rather than a psychological or medical process. As we will discuss in Chapter 9, "making meaning" of what happened is a key aspect of recovery for many people. This process is often experienced as a spiritual journey or as a struggle to resolve deep philosophical questions. Several inspirational essays and articles written by people with psychiatric histories are listed in the resources section at the end of the chapter and can serve as an introduction to the topic.

Religion and spirituality can also be important in creating a culturally sensitive environment that respects all religious traditions of the members, as well as creating space for people who do not want to associate with any religion. While strong religious beliefs are not limited to particular racial or ethnic groups, there are major differences between groups in the form and meaning of religious expression. For example, in some African American communities, the church plays an extremely significant social role, dating back to slavery and the civil rights movement. It is very common for religious practices to interact with local cultural traditions, creating unique forms of religious observance tied to cultural identity.



As a peer supporter, it is critical to be aware of the differences that exist within religious traditions. For example, a growing number of Hispanics practice a unique form of charismatic Catholicism which differs in many ways from Roman Catholicism.[5] In Islam, as in Christianity, there are many different schools or traditions (including Sunni, Shi'a, Sufism, and others) and the form of Islam practiced in many parts of Africa incorporates beliefs and practices of indigenous African traditions. Newcomers to the United States may be accustomed to societies where church and state are not at all separate, and they may want to bring religion into peer support relationships in ways that are unfamiliar to most of us. As peer supporters, you need to be curious about the women you encounter and partner with them to understand the role spirituality or religion has in their life. Learning about the religious and spiritual beliefs and concerns of the women you work with is an essential part of becoming culturally sensitive.

Raising the Issue

Many people find it healing to talk about their religious or spiritual beliefs and experiences and, by creating a safe environment for people to discuss these issues, you can serve as a resource to help women explore and heal from past trauma. Some people are concerned about violating the principle of separation of church and state, but as long as you do not promote one religion over another or allow your personal beliefs to cloud your ability to offer peer support, you will not be in violation of the "separation clause" of the Constitution.[6] In fact, the Joint Commission on the Accreditation of Healthcare Organizations mandates that the spiritual component of a person's life be considered in health care. People who have experienced trauma deserve to have every potential resource for healing made available to them. It's like any other issue—all you have to do is ask.

Even so, many people are uncomfortable with this topic. Very few people other than religious leaders receive training in how to talk about religion. Many people using behavioral health services have learned to avoid the subject altogether, since professionals are sometimes uncomfortable with discussions of these topics. Some fear that mentioning the topic could "destabilize" an individual.[7] In a peer support context, however, it is important to see people's experience not as sick or symptomatic, but as part of being human. From this perspective, it really doesn't matter if a particular belief is "rational" or "true"—if it has meaning to the individual, it is worth exploring.

People have a wide range of emotional responses to religious and spiritual concerns. For some people, their higher power (whether they call it God or something else) is a benevolent, forgiving, and healing force. Others may focus on the harsh, critical, or punishing aspects of God. People who have experienced violence and trauma may come to question their faith, or their faith may be strengthened. As a peer supporter, your role is to accept the person's belief system as valid for them, to be open to the different ways in which people explain their own suffering, and to help them find within themselves the beliefs and practices that are most healing.

Western psychotherapy has hardly paid any attention to the experience and interpretation of disturbed physical sensations and action patterns. Yoga is one of the Asian traditions that clearly help reintegrate body and mind. . . What is beautiful about yoga is that it teaches us — and this is a critical point for those who feel trapped in their memory sensations — *that things come to an end.*

– From an interview with Bessel van de Kolk, MD

In order to help others, you need to be clear about your own implicit beliefs. Before you engage in religious or spiritual discussion or group activities with your peers, you should explore your own feelings about this topic (see sidebar on exploring your religious identity). These same questions can help you begin the conversation with the women you support. Of course, no one should be forced or even encouraged to explore these issues if they show no interest. And if you don't feel comfortable discussing this topic, you should arrange for someone else to be available for women who want to address spiritual and religious concerns.

[5] *Pew Hispanic Center and Pew Forum on Religion and Public Life. Changing Faiths: Latinos and the Transformation of American Religion.*

[6] *The "Establishment Clause" of the First Amendment states that "Congress shall make no law respecting an establishment of religion." This is usually interpreted to mean that the government (construed broadly) is prohibited from establishing a national religion or aiding one religion over another.*

[7] *Shorto, R. (1999). Saints and Madmen. NY: Henry Holt and Company.*

Avoiding Re-traumatization

As a peer supporter, you may encounter individuals who have been traumatized by religious practices and it is important for you to know how to engage in healing dialogue about this subject. As we discussed in earlier chapters, one of the most fundamental principles of trauma-informed practice is to be constantly vigilant about possible sources of re-traumatization. One of the first things you need to do is to put aside your own religious or spiritual beliefs, even beliefs that have become so much a part of your worldview that you don't think of them as spiritually based. For example, the statement that "everything happens for a reason" may seem obviously true to one person, but be deeply offensive to another. We will discuss some ways to do this in the next section.

Art is a spiritual medium—a means of learning to appreciate and work with the emotions that afflict us. We can take our blackest depression, and smear it on the page for all to see. We can draw out our anger with sharp lines and angles, and put it into a design with the cloud of the depression. Added to that, we can portray our deepest yearnings with waves of color. If we allow ourselves to express these feelings honestly and creatively, our work will at the same time reflect our pain and become something beyond it, something good and beautiful. We can take the actual cause of our suffering, the conflicting emotions and, by expressing their essential qualities, transform them into liberation.

– Sally Clay, Transforming Poison

www.sallyclay.net

It is important to remember that some of the women you work with may have been directly traumatized by religious practitioners. Since 1983, repeated clergy child sexual abuse scandals have rocked institutional religion in the United States and across the globe. Catholic Church experts estimate that 6-12% of all priests have engaged in illegal sex with children under the age of 16, affecting hundreds of thousands of children. Sexual abuse of minors has also been reported in a wide range of other organized religious and spiritual communities.[8] In some American Indian and other indigenous communities, entire generations were traumatized by being removed from their homes and sent to religious schools where abuse was the norm.

Sexual abuse committed by religious leaders is a lot like incest—it involves the betrayal of a beloved and trusted authority figure. But it also involves a misuse of spiritual power, and it involves fear, awe, and respect for clergy based on religious faith and training. The results can be devastating. Religious communities often deny the abuse, attempt to cover it up, or blame the victim. This can result in an acute sensitivity to authority figures, to cover-ups, and to the abuse of power, wherever it occurs.

While much media attention has focused on clergy sexual abuse of boys, girls and women are frequently victimized. Religion is sometimes used to justify child abuse or domestic violence. Abusers may act without consequences because they are part of a hierarchical structure that endorses their position of power and/or relegates women to prescribed roles. Some of the women you work with may have been coerced into religious practices by families or religious schools. Others may have experienced distorted versions of theology. For example, the concept of surrender to God or a higher power can easily become submission to authority, forgiveness can be used to excuse abuse, and suffering itself can be justified as spiritually desirable. While some women may have found support in religion to overcome trauma or to leave abusive situations, it is critical for a peer supporter to be alert to ways in which women may have been harmed.

As we discussed in an earlier chapter, a trauma-informed peer support environment will always be cautious about any trappings of power or authority. Introducing religious or spiritual material into peer support environments must be handled with caution. The use of sacred texts, practices, or symbols; working directly with clergy or spiritual leaders; or being in environments with incense, candles, stained glass windows, prayer rugs, or religious music are all potentially re-traumatizing. No religious or spiritual elements should be introduced in a peer support setting without asking permission from everyone who might be affected.

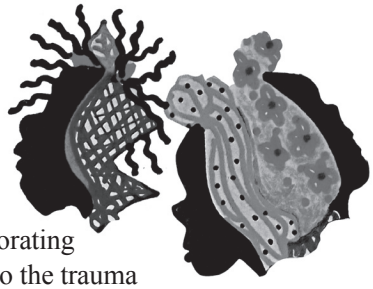
[8] *Fallot, R. & Blanch, A. (forthcoming) Psychological trauma and PTSD. In K.I. Pergament, et al (Eds.), APA Handbook of Psychology, Religion, and Spirituality.*

Creating a Safe and Inclusive Environment

One of the most essential things you do as a peer supporter is create a safe and inclusive environment. When it comes to religion and spirituality, it is important to make sure that people of all faith traditions and spiritual paths, as well as those who are not religious or spiritual, feel welcome and respected. It is important to establish some ground rules when opening this conversation, including:

- No proselytizing (trying to convince people to endorse a specific religion).
- A non-judgmental attitude is essential. Regardless of what you might have been taught in your religious upbringing, while in the group, the assumption is that no religion or faith tradition is better than another.
- Atheists and others who do not believe in God or a higher power are welcome to reflect their own philosophy of life.
- Differences in belief and practice, like other forms of diversity, are something to learn about and celebrate, not to avoid or ignore.
- Every person's experience is unique and important. People need to feel free to express both positive and negative experiences with religion and spirituality without implying that others should feel the same way.

One way to help establish a safe and inclusive environment is to make sure that the women you support are the ones making decisions about what spiritual activities they engage in. Of course, you also need to ensure that nothing occurs in a group setting that is offensive to anyone. The arts are one way to help people explore their inner dimensions. People can write about their personal spiritual journey, or draw their lifetime spiritual "timeline" or "map" using whatever art supplies are available. In drawing their maps, people portray their spiritual journey visually, illustrating key turning points (like getting baptized or initiated, engaging in religious study, joining a group, or having a particular inner experience). They can also illustrate the relationship between their spiritual journey and other aspects of their lives, including trauma healing. All of these techniques allow the individual to explore their spiritual experience and, if they choose, to share it with the group in a nonjudgmental way.



Connecting with Religious and Spiritual Supports

Many possibilities exist for incorporating religious and spiritual practices into the trauma healing process. All of the world's religions and "wisdom traditions"[9] offer important insights about suffering and healing, and many include concrete strategies for managing thoughts and emotions. The first step is to become familiar with the resources in your community and to discuss with the women you support whether or not they want to explore spirituality and, if so, how. A number of spiritual tools and practices are listed in the sidebar. Helpful materials can be found in many communities and online. For example, the Capacitar website has instructional materials for a variety of healing techniques based in indigenous religious tradition—and they are available in 13 different languages *(see Resources)*.

While some of the women you work with may choose to discuss their religious and spiritual issues with you or with their peers, others may prefer to develop relationships with religious teachers or faith groups in the community. They may want the support of a like-minded community outside the human service system, be comforted by the traditional rituals and environment of an organized religious setting, or seek wisdom from acknowledged spiritual teachers. Helping the women you support to establish a faith connection in the community—perhaps with a local church, synagogue, ashram, mosque, or traditional healer—is an important step in community integration. Although all faith traditions deal with suffering, many religious leaders are uncomfortable with extreme states and may need some coaching on how to work effectively with trauma survivors. If possible, see if you can develop a partnership where you can learn about the wisdom within the religious tradition and, at the same time, teach the faith community about trauma-informed care. Several resources listed below can assist in helping religious leaders become more trauma-informed.

[9] *"Wisdom tradition" is a term used to describe the inner core or mystic aspects of a religious or spiritual tradition without the trappings, doctrine, and power structures that are associated with institutionalized religion.*

CHAPTER SUMMARY: KEY POINTS

- Chances are good that many of the women you work with have an active spiritual life, considering themselves either "religious" or "spiritual."
- Many common trauma healing practices were or are associated with religion or spirituality, including meditation, massage, yoga, and prayer.
- As long as you do not endorse one religion over another or allow your personal beliefs to interfere with your ability to offer peer support, you will not be violating the principle of separation of church and state if you are involved in discussions about spirituality or religion in the context of peer support.
- It is important to be vigilant about possible re-traumatization in discussions of religion and spirituality, since some of the women you work with may have been traumatized by religion.
- Some of the women you support may choose to discuss their religious and spiritual issues with you or with their peers, and others may prefer to develop relationships with religious teachers or faith groups in the community.
- It is important to recognize that, for many people, religion or spirituality plays no role in their lives, and that must be honored and respected.

RESOURCES

Bilich, M. et al (2000). *Shared Grace*. Binghamton, NY: Haworth.

Capacitar Emergency Response Kit in 13 languages, **http://www.capacitar.org/emergency_kits.html**

Clay, S. *Spirituality and Anger; Recovery through Mind Training: Transforming Poison; The Wounded Prophet.* Available at **www.sallyclay.net.**

Day, J.H. et al (2005). *Risking Connection in Faith Communities.* Baltimore, MD: Sidran Press.

Deegan, P. *The Flyer of the Kite*, **http://voices-of-recovery-schizophrenia.blogspot.com/2008/01/dr-patricia-deegan-flyer-of-kite.html**; *Spiritual Lessons in Recovery*, **http://www.patdeegan.com/blog/archives/000011.php.**

Fallot, R. (1997). Spirituality in Trauma Recovery. In M. Harris & C.L. Landis (Eds.), S*exual Abuse in the Lives of Women Diagnosed with Serious Mental Illness*. New York, NY: Harwood Academic Publishers.

Knight, E. *Spirit of Recovery. Ed Knight's Tale*. Available at **http://www.verrazanofoundation.org/spirit_topstory.html.**

Lozoff, B. (2006). *We're All Doing Time.* Durham, NC: Human Kindness Foundation. Available at **www.humankindness.org** (copies free to anyone in jail or prison or who cannot afford to buy.)

Perry, J.W. (1998). *Trials of a Visionary Mind: Spiritual Emergency and the Renewal Process.* Albany, NY: SUNY Press.

Yoga and Post-Traumatic Stress Disorder: An Interview with Bessel van de Kolk. Available at **http://www.traumacenter.org/clients/MagInside.Su09.p12-13.pdf.**

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

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

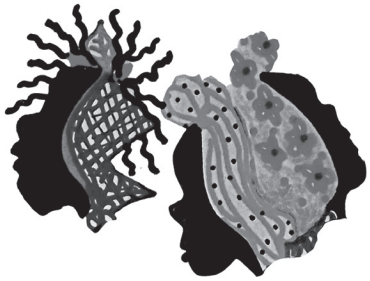
violence, but they may need help in doing it. Trauma survivors may not have had good role models for effective parenting and may need to learn the basics of how to support and nurture their children. They may have difficulty bonding, even with their own child. They may have trouble with certain aspects of child 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).

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, 2009)

[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.*

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 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.

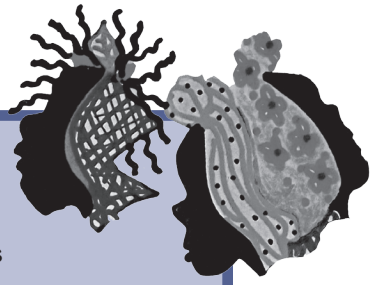
Generational Issues

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."

[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

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 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]

[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.*

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?

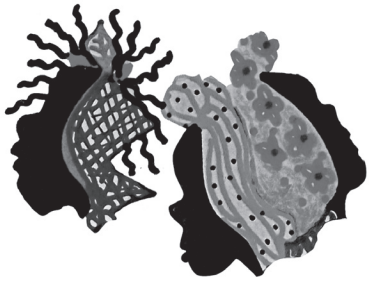
3) What was it like for you when Anna took her life?

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."



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 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 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

Covington, S. (2007). *Working with Substance Abusing Mothers: A Trauma-informed, Gender-responsive Approach*. A Publication of the National Abandoned Infant Assistance Resource Center, 16(1), Berkeley, CA.

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

Department of Defense Report to the White House Council on Women and Girls, Sept 1, 2009. Available at **http://www.sapr.mil/media/pdf/reports/fy09_annual_report.pdf.**

Girls Educational & Mentoring Services (GEMS): designed to serve girls and young women who have experienced commercial sexual exploitation and domestic trafficking, **http://www.gems-girls.org/about**

Goddess, R. & Calderon, J.L. (2006). *We Got Issues. A Young Woman's Guide to a Bold, Courageous and Empowered Life*. Makawao, HI: Inner Ocean Publishing, Inc.

Institute for Health and Recovery (2001). *Nurturing Families Affected by Substance Abuse, Mental Illness and Trauma.* Available at **http://www.healthrecovery.org/services_and_products.**

Tudiver, S., McClure, L., et al. Remembrance of things past: The legacy of childhood sexual abuse in midlife women. *A Friend Indeed,* XVII (4). Available at **http://www.cwhn.ca/en/node/41877.**

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.

The chart below shows how natural responses to threat can lead to patterns of relating to others that can be—and often are—mislabeled in behavioral health settings or other systems.

SURVIVAL RESPONSES	PATTERNS OF RELATING TO OTHERS	OFTEN MISLABELED BY SERVICE SYSTEMS AS
Fight	Struggling to regain or hold on to power, especially when feeling coerced	"Non-compliant" "Combative"
Fight	Disengaging; "checking out" emotionally	"Treatment resistant" "Uncooperative"
Freeze	Giving in to those in a position of power	"Passive" "Unmotivated"

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.

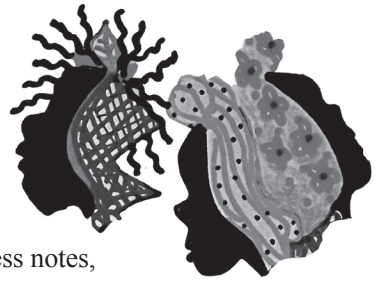
Re-traumatization in Peer Support Relationships

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.

In the table below, the right column lists some activities that paid peer supporters working in mainstream programs might be assigned as part of their daily work. The column on the left lists some characteristics of traumatic events. Which activities in the right column might reinforce some of the trauma responses in the left column?



If you answered "all of them," you are right. 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"

CHARACTERISTICS OF TRAUMATIC RELATIONSHIPS	POSSIBLE ACTIVITIES ASSIGNED TO PEER SUPPORT STAFF
• 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
• Program That is NOT Trauma-informed Asks	• Grant privileges based on compliance
	• Trauma-INFORMED Program Asks
	• "What happened to you?"

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.

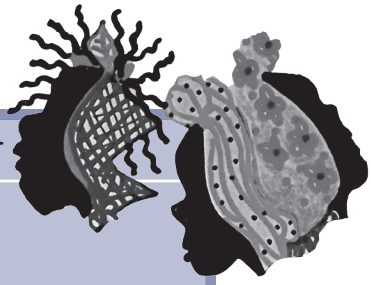
Trauma-informed peer support provides a lens for understanding the larger context of women's lives.

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

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

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

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.

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 below, 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.

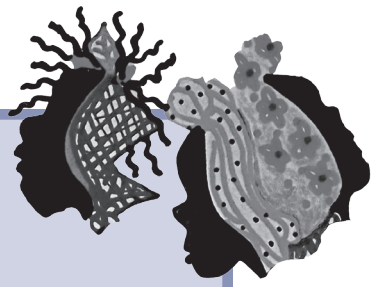
Tammy: That anger sounds pretty powerful, and pretty helpful. When I think about it, my own anger kept me alive, too.

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.

Continued on page 53



Continued from page 52

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:

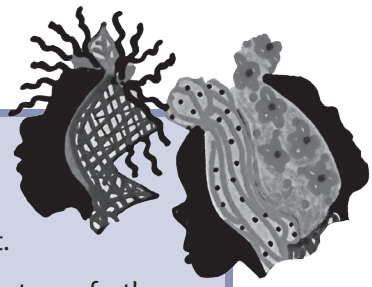
- Has a non-clinical focus.
- Creates the type of relationships we have in the community rather than service relationships or "helping" relationships.
- Provides a context for understanding what is going on for the person.
- Supports individuals to move beyond the identity of "mental patient," "addict," 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/**

CHAPTER 9

SELF-AWARENESS AND SELF-CARE

In peer support, self-awareness and self-care are essential to the development of mutually satisfying relationships. Self-awareness is defined as knowing enough about yourself—what nurtures you, what your vulnerabilities are, what upsets you—to be able to stay connected to yourself and to others. Self-care is defined as using that self-knowledge to create routines that keep you healthy, whether these are things you do alone or in groups, and understanding how this contributes to building communities of intentional healing.

Self-Awareness

You may be wondering, "Don't people already know themselves well enough to know what they need and want?" The truth is that people vary in their level of self-awareness. Some circumstances can interfere with people's natural ability to know themselves. Being a good daughter, mother, partner, student, or a "good patient" may have meant listening to everyone else's insights about you rather than listening to your own. When we rely on others to tell us what we need, we may not learn how to pay attention to our own inner wisdom. Developing self-awareness requires time and space for reflection.

Recognize Your Emotional Vulnerabilities

Becoming aware of what evokes a strong emotional reaction for you can help you respond in a way that feels right for you. If you have ever wished you could take back something you said or did, it might be helpful to consider the questions in the side bar "What Provokes Powerful Emotional Responses in You?" Many of those kneejerk reactions helped you survive. However, being aware of the factors that cause those reactions, often referred to by clinicians as "triggers," can put you in charge of how you relate to others.

Those powerful emotional responses often relate to something from your own life story. They may include certain things others do or say. They might be specific smells, sights, sounds, or other people's emotions or behaviors. For example, have you ever felt like someone "rubbed you the wrong way?" Perhaps you were picking up on traits in others that you were not fully aware of, characteristics you reject in yourself or associate with others in negative ways. Having your "buttons pushed"—igniting those "hotspots" or vulnerabilities—often prompts reactions that may have little to do with the other person, but a lot to do with you. Knowing where you are vulnerable will help you make decisions about how you want to participate in the world and in your relationships.

WHAT PROVOKES POWERFUL EMOTIONAL RESPONSES IN YOU?

Are there certain smells that bother you: a whiff of alcohol, or certain perfumes or aftershave lotions?

Does lighting affect you: fluorescent lighting or natural lighting at a certain time of day, month, or time of season?

Are you sensitive to noise? Do certain sounds distract you, create anxiety, or make it hard to focus?

How do you react when someone is angry at you?

How do you react when you think someone is not being truthful or seems to make demands on you?

At work, if someone feels controlling, do you back away, get angry, shut down, or avoid the person?

Are there things that people say or do that cause you to react intensely, even if you don't know why?

Once you have identified specific environmental factors, personal traits, or characteristics that can cause you discomfort or alarm, it is possible to avoid them or to develop strategies to manage your emotional reactions. Being aware of how strong a grip these environmental and personal cues can have will help you to empathize with the people you are supporting, rather than reacting and causing disconnections that take time to heal.

The purpose of paying attention to self-care practices is that, in the thick of this work, we often forget about our own needs until they're so big that we can no longer meet them in simple ways. Then, perhaps, we get resentful, drop out of everything, or get really depressed. We also think self-care is dependent on someone else's approval. Is it self-care when you work 75 hours a week so that you can feel accomplished?

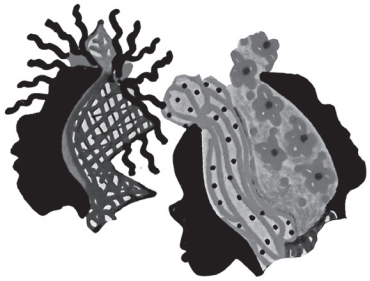
– Shery Mead?

Self-Care

Anyone who offers support to others probably knows how easy it is to slip into caretaking or rescuing behavior. Rescuing others or taking care of them can happen when the decisions others make feel risky and uncomfortable, or if a peer supporter does not really believe in a woman's ability to manage her own life. Rescuing and caretaking can be ways you deal with your own distress. Most peer supporters realize how necessary risk is to growth and change, so being able to sit with your own discomfort when you do not agree with the decisions of women you support might make is very important. Learning ways to manage your own stress and being able to respect your own limits and needs is important.

Messages about Taking Care of Yourself

What are some of the messages you have learned about taking care of yourself? For example, certain religious traditions view self-denial and suffering as a means of strength and purification or as a path to God. If you come from a military family, you probably are familiar with the phrase, "pull yourself up by your boot straps." Many girls grow up with the message that their primary role is caretaking as a mother, wife, or older sibling. Perhaps you came from a family where taking care of yourself was equated with weakness.



Or perhaps self-care was not something that was discussed in your family. These social/cultural messages reinforce the idea that taking care of oneself is not necessary, or is even indulgent or selfish. While respecting the teachings from your own traditions that have added value to your life, you may decide that there are other practices that are not meeting your needs.

Choosing Self-Care Techniques that Work for You

The purpose of self-care is to strengthen your ability to be in charge of your own life. It is in many ways a practice of wellness. Its focus is health in mind, body, and spirit. Choose strategies that fit your lifestyle, needs, and interests. Many of us think of self-care as activities one does alone, but, for many people, self-care involves being with others and doing activities as a group.

Four Components of Self-Care

There are four primary components of self-care: physical health, intellectual health, emotional health, and spiritual health. All four are equally important. You might think of self-care as the four legs of a chair. If any one leg is short, the whole chair rocks; if it is too short, the chair tips over!

Physical health includes playing sports, participating in exercise classes, dancing, walking, swimming, and stretching, as well as getting enough sleep and eating healthy, fresh food.

Intellectual health comes with reading, having stimulating conversations, learning a new skill or language, doing crossword puzzles, exploring new areas of interest by taking classes, going to museums and libraries, or listening to lectures.

There are many ways to enrich our emotional lives, including journaling, writing poetry, listening to or playing music, or spending time with people or companion animals. Many people have found that animals are especially attuned to the emotional needs of their caretakers, and both the human and the animal find reward in their bond.

Interacting with animals and nature has often been a source of great healing for many survivors of trauma. One survivor talks about what she has learned from her commitment to rescue abused and abandoned dogs. "I take the ones that no one wants—the ones that are too mean or too old or too sick, like I was. We heal together." Other peers talk about finding new levels of emotional wellbeing through their bond with service animals that are specially trained to provide comfort and support. If you would like more information about support animals, check out the resources at the end of this chapter.

Connecting to nature and animals can also be a source of nurturing one's spiritual dimension. Many people find that meditation, prayer, doing breathwork or yoga, as well as healing touch, and other mind/body practices support their holistic approach to health.

Taking Care of Relationships Together

People tend to think about strategies and tools for self-care as something that is done on your own and separate from your relationships with others. But, as service animals demonstrate, self-care can be about relationships, too, if both people take responsibility for the relationship. This is different from therapeutic support, where the role of helper and helpee remain relatively fixed. The practice of relational self-care involves important principles of peer support, such as mutuality and reciprocity.

PHYSICAL SELF-CARE TECHNIQUES TO TRY

Cook's Hookup. If you are experiencing anxiety on a regular basis, practice this exercise twice a day for approximately 2 minutes. Also, do it if you feel as though you are about to be flooded with feelings.

- Sit on a chair.
- Place left ankle behind right ankle.
- Place right hand on left knee.
- Place left hand on right knee.
- Place tip of tongue where teeth and gum meet.
- Holding these positions, do slow deep breathing for 2 minutes.

Slow, Deep Breathing

Practice doing this daily and gradually work up to 15 minutes a day. This exercise, done on a daily basis, will lower levels of excessive adrenaline and cortisol in the body. After a couple of weeks, you will feel more centered, more in control, more in touch with what you need. In addition, this exercise will boost your immune system.

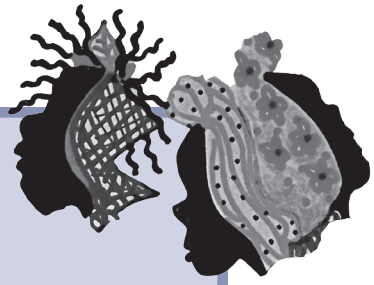
- Sit in a Self-Awareness and Self-Careon the floor or in a traditional meditation position.
- *Begin to breathe slowly and deeply by doing the following:
- Inhale all the way down to your navel. Your ribs will expand.
- Hold your breath for a count of 3.
- Exhale slowly by blowing through your mouth.
- When you think you've exhaled all the air, exhale a little more.

Repeat from *

Anger Release #1

Take bunches of old newspaper and forcefully rip them up!

Continued on page 59



Continued from page 58

Anger Release #2

- Kneel with pillow under knees at bed or couch.
- Fold hands, as if in prayer. Lay them on mattress or couch with arms straight.
- Inhale. At the same time, raise clasped hands and straighten arms up over your head.
- As you exhale, quickly bring clasped hands down forcefully on the bed. Feel free to make noise as you do this.

Repeat starting at #3.

Keep doing this. It will pick up speed and assume a life of its own. Keep deep breathing as you do it. This is very important for your physical safety.

After 3-5 minutes, you will suddenly stop and need to catch your breath.

Notice your feelings. You may still feel angry, you may feel a need to cry, or you may feel incredibly light and relieved. If you still feel angry, repeat the exercise. If you feel like crying, allow your breathing to help you cry and release the pain. If you are feeling better, relax and do something self-nurturing.

Sleep

If you experience difficulty falling asleep, try this simple little exercise: as you are lying in bed, use your finger to repeatedly trace an infinity sign (a figure eight on its side) in the air. After a few minutes, you will notice your eyelids are getting heavy....

Adapted from Davis, H. "Self-help Techniques for Managing PTSD." Mental Health Association in New York State, Inc. (undated).

Consider the following example:

Deena, a peer supporter, is very worried and anxious about her relationships with the women she provides support to. She is trying very hard to be there for everyone, but fears she is failing. She tells herself:

- *"I don't think I can handle the pain these women are in. There's just one of me!"*
- *"The more I listen, the more I am aware of my own stuff bubbling up. Who can I go to? I'm supposed to have it all together!"*
- *"I know she needs to get to that appointment. I can't just say no, can I?"*
- *"I wonder what I should do. Felicia just got sober and now she's late coming in! What if she is on her way to a bar?"*

How does Deena see her role? As the "helper" in these relationships, she sees it as her responsibility to be able to handle it all, to deal with her own stuff and make sure the needs of the women she supports are met.

She may also be doing some caretaking, which is a kind of helping that can hurt, as it gets in the way of women taking control over their own lives.

So how do peer supporters create mutual relationships in which everyone's needs are met and people are responsible for their relationships with each other? As Deena begins to focus more on building mutual, two-way relationships in which both people's needs matter, she might engage in conversations with women that sound more like this:

" As we get to know one another, it's likely that our stories will spark some pretty intense feelings in each other. I need you to know that I am still on my own journey of healing. So if something comes up, if I misunderstand you, or it seems like I am reacting to something you said, I hope you will stop me so we can talk about it. What I am learning is that real connection means that both people matter. What do you think?"

" Hey, I'm sorry you missed that appointment. But I'm curious about why you felt like you couldn't call to reschedule it yourself. At one time in my life I felt like I didn't have the right to make those kinds of decisions. I was scared I'd do the wrong thing and I'd get in trouble. Is it like that for you?"

" I have to tell you that I am feeling over protective of you since you just got sober. I don't want to get in the way of you taking the risks you need to take, so if you feel like I'm overreacting, I would like to talk about it. Would that be ok with you?"

Peer support is about building community. Keeping this in mind, what would you do if you felt overwhelmed by the story a woman shares with you about her childhood rape? What would you do if you felt helpless in the presence of another woman's anguish, or if your own fear, rage, and helplessness threaten your ability to stay connected? Hopefully you will remember that you belong to a community of diverse talent and ability. You could say something like, "Would it be ok with you if we talk about involving someone else? Someone you trust or would like to get to know….I know there are many others in our community who will want to help you and me walk this journey."

Using Your Own Story to Create Hope and Connection

Sharing experiences in peer support is a powerful way to create connection. Stories can communicate to others that they are not alone and can serve as important tools in advocacy and education. Self-disclosure is an important way to dispel myths about what it means to be a trauma survivor, to carry a psychiatric and/or substance abuse diagnosis, or to have experienced incarceration, homelessness, or other difficult experiences.

But sharing your personal story also raises issues about protecting and addressing your own needs. Because of the emphasis on sharing experiences, you may feel like you do not have the right to create boundaries around what you choose to share. Maybe you never realized that you can make decisions about what you are comfortable sharing and what you might want to keep private.

Everyone has unique strengths and vulnerabilities. You are probably aware that there are certain areas of your life that you feel comfortable thinking about, remembering, discussing with others, or drawing from in order to support women in pain. But it is also a good idea to be aware of those areas that you are still unsure of or feel particularly sensitive about. Sometimes you do not know what those areas are until you hit them.

Each person has the right to feel safe. One way to feel safe is by understanding your own personal limits and honoring these. You get to decide how much, to whom, how often, under what circumstances and when you feel comfortable talking about your own experiences. When you begin to feel uncomfortable sharing aspects of your story, feel free to acknowledge your discomfort and pull back. In this way, you will model self-care for the women with whom you are connecting. This may be their first experience with the idea that dignity and self-respect are ways of honoring who you are and where you have been.

PROTECTING MY OWN STORY

Which parts of your story are you comfortable with others knowing?

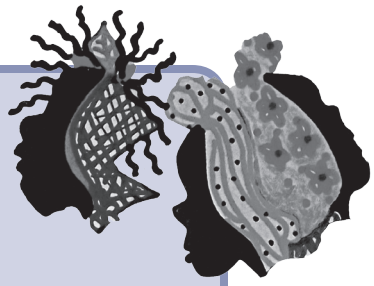
Which parts of your story are private?

Which parts of your story are only for certain trusted people?

How will you know when you are ready to share certain parts of your story with others?

How do you know when you are not comfortable telling certain parts of your story? Does your body react in particular ways? How does this confusion affect your emotional wellness?

What parts of your own personal experience do you find yourself marveling over? What are you surprised by or proud of? These might be OK for you to share, but it's up to you!



CHAPTER SUMMARY: KEY POINTS

- Self-awareness builds self-care. Both are essential to personal and relational health.
- Building self-awareness begins with understanding your emotional hot spots as well as what nurtures and soothes you.
- There are four components of self-care, including intellectual, emotional, spiritual, and physical health.
- Peer support and its focus on mutuality allows both people to pay attention to what the relationship needs in order to stay healthy.

Resources

Adams, M. (1998). *Change Your Questions, Change Your Life*. New York, NY: John Wiley & Sons. Available at **www.InquiryInstitute.com.**

Capacitar International—Indigenous Wellness Practices that Lead to Healing. Free information and techniques for self-help at **http://www.capacitar.org/**

Copeland, M.E. *Wellness Recovery Action Plan. Dummerston*, VT: Peach Press.

Copeland, M.E. (2002). *Dealing with the Effects of Trauma: A Self-Help Guide.* Available at **https://store.samhsa.gov/shin/content//SMA-3717/SMA-3717.pdf.**

Kenney, Kristi (2007). *What Sustains Us? What Stops Us? Thoughts on Activism and Mental Health.* Free download available at **http://bloominginspace.files.wordpress.com/2008/12/counterbalance.pdf.**

Miller, D. (2003). *Your Surviving Spirit: A Spiritual Workbook for Coping with Trauma.* New Harbinger Publications. Available to order at **http://www.newharbinger.com.**

Psychiatric Service Dog Society. A peer-run website for information on psychiatric and emotional support service dogs, **http://www.psychdog.org**

Service Dog Central, **http://www.servicedogcentral.org**

Vermilyea, Elizabeth G. (2000). *Growing Beyond Survival: A Self-help Toolkit for Managing Traumatic Stress.* Baltimore, MD: The Sidran Press. Available at **http://www.sidran.org.**

Wilkerson, Jennifer L. (2002). *The Essence of Being Real: Relational Peer Support for Men and Women Who Have Experienced Trauma.* Baltimore, MD: Sidran Press.

CHAPTER 10

ORGANIZATIONAL CONTEXT: WORKING IN SYSTEMS

Peer supporters who work in behavioral health settings, the judicial system, or other hierarchical settings alongside non-peer staff face unique challenges that can intensify when these organizations are not trauma-informed. This chapter will look at issues that can arise for peer supporters, help you identify program elements that can cause re-traumatization, and explore some basic strategies for promoting trauma awareness. It will also outline some communication strategies that can help you avoid conflict as you work with non-peer colleagues and co-workers to address trauma and healing with the women you support.

PROVIDING PEER SUPPORT WITHIN ORGANIZATIONS

Understanding Your Role

As a paid or volunteer peer supporter working within an organization, you represent a kind of relationship not typical of service systems, one in which you and the people you support share responsibility for your relationships, and in which growth and learning are the goals. As we discussed in earlier chapters, peer support is not like the support you might get from a doctor, counselor, or case manager. While there may be exceptions, most of the time non-peer supporters remain helpers throughout the life of the relationship, while the person they are helping remains in that role until they do not need help anymore.

The principles of peer support sometimes conflict with established ideas about what "helping relationships" are in traditional human service systems. How well you are able to use the principles of peer support in your work depends to a large degree on organizational culture: what your organization believes about recovery; whether it recognizes the prevalence and impact of trauma and the importance of being trauma-informed; what its values and usual ways of doing business are; and whether its policies, procedures, and practices support what peers bring to the organization.

Partnering with non-peer staff means navigating multiple viewpoints about recovery, peer support, and trauma. You are likely to be involved with multiple relationships, including relationships with women seeking support, with your co-workers, and with your supervisors and administrators. Each of these relationships will put different demands on you. As a peer supporter, you may have multiple (and sometimes conflicting) goals, including to:

- communicate a basic understanding about what you bring to your work;
- communicate the importance of trauma-informed organizations;
- engage in trauma-informed peer support with women, even if the organization is not fully trauma-informed; and
- help your organization begin to see women in a gender-responsive and trauma-informed way.

No matter what the challenges might be, it is important to keep in mind that your very presence as an employee is a statement that your organization is attempting to change its values and beliefs about healing and recovery.

Understanding Your Impact

Your role at your agency is not just to perform the duties listed in your job description. You also represent a new (and possibly misunderstood) way of doing business. Your "job qualifications" include your personal insight into recovery and your understanding of the challenges that can get in the way of healing. In some organizations and systems that have hired peer support staff, their perspectives have played a dramatic role in shifting attitudes and beliefs. But it is unrealistic to expect peer supporters to make significant organizational change without strong and consistent support from organizational leaders and administrators. Being clear about your role and your expectations about what you can accomplish will be important as you partner with non-peer colleagues and co-workers to support women healing from trauma.

Key questions you should consider:

- What impact do I want to have on the women I support?
- What impact do I hope to have on my co-workers and colleagues?
- What kind of change do I hope to help create in my organization or in the larger system?
- In my current role, where will I have the most impact?
- Who in the organization is most supportive of my work and my values? Can I cultivate them as allies and supporters?

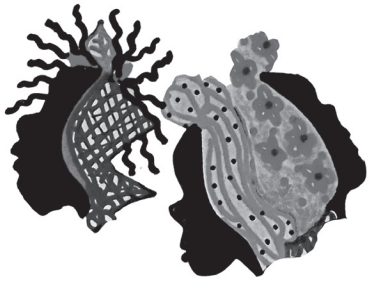
When organizations hire peer support staff but do not create new policies and procedures that actively support these roles, difficult issues will inevitably emerge. For example, an agency might create a policy that prevents employees from sharing any personal information with clients. If the policy is not adapted when peer supporters are hired, there will likely be a lot of confusion for everyone, as sharing personal information is essential to peer support.

Peer staff are often more isolated than their non-peer colleagues, as there are usually fewer peer staff than non-peer employees. When you experience challenges, it is harder to compare notes with others, which could cause you to doubt your own perceptions. Conflicting expectations can become stressful if peer staff are expected to use their status to persuade their peers to comply with treatment plans that do not support individual voice and choice.

When working in organizations that are not trauma-informed, this conflict can become extreme if peer supporters are required to participate in interventions that their agencies think are helpful, but which actually reinforce or re-create traumatic experience. How you navigate such conflict is critical to your effectiveness at work and to the nature of your relationships with co-workers.

Understanding Your Organization

Hopefully, you and your colleagues are working in an organization because you want to make a positive difference. However, it can be very difficult for one person to make meaningful change unless there is a fundamental shift in beliefs within the organization. Understanding how organizations operate may help you avoid some frustrations and help you think about what changes you can make, what impact you want to have, and who you need to involve in that process.



Organizations are complex collections of stated mandates and unspoken beliefs. Just as people have their own history and culture, so do organizations. The culture of an organization is the sum total of the beliefs, values, and usual ways of doing business created by the people working there, as well as its history of past successes and failures. The "job description" of the organization—the purpose for which it was created—places constraints on the activities and the decision-making ability of individual workers.

Where I worked, I had to administer an assessment at intake and again at 6 months to satisfy funding requirements. I hated having to do this assessment with the women. I knew they had been traumatized. I knew that my agency was re-traumatizing them. Fear of losing funding tends to desensitize agencies to the emotional needs of their clients. Among other things, the assessment asks people to disclose whether or not their parental rights were terminated. I will never forget the shame, the pain, the rage, and the humiliation on these women's faces. There was no way to open that subject responsibly-especially in a first meeting-when I typically only had an hour to work with someone. Even now, I feel disgusted about what I was mandated to do.

– Kristin Simpson

There may be times when your values are in conflict with the culture and prevailing practices of the organization. It is commonplace for people working in hierarchical institutions to feel caught in the middle. As a peer supporter, how can you be empowering to the women you support when your supervisor and her supervisor are demanding compliance? There are no easy answers to this dilemma, but recognizing that the stress you are feeling is the result of the situation you are in—that it is not due to some failure on your part—is a good start. It is also helpful to have a peer support group where you can discuss what is going on without fear of repercussions.

Most peer supporters can expect to encounter challenges to peer support practices, especially in creating mutual relationships based on authentic, personal experience where power is shared. For example, the funding needs of your organization may require you to write daily progress notes on the women you support. By doing so, you may create the perception that your voice, rather than theirs, is the only valid voice. Perhaps you are expected to talk about women at team meetings that they cannot attend. It is hard to avoid power differences and inequality if the organization's practices create this kind of unequal power, and these practices start to shape your relationships with women, rather than the values and principles of peer support.

These issues are magnified when you are aware of the link between power and trauma and how the loss of control impacts women. Many practices that an organization considers business as usual can re-traumatize women. This includes coercion, such as seclusion and restraint; forcing women to accept unwanted services in order to receive vital resources like food and shelter; or monitoring women to ensure that they take prescribed medication or attend certain programs. When women are not involved in collaborative decision-making about their treatment or what is happening to them, this can derail trust and safety in relationships.

There is something you can do! Even if your organization does not yet see women in a trauma-informed way, you can. The change you hope to bring to organizations that are not aware of trauma can happen at the level of your relationships with women you support. Here are some ways to address these issues.

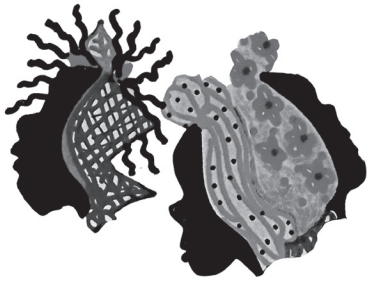
- *Be transparent in your relationships.* Let the women you work with know about any limits to confidentiality of the information they share with you. Be clear about reporting requirements that you are subject to—for example, the duty to report child abuse and elder abuse or imminent harm to self or others. This will help them decide what information to share with you. At the same time, help the woman create connections to others who can support her while keeping her information confidential: linkage to her faith tradition, healers in her community, or independent self-help and peer support groups that are not subject to these requirements.
- *Let women know up front the limits of your relationship.* Your agency may have policies about contact with clients outside of work hours. Try to maintain an authentic connection by talking openly about these limits and exploring what your peer relationship can accomplish. Provide links to others with whom women can develop meaningful connections in their communities. Support their explorations of intimacy and friendship beyond the limits of the program.
- *Don't assume the women you are working with know what peer support is.* You have an opportunity to explore any assumptions that you and the women you support may have about the nature of peer support. When people can identify the intent of their peer support relationships, they begin to establish some of the ways in which peer support is different from friendship. It is the intention that makes peer support what it is about, building relationships that are respectful, mutually responsible, and mutually transforming.[1]

CHALLENGES

Boundaries and Peer Support

Some of your organization's policies about outside contact may differ from the type of relationships common in the peer community. You may want to discuss this issue with a supervisor. For example, what do you do if your agency has a policy that does not allow you to associate with people receiving services outside of your work hours, but someone you have been supporting shows up at an NA group that you attend, which is also the only NA group in your area? Or maybe you are a member of a local peer organization and have been hired as a peer supporter at the local community mental health center, where many people you know from the peer organization also go for support. Peer supporters should not have to choose between a job and participation in their community, especially community activities that are part of their enrichment and self-care routines. You may want to explore ways that you and your organization can negotiate boundaries rather than try to adopt a one-size-fits-all that forces unhelpful choices on you and the women you support. Keep in mind that "professional boundaries" reinforce unequal relationships that separate people. Discuss with your supervisor ways that you can lessen potential sources of inequality.

[1] *Mead, S. & Copeland, M.A. (2004). Wellness Recovery Action Plan and Peer Support. Dummerston, VT: Peach Press, page 10.*



Does this mean that there should never be boundaries between peer supporters and those they support? Not at all. If a friend or intimate partner receives services from the agency where you work, you may not provide peer support to them in your paid role. Think about what it would mean to a friend if you had access to confidential information about her that she may not want you to have. It would also be unfair and potentially traumatic if you were to facilitate a peer support group in which a former intimate partner is seeking support. Figuring out what boundaries exist and how useful they are is not a clear-cut process for peer staff. New policies and creative ideas are needed to support peer relationships in traditional organizations.

Traumatized Organizations and Staff

Organizations themselves can be traumatized. Events like layoffs, reorganizations, the death of a co-worker or someone served by the organization, lawsuits, or negative media attention can be intensely traumatic. Most organizations deal with such stressors by trying to move on. But, just like with individuals, trauma can affect every aspect of organizational behavior.

For example, tragic circumstances, such as a worker being assaulted on the job, can radically change organizational culture, redefining what safety, support, and help mean for everyone. Traumatized organizations may legitimize force and control as a way to deal with distress rather than address the complex factors that contribute to violence. In extreme situations, assault and injury of workers by clients may result in controlling or even abusive practices that become embedded in the culture of the organization for years to come.

We know from the statistics presented in Chapter 1 that many workers in human service systems have experienced trauma in their own lives, making them susceptible to re-traumatization, particularly if they have not done their own healing. Addressing trauma may be difficult for them, since it raises uncomfortable personal issues. As a trauma-informed peer supporter, what can you do if you think a co-worker or your supervisor is displaying a traumatic response?

Recognizing the behavior as a trauma response and applying what you know about trauma is the first step. For example, we know that trauma survivors need to feel that they are in control. If a co-worker or supervisor is acting particularly controlling, it may be unwise to challenge or confront their behavior immediately. It is better to wait until the situation has calmed down to talk things through. We also know that when people's trauma histories have been activated, they are likely to respond emotionally rather than logically. If possible, always take a second person with you to act as an emotional buffer, to witness the interaction, and to help you process your own reactions afterwards. You might also want to keep a record of your interactions.

Co-optation

In the context of peer support, co-optation happens when peer supporters lose connection with peer values and begin to take on the perspectives and beliefs of non-peer staff. This may lead them to engage women in ways that are more typical of professional or therapeutic relationships, rather than peer support relationships.

It can be hard to keep true to the principles of peer support when agency policies are written for non-peer staff and the agency has not developed new policies that support the unique role of peer support. If co-workers think of peer supporters as less valuable than other employees, resentments can build and peer supporters can feel alienated. The pressure to conform and fit in can lead to self-doubt and confusion about your role. Becoming like non-peer staff can happen simply because there is no one to compare notes with or learn from.

Your own experience with powerlessness and disenfranchisement may make you especially vulnerable to group pressure to conform to organizational attitudes that do not support healing. Co-optation can be accidental; perhaps you are trying to model the kind of relationship you may have had with a clinician that was helpful to you. You may be the only peer support worker at your organization and really not know how to navigate critical issues that compromise your ability to maintain shared power and mutuality with women survivors. Even past experience with victimization can cause peer supporters to identify with staff in a position of power, equating recovery with authority and control. If your agency does not value its peer support workers, you may be uncomfortable or even ashamed of your role.

While there are no easy answers to the pressure to conform to expectations that do not reflect the principles of trauma-informed peer support, there are resources available for networking and support.

- Educate yourself about the history of the consumer/survivor/ex-patient movement and the evolution of peer support.[2]
- Reach out to local, state, and national organizations for consumers/survivors and peers. There are resources at the end of this chapter for you to explore. If you do not have access to the Internet, contact local networks in your region. See if there is a statewide consumer/survivor organization. You may also want to become familiar with your local Independent Living Center and other resources for people with disabilities.
- If you are considering a position as a peer supporter, it might be helpful to sit down with peers that work for the company to find out more. In your interview, you might ask how the organization views the role of peers and the value it places on peer staff. Ask about the policies that will support your ability to use your recovery story in your work and your ability to offer alternative perspectives about services and supports based on your own experience.

Peer support is a way of relating that maintains equality in your relationships with your peers while sharing responsibility for these relationships. The frame of reference from which peer supporters operate has to do with an empathic understanding of powerlessness and the disabling aspects of alienation and discrimination that are often the result of living with a psychiatric diagnosis or other labels of disability. Explore with your supervisor and/or administrators, co-workers, and the women themselves the kinds of policies and practices that can best support trauma-informed practices in your engagement.

[2] *The Substance Abuse and Mental Health Services Administration's (SAMHSA) Resource Center to Promote Acceptance, Dignity and Social Inclusion Associated with Mental Health (ADS Center). The History of the Mental Health Consumer/Survivor Movement by Gayle Bluebird, Su Budd, and Sally Zinman; archived presentation December 17, 2009. Available at http://www.stopstigma.samhsa.gov/teleconferences/archive/training/teleconference12172009_TRANSCRIPT.aspx*

SMALL STEPS TO BIG CHANGE: SUPPORTING THE SHIFT TO TRAUMA-INFORMED ORGANIZATIONS

Awareness about the impact of trauma has resulted in a re-examination of what were once considered good practices in mental health and substance use, including the use of seclusion and restraint and the recognition that their use constitutes "treatment failure."[3] The issue of violence in our communities has made the need for trauma-aware social services and supports essential. The justice system needs to become trauma-informed so that it recognizes and can respond to the criminalization of survivors and the role of violence and unaddressed abuse in recidivism rates.

You can take part in building trauma-informed organizations through your relationships with women survivors and your co-workers; through activism at the local, state, or national level; or by participating in government advisory boards and committees. There are resources at the end of this chapter about trauma-informed philosophy and practices and what a trauma-informed organization looks like. There is no change too small; the following sections may offer you ideas that you can try.

Help Educate Staff

Use your own recovery story to help others understand what coercive practices feel like for those receiving services. But make sure that you do so in a way that builds cooperation by offering alternative ideas. Use any part of your story that illustrates your point. Many providers have been taught that what they are doing is good treatment. Bringing your perspective to the discussion can be a helpful first step in identifying practices that do not support healing. One of the most important tools you have in helping staff understand a new perspective is not to use clinical language.

[3] *SAMHSA. (2003). Breaking the Bonds. SAMHSA News XI(2). Available at www.samhsa.gov/samhsa_news/VolumeXI_2/article6.htm.*

Make Changes in the Physical Environment

Help your organization understand that women may be responding negatively to stressors in the program environment. Overhead fluorescent lighting, noise, and the lack of personal space can be problems. Coercive or controlling environments are disrespectful and may feel unsafe. Irrelevant groups and lack of meaningful relationships with staff can result in coping strategies that are misidentified as symptoms. All of these factors can elicit fight, flight, or freeze responses in women. Helping staff connect women's behavior, thoughts, or feelings to the context in which they emerge is central to making an environment trauma-informed. The resource list at the end of the chapter has information on creating trauma-informed cultures.

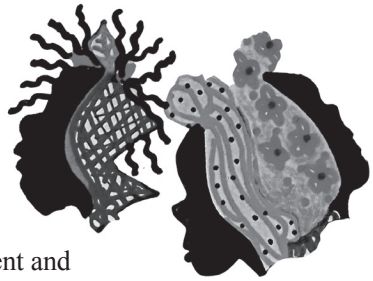
Using Collaborative Conversations

Effective communication is vital to creating change in your organization. Here are some ways you can keep your relationships with staff open and avoid arguments that shut down opportunities for collaboration.

Create Understanding by Exploring Worldview

A person's worldview is the theory of the world that they use (consciously or not)—their mental model of reality. Each of us has a unique worldview, shaped by everything that has taken place in our lives: what we have been taught and what we have come to believe based on our experiences. Understanding another person's worldview is important to effective communication and builds new opportunities for partnerships that better meet the needs of the women you support. Let's consider an example:

You may be aware that how you think about healing and recovery and how your non-peer colleagues think about it are very different. While you may both use the same language, what you mean can be worlds apart. Workers on a crisis unit who come in contact with people only when they are in profound distress may think of recovery as getting individuals stable enough to leave the hospital or increasing the length of time between hospitalizations. For you, based on your own experience with hospitalization, incarceration, homelessness ,or drug addiction, recovery probably means a whole lot more; you may see it as a profound transformation that can occur for anyone. In the following dialogue, listen for how the peer supporter explores her supervisor's world view:



"I was wondering if we could talk about something that has come up for me around one of my job duties. It feels like there is a contradiction between helping women become independent and what I am supposed to do in my first meeting: sign women up for SSDI. Can you help me understand how our agency sees SSDI helping women get back on their feet?"

"Well, we feel that some of our guests have gone through so much that trying to go to work right away is setting them up for failure. We prefer to help women transition slowly."

The peer supporter now understands the agency's perspective and how they define support and help. Exploring the supervisor's worldview has allowed this peer supporter to maintain a partnership without alienating team members and to find common ground in a desire to be of assistance to women trying to rebuild their lives. Understanding another person's worldview also sets the stage for ongoing dialogue and using your recovery story.

Creating Collaboration by Using Your Recovery Story

Let's keep working with the scenario above. The peer supporter has done a good job finding out where her supervisor is coming from, but now needs to offer a different perspective based on her own experience. The peer supporter might say:

"I understand that our agency wants to help women who are struggling. After a long- term hospitalization, I asked a social worker at the hospital how I was going to keep a roof over my head. I didn't have a clue about how to find a job, but I figured she could help. Instead, she told me it would be to my advantage not to work and to go on SSDI. But when I was on SSDI, the message was that I would be sick and dependent for the rest of my life."

"The peer supporter is letting the supervisor know what it feels like on the receiving end of a certain conversation. This may lead to more discussion, and it allows the peer supporter to offer a new way of understanding help."

Create Collaboration by Offering New Ideas

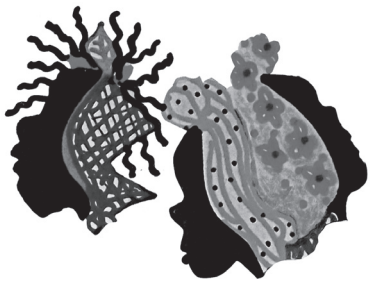
Working on a team means working in collaboration with multiple points of view and beliefs, all based on the experience of the people involved. It would be a mistake to think that the peer supporter's experience is the only truth about the consequences of SSDI. The peer supporter's story is simply another way of seeing the situation. Trauma-informed principles—voice, choice, safety, trust, empowerment, and collaboration—can offer new ways of doing business. The peer supporter might say:

"What would you think about offering women choices around SSDI or employment instead of automatically signing them up? No matter what they choose to do, it would send the message that we believe in their ability to make their own decisions and that we are here to support them to do that. I'd be happy to look at what we may need to do to create better supports for women who want to start working right away."

While the challenges of working as a peer supporter in traditional systems may seem daunting, it is easier to figure out how to deal with them once you understand the boundaries set by organizational culture and have some tools to address these issues. Most importantly, remember that you are not alone in facing these issues. Actively cultivate peer support for yourself and resources to help educate co-workers and administrators.

CHAPTER SUMMARY: KEY POINTS

- Peer supporters represent a different type of relationship than that found in many organizations that work with trauma survivors and that are not peer-led or peer-operated.
- Organizational structure can challenge the principles of peer support.
- Trauma-informed change can occur at the level of one's relationships with women survivors and at the level of the organization, as well as the level of the system.
- There are many resources that can aid peer supporters in maintaining the integrity of their role even when working in organizations that are not trauma-informed.



Resources

Blanch, A. & Prescott, L. (2002). *Managing Conflict Cooperatively: Making a Commitment to Nonviolence and Recovery in Mental Health Settings*. Free download available at **http://www.nasmhpd.org/general_files/publications/ntac_pubs/reports/ManagingConflictCooperativelyADR.pdf.**

Bloom, Sandra L. (1997). *Creating Sanctuary: Toward the Evolution of Sane Societies*. New York: Routledge.

Bloom, Sandra L, & Farragher, Brian J. (2010). *Destroying Sanctuary: The Crisis in Human Service Delivery Systems*. Oxford: Oxford University Press.

Bluebird, Gayle (undated). *Peers Working in In-Patient Settings.* Available at **www.nasmhpd.org/general_files/publications/ntac_pubs/Bluebird%20Guidebook%20FINAL%202-08.pdf.**

Fallot, Roger D. & Harris, M. (2009). *Creating Cultures of Trauma-Informed Care: A Self-Assessment and Planning Protocol.* Available at **http://www.theannainstitute.org/CCTICSERVIMP.pdf.**

Forum on Integrating Peer Services in Community and Inpatient Settings in Vermont's Mental Health System of Care (2008), **http://www.nasmhpd.org/general_files/publications/Bluebird/VTConsultreportFINAL7-1-08.pdf.**

Mead, S. & MacNeil, C. (2004). *Peer Support: What Makes it Unique?* Free download available at **http://www.mentalhealthpeers.com.**

National Association of Peer Specialists, **http://www.naps.org**

National Coalition for Mental Health Consumer Run Organizations, **http://www.ncmhr.org**

National Institute of Corrections, Resources and information for free download at **http://nicic.gov/wodp/default.aspx?View=Tag&T=6&pg=8.**

Non-Violent Communication, **http://www.cnvc.org**

Rosenberg, Marshall B. (2003). *Nonviolent Communication:* A Language of Life; 2nd ed. Ecinitas, CA: PuddleDancer Press.

National Association of State Mental Health Program Directors (NASHMPD) (2006). *Training Curriculum for the Reduction of Seclusion and Restraint: Creating Violence Free and Coercion — Free Mental Health Treatment Environments. Volume 4, Seclusion & Restraint Prevention Tools: A Core Strategy.* (NASMHPD), National Technical Assistance Center (NTAC). Available at **www.nasmhpd.org.**

The Substance Abuse and Mental Health Services Administration (2005). *Road Map to Seclusion and Restraint-Free Mental Health Services. Available* at **http://www.store.samhsa.gov/shin/content//SMA06-4055/SMA06-4055-A.pdf.**

CHAPTER 11

TRAUMA-INFORMED STORYTELLING AND OTHER HEALING PRACTICES

When peer supporters shift the context of their relationships with women survivors from the question "What is wrong with you?" to "What happened to you?" they emphasize storytelling. Telling another human being what has taken place in one's life can be an important part of healing from trauma and can lay the foundation for new stories about what the future holds. While some women will want to reveal actual events, others may choose not to. Peer support can be an opportunity for women to explore multiple forms of communicating through performing and visual arts, such as dance, music, or painting. This chapter will describe the function of story, the role of the listener and some of the common challenges that can occur when trauma narratives are shared. This chapter will also examine the role of mutual responsibility in the storytelling process.

Why Are Our Stories So Important?

Storytelling is an important organizing force in cultures throughout the world. Individual stories become the story of a people or a group. Transmitted over time—from cave paintings of pre-history to folk songs to social media and the Internet- stories reflect who we are and what we believe about the universe and our place in it. Stories are the basis for history, art, religion, politics, philosophy, and more, reflecting the ways in which we are uniquely separate, while revealing our interconnectedness. As Vanessa Jackson writes, "The telling of stories has been an integral part of the history of people of African descent. From the griots (singers/story-tellers who carry the oral history of a local culture) of ancient Africa to the sometimes painful lyrics of hip-hop artists, people of African descent have known that our lives and our stories must be spoken, over and over again, so that the people will know our truth."[1]

Our personal accounts—what we survived and how, what these experiences mean to us, and what we know now that we did not know before—are what we mean by "stories." Personal narratives organize experience and help us make sense out of what has taken place. Stories can be true or not true, entertaining or horrifying. Stories can be communicated with or without words. They can be literal or metaphorical, using the language of symbols to convey deeper truths. No two stories are the same, yet every story contains some aspect of the universal.

> **When violence leads to physical and mental injury, it also engenders a healing response. One aspect of this is the trauma story, whose function is not only to heal the survivor, but also to teach and guide the listener—and by extension, society—in healing and survival.**
>
> ***– Richard F. Mollica M.D., Healing Invisible Wounds***

In trauma-informed peer support, the story can be the gateway to peer support relationships. When listening to another person's story, you may catch glimpses of yourself. Knowing what it feels like to be in pain allows people to act when a stranger is suffering. This awareness can cause you to shut down emotionally at times, especially when the magnitude and constancy of suffering feels unbearable. But stories can also create unity and inspire action, as when many individuals come together to find the strength to confront social problems. Sharing personal stories can communicate that it is possible to move beyond the circumstances of one's life. It sends a message of hope: If you can, I can!

As you talk with women about what happened in their lives and what those events mean to them, remember that your own experiences, including your needs and feelings, are an important part of your connection. Hopefully you are part of a peer community that will determine what your culture of mutual healing and growth looks like. Grow and expand what works. Use the principles of peer support as your guide.

[1] *Jackson, Vanessa (undated). In Our Own Voices. Available at http://www.healingcircles.org/uploads/INOVweb.pdf*

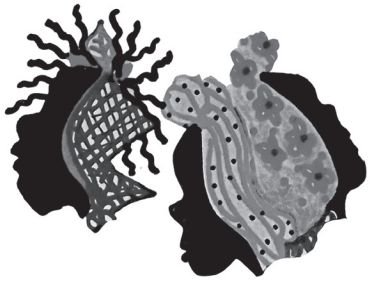
Keep in mind that creating new stories—about who one is, what one is capable of, and what the future holds—can also be a part of storytelling, leading to a sense of possibility and hope. Peer support can create space for women to craft stories about the future; to try out, revise, and build upon what they hope to create in their lives. Through trauma-informed peer support, women can use the strength of their relationships to challenge negative beliefs, re-evaluate strengths, and re-define capabilities.

Supporting Women in Telling Their Stories

Perhaps you ask a survivor "What happened to you?" and she remains silent. Simply asking the question is not enough. Creating safe space, communicating respect, and building trust take time. Ignoring what women say or trying to close down their attempts to communicate what has happened in their lives can create profound disconnection in relationships. As a peer supporter, you may have been taught to re-direct the conversation if intense parts of a woman's story emerge in your work together—but, tragically, this is likely to reinforce old messages: no one will believe you; what happened to you wasn't so bad; if you don't think about it will go away; you shouldn't talk about those kinds of things. Her feelings of being different may grow if she gets the message that "who she is" and "what she has experienced" is somehow beyond the scope of her relationship with others and requires specialized care.

Telling one's story is not always a literal event and, even when it is, the story may not flow from beginning to middle to end. She may share pieces and parts of her story over the life of her relationship with you. You may know parts of her that others do not and vice versa. As women open up and share traumatic life events, the most important things you can do may be the simplest. Bearing witness to another person's grief, rage, or anguish is a powerful way to stand with someone in the immensity of their pain. Listening from a place of deep attentiveness and caring and asking questions can demonstrate that you honor what she is giving of herself and that you want to know more about her life.

There are three characteristics of trauma that may be expressed through one's story: the event (what happened, where, when, and how), the meaning of the event (including its cultural meaning and the woman's personal interpretation of what happened), and the impact of the trauma on her present life.



You may be more comfortable with certain parts of the process than others. The hardest part for a listener is often the factual accounting of events. It is easy to get hung up in the details. But you might find that you are frustrated with the meaning a survivor makes of traumatic events: "It happened to me because I am bad and deserved it." Or you may witness women trapped by the impact trauma has on their lives, repeatedly returning to jail, or losing hard-won jobs, or dropping out of sight. These issues are not indicators of irreparable damage. What may look like "relapse" or perceived "failure to recover" may be a woman who is still trying to figure things out, or trying to explain what has happened to her, or how it feels. Looking at the meaning and the impact of trauma—not just the event itself—is often where the real work of healing takes place.

> **While in jail I was put in isolation and all my clothes were taken . . . Saying that I was depressed got me punished worse. I learned that day not to tell the system your real feelings.**
>
> ***– M.E., a Peer Specialist***

Common Challenges and Solutions

Telling one's story is often difficult. Hearing a painful narrative can be a reminder of one's own painful experiences or can push supporters beyond their ability to listen empathetically to horrifying details. Knowing how to respond respectfully in these circumstances is crucial to effective peer support.

Stories That Are Difficult to Hear

One of the dimensions of a trauma story is the factual accounting of events. The powerful details of what a woman has survived may include images and experiences that evoke strong feelings or memories in a listener. It is very hard emotional work to stay with another person in pain, to listen to her story without shutting down.

Not everyone wants or needs to go into detail, but for some, this is a vital part of the healing process. Why are the actual events important? Richard F. Mollica of the Harvard Program in Refugee Trauma writes that, "when survivors begin to tell their stories, they are struggling to create something whole from the physical and psychological destruction that has happened to them."[2]

Some aspects of the story may shock or numb you, creating a sense of distance between you and the woman telling her story, despite your best intentions. Stories may be chaotic. They may lack order or be anxiety-producing. They may not sound like stories, but may be a series of images that may be literal or symbolic. Literal interpretation may not be as important as relating and responding to the emotional content.

Mollica suggests that there is a vital, reciprocal relationship between storyteller and listener when the survivor is viewed as teacher, as someone who knows about coping with human violence or surviving the impact of natural disaster. This idea of survivor as teacher lends itself to the role of the listener/peer supporter who benefits from the survivor's knowledge about how to cope and live beyond the extremes of human suffering. The peer supporter is also a co-learner, exploring other dimensions of a trauma narrative with the survivor, such as its meaning and its impact on her current situation. This can become an incredible mutual exploration, as both people use their relationship to examine who they are, how they make sense out of their lives and the events that have impacted them, and to explore new possibilities based on what they discover together.

It is likely that you will find yourself in some difficult places doing this work. It is okay to communicate what you need in respectful ways. You can suggest a short break, or take a silent walk together—whatever feels necessary at the time. You can cultivate a community of healing by opening up your relationship to include others who can support a woman in areas that may be too difficult for you. Healers, other peers, friends, and supporters can be part of her healing. This is how trauma-informed relationships can grow into trauma-informed communities.

[2] *Mollica, Richard F. (2006). Healing Invisible Wounds. New York, NY: Harcourt, p. 122.*

MAKING MEANING OF TRAUMATIC EVENTS

- What makes you unique? Is it a talent, a perspective on living, a strength, your family, or how or where you were raised? Or is it something you've experienced—something that happened to you?
- If someone else has experienced the exact same thing, how would you define your uniqueness? Do you know something now that you did not know before? What?
- How have you dealt with loss/grief/rage? How have others responded to you as a result of what you've gone through? What has that been like for you?
- Do you have a personal philosophy of life based on past trauma? How has this philosophy helped you survive?
- What got you from your darkest hour to where you are now? What did you do? Did someone do something that helped you?
- What is the cultural meaning of the event for you? How does your culture see you due to this traumatic experience?
- If you were able to reject cultural (family, neighborhood, job, community) evaluation of yourself, how were you able to do this?
- Based on what you learned as a result of your experiences, what would you want to teach others about survival and suffering?
- How does what happened to you play out today? How do you know if the events still affect you? Is this something you would like to change? If so, what would you like from others to support you in taking risks around change?

Competing Trauma Stories: Outdoing Each Other

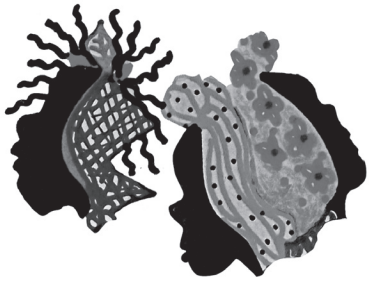
One of the most bewildering challenges in telling trauma narratives in a group has to do with competing stories, or what appears to be an effort to "outdo" one another by describing the extremity of traumatic experiences. Peer support groups can easily be derailed if the focus shifts to "who had it worse." The tragedy of competing stories is that some women may readily agree that they did not have it as bad as someone else, thereby invalidating their own experience of pain, grief, and outrage.

While on the surface this kind of behavior may seem self-serving or "attention-getting," it often has a deeper meaning. Trauma often annihilates personal boundaries, rupturing the survivor's sense of herself and what makes her unique. For many women who have experienced violence, their personal identity becomes defined by what happened to them. The statement: "You think that was bad, let me tell you what happened to me!" may be her way of asserting her unique place in the world, an attempt to show how she is different from all others and, therefore, uniquely herself.

Peer supporters can help groups that get bogged down in "who had it worse" scenarios by engaging the group in an exploration of meaning behind the traumatic events. The exploration of meaning will likely reveal how each individual is unique. This can include examining the impact of trauma, as participants see how past events may be informing their current experiences. The exploration of meaning and impact validates whatever experience a survivor brings to the group or names as traumatic. The sidebar Making Meaning of Traumatic Events offers some possible questions for group discussion.

Telling the Same Story Over and Over

Sometimes professionals have asked women to tell their stories over and over again, and sometimes women seem to be unable to move beyond endless repetitions. Recounting the details of what happened can be re-traumatizing, especially if the woman relives the feelings she experienced during the traumatic events. This has led some people in the trauma field to question whether telling trauma stories is even a good idea, or whether it reinforces destructive and traumatic memories.



For some women, repeating their story may help them to get a handle on the impact of trauma in their life. An often-repeated story may act as a kind of exclamation point on experience, delivering the message: "I know what happened to me!" A story that is frequently repeated may also be a rehearsed event—a version of the story that the survivor feels she has the best control over, even if it incites the same intensity of emotion.

HMONG STORY CLOTHS: TALES OF A COLLECTIVE TRAUMA

The Paj Ntaub Tib Neeg or "story cloths" of the Hmong women depict their experiences during the Vietnam War and their flight to Thai refugee camps. Elaborate and difficult needlework was a long-standing tradition of their culture. The patterns were symbolic events that preserved tribal culture and identity in the place of a written language or history. Persecuted for aligning with the United States during the Vietnam war, the Hmong fled to Thailand where they found themselves in a kind of limbo —neither starting a new life or nor able to return to their own life, Hmong women began to embroider their stories, especially stories of survival and flight, into their traditional craft. These story cloths have become a means of economic survival.

In peer support, being curious is a wonderful way to connect with women and encourage them to think about what they can teach others about healing. Beginning a new conversation might be as simple as asking: "What does this particular story mean about you?" or "How does this story explain who you are?" It may be helpful to ask, "How were you able to survive?" In some cases, women may have overlooked their own heroism, the smallest act that preserved them. Women who have seen themselves as victims may welcome a chance to reconstruct their narrative.

In other cases, asking women what's right with them or pushing them to focus on positive aspects of their behavior or future goals may miss the point she is trying to make: that healing is about being seen. Healing is about validation. Healing is about being recognized for who and what she is and what she survived to tell.

Stories Told Through the Language of Behavior

You are probably familiar with women who try to communicate their pain and distress through the language of behavior. For example: A woman runs out of your peer support group after she got close to painful or distressing feelings. Even though she is no longer present, she is still communicating powerful messages. What is going on, and how do we support a different way of telling the story?

Instead of dismissing what this woman is doing as "acting out," keep in mind that, while this behavior may be disruptive, it is an attempt to say something important. Language is not just what one says, but also what one does. What she does may be her best attempt to explain who she is and what she knows. For many people, trauma is literally unspeakable. This failure of words can create a need for communication based on behavior.

Often, the system sends the message that trauma survivors are fragile and that it is important to avoid "triggering" them. Maybe you expect that women will not be able to handle difficult material or their own sudden, intense, and distressing feelings. These expectations teach women to put a lid on their own narratives, preventing them from tapping into their own sources of resiliency. If people continue to get messages about their inability to handle difficult encounters, behavioral reactions can take the place of words in communicating just how painful the past is.

When the language of behavior keeps the group from moving forward, peer supporters may want to engage the group in a discussion about the failure of words to communicate distress. The group may be able to help individual members begin to try to reconnect events, feelings, thoughts, and perceptions to words as survivors' attempts to articulate their unique truth.

Talking About the Taboo

Stories are about one's internal experiences, including the feelings, ideas, and perceptions about events. In the case of violence and abuse, the internal experience can be devastating, creating a sense of shame, humiliation, embarrassment, and dread. These feelings are hard to talk about and hard to listen to. It is not just the abuse that can separate a survivor from others, but also the tragic meaning she has made out of the experience: I am damaged. I must not let anyone know. Similarly, women trauma survivors who have been violent to others, including their own children, are often extremely isolated and face great internal shame.

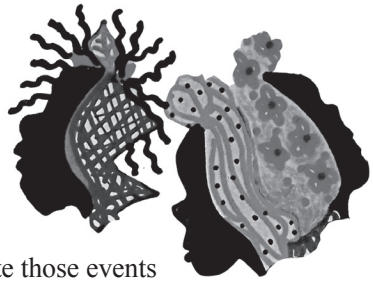
Special, sensitive care should be taken in creating safe space for women to explore taboo areas of their lives, especially for women who have perpetrated violence in the past and now seek help through peer support. Creating a healing community requires preparation, such as letting prospective group members know what kinds of topics will be explored. This will allow women to make decisions about whether they can support each other, and ensures that when survivors reveal certain facts about their experiences, they are with a group that can accept them.

Group and Individual Identity

Some cultures strongly value group identity and, in some situations, there may be a complex relationship between one's individual story and the story of the group. For example, by law, refugees must establish that they are fleeing a situation because of a "well-founded fear of persecution." The individual's story must therefore be consistent with the overall narrative of the refugee group, or both the individual's and the group's future may be in jeopardy. In situations like this, women may feel more comfortable talking about their group's historical journey than about their individual experience. They may find it possible to heal completely without ever revisiting what happened to them as individuals, if they can focus on the survival narrative of their people. Holocaust survivors who vow "never again" and survivors of the bombing of Sarajevo who tell stories of their city's heroism are two examples of collective historical healing.

Supporting Women in NOT Telling Their Stories

It is a choice, not a problem, if a woman chooses not to divulge her story. We all participate in healing in different ways, and telling one's story is NOT a requirement of healing. Women who experienced abuse very early in their lives, before they were able to talk, may not have words to describe their experience. Not everyone will want to tell their trauma story. Many survivors have faced negative consequences in their attempts to get help. They have learned not to divulge their truths. Perhaps the story is too painful to revisit or there are cultural constraints on self-disclosure. Women may remain silent because they feel unsafe in their current environment. Some women may relate to their stories internally without sharing them, needing to maintain some space around personal events that might feel too big for words. Some women may feel that their traumatic experiences were so extreme that remembering has worse consequences than forgetting. Others may simply prefer to keep their stories private.



Art and Healing

Art is another source of healing that may not use words. Creative expression allows women to take painful experience and re-constitute those events into visual and performing arts. When an audience participates in this event, it bears witness to a survivor's transformation. Whether alone or in a group, with an audience or without, the power of creativity defies the destructive force of trauma. Creative projects can also bring women together to re-interpret their abuse experiences through art. For others, creative self-expression such as writing or journaling provides personal time and space to reflect on their experience. No matter what form it takes, art is a way to make a world that the artist controls entirely, a world infused with the meaning she gives to it. Involving traditional healers and cultural modes of expression such as drumming or traditional dance can also be a way for a woman to reclaim cultural experiences that she may have lost or never had the chance to experience.

WORDS OF HOPE

Most of my adolescence was spent in and out of institutions: I am a survivor of trauma and multiple suicide attempts. I was forced to take a series of harmful psychiatric drugs that made me feel like a shadow of myself. At eighteen years old, coming out of my final institution, I hazily remembered that I once loved to write. When I was fourteen, Mrs. McAuliffe wanted to groom me as editor of the high school paper, but I never got to realize that dream because I ended up in a long-term "treatment facility." In the psych ward, words had been used against me—to label me, define me, and to silence my spirit. As a young woman, I never felt safe keeping a journal because there was no secure place to hide it—I was always under surveillance in the psych ward.

In the end, it was more painful for me not to write than to write. I started with small scribbles that might have been poems. I began to journal again. I laughed as I put my thoughts on pages smeared with tear-stained ink. After several years, I joined workshops and nervously started sharing my work with others. Eventually, I hesitantly admitted that I might just be an artist! Words were slowly working their healing magic on my spirit.

The first time I read a poem in front of a live audience, my whole body trembled. Then the applause came. I was heard! I knew that I was home. In spoken word poetry, I found a healthy outlet for all the years of pent-up rage and pain. I could finally use my anger and hurt constructively, instead of turning them against myself or others, or suppressing them.

Today, I look down at the criss-cross of pale, jagged scars on my wrists, inflicted by a mentally tortured, traumatized young woman, and I wonder how I will explain them to my young son if and when he asks about them someday. When he is old enough to understand, I will read him my poetry and hope it tells him everything he needs to know: his mother was once without hope, but words gave her new life.

– Leah Harris

CHAPTER SUMMARY: KEY POINTS

- Storytelling has always been a part of human interaction and is the foundation upon which religion, history, philosophy, law, and the arts are built.
- Women heal in many different ways. Self-disclosure is essential to healing for some, and others wish to keep their stories private. Either approach is fine.
- The listener-storyteller relationship between peer supporters and survivors is a mutual, reciprocal process in which both people benefit and both explore how they have come to know what they know based on what they have lived.
- Listening to someone else's pain can be difficult. Peer supporters can develop trauma-informed communities by cultivating other supporters in the survivor's healing journey.
- Peer supporters can navigate the challenges of addressing trauma in a group by helping members explore the meaning and impact of events rather than the events alone.
- Art is an important healing tool for many women.

Resources

Bluebird, Gayle (undated). *Reaching Across with the Arts.* Free download available at **http://www.alteredstatesofthearts.com/Reaching%20Across%20with%20the%20Arts.pdf.**

DeSalvo, L. (2000). *Writing as a Way of Healing: How Telling Our Stories Transforms Our Lives.* Beacon Press.

Frank, Arthur W. (1995). *The Wounded Storyteller.* Chicago, IL: University of Chicago Press.

The Glass Book Project, **http://www.glassbookproject.org/**

Penney, Darby & Stastny, Peter (2008). *The Lives They Left Behind: Suitcases from a State Hospital Attic*. New York: Bellevue Literary Press. **www.suitcaseexhibit.org**

Jackson, Vanessa (undated). *In Our Own Voices*. Available at **http://www.healingcircles.org/uploads/INOVweb.pdf.**

Mollica, Richard F. (2006). *Healing Invisible Wounds.* New York, NY: Harcourt.

Pillows of Unrest, **http://www.alteredstatesofthearts.com/index_files/Page1455.htm**

Poetry for Personal Power, **http://poetryforpersonalpower.com/**

Women's Work, **m-amandamillis.com**

SELF-INFLICTED VIOLENCE AND PEER SUPPORT

Traumatic events create extreme and overwhelming feelings with which survivors must find ways to cope. Self-inflicted violence is a coping strategy that includes cutting, hitting, burning, punching, or engaging in other acts intended to harm the body. The primary difference between self-inflicted violence and other coping strategies such as dissociation or addiction is how other people respond to it. The link between self-inflicted violence and trauma is not always recognized. Education and understanding are the best tools peer supporters have in responding to women who use self-inflicted violence in order to form non-judgmental relationships where healing can begin. This chapter will help you understand what self-inflicted violence is and why it may continue long after traumatic events. We will explore ways that the principles of peer support can guide mutual and reciprocal relationships so that the focus remains on the most essential aspect of healing, peer support relationships. We hope this will provide a context for understanding and relating to women survivors who use self-inflicted violence, even if you do not.

What is Self-Inflicted Violence?

Most of us have engaged in self-injurious behavior at some time in our lives. Have you ever had too much to drink? Have you ever over-exercised or eaten too much? Have you ever worked so hard that you had little time for yourself? Are you a current or former smoker? Do you ever over-spend? These behaviors can be seen as self-hurtful and people often used them to help deal with life stressors. They can be destructive when used in the extreme, but society is generally more accepting of addiction, for example, than it is of someone who deliberately inflicts damage to her body. The term "self-inflicted violence" is used to designate specific forms of self-injury used as a coping strategy.[1] Self-inflicted violence is distinguished from practices that have meaning in the cultural or social contexts in which they occur; for example, tattooing, body piercings, or body modifications.[2] Self-inflicted violence is also different from being clumsy or accident-prone, since these behaviors typically happen without real awareness or intention of doing harm to oneself.

Self-inflicted violence is sometimes also called self-harm or self-injury. Clinicians sometimes refer to it as para-suicidality, self-abuse, and self-mutilation, terms which many survivors do not find useful. Women who use self-inflicted violence may refer to it in different ways, and it is important that you allow them to name the actions for themselves. One survivor refers to it as "self-mute" rather than "self-mutilation," articulating the pain she cannot put into words. Another woman names the behavior "self-healing." For some survivors, self-inflicted violence has allowed them to take control over their bodies; it has allowed others to name their pain or it serves as proof of their strength and determination to survive. For still others, the marks of self-inflicted violence are proof of life.

> **The importance of relationships cannot be underestimated. Because the experience of trauma is isolating to begin with, and people react so strongly to discovery or disclosures of self-injury, a genuine connection based on mutual respect rather than on power dynamics is invaluable to those who use self-inflicted violence.**
>
> ***– Ruta Mazelis, Self-Injury: Understanding and Responding to Those Who Live With Self-Inflicted Violence***

This chapter will use some of these terms interchangeably, but keep in mind that most people have harmed their bodies in some way. This knowledge will help you to better understand self-inflicted violence and respond in ways that allow you to find common ground, even if you have never used this form of coping.

[1] *Mazelis, Ruta (2002). A Newsletter for Women Living With Self-Inflicted Violence, 13(2-3): 50-51, Summer and Fall, 2002. Available for free download at http://www.healingselfinjury.org.*

[2] *Conors, Robin (2008) Self-Injury: psychotherapy with people who engage in self-inflicted violence; pgs. 8 – 10.*

Myths and Misinterpretations of Self-Inflicted Violence

There is an extensive literature on self-injury: what it is, who self-injures, why it happens, and how to treat it. Sadly, much of this work perpetuates negative stereotypes about women and self-harm. Many do not understand that self-inflicted violence used as a coping strategy is not a suicide attempt. In the popular press, little is written about the cultural ramifications of self-injury, leading to a common myth that this behavior occurs primarily among young white women. The belief that women of color do not self-injure may reflect the fact that providers are not looking for this behavior among these women and that the scarcity of trauma-sensitive services may make seeking help very difficult.[3]

> **A lot of the so-called help that is available for people who self-injure is shame-based and makes the individual struggling with self-injury feel even more shame. I think that is because some people find self-injury repulsive and/or something to control.**
>
> **When I experienced shame-based help and other people trying to control my behavior, it drove my self-injury behavior more underground and made it even more dangerous at times. I also don't respond to behavior contracts. I felt that behavior contracts were generally one-sided. I promised to not self-injure in exchange for what, exactly?**
>
> ***– Beckie Child, MSW***

Practitioners may not understand the relationship between trauma and self-inflicted violence. Even if trauma is acknowledged, the focus is often on trying to stop the behavior, rather than understanding what drives it. Women who self-injure are often described negatively and may be seen as "attention-seeking" rather than as needing the attention that comes from healing relationships. They are often given negative psychiatric labels such as borderline personality disorder. Self-inflicted violence is often described as "manipulative," a term that is used to justify punitive responses or neglect.

Why Do Women Use Self-Inflicted Violence?

Self-inflicted violence is an expression of a survivor's attempt to cope with emotional anguish that results from something traumatic that happened to her. Self-inflicted violence may be a survivor's best attempt to cope with overwhelming feelings of shame, powerlessness, humiliation, and despair. Women who self-injure may or may not experience it as shameful; they may want to stop, or not. They may hate doing it, or they may see it as useful and even life-sustaining. Many women who self-injure never reveal their histories and never come to the attention of service providers, as they keep their pain hidden. Culture and Self-Injury

Women of color who self-harm may experience difficulty in accessing services. These race-based disparities in behavioral health services are well documented. Self-harm may have cultural meaning and it is important to understand the unique cultural connection for each woman you support. Asking questions with sensitivity about the way her culture, community, family, or social network view self-harm may help her begin to think about these issues in a different way. She may not view health care in the same way that you do. Healers in her community may not be defined in the same way you might define them. You might explore what healing in the context of trauma or self-injury means to her and who in her community she views as trustworthy or helpful.

The best approach is to assume nothing, but to continuously make culture part of your discussion. For example, since self-inflicted violence is frequently an attempt to cope and to articulate one's personal experience of trauma, historical trauma (trauma that a cultural group experienced as a result of issues like forced immigration, genocide, or slavery) may influence how she views her personal experience. Her experience may be shaped by the cultural expectations and roles of women in her social class or community. To understand the source and depth of pain related to self-injury requires a willingness to step out of your own world to engage her in a conversation about her world.

[3] *Medical News Today, September 01, 2010, http://www.medicalnewstoday.com/articles/199600.php*

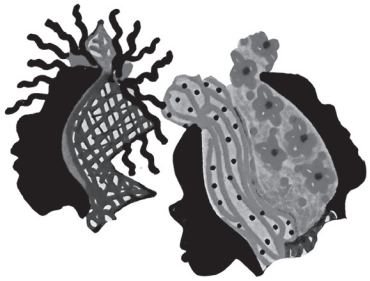
How Does Self-Inflicted Violence Develop?

For example, a young girl molested by an uncle may not have the vocabulary nor the developmental capacity to make sense of what is happening to her. Fear of retaliation and punishment often keeps survivors isolated from adults who might help. But what if a girl does find the courage to tell and is met with disbelief or is told she is lying? Pain, confusion, fear, and other extreme feelings may overwhelm her capacity to deal with the experience, making it impossible for her to live in her body and shattering her sense of self and safety. Self-inflicted violence may serve to regulate some of the physiological consequences of trauma, or it may validate the experience that no one else will acknowledge. She may use self-injury to punish herself, taking on the blame for the abuse perpetrated against her. As a teen or young woman, she may use self-injury to help ground her when memories of the past threaten to overwhelm her. In some ways, who she is and how she understands herself may become inseparable from her traumatic experiences and her self-injury.

This is just one scenario about the development of self-inflicted violence in a survivor's life. Self-inflicted violence has as many meanings and uses as there are individuals who use it. Women report using self-injury in many different ways, including:

- To stop feeling pain
- To calm myself
- To make sure I am actually alive
- To stop flashbacks or drown out voices
- To go away, numb out, disappear
- To ground myself, bring me back to reality
- To punish myself
- To talk to myself, get in touch with myself
- To enter my own world

When the impact of trauma in a woman's life goes unrecognized, why she self-harms seems to makes little sense. Without understanding the centrality of trauma in her development, we may focus on the question "What's wrong with her?" instead of understanding how this coping strategy is helping her today. The focus can shift to trying to get her to stop the behavior, rather than on understanding her relationship to self-injury. There may be an assumption that if she stops hurting herself, everything else in her life will be better, too.



Some women describe learning to use self-injury from others. Some discover it by accident or feel that has seemingly always been a part of their lives. One survivor shared, "When I was little, I would bang a rock on my hand to prove to myself how strong I was, that I could take the pain—that I was bigger than it. It was just something that made sense to me. Anybody else seeing me would have said I was crazy. I never associated it with what was happening to me at home until I was in my twenties."

Trauma violates survivors' personal boundaries and they may use self-injury to reassert those boundaries by creating a private, internal world into which no one can trespass. For some survivors, keeping self-inflicted violence hidden is vital to their ability to find an emotional connection to themselves that was disrupted by abuse and betrayal. Women who attempt to get help are often met with intense, negative responses that further isolate them. Survivors may hide self-injury to avoid the judgment and criticism of others. Tending to her own wounds may become an expression of self-care and the only healing response she sees as possible.

Self-inflicted Violence and the Language of Crisis

In situations where people respond to statements like "I'm sad" or "I 'm lonely" with compassion and attentiveness, language serves to connect people. In institutional settings like jails, prisons, and psychiatric units, women rarely experience such responses to their statements of distress. Instead, their ongoing pain is ignored. Unresolved trauma may produce a reality for survivors where anguish and grief become the dominant experience. Without understanding its source, others may become hardened to the constancy of suffering.

While the language of crisis creates connection with others, it often does so in a manner in which the focus of the relationship is to control or contain the behavior, rather than understand it and what drives it. The diagram below suggests how repeated crises and subsequent interventions to address crises may create a connection, but perpetuates a relationship that does not lead to healing. Over time, crisis may become the way that service providers and women in pain understand their relationship to each other.

In the illustration above, the focus of the relationship is on the helper controlling the other person's behavior.

- What are the characteristics of the relationship?
- If power was shared by both people, how would their relationship be different?

Trauma-Informed Peer Support and Self-Inflicted Violence

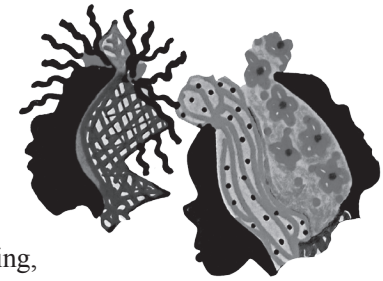
When people see others hurting themselves, they often react out of fear and attempt to stop the behavior. This is understandable; it is very difficult to know that someone is in so much pain that she harms herself. The issue of risk and liability can exert huge pressure on others to act swiftly and immediately to get the person "under control," placing human connection and relationships on the back burner.

In trauma-informed peer support, the focus is on creating healing relationships rather than trying to make women stop using self-injury. Keep in mind that women self-injure for their own reasons. Trauma-informed peer support is about creating mutual relationships and groups in which the focus is not on controlling each other but on discovering together what is possible for the future. This exploration can provide new meaning for people. Challenges offer new information about what relationships need, what people want out of them, and how to move forward individually and collectively.

INSTEAD OF ASSUMING	TRY ASKING
• She does it to get attention • That's just what borderlines do. • She's so manipulative • She always sabotages her success.	• **What is driving her pain?** • **Who is she? What is her view of theworld? What does self-injury mean for her? How has it allowed her to endure?** • **How can we create space in our relationship that will let both of us learn and grow?** • **What is the unfinished work here?**

Mutuality and Self-Injury

When women decide to disclose their use of self-inflicted violence, it is an opportunity for connection and communication. Disclosing a history of violence can be dangerous for a woman. Her past experiences of not being believed, of living in a situation in which revealing her abuse may threaten her survival, can create enormous hurdles to finding help. Revealing that one self-injures may be a huge leap in overcoming the barrier of silence and secrecy.



Trauma-informed responses to self-injury require a shift in thinking. Rather than seeing a woman who self-injures as engaging in meaningless, frustrating, or dangerous behavior, it is important to understand that self-harm is an expression of profound pain which has meaning for her, even if you do not understand the meaning.

STATEMENTS	WHAT IS BEING COMMUNICATED?
"I hurt to see you in this much pain. There must be an awful lot going on for you… Would it be helpful to talk about it, or would you like to just sit together for a little while?"	Peer supporters are sensitive to the discrimination and sense of disenfranchisement inherent in the shared experience of being labeled or experiencing loss or extreme distress. Relationships are non-judgmental. Empathy and validation are essential.
"I want to be there for you, but I have to admit that I'm scared. I'm not sure what to do.I am not sure what you are asking me to understand."	In a mutual relationship, peer support is a two-way relationship.
"I know other people have responded to you with alarm, sometimes forcing you into the hospital. I don't want to have that kind of relationship with you. There was a time in my life when I felt pretty powerless. Other people made decisions about what was best for me, and I saw myself as fragile and incapable of connecting to others. Is this at all what you are experiencing? Would it be helpful to talk about your experiences with power or powerlessness?"	In peer support relationships, both people take responsibility for their relationship and power is shared. This may begin with exploration and evolve and strengthen over time.
"I remember when I was in a really bad place and didn't have words for what was happening. I had huge, terrible feelings all the time. It really took a toll on my life. I wonder what is going on for you. I'd like to know more about what self-injury means for you, what it helps you deal with."	Common experience in peer support is explored rather than assumed. Each person is unique in how they make sense out of their experiences. The focus is on learning about one another rather than "helping."1
"I started my healing journey when someone helped me put words to what I was feeling. That was hard. Words never meant what they were supposed to mean growing up. I discovered how much I had to say! If your wounds could talk, what would they say?"	Peer support is a way to try out new ways of being in the world. It is not a stagnant relationship where both people stay in their comfort zones. It provides opportunities to explore what they want their lives to be about.

There are many different ways to bring mutuality into peer support relationships with women who self-injure. In the table below are statements that a peer supporter may use in speaking to the women he or she supports. Read each statement and think about how the principles of peer support operate in the relationship. How do you hear common experience defined? How does the peer supporter make his or her own needs known? What does he or she do to maintain shared power in the relationship? How does mutuality shift the focus from "What do you need and what I should do to meet that need?" to "What do we need and what we will do together to build this relationship?"

Guidelines for Peer Supporters

In the examples above, the peer supporter did not just jump into the conversation. She thought about her relationship with the woman she was supporting and did some preparatory work. Even if you are not currently working with someone who self-harms, it is important to consider ways of responding should the situation arise. The following guidelines are offered to help you navigate some of your own concerns and needs.

1. Examine your own feelings and beliefs about self-inflicted violence.

Understand your own limits around supporting women who self-harm. Is this a hot-button issue for you? What are some of your knee-jerk reactions? Are there some self-harming behaviors that you know are too difficult for you? How does self-harm affect you when you are not directly supporting a woman who self-injures? Knowing your own areas of discomfort and your own limits allows you to honestly bring your needs, feelings, and concerns into your conversations so that you can authentically engage in a mutually responsible relationship.

2. Educate yourself and the women you support, if that feels right for both of you.

You may want to share and discuss the resources at the end of this chapter with the women you support as a way to educate yourselves and explore the possibility of a community of healing. A benefit of exploring self-injury together is that it can be a focal point for connection, a hunt for meaning in which women who self-injure become your teachers, revealing what they know because of what has happened to them and how they have learned to survive.

3. Don't do anything different with women who self-injure and women who do not.

The principles and practice of peer support do not change because you know someone is self-harming.

4. Understand the cultural ramifications of self-harm for women of color.

Support her access to culturally sensitive services and or find out what healing looks like for her and what her culture's view of illness and healing are.

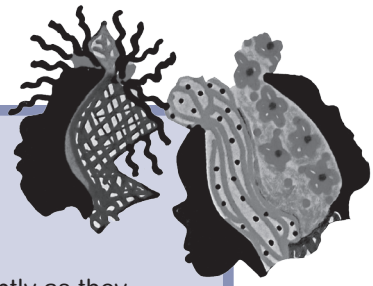
5. Use your own experience as a guide.

Have you have ever tried to quit smoking, drinking, overeating, or any other behavior that you felt was detrimental? If so, you have also experienced what it is like to try to stop harming yourself. Use your own struggles as a way to understand the difficult reality of self-harm.

6. You are not required to fix anyone.

Bearing witness to a woman's pain, grief, loneliness, and other extreme feelings is the foundation for healing. It says, "I see you. I hear you. You are not alone anymore."

The following is a Bill of Rights for people who self-harm. You might want to post this in your office or use it as a handout for educating women who self-injure about their right to dignity and validation. You may also want to use it to educate providers, family members, and others about what they can do to support women in their healing.



A BILL OF RIGHTS FOR THOSE WHO SELF-HARM

1. The right to caring, humane medical treatment.

Self-injurers should receive the same level and quality of care that a person presenting with an identical but accidental injury would receive. Procedures should be done as gently as they would be for others. If stitches are required, local anesthesia should be used. Treatment of accidental injury and self-inflicted injury should be identical.

2. The right to participate fully in decisions about emergency psychiatric treatment (so long as no one's life is in immediate danger).

When a person presents at the emergency room with a self-inflicted injury, his or her opinion about the need for a psychological assessment should be considered. If the person is not in obvious distress and is not suicidal, he or she should not be subjected to an arduous psych evaluation. Doctors should be trained to assess suicidality/homicidality and should realize that, although referral for outpatient follow-up may be advisable, hospitalization for self-injurious behavior alone is rarely warranted.

3. The right to body privacy.

Visual examinations to determine the extent and frequency of self-inflicted injury should be performed only when absolutely necessary and done in a way that maintains the patient's dignity. Many who self-injure have been abused; the humiliation of a strip-search is likely to increase the amount and intensity of future self-injury while making the person subject to the searches look for better ways to hide the marks.

4. The right to have the feelings behind the self-injury validated.

Self-injury doesn't occur in a vacuum. The person who self-injures usually does so in response to distressing feelings and those feelings should be recognized and validated. Although the care provider might not understand why a particular situation is extremely upsetting, she or he can at least understand that it *is* distressing and respect the self-injurer's right to be upset about it.

5. The right to disclose to whom they choose only what they choose.

No care provider should disclose to others that injuries are self-inflicted without obtaining the permission of the person involved. Exceptions can be made in the case of team-based hospital treatment or other medical care providers when the information that the injuries were self-inflicted is essential knowledge for proper medical care. Patients should be notified when others are told about their self-injury and, as always, gossiping about any patient is unprofessional.

6. The right to choose what coping mechanisms they will use.

No person should be forced to choose between self-injury and treatment. Outpatient therapists should never demand that clients sign a no-harm contract; instead, client and provider should develop a plan for dealing with self-injurious impulses and acts during the treatment. No client should feel they must lie about self-injury or be kicked out of outpatient therapy. Exceptions to this may be made in hospital or ER treatment, when a contract may be required by hospital legal policies.

7. The right to have providers who do not allow their feelings about self-injury to distort the therapy.

Those who work with clients who self-injure should keep their own fear, revulsion, anger, and anxiety out of the therapeutic setting. This is crucial for basic medical care of self-inflicted wounds but holds for therapists as well. A person who is struggling with self-injury has enough baggage without taking on the prejudices and biases of their care providers.

Continued on page 84

Continued from page 83

8. The right to have the role self-injury has played as a coping mechanism validated.

No one should be shamed, admonished, or chastised for having self-injured. Self-injury works as a coping mechanism, sometimes for people who have no other way to cope. They may use self-injury as a last-ditch effort to avoid suicide. The self-injurer should be taught to honor the positive things that self-injury has done for him/her as well as to recognize that the negatives of self-injury far outweigh those positives and that it is possible to learn methods of coping that aren't as destructive and life-interfering.

9. The right not to be automatically considered dangerous simply because of self-inflicted injury.

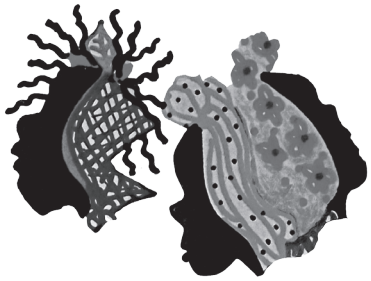
No one should be put in restraints or locked in a treatment room in an emergency room solely because his or her injuries are self-inflicted. No one should ever be involuntarily committed simply because of self-injury—physicians should make the decision to commit based on the presence of psychosis, suicidality, or homicidality.

10. The right to have self-injury regarded as an attempt to communicate, not manipulate.

Most people who hurt themselves are trying to express things they can say in no other way. Although sometimes these attempts to communicate seem manipulative, treating them as manipulation only makes the situation worse. Providers should respect the communicative function of self-injury and assume it is not manipulative behavior until there is clear evidence to the contrary.

CHAPTER SUMMARY: KEY POINTS

- The link between trauma and self-injury is often not recognized, or is minimized or ignored. This has hurtful ramifications as women attempt to find help and support.
- There are many different reasons why women self-injure, and many different ways women relate to self-injury. Exploring what it means for each survivor is an important opportunity in peer support.
- Trying to get women to stop self-injury can disregard ways in which this practice is helping them cope in the present.
- Trauma-informed peer support provides a context in which self-injury can be explored and both people can learn and grow.
- The following is a Bill of Rights for people who self-harm. You might want to post this in your office or use it as a handout for educating women who self-injure about their right to dignity and validation. You may also want to use it to educate providers, family members, and others about what they can do to support women in their healing.



Resources

Healing Self-injury. Numerous articles, resources, and archived newsletters available for free at **http://healingselfinjury.org/resources.html.**

Mazelis, Ruta (2008). *Self-Injury: Understanding and Responding to Those Who Live With Self-Inflicted Violence.* Sidran Institute Traumatic Stress Education and Advocacy/National Center for Trauma-Informed Care (NCTIC).

Mead, Shery (2005-2008). *Intentional Peer Support: An Alternative Approach*. Available to order at **http://www.mentalhealthpeers.com.**

Palace: a website by and for people who self-harm, **http://www.palace.net/~llama/selfinjury/**

Sandoval, Gabriela (2006). On Skin as Borderlands: Using Gloria Anzaldúa's New Mestiza to Understand Self-Injury Among Latinas. *Human Architecture: Journal of the Sociology of Self-Knowledge,* IV: 217-224.

To Write Love on Her Arms: A website geared to younger women with resources including blogs, a calendar of events, music, and links to YouTube and Flicker, **http://www.twloha.com**

The Sirius Project: a website on harm reduction, what to expect in the ER, and other resources, **http://www.siriusproject.org/firstaid.htm**

Trauma-informed Self Injury compendium, **www.trauma-informed-california.org**

Trautmann, Kristy & Connors, Robin (2004). *Understanding Self-injury: A Workbook for Adults*. Pittsburgh Action Against Rape. Available to order at **http://www.sidran.org/sub.cfm?contentID=168&sectionid=4.**

Handbook on Sensitive Practice for Health Care Practitioners: Lessons from Adult Survivors of Childhood Sexual Abuse. Available for free download at **http://www.phac-aspc.gc.ca/ncfv-cnivf/pdfs/nfntsx-handbook_e.pdf.**

Website dedicated to helping health care practitioners work with survivors of sex abuse, **http://www.csacliniciansguide.net/index.html.**

CHAPTER 13

RECLAIMING POWER THROUGH SOCIAL ACTION

One of the hurtful effects of trauma is that it often leaves survivors feeling powerless and voiceless. In a culture where women generally still have less power then men, this can leave women trauma survivors feeling especially hopeless or immobilized. In this chapter, we will examine how taking social action, individually or as part of a group, can be a positive act of healing for women trauma survivors, helping them to reclaim their own power in the world.

Social Action as a Tool for Healing

As we move through the healing process and begin to emerge from feelings of powerlessness, we may become aware of a sense of rage about what was done to us. We may also become outraged when we see others harmed or treated unjustly. This understandable anger is a potent force. Unexamined and unchecked, it can be hurtful to ourselves and others.

But if we recognize our rage as a force that can be channeled for our own benefit and for the good of others, it can be a powerful force for positive change. Taking social action—working to change harmful policies and practices and to overcome injustice—can be a healing and productive way to explore and express our newfound power.

TRANSFORMATION THROUGH SOCIAL ACTION

Whether we talk about the sexual and physical abuse of women and children, the abuse of the inmates of asylums and prisons, the imprisonment and torture of people of conscience, or the abuses of the totalitarian state, all violence focuses on the unfair distribution of power and the abuse of this power by the powerful against the helpless. The solutions to these problems are not individual solutions; they require political solutions. It is not surprising, therefore, that many traumatized individuals turn to political action as a way of transforming their own individual and group pain.

– Sandra Bloom

Organizing for Social Action

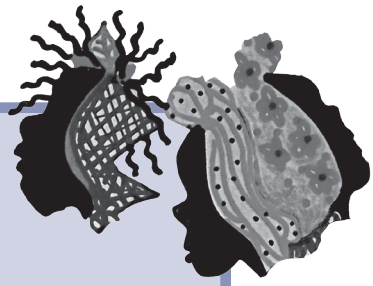
There are many issues around which a group can organize that are relevant to women trauma survivors. For example, women may wish to advocate for their local behavioral health system to provide trauma-informed services and supports. Maybe there is not enough funding for domestic violence shelters or rape crisis services in your city. Perhaps state law makes it difficult for women with behavioral health issues to keep custody of their children. Every woman and every community will have their own priorities. It is likely that there are existing groups in your community interested in the same issues who would be happy to collaborate with you and may have existing campaigns that you can become involved with.

Organizing for collective social action requires many different skills, which means that each person in the group has the opportunity to use their strengths in the process. For example, some people are good at sizing up a situation and planning strategy. Others excel at gathering information. One person may be good at writing letters, while another has the ability to remain calm in stressful situations and is a good negotiator. Since social action in a group uses many kinds of skills and personal strengths, everyone has the chance to shine!

No matter what issues you choose to tackle, organizing for social action requires planning, preparation, and coordination to be effective. An important first step is to express the issue from the group's point of view.

To break down the problem, ask questions like:

- What is it that we want to change?
- What outcomes or solutions would satisfy us? What are we willing to trade, compromise about, or just let go of? What are we not willing to trade, compromise about, or give up?
- Research the issues. Is there a written statement of rights? Is a rule, policy, or law being violated?
- What additional information or resources do you need? How can you get these?
- Who has the power to change the situation or fix the problem? If you are not sure who is ultimately in charge, how can you find out?



SOCIAL ACTION PRINCIPLES FOR TRAUMA SURVIVORS

- We express our rage nonviolently and humanely.
- We are focused and strategic; we are aware of the effects of our actions on others.
- Our means are consistent with our ends. We are committed to not acting abusively, regardless of — and in resistance against — how we have been abused.
- We maintain compassion for ourselves and compassion for others.
- Our actions are linked to positive visions. We react against our own mistreatment and broader conditions of social injustice. We also take responsibility for translating that reaction into ideas and possibilities for a more just society.
- We know that we are not powerless in the present, despite the ways that we have been overpowered by abuse and trauma in the past.
- We act from a commitment to equal power relations. Our goal is to share power to the greatest extent possible—to step outside of the oppression paradigm which places people in subordinate and dominant roles.

– Adapted from Steven Wineman, Power-Under: Trauma and Non-violent Social Change

- What are some possible barriers to reaching an outcome that everyone can live with? Think about how you might find a solution for each of these problems.
- When there is conflict, is there a point of shared interest on which there is some agreement? This may be a good place to begin conversations and build understanding of the concerns from both points of view.

Develop a clear and concise understanding of the problem and the group's desired solution in about five spoken sentences or no more than one written page. Once you have developed your position statement, you need to frame it in a way that is likely to get results. Think about what the other side has to gain by agreeing to resolve your problem and how to express this in a positive way.

Next, decide *who* to approach and how to approach them. Here are some tips:

- Focus on facts, not on feelings. While you may be angry about the problem, present your information in a calm, matter-of-fact way. This will have a stronger impact on the decision-maker.
- Usually, it is best to start with the most direct approach, such as meeting with management or with the government officials who are most clearly responsible for the issue.
- You can move on to methods that are more public and bring more pressure if the first steps are not effective. The techniques you choose will depend on the nature of the problem and your desired solution, as well as who the target of the advocacy is and what approaches might be most effective with them.
- Start by asserting the lowest-pressure technique and apply only as much as is necessary to succeed. The activities below are arranged in order of increasing pressure, from lowest to highest:
  - Meet with management or policymakers
  - Meet with the responsible government officials
  - Letter-writing, fax, phone, e-mail campaigns
  - Develop and distribute position papers and fact sheets
  - Join relevant committees and task forces
  - Testify at public hearings
  - Media campaigns
  - Rallies and demonstrations
  - Lawsuits

Organizing for social change is not only a tool for reclaiming our own power as individuals, it can help rebuild the trust and sense of community that is often shattered by traumatic events. Even when we face barriers or our short-term social action goals are not met, we can still feel a sense of satisfaction and camaraderie in the work itself.

BUILDING & MAINTAINING GRASSROOTS PROJECTS

Not all social action involves organizing to change policy, practices or funding priorities. In many instances, people come together to create projects or structures that meet a local need which is not being well-addressed by existing systems. Often largely based on volunteer labor and donations of goods and services, such grassroots efforts can give disempowered people a feeling of ownership as they work to solve the problems that affect them and their neighbors. Women can come together to decide what is needed in their communities.

Examples include:

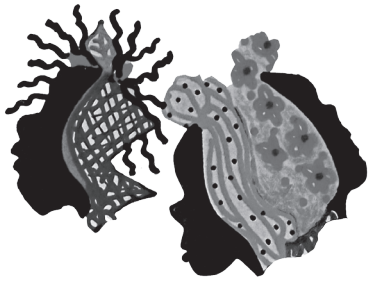
- **Food pantries and soup kitchens**
- **Ride-sharing services**
- **Self-defense classes for women**
- **Community gardens**
- **Safe houses for domestic violence survivors**
- **Childcare cooperatives**

WITNESS TESTIMONY: SEEKING JUSTICE AND HEALING THROUGH TELLING ONE'S STORY

There is a long history of survivors of violence and injustice seeking justice by giving testimony about what happened to them. Survivors of the Holocaust, families of the "disappeared" in Latin America, and survivors of torture and political violence across the world have all used this technique. This serves to document the truth about the violence and injustice that has been done. But people often find that telling their story is a cathartic and healing activity.

Psychotherapists in Chile pioneered a therapeutic approach based on giving testimony that was later adapted by therapists in Europe. As Dick Blackwell explains it, "The client would tell her/his story to the therapist who could interrupt, question, and explore the emotional experience of the events recounted. The testimony was recorded, typed up, given to the client to review with the therapist and revise and develop as necessary, again including 'therapeutic' attention to the emotional experience. The final document constituted an indictment of the regime under which the client had suffered, which (s)he could use as (s)he chose in the pursuit of justice. The testimony locates the victimization in the context of the rest of the client's life and in the contemporary political context in which it has occurred, and it provides the client with a form of positive action within that context. It also locates the therapist within that context as a participant in the struggle for social justice."

As peer supporters, we can adapt this technique as a way for women trauma survivors to tell their truths and consider what kind of justice would be necessary for healing. We can interview each other, write our individual stories as narratives, or record our testimony on video. These records could be kept private, could form the basis for discussion in peer support groups, or could be used as raw materials for arts and cultural projects.



Resources

Blackwell, Dick (2005). Psychotherapy, Politics and Trauma: Working with Survivors of Torture and Organized Violence. *Group Analysis*, 38(2):307–323.

Bloom, Sandra (1998). By The Crowd They Have Been Broken, By the Crowd They Shall Be Healed: The Social Transformation of Trauma. In R. Tedeschi, C. Park, & L. Calhoun. *Post-Traumatic Growth: Theory and Research on Change in the Aftermath of Crises*. Mahwah, NJ: Lawrence Erlbaum.

Bobo, Kim, Kendall, Jackie, & Max, Steve (2001). *Organizing for Social Change: A Manual for Activists, 3rd Edition*. Santa Ana, CA: Seven Locks Press.

Center for Community Change, **http://www.communitychange.org/**

Community Problem-Solving Project@ MIT, **http://web.mit.edu/cpsproject/home.html**

Highlander Research and Education Center, **http://www.highlandercenter.org/index.html**, includes Spanish-language organizing resources at: **http://www.highlandercenter.org/r-spanish.asp**

Midwest Academy, **http://www.midwestacademy.com/**

Organizing for Social Change: Tips for Group Organizing for Everyone, **https://www.msu.edu/~corcora5/org/grouporgtips.html**

Resources for Organizing and Social Change, **http://resourcesfororganizing.org/**

V-Day: A Global Movement to End Violence Against Women and Girls, **http://www.vday.org/home**

Wineman, Steven (2003). *Power-Under: Trauma and Non-violent Social Change*. Available for free download at **http://gis.net/~swineman/**

Young Women's Empowerment Project, **http://www.youarepriceless.org/**

We Are All Here by Sharon Wise