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

**Reconnecting with Self and Others in Peer Support Relationships**

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

**The Need for Reconnection**

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

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

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

You may be familiar with the three responses to danger referred to as fight, flight, or freeze. These are natural responses to any perceived or real threat that allow for optimal use of the body’s resources for self-protection. For example, in a fight or flee response, adrenalin courses through your body while oxygen rushes to your limbs, providing extra energy to run for your life or stand and fight. The freeze response allows both your mind and/or body to shut down, perhaps to lie still until danger passes, or to “zone out,” or “disappear.” These responses can be misinterpreted and labeled in ways that often lead to negative or punitive reactions to women who are simply struggling for control over their bodies, minds, and selves.
As a result of their responses to trauma, survivors often find themselves involved with behavioral health, criminal justice, child welfare, or homeless services. When staff in these organizations are not aware of the impact of trauma, they may use power and control in ways that make a trauma survivor’s sense of powerlessness even more intense. While staff may believe they are doing something for the individual’s own good, they may actually be doing harm, as this reinforces a survivor’s experience of powerlessness. Practices that are meant to help but which do not take trauma into account run the risk of re-traumatizing women who are already trauma survivors, or causing traumatic response in women who have not previously experienced trauma. In Chapter 1, we saw that re-traumatization happens when something in the environment recreates an aspect of a previous traumatic situation and triggers a trauma response.

Consider this example:

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

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

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

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

Re-traumatization in Peer Support Relationships

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

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

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

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


Characteristics of Traumatic Relationships

<table>
<thead>
<tr>
<th>CHARACTERISTICS OF TRAUMATIC RELATIONSHIPS</th>
<th>HOW PEER STAFF MAY REINFORCE TRAUMA</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Impose authority</td>
<td>• Tell her that she needs to take her meds</td>
</tr>
<tr>
<td>• Invalidate personal reality</td>
<td>• Interrupt her to take a call or answer email</td>
</tr>
<tr>
<td>• Take away voice</td>
<td>• Dismiss her distress since she has a diagnosis of borderline personality or assume her reactions are paranoid or delusional</td>
</tr>
<tr>
<td>• Communicate worthlessness</td>
<td>• Write your opinions of her progress in daily notes</td>
</tr>
<tr>
<td>• Humiliate and shame</td>
<td>• Enter a “staff-only” area with a card key</td>
</tr>
<tr>
<td>• Create mistrust and alienation</td>
<td>• Walk into the “staff” bathroom rather than the “client” bathroom</td>
</tr>
<tr>
<td>• Take away power and control over what is happening</td>
<td>• Tell her you are only there to help and she needs to stop fighting you; discuss her when she is not present</td>
</tr>
<tr>
<td>• Use power to control or intimidate</td>
<td>• Lock a door; create program schedules without her input</td>
</tr>
<tr>
<td>• Include the experience of being dominated, controlled, or manipulated</td>
<td>• Wear keys to parts of the building attached to a belt loop or arm loop</td>
</tr>
<tr>
<td>• Violate personal boundaries and sense of safety</td>
<td>• Decide who gets to talk next in a group</td>
</tr>
<tr>
<td>• Involve coercion</td>
<td>• Press her for personal information</td>
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<td></td>
<td>• Grant privileges based on compliance</td>
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Trauma-informed peer support provides a lens for understanding the larger context of women’s lives. While “helping” relationships that are not trauma-informed are often based on the assumption that the problem originates in the person, trauma-informed relationships take into account the ways that trauma may have shaped a woman’s experience in the present. Her current environment—her family, community, program, or relationships—plays a huge role in her experience of self and her relationships to others. The way that people participate in the present has everything to do with their past experience.

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

<table>
<thead>
<tr>
<th>PROGRAM THAT IS NOT TRAUMA-INFORMED ASKS “WHAT IS WRONG WITH YOU?”</th>
<th>TRAUMA-INFORMED PROGRAM ASKS “WHAT HAPPENED TO YOU?”</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Examples:</strong></td>
<td><strong>Examples:</strong></td>
</tr>
<tr>
<td>• “I am hearing voices.”</td>
<td>• “I was raped, so now I’m scared and afraid to leave my house and go to work.”</td>
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<tr>
<td>• “I want to hurt myself.”</td>
<td>• “I don’t think I’ve ever felt like someone cared.”</td>
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<tr>
<td>• “I’m depressed/can’t stop crying.”</td>
<td>• “My partner of thirty years died suddenly. I’m all alone now.”</td>
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<tr>
<td>• “I feel like dying.”</td>
<td>• “I was called crazy and locked up while I was a teenager, so I don’t know how to make friends.”</td>
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<tr>
<td>• “I feel like hurting someone.”</td>
<td>• “I was sentenced to prison and lost custody of my child, so now I can’t keep her safe.”</td>
</tr>
<tr>
<td>• “I can’t manage my anger. I’m in trouble with the law.”</td>
<td>• “After I was diagnosed, all my dreams and hopes died.”</td>
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<tr>
<td>• “I keep using even though I can’t pay my rent now.”</td>
<td><strong>What does “help” look like?</strong></td>
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<tr>
<td><strong>What does “help” look like?</strong></td>
<td>• Creating and sustaining a sense of trust and safety in relationships.</td>
</tr>
<tr>
<td>• Focus is on her “needs” as defined by staff: “She needs to stop hearing voices.”</td>
<td>• Safety is mutually defined by both people.</td>
</tr>
<tr>
<td>• The “helper” decides what “help” looks like.</td>
<td>• Collaboration and shared decision-making.</td>
</tr>
<tr>
<td>• Relationships are based on problem-solving and resource coordination, not on creating meaningful connections.</td>
<td>• Understanding and acceptance of big feelings.</td>
</tr>
<tr>
<td>• Safety is defined as risk management.</td>
<td>• Crisis becomes an opportunity for growth.</td>
</tr>
<tr>
<td>• 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.”</td>
<td>• 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.</td>
</tr>
</tbody>
</table>
IMPACT OF TRAUMA

- Invalidates personal reality
- Creates mistrust and alienation
- Loss of power and control
- Feelings of helplessness and hopelessness
- Feelings of voicelessness
- Being dominated, controlled, or manipulated
- Violates personal boundaries and sense of safety

PRINCIPLES OF PEER SUPPORT

- Non-judgmental
- Empathetic
- Respectful
- Honest and direct communication
- Mutual responsibility
- Power is shared
- Relationships are reciprocal

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

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

What is “Common Experience” in Peer Support?

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

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

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

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

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

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

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

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

**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*
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.”

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.

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.

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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


Emotional CPR, [http://www.emotional-cpr.org](http://www.emotional-cpr.org)

