

## What Makes Trauma Informed Peer Support Unique?

Shery Mead  
Cheryl MacNeil  
2004

- Peer support does not necessarily assume a problem orientation. In spite of the fact that people might congregate around the shared experience of mental health issues, conversations do not have to focus on that experience. It may be that there is more trust and openness with others they assume “get it,” which then allows them to try on other ways of constructing personal and relational narratives.
- Assessments and evaluation are not part of relationships. Instead, people strive for mutual responsibility and communication that allows them to express their needs to each other without threat or coercion. An example of this might include a negotiation of how to talk about difficult feelings without scaring each other (“Is there another way you could name your difficult feelings? It scares me when you talk about feeling suicidal”).
- Peer support does not utilize a medical framework. Instead the focus is on building relationships that support learning and growth across whole lives. This might take the form of challenging one another’s language or assumptions about what it is they experience. Following is an example from a peer program.

In a peer gathering one day, a woman said that she was having a “tough time.” She said that she was thinking about putting herself in the hospital or at the very least, calling her case manager and asking her to assess the situation. I asked her what the hospital offered her that had alleviated her “tough times” in the past. I asked her how the hospitalizations had helped her in the rest of her life, and I noticed with her the many times before when she’d gone into the hospital as a response to her “tough time.” Initially she was not too thrilled with this conversation, but she was able to listen and begin to think of alternatives. With an “outsiders” perception, one can begin to look at the patterns that have developed and look towards developing patterns with more positive outcomes, if not more flexibility (Littlejohn & Domenici, 2001). It was also interesting to share with her, some of the circumstances in which I had thought primarily of hospitalization as the answer to my discomfort. I shared with her what some of the results had been and also some of the alternatives I had since begun to pursue. The telling of our stories helped both of us look at the patterns and the ways in which our “stories” impacted the other. With continuing conversations the confluence of stories turned into the development of an on-going story; a story in which we were both able to take new risks, both with each other, and with our shifting patterns. (Littlejohn & Domenici, 2001).
- Peer support assumes full reciprocity. There are no static roles of helper and helpee. Although this may not be surprising, reciprocity is the key to building natural community connections. This is an enormous shift for people who have learned to think about community as a series of services.
- Peer support assumes evolution as opposed to individual recovery from a specified illness. The very fact of conversation changes the ways in which people speak and know. As Gergen (1991) explains, “We come to be aware that each

truth about ourselves [and others] is a construction of the moment, true only for a given time and within certain relationships” (pg 16). Many may find that through this willingness to remain open, it becomes possible to transform larger systemic conversations. As Littlejohn and Domenici (2001) explain, “Systems are like networks of interacting parts, webs of influence where ripples can fan out in a number of interesting directions” (pg. 19)

- Lastly, peer support requires people rethink definitions of safety. Beyond the traditional confines of program liability and harm reduction, the responsibilities of peer support require people to embrace relational meanings of safety. For example, relational safety has been described as: the emotional safety one feels through validation, being involved in compassionate relationships, having a place where you can be who you are, being provided the tools and education to be in mutually responsible peer relationships, feeling like you are not being judged, and not feeling like you have to have all the answers. (MacNeil and Mead, 2005).

Shery Mead is an independent consultant and trainer working with peer support programs towards the development of a strong theoretical, practice and research base reflecting true peer support values. She can be reached through her website at [www.mentalhealthpeers.com](http://www.mentalhealthpeers.com). Or by phone at 603-469-3577.

Cheryl MacNeil is an independent consultant and evaluator and has conducted extensive program evaluations for peer services. She can be reached at [macred@capital.net](mailto:macred@capital.net).