

Trauma informed Peer Support

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This paper is written to generate discussion about the importance of trauma informed peer services. We will examine how people who have experienced sexual abuse and other severe personal traumas have built their way of “seeing” the world and of “making meaning” from their experiences, and consequently why and how they end up in the mental health system defined as “mental patients”. We will explore the ways in which peer support is the logical environment for deconstructing these trauma-based worldviews and for building relationships that are based on mutuality, shared power, and respect. Finally we will identify ways that peer support programs can offer an environment where social action becomes an integral part of people’s healing, help people to find and use voice and to build mutually empowering relationships, and to expose the cultural violence that has kept us silent prisoners in our own skins. This paper will present both a theoretical base and offer stories and journal entries in order to personalize the concepts presented.

Those of us with histories of past violence often feel “other-than.” We have been told again and again that something is wrong with us, that we’re “crazy,” that it was our fault, and that we’re bad. We learned that “fitting in” was the way to connect with others and the way to “fit in” was to “not tell”.

We learn that what we know – based on what we see, feel and experience is not “true.” What has become our truth – what is our reality – has been defined or “named” by others – not by us. Our instinctive feelings of terror, anger, despair have never been accepted or acceptable. We can no longer trust how we perceive the world, or feelings and perceptions, or construct meaning from our experience.

We begin to live on two levels – what we “know” internally to be true and how we must adapt our external lives in order to “fit in.” What we know internally and externally is divided by a physical self that simply “experiences.” As this division continues, the body becomes simply an entity through which the internal and distanced physical self must relate, as one relates without connection to a mirrored image.

I think a lot about the mirror image. She was the one in the mirror. The enemy. The one who existed and let the abuse happen. The one who learned that nothing was wrong and who learned to act as if. Voice was not congruent outwardly and inwardly. What was consciousness was the membrane of the skin. Though the body was visible from the mirror it was only a container (prison), leaving internal screaming and external complacency communicating through the battlefield of the skin

When our sense of self is filtered through the lens of trauma, our relationships can only serve to reinforce the perception that we are “other than”. We seek treatment for our problems, marry batterers, keep secrets, stay isolated and treat our bodies as the enemy. We also learn to ‘act as if:’ as if it were OK, as if it never happened, as if we believed how others named our experiences, as if we

felt whole and never divided within ourselves. This only supports the wall between what we lived and how our experience was defined for us. For any number of reasons, this split has often landed us into the institutions of the mental health system, further supporting and even magnifying the perceptions by both ourselves and others that somehow we were ‘other-than’.

The Naming of Pain as Pathology

In the dynamics of abuse, the abuser is the one with the power. And the abuser assumes the power to define the situation for all. Within this dynamic, a particular kind of communication pattern is created. (White, 1995; Mead et al, 2000; Rogers, 1994). The one in power may blame, while the one with less power feels at fault. These messages become part of a dance in which both parties learn the steps. A shared but usually unspoken agreement is developed about the “rules.” Normal feelings of pain or terror are described as an over-reaction. Abusers tell us that we wanted it, we asked for it, that it’s normal, but should not to tell. Over time, we learn how to buy into the conversation; we may even believe it ourselves. Self-blame becomes integrated into our self-perception and into all our relationships. And so the abuse continues, unchallenged, if not by the original abuser, than by a new abuser or by ourselves. Sometimes we even come to expect abuse, demand abuse, need abuse because there is no “safety” in the world unless we are being abused. Annie Rogers writes (1994): “This is the real devastation of trauma: It isn’t so much the rush into dissociation, or the physical violence in itself, however brutal, but the human ways we try to protect ourselves from what is so terrible to know, to image really (pg 7).”

As a culture we often talk about pain as if it were always pathological – a by-product of a wound or symptom of an illness. But as Elaine Scarry (1987) points out, pain is a uniquely individual experience. It cannot really be measured or even described without metaphor. And it continues to get compounded when the lived experience of “pain” has been both inflicted and named by the abuser.

It’s hard to distinguish pain when the naming of pain is taken away. How does one name pain when it is mixed with the confusing sensations of sexual abuse? How then does one find a way of minimizing pain when it is woven into so many other sensations? The body in pain is the body holding on. The experiences of sensation and emotion become meaning as they pass through fundamental relationship. Pain also becomes adaptation and survival. The pain that is inflicted with tone and words that connote caring and comfort further bifurcation. The action of the other (mirror self) becomes behavior and development as it relates to abuser, building a stronger and stronger enmeshment. How do you know what action to take if pain and pleasure, reward and punishment are indistinguishable? Action must be based on the success of developing a symbiotic relationship with the abuse. Instinctive response or intuition is erased when there is no one else contradicting the meaning that is now being created.

Finally we come to see the pain as part of us. We view the world through our lens of pain and no longer fully trust our own perceptions. Pain and confusion

becomes manifest outside of us and we become “the problem.” We either seek treatment or we are forced into it. If we are lucky (and economically privileged) we may find treatment that supports us to find and rebuild our voice, and helps us to move away from seeing ourselves as “the problem”.. If we are not so lucky, our actions (or other’s assessment of our actions) may lead us to further abuse in terms of forced treatment, locked doors, physical restraints, and debilitating medications. Either way, we are labeled with a psychiatric diagnosis and our experience is further embedded in the “self as problem,” and our pain as a symptom to be treated. We again learn to view ourselves and our experiences through others’ eyes rather than through our own. We again are defined by others. Our most personal experiences are interpreted and named by others. We learn to believe that we are “mentally ill.” We give up our homes, our money, our children, and any relationships outside the context of our “problem.” AND we are stuck in a vicious circle. If we challenge the treatment we are considered non-compliant, if we disagree with the label we are in denial, and if we ask too often for the help we’ve been told that we need, we are considered “frequent flyers.” Yet all of these things seem to validate and justify others’ opinions that we are the “problem” – that we are “sick” and in need of “treatment”. Needless to say, we are stuck once again with being silenced and labeled.

Peer Support and a Reconstruction of Story

Peer supports can offer a fundamentally different framework for making meaning about our experiences and perceptions of our past, present, and futures. It can provide us with opportunities to find new ways of understanding our world and our experiences and of finding new ways to respond to it.. In peer support we can learn to form relationships outside of the definition or context of “illness” and to talk about the effects of trauma and abuse in our lives. We can share our stories with each other and we can begin to question how and why other people have learned to tell their stories in the ways that they do. We can begin to listen to each other in new ways, hearing the story rather than evaluating and assessing the problem. We can be witnesses to each other’s pain. And most importantly we can validate the reality of each others’ feelings, perceptions, and experiences. These conversations can influence the ways in which we respond to the situations we face, the ways we think about things, and can ultimately lead to our questioning the reified status of having an “illness.” As we challenge the naming of our experience by others we shake the whole foundation of a trauma worldview, and we begin to identify the larger cultural context in which we have been situated.

Sarah had been a recipient of mental health services for most of her life. She had been diagnosed with bipolar disorder and because of her history she was told to expect periodic episodes of mania. She was so accustomed to this schedule that she virtually prepared herself for hospitalization every year. This year, at the beginning of August, she came to the local peer center. She described not sleeping, racing thoughts, images of death and blood, and an

urgency about running into the woods with a knife. Rather than calling her case manager I talked with her about having often felt like this as well and told her how terrified I had been. We talked a lot about our images of death and blood and shared related experiences. We both talked about histories of past violence. She finally told me the story of an August where she had been kidnapped, held in an outhouse, and repeatedly raped. When she had finally been released she ran through the woods for a long time, not knowing where she was or what she should do. Many years later, just before August, when she finally brought it up to her case manager, she was told to put the past behind her. That's exactly what she did, always one step behind her. Out of her sight but not out of her experience.

The day we met we put both our pasts into the 'conversation.' We shared strategies and ideas. Mostly we built a relationship that was not based on assessment but rather on shared truths and mutual empathy. Each year since then Sarah has asked people to "wrap around" her in August. She talks to people and they talk to her. Her experience is not named, it is witnessed. She no longer has delusions, she has strong feelings. She doesn't see herself as out of control but rather in great pain. This pain now has meaning for her. It is her history and her experience and she has begun to transform it. She now helps others develop plans and strategies to move through crises differently or even to prevent them all together. (Taken from Crisis and Connection, Mead 2001, pg.1)

As we unite in shared experiences and begin to expose the very structures that have kept us silenced, we find that "doing" social action becomes inextricably linked to healing-personally, relationally and culturally. People who have seen themselves as powerless suddenly find that they are not alone in their perceptions. Through shared experience, people find validation and acceptance; they find voice; and with voice power. They begin to speak out. Judith Herman writes about the healing effects of social action.

The survivor gains the sense of connection with the best in other people. In this sense of reciprocal connection, the survivor can transcend the boundaries of her particular time and place. At times the survivor may even attain a feeling of participation in an order of creation that transcends ordinary reality (Herman, pg 207-8).

Developing trauma-informed peer services are crucial. We are at a difficult juncture in the history of mental health treatment. The trauma agenda (or our attempt to build more trauma-informed mental health services), once again has been put on the back burner. Treatment outcomes are based on acceptance of psychiatric diagnoses/labels given by others, on compliance to what others think is "good for us," and adherence to medication regimes that once again require our bodies to be in the power of others. Even if we are given a "trauma" diagnosis (PTSD, Borderline Personality Disorder, Dissociative Identity Disorder) we are considered manipulative, hard to work with and needy. We are mandated

to rigid and controlling therapy programs such as DBT and lose treatment resources if we don't go. We are considered inappropriately angry and unsuccessful at relationships and we are banned from calling hotlines. Further, as managed behavioral healthcare has developed a stronger voice across all mental health treatment, we are losing many resources that might help us to work through the abuse, to build healing relationships and to move through the anger that has kept us bound to our cycles of pain. In fact, rather than helping people truly to heal from the effects of past abuses and offering them the opportunity to break the cycle of violence, we are creating lifelong "mental patients" – people who are firmly embedded in the notion that they have something permanently and organically wrong with them.

Peer support programs must challenge the current system's approach to how people with histories of abuse are treated. The devastating impact of abuse must be recognized for what it is and not viewed as psychiatric pathology or biological brain disorders. Through peer support services we can offer each other relationships that are respectful of our experiences, our ways of communicating, and how we have learned to tell our story.. We can challenge each other to both face and to move beyond these stories and patterns. We can build new community norms that replace the illness environments that have kept us trapped. Finally, we can conscientiously name and expose the cultural violence that caused us to end up in these institutions. If we can learn to tell our stories in new ways, we can create communities where the sanctioned outcomes include non-compliance to "mental patient" identities or expectations, rejection of unhelpful treatment regimens, questioning the overuse of medication, and speaking out about the prevalence of trauma and abuse. Finally, we can call into question whose "problem" it really is.

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