Lifelong Learning Programme

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PEER TO PEER: A ROUTE TO RECOVERY OF PEOPLE WITH MENTAL ILLNESS THROUGH PEER SUPPORT TRAINING AND EMPLOYMENT

Project Nº 2013-1-ES1-LEO05-66277-AN

PEER SUPPORT PILOTING COURSE CURRICULUM OUTLINE

SESSIONS

Session 1: Introduction exercises: icebreaker, learning environment and feedback

Session 2: Development of recovery approach and key concepts in recovery

Session 3: Societal influences and effect of force and trauma and Trauma-informed practice

Session 4: Working with the effects of labeling

Session 5: Understanding peer support

Session 6: Key concepts of peer support and peer relationship

Session 7: Review and evaluation

Session 8: Strengths-based approaches, resilience, role modeling and hope

Session 9: Formalised peer support, considering boundaries, supervision and goal setting

Session 10: Effective communication and working with risk

Session 11: Self-care, safe practice and self-management in peer support

Session 12: Reflecting on personal experience: Understanding the process of change

Session 13: Remediation, review and evaluation

GENERAL ESTRUCTURE

The main objective of the course and the material proposed is to facilitate the future work of candidates, by presenting theoretical material, case studies, scenarios, exercises, interesting readings and space for reflection and discussion. In other words, the manual will seek to clarify the role of a Peer worker and enable candidates to carry out their duties as peer workers.

The fifty hours course consists of an introductory session, nine four hour training sessions and two assessment sessions (mid-term and final).

All sessions follow a similar structure; firstly objectives of each session and the recommended methodology. Each session includes an extensive theoretical section with concepts and approaches to be developed during the session. After that we explain the theoretical background and introduce all of the activities one by one. This section also contains clues to guide thinking and case studies to reflect upon. Some sessions incorporate scenarios which require the use of Role Playing and video-therapy. Each scenario provides the space needed to overcome fears, frustrations and work with emotions in a controlled and safe environment.

Each session concludes with an individual assessment (evidence requirements). This evaluation includes technical concepts that each candidate must have acquired during the session and should be attached as *Portfolio of evidence*.

Both, the mid-term assessment and the final session will be useful to pin down the concepts that candidates have already learnt. Furthermore, these two sessions will be useful to review candidates' portfolios and reflect upon them.

Session 3:

Societal influences and effects of force and trauma

OBJECTIVES

The aim of this session is to explore the impact of societal influences on mental health recovery, to examine possible effects of force and trauma on mental health and the implications of this for practice. This is likely to be a challenging topic for some, so it would be beneficial to discuss some ground rules before beginning. We have suggested the following as starting points for discussion: There is no need to share anything personal if you do not want to; It's ok to take a break; Don't share anything you're not comfortable sharing; Be respectful of other people's confidentiality; This is a discussion about trauma and recovery, not group psychotherapy!; The aim is not to 'open people up' to raw experiences as we won't have time or capacity to properly attend to distress during and after the session.

METHODOLOGY

Session 3 has a total duration of four hours. In this session the following activities and learning methods are proposed:

SESSION 3	TIMING	METHOD	TYPE
INTRODUCTION	10´	Expositive	Conceptual
ACTIVITIES			
3.1 Societal beliefs	20´	Workgroups	Conceptual
3.2 Thoughts, feelings and behaviours around trauma	20´	Individual reflection	Conceptual
3.3 Trauma, recovery and peer support relationships	20´	Workgroups	Conceptual
Break	20´		

3.4 Importance of social context	20´	Group reflection	Conceptual
3.5 Trauma-informed peer relationship	20´	Workgroups	Conceptual
3.6 Role play Psychodrama and Videotherapy	70´	Roll play	Procedural
Break	10´		
PORTFOLIO	30´	Individual work	Procedural

THEORETICAL BACKGROUND

Societal influences and effects of force and trauma

Societal influences are a composite reflection of things like advertising, politics, traditions, conventions and mass media representations. These powerful (and sometimes hidden or disguised) forces affect everyone and are embedded in our attitudes, beliefs, values and behaviours.

Their influence can lead to a shorthand way of thinking about important issues — for example, ‘old people will be a burden on the younger generation’ or ‘prison works’. Social norms and attitudes can be internalised at the individual level and accepted as universal truths. Those who challenge these ‘universal truths’ can find themselves ridiculed or marginalised.

This session will explore the societal influences of stigma (including internalised stigma), stereotyping and exclusion. It begins by looking at generally accepted beliefs about mental health problems.

Self-stigma or internalised stigma

Stigma remains one of the great barriers to recovery from mental ill health and has been described as ‘the most serious obstacle in the field of psychiatry’ (Sartorius 2002).

Self-stigma refers to the idea that negative beliefs and prejudices about mental illness held by the wider community (Corrigan and Watson 2002) can be unconsciously absorbed into the belief system of the individual who has a mental health problem, so that they may start to behave as if they actually had these negative characteristics attributed through societal prejudice. For example, there is a societal attitude that says that people with mental health problems should not have children. People who have experienced mental health problems could internalise this, and consequently decide not to have children: self-stigma has therefore affected their behaviour and opportunities.

Self-stigma or internalised stigma tends to ‘make people accept their status as “damaged goods”, accept any communication that they are different or less than human, and shouldn’t participate fully in community life…this in turn leads to marginalisation by others.’ (Lindberg 2006)

Negative reactions from others can actually exacerbate mental health problems and be experienced as shame and disgrace, thus presenting another barrier to recovery (Corrigan 2007).

Stigma, stereotyping and exclusion in relation to employment

Employers, too, can be influenced by the societal perception that people with mental health problems make unsatisfactory employees, because they think they will perhaps be ‘needy’ and unreliable and will be frequently absent. Employers appear to be disinclined to appoint people who disclose a mental health problem.

The impact of these discriminatory attitudes could be called ‘employability self-stigma’ — ie when the person affected by mental health problems introjects a belief such as ‘I am unemployable because I have a mental illness’. This should be distinguished from self-discrimination, which is the behaviour associated with the belief. In this case the behaviour might be to avoid applying for jobs based on the logic of the underlying negative self- stigmatising belief.

Carers who have been influenced by these prejudicial societal beliefs might find themselves subtly discouraging the person whom they are caring for from taking the perceived risk of applying for jobs, given their fear of rejection and the inevitable subsequent distress.

The Government’s Mental Health and Social Exclusion Unit Report (Office of the Deputy Prime Minister, 2004) revealed that 76 per cent of adults suffering from long-term mental health problems were out of work, this being the lowest rate of employment for any of the primary groups of people with a disability. This report also found that people affected by mental health problems stood twice the risk of losing their job in comparison to those not affected.

Repper and Perkins (2003), consider the level of exclusion of people with mental health problems from employment and describe their aspirations for the future: ‘…it is possible to end the national disgrace demonstrated by 82% unemployment among people who experience mental health problems.’

It has been long known that being in meaningful work is a major contributor to good mental health:

‘In 172AD, the Greek physician and philosopher, Galen, described employment as

“nature’s best physician” and said it was “essential to human happiness.”’ Perkins et al (2009).

From this, it can clearly be inferred that exclusion from employment represents a significant barrier to recovery.

‘Worklessness robs people of their identity, status, social networks, and a sense of purpose. Those who are already excluded by the prejudice and discrimination that surrounds mental health conditions are further marginalised by being denied the opportunity to use their talents and contribute to their communities via work.’ (Perkins et al (2009).

Peer support workers who have faced these kinds of difficulties themselves, yet who despite this have returned to employment, are a particular source of inspiration and optimism to people excluded from employment as a result of poor mental health.

Exclusion and inequality

The ‘big three’ social determinants of physical and mental health are power, money and resources. Anything that impacts on any or all of these will impact on mental health. Having power, money and resources enables people to have control over their social determinants of health, with obvious benefits to physical and mental health.

At the other end of the scale, stigmatised individuals affected by mental ill health and excluded from employment have scant resources and are often not in control of their housing or environment. Marginalised groups — including people with mental health problems — tend to have less power, resources and money, and are therefore at greater risk. These structural inequalities in society, reinforced by stigma and internalised stigma, represent significant barriers to recovery.

Exclusion from employment increases the risk of poverty. Poverty is a social determinant of health. Poverty strongly correlates to poor health and poor mental health and this makes it less possible to gain employment and this circular process builds ever more obstacles to recovery.

Gender inequality is also a potential societal hindrance to recovery. According to Williams and Miller (2008), society has gender inequality built into it which tends to give more advantages to men in terms of power money and resources. Women are generally (despite legislation) in less well paid employment and often have less favourable pension arrangements.

Belonging to a Black or Ethnic Minority (BME) group and experiencing racism is also a cause of mental health problems and a barrier to recovery. It has been noted that BME service users can face barriers to recovery when dealing with

mental health professionals:

‘Problems may range from getting the right interpreters when they are needed, for as long as they are needed, to accessing psychotherapy and social help for refugees and asylum seekers.’ McKenzie (2007)

The effects of force and trauma

Trauma occurs when an external threat overwhelms a person’s coping resources. It can result in immediate psychological distress, sometimes diagnosed as post-traumatic stress disorder (PTSD), or it can affect other aspects of the person’s life over a period of time. Sometimes people aren’t even aware that their problems are related to a 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 and does happen to anyone, but some groups — including women and children, people with disabilities and people who are homeless or living in institutions — are particularly vulnerable due to their circumstances. ‘Traumatic reactions occur when action is of no avail. When neither resistance nor escape is possible, the human system of self-defence becomes overwhelmed and disorganised’ (Herman, 1992).

In her important 1992 book, *Trauma and Recovery,* Judith Herman describes features of trauma, including how trauma:

- can render a person helpless by overwhelming force
- involves threats to life or bodily integrity, or close personal encounter with violence or death
- disrupts sense of control, connection and meaning
- confronts people with extremities of helplessness and terror, evoking responses of catastrophe

There are many effects of trauma, but they are often grouped into three headings:

Re-experiencing

- Flashbacks — reliving the trauma suddenly and unexpectedly — this can be like re-experiencing the event ‘live’ in the moment, and can induce racing heart, and fight or flight effects
- Nightmares
- Frightening thoughts

Avoidance

- Staying away from places, events, or objects that are reminders of the

experience
- Feeling emotionally numb
- Feeling strong guilt, depression, or anxiety
- Losing interest in activities that were enjoyable in the past
- Having trouble remembering the traumatic event

Hyper-alertness that cannot be easily controlled

- Being easily startled
- Feeling tense or 'on edge'
- Having difficulty sleeping, and/or having angry outbursts
- Being constantly alert and vigilant (known as hypervigilance)

Hyperarousal effects are usually constant, rather than being intermittently triggered by reminders of the traumatic event. This can induce anxiety, stress and frustration. High arousal and high alertness make it hard to perform essential behaviours like sleeping, eating, or concentrating.

All or any of the above manifestations of trauma are very distressing in themselves, and are very damaging to mental wellbeing. They are of course impediments to recovery, and they limit the possibilities for healthy social interactions and living an enjoyable life.

Sources of trauma

Trauma can result from a wide variety of events: experiencing or witnessing violent crime, domestic abuse, witnessing domestic abuse, accidents, abandonment or neglect (especially for children), emotional, physical or sexual abuse, cultural dislocation, terrorism, wars, violence against a specific group (as in enslavement or genocide), natural disasters, or any situation where one person abuses power. Chronic stressors like racism and poverty can also have traumatic effects over time.

Interpersonal violence is a major source of trauma. One source of severe trauma that can occur in domestic abuse is where the child can hear violence taking place in another room, typically against his or her mother, but is helpless to intervene.

'At least half of women in touch with mental health services have experienced domestic abuse.' (DoH, 2002).

Factors that intensify trauma

While all forms of violence can be traumatising, the earlier in life the trauma

occurs, the more severe the long-term consequences.

Intentional violence is particularly damaging, especially when it is inflicted by trusted caregivers. Examples of such 'betrayal trauma' include incest, clergy abuse and abuse by professional caregivers.

Another factor that intensifies trauma is secrecy. Often perpetrators will threaten victims to keep them from revealing what has happened. In other cases, victims will maintain secrecy due to self-blame and shame.

Recurrence increases the damaging consequences too — for example, being raped repeatedly over a number of years. When violence is compounded by betrayal, silence, blame or shame, it can have lasting effects on people's ability to trust others and to form relationships — and this can affect their work in peer support, as building trusting relationships is a key objective.

What impact does trauma have?

Scientific findings now confirm that trauma affects the nervous system — and in children, brain development — and can have a lasting impact. One study looked at the 'adverse childhood experiences' (ACEs) of 17,000 people, correlating their 'ACE score' with a range of medical and social problems. According to this, people with high ACE scores are much more likely to develop mental health symptoms, abuse substances, have chronic illnesses and die early. Women are significantly more likely than men to have high ACE scores.

There are two basic pathways through which adverse events have an impact. First, trauma affects the developing brain and body and alters the body's natural stress response mechanisms.

Second, trauma increases the need to 'self-soothe' through inherently risky behaviours such as smoking, drinking, over-eating and engaging in risky sex — things that trauma survivors sometimes do to manage difficult feelings.
Recognising these behaviours as coping responses rather than 'bad choices' is essential to effective peer relationships.

The table below offers a list of behaviours, viewed from two perspectives: one is the professional or societal perspective and the other is from the perspective of the person who is exhibiting the behaviour.

Behaviour	**Societal perspective**	**Individual's perspective**
Self-harm — eg cutting self with a razor blade.	Self-destructive, attention seeking, madness, failed suicide attempts.	Soothing, releases endorphins, slows racing mind, has personal symbolic meaning, control.

Drug or alcohol addictio	Self-indulgence, fecklessness, anti-social, 'waster', person has the disea of addiction.	Escape from distressing thoughts, changes body and mind, changes feelings, allows coping.
Eating disorders — eg bingeing or anorexia.	Lack of self-control, mentally ill, obstinate, stupid.	Comforting, establishes control, Used t cope with distress. Avoids unwanted sexual attention.
Bathing in bleach, excessive cleanliness o tidiness.	Obsessive compulsive disorder.	Purging past dirtiness, symbolic purification.
Poor personal hygiene.	Person is chaotic or anti- social or lacking personal pride.	Unpleasant appearance and odour hel ward off unwanted sexual attention.
Vigilance and scanning environment.	'Paranoia' a symptom of mental illnes	Evidence-based alertness for next surprise attack or assault
Running away from hom or place of care.	Deviant, anti-social behaviour. Out of control, hyperactive.	It feels safer on the streets! Gets perso out of the immediate danger.

Perhaps there lies purpose, strategy, and meaning behind what appears to be people's dysfunctional behaviours? Consider the argument that trauma responses are the normal human responses to abnormal experiences involving horror and terror. This way of looking at trauma tends to normalise behaviours like 'exaggerated startle response' rather than seeing them as symptoms of an illness.

Trauma and the peer support relationship

Trauma is potentially contagious. It has long been understood that human beings affect and influence each other. Just as you can recall being with someone who inspired you, you can equally recall being with someone who saps your energy. Relating to people who have experienced trauma can be exhilarating and worthwhile, but it can also be devastating and disturbing. It is possible to be traumatised by listening empathically to someone's trauma story.

We are all encouraged to try to feel what it feels like to be the other person. The ability to skilfully sense our way into someone's life experience and emotions is useful, because empathy helps. Obviously to truly empathise with someone's experience of torture or assault and really share those feelings is a risky business. The impact of sharing such distress can lead the listener to start having intrusive thoughts, horror, sleeplessness and the kind of trauma responses previously described. This phenomenon is well documented and known as vicarious trauma.

To help prevent vicarious trauma, peer support workers and indeed anyone in the

helping role must be aware of their own triggers and vulnerabilities. Good quality support and supervision can help with the preparation for this work and also in debriefing the difficult feelings that will inevitably arise. People who have had their boundaries violated will tend to test the boundaries of those they interact with. People who have experienced trauma can also experience 'victimstance thinking', where they perceive themselves as being attacked where no such intent existed. This can result in a sense of being persecuted, which in turn invites the other into the role of rescuer. At some point the dynamic may change, and this is all very confusing and perplexing. It is best described in Karpman's *Drama Triangle* (1968) which explains the dynamic of victim-persecutor- rescuer.

Mental health service users as a group have a high prevalence of trauma. One paper which reviewed 51 research studies on the connection between trauma and psychosis found that:

'The majority of female patients (69%) reported either childhood sexual abuse (CSA) (48%) or childhood physical abuse (CPA) (48%). The majority of male patients (59%) reported either CSA (28%) or CPA (50%)' (Larkin & Read, 2008).

The authors point out that these rates are likely to be underestimates as child abuse is generally under-reported.

In addition to this past experience of trauma, some people face trauma within mental health services.

Traumatisation within the system can be caused by forced treatment, loss of liberty, physical restraints and debilitating medications. When labelled with a psychiatric diagnosis, the service user's experience can be further embedded in the 'self as problem,' and their pain viewed as a symptom to be treated.

In the role of 'patients' we can learn to view ourselves and our experiences through others' eyes rather than through our own. Our most personal experiences are interpreted and named by others. Through this we learn to believe that we are 'mentally ill.' If we challenge the treatment we could be 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 'revolving door patients'. Yet all of these things seem to validate and justify others' opinions that we are the 'problem' and in need of 'treatment'.

As peers we have the opportunity to break the cycle by developing relationships that share power, generate new ways of seeing and thinking, and by listening to each other in ways that don't judge or assess. These relationships can then become the basis for challenging the ongoing proliferation of trauma as well as building more empowered communities.

Seclusion, force and restraint and the impact on recovery

Coercion, compulsion, seclusion, force and restraint are terms used for a range of actions taken by mental health professionals to contain or sedate a person whose behaviour has been deemed unacceptable in some way.

Sedation is pharmacological or chemical restraint where the drug will in some cases be forcibly administered and this might involve a number of staff members holding a person down in order to inject them against their will.

Seclusion might be done forcibly and involves the person being locked into a secure area where they are contained and isolated.

Physical restraint begins with staff physically taking hold of the person, and can make use of a range of devices such as restraining sheets or seats that limit movement, or being strapped into a bed.

The research by Mayers et al (2010) found that service users undergoing forced interventions tended to feel that they were being punished. People reported feeling that they had been incarcerated, dominated and humiliated. This increased their level of distress and in some cases led to resentment. The three overarching themes that emerged from descriptions of restraint, seclusion and force were:

- inadequate communication
- a violation of rights
- the experience of distress.

As already emphasised, it is now accepted that very high percentages of people in psychiatric facilities have experienced trauma and this has led to a greater emphasis in what are described as ‘trauma informed’ practices. These practices are informed by the knowledge that subjecting people with histories of trauma to force and restraint is likely to cause what is known as ‘retraumatisation.’

To consider the impact of forced interventions on recovery it is useful to recall the elements that are commonly recognised as key to recovery.

Trauma-informed peer support

We learned that trauma occurs where an external threat overwhelms a person’s coping resources. Let’s use an analogy to talk about what that means. Say, for example, that a mountain suddenly appears in the middle of the road that you have to walk every day to get home. You’ve never had to climb a mountain before. What do you do? You might start to climb it, but then discover that you simply don’t have the strength or stamina to make it to the top. Or you might make it to the top, but are so exhausted and worn out that all you can think about is catching your breath. You simply don’t have the resources — in this case physical stamina,

lung capacity or muscle strength — to deal with the mountain. This is what we mean when we say that trauma overwhelms ones coping resources.
There can be many sources of trauma and that trauma can occur at any life stage. So when we talk about trauma, we don't just mean early childhood experiences, but any event at any time that overwhelms a person's coping resources.
People's responses to trauma vary. Someone else — due to their own unique life experiences — might climb the same mountain with ease. But the fact that the mountain is easy for one person to climb and not for another does not take away the reality of the other person's pain or distress. That is what trauma is like. We all respond to traumatic life events in our own way.
Trauma also has a cumulative effect, meaning that each traumatic event builds on previous traumatic events. Using our mountain analogy again, let's say that you make it to the top of the mountain only to discover that there is another mountain you have to climb before you can get home. How well you are able to master that second mountain depends on what kind of resources you have left over. We'll say more about this in just a moment.
Trauma is not just the event. It's not just your exhaustion over having to climb the mountain that impacts on you. Trauma has three characteristics:

- There is the event itself. (The mountain.)
- There is the personal and unique meaning and the cultural meaning that the event has for the person. (Why is this mountain here? Do I deserve this? What did I do to deserve this trouble? Maybe I'm being punished?)
- There is the impact that the event has on the person's quality of life — including the quality of their relationships. (I'm never leaving home again. It's too dangerous. No-one was there to help me climb that mountain. You can't trust people.)

The destructive force that trauma has on a person's life has to do with the type of event, the meaning of the event and the impact and the coping resources that the person can use to help them overcome the event. When those resources are depleted, our relationships with others become a crucial way of being able to cope.

Special concerns around trauma include the significant impact it has on our sense of identity as well as its effect on how we form relationships. Since peer support is all about building relationships, we need to pay attention to how trauma can make that even harder.

Constructing our stories

Our past experiences create personal stories about who we are. Our stories help us define ourselves and include our beliefs about the world and others, what we think of as true, our interpretations of events, and the meaning we make out of what has taken place in our lives. Our stories are true for us.

Our stories guide what we do and the following series of diagrams are designed to help us understand how we construct our stories, particularly around the experience of trauma. They show how our stories impact on how we interact with the world and how cycles can develop. They also help us think about what we can do to help each other evolve new stories. When you look at them, do keep in mind that the points made in the diagrams are deliberately exaggerated to help illustrate key points.

Diagram 1 demonstrates how a story can be constructed around the experience of trauma.

Firstly, trauma can impact on our connection to ourselves. We might begin to experience ourselves as damaged, unworthy, dirty, bad or crazy. This is especially the case when our reality is denied. This can be the case for children who have been abused, or for combat veterans where atrocity may be normalised by others as a way to cope. Perhaps we feel that we deserve the events that have taken place, or perhaps we come to believe that if we had been stronger we could have handled the events.

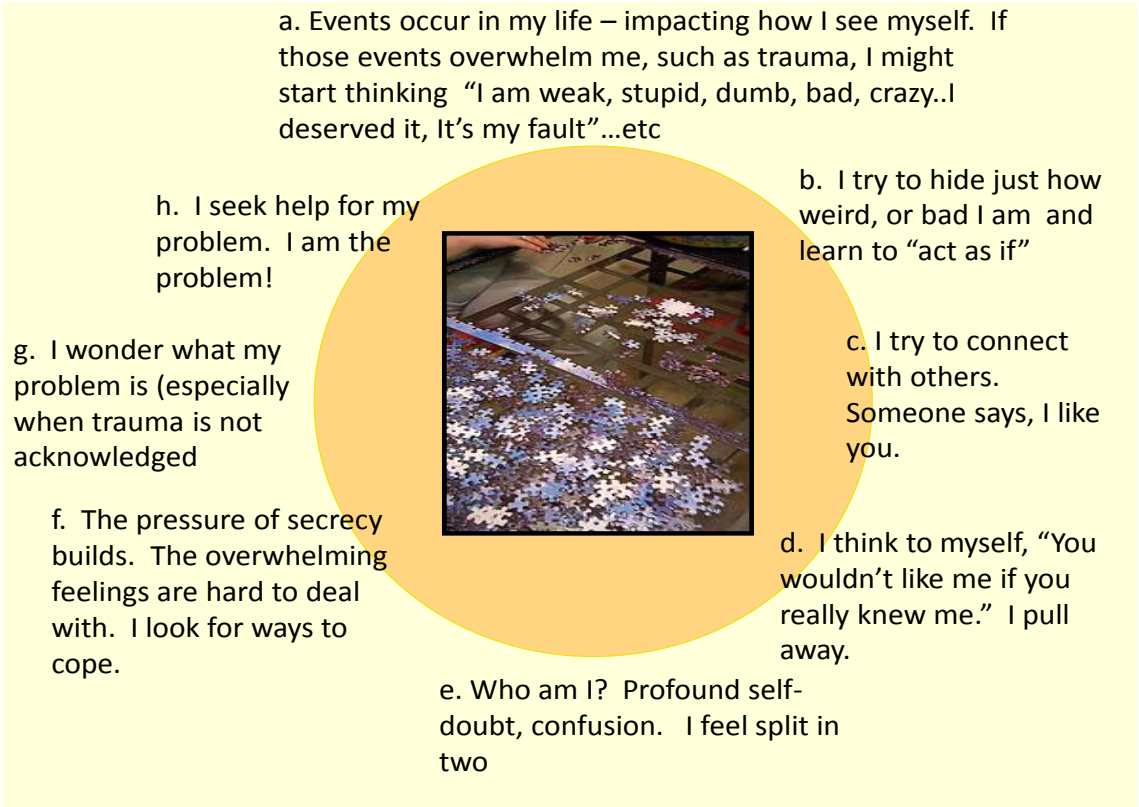

Diagram 1 The impact of trauma

Trauma can also impact on our connection to others and peer support workers should be particularly aware of this. Trauma — especially in situations where it is interpersonal such as domestic violence, early childhood abuse, adult sexual assault or combat experience — can call into question what relationships mean. We can conclude that we don't deserve much, or that we don't have the right to expect love, or respect, or to be treated with dignity.

The dynamics of trauma can be subtle or extreme. Forming healthy, meaningful relationships with others when your story is about being undeserving can be hard. What if someone tells you that they like you, or that they think you are smart, or funny, or sensitive? The first thing you might think is, 'That person wouldn't like me if they really knew me.' So you back away. Or maybe you do something to get the person to go away, or to prove just how bad you really are.
The overwhelming feelings that are associated with trauma, and the conflict around making a connection with people can result in coping strategies that are less than healthy.

In some cases it is people's coping strategies (for example, self-injury, substance abuse or risky sexual behaviour) or their adaptations to trauma (for example, profound distress, suspicion, fear, dread or feeling like dying) that bring people to mental health services.

Diagram 2 demonstrates what might happen when someone in this situation seeks help from a traditional mental health professional. Remember the points made are exaggerated to demonstrate the dynamics that can be at play.

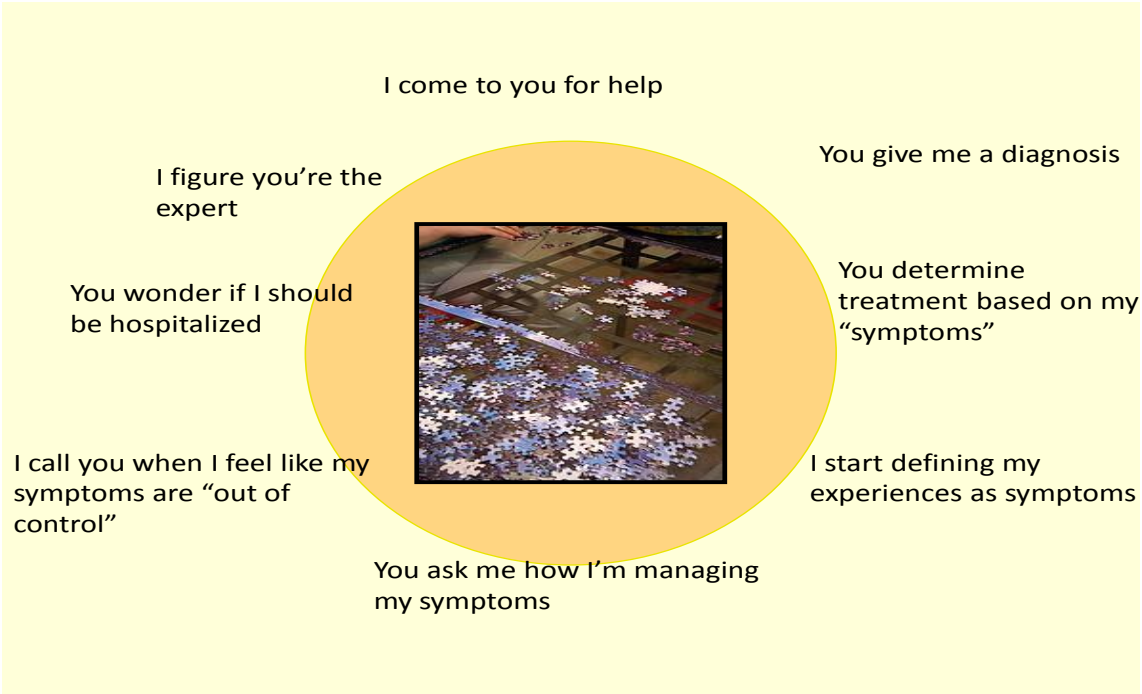

Diagram 2 What might happen when someone seeks help from a traditional mental health professional

In our culture, when we have any emotional conflicts we are most likely to be offered mental health support. When this happens, usually the first interaction is about assessing needs to reach a diagnosis. This evaluation and assessment is designed primarily to answer the question, 'What's wrong with this person?' From a trauma-informed perspective this is, in many respects, an odd sort of first conversation to be having, since so much of 'what's wrong' has to do with what has happened to the person. The result of this initial assessment might be to reinforce the idea that there is something wrong with you that can be diagnosed (given a label or a name) and treated. The trouble is that once you have a diagnosis, all your experiences (and even your identity — for example, 'schizophrenic') become defined in the language of symptoms. The treatment and support that is offered is based on the symptom cluster within the context of the agreed diagnosis. We will revisit this in session 6 when we look in more detail at 'Working with the effects of labelling'.

You could begin to confuse all kinds of feelings with symptoms, and pretty soon you might not know the difference between a feeling and a symptom. This is reinforced in treatment relationships, when you are regularly asked how you are managing your symptoms. In many ways, relationships in the mental health system have encouraged people to focus on what's wrong with them. Treatment relationships could be preventing you from exploring what is happening in your environment. Indeed, they could actually be causing the distress because you are encouraged to rename your experiences as symptoms rather than to understand them as potentially normal reactions to abnormal events.

When the focus of support is on managing symptoms, you could feel more vulnerable and fragile. Who are you to question authority, anyway? So now, when you have difficult feelings, you might call someone and say, 'I'm out of control'. What might be the response from a crisis team if you call and say that your symptoms are out of control? More medications or possible admission to hospital? Now that you've established other people as the expert (you are sick, and you cannot trust your judgement), how can you do anything but listen to their interpretation of what's going on, and take their advice?

Now think about the scenario from a trauma-informed peer support perspective. Diagrams 3 and 4 demonstrate some of the challenges and potential pitfalls when working in this way as a peer support worker.

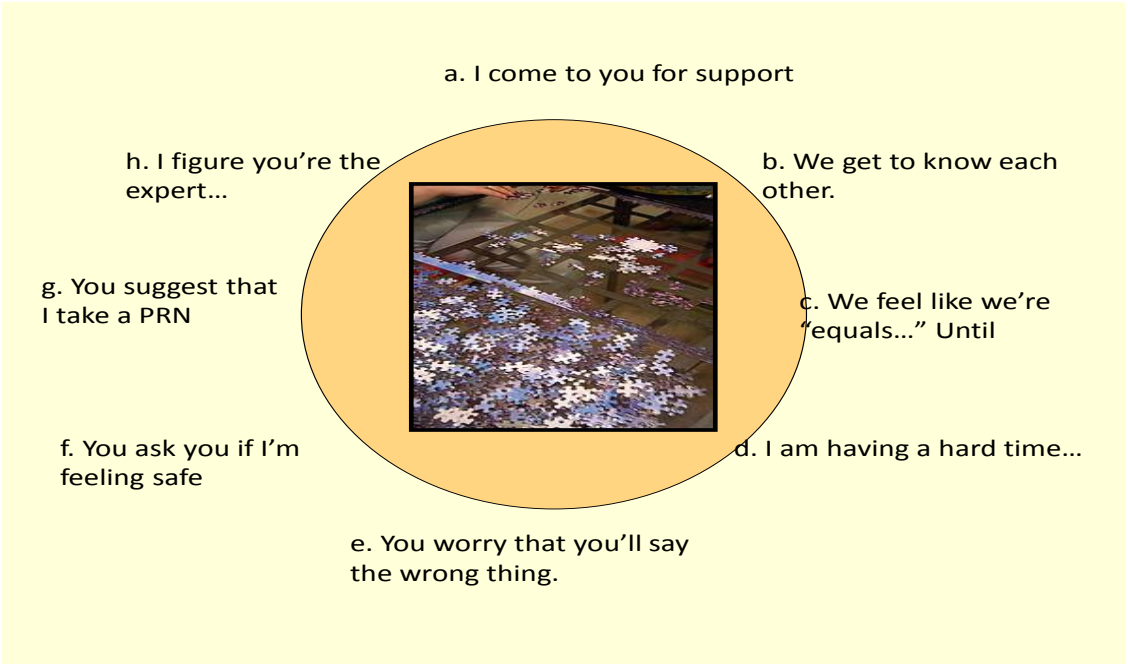

Diagram 3

The next diagram is intended to demonstrate what support would look like in a trauma-informed and mutually responsible peer relationship.

Diagram 4

As peer support workers our aim is to create different conversations and different responses. But peer support has some unique challenges when operating within formal mental health services, and we will examine some of these in more detail in session 9.

Employing organisations require peer support workers to follow policies and protocols. It is therefore important for you not only to understand your responsibilities but also to bring this understanding into your conversations with the peers you are supporting, and to discuss your role and organisational responsibilities at an early stage.

Let's return to diagram 4, where you have listened to each other and clarified roles and responsibilities and you can really feel mutuality in the relationship. But what happens when things start to wrong? Perhaps one of you is having a really hard time. Perhaps the person you are supporting is not feeling great and is acting in a way that scares you. In this scenario instead of talking immediately about safety (as in diagram 3), you actually struggle with your fear, which you name if you need to. You talk about what you both need and want in the relationship, and what works for you both in a way that keeps you both in the conversation. The result is that you both come away feeling like experts.
When this kind of conversation is ongoing and practised, the focus is no longer on symptom management but rather on what's going to make the relationship strong, reciprocal and healthy. To support this scenario we might also have conversations in advance about what might happen should one or the other of you get scared or uncomfortable.

So in trauma-informed peer support, the goal is to build relationships where you try to understand, try out new ways of relating, take risks by being honest or pushing your discomfort and by negotiating what will be of benefit to you both.
Let's consider a scenario that illustrates the peer support relationship outlined in diagram 4.

ACTIVITIES

3.1 Societal beliefs

Objective

Identify the consequences of societal beliefs in relation to mental health problems.

Timing

30 minutes

Description

Working in small groups, can you think of some societal beliefs that are generally accepted in relation to mental health problems?

What are the consequences of these beliefs for:

- society
- individual members of the public
- people affected by mental health problems?

Why might people affected by mental ill health be stigmatised? What is it that wider society believes about people who have mental health problems that might lead to widespread negative attitudes and behaviours?

Comment on Activity 3.1

'Stigma' is a word that has biblical connections: in Genesis, Cain has a symbolic mark put on him by God signifying that he is cursed, but is not to be killed. This is not to be confused with 'stigmata', which refers to the crucifixion wounds of Jesus Christ. The actual term 'stigma' was first used by the ancient Greeks and referred to signs that were literally cut or burnt into the body. These stigmas were a punishment to the offender and a warning to others that the bearer was disgraced, spoiled and to be avoided.

Erving Goffman (1963), who wrote ground breaking books on the subject, defined stigma as 'an attribute that is deeply discrediting within a particular social interaction' and that the stigmatised individual is 'reduced in our minds from a whole and usual person to a tainted, discounted one'. The stigmatising characteristics are therefore seen to belong to the individual, singling them out and devaluing them in some undesirable way. The stigmatised individual then experiences discrimination, exclusion and social disapproval.

Western cultures have traditionally connected ideals of morality and virtue with good physical and mental health, and early Christian societies linked madness with images of the satanic, the perverse, the promiscuous and the sinful. These powerful associations still have unconscious resonance, even in more enlightened times. Current prejudices include the notion that people with mental ill health have a propensity for violence and aggression, or irrational and unusual behaviour.

Stigma is created by society itself, and is generated in response to its own fear of 'the other':

'That which we do not understand, we fear. That which we fear, we destroy'.

(Anonymous)
The three main elements that comprise social stigma and that feed into social exclusion are prejudice, discrimination and ignorance.

Prejudice means literally to prejudge and involves making judgements without reference to knowledge or facts. Prejudice expressed as racism, sexism, and ageism has been made an offence by legislation.

Discrimination is disadvantageous or hostile behaviour towards a particular individual or group and can involve exclusion or deprivation of opportunity. Discrimination is the action that follows from prejudicial beliefs and attitudes.

Minority groups — including gay, lesbian, bisexual and transgender groups, black and minority ethnic groups, and people experiencing homelessness — are already subject to prejudice, discrimination and stereotyping, which are themselves a source of distress and disadvantage. When someone in a minority group also has a mental health problem, then the phenomenon of 'double discrimination' can manifest itself. This amplifies the sense of stigmatisation and exclusion and is clearly a societal barrier to recovery.

3.2 Thoughts, feelings and behaviours around trauma

Objective
Consider how trauma affects people's thoughts, feelings and behaviours.

Timing
30 minutes

Description
Although it's not a pleasant exercise, it can be instructive to try and empathically enter the worldview of an adult who has experienced some kind of childhood abuse from someone who abused their power.

Like all of us, that child is trying to make sense of the world and understand 'the rules' and these rules are based on the data observed and events experienced by that child.

So this child is assaulted by a loved one — suddenly, shockingly and unexpectedly. Time passes, the assault recurs some days later and this process is repeated over a number of years.

What thoughts, feelings and behaviours might this process engender? Think of normal responses to abnormal circumstances.

Comment on Activity 3.2

We could discuss possible thought processes that can result from these experiences:

- People who claim to love me are dangerous and unpredictable.
- I should expect sudden horror and terror to be inflicted on me, and it will happen again.
- Trust no one, assume the worst, attack first ... ask questions later.
- Be ever vigilant, look like you don't care, don't let them see vulnerability.
- Be invisible!

Certain types of thoughts are rooted in trauma. These thoughts lead to behaviours, hence the mantra 'where the mind goes, the person follows'. Trauma-based thinking leads to trauma-based feelings and behaviours.

The good news is that some people find resilience within trauma. Some people's thinking process is more geared to overcoming problems and turning pain into determination or compassion for others, with a mindset of 'that which does not kill me makes me stronger'.

Over time, trauma can alter everything about a person's life and behaviour. Because it shatters trust and safety and leaves people feeling powerless, trauma can lead to profound disconnection from others, always being on guard, or overwhelming despair. Coping mechanisms can become habits that are hard to quit. Trauma can lead to problems at home, at school or at work.

Trauma can cause an inner rage, which can manifest in a number of ways:

- rage acted out against others in the form of violence — often seen as a male response
- rage turned inward on the self, perhaps manifesting as self-harm or despair — often seen as a female response — although these responses can be associated with either gender
-

3.3 Trauma, recovery and peer support relationships

Objective

Relate the importance of trauma in the peer support relationship and how affect to recovery

Timing

30 minutes

Description

In small groups discuss the following questions:

How would you differentiate trauma from 'having a bad day'?

Why is it important for peer supporters to talk about trauma?

What are some of the potential effects of trauma on peer support relationships?

How might trauma affect recovery?

Comment on Activity 3.3

Here are some points to consider:

- Not everyone reacts to events in the same way — trauma can result from a variety of experiences depending on the person's circumstances.
- Peer supporters could find themselves in situations where others don't trust them, where others struggle with power issues and a variety of other dynamics. If we know and understand the impact of trauma we can empathise more deeply and not get into a blaming trap.
- Power balanced relationships are what heal and they take time, effort, patience and most importantly, honesty, respect, authenticity and integrity.

3.4 Importance of social context

Objective

Compare the implications for relationships in peer support to take account of the social context of the people and not just what is wrong with them.

Timing

20 minutes

Description

Trauma-informed relationships are oriented around the question 'What happened to you?' rather than around the more traditional question, 'What is wrong with you?'. We will now consider how this shift affects relationships and peer support practice.

In small groups, read scenario one:

What's wrong with Mary?

Mary comes to your service. You ask Mary, 'So what's wrong?' Mary says, 'I can't stop crying. I feel confused. I don't know what the purpose of my life is. I don't deserve to be here. I can't sleep anymore. I don't know what's going on! I need help. I don't deserve to be alive!'

Describe the kinds of services and types of support you think will help this person.

In small groups, read scenario two:

What happened to Mary?

Mary comes to your service. You ask her, 'Mary, what happened to you?' She says, 'I was asleep in my hotel room when I woke up and heard screaming. I smelled smoke. I ran out into the hall and all these people were running toward the fire escape. We couldn't all get through. Some people got hurt. People were yelling Fire! Fire! My heart was racing. I didn't know if I should save myself or try to stay and help save others. It was awful!'

Design services and supports that you think will be important to help Mary to heal.

Now as a whole group discuss the following questions:
Were there any differences in the services and supports identified for the two scenarios?
What were those differences? Why do you think identified services and supports changed?
How does context inform situation?
What was the role of peer support in each scenario?
How do you think that knowing what has happened in a person's life changes what you do in peer support?

Comment on Activity 3.4

Being trauma-informed in peer support means understanding that people often have normal responses to abnormal events. Good practice in peer support includes understanding how vital it is to create relationships with others that support their ability to:

- name their own experience (voice)
- make meaningful choices (choice)
- experience safety and trust in their relationships with others (safety and trust)
- be an equal partner in their treatment (collaborate).

The principles of trauma-informed care (voice, choice, safety, and collaboration) apply to peers and to non-peers alike. These principles make it clear why values such as equality, reciprocity, shared power, and shared responsibility are so important in peer support and why relationships that support these principles can lead to empowerment.

Trauma-informed relationships also address experiences common to many of us — for example, feeling or being powerless, not having a say in what is happening to us or being violated or betrayed — whether traumatic or not.
It is important to see people and their problems within the context of their lives. The clinical paradigm that has operated for a long time in mental health has

separated people from their social context when identifying (diagnosing) what is wrong with them and then treating what is wrong. Indeed, many peer support workers have come to view help as meaning diagnosis and treatment with no account being taken of their past or present life situation.
Research has shown that trauma and past experiences play a significant role in shaping people's current struggles. If these are ignored while treating the problem (illness) then in many respects people fail to reconnect to their lives. Being trauma-informed simply means recognising that people are who they are, see how they see, and do what they do because of their histories.

3.5 Trauma-informed peer relationship

Objective

what support would look like in a trauma-informed and mutually responsible peer relationship

Timing

15 minutes

Description

In small groups discuss the diagram 3 and consider:

At what stage do things start to go wrong from a peer perspective? Why might this have happened?

Comment on Activity 3.5

If as a peer support worker you have not had many role models or teachers to show you how to take a trauma-informed approach, you might only be able to replicate the kinds of things that have been done to you When you engage with people who have experienced trauma it can be easy to respond by 'doing what's been done to you' — in other words, blaming or controlling or feeling responsible for others, or even labelling each other.

In peer support, even when you're looking for help, your first conversations are geared around your shared experiences. You get to know each other. Helping, sharing stories and support go both ways and you feel like equals. This is a real shift in how we begin to think about what support can look like.
But how would you know how to provide peer support if all you have known is a treatment-type of relationship? If your treatment relationship has been life-saving or positive and helpful in your recovery journey, you may want to provide the same experience to others and replicate your own role models. For some of us, responding to someone in crisis by hospitalising them or calling emergency services might be what care and concern look like.

As peer support workers we might feel pretty scared if someone we provide support services to has a bad day. We could start worrying that if we say the wrong thing to someone who looks like they are in distress, they'll go over the top and something bad will happen. This is where it's very easy to fall into doing what's been done to us, or to try to help in the only way we understand — by replicating clinical support, or seeing distress through a risk management lens.
As a peer support worker, you might be afraid that something dangerous will happen and that you will then be held responsible. You start asking the person if they feel safe, if they've taken their medication or seen their CPN. Pretty soon you're both quickly creating a dynamic in your relationship in which one person takes responsibility for the other person's life, whereby an expert needs to be involved.

So how can we change this story? How do we change our relationships so that people don't continue these cycles that are based on management and maintenance and not on recovery?

3.6 Role play Psychodrama and Videotherapy

To practice and explore the importance of self-care in peer support working practice, it may be interesting and useful to provide candidates with a space for simulating. Please use Role Play and conduct the following scenario, record it and then, make the group watch and comment on it. For more information about how to conduct a Role Play scenario see annex 1: Peer2Peer Role play scenarios.

Timing

70 minutes

Description

In small groups consider the following two scenarios and discuss the questions that follow.

Scenario

Margo has been receiving support from Anytown Mental Health Services for five years and has been supported by Sean for about the past six months. At times she is very positive and motivated and full of dreams and plans for the future but at other times she feels very low and despondent. She can also appear very angry at times and paranoid, particularly about her contact with services and official agencies. When low or angry Margo sometimes talks about getting back at the people who she feels have let her down but this is not something that she has gone into any depth about.

She has recently received notification that she is to be re-assessed for the support she is receiving by the local council and is feeling very anxious about this. At a meeting with Sean she has been discussing the re-assessment and suddenly states that she feels like hurting herself.

In groups of three with one person playing the role of Margo, one playing the role of Sean and the third person observing, role play the third scenario where Sean understands and demonstrates that his relationship with Margo has to be based on mutuality, shared responsibility and equality.

Comment on Activity 3.6

This scenario provides an opportunity to explore what a peer support rather than a traditional support relationship may look like. In a traditional support relationship the worker would immediately seek to minimise or manage risk and consider their requirements to report such statements or behaviour to a manager or other individual. However this not only focuses on the immediate situation or symptom rather than the reasons behind the behaviour but also removes power and responsibility from the individual being supported.

In a peer relationship based on mutuality, shared responsibility and equality the peer worker will seek to listen to what the person is really saying. To do this they will have to ask open questions focused on how the person is feeling and why that may be to facilitate a real conversation. Through this they will be able to show empathy and also seek to share the pain of the other person. Through sharing their own experiences they may also be able to validate the feelings and experiences of the other person and encourage them to discuss them in an open way.

One way to think about this is to ask a person ‘what happened to you?’ instead of asking ‘what is wrong with you?’.

The aim is for the discussion to proceed in a way that supports Margo to talk about how she feels and the reasons behind this and for her and Sean to work on this together. Through this Margo understands that a peer support relationship is different from those she has previously experienced and shows her that she now has some choices about how she wants to move forward.

EVIDENCE REQUIREMENTS

3.1 Analyse two societal influences that impact mental health recovery.
3.2 Explain two possible effects of force and trauma on mental health.
3.3 Demonstrate an awareness of the effects of trauma

TO LEARN MORE

Engaging Women in Trauma-Informed Peer Support: A Guidebook.
www.scottishrecovery.net

You can read an article about self-stigma from leading researcher, Professor Richard Warner, on the SRN website:
http://www.scottishrecovery.net/Latest-News/the-stigma-inside-us.html

SRN Discussion Paper 5 on *Mental Health, Recovery and Employment* provides background on some of the issues, challenges and opportunities in employment:
http://www.scottishrecovery.net/Download-document/88-Mental-Health-Recovery-and-Employment.html

See the table on page 6 of 'What you need to know about mental health inequalities' (NHS Health Scotland 2010).

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