# intentional peerSUPPORT For INTAR 2016

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# INTRODUCTION

Dear Participant,

Welcome to Intentional Peer Support! You are about to embark on a new and exciting path. I hope this workbook will help you discover many things, but the main goal will be to provide you with a very different way of thinking about "help."

Over the last 35 years, peer support in mental health has evolved out of a human rights perspective. Starting in the late 1970s, when most of the mental health community was talking about lifelong illness and containment in the community, people working in peer support were talking about rights, consciousness raising, alternatives, and choice. While all this was developing, so were the ideas about what makes peer support different from other kinds of help. Not better or worse, but a whole different way of thinking about life and supportive relationships.

This workbook is the product of many years of working with peer support practices. I have drawn from a variety of fields; so much of what you'll read and learn really has little to do with traditional mental health. For example, we will rarely talk about illness and never about diagnosis, assessment or treatment. What we will discuss is your learning and growth and how to form relationships that are mutually transformative, supportive and challenging.

There are a few things that you'll want to know that are very important:

- First, there are no wrong answers! Everything we do, think, and say helps us to learn while challenging some of our beliefs.
- Second, I suspect that this information will be life changing for many of you (especially if you really do the exercises, apply the material, and s-t-r-e-t-c-h!).
- Third (and best), you already know all there is to know about peer support! That's because you are you – and that is the best any of us has to offer. Now, having said that, we are also endlessly evolving and learning and changing through relationships.

Ultimately, this course is about building a healthier world – one in which people aren't labeled but rather understood through the lens of their experience. It is about helping each other examine the lens we look through and decide whether this perspective has been useful to us. And finally, it is about helping each other move towards the lives we want.

You see, simple. There's no assessment, there's no treatment, and you don't need to know anything about psychology or psychiatry. All you need is the ability to be challenged, to stick with the process, and to express your needs while negotiating the needs of others.

So let's start right off with some questions to ponder in order to gear you up for what's ahead.

What's the strongest quality you bring to the peer relationship?

What do you think you'll most need to work on in terms of building strong peer relationships?

## Journal Writing

In all of these modules, you will be expected to do some reading, some exercises, and participate fully. Since most of the material is about doing things differently, I will also ask you to keep a journal of those things. This will be structured by some guiding questions that we'll offer throughout each module. For those of you who don't love to write, journaling can take many forms. Sit down and talk to a friend, talk into a tape recorder, write a poem, draw, or anything else that helps you really think about yourself and this material.

Please note that although we would like you to share your responses and ideas, you don't have to share anything you are uncomfortable with sharing.

# About Peer Support...

### Learning Objectives

To begin an exploration of what makes peer support different from other kinds of help

To learn about the specific tasks of peer support

To discuss the notion of worldview and it's relevance to "doing" peer support

## What Is Peer Support Anyway?

What is this thing that we're calling peer support?

Is it about being a paid friend? Not really. Is it about taking care of someone? Definitely not. Are you providing treatment? No. Are you connecting with someone in a way that contributes to both people learning and growing? That's it!

So what makes this different from other kinds of help?

### It's about giving and receiving

This might not sound like a big deal, but for many people relationships have become all about getting: telling your problem story and then getting help with it. There is little, if any, emphasis placed on giving back. That's a big deal! Service relationships are like a one-way street and both people's roles are clearly defined. But in "regular" relationships in your community, people give and take all the time. No one is permanently on the taking side or the giving side. This exchange contributes to people feeling ok about being vulnerable (needing help) as well as confident about what they're offering. For many of us, being in the role of 'getter' all the time has shaken our confidence, making us feel like we have nothing worthwhile to contribute. Peer support breaks that all down. It gets complicated somewhat when one of us is paid, but modeling this kind of relationship in which both of us learn, offers us the real practice we need in order to feel like a "regular" community member as opposed to an "integrated mental patient."

Was there ever a time where you felt like most of your relationships were based on just getting support? How did you begin to think about your relationships? How did you think about yourself?

## Peer support is not based on psychiatric models or diagnoses

This may sound obvious, but it is a stumbling block for many people. We'll talk about this a lot throughout the training because it is much harder to do than we might think. Too often, when we get frustrated, confused, afraid or uncomfortable, it is easy to fall into seeing each other through the lens of illness. It will be important for us to notice throughout the training when we find ourselves falling into psychiatric assumptions about ourselves or others.

## In peer support, we encourage one another to re-evaluate how we've come to know what we know

We'll spend a lot of time on "worldview" later but it's important to think about how you've made sense out of your experience. How we look at things and how we relate to each other is a product of lots and lots of messages through our lives. In other words, the way we see the world and make sense of things is based on everything we've ever experienced. Just thinking this way helps us to consider the possibility that there are many truths out there.

What's the difference between a strong feeling and a symptom? How did you learn to make that distinction?

**Peer support is about creating relationships that make it okay for us not just to be in peer relationships, but to use them as a tool to take a bigger look at how we've learned to operate in the world.**

This really gets at the heart of peer support. Peer support relationships give us the opportunity to explore where we may have gotten stuck in certain interpersonal patterns. The challenging part in this is sticking with it even when it doesn't feel like it's comfortable or supportive. It means sticking with the process of working out our differences and tolerating the discomfort of trying on new ways of thinking. It means being willing to support and challenge each other to "walk the talk."

Describe a relationship that really made you take a look at yourself in new ways.

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## This Is Trauma-Informed Peer Support

Trauma-informed peer support is distinguished from some of the other kinds of peer support models, in that it starts with the fundamental question, "What happened to you?" rather than the traditional question, "What's wrong with you?" There is much we can learn about being with each other when we make this shift. We will spend more time talking about this later in the workbook.

## Peer Support Is Intentional

Being intentional means that we come into the relationship with a specific purpose in mind. While peer support assumes the characteristics of any healthy relationship, there is also a specific intention.

**This intention is to purposefully communicate in ways that help both people step outside their current story.**

Complicated? Not really. It simply means that when we communicate, we try to stay very aware that what we're hearing and saying comes from "how we know what we know." It means that in real dialogue, we are able to step back from our truth and be very deeply open to the truth of the other person while also holding onto our own. When this type of dialogue occurs, both of us have the potential to see, hear, and know things in ways that neither of us could have come to alone. These are the conversations that can be life-altering!

## The Tasks Of Peer Support

So, if we start with that definition, how do we go about accomplishing this thing called peer support? As I see it, there are four central tasks. They go something like this:

- Task 1: Connection – The core of peer support
- Task 2: Worldview – Helping each other understand how we've come to know what we know
- Task 3: Mutuality – Redefining help as a co-learning and growing process
- Task 4: Moving Towards – Helping each other move towards what we want instead of away from what we don't want

*Note: It is critical (as you'll see through the workbook) that these tasks are tackled specifically in this order.

### Task 1: Connection

When you think about it, connection is the core of peer support. It is the magical moment when we realize that someone else "gets it." It is the beginning of building trust…but often it doesn't last for long. We have to work at it, notice when it's there and when it's not and be willing to work at it.

How do you know when you do or do not have a connection with someone?

Sometimes when we lose connection, we find ourselves in judgment ("Maybe that person is mad at me" or "I can't believe he just said that"). In order to reconnect we have to try to understand the situation in terms of context ("What did he mean when he said that?"). Sometimes it means taking a deep breath and apologizing for our part in the 'disconnect' ("I'm sorry, I just had a really strong reaction to what you said").

What are some of the things that cause you to disconnect?

Reconnecting is also sometimes challenging when we feel hurt, blown off, misunderstood, or distracted. It may not happen the second after you've had a disconnect, but there are some strategies for reconnecting:

1. Name what happened (e.g. "I just noticed that we kind of disconnected, did you?")
2. Own your part (e.g. say it when you've found yourself disconnected)
3. Apologize (it's ok to notice what happened and apologize for your part in it)
4. Ask (e.g. "I wonder if I've said something that bothered you?")

What are some other things you can do to reconnect?

## Task 2: Worldview

We've talked a little about worldview, but let's make sure we understand. Helping each other understand how we've come to know what we know means stepping back from our "knowledge" and thinking about how we've acquired that knowledge – a combination of our cultural background, our family background, and all the individual experiences we have had. Sometimes it's a real leap of faith to truly believe that there are many ways of understanding an experience.

How do you describe someone who hears voices?

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How did you learn to think about it in that way?

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What might "help" look like based on this way of thinking?

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What might someone who grew up in a culture where hearing voices is considered a valuable experience think about someone who hears voices?

What language might they use to describe it?

What would "help" look like based on this definition?

If we're gong to help each other think about how we know what we know, the first thing we've got to do is explore how I know what I know. I can't help you get unstuck if I'm still stuck myself.

Think of a time when you felt emotional pain for no apparent reason. What did you call it and how did you explain it?

How did you learn to think of it that way?

What did you do about it?

Now think of a time where you felt emotional pain because you lost someone close to you. What did you call it?

How did you learn to think about it that way?

What did you do about it?

**Task 3: Mutuality**

"Peer support relationships are mutual and reciprocal. This can be very healing for people who have been in the patient or client role for a long time. That is, being socialized into the role of a "good" mental patient often means learning to become preoccupied with matters pertaining to "me." Socialization into self-preoccupation starts in the hospital where each day begins with a nurse asking you if your bowels are moving, if you slept that night, etc. Socialization into "me-ness" proceeds on through the years as each and every case manager, therapist, residential worker or vocational rehabilitation counselor asks, "How are you doing?" Unlike normal social discourse in which 'how are you doing' acts as a perfunctory greeting, mental health discourse requires the client to take the question seriously and to answer by revealing more about "me." In addition, in most mental health settings, clients are not encouraged to help each other or anyone else. In this sense, the currently popular term "consumer" seems apt. It conjures the image of a large mouth consuming and consuming without a hint that it would be possible to contribute something back.

Socialization into me-ness, self-preoccupation and being a consumer means that many people are denied the opportunity to discover they have something to offer to other people. This iatrogenic wounding is another reason relationships can be so healing. It is healing to learn that one needs and is needed, cares and is cared for, and can receive as well as give."

- From Pat Deegan website archives, http://www.patdeegan.com/blog/archives/000015.php

While the third task sounds pretty easy, it means really taking a hard look at how the ways in which we've been "helped" might have rubbed off on us. For example, when various helpers have thought they were being helpful by doing things for us or assuming we were fragile, we may have gotten the idea that "help" meant just that (doing for). Then, when we become the helpers, it wouldn't be too surprising to fall into some of those old "helping" behaviors. After all, it feels pretty good and pretty powerful to know that we are doing something for someone who we see as in need.

We talked before about how important it is to create community-type relationships rather than service-type relationships. Again, this gets tricky when one person is paid, but think about how

important feeling valuable and helpful has been to you. Think about how your life has changed when you've been able to successfully negotiate (and deepen) your relationships.

Think of a situation (as an adult) where someone assumed that they needed to take responsibility for you. What happened to that relationship?

How did you feel about yourself?

How did this make you think about 'help'?

Now think of a situation where you and another person were able to help each other through a difficult situation. How did you feel about yourself?

How did this make you think about 'help'?

## Task 4: Moving Towards Instead Of Moving Away From

The fourth task also sounds easy, but in fact is quite difficult. Rather than helping each other move away from what isn't working (problems and solutions), we help each other move towards what we want (vision and action). In traditional mental health, the focus has been developing solutions or strategies to deal with problems. Most of our conversations are about what's not working. BUT when we're moving away from what's not working, we stay tied to the problem. When we're moving towards what we want, we can create the beliefs and the actions that we'll need to get there. Believe it or not, this is a radical shift in thinking, and one that challenges our traditional assumptions about help. Later on in this workbook we will talk specifically about how our conversations can change in order to help make this shift.

What happens to your energy when you're constantly trying to keep "problems" at bay?

What happens to your energy when you focus on moving towards what you want?

Why is it crucial to define this kind of peer support differently from other kinds of help?

Well, that's easy but it's also complicated. Over the past decade or so, the mental health field has started to talk about recovery. They've realized, through research and experience, that people can and do get better, move out of the mental health system, have lives, and can become indistinguishable from anyone else in the community. People in the mental health field have

spent a lot of time thinking about how to make that happen. The problem is that they're still attacking it from an illness perspective. In other words, if they can get people to better cope with their illness, maybe work through their trauma and abuse issues, perhaps they will become more independent. Though this way of thinking isn't bad or wrong, it is not our focus in peer support. In fact, we really don't think about illness at all!

Peer Support is about creating mental health, but mental health is not the opposite of mental illness. For me, mental health is simply one's ability to feel connected in the family (whatever that is for you) and in the world while continuously learning and growing. It is a creative process rather than a coping process. It is also not an individual phenomenon. It's more like playing with a great jazz band where you're giving, getting, and creating together. In a jazz band, each musician contributes their voice and their heart and soul while simultaneously listening to (and being affected by) the hearts and souls around them. When this works well, the piece of music being created is way more powerful than any of the parts combined. As this type of creation happens, the process becomes invisible and the players become part of something that invigorates and energizes them. Out of this energy come possibilities that we couldn't have found had we not been part of the creating.

If we just come into peer support with the expectation that we're here to help people deal with their problems, we miss the opportunity to dramatically change the overall conversation (and probably the outcome of it). This is why it is so important for us to have a voice in what constitutes a truly 'recovery-oriented' mental health system.

So you see, it is not about me just listening to you tell me about your problems and then helping you figure out what you're going to do (which ultimately keeps us stuck in an old story). Instead it's about moving out of what's comfortable and familiar and become open to possibilities otherwise unknown. This means that we need to get more familiar with what and how we've "known."

**What are you moving towards?**

What are the things that energize you about this vision?

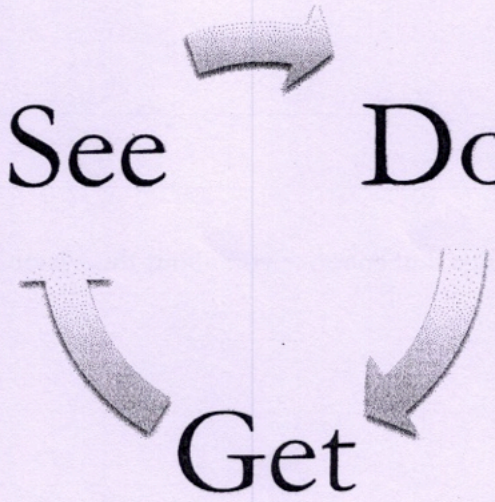
What gets in the way of 'thinking outside the box?'

## A Deeper Understanding Of Worldview

*"There is no such thing as human nature independent of culture" – Clifford Geertz*

As we've said earlier, the way that we see the world, think about our experiences and relate to one another is influenced by a gazillion experiences throughout our lifetime. If that weren't enough, our ancestors also had a zillion experiences, which influenced how their parents brought them up and taught them. On top of that we all grew up in different families, and in different cultures and, of course, in many types of environments. I, for example, grew up in a small town and never even thought about locking a door or riding my bike to a friend's house. Others grew up way out in the woods where everything and everyone was a long drive. You counted on your brothers and sisters or extended families as playmates. Still other people grew up in lots of different places and learned many different ways of being in the world. The point is we've learned to see/think/act/relate/believe based on our cumulative experience. Let's take

this one step further. Steven Covey (1989) taught a basic change model that looks something like this:




What does this mean? Let's think about that. When I've learned to see the world as a safe place where people are basically trustworthy, I won't think about locking my door when I leave my house. When no one breaks into my house, it reinforces my belief that the world is a safe place. On the other hand, if my house gets broken into, my sense of safety (or the way I see the world) will be challenged. I may begin to see the world as less than a safe place. In the context of mental health, if I see myself as fragile and in need, what I do is look for people who will take care of me. What I get is people believing that I am fragile and incapable which reinforces the way I see myself. If I still see myself as fragile and in need but I do something new, I very well may feel uncomfortable. If I haven't changed the way I see myself, I might "get" failure with the new thing I've tried, which still leads me back to the same old way of seeing myself. It's only when I change how I see myself that doing something different gets me different results. For example, if I see myself as strong and capable, I am willing to do new things and tolerate the discomfort. This gives me a sense of accomplishment that then reinforces my belief that I'm able.

Well, all this is a lot of information and probably doesn't mean a whole lot yet...be patient! Seeing, doing, and getting in new ways takes lots of practice. As you go through the training,

keep notes on how your 'seeing' is changing and what's happening because of that. It has to happen with us before we can support having this conversation with someone else.

**I need to make changes in how I see myself before I can make significant changes in what I get.**

How will peer support be different from just being friends? How will it be different from clinical help?

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## Learning Objective Questions

1. Please describe and provide examples of how peer support is different than other kinds of help.
2. Please describe (in your own words) the tasks of peer support. Give examples of how they apply in your own life.
3. Please provide an example of how your worldview (your beliefs) influences what you do.

## Summary

<u>Peer Support Is About:</u>

- Putting energy into mutual learning relationships as opposed to service relationships
- Connecting/reconnecting with family, our culture and the community
- Helping each other take a look at how we've come to make sense of the world
- Redefining mental health
- Figuring out how to make this work for both of us
- Supporting and challenging each other to move towards the life we want

- Changing the world!

# First Contact And Language

### Learning Objectives

To understand the relevance and importance of first contact

To be able to "do" first contact

To develop an understanding and awareness of the importance of language

Up to this point, we've talked mostly theoretically. As we start to think about actually doing peer support, we can use theory as a kind of scaffolding. Scaffolding is the structure (support) we put up outside of a building in order to work on it (e.g. when we paint, put in windows, etc). Without scaffolding we may not be able to reach as high, complete as much, or we may literally fall on our faces. As we go through the workbook and as we practice, it will be important to be really well grounded and supported when we're doing peer support. It will be particularly important to think about the theoretical discussions, the scaffolding of peer support, in our very first conversations with people.

Meeting someone for the first time usually just involves an informal conversation, right? Well it's often more complicated than that. Let's go back to the idea of worldview. Long before we meet, each of us has built up certain ways of seeing ourselves and understanding our identity, culture and experiences. We've made assumptions about our relationships and where we fit in the world, and we've built ideas about what different things mean and often assume that others see/think/know and do as we do. So before a word is uttered, we kind of size each other up based on these assumptions.

Before you started this workbook, what were your assumptions about peer support? How did they change after the first couple of chapters?

If the people we're working with have received services for a while, they might assume that we are there to provide a particular service and they probably have some preconceived ideas about what that will look like. If our first conversation takes place in a mental health center or peer center, the assumptions may be strengthened. No matter what, the people we'll get to work with have some assumptions about our role if they've had a lot of helpers in the past.

> Think about how the notion of help was introduced to you when you started in mental health treatment.

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The role of first contact is critical in establishing a different kind of conversation. Believe it or not, the very first conversation that we have with the person we're working with will influence our whole relationship and assumptions about it. It's hard to get out of these assumptions once people have kind of made up their minds about us, and our role with them. So, for example, when we meet someone for the first time and they ask who we are:

> If we say something like "I'm here to help you" or "I provide help for people with mental illness," what do you think their assumptions might be about us and what we will be doing together?

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In peer support, it is very important to make your first contact a different conversation.

> Just for fun, at this point in your learning, how would you describe peer support to someone who knew nothing about it?

What might be their assumptions of what you're going to do based on this explanation? What do you think some of their questions might be?

This is tricky stuff. Here is one way I've explained peer support to someone who didn't know what it was about. After the initial introductions I might say something like,

"There was a time in my life when I felt like all the relationships I had were with mental health providers. Have you ever felt that way? It seemed to me that I was always the person with the problem and others were there to help me figure it out. That bled over into other relationships until I started feeling like a basket of problems. Then when I got to know some people who valued my ideas, expected me to be accountable, and who expected me to offer them help and support once in a while, I started to realize that I wasn't too different than anyone else. I found that my best relationships (the ones that I valued the most) were the ones in which people gave me room to be where/who I was but also didn't hesitate to challenge my thinking. They also asked for the same in return. With these conversations, I found there wasn't much need to talk about illness and instead we started offering each other lots of ideas, creative ideas that helped both of us see things in new ways. These are the relationships that help change my life… Have you ever had a person in your life like that?"

If you met someone who introduced themselves in this way, what would be your assumptions about the kind of relationship you're going to have?

What if your first question was, "Tell me about the most recent experience you've had doing something you didn't think you could do?"

**Exercise**

Role-play some of these "first contact" introductions with a friend. Notice where the conversation goes.

## Language

Recently in mental health there have been some fundamental shifts in language use. For example, most of us don't think of people as "chronically mentally ill" anymore. Instead (hopefully), we assume that everyone is simply at a different place in their growth and development. However, though some language seems to be changing for the better, subtle assumptions are still being conveyed in a variety of situations. Think about it…when we say someone is "at a lower level of recovery/healing," or when we ask, "How do I get this person empowered?" – what is it that we're really saying? So it's not just a matter of changing the language (although that's a step in the right direction), it's a matter of checking the implications and assumptions behind what we're saying and hearing.

We also need to take a look at how some of the current recovery language is being used. If recovery is tied to the other side of illness, we get back into the same dilemma we did with mental health and mental illness. Using words that are more personal and descriptive of our experiences forces us to think more broadly, and that impacts what people will assume about us.

What do you think is being implied when someone says, "My clients aren't motivated to change?"

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...and when someone says, "I'm afraid if I say the wrong thing, Sarah will lose it."

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There are lots of different ways we say things that we think are respectful, but in fact are full of negative assumptions about people. When we talk in these ways, it also defines our role as one of power and thinking we know what people's reactions will be. So that's the first thing to be aware of.

Second, changing the language we use in and of itself changes our conversations. Mental health language in particular keeps us kind of stuck in certain assumptions about what people are experiencing and what our role is with them. Just for fun write down your "story" using mental health language, then write approximately the same story using no mental health language. For example, my two stories would look something like this:

"I was 15 when I started to suffer with mental illness. I went to see a psychiatrist who told me that I had something called schizophrenia. For a couple of years, my symptoms got really bad and people were afraid I was going to get hurt so I was hospitalized. They stabilized me on thorazine and shock treatments and sent me home. For a long time, I didn't get really sick again.

Later, though, as an adult, I started to get symptomatic again. I got pretty psychotic and once again got put in the hospital. They told me there that I was really sick and should go on disability. For a long time, I was pretty sick but then started to be able to manage my symptoms."

Now let's try it again without the mental health language:

"I was 15 when I started feeling different than other people and really alone. For a couple of years after that, I would do things in pretty extreme ways. They made sense to me based on what I was thinking and feeling, but I guess it was scary for other people who didn't really understand what I was thinking and feeling. I got put in a hospital. There I really kind of lost hope and beliefs about being a "regular" person. They put me on a lot of medication that made me feel sleepy all the time. After I left, I threw out all the medication and put my intensity into music.

Years later, just coming out of a difficult marriage, I started to have similar kinds of experiences as the ones I had as a kid. I had really strong feelings and felt pretty separate from others. I got put back in the hospital again. I was told that I had a major mental illness and that I should go on disability. Though I did that for a while, I realized that I was just going along with their beliefs rather than looking at how I'd come to think in certain ways. Little by little, I figured out what to do with my intensity and I've been really growing ever since."

What were your assumptions about the person in the first story?

_____

_____

_____

The second?

_____

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_____

What kind of peer support conversation might you have with the person in the first story?

The second?

## Two Stories Exercise

Try writing your own two stories and then answer the following questions.

Story 1

Story 2

How did you feel after writing the first one?

The second?

So to summarize this, it will be important to really pay attention not only to the language we use, but also to the kinds of things we're implying in our communication. If you stop and think about it, there really is no need for medical language at all in peer support. Medical language is

simply a language that we've learned and that has offered us a certain way to think about things. When we find ourselves using this language just because others are familiar with it, we limit our conversations. How we talk matters!

Take some time now to think about how you've used mental health language to describe your experiences or to talk about someone else.

How will you stay aware of your use of language when others continue to use medical words?

How will you respectfully challenge the mental health language of someone else? (Think about this one as you go through the next section)

**Learning Objective Questions:**

1. Please describe why your first contact conversations are so important.
2. Provide a sample first contact conversation that really gets peer support across.
3. How do you think the way you "tell your story" will change? Why?

## Summary

- First contact is critical in establishing a different kind of conversation, and needs to clearly define the nature of the relationship
- Language is full of hidden assumptions and can affect the way we and those we communicate with think about our experiences

# LISTENING DIFFERENTLY

## Learning Objectives

To build an understanding of your listening abilities

To learn about and practice listening skills for peer support

Many of us have had some training in active listening at one time or another. Traditionally, active listening has meant things like paying attention (not being distracted), using open body language (not folding your arms across your chest) and using eye contact. We've learned to think that if we look the part, and say the right things, then it's "good communication." But we often don't pay attention to the communication itself. Let me explain.

Good communication involves two people at any given time. It requires that each of us understands how, what, and why we're saying the things we're saying (or not saying). It also requires that as listeners, we're aware that what we're hearing is only one story among many possibilities. In other words, when we listen to people we are hearing versions of their "story" (e.g. what they've chosen to share with us based on their assumptions about who we are, and based on how they currently see themselves at this moment in time). When we listen with genuine curiosity and interest, we listen to what is being said, how it's being said, what's not being said, etc. We listen for how this person has learned to think/see/understand things in this way (remember worldview?). This kind of listening is hard work…and very rewarding.

I'd like to begin this section by asking you to fill out this questionnaire. It should help you take a look at your part in the listening process. This will help you identify the situations that might be more challenging and will also help you stay very aware of how you're communicating.

# Listening Questionnaire Part 1

Use the following scale to answer questions 1-9:

I'm a great listener I stop listening

5 4 3 2 1

How well do you think you listen to people…

1. Who are like you? _____
2. Who are different from you? _____
3. Whose values are very different from yours? _____
4. Who don't make a lot of sense to you? _____
5. Who have "an edge" when they talk? _____
6. Who speak very quietly? _____
7. Who seem unsure of themselves? _____
8. Who easily show emotion? _____
9. Who are argumentative? _____

## Listening Questionnaire Part 2

Use the following scale to answer questions 10-15:

Very curious/interested Not at all curious/interested

5 4 3 2 1

When you are listening, how curious/interested are you…

10. About the life experiences of people you know well? _____

11. About the life experiences of people you don't know? _____

12. About how a person has come to think in the way that they do? _____

13. About people with different worldviews from yours? _____

14. About people with really opposing worldviews to yours? _____

15. About what's not said in the conversation? _____

**Adapted from Pearce, K. Making Better Social Worlds: Engaging in and Facilitating Dialogic Communication*

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These questions help us take a look at how/when/where and why we really listen. Take a few minutes now and try to figure out what specific kinds of situations make it harder for you to listen deeply.

Why do you think that's true?

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So how do we learn to listen differently? The example of "the house" might be helpful.

## The House

**Adapted from WRAP and Peer Support, Mary Ellen Copeland and Shery Mead*

Each of us lives within a house. It has an outside that others see and an inside no one else can see or fully know. Its framework has been built with the physical, emotional and spiritual self that we are born with. But even this framework is influenced by the culture in which we are born. (e.g. adobe houses in the southwest).

Over the years, many changes are made to our house—both inside and outside. Its rooms become "decorated" by all the messages and experiences we've had. For example, if early in life we are adored, talked to, held and told that we are the most wonderful person on earth, our house might include a living room with plush rugs, attractive furniture and a fireplace. We feel comfortable, safe and lovable.

If someone we view as an important person then comes into our life and gives us negative messages that lead us to doubt ourselves, the interior of our house changes. Often negative messages and fears are put in our dark, cluttered, dusty "basement" where we feel less than adequate. More positive messages will create upstairs rooms with windows and doors where it is sunnier, where relationships are more transparent and communication goes back and forth.

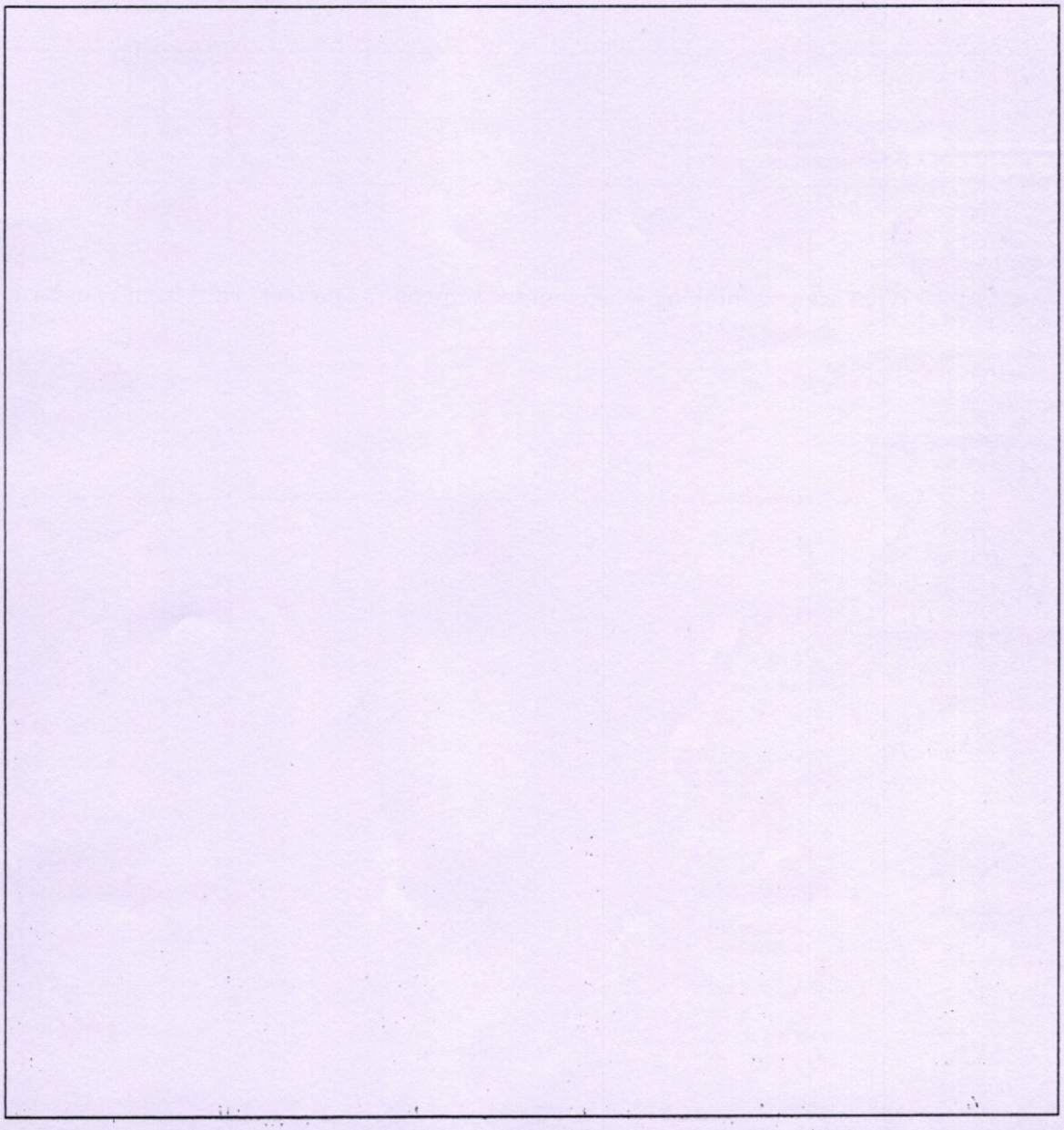
Messages of "otherness" might create an attic that is inaccessible from other parts of the house and where we feel really different than other people.

As we move from room to room, our perspective of the neighborhood changes. The view from the basement is different than the view from another room. Sometimes we even forget that there are other rooms (or that a basement could potentially be turned into a family room). We think that what we know right now is "the truth" and that it "just is this way."

Describe how you see the world from your "basement."

What are you thinking when you see someone's "perfect" yard from your basement?

**Describe, draw, or illustrate your house…**



The houses in many neighborhoods look similar on the outside but we really can't see their insides. Because they look similar on the outside, we think we know what they look like inside. Then, when we talk to a person, we sometimes make the mistake of "over-relating." We say: "I know what you mean, I've had the exact same experience."

This is one of the mistakes often found in peer support groups where we over-identify and keep relating to each other from the "patient" role. We assume that we understand the person based on that shared experience and role. We relate based on the outside of our "houses."

What happens to your listening when the other person describes something that feels very familiar to you?

What happens to the conversation if you assume you mean the same thing as someone else?

We use the house as a way of thinking about how each of us has learned to see the world, and also to help each other remember that people are complex, unique, and forever changing. The way we listen matters! Supporting each other in exploring "how we've come to know what we know" can help both of us move towards what neither of us alone could have envisioned (like turning the basement into a family room).

Describe a conversation where you felt really understood and saw things in a new way.

By now you may be thinking, "How did I get myself into this? This is hard!" Although it is complex, it really isn't hard. Ultimately, it's about rethinking how we've learned to listen (and view the world within a mental health context), and then making a shift in how we approach all

our relationships. If you stop and think about it, this kind of communication is what builds really good relationships for anyone!

There are a variety of common and not so common listening skills that will enable us to explore people's houses and how they came to be, such as:

## Listening From A Position Of Not Knowing

When people talk about peer support, one of the often-stated benefits is that you are talking with people who "get it." This "getting it" is certainly a quality that helps break isolation and secrecy, but what happens when we over-listen from a position of "getting it?" When is our listening affected by our own experience? If we consider starting with the assumption that we've had some similar experiences but then attempt to listen from a position of "not knowing," we can listen with curiosity, imagination, intuition, and wonder. This position allows us to explore someone else's house without assumptions. It allows us to stay away from assessment, evaluation and judgment; and hopefully it begins a conversation in which both people become more self-aware while learning and growing together.

> You've just moved to a foreign country where things are really different. You want to "fit in." What kinds of questions would you ask people to learn more about their culture?

### Ask clarifying questions (learn more about the inside of their house)

When we listen from the perspective of "the house," asking questions that get beyond assumptions helps us see the bigger picture. For example, when someone is talking about depression, we might ask, "What does depression mean to you?" or "Help me understand how

depression is different for you than feeling sad." Here are some question words and phrases that may help open up the story:

- I wonder ….
- Help me understand…
- How did you learn…
- What makes that so…(hard, scary…)
- How would you like it to turn out?
- What can we do to get there?

## Listening For The Untold Story

Most of the time, we listen to the story being told as if it is the "truth." We forget about perspective and we react to what is being spoken. However, if we look at the bigger picture, we can listen for how this person has learned to tell the story in this way. We can listen for assumptions they may have about us and themselves; and we can ask questions that explore what different things mean. This takes us away from just jumping into problem-solving based on the "told" story. If we go back to the house metaphor, we can consider what room they're in, what the room might look like from their perspective, what they're seeing out of the windows of that room. We can show interest in how that room came to be and how the person got to that room. Here is an example of this type of conversation:

Susan: "Hey Tom, how's it going?"

Tom: "Hi Susan, things aren't going so well I'm afraid. I've been really depressed, and my doctor has told me that I should increase my anti-depressant. I feel like a failure if I have to increase my medication, and yet I know I should listen to my doctor."

Susan: "Wow that sounds difficult! Can you help me understand what "really depressed" means for you?"

Tom: "Well, I feel anxious about everything and feel like I'm not keeping up. Sometimes I just want to give up on everything."

Susan: "What would it feel like if you were really keeping up?"

Tom: "Well I'd feel confident and comfortable and not so overwhelmed. I'd feel like a responsible human being."

Susan: "Sometimes when things pile up for me, it feels more comfortable just to think I can't do it – and that gives me an excuse to say I'm not capable. I've also found myself going right down that road to thinking, "What's wrong with me?" I'm curious about how you think the anti-depressant will help you feel like you can keep up?"

Ok, let's take a closer look at the untold story. Right off the bat, when Susan asked Tom how it was going, Tom fell into what we've termed "the mental patient role."

Why do you think Tom might have responded to Susan that way? What were his assumptions about her role?

_____

_____

_____

If Susan had responded to Tom's concerns about depression and medication (the told story), she would have had a fairly narrow conversation that probably would have ended up in problem-solving around the issue of medication.

Now that we've seen his response, what more do we understand about Tom?

_____

_____

_____

What would have happened to the conversation if Susan had responded to the "sometimes I feel like giving up" as a statement about Tom's safety (e.g. responding with something like "Are you feeling suicidal?")?

Finally, what story did we learn about when she asked what it would look and feel like if Tom was doing the "'keeping up?"

In this short example, we can get an idea about looking for the untold story, and we can begin to identify patterns of communication that many of us have fallen into (e.g. the illness story). The "keeping up" story may simply be hiding behind the illness story.

## Providing Validation (Rather Than Jumping Straight To Problem-Solving)

As we said earlier, we miss a lot of potentially different conversations if we find ourselves jumping into the conversation as 'the fixer.' Taking the above example, when Tom said,

"Hi Susan, things aren't going so well I'm afraid. I've been really depressed, and my doctor has told me that I should increase my anti-depressant."

What if Susan had said,

"Well, let's figure this out… do you want to increase your medications? What will you say to your doctor?"

Where would the conversation have gone? What do you think their relationship would be like after that?

Sometimes when we jump right into problem-solving, not only do we get stuck in sort of an "expert role," we also lose out on a much richer conversation, and the person may walk away feeling somewhat unheard and disconnected. Validation supports us in feeling really listened to. Susan says, "*Wow, that sounds difficult!*" Do you think Tom thinks Susan really cares about him as a person? As the story progresses, Susan shows interest and listens with curiosity. If the conversation continued, she might further validate Tom by saying something like,

"It sounds like you're feeling really frustrated and like you don't have a lot of choices but I admire that you also know what it is that you want in terms of keeping up."

**Please write about a conversation that made you feel really heard, cared about and validated. How did that conversation impact the relationship?**

## Reflecting Feelings ("That Must Make You Feel Really Sad…")

Many times we listen to other people's words without noticing emotion. Other times we assume that they're feeling a certain way because we know how we'd feel in the same situation. When either of these things occurs, we only hear a small part of the story, and we don't learn much about the inside of their house.

**Think of a time where you and someone else had different feelings in response to a similar situation.**

## Asking Powerful Questions

Do you remember when we talked about the fourth task of peer support as "helping people move towards what they want instead of away from what they don't?" Asking different questions will move the conversation away from problem-solving and toward creating possibilities. By asking certain questions, we can begin to help people move more in the direction of what they want in their lives rather than always moving away from what they don't want in their lives.

*Note: Moving towards what you want needs to be the fourth task; asking these questions too early in the relationship will only elicit responses from the current "story."

Use these questions to "move towards something you want."

What do you want?

Do your current beliefs support what you want?

What would you have to believe to have what you want?

What do you want to feel?

If you were feeling that way what would you be able to do?

Another method for moving towards what you want is something called "focus planning." Following is a guide for creating a focus plan (these are good to do for yourself and with someone else who can help you flesh it out).

## Personal Focus Plan

Instructions: Please use the following statements/questions to flesh out "what you're moving towards." Provide as much detail as you can in each of the sections.

This is your personal focus plan. The idea is to come up with a complete vision of "what you want." In other words, if you think about 6 months or so down the road and everything is going exactly the way you hope, what will you be doing? Where will you be? What are some of the things you might have? Who are the people around you? What are you feeling?

## Resistances

List all the beliefs, fears, doubts, and reasons why you think that you can't have what you want.

## Shifting Tools

List all the tools you have to move towards what you want (including things that contradict some of your resistances). For example, when you've done what you've wanted, what did it take? Can you imagine yourself there? What are the beliefs that you'd have to change to have what you want? What are some small ways you've shifted your beliefs? Can you picture those here?

## Inspired Actions

Write a few things that "came" to you while you were thinking about shifting. These are the things that help you focus your energy towards what you want.

## Commitments

One thing I will commit to doing this week to move towards my dreams:

## Accountability

What are three things I'll do to hold myself accountable?

### Triggers

Sometimes shortly after we start a new practice, something comes up that puts us right back into our old patterns and ways of thinking. What might some of those things be?

What will I need to do to get back on track?

## Building Connection (Using Task 1)

Building strong connection is less about skills and more about authenticity. It is the cornerstone of all communication and of all relationships. Connecting with people requires all of the other listening skills as well as deep presence, commitment, honesty, and a willingness to be affected and changed. There are times when for a variety of reasons we may disconnect or feel disconnected. It will be critically important during these times to notice the disconnect, and then to reflect on what happened. There are many reasons people disconnect (e.g. hurt feelings,

feeling frightened, being distracted, etc.) but the important thing is to get back on track and maintain the connection.

Example:

> Sarah and Molly are getting to know each other and finding that they have many similarities. Things are going along great until Molly starts talking fondly about someone Sarah is angry with. Sarah starts disconnecting by way of thinking to herself, "Molly doesn't really know this person…maybe I won't be able to work with Molly," and so on. Rather than pretend to continue to listen Sarah says honestly,
>
> "I'm sorry, I found myself getting kind of disconnected when you were talking, and I realized that something hit a nerve for me. Do you mind backing up a couple of sentences, because I really want to understand your experience?"

## Listen With An Ear For Role

How many of us are, or have been, "good patients"? "Good patients" do what they are told, don't question the doctor, believe they need to be taken care of, etc. In mental health many of us have learned to become "good patients" and some of us have gotten stuck there. We are not familiar with other ways of thinking about our experiences and our lives. This role has been compounded by stigma, poverty, lack of resources and someone else defining our experience (e.g., you are sick; these are symptoms of a mental illness; you need to be taken care of). We have been taught to believe that help goes in one direction only. "You're the helper, I'm the patient." By listening for this "patient" role, we can help each other try on new ways of seeing the world and seeing our current situation. We can remind each other that basements can be turned into family rooms.

> Someone has been coming to you repeatedly for help but doesn't really want to make any changes themselves. You are frustrated after hearing, "I don't think I could handle that" over and over. What might you say that will encourage a conversation about roles we fall into?

## Direct Honest Respectful Communication

Believe it or not, this is probably the hardest skill to master. It gets particularly difficult when there's something emotional involved. We walk on eggshells, we tell little lies, we tell big lies, we avoid the person, or worst of all, we talk about them behind their backs. All of these approaches are pretty common because much of the time, we're simply not willing to put a lot of effort into casual relationships. But once we get started taking one of these approaches, we're falling off the peer support track. Here's an example of how to communicate something when there's a lot of emotion behind it.

> Scenario: Mary and Joe are both working at a peer program. They've gotten along really well until recently when Joe seems to be leaving a lot of the every day cleaning up to Mary. He also seems distant and distracted. Mary's pretty angry and a little worried.

One thing Mary could do is go to her supervisor and say, "Joe's not pulling his weight and he seems really out of it." At that point, they could both get into an assessment and evaluation conversation based on Mary's assumptions and observations. Or the supervisor could go to Joe and say, "I hear you're not really pulling your weight…" Either way, this turns into operating from assumptions and pulls everyone into a power struggle.

On the other hand, Mary could go to Joe with honesty, openness and a willingness to own her part. Maybe she would say something like,

> "Hey Joe, this is a little uncomfortable for me, but I find myself feeling frustrated that I'm doing much of the cleaning that we used to share pretty equally. What it feels like to me is that you're distracted which leaves me feeling a little disconnected. What I'd really like is to know if you've noticed any of this and if so, how it feels to you."

This kind of communication doesn't start with the assumption that something's wrong with Joe (or the situation) that Mary has to fix. Instead it assumes that both people have a story about what's going on, and Mary is just sharing her version in a way that invites Joe's perspective. In the best of all worlds, Joe would feel comfortable enough to say what his perspective is, and then work things out.

You'll find that the more you practice honest direct respectful communication, the deeper and more trusting your relationships will become. You'll also notice that as you are open to owning your part, others are more willing to do the same.

## Negotiating Reality

We will talk much more about this skill when we get to challenging situations, but for now it's enough to think about the fact that truth is simply perception and that everyone's perceptions are as true as anyone else's. If we find ourselves in a situation where someone is experiencing what seems "unreal" to us, we simply apply the same skills as above. Let's go back to Joe. What if Joe is angrily talking a lot to himself and seems to be responding to questions or statements that we don't hear? From the medical perspective, we could assess the situation and say that Joe is delusional, but that's not going to help us do peer support. Instead, if the timing seems right (in other words, if Joe is interested in engaging with us), we could say something like,

> "Joe, I keep hearing you make statements as if you were responding to something; you sound very upset. Is there anything I can do to help?"

If Joe says, "You know what they're saying, you're one of them!", we could get defensive and say, "Joe, you're hearing things and I didn't say anything," but that will create an instant disconnect. You've just assessed, blamed and denied that there may be more truths than just yours.

Let's try again.

What if you say,

"I'm not hearing the things that you're hearing, but I hate it when I think people are saying nasty things about me. I can imagine you might be feeling pretty hurt or defensive?"

Do you see how this is different than arguing about whether Joe is hearing anything real or not? Can you begin to see that without all of our medical assumptions, we can stay authentically connected and we can choose to leave if the disconnect continues?

**Someone says they know you've been telling lies about them to all their friends. As far as you know, you haven't talked to anyone about this person. How might you negotiate reality with this person?**

## Sitting Comfortably With Silence

Many of us are not very comfortable when others are quiet for long periods of time in our conversations. We tend to finish people's sentences, jump in with something to fill the gap, or even assume that the person doesn't want to talk to us. There are many reasons why people take a long time to talk. For some people, medication slows their thinking, and so it takes longer to hear and understand what's said, and then to respond. Some people simply take their time, and others may be shy, untrusting, or a number of other possibilities. Silence is a kind of communication. Sitting with silence can be very connecting because it's clear that you're working that much harder on connecting with the non-verbal. The important thing about silence is that you don't assume what's going on based on your discomfort and that you are patient while the process unfolds.

## Conversations About Diagnosis

Although we've covered some of this in other sections, I think it's important to talk specifically about how to deal with the whole issue of diagnosis. Regardless of the fact that it has nothing to

do with peer support, we will all come up against it in one form or another and it's worth considering how to address it.

I've heard many people say that getting psychiatrically diagnosed was life changing…for the better and for the worse. If we go back to worldview we can begin to understand that diagnosis is simply another "lens" to see the world through. What we need to remember is that it is only one lens and no more the truth than any other way of thinking about things. So what do we do when people talk to us about their diagnoses?

In other parts of this training we've talked about asking meaning questions. For example, when Susan asked Tom what feeling "really depressed" means for him, she was asking how he understood the notion of depression. She wasn't assuming it was something concrete that both of them would understand in the same way.

Another approach is to think about the illness story we talked about in the beginning. We could, for example, ask people to describe how they talked about their experience before they were diagnosed. We can ask what it is about the illness story that works for them, and also what doesn't work so well. What are its limitations and where does it help them with learning and growth. We can share how our own illness story has helped and hindered us, and we can demonstrate other ways of knowing. Now, this doesn't mean shoving our way of thinking down anyone's throat!

Having said that, we are also going to be confronted with situations that may make us uncomfortable. We may find ourselves falling into assessment mode (e.g. "This is really strange, I wonder what their diagnosis is?"). We may also find ourselves feeling more instant connection with people who have been given the same diagnosis that we were given, thinking we really understand their experience. These are all traps! They all keep us tied to looking at and understanding the world through the lens or worldview of illness and will take us in the opposite direction from peer support!

**Peer Support is about understanding someone's experience in the context of their experiences and interpersonal relationships.**

If we think about people through the lens of diagnosis, we are not doing peer support!

## Sharing Relevant Personal Change Stories

Sometimes, when it seems that someone is stuck in their illness story, we may begin to feel frustrated and judgmental and find ourselves trying to "get them to change." BEWARE! This is your frustration and your need, not theirs! This is a great chance to remember times when you were stuck and then to think about how to share your story so that it might trigger a "light bulb" moment for them. Following is an example:

> Pete has been spending a lot of time with Tane. They've been making plans to go together to a local men's group. Just when the night of the group rolls around each week, Tane calls Pete and says he doesn't think he's ready to be out with other people. He goes on to say that he's really anxious and is going to call his psychiatrist for more medication. Pete finds himself thinking that Tane is stuck in the "mental patient" role. Very quickly, however, Pete reminds himself how long it took him to get out and try something new. He shares this story with Pete, but he doesn't do it like "Look at me, you can do this too!"

Instead he says honestly,

> "Hi Tane, I need to tell you that I've been feeling a little frustrated and disappointed when you cancel on the men's group at the last minute every week. But I realized that this is my frustration and it got me thinking about a time when I was afraid of going to a parent's night at the school. It took me forever to get over the thinking that 'every one was going to know…' Finally I realized that people probably don't think one way or the other about me and I just went. In fact, it had been much scarier to think about going than just doing it. So even though I've been disappointed about not getting to the men's group with you, I just wanted you to know that I think I understand what you might be going through. It would just work out better for me if we could talk about this before the last minute."

## Staying Peer

Now that we've gone through a variety of skills we'll need to do a considerable amount of practice. In the beginning it won't feel very natural or authentic. You may even feel pretty uncomfortable. But stick with it. Remember in the beginning when we talked about real learning? Doing this type of intentional communication is new and challenging, but if you practice it you will find that you build stronger connections, do more growing, and build better relationships. So the first thing to remember is that this is going to take lots and lots of practice.

One of the first pitfalls you may encounter is that you'll fall into the "doing what's been done to you" trap. In other words you'll find yourself wanting to assess, pass judgment, say "the right thing," or even talk behind people's backs. So we'll need to focus, focus, focus on what makes it peer support. Here are some self-evaluation questions that might help you get back on track:

- What am I feeling right now?
- Whose need am I trying to meet?
- What's making me uncomfortable?
- Am I doing assessment or evaluation?
- Am I being honest and owning my part (e.g. taking responsibility for the role that I play)?
- Am I listening for the "larger story"?

There are probably lots of other questions you can ask yourself to get back on track.

> What do you think some of your patterns might be in relation to "doing what's been done to us?"

Another pitfall you may find yourself in is the "trying to make a difference" pattern. We get caught up in the heroic role of provider/rescuer/savior! This pattern establishes itself if we get away from the notion of mutually responsible, mutually growth-producing relationships.

Here are some self-evaluation questions we might use to check ourselves:

- What happens in my relationships when someone is trying to 'fix' me?
- What am I working on in terms of my own changes?
- Am I being honest about my own needs?

## Exercise

Create groups of three people. Two people take a part in the following role-play and one person observes. Build a dialogue around the following scenario that uses the skills we've been working on. After you've completed the role-play, try to identify the skills you used and how you used them. People should talk about what it felt like from their particular vantage point (I'm guessing you'll hear three different stories). Finally, go through the self-evaluation questions and answer them from the different vantage points.

You are spending time with Rose, and things seem to be going well. You've shared your interests and you've built what feels like a pretty trusting connection. Rose comes to you one day and tells you that she doesn't feel safe with you anymore because her case manager told her that you were trying to get her to go off her medications.

What it felt like from my perspective (notes from each participant):

Rose:

_____

_____

_____

Peer Supporter:

_____

_____

_____

Observer:

## Learning Objective Questions

1. How would you describe your listening strengths? Listening weaknesses?
2. Make up a conversation and use as many examples of the listening skills described in this module as possible.

## Summary

We all find it easier to listen to some people than to others. Being aware of this is useful in helping us to listen effectively and to be aware of some of our natural biases.

Listening Differently Is About:

- Understanding how each of us has learned to see the world
- Remembering that people are complex, unique, and forever changing
- Listening from a position of "not knowing"
- Listening for the "untold story"
- Providing validation (rather than jumping right to problem-solving)
- Reflection of feelings
- Asking clarifying questions
- Asking powerful questions
- Building connection
- Listening with an ear for role
- Direct honest respectful communication
- Negotiating reality
- Sitting comfortably with silence

- Thinking and talking differently about diagnosis
- Understanding someone's experience relationally and contextually
- Sharing relevant personal change stories
- Staying peer

# Intentional Peer Support: A Personal Retrospective

The door of the mental hospital locks noisily behind me and I realize that I have succumbed. "You know that you need to be here. You are ill and we're here to help."

It's been five minutes and already I'm a mental patient. Up to this point, I've understood my experience as a "normal reaction to abnormal events." But that understanding is now shattered with the realization that I am ill and science is on their side. Reactions become "symptoms," feeling at the end of my rope is "suicidal ideation," and forgetting becomes "dissociation."

All my life I have been running from messages from the outside world that define how I see myself, interpret others, and generally how I operate in the world. Early on, it was all the messages of shame and otherness: "It's your fault. You made this happen. You are just bad. What's wrong with you anyway? What's your problem?"

I have learned that others can assign fault, that somehow it always seems to be mine, and that pain is controlled by the person who has the power ("It doesn't hurt that much"). Their cumulative messages become truth and truth becomes my skin while otherness becomes my identity.

Shame becomes an indictment of who I *am* as opposed to a reaction to anything I've done. Rather than feeling ashamed, I become shameful. My body is bad, I am bad. It's like a megaphone in my ear and I can't remove it. It is the story without context, and it is all-

encompassing. The "otherness" of always feeling like everyone else knows how to do things, how to act, what to say… But I feel "different," always watching others to see just how "normal" people act.

I am a teenager and the shame is starting to leak out. Up until now I've squeaked by rather unnoticed, but adolescents are compelled to act on feelings. I am convinced that I can fly and believe me, I try. Night after night I don't sleep. I start to see things that other's don't and I begin to shake and stutter. My communication becomes more and more obtuse until my mother finds me one snowy day walking barefoot around in circles muttering to myself. I don't know I am here but I do know that I'm supposed to be. My mother is afraid and doesn't know whether to be mad or ignore me but finally reacts and does the inconceivable. She calls a psychiatrist who tells her that I am not safe, and the next thing I know I am being dropped off at the local psychiatric hospital. My mother drives away, worried that maybe she's been seen here with her child. No one in our family has ever even seen a psychiatrist. People should learn to pull themselves up by their bootstraps and get on with their lives.

It is the late sixties/early seventies – not times when it is "cool" to be crazy. I live in a small WASPy New England town where everyone wears the same clothes, goes downhill skiing on weekends, and has vacations at their summer homes. If they have any problems they don't tell, although I can remember a time when my friend's sixteen year old sister got pregnant and was sent to Florida. When she finally came home, she was the person everyone in school gossiped about but no one talked to.

I walk in the door of the psychiatric hospital and fearfully go inside. The walls are made of ugly cement painted light green, and I don't know what I'm supposed to do. I meet with the psychiatrist who says they're going to watch me for awhile. I get a room with a little window that nurses periodically peek into. He tells me I have something called schizophrenia and I have a feeling that I'm going to be here for the long haul. I quickly learn the doctor's "story." All that I have been experiencing is part of the illness. These kinds of things will probably keep happening, but with medication and occasional hospitalization, it can be managed. I am told that after I leave here there will be a group

home I will go to where there are others like me. Those others like me include my roommate who is just in for a medication adjustment. After our door closes, she shows me the stash of drugs she keeps "in case she needs them," and she shows me how to "cheek" my medication.

The drugs make my tongue thick and I am leaning down to the ashtray to smoke my cigarette because it's too much effort to reach with my hand. On New Years Eve, we are taken for a walk around town. We are a herd of sheep and the nurse is our shepherd. My legs are heavy as lead and I pick them up with my hands to put one foot in front of the other. "Come on legs," I say, "Move!" My roommate gives me the signal that I shouldn't say anything. On the ward, it's the staff versus the patients and each has their own power. I learn to hoard "sharps" and pills for the time when I might need them and they tell me many times a day: "You are sick, you need to be here, just do what the doctor tells you to do."

One day I commit an act of revolution. I take the LSD that my roommate has given me thinking it will help me tolerate occupational therapy where we make belts. Just before it kicks in, I am told that I have to go have an EEG, whatever that is. I am paraded through a tunnel to the "regular" hospital and when I get there, they tape electrodes to my head. Is this for real? I am in outer space and the technicians are aliens. When it's all over and the drugs wear off, I go see the psychiatrist for the results. He says it was the strangest thing, there was no brain wave motion at all. I freak, thinking he's found out about the LSD, but he is joking! After several shock treatments and large doses of Thorazine, I am discharged – for better or worse – to my parents custody, the halfway house plan somehow never materializing. I vow never to speak of this experience again (bless the family secrets).

At home, I belong to a band. I am a musician and it is the one thing in my life that makes me feel whole and real. I will never tell the other band members that I've been in a mental hospital, but inside, I still know I'm crazy. I put all my intensity into music and try hard to put the strange experiences and feelings into my playing. I just never want to end up hospitalized again. The other guitar players seem to somehow understand the intensity of my feelings. We talk, and I begin to discover the power of true "dialogue." We all speak from our hearts simultaneously and create something altogether new, albeit illusive. We

connect in some special way, as if our true language is music and through it, we all know what we mean.

This takes care of the feeling side of things, but I still struggle with trying to understand my own experience. It is my head that won't change. I go on to college and I find that there are others like me who also struggle to comprehend what their feelings and experiences actually mean. We are all curious about "reality." I study phenomenology trying to get to the essence of things. Is there a truth or is it all relative and constructed? I'm curious about how meaning gets made, how things get defined to be one way or the other. I have some great conversations but on the inside I still know I'm bad/crazy/different. I decide that the only language with any credibility for me is music.

For years this back and forth between head and heart serve me well, but then I am going through a divorce, single parenting three small children, working part time at the local boarding school and quickly going broke. Although I am teaching music I know that I am a fake because my music school experience was too short. But I love the energy of the teenagers and so want to keep them from learning to think that their intensity and their ideas are crazy.

One summer, one of the band members is killed in a car crash. The school wants to hire a grief counselor so that the other kids can get "help." I pull them all together and we talk. We decide to spend the summer writing a piece of music for our young friend to perform at the beginning of the next school year. Over that summer, the music that we play not only speaks our grief, but binds us together in a way that transforms much of the pain.

The summer is over, the kids graduate, and I know that I've got to do something else. I decide that maybe social work school is a place where I could learn to work with teenagers using music as a medium. It occurs to me that many of the kids that I worked with in the music department were the same kids that got talked about in faculty meetings as "having problems." The other teachers thought that they were not college material and suggest they get into counseling. I have hope that I can create a new kind of opportunity to build voices rather than silencing kids as I had been silenced.

School is hard. I like the headiness of it but the walls that for so long contained the messages of shame in me begin to leak once again. Desperately trying to stay in school, I vow that I will never end up hospitalized again. Yet I am doing things that scare people. I can't slow down, I can't sleep, and I feel like I'm doing school while also running with a ball and chain. There is one person who keeps saying, "It doesn't have to be like this," but I am totally out of control. There are no options but hospitalization and I am terrified. I will not see myself as ill; I am a scholar, a musician.

But…the door locks and I am there again.

This time there are yellow concrete walls and they search my bag for anything dangerous, including paper clips, and I find that I'm tired – maybe they're right, maybe I am just crazy. In some ways, the diagnosis is a relief. I no longer have to take responsibility for myself. That is good because the responsibility of parenting three kids with no support and too little money has been grueling and I am exhausted.

But then they suggest I go on disability, perhaps give up custody of my children. I am far too ill to care for them, they think they know.

Right then, there is a little spark of anger. "Who are these people?," I think. But almost as soon as it flares the spark expires. I am too worn down to fight them. It has been too long of a haul. They are too clear that they know what they know, and that nothing that I know about me matters.

Soon I am just doing what they say. It appears to work. For awhile, I go back to my life and "cope." And then "it" happens again.

I am back in the hospital. This time something happens that revives my anger. My lawyer calls me shortly after I'm admitted and says that my ex-husband is demanding custody of the children. He doesn't want to pay child support. The nurses, however, say that I can't worry about that now – I'm here because I need to be. Another patient sits with me through my hysteria and, when I can listen, says that she too was told that she would lose her children. She is angry and challenges me to think about what's important: my love for my kids, the connection we have, the emotionally abusive life they will have with him.

This is the beginning of dissonance. Not a lot. A little. But still something. Something she is saying makes sense to me even though she, like me, is a patient. Something they are saying does not, even though they are doctors and experts. And the distance between what they are saying and what she is saying is the beginning of my seeing things differently.

Time passes. In between hospitalizations, I'm in and out of school, and I go through this for several more years until I realize that most of my conversations are about mental illness and my friends are all mental patients. We believe that we are sick and all we can really do is commiserate. I learn to live the life of a "mental patient."

There comes a time when I am interning for school at a domestic violence program. A woman comes to see me. She has been told that she is a courageous survivor by other workers but she probably should get into counseling. She gets sent to a community mental health program. The next day she comes to see me and says that she has a serious mental illness. She no longer sees herself as a survivor but as sick.

What happened here? Why the sudden shift in explanation? Yesterday we were talking about what happened to her. We both knew the problem was abuse in the world. Today she is talking about what's wrong with her.

This troubles me. Over the next months, as we talk I gradually get the courage to bring it up. How did she go from talking about what had happened to her to talking about what is wrong with her?

Together we ponder this question. Our shared stories spark a modicum of self-reflection. We talk about what our lives have looked like since we were diagnosed and slowly we start to make some decisions about whether we want to stay there or not. We both acknowledge some comfort – feelings of safety, perhaps relief – from the fact of our diagnoses. Yet, somehow, our experiences begin to mean something different to us. Increasingly, we begin to challenge the idea that something is "wrong" with us, and consider instead that it is perhaps the events that happened to us that were wrong.

Sadly, however, almost nowhere else in my world is this message reinforced. We are two small women on a large and indifferent planet. We are not yet strong enough to stand on the

strength of our fledgling convictions. I continue my bouts of going in and out of mental hospitals.

Fortuitously, however, insight and understanding can be found in unexpected places. One is, believe it or not, a psychiatric nurse in one of the hospitals I am frequenting. It is Thanksgiving time and I once again am told that I am losing custody of my kids. I go to the locked door and demand to be let out. When everyone ignores me I start pounding on the door. The nurse, whom I know quite well at this point, comes over and says to me. "Shery, you know you have a choice. You can decide whether you want to be a mental patient for the rest of your life or a social worker. Maybe you can decide in the next ten minutes." I am taken aback by this dressing down – I hadn't known that I had that choice!

This time I make it. I get out. Continue on. Don't lose my kids. Continue to discover that there are other ways to understand what happens to me than through the lens of illness. I am lucky. I make a few more friends who help to reinforce this message.

As time goes on, I work with women trauma survivors using music as a communicator. We think that instead of therapy we are doing social action. We decide to record some of our pieces. One day, something strange and wonderful occurs to us. We wonder why we hadn't noticed before. But we do now, and we all get it: we notice the power of our music. And, through this we notice our own power. We realize what we can achieve and what we can say through it. We realize that the music we make – the poignancy, the meaning, the rhythms and melodies that cut to the core of things – expresses something entirely different from our view of ourselves as mental patients. The dissonance is mind-blowing. It is at that point that I know something. I know that it is about me. I know that it is important. And I know that I know it.

I know that I have a choice.

I know that I have the choice to see myself as mental patient and continue to live into that role. And, I know that I have the choice to own and live into the power of the self that the music I make is pointing me to. The vastness of the chasm between these two stories about myself is unavoidable. And, I know I cannot escape my responsibility to choose. I know what I will decide.

My internship in the Domestic Violence Center ends, but my work continues. I decide to find some way to work with the idea that stories can be redefined. I am betting that there are others, like me, who have been stuck in a mental illness story that is not of their own choice or making. I want to find out whether, through dialogue, we might be able to re-define ourselves and our experiences along the lines of my experience with the trauma survivors band.

I start making calls. I find that there is interest at the state level in developing what are called "peer support programs." I talk to the Director of what's called the Office of Consumer Affairs and tell him about my experience with the women at the domestic violence center. I tell him how their abuse stories get lost – how they go into a mental health agency to get help with their experience of being abused and come out instead with a diagnosis of mental illness and a bagful of medication. I tell him how this leads to more and more psychiatric involvement and less and less community involvement. I confide in him my conviction that services are turning survivors into patients!

What, I ask him, are the resources for people who have gotten stuck in this situation? To my surprise, he tells me there is some seed money available for peer support. He explains that peer support is support provided by people who have been consumers of mental health services who want to support others in a similar situation – a bit like AA. He hopes that there will be enough interest to start a program that will provide an alternative to traditional services.

I tell him that this sounds amazing! It's not long before I take the job as director of this project. I have two missions: one, keep people out of psychiatric hospitals, and two, continue to work with women who have experienced past violence to keep them from seeing their experience as illness.

This is when I learn about "drop-in centers." I learn these are places where people who have learned to describe themselves, or are described by others, as seriously mentally ill spend their days under the supervision of staff. The program consists of a basement room with a pool table and a coffee pot. Though they are thought of as an innovative way to help

people with mental illness have some meaningful interaction back in the community, these centers don't seem much better to me than the institutions people have been released from.

I go and have dinner with the members and try to find out if they are interested in developing a new program. It takes awhile to wade through the medication haze clouding out most semblance of their motivation. Nevertheless, there are a few people who say they would like to help.

I feel good about this. Hopeful. We might really go somewhere. This could lead to real change.

Then I ask the group what they envision, and I get my next eye-opener. I'm expecting them to say, "We want to work together for better housing, education, jobs, respect, an end to discrimination, to stop being treated like children." Instead, I get responses like, "I want you to take us to the beach, I want you to cook for us."

I want, I want, I want. I am taken aback. How did we get like this? Again, my mind returns to our stories. First to my story, then to the story that my logic and my intuition working together imagine them to have based on my story. How does this dependency make sense? Where did it come from? Where do we go from here? Because, having raised 3 kids, I'll be damned if I'm carting grown adults off to the beach.

It takes me some time, a lot of self-reflection. Eventually, I realize that we have learned to be this way. It is part of our role as a good mental patient. We are "incapable" and therefore receive help, they are the capable and therefore give help. That is the implicit social contract – of the one-way service relationships that freeze us in a neverending incompetent role. We are never allowed to give the help, only to be the ones who "get" the help.

It is then that we begin to really talk about ourselves. Not the people who we are now – the incompetent incapable ones with medication haze and the gimme parrots squawking from their perch on our shoulders. But ourselves – the people we were before the doctors, the hospitals, the labels, the diagnoses and the medications that de-invented us – the people with dreams and families and talents and relationships that meant something, something important – on both sides.

I tell them I once was the lead guitar player in a rock and roll band. They laugh, but it seems to spark a different conversation nonetheless. I find out all kinds of things. One person has studied geology and knows a lot about rock formations. One person has been in the military and travelled all over the world, and one woman used to be an ER nurse.

We begin to recover the parts of ourselves we learned to forget – that we were taught to forget, were socialized out of in learning to play our reassigned role as incompetent, incapable, incurable mental patients.

We start building a new program slowly. Since it is Thanksgiving time and I am not in the hospital for the first time in several years, we decide to put on a potluck Thanksgiving dinner. It's a bit of a fiasco because most of us have never cooked anything other than with a microwave. We have been conditioned to think about ourselves as "unsafe," and therefore in need of constant monitoring. But after awhile everyone puts their best foot forward and says they will bring or do something. We end up having one big turkey, my salad, and thirteen boxes of microwaveable stove top stuffing.

Well, this is the most fun any of us have had in a long time. There is lots of conversation that isn't about our symptoms, and there is lots of newfound energy – quite a change from the old "Thorazine shuffle." We begin to realize that we aren't as "sick" as we thought. In fact, we begin to realize much of what we understood as symptoms are simply reactions to things that make us uncomfortable.

It is at that point that we start to have very different conversations. The questions become less cautious, more daring, even seemingly outrageous: What if we can move on with our lives? Do something other than be mental patients? Start our own support network? Replace the whole hospital system?

We start reading the word "recovery" in some of the other peer support literature and get curious. Then excited. Then inspired. Soon we begin to tell our case managers and our doctors that we want real friends rather than paid "friends," choices rather than decisions made for us, and most importantly a sense of hope.

It is not long before we turn to each other rather than calling emergency services when we're feeling frightened or really down. It's much nicer being listened to by a friend rather

than asked about our safety. As our confidence builds, we even decide to start our own alternative to psychiatric hospitalization. Quite a shift in the status quo – patients running the asylum!

In our crisis alternative program, people can come in when they're worried they might get hospitalized, and instead of assessing each other we simply talk. Unafraid that we'll be hospitalized, we're freer to talk about things like suicidal feelings and find that most of us have felt that way at one time or another.

A young man comes to us and says he wants to use our respite bed. He is hearing voices and is afraid. Prior to this he has had many long hospitalizations, lost jobs, been heavily medicated. He feels disconnected from everyone and everything. He just wants to make some sense out of his experience, he says. And so he comes and just talks…for four days he is up talking to people, explaining what he's going through, getting each person's take, comparing experiences, and then he sleeps. Instead of three months of being forced to take medications that make him forget, he has had a week of conversations that allow him to feel more fully alive and aware. He's made friends with people he can call on down the track and he decides to write about his experience for a graduate program in eco-psychology.

No one in the medical field believes us. We must be wrong. There is no way to achieve this result with someone who is a "true psychotic."

We ignore them. Continue on. We know the power of our work together – have seen and experienced it in our own lives.

We face down problem after problem. Turn lived experience into solutions. Engage in honest dialogue about what works and what doesn't.

We start new groups, try new approaches, as old stories are re-examined and new stories are tried out. Our members with trauma tell us that their talk therapy groups don't work. They tell us they end up feeling worse when they leave than when they went in –with the added insult having to pay for the privilege. They think the problem is the horrific stories they are forced to recount – one survivor after another – the purported therapeutic purpose of "dealing with the abuse."

So we start a new group. It involves music. We use music as a way of communicating. And, instead of telling horror stories, we are finding our voices through music, putting them together and feeling the energy and power of what we can create.

So, what is it that's happening that has contributed to so much change in the culture of people who have historically been marginalized, voiceless and contained? And I realize that it's quite simple: we are interacting differently. We no longer talk with or about each other in ways that define us by our problems or deficits. Instead, we are communicating through our strengths and possibilities.

As we continue to play with new assumptions and beliefs, we are writing ourselves a new reality. We are creating community, and we are challenging the secrecy of conversations that lead to new behavior.

This isn't rocket science. But it's certainly different from what we've been told to expect. Which, happily – as we are learning to get new results through challenging old assumptions – is both the process and the product of our efforts.

And so I wonder what your stories are…when did you learn to be a "mental patient?" When and with whom do you tell different stories? It is an important discussion.

And what are some of the things that get in the way of doing something differently? How will you know? What are the things telling you that you are possibly going in the wrong direction?

The first thing you may notice is that you're dying to "help." Now, help is not necessarily a bad thing at all, but when you are out for your own satisfaction, help can turn into control. Remember the times when you've heard people say things like, "I'm only doing this for your own good?" Is that necessarily true or did they do it so they wouldn't have to feel so uncomfortable watching while you did things your own way, however painful it might have been? Help can become a double-edged sword if it's used to be coercive, controlling, is fear-based or is just done to make the helper feel better about having done something.

Let's think of an example. Someone you know seems to be really self-destructive, is always doing things that seem to take her away from what she seems to want. This friend says she wants to "get better," to work on her recovery and so forth, but you see her doing things that

get in the way, like having a second glass of wine, like not exercising, like sitting around reading all day when she could have been out looking for a job. You say to yourself, "If *I* really wanted to 'get better' and recover, I would be doing everything people told me to do!" But maybe this is not the way your friend learns or gets things done. Maybe she learns differently than you do.

And that is the key, right there – learning. What happens if we take the time to learn a little more about our friend? What if that second glass of wine loosens her up enough to go to the interview she is dreading? What if not exercising but sitting around reading all day is exactly what she needs to do to get up the next day and go to the interview? And this is the lesson for us. Our assumptions about what others need is not always/if ever accurate. Our assumptions are based on our perspective, our "worldview." They are there because they belong to us and to our way of knowing, but try and impose them on someone else and you may find that you are not only not helpful, but losing a friend at the same time.

And so we talk about learning together versus helping. Let's think about this for a minute. What's different about learning rather than helping? Learning implies a curiosity, an inquisitiveness about the other, their way of knowing, their way of making sense of the world, whereas helping often implies that you already have the answers, that you know better, that you can come in and tell someone what to do, and if they do it, everything will work out the way it did for you when you were in their shoes. Well maybe and maybe not, but one thing is for certain: helping based on what's worked for you can also be tremendously damaging.

The next principle to remember is to focus on the relationship rather than on the individual. As in "help," when we pay attention exclusively to the individual, we can easily fall into the kind of "help" we talked about before, where all my time and focus goes into you and what you need rather than into our process of relating.

When we pay attention to the relationship, it is quite different. Then we are paying attention to what is going on between us. In other words, we focus on the "space" between us, what is happening right here, right now that can either move us forward or back.

Let's take another example. If I come to "help" you and all my attention is on you and what's wrong, then I'm not going to necessarily factor myself and my actions into the equation. But what happens if we're not communicating well, what happens when something I do pisses you off and I simply take it as a sign of your further incapacity. Do you see where this is going?

But if I pay attention to our relationship and to our communication, I can see that something I'm doing really pisses you off and I can apologize, stop doing it, or try and figure out what it's about *with* you.

When I pay attention to what's going on between us, it opens up a line of communication that supports honesty, safety, integrity, and ultimately changes the very direction I had wanted to go without you. In other words, when I pay attention to you and your changes, nothing I do factors into it, but when I put myself into the equation, I realize that yours and my interaction was just that, an interaction that might go anywhere. There is no predictability, just a seeming randomness. This randomness, this unpredictability is exactly what we are striving for in peer support, not the linear outcomes we've come to think of as success.

Finally, the third thing (and perhaps the hardest) to remember is to not react out of fear but to try new ways of relating based on hope and possibility.

Now this is easier said than done. When we're afraid, we often just want things to go back to the way they were before, to settle down, to become more "stable." Yet "stability" may not be the goal here. Think of a time when things seemed really out of control for you, yet you had a sense of what you needed and wanted even if others around you said things as if they knew better. Chances are, things happened that were out of your control, perhaps even slowing your process. This may have led you into dependence on someone else's experience of the "problem." In other words, you may have become reliant on someone else's interpretation of your experience. This happens simply when someone says to you, "That doesn't hurt, don't cry over spilt milk, etc." and you wonder why you're making a big deal out of something that others see as insignificant. Or the opposite, when what you're doing doesn't affect you at all and someone else is scared that you're going to get

hurt. And they continuously say, "Be careful." Pretty soon you're terrified of something bad happening and you're reacting to their fear. This leads to complicated dynamics where one person's emotions drive the reaction of the other. This is too often what happens in mental health services when they tell us we are helpless. We have learned to be that way based on their fear.

And so today, I put out a bit of a warning…that it's quite easy to "do what's been done to us." And for all the right reasons. We just want to help, we care about the other person and we are afraid for them…or really are we afraid for our selves? What might be the consequences of this person's actions? Will we be seen to have failed them?

And so we go into doing peer support with a focus on learning rather than helping, with an attention to the relationship rather than on the individual, and onto creating opportunities for hope and possibility rather than fear, power, and control. Or at least we try. Although it sounds like a lot of hard work (and it is), it's also fun, rewarding, and simply about creating dynamics that promote health in all our relationships. If we can do this, we can quite literally change the world.

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# GLOSSARY

**Abuse**: causing someone else harm (can be physical, emotional, sexual and/or spiritual)

**Abuse of power**: using one's power or role to take advantage of a situation

**ACT** (Assertive Community Treatment): a model of community mental health care organized as a 24-hour team approach

**"Act as if"**: pretending as if everything's fine when it's not

**Active listening**: a process of paying careful attention to what someone is saying

**Auditory**: 'auditory learning styles' refers to people who learn by hearing

**Authentic connection**: a genuine bond with another person

**Boundaries**: the physical and emotional space between you and me

**Clarifying questions**: asking questions that help you better understand what someone is saying

**Clinical**: a professional mental health approach

**Coercion**: using force to get someone to do something

**Co-learning and growing**: learning from each other

**Community relationships**: the kind of relationships one might have with people in their town

**Connection**: the feeling that exists when two people are really paying attention to one another

**Consensus**: a process of reaching an agreement where everyone gets a say

**Crisis as opportunity**: using difficult situations to explore new ways of thinking about things

**Crisis interview**: talking with someone about what you might need if you should find yourself in a difficult situation.

**Crisis response**: the patterns of behavior we have in difficult situations

**Critical self-awareness**: an ability to step back from your experience and reflect

**Critical thinking**: an ability to take concepts apart and think about them from many angles

**Cultural beliefs**: shared ideas, ways of thinking about things, assumptions

**Cultural violence**: large scale, often condoned violence

**Culture**: a particular grouping with shared beliefs, values, rituals

**Decompensating**: a word sometimes used in mental health to describe someone having a difficult time

**Delusional**: a word used in mental health to describe someone who may be seeing or hearing things that others don't

**Dialogue**: building a respectful conversation in which both people are learning from the other

**Direct communication**: being direct and honest when you have something to say

**Discomfort**: an experience that feels uncomfortable

**Empower(ment)**: to help facilitate choice and help people find their "voice"

**Evaluation and assessment**: to analyze what someone is saying in order to figure out what they need

**Expert/patient relationships**: relationships where one person is there to provide information and possibly answers to the other

**First contact**: the very first time you talk to someone

**Holding multiple truths**: knowing that everyone has their own accurate view of the way things are

**Hot spot**: a personally sensitive area

**Iatrogenic**: problems caused by the treatment (learned helplessness, etc.)

**Illness perspective**: understanding one's experience as illness

**Institutions**: hospitals, schools, residential programs, etc.

**Integrated community member**: someone fully participating in their community

**Intentional**: with purpose or with a specific task in mind

**Interpretive framework**: a conceptual way of thinking about things

**Kinesthetic**: learning through doing

**Learned helplessness**: having been robbed of choice, one learns that they are unable to make decisions

**Learning community**: the purpose of a particular community is learning

**Learning style**: how each of us absorbs information (seeing, hearing, doing, etc)

**Lens of illness**: see 'illness perspective'

**Limit-setting**: ability to say no

**Listening differently**: in this case, a particular way of listening that is skills based

**Meaning questions**: asking questions that help get at what someone means by what they say

**Medical (mental health) language**: the kinds of words used in mental health treatment

**Mental health provider**: a professional working at a mental health program (hospital, community mental health center, etc.)

**Move away from**: to think about something you want to stop (e.g., quitting smoking)

**Move towards**: to figure out what you want and focus on getting there

**Mutual responsibility**: both people making something work

**Mutuality:** sharing (also help and support) goes both ways

**Mutually responsible relationships**: relationships in which both people's needs are met through a process of explicit negotiation

**Narrative:** looking at events or situations through stories

**Negotiating reality**: coming to a mutual agreement about reality

**Non-compliance:** doing what's right for us regardless of what we've been told

**"Not knowing":** checking our understanding of another person's experiences

**Patterns:** the thinking and behavior we habitually fall into

**Peer:** another person with lived experience of using/surviving mental health services. Other names used are: *consumers, users, survivors, clients, patients, ex-clients, ex-patients of mental health services*

**Peer center:** funded peer-run organization

**Peer community:** peers living and working in relationship with one another

**Peer relationship:** relationship with another peer

**Peer-run crisis alternative:** alternative to hospital or inpatient care run by peers

**Peer support:** support given by one peer to another (in this context often in an organized, funded environment)

**Perception:** way of seeing or knowing

Personal change: recovery journey

**Personal change stories:** our description of our recovery journey

**Power**: ability or official capacity to exercise control over someone

**Power dynamics:** the relational patterns that occur when power is exerted

**Power reactions:** responses to power

**Power shifts:** changes in who has the power

**Powerful questions:** questions that have the potential to enable change

**Privilege and/or bias:** an advantage enjoyed by an individual or group, and used to exclude others.

**Problem solving:** in this context, one person feeling the need to 'solve' someone else's problems (a form of power)

**Provider/rescuer/savior:** the role a person falls into when problem-solving

**Psychiatric assumptions:** seeing a person's situation(s) as illness, i.e., in terms of diagnosis, medical treatment

**Reactivity:** automatic responses to something

**Reciprocity:** ensuring each party is both giver and receiver

**Recovery:** the journey from crisis to a place of 'living well'

**Redefining help:** finding roads to recovery that break out of the 'experts helping non-experts' mold

**Re-enacting/re-enactment:** doing the things that have been done to us (often repeating power plays)

**Reflection of feelings:** checking that we understand the way a person feels

**Relational change:** changing the power dynamics in a relationship

**Relational dynamics:** the power interactions in relationships

**Responsible communities**: groups of people committed to positively redefining relationships, power and our collective stories

**Re-storying**: finding new ways of talking about ourselves and our relationships

**Role**: the part we play in relationships (e.g., victim, helper, aggressor)

**"Rules vs. Negotiation"**: the tension between wanting to put hard and fast rules into place, and the harder option of coming to a mutual agreement

**Self awareness:** awareness of one's own patterns of roles and stories

**Self care:** ensuring our own needs are adequately met

**Self injury:** physically or emotionally hurting oneself

**Self pre-occupation**: focusing solely on one's own problems and situations in isolation from one's relationships with others

**Service relationships:** relationship between a paid 'expert' and a peer

**Shared responsibility:** all parties in a relationship taking some agreed upon responsibility for a difficult situation

**Shared risk:** agreement that responsibilities for the notions of 'safety' and 'risk' lie within relationships

**"Sit with discomfort":** staying in relationship when things are uncomfortable or difficult without trying.to problem solve

**Sitting comfortably:** see 'sit with discomfort'

**Social action**: actively working to achieve social change

**Social change**: positive change in the attitudes and/or behavior of a community

**Socialization:** the ways we learn to fit into what we think our community/society expects of us

**Staying peer:** maintaining reciprocity without falling into power roles

**Stories:** the accounts we tell ourselves about how we make sense of our lives, roles, and power dynamics in relationship to those around us

**Story-telling:** relating or re-enacting our stories with one another

**Stuckness:** finding ourselves unable to move on from the way we think about things

**"Thinking outside the box":** looking at something in a different way

**Transformation:** changing from one state of being to another

**Trauma:** an experience that causes physical/psychological injury or pain

**Trauma worldview:** the way trauma, crisis or conflict affects the way we see the world

**Trauma-informed:** relating to one another through an awareness of the way trauma has influenced the way we see and think

**Trauma-organized:** the power dynamics that a group, organization, family or community collectively develops as a result of their collective trauma experiences

**"Untold story":** the kinds of things that have influenced how we see

**Validation:** acknowledgment of the value of a person and/or their experiences

**Vision:** the mental picture we build of what we would like to be/have/do

**Visual:** a visual learner learns best by seeing things

**Warmline:** a peer-operated telephone line that offers basic support

**Worldview:** the way we have learned to think about things as a result of our life experiences

**WRAP (**Wellness Recovery Action Plan): a personal plan that supports your wellness

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# VALUES AND COMPETENCIES

| Value | Competency | Example | Unique Outcomes |
|---|---|---|---|
| 1. Commitment to recovery, growth, evolution, inspiring hope | Demonstrates willingness to challenge self, others, and the relationship<br><br>Demonstrates the intention of learning as opposed to the intention of helping | Troy takes Intentional Peer Support training and learns new ways of relating. He begins using those new approaches with his family. His mother then begins using those new ways of relating in her interactions with her friends and community. | Peer support staff, members, and programs are energized, evolving, and have a commitment to change (trying things they haven't done before)<br><br>What's been learned carries over into other areas of peoples lives |
| 2. Accountability (personal and relational) | Follows through with commitments<br><br>Attends and fully participates in co-supervision<br><br>Continues to become accomplished in IPS skills | Phoebe used to complain that people didn't call to remind her of the monthly meetings. After a colleague questioned how that fit with the values of peer support, she realized she needed to figure out a way of reminding herself of the meetings as well as the tasks she agreed to complete | Peer support centers run smoothly and difficulties are worked through openly |
| 3. The Power of Language | Has awareness of the power of language.<br><br>Uses language that is free of jargon, assumptions, judgments, generalizations and characterizations. (e.g. medical language) | Mary has always described her "bad" days as feeling suicidal. She realized that just by using that language, it was hard to tell what the actual feeling was. She also realized that the use of the word suicidal was a conversation stopper. | People are able to use language in a way that opens new perspectives for themselves and others.<br><br>People no longer see themselves through the lens of a diagnosis. |
| 4. Direct honest respectful communication | Awareness of own intentions (e.g. agendas, assumptions)<br><br>Is authentic<br><br>Values and validates others<br><br>Gives and receives difficult messages with awareness of other worldviews<br><br>Ability to communicate in a | James was feeling resentful with Earl because it seemed that he was always paying for all the things they did together. Finally he realized that he was contributing to the dynamic and was able to say that. He also asked Earl if they could have a potentially difficult conversation around money and assumptions. | Communication that inspires change and growth<br><br>Members and staff feel heard, validated, and valued<br><br>Peer support becomes a place where people feel safe to have and voice their own perspective |

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| | way that invites sharing of perspectives | | |
| 5. Consciousness raising/critical learning | Desire and ability to self reflect<br><br>Demonstrates an understanding of how people can get stuck in a "mental patient "role<br><br>Uses personal self-awareness to stimulate growth in others | Pam usually does her shopping at night because she is very uncomfortable around other people. She discovered, in conversation with Jen, that she wanted to be able to feel comfortable making new friends. Jen and Pam arrange to go shopping together during the day. | People (members and staff) are consistently able to challenge and move beyond beliefs that have kept them stuck<br><br>People consider discomfort a natural part of the learning process |
| 6. Worldview, diversity, holding multiple truths, trauma-informed | Demonstrates an understanding of how people's past experiences impacts who they are, how they think, how they relate etc.<br><br>Awareness of when personal strong beliefs cut off other's "truths"<br><br>Ability to self-reflect | Tony has grown up in a warm family. He is shocked when he hears people talking about being abused by their families. At first he says things like, "oh, I'm sure they didn't mean anything by it…" However after talking to enough people, he realizes that abuse has had profound effects on many. | Acceptance, interest, and curiosity about different ways of thinking<br><br>Valuing other perspectives and truths as opportunity for personal growth and discovery<br><br>People begin to understand their experiences based on what's happened to them rather than what's wrong with them<br><br>The effects of trauma are not viewed as illness but rather a reaction to what has happened and been experienced |
| 7. Mutual responsibility and belief in the power of relationship | Maintains awareness of power and privilege<br><br>Focuses on the relationship and whether it is working for both parties<br><br>Is able to state observations, | Dan couldn't understand why his friends were treating him differently since he'd become a paid peer. They seemed to want him to do everything. Finally, realizing that they did, in fact, see him differently, and that he did have new responsibilities, | People have a willingness to ask for what they need as well as a responsibility to consider the views of others<br><br>People focus on taking care of the relationship rather than taking care of each other |

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| | acknowledge own feelings, and request what is needed for the relationship to work<br><br>Is able to see and "own" their part of a conflict | he was able to start a conversation where he shared what the change in role had been like for him. His friends were surprised by his honesty. They were then able to talk about how to better make it work for all of them. | People understand they are responsible for themselves and their part of any relationship |
| 8. Shared risk | Ability to demonstrate sitting with discomfort<br><br>Ability to negotiate fear/anger/conflict<br><br>Ability to avoid overreacting and taking over even when things get tough (e.g. being mindful of power, mutuality and personal accountability) | Iris tells Richard that she feels like cutting herself. Richard feels unprepared and is frightened. He wants to pass this 'safety' problem on to someone who 'knows more than he does', a professional. Richard self-reflects, acknowledges his fear, and implements IPS. Richard asks if this is an old response to some tough feelings, and asks if there's a way to talk together about it so **they can both feel comfortable enough talking about it** | Less coercion and more ability to work through hard times without professional intervention<br><br>People feel more capable and have hope even in difficult situations |
| 9. Moving towards | Demonstrates an ability to distinguish between moving towards something positive and moving away from something negative<br><br>Invites conversation that shifts problem-focus to creating-focus | Richard had once thought that he was a good peer support worker only when he was helping people with their problems. He couldn't believe the difference in thinking, feelings, hope and attitudes when he started to pay attention to what people were moving towards rather than focusing on their problems | What brings peers together in a healthy, healing way is not problems they have in common, rather the dreams they have in common |

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| 10. Creating community and social change | Demonstrates IPS in all relationships and actions<br><br>Draws on people's interests outside peer support<br><br>Has familiarity with local resources<br><br>Supports people in finding and trying new community resources<br><br>Advocates for people to address mental health challenges in the context of community relationships | Bruce, a peer support worker, has worked with Jill in crisis respite. While Jill was there, they got to talking about politics. They decided to work with local campaigns around mental health issues. When they did this, it was not long before others working on the campaign spoke openly about personal issues of their own. | The greater community is becoming more aware of mental health and wellness issues<br><br>There is an active flow of members (e.g. people move on and are able to work through their issues in the conext of the community )<br><br>Larger community is more receptive to and comfortable being with each other through difficult times (e.g. peer support becomes a natural community response) |

intentional
# peer SUPPORT
CORE TRAINING

*Day One*



## Whakatauki

Ko tatou kotahitanga kia kohangia
nga hina kia mahi
Me hangiaotanga ki te hurihuri o te
hou ora mo tatou te iwi

We unite to strengthen networks
Creating change and wellness
For the betterment of our people

Introduce yourselves by saying:

- *Your name and where you're from*
- *One thing that inspires you about peer support*
- *One thing you think people might be interested to know about you*