LWSN

LIBRARY WORKER SUPPORT NETWORK

Preparatory Materials for Convening Participants

Urban Librarians Unite

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The Library Worker Support Network is a partnership between the New York Library Association and Urban Librarians Unite.

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Welcome

Welcome, and thank you for joining us! You are the core of this work, and we need you to help us begin to build the solutions to our shared experience of trauma in library work. Library Worker Support Network grew out of our 2022 Urban Library Trauma Study (ULTS). This study was formulated in response to the realization that every member of the Urban Librarians Unite leadership group had experienced some degree of trauma in the performance of their professional work.

As part of this study, we asked our participants to join us in dreaming of solutions that could be executed by ULU in roughly three years. The Library Worker Support Network (LWSN) is the result of this promise.

One of the major suggestions to come out of our workshop was the creation of a space where library workers can connect with one another and find support. In the previous study we found that many library workers did not realize their experiences with trauma were not limited to contained, individual circumstances. Rather, they are far more pervasive. Others had been given the (bad) advice that they just have to "earn their stripes" and that because other library workers have dealt with traumatic workplace experiences, theirs need not be dwelled upon. When this study was published it resonated strongly with so many more people than just urban library workers.

As a consequence, we are creating a peer support network for library workers at all levels and types of library work. This is a support network *for* library workers, *by* library workers. Following the successful feedback from our first study, we plan to use similar frameworks to actually create this support network. We will continue to be grounded in the lived experience and needs of library workers, which means drawing on innovation and design thinking structures to create space for practitioners in libraries, as well as a democratic peer support network.

Why have we taken this approach? What is your role?

The focus of this study is to create our peer support network and to train one another to become facilitators for it. You are here because you are a member of the community most affected by this issue. Our hope is that your background and valuable experiences will enable you to see connections and solutions that might elude people who are not engaged in library work daily.

What kinds of things are we looking for?

We are looking to create a real, tangible, support network with all of the policies, training, knowledge, and structure that go with creating a community.

Do we expect you to have all that knowledge and answers?

No, but we expect you to bring your lived experience to our group in the hope of creating something actually useful. As we have said before, we need a culture change grounded in practical solutions, which can be used by library workers throughout America to improve their working lives. And most importantly, we need *you*.

Welcome, and thank you for being here.

Process

The design convening for the Library Worker Support Network will be like a high school group project, but way more organized and with a clear end goal in mind. We will gather for four days to share our thoughts and build the structure for the support network itself. To do this, we will be structuring our work using the design thinking process.

Design thinking is a community and user focused process for problem solving. It is best used for addressing "ambiguous problems"—complicated problems involving a lot of stakeholders, who aren't necessarily acting in predictable ways. Building a support network for library workers experiencing trauma absolutely qualifies as an ambiguous problem!

Understand - The first stage of the design thinking process is building an understanding of the broader topic. LWSN staff have pulled together a literature review covering how peer support groups have been implemented in other industries. Your first assignment as a Peer Leader is to read through the lit review and related articles to develop a common understanding.

Define - At the beginning of the convening we will work together to define the scope and structure of the LWSN as a potential solution. .

Ideate - During the ideation stage we will work in groups to come up with a wide array of ideas for creating the support network. We will do this through a series of exercises to create as many ideas as possible, then narrow them down to the most feasible, before moving on to the next step.

Prototype and Test - Next, we will build simple prototypes of our ideas and test them with each other. At the end of the convening we'll share our revised projects with the whole group. After the convening, we will work virtually to complete projects developed at the event. Then we will have one more full group meeting to train one another on the work we have done.

Implement - Finally, we will roll out the Library Worker Support Network! For this implementation we will be relying on you to lead support group sessions.

Review and Revise - The final step will begin during the implementation phase, and be completed by the end of July 2025. The support network is not something we can just create and never change. Throughout the project we will build in evaluations so we can review and adjust as needed.

We are excited to spend a few days with you working through this process and appreciate the time you are dedicating to this collective effort.

Research Results

Literature Review

Intro

This literature review has been assembled in response to the 2022 Urban Librarians Unite Trauma Study (ULTS) (Comito & Zabriskie, 2022; L. T. Dudak et al., 2022). In the focus groups, there were many great suggestions for improving library workers' trauma experiences and changing library workplaces/culture. One of the suggestions was to start a Library Worker Support Network. In order to create this network, we must dive into the literature to see how other groups have put together peer support networks to create community, support, understanding, flexibility, and trust.

What is peer support?

Peer support can be called by many names such as "mutual support," "circle" (Goerdt et al., 2022), "peer-to-peer or kinship navigator" (Littlewood et al., 2023), "peer relations" (Ryan et al., 2020), intentional peer support or IPS (Ley et al., 2010), distributed networks (for online groups) "peer networks" (Cox et al., 2021), "peer support specialist" (Poremski et al., 2022), and more. While there may be many names out there, we will use "peer support" for this paper, with the acknowledgment that there are other names. There are also many more detailed literature reviews diving into the nuts and bolts of this topic, but the purpose of this review is to set the stage for creating a Library Peer Support Network.

Sherry Mead was among the first scholars to write an academic, theoretical paper on peer support. She defines it as "... a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful. Peer support is not based on psychiatric models and diagnostic criteria" (2001, p. 135). Mead creates her definition of peer support in direct opposition to psychiatric models of mental health care.

While humans have always created networks of mutuality and support, peer support was a push to validate these care methods. After the deinstitutionalization of many mental health services in the 1970s, peer support, self-help, and psychiatric survivor (sometimes called consumer) movements sprung up as a way for previously institutionalized individuals to reclaim their independence while also creating a new path for healing grounded in recovery philosophies. (Scott et al., 2011). This movement became more mainstream in the 1990s, applying the disability slogan, "Nothing about us, without us," to highlight the need for generative and peer power (Ryan et al., 2020; Solomon, 2004). The movement was an attempt to reclaim mental health care while fighting against involuntary institutionalization and forced medication. (Scott et al., 2011). Support groups aim to meet people where they are and respect an individual's choice (Mead et al., 2001).

Since then, some medicalized mental health services and health insurance have also employed peer support navigators to run peer support organizations. Peer support navigators' employment has been controversial due to low pay, lack of understanding by mental health professionals on their roles/impact, job creep, and the fact that peer support is going back to the organization that they intentionally broke away from (Heisler et al., 2010; Krumm et al., 2022; Ley et al., 2010; Shalaby & Agyapong, 2020; Tamworth et al., 2022; Vandewalle et al., 2016).

However, peer support remains rooted in empowerment, the sharing of power, shared knowledge and experiences, and social and/or practical assistance given to support others with similar lived experiences (Fortuna et al., 2022). Peer support intends to assist people in dealing with emotions like anger, guilt, impotence, grief, frustration, and anxiety. It also helps to meet the needs of having understanding, recognition, listening, care, and respect (Schrøder & Assing Hvidt, 2023). Mead and Filson define what peer support can do as the following,

> "Intentional peer support (IPS) offers the opportunity to find and create new meaning through our relationships and conversations that lead to new ways of understanding crisis. It provides a lens through which to address these issues by talking very overtly about power, who has it, who does not and to negotiate how we can share it. We do this by coming together based on the understanding that both of us have experiences or stories to tell, that explain who we are and how we see the present. This gives both people power, visibility, and expertise. This sort of relationship is more proactive, building mutuality, and shared meaning making. We offer three principles; or ways of thinking about what we are doing in our relationships, and then use four tasks to carry out that intention" (2017, p. 144).

Defining Characteristics

The literature shows a handful of defining characteristics of peer support networks or groups. As previously stated, the essential element of peer support is that the networks are created by and for the people they serve (Pahk & Baek, 2021; Ryan et al., 2020; van de Ven, 2020). This allows for connections based on the mutuality of lived experience to create community, relationships, and understanding. In these groups, while there is a baseline shared experience, there also must be an acknowledgment of differences and situatedness (Haraway, 1988). With this, it honors that we know ourselves best, and people may understand our ways of looking at the world or see it differently. It also is essential to consider how different social factors may impact people differently. There may be a need, even within a support group, to create different affinity groups so people can connect more deeply and share more freely (Goerdt et al., 2022; Stoll et al., 2023).

These differences become acknowledged and celebrated through strengths-based approaches. This approach focuses on what people can do and are doing rather than critiquing what they are not doing or could be doing (Leath et al., 2022; Littlewood et al., 2023; Ryan et al., 2020; SAMHSA, n.d.-a). Strengths-based approaches build confidence and empower, leading to real change. This confidence creates an environment where learning and exploring are valued over expertise.

When value is placed on validation, support, unconditional listening, and encouragement, it creates a space for the support of the whole person in their various roles, such as work, home, school, etc. (Cox et al., 2021). It allows individuals to release the burden of performing their struggle for others or explaining their lived experience but instead leaves room for witnessing and reciprocity (Goerdt et al., 2022; Heisler et al., 2010; Mead & Hilton, 2003). This unconditional listening allows for "...normalizing what has been named as abnormal because of other people's discomfort" (Dass & Gorman, 1985). Listening and witnessing provide positive accountability to ourselves and others in the group and allow for reflection about ourselves, our relationships with others, and systems of power.

While these groups often focus on listening and supporting others, there is also space for sharing information and resources to help others navigate tricky systems, social systems, and systems of power. Also, while we should never lead with suggestions, there is space for kind suggestions when specifically requested (Goerdt et al., 2022). Mead and Hilton remind us that, "Being there for people, stepping in to lend a helping hand, or delivering aid of any kind is crucial to our humanity, especially given the magnitude of suffering all around us. But all too often we are in a hurry to fix or problem solve" (2003, p. 145). The sharing of information and suggestions helps to build space for mutuality and support across the peer network and allows for a more profound creation of community by creating community resources and information.

Solomon laid out ten critical ingredients to peer support. However, one that they touched on, that other authors did not explicitly mention, is the importance of having diversity and accessibility in services provided by the peer network and having the networks reflect the cultural diversity of their community (Solomon, 2004). It makes sense to consider different groups' needs in groups that rely on similarities to work. For example, a white library worker's experiences are different from those of their Black colleagues since they do not have to contend with daily racism and microaggressions. As such, there may be elements of lived experiences that people in the group may not understand or consider, so it must be considered in the structure and implementation of the peer support network.

Facilitation

Mullard specifically identified three design/delivery models for peer support: service lead, community-based, and social media-based. Service lead is usually top-down and tied to an

existing health service. So, it may be the extension of a cancer center, addiction unit, or maternity ward. However, community-based models are created by the community and exist outside of any other service, like social media. These are typically considered bottom-up, although social media could also be facilitated by a health service (Mullard et al., 2023).

In the case studies read, when support groups linked to a health service, they were usually organized by that health service and service professionals in tandem with any employed peer support staff (Heisler et al., 2010; Ley et al., 2010; Moore et al., 2020; Schrøder & Assing Hvidt, 2023; Stoll et al., 2023; Vandewalle et al., 2016). However, when groups were more community-led, there was more space for self-determination and flexibility within the group (Campbell, n.d.; Goerdt et al., 2022; A. H. Johnson & Rogers, 2020; Mead et al., 2001). As such, flexibility was often listed as an essential feature of peer support.

However, both peer-to-peer and group-to-peer support need a level of oversight and supervision. This supervision can be executed in multiple ways, like peer support groups. In more medicalized settings, sometimes called "the institutionalization of peer support," there is a more formal, traditional, and Western work structure to supervision. Nevertheless, supervision can also be done collectively with various peer leaders meeting to assess, address, and update anything needing attention (Foglesong et al., 2022; Ley et al., 2010; Littlewood et al., 2023). Either way, supervision allows reflection, question-asking, and accountability.

There also are two primary sources of guidelines, training, and structure can be adopted. Many states have their own training, but the Substance Abuse and Mental Health Services Administration, as well as the Intentional Peer Support group, have guidelines and training guides that can be used to help facilitate the start of a peer support program (Intentional Peer Support, 2013; SAMHSA, n.d.-b, n.d.-a, 2022, 2017). While they share many commonalities, as seen in Figure 1, SAMHSA is much more brief, potentially due to the more medical model, whereas IPS comes out of Mead's Work, which relies highly on creating groups for peers by peers.

SAMHSA Competencies	IPS Competencies
Recovery Oriented	Connection
Person-Centered	Shifting from helping to learning together
Voluntary	Awareness of one's worldview and others
Relationship Focused	Mutuality
Trauma-Informed	Move focus from fear to hope and possibility
	Moving towards things rather than moving away
	Self- Regulation
	Able to give and receive feedback
	Co- reflection

Figure 1. SAMHSA (SAMHSA, n.d.-a) and IPS Competencies (Intentional Peer Support, 2017)

Potential Benefits and Risks

Many studies highlighted the positive effects of participating in and facilitating peer support groups. Johnson conducted a study examining the benefits to the individuals leading the peer support groups. He identified growth in peer supporters in interpersonal, social, mental health, recovery, spiritual, and professional skills. Facilitators became inspired and hopeful, gaining confidence, stability, satisfaction, interest in the future, deeper connections, finding more time for themselves, socializing more, and even reduced medication (G. Johnson et al., 2014). As such, we can see how peer support groups invite mutuality where someone is not only giving but also receiving benefits from the experience.

However, like anything in life, boundary setting and mindset are vital in peer support work and settings. In mental health, there is always the possibility of risk. Scott highlights the need for reframing the ideas of care and responsibility. They write that in peer support, participants need to have a responsibility towards each other rather than for each other (Scott et al., 2011). This reframing ensures care and support but also acknowledges that we are not responsible for the actions of others. We can care for one another and create peer environments, but each peer gets to decide what they do with that space and in their lives. This may feel stressful, but it also reiterates one of the critical principles of the deinstitutionalization movement—each individual is empowered to make their own decisions. As such, it is crucial to set boundaries and space to recognize that we are not responsible for each other's actions but are responsible for how we treat and respect each other. Boundaries are born out of respect for ourselves and those around us.

The Library and Peer Support

One of the compelling aspects of peer support is that people generally know what it is without having to do deep research to understand it. While some of the participants in our ULTS study may have known the history and whole meaning of peer support, we are sure not all of them did. However, they knew precisely what peer support was—a call to create community and support for library workers' difficulties. In this way, peer support seems to be, as Ley calls it, a "naturalistic phenomenon" (2010, p. 16).

Peer support for library staff trauma has not been implemented yet. However, many libraries are adapting peer navigators/support specialists to help community members experiencing homelessness, who have housing needs, mental health, substance abuse and more (Badalamenti, 2019; Beth, 2021; Bryson, 2018; Chant, 2017; DC Public Library, n.d.; Elia, 2018; Enoch Pratt Free Library, n.d.; Erie County Public Library, 2019; Formerly Homeless Help Current Homeless Through Peer Program At Denver Public Library - CBS Colorado, 2019; Meet with a Peer Navigator, 2023; Pratt Library Launches Peer Navigators Service Promoting Overall Well-Being At Pennsylvania Ave. Branch - CBS Baltimore, 2022; Kalamazoo Public Library, n.d.; Kamau, 2023; KCLS Director, 2022; Ross, 2022; Sullivan, 2022).

But, much like trauma-informed care, we often apply things to our patrons and community and support them before we support ourselves. Much like the suggestion to turn trauma-informed care inwards to staff (L. Dudak, 2023), we also need to turn these peer support groups inward. While only some libraries utilize peer support networks to support patrons, this idea is familiar in libraries; it has yet to be widely applied to library workers. While library workers may have different struggles than our community members, ULTS has shown (Comito & Zabriskie, 2022; L. T. Dudak et al., 2022) that library staff still need support, connection, and community. We also need help navigating library work, especially when stressed, burnt out, and traumatized.

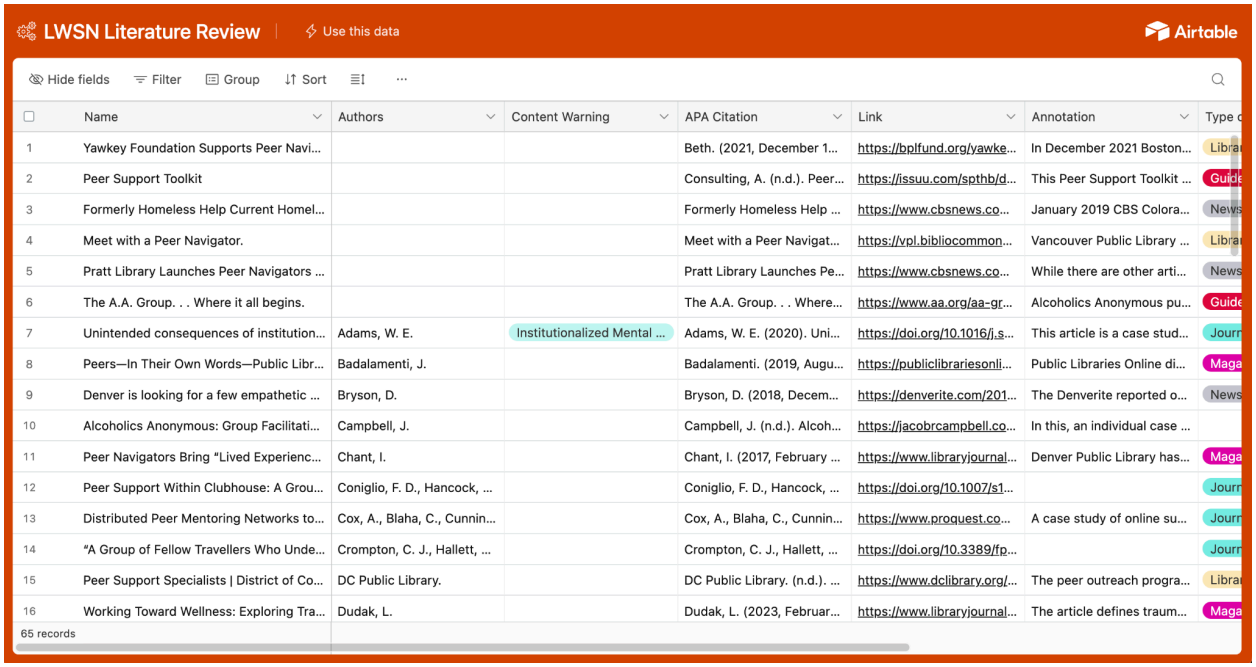
Additionally, other scholars are looking at how work may play a role in peer support groups. Moore discusses the loss of personal identity that can be lost when stepping into a professional role. They also mention how this shifts pre-existing support because friends and family may not understand the totality of the professional role (2020). While this is not about library workers but medical interns, many connections can be made. The public (including personal networks) does not understand what library workers do and the identity the work creates. Moore mentions how needed peer support networks are in these professional settings so that the interns, or library workers in our case, can talk to people who get it and have been there, fighting isolation, which can lead to more stress and burnout (2020). As such, peer support networks appear to be a good source of support and healing for library work.

Conclusion

Peer support is utilized in library settings but has not been strategically applied long-term to library workers. However, it promises to be useful in creating systems of support, community, and to help library workers not feel alone or ashamed in their experiences. Concerning the ULTS trauma cycle, peer support networks appear to have the potential to disrupt the cycle at the community level by validating experiences, offering support, and resource sharing. Peer support groups have been applied to various uses and settings and have the flexibility to be molded by the peer members. As such, it can be a highly liberatory practice, breaking down traditional mental health services' power dynamics and focusing on moving forward and recovery.

Citations

Citations used in this literature review can be found in the Airtable base linked here: https://urbanlibrariansunite.org/lwsn-lit



Homework

You made it through the research information! Now it's homework time. We have included some suggestions for further reading, and also some questions to sit with as you process the results of the literature review. Since we will be using the packet to inform our work in March, we hope that the readings and questions will be helpful in framing your relationship to the problem itself and the data around it.

Pre-reading

If you haven't read the ULTS report or need to familiarize yourself with it you can find it on our website or by following this link: https://urbanlibrariansunite.org/pdf-report.

Mead, S., Hilton, D., & Curtis, L. (2001). Peer support: A theoretical perspective. *Psychiatric Rehabilitation Journal*, *25*(2), 134–141. https://doi.org/10.1037/h0095032

Goerdt, M. N., Resurreccion, A. A. G., Taziyah, B., Johnson, R., Lorenzo de la Peña, S., & Johnson, T. (2022). BIPOC Art Therapists: Antiracism Work Through the Virtual Circle. *Art Therapy*, *39*(2), 103–107. https://doi.org/10.1080/07421656.2021.2024318

Questions to Consider

What would peer support look like for you?

How does the research impact your view of peer support?

Did anything in the lit review or readings surprise you? If so, what and why?

Which area of the research grabs your interest? What ideas do you have for action?

Travel and Local Information

https://urbanlibrariansunite.org/lwsn-map

Subway Stations:

L to Bedford Avenue
G to Nassau Avenue

Lodging:

The Hoxton Williamsburg
97 Wythe Ave
Brooklyn, NY 11249
718-215-7100

Travel Planning:

- Please make your best effort to fly into JFK or Laguardia
- First day (3/26), please be here for the start of the meeting at 1:30pm.
- For the last day (3/29), please do not schedule any travel that leaves earlier than 3:30pm.

Convening Location:

The Annex
97 N 10th St Suite 1D,
Brooklyn, NY 11249

*** Need help or information? Lauren is local and can be reached at 646-662-6209.

Covid Safety Guidelines

- Participants will be required to be fully vaccinated and boosted by the date of travel.
- Organizers will have masks and tests available for any participants who want them.
- By traveling to and joining the convening you certify that you are not experiencing any symptoms of Covid-19. If you begin to experience symptoms please notify organizers immediately.
    - We will not leave you hanging. If you contract Covid or become ill during the convening, organizers will make sure that you are safe and able to get home.
- Organizers may choose to require a self administered rapid antigen test during the convening if supplies are available.
- If you need any accommodations around this, please reach out to the organizers and let us know.

Acknowledgements

A project of this size is never completed alone. We are grateful for the support of the many people and organizations who have provided support and advice through this process. The time, labor, and creativity of our research assistant Leah Dudak has been essential to this project. We are particularly grateful to the current and past board members of Urban Librarians Unite, ULU staff, the eternally patient staff at the New York Library Association, and Sarah Fuller at IMLS.

Finally, we are grateful to you! Thank you for your time and work. Thank you for being willing to join us at this convening and work to create a better culture around trauma in urban public libraries. We couldn't do this without you.

Notes

Art Therapy

Journal of the American Art Therapy Association

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BIPOC Art Therapists: Antiracism Work Through the Virtual Circle

Miki Nishida Goerdt, Ashley Abigail Gruezo Resurreccion, Brandi Taziyah, Rhonda Johnson, Sheila Lorenzo de la Peña & Tuesdai Johnson

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viewpoints

BIPOC Art Therapists: Antiracism Work Through the Virtual Circle

Miki Nishida Goerdt, Ashley Abigail Gruezo Resurreccion, Brandi Taziyah, Rhonda Johnson, Sheila Lorenzo de la Peña, and Tuesdai Johnson

Abstract

In the wake of 2020's racial tension and civil unrest in the United States, Black, Indigenous, and People of Color (BIPOC) art therapists and graduate students found themselves in need of support from like-minded, social justice-oriented peers. A virtual monthly peer support group called the BIPOC Art Therapists' Circle was formed. A different member selected reading materials to which members created response art. Outcomes of the Circle include: shared experience of oppression; connection and empowerment through art sharing; safety; emotional support and validation; vulnerability and authenticity; widened perspectives; and motivation to advocate outside of circle meetings. The experience of the BIPOC circle confirms its critical importance as a source of support for BIPOC art therapists and students.

Keywords: *Art therapists of color*; *peer support*; *oppression*; *social justice*; *response art*

The year 2020 was marked by the COVID-19 pandemic, racial tension, and civil unrest in the United States. The authors of this article identify as Black, Indigenous, and People of Color (BIPOC) art therapists who occupied spaces where support from like-minded, social-justice oriented art therapists was not readily available. Since October 2020 to the present date, we have supported each other through an ongoing virtual monthly peer support group called the BIPOC Art Therapists' Circle. This viewpoint describes the nature of the circle and its impacts.

We formed this meeting of art therapists and students to autonomously build solidarity and create a safe space for ourselves without worrying about oppression by, or needing to take care of, White individuals. As voices of oppressed individuals are often ignored and questioned by dominant cultures, we consider claiming space exclusively for BIPOC art therapists as embodied social justice work (Blackwell, 2018). The framework is similar to feminist consciousness raising groups, which were the hallmark of the second-wave feminist movement in 1970s. Consciousness raising groups were grassroots-level strategies to question "common senses" of the male-driven dominant culture and were aiming at feminist social transformation. Such groups generally met with a pre-set topic for discussions on a regular basis to identify commonalities between their experiences and to understand the impact of structural oppressions (Firth & Robinson, 2016). Although feminism has been known to center White women's needs, consciousness raising groups were utilized by Black feminists such as the Black Women's Liberation Group of Mount Vernon in order to address sexism and racism (Norman, 2006).

Goerdt, an East Asian/Japanese immigrant, posted an announcement on the American Art Therapy Association's online forum, encouraging BIPOC art therapists who wished to further their understanding on antiracism and social justice to participate in a monthly circle. As the willingness to learn and explore antiracist practice was more valued than the degree of clinical expertise, both students and practicing art therapists were invited to the circle. This intentional decision dismantles an unhelpful belief that professionals with a higher degree or license should be seen as more knowledgeable about lived experiences. It also establishes the circle as an autonomous space honoring lived experiences of BIPOC art therapists as opposed to one that perpetuates exclusively academic or clinical knowledge. To

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Table 1. Topics of Discussion

Month/Year	Topics of Discussion	Samples of Discussion Materials*
October 2020	Introduction; Cross-cultural issues; Historical trauma	Mandley (2020); Hocoy (2002)
November	Cost of racism for BIPOC individuals; How to keep creativity channels open as BIPOC art therapists	Scott (2017)
December	Cultural identity as a BIPOC art therapist; Acculturation	Lumpkin (2006)
January 2021	Expression of the cultural/racial self	Brown (2018)
February	Addressing race in therapy sessions	Bartoli & Pyati (2009)
March	Settler colonialism and native rights	Kuo (2015)
April	Cultural appropriation	Napoli (2019); Johnson (2015)
May	What do you want to celebrate? What brings joy?	None
June	Self-care for BIPOC individuals	Ortiz (2020) Menakem (2020)

*Full list available upon request.

achieve a sufficient sense of trust for members to be vulnerable, the circle has intentionally operated as a small and closed group with an average of six participants, including the authors of this article.

To promote ownership and belonging, a different member has been responsible for selecting materials relating to antiracism, social justice, and decolonization (Table 1). Scholarly works can reinforce the stereotyped notions and narrow expectations that inhibit the flourishing of BIPOC clinicians and students, and thus we diversified resources with non-scholarly articles, podcasts, and videos created by BIPOC professionals. We have encouraged each other to create response art regarding the selected materials. Response art is a vital method for art therapists to process clinical work and facilitate activism (Fish, 2019).

Members' Reflection on Their Experiences

Whether through reading, artmaking, or discussion, honest exchanges have brought up emotional responses. Sometimes, we have faced difficulties when witnessing personal and shared anxieties, learned dependence, and feelings of guilt and race-based shame. Goerdt voiced, "I often feel gratitude and joy but also a sense of discomfort, regret, and/or shame [in circle meetings]. These feelings are what I am conditioned to feel when I engage in race talk with others." However, successes and inspirations were also celebrated. In June 2021, we explored these experiences through written reflections. Seven types of shared experiences illustrate the impacts of the circle.

Shared Experiences of Oppression

Circle participation is motivated by a desire to navigate race-related experiences in the art therapy field and in lived experiences. Experiences include microaggression, not being understood as a "whole person" with intersectional identities, and facing dismissive attitudes from colleagues/classmates regarding challenges that BIPOC art therapists face (Figure 1). Many of us are, or have been, the only person of color in an art therapy program/work setting, which has led to feelings of isolation. We painfully recalled patterns like "being the 'other' and the desire to be amongst 'others'" (Johnson et al. 2021, p. 52). As one Black member, T. Johnson, stated, "I, as a person of color, felt on display to offer a learning experience for the dominant culture in the shared space." In this way, oppression by the dominant culture compromised the dynamics of the BIPOC autonomous space.

Safety

Strategies acquired by each one of us to survive White dominant spaces have appeared as barriers to establishing safety within this circle, despite the absence of White members. For example, code-switching is a survival strategy of suppressing oneself for the increased comfort of dominant groups when participating in such spaces (DiAngelo, 2018; Harris, 2019). For several of us, prior experiences with "safe spaces"' led to the suppression of our cultural identities. They were also marked by our acquiescence to *white fragility*, a state marked by the intolerance and defensiveness of White individuals when racial tension is present (DiAngelo, 2018).

These lived experiences and survival strategies created heightened weariness and anxieties during the initial phase of the circle development. We struggled to turn off the switch for vigilance to look for signs of rejection, mistrust, and dismissal. For example, T. Johnson, a Black member, voiced, "My experiences with previously identified racially shared 'safe spaces' allowed individuals of the dominant race to control the space." Equally, Lorenzo de la Peña, a White-presenting Latina, indicated that "[I felt like] the color of my skin [is] too white to be a member of the group – yet not being white enough or having too much of an accent for other spaces – [felt like] I didn't belong there either." Resurreccion, a

Figure 1. "Karens, Covid and Trump" (2020) (Watercolor paint, watercolor pencils, and markers, B. Taziyah)

Filipina/-American, also shared, "Though colleagues encourage me to speak in my own language even if they don't understand, I struggle to do so. This is not the circle's fault; rather, it is a triggered somatic response to historically participating in academic spaces, work cultures, and white-advantaged communities where I am expected to assimilate."

Connection and Empowerment Through Art Sharing

The circle consists of entirely unique BIPOC individuals with different ethnicities, ages, personalities, cultures, professional histories, intergenerational traumas, and environments, yet all of us voiced that sharing artwork illuminated how interconnected our lives were. We credited art sharing as a vehicle for feeling seen, heard, and supported; descriptions that BIPOC art therapists yearn for in the profession and graduate programs. Simultaneously, we expressed feelings of belonging from sharing our artwork along with an increased depth of intellectual connections while witnessing others share.

Emotional Support and Validation

All of us reported that the circle provided emotional support and validation such as: unconditional listening,

Figure 2. "NO (TAN) PEOPLE" (2021) (Pastels on Notan, A. Resurreccion)

exchanging advice with permission, giving encouragement, and accepting expressions in native languages. The validation process promoted healing from memories of being dismissed or perceived as overly sensitive when addressing negative racialized experiences. It also welcomed creative expressions, like notan, in unconventional ways not commonly explored in White-centered spaces (Figure 2). This cultivated opportunities to be witnessed as a "whole person" (the BIPOC and art therapist self together) and to avoid identity compartmentalization.

Vulnerability and Authenticity

We faced the vulnerability of full disclosure with caution, skepticism, and apprehension. Taziyah reflected, "Early on, I challenged the notion of trust and whether the women seemed worthy of me letting down my guard. I questioned their ability to handle my level of vulnerability or more importantly, I questioned myself: could I allow myself to be vulnerable?" Over time, we felt that the safe, supportive nature of the circle allowed us to be vulnerable and authentic. Figure 3 is an example of artwork that allowed our vulnerability to appear without the fear of being judged. In this embroidered piece, created on upcycled synthetic fabric and illuminated with mini-lights, the theme of self-care led R. Johnson, a Black member, to an expression of anger and woundedness as she realized how often her attempts at self-care have been sabotaged by microaggressions.

Widened Perspectives

Many of us described having a widened perspective as a result of the circle. The profession, group members' make-up (of students, graduates, professionals, and educators), reading and video materials, and reflective

Figure 3. "Self-care: hanging by a thread" (2021) (Embroidery on microfiber, R. Johnson)

artworks were described as areas to warrant a shift in perspective. Participation impacted our professional work, promoted non-Eurocentric practices of art therapy, and presented various roles to be explored in the field as a BIPOC art therapist.

Motivation to Make Changes Outside the Circle Meetings

Lessons from meetings prompted us to advocate outside of the circle. We frequently discussed efforts to negotiate for change within our environments, bring awareness to the lack of diversity in the profession, and apply new perspectives to clinical and personal practices. This supports the notion that creating autonomous space for BIPOC art therapists can increase motivation within the field and influence those who are most impacted.

Implications

The BIPOC Art Therapy Circle has been held to unburden us from shared experiences of oppression, frustration, and isolation of being the only member of a particular minoritized group among colleagues. Connection has been a recurring experience in reflections of the circle. Emotional support, validation, and art sharing empowered us to find relief and express ourselves authentically outside the circle. By releasing the burdens of representing, defending, and explaining lived experiences, we have felt free to attend, listen, and witness for each other. These nurturing experiences are consistent with Blackwell's (2018) reasons to advocate for BIPOC autonomous spaces. The BIPOC circle has become more than a place to release our emotions but a place for us to draw energy for our personal lives and professional work.

Reflective writings for this viewpoint indicate that we have positively influenced each other through shared experiences of vulnerability, authenticity, and widened perspectives. We have communicated complex, contradictory, and cathartic feelings through altered books, paintings, drawings, collage, mixed media, notan, embroidery, and clay throwing. Sharing stories, and experiencing one another's response art, helped us metabolize new insights and information about intersectional identities as a BIPOC art therapist and individual. Such experiences are consistent with how Fish (2019) described response art as an important tool for introspection.

Much like feminist generated social movements, our widened perspectives motivated us to make changes outside the circle meetings (Firth & Robinson, 2016). Response art functioned as a vehicle for our social justice efforts, which rippled real world impacts. We incorporated antiracism work by teaching and providing therapy, writing for public audiences, exhibiting social justice artworks, facilitating an Asian Healing Circle, leading an Open Studio Process workshop with a theme of race, and advocating for social justice in a school district. These unexpected gifts spurred members to continue participating and encouraging the formation of similar groups.

For those who seek their own version of this experience, we have several suggestions. Firstly, flexibility toward the establishment of the group and maintenance of participant wellbeing is the priority. Providing opportunities to share, step away, process, and return as needed allows members to maximize their personal healing and tend to personal challenges. This is encompassed by quiet reflection within a meeting as well as time away from them. Secondly, readings from non-scholarly sources provide a variety of evocative and resonant materials from which to make reflective art and spark lively discussion. For example, podcasts, videos, and personal essays are robust sources for antiracism material. These nonacademic sources can provide relief from dominant culture assumptions and framework. Thirdly, supporting each other through asynchronous means such as texts and emails can extend connections. Personal accomplishments, links to resources, and images of interest are valued touchstones to share between meetings. Lastly, it is

helpful to have an organizer. In our BIPOC circle, Goerdt initially provided continuity, grounding and organization for each meeting. Several months later, the circle transitioned to different members leading each month. In other groups, this model could be duplicated or shared in rotation by all members from the beginning. An organizer role, combined with a thematic structure, makes the scaffolding upon which, and from which, we have built a rich and robust vessel that continues to transform our cares and fears into energy, enthusiasm, and sometimes, joy.

Conclusion

The experience of the BIPOC circle confirms its critical importance as a support for cultivating authenticity, confronting stereotypes, and building trust among BIPOC art therapists and students. The formation and sustainability of the BIPOC circle echoes Johnson's et al. (2021) findings, showcasing the heightened level of comfort and openness in discussing racial topics of concern amongst BIPOC art therapists and students alike. Additionally, facilitating antiracist expression can clear the space of stereotyping and silencing that occurs in non-autonomous art therapy spaces. Response art sharing plays a significant role in connecting and empowering each other in this safe space, which resulted in social justice efforts and greater well-being outside of the circle.

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PEER SUPPORT: A THEORETICAL PERSPECTIVE

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This article offers one theoretical perspective of peer support and attempts to define the elements that, when reinforced through education and training, provide a new cultural context for healing and recovery. Persons labeled with psychiatric disability have become victims of social and cultural ostracism and consequently have developed a sense of self that reinforces the "patient" identity. Enabling members of peer support to understand the nature and impact of these cultural forces leads individuals and peer communities toward a capacity for personal, relational, and social change. It is our hope that consumers from all different types of programs (e.g. drop-in, social clubs, advocacy, support, outreach, respite), traditional providers, and policy makers will find this article helpful in stimulating dialogue about the role of peer programs in the development of a recovery based system.

In the mental health arena, the consumer movement seeks social justice through understanding mental illnesses in terms of human rights, the social suppression of difference, and treating differences through psychiatric diagnosis. The consumer movement seeks personal liberation and wellness in the context of recovery-based environments (Curtis, 2000). Through developing an understanding of oppression as a common theme among all of us with psychiatric labels, we discover the ways in which people have been marginalized by their culture, as opposed to seeing us simply as "insane."

Cultural Context

The cultural mainstream defines and decides ranges of "normal," seeking to have those of us with psychiatric labels blend into those ranges. People labeled with mental illness often fall outside the typical definition of "normal" and do not smoothly blend with the dominant culture. We, as users of mental health services, often referred to as consumers, are forced to understand our problems as solely a biological matter. This denies the social and environmental factors that may have precipitated or contributed to the distress. Having been marginalized by this model we have adopted roles as "mental patients."

Some of us have accepted this role, while others have not.

In general, people with perceived differences internalize the dominant cultural perception. This is true of the "mental patient" role in society, and is largely why we have a mental health industry. Yet, even in "insanity," there are "islands of clarity" (Podvoll, 1990). If we can pursue a broader discussion, if we can step outside of the box of the medical model, what we have revealed is that environments of health create healthy members and environments of illness create professional mental patients.

Early on in the consumer movement, Zinman and Harp (1987), made clear how pervasive the impact of the medical model was on mental health policy, on practice and research: our "problems" have been defined as diseases to be "treated" by professionals. This process tends to deny that other contributing stressors (e.g. abuse, poverty, loss, violence, and trauma) are factors. Perpetrators are thereby overlooked; children are overmedicated; and society ignores the culturally sanctioned epidemic of violence. For example, White (1995) writes, "these ways of speaking and interacting with people put them on the other side of knowledge, on the outside. These ways of speaking and acting make it possible for mental health professionals to construct people as the objects of psychiatric knowledge, to contribute to a sense of identity which has 'otherness' as its central feature" (p. 14).

Traditional research methodologies and hypotheses are founded on beliefs that we won't get over having a mental illness; we are only capable of "functional" healing as we attain certain socially prescribed goals—housing, job security, social integration, and so forth. There is no dialogue about wellness or about how we might exist, even thrive, within a culture that values and evaluates *our own* personal goals. If researchers would let go of methodology and epistemology that defines mental illnesses as a permanent disability, we could, through a dialectical evaluation of how people have recovered, explore the relationship of peer support and self-help to recovery. In this we could establish a new foundation for how we understand mental illness within the context of recovery. What peers know is that we can and do get well. We outgrow the role of "mental patient." This discovery came from the arena of peer support and advocacy, however, hence the need to understand and document the theoretical underpinnings of how this works in these environments.

At the same time peer support programs are developing, they must participate in the design of research and evaluation processes that are drawn from the rich evolving nature of what we are learning. Some of these research methods might include action research (Rogers & Palmer-Erbs, 1996); narrative research (Polkinghorne, 1988); ethnography Denzin, 1997); life story models (Hertz, 1997); empowerment research (Fetterman, Kaftarian, Wandersman, 1996); measures of "healing cultures" (Mead & Curtis, 2000), and quantitative studies that show patterns of recovery that challenge traditional prognoses (Harding, Zubin, & Strauss, 1992; Ralph et al., 2000). Internally, for the peer organizations, these methods could establish the benchmarks for quality and effectiveness that will support continued funding.

Defining Peer Support

Peer support is a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful. Peer support is not based on psychiatric models and diagnostic criteria. It is about understanding another's situation empathically through the shared experience of emotional and psychological pain. When people identify with others who they feel are "like" them, they feel a connection. This connection, or affiliation, is a deep, holistic understanding based on mutual experience where people are able to "be" with each other without the constraints of traditional (expert/patient) relationships. Further, as trust in the relationship builds, both people are able to respectfully challenge each other when they find themselves in conflict. This allows members of the peer community to try out new behaviors with one another and move beyond previously held self-concepts built on disability and diagnosis. The Stone Center refers to this as "mutual empowerment" (Miller & Stiver, 1997).

Peer support can offer a culture of health and ability as opposed to a culture of "illness" and disability (Curtis, 1999). The primary goal is to responsibly challenge the assumptions about mental illness and at the same time to validate the individual for who they really are and where they have come from. Peer support should attempt to think creatively and nonjudgmentally about the way individuals experience and make meaning of their lives in contrast to having all actions and feelings diagnosed and labeled.

Many people have learned roles that build a strong sense of identity as "mental patient." Because this becomes a primary identity we find a sense of affiliation with others who have also been labeled. Zinman (1998) refers to this as "client" culture. This "identity" leads us to the assumption that the rest of the community can't understand us and creates an "us/them" split with others. An imbalance of personal and social power lies at the heart of mental illness and is the cornerstone of the theory of recovery that we wish to present. Recovery lies in undoing the cultural process of developing careers as "men-

tal patients." We undo this by practicing relationships in a different way.

Peer support, therefore, becomes a natural extension and expansion of community rather than modeling professionalized caretaking of people defined as defective. As peers feel less forced into their roles as "patients," they naturally come to understand their problems in the larger social and political context from which they emerge, rather than pathologizing themselves. Peer support is a simultaneous movement towards autonomy and community building. It is not based in deficits model thinking. It is a model that encourages diversity rather than homogeneity, and recognizes individual strengths.

Finally peer support is not about "joining a club for the mentally ill." It is not a competition of stories or symptoms or about being rescued or infantalized. Peer support is an inclusive model that creates room for all people to fully experience "being who they are," growing in the directions of their choice and, in the process of being supported in these goals, begin to help restructure larger systems.

Historically many peer-run drop in centers have been "illness assigned" cultures in which people felt an affiliation based on their shared experience of having mental illness, being labeled, infantalized, oppressed, and marginalized. The assumptions about mental illness and the internalizations of "otherness" have significantly contributed to the cultural acceptance of "problems" as illness, or abnormal. We see ourselves in the role of the "mental patient" and learn to make meaning as defined by the roles that keep us feeling hidden and separated from others (Mead & Palmer, 1997). Being labeled, or even living with perceived unacceptable differences, creates a self-image or central belief, that controls the way we live, the way we think about controlling our behavior, and how we define and react to problems versus opportunities. It is the premise of this analysis that, in the context of mutually empathic relationships in peer support environments, we can practice seeking and finding new meaning and seeing ourselves as having personal worth and social power (Friere, 1995).

Relationships that heal challenge the need to hide and to use defensive, self-justifying explanations in social encounters. Peer support can and should contribute to the challenge, not foster collusion with roles that we have defined ourselves by in the past. At its best, peer support should begin a process of building "affiliation" but not end there. People have felt alone in their "otherness" for a long time, and need to practice "their new identities" within a context of safety and mutual support.

Affiliations are a property of a successful, dynamic society. Affiliation helps us see our commonalities and builds trust. It helps us understand each other as "whole" people with a range of experiences that are familiar and therefore acceptable. Without a sense of affiliating, many people build a dual identity of "other-than," and "acting as if." One woman who spends time at a peer center describes this:

> There was a time when things were totally out of control. I would just be alone in my apartment and be bombarded by the voices. I felt like there was nothing I could do but be alone and get through it. Then I got told that if I wanted to have visitation with my kids that I would have to have a job. Having a relationship with my kids was really important to me. I was terrified about having a job but I did it. I got a job at an art supply store. Every morning I would get up and go watch every move of the people around me, on the bus, at the store and on the way home. I would imitate whatever I saw other people doing, trying my best to make sure that nothing about me looked out of the ordinary. It was exhausting. I had everything in strict control. I knew, over time, that I had to reach a balance of being "out of control" and "being in too tight control (T. Thomson, personal communication, April 1996).

When new members of most peer programs first start attending, there is an obvious reluctance to engage in activities because of feelings of vulnerability. As in any community, feeling welcomed, learning the rituals and language are part of a larger process of building trust. When new members hear stories about types of situations that they've experienced, there is a sudden relief in knowing that they're not alone and that others share the same concerns. Caring is offered and received. Where we have felt isolated most of our lives, we begin to make friends and establish a sense of community. We build a deepening commitment and a willingness to share in community growth.

Although peer programs would like to think we act differently than other providers, however, we often run into the same quandaries around "managing" difficult, frightening behaviors. Often the focus of both peer centers and traditional services is on relaxing, "calming down," and avoiding conflict or stressful situations. When people behave differently they are sometimes categorized as "symptomatic," in need of more intensive services, or outside of peer jurisdiction. Even with training and dialogue it is hard to develop new cultural norms. In other words, the spontaneous reaction to a situation that makes us feel afraid is the need to take control. We develop an inability to explore or reevaluate someone's experience as his or her subjective experience; one that we are not comfortable with. An example of this might be a person with first

hand knowledge of hallucinations, feeling unable and afraid of another person who cuts themselves as a reaction to their abuse history. Another example is how we react to other peers in crisis by modeling how staff members in the hospital reacted to us when we were in crisis, even, for example, suggesting that a peer might think about increasing his or her medication.

Peer support training can help develop our ability to tolerate discomfort while we explore the dynamics of our relationships. It is helpful to understand what people's "hot spots" are, and the kinds of situations that feel comfortable, tolerable, or absolutely intolerable. Peer support is about normalizing what has been named as abnormal because of other people's discomfort (Dass & Gorman, 1985). Discovering this in a peer community reveals a different way of understanding our behaviors and presents an excellent framework to explore personal and relational change.

If we are truly committed to the development of peer programming, we must take the time to consider the kinds of programs that we will most benefit from. Traditional services have generally been reactive to crisis. Prevention based services, which is the larger category within which peer support services fit, should include an array of services that meet a continuum of needs (Biss & Curtis, 1993). In that context, it is useful to think of all the options really necessary to have effective peer-run programs. The use of warmlines, hotlines, peer programs, advocacy programs, outreach, mobile crisis teams, and respite are all necessary if we really want to help people grow out of their patient roles. The prevention based peer center may offer resources, groups, activities, and opportunities to give members a chance to rethink their ideas and beliefs about mental illness and move *beyond disability* (Mead & Palmer, 1997). Some of the resources might include:

- Strengthening self-advocacy (creating your own wellness and/or treatment plan, creating advanced directives, negotiating with your psychiatrist, ways of getting out of the payee system, etc.)
- Understanding the difference between advocacy "with" and advocacy "for"
- Developing advocacy and action skills for social and systemic change
- Practicing mutuality and reciprocity—building mutually empowering relationships, understanding conflict as a tool for relationships to grow
- Recognizing and diminishing codependency in multiple forms and guises
- Parenting classes for people trying to get back or keep custody of their children
- Working through the damaging effects of past or current abuse and violence (understanding the personal, relational, and political)
- Generating Wellness Recovery Action Plans (WRAP) which can help people strategize ways to stay well (Copeland, 1997)
- Offering alternative views and strategies for people who hear voices (Deegan, 1995)
- Creating music as a form of taking social action and a way to communicate difficult feelings (Mead, 1995)
- Developing a variety of social activities that break down isolation and help build community.

The above discussion has outlined the philosophical framework within which peer supports operate. Within that framework there are a number of concepts and values that have been identified over time by the actual process of "doing" peer support. The following section will attempt to specify what those concepts are, and then offer ways to put them into action in peer services and in training curriculum. These components can be useful to any aspect of peer programs but particularly important to peer support (e.g. warmline, hotline, outreach etc.) and peer supervision where these same guiding principles would be utilized.

From Concepts to Action

Concepts

1. Turning oppression into consciousness
2. Self-awareness and self-reflection
3. Creating dialogue
4. Understanding mutuality and reciprocity
5. Honest direct communication
6. Flexible boundaries
7. Shared power
8. Shared responsibility
9. Creating new ways of "making meaning"
10. Empathy and accountability
11. Respect that comes from your heart
12. Absolute belief in the recovery of everyone
13. Valuing community
14. Having fun
15. Not using symptoms as an excuse for bad behavior
16. Being held accountable
17. Mutual validation
18. Taking care of yourself
19. Giving and receiving critical feedback

20. Learning to work through conflict
21. Understanding of larger cultural and political issues

Action 1: Participatory listening. Participatory listening means that, rather than just listening to someone retell their story, the listener engages in a dialogue about the story and what it means (Rogers, 1999; White & Epston, 1990). The intent is to help a person develop a new sense of self in the larger social context of their peer community and hopefully in the general community in which they live. It requires an ability to take a fresh and critical look at oneself and each other, and an openness to examine both our strengths and weaknesses. Rather than continually justifying ourselves, tugging and pulling another person into our way of seeing things, we share our perceptions and our critiques without worrying about the "fragility" or the stability of the other person.

Many people get stuck in their need to feel safe and good about themselves and stunt their social success through protective behavior that avoids responsibility for personal actions and the effects they have on others. This dynamic gives rise to a number of problem behaviors that require confrontation, examination, and reform. Participatory listening creates a dialogue that pursues a mutual commitment to personal and social improvement (Friere, 1995). One begins by admitting that personal change is necessary and that one's peers will be able to assist in that process.

Action 2: Understanding perceptional frameworks: Story telling and the reconstruction of self. People have different ways of looking at the world. We each come from a context of community and family, or culture, that defines how we think about things, how we describe ourselves and ultimately, how we understand and live our lives (Gergen, 1991). The medical model is the dominant perceptual framework in the mental health environment. We have learned how to speak and think about our experiences within the context of that model. Because of this imposed way of making meaning we become unable to experience life to its fullest.

One of the ways that we can help each other to grow beyond the stereotypical identity is to examine the interior models that we have constructed. These models have shaped how we think about ourselves and how we perceive the world. Peer support environments help us to safely examine our assumptions about who we are and where we've come from by learning new ways of interpreting what has happened to us. Introducing people to the idea that we have "perceptual frameworks" is a key contribution to helping people get well. The following teaching metaphor is one way to help people revisit their self-concept and begin to change it into a more positive and fulfilling self-image (White & Epston, 1990).

The house as self. Each of us lives within a house. It has an outside that others see as well as an inside that no one else can see or fully know. Its basic framework is the physical, emotional and spiritual self that we are born with. Over the years, many changes are made to the house—both inside and outside. Its rooms become "decorated" by all the messages and experiences we've had. 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 plush rugs, attractive furniture, and a fireplace. If an important person comes into our life and gives us negative messages, the interior of our house changes. Often negative messages and fears are relegated to our "basement" where dark secrets are kept. More positive messages create upstairs rooms with windows and doors where it is more sunny, relationships are more transparent, and communication goes back and forth. Messages of "otherness" might create an attic.

Our perspective changes, depending on the view as we move from room to room. The view from the basement is different from the view from another room. If we spend too long in the basement we may find ourselves defining ourselves solely from that dark perspective, and even forget that there are other rooms in our house. Bachelard (1958) writes about this phenomenon in the following way:

> All inhabited space bears the essence of the notion of home. Whenever the human being has found the slightest shelter we see that the imagination build "walls" of impalpable shadows, comfort itself with the illusion of protection—or just the contrary, tremble behind the thick walls, mistrust of the staunchest ramparts. In short, in the most interminable of dialectics, the sheltered being gives perceptible limits to his shelter. An entire past comes to dwell in a new house (p. 5).

Furthermore no one can actually see the interior of our house. We can try to describe it to others, but language is not the reality (Gergen, 1991). We often use language as a way to recognize similarity and then 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 through the mental patient role.

Describing our "house" to another person is a broader description of our whole self—if we don't get stuck in one room or view (e.g. a negative identity). If we find ourselves stuck in one room, effective peer support environments can help us break out of this room and begin to explore the rest of our house

and the community in which it sits. If we think about our houses in the context of relationships, we see that we are constantly changing and reconstructing the house and the contents of its rooms, based on our interactions with other people and environments, and the meaning we attribute to our past and present experiences. If we think about our house as being in a neighborhood of similar looking houses, we can begin to understand how our "stories" about ourselves are embedded in the culture and language of the "neighborhood." This process dialog opens the "windows" to both self-exploration and to the deepening of relationships.

Action 3: Considering trauma worldviews: An alternative perceptual framework. Trauma worldview is one way that people have learned to be in a relationship. Those of us who have experienced trauma in the form of sexual and physical violence, don't trust, we blame ourselves as innately bad, we are afraid of conflict and we "act as if" in our relationships. Understanding the impact that trauma has had on our lives and relationships gives us an alternative perceptual framework and provides a more accurate context or understanding of the dynamics in peer communities.

Violence is a fact in our society. We implicitly and explicitly condone violence and then we blame the victims. Although the sequelae of violence and abuse are profound, mental health professionals have often either neglected to ask or have ignored the situation. Lately more educated professionals (with the help of domestic violence and sexual assault programs) are recognizing and understanding the long-term damaging effects of past violence. Questions like "what happened to you?" vs. "What's wrong with you?" are being asked in the more trauma informed systems of care (Bloom, 1997, p.191).

Peer programs are the natural resource to help synthesize our knowledge of domestic violence and mental health. Grass roots, advocacy, empowerment-centered peer organizations have long grappled with the labeling of oppressed groups and have focused on choice, rights, and systems change (Friere, 1995). Translating this philosophy into the development of trauma informed peer organizations is not a stretch. The difficulty is that many members of peer programs have been taught to think of their difficulties as mental illnesses and been treated with medications and offered no explanation of the correlation between past violence and current life difficulties. Consequently a parallel "dissociation" occurs as a result; a secondary level of abuse takes place. Often, the discovery that this has happened takes place in peer programs. Therein lies the opportunity to reeducate and liberate the individual from the place in their house where they have been imprisoned by society and from the coercive practices of the mental health system. Conversations and education about the extent to which trauma and past abuse impact self-concept, relationships, and community is a way to break down people's sense of victimhood—feeling responsible for making the abuse happen, incapable of mutually supportive relationships, or discomfort with their bodies. When we begin to speak the truth of our lives, express our pain, and find out the depth of the embedded messages common to abuse survivors, the language of symptoms is replaced by the deepening of personal relationships and our ability to advocate for a more politically astute mental health system.

Action 4: Accepting flexible boundaries. Boundaries are often cited in peer programs as an arbitrary construct for negotiating the terms of a relationship (Mead & Copeland, 2000). Rather than exploring each individual interaction and developing relationships, people have learned to set traditionally clinical boundaries when some situation might be difficult to negotiate. Being honest has long been associated with "hurting someone's feelings" or even getting in trouble. Clinical boundaries have been the model for what is "appropriate" in particular circumstances. For example, when asked in peer training if people would give out their home phone numbers to members they are being paid to serve, the response is often an emphatic no. We forget that the people we serve are also long-term friends we've been receiving and making phone calls to and from for years. Without these flexible and individually negotiated boundaries we perpetuate the power structure of a more formal professional relationship (Curtis & Dupre, in press).

Action 5: Building mutually empowering relationships through shared responsibility and shared power
Assumptions about power define the dynamics of any community. It is no different in peer communities. Many peer support center mission statements include statements about everyone being equal, with no one having power over anyone else. While fine in theory, there are often overt or covert hierarchies. Some members are considered staff, some supervisors to staff (directors), and some just members. Where there is money, and where there are titles, there are power differences, even if they are minimized. If this power dynamic goes unrecognized, it leads the community members to being less than honest and saying or not saying things from fear of retribution.

Many power inequalities are less visible than the ones to do with money and title. Some of these include: level of education, professional type job (or having any job), financial means, charisma, service level (e.g. person in an Assertive Community Treatment (ACT) team vs. someone no longer in the system), con-

fidence, and the more obvious ones such as gender, race, age, sexual preference, and background. In communities of people who have been marginalized, there is an embedded sense of powerlessness that goes unrecognized. Identifying and talking about power dynamics is a beginning step toward breaking them down.

This is also true for sharing responsibility in relationships. When one person is the "helper," it is often difficult to switch roles and ask the other person for help. Sometimes people are afraid to say what they really mean, because they worry about what the other person might do (for example, "If I say that, maybe he/she will get symptomatic ... commit suicide"). Shared responsibility is a fundamental operating principle for peer programs to maintain a nonclinical, growth-oriented philosophy.

Action 6: Managing conflict. Within all communities there are tendencies to faction or split. There are internal conflicts (ongoing internal self-criticism), interpersonal conflicts, and community conflict. Often our own internal conflict influences all the other types of conflict. If we are struggling with the internal turmoil that voices itself through negative messages, interpersonal conflict style becomes one of avoidance and submission. If the message is "if you don't win, you're dead," conflict can become a battle of wills and blaming. The form that this then takes is a covert conflict within the whole community, with the formation of cliques or factions that vie with each other for control and authority. Gossip becomes the main mechanism for communication, and the atmosphere becomes filled with tension. When conflict or difficulties arise we often fall back into old roles of silence and avoidance, or of power and control. For many, conflict is linked to stressors that lead to escalating symptoms and therefore, in the medical model, should be avoided. However, in this model, learning to confront conflict is a way of building and deepening relationships and community. It is an unavoidable dynamic, part of the real world, present in all programs, but people in peer support programs have learned how dangerous it is supposed to be and the potential results for engaging in it. Yet, if conflict is addressed proactively, people learn ways to negotiate, facilitate, and manage it. This approach moves beyond the medical model definition of struggle as symptoms to be avoided and leads to building respect, reciprocity, and tolerance for others (Shore & Curtis, 1997).

Action 7: Strengthening peer supervision, reflection and evaluation. Every peer program starts out with the best intentions. There comes a time, however, when conflicts arise, gossip is out of control, and communication and relationships at the center break down. Our communities tend to retreat to what we've known in the past. Peer supervision that transcends roles is helpful in revealing to the community how it self-destructs. Peer supervision needs to model the concept of reciprocity (everyone gives and receives critical feedback). Supervision helps the community learn to sustain its commitment to personal change. In addition, supervision can create a framework to begin the evaluation and long-term research needed to document how peer support works.

Self-reflection and critique are tools to help one another keep from defining any one way as "right." Being able to deliver and receive difficult messages, as common practice, maintains the peer support philosophy and supports the stability and integrity of the center and its community of members and staff. Fostering this level of mutuality, supervision assumes a proactive role in creating an environment in the peer support program that supports the dynamics for personal change described above. Supervision maintains the program philosophy and interpersonal skill building that enables the membership to deal with the fear, the conflict, and the power dynamics essential for our personal and social growth.

Results

Implications for the Future

We are developing peer programs at an exciting time in mental health care reform (Jacobson & Curtis, 2000). Warmlines are run in almost every region of every state, protection and advocacy groups are part of every system, and peer support respite programs (offering an alternative to traditional hospitalization), are starting to appear around the country. Peer support centers are emerging in a variety of forms serving diverse interests.

Unfortunately there is little funding for peer support services compared to other mental health care funding. Rarely, if ever, has funding for peer support services comprised even one percent of a state mental health budget. Peer centers are competing with each other for the little money states are willing to invest. Research dollars have not been allocated for examining the effectiveness of peer supports, and state government will remain reluctant to invest significantly until this approach has been validated by the mental health establishment.

We find ourselves in the same battles as any other competing organizations. As in any movement there will be "turf" battles and a struggle to develop the solidarity required to move the research agenda and achieve true systemic acceptance of the peer support model and thereby justifying its inclusion in state mental health care budgets.

If peer support programs can standardize their models, build them on effective

values and principles as we have described in this paper, they will draw more resources to each other, but they also will be a powerful voice in the future design of services. Already we've helped to reduce people's dependence on professional supports, learned effective ways to help people go back to school and return to work. We have helped many to learn how to stay out of crisis and thereby stay out of the hospital.

As an evolving culture, peer support has the opportunity to forge not just mental health system change but social change as well. As we eliminate the notion of "otherness" as deviant, and support each other in healing, assumptions must change (Aronson, Wilson & Akert, 1994). The focus of responsibility for healing and change will be on a culture that currently condones violence and supports homogeneity. Instead of social control, perhaps there will be social responsibility. It is at this level of change that peer programs must come together. It is at this level of development that "we can change the world."

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