Peer Support for Survivors of Childhood Sexual Abuse

A Comprehensive Review

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Contents

Introduction

Childhood sexual abuse (CSA) is a critical concern in Canada. Approximately 2.4 million Canadians reported experiencing sexual assault before they were 15 years old (Canadian Centre for Child Protection, 2018). The short and long-term impacts of experiencing such trauma are intrusive and pervasive, often including mental illness, compulsive coping, and social isolation (Blanch et al., 2012; Gregory et al., 2021; Nolin et al.,2020). Interventions designed to support the recovery and wellness of childhood sexual abuse survivors center around medical models that prioritize trauma-specific treatment such as EMDR or CBT (Blanch et al., 2012; McCormack & Katalinic, 2016). Although these treatments have been effective at improving trauma symptomology, they have done little to address or improve other aspects of the quality of life and wellbeing of those impacted (Blanch et al., 2012; McCormack & Katalinic, 2016). Shame, stigma, and social isolation play a large role in survivors' lives, impeding their ability to connect authentically with others (Goodwin & Patton, 2009). These impacts of trauma can be greatly improved through remediating experiences of social acceptance and belonging (Gregory et al., 2021). Trauma-informed practices are considered a best practice in working with trauma survivors (Blanch et al., 2012; Phillips et al., 2015). Although peer support models are rooted in trauma-informed values, the application of trauma-informed peer support in direct service to trauma survivors has not been adequately studied.

Peer support is a globally growing trend within addiction and mental health services that operates by the principles of the recovery philosophy (Cyr et al., 2016; Shalaby, 2019). It has recently received a great deal of attention for its success in creating experiences of social acceptance and belonging among individuals with mental health or addiction challenges. Making the Case for Peer Support (Cyr et al., 2016) defines peer support as social support and networking between two or more people with lived experiences of mental illness or addictions, that experience recovery through reciprocity. Although the literature acknowledges that not all peer support is centered around addictions and mental health, there is a dearth of information regarding other types of peer support services. Research offers evidence that peer support improves the quality of life and well-being of its recipients (Agarwal et al., 2019; Cyr et al., 2016; Gregory et al., 2021; Konya et al., 2020). The relationship between childhood sexual abuse, mental illness, and addictions suggests that peer support may be an appropriate and effective intervention for adult survivors of childhood sexual abuse.

Heartwood Healing Centre

In 1985, Women's Post Treatment Centre was founded to provide services to women who had experienced childhood sexual abuse and were struggling with compulsive coping behaviors. Now known as the Heartwood Healing Centre (Heartwood), the agency has expanded its

services to include all people over the age of 16 and has adapted how people access their services to foster self-determination through participant choice.

In 2019, Heartwood Healing Centre received funding from The Department of Justice Canada to develop a third stage program. Committed to feminist, anti-oppressive, trauma-informed, and participant-centered values, Heartwood interviewed past and present participants, staff, local community organizations, and agencies across Canada that provide services to adults who have experienced CSA to inform their re-imaging of services and development of the Stage 3 program. The desire for social connection, personal and professional growth, and greater accessibility was highlighted throughout participant feedback. Participants wanted a combination of traditional and alternative healing and support services. Among other modalities, art therapy, peer mentorship, and Indigenous programming were recommended, with requests for smaller groups with eligibility fixed to specific points of identity (such as age, ethnicity, gender, or sexual orientation). Consultations with staff indicated a commitment to building greater inclusivity, accessibility, and community connection through revisiting organizational practices and policies, establishing more inter-agency collaborations, and shortening waitlists.

Heartwood now offers three (3) stages of service in recognition of the non-linear nature of recovery and the varying needs of survivors on their healing journey. The first stage of services, Building a Foundation, is directed at supporting participant safety and stabilization through psychoeducation, short-term counseling, foundation building webinars, and resourcing. The second stage of Heartwood services, Reflect & Reclaim, is directed at supporting participants in exploring and processing trauma more deeply through long-term therapy of 2 years, processing groups, and alternative therapies. The third stage of services, Connect &Thrive, is aimed at connecting participants to family, community, and culture through workshops, community collaboration, and peer support. Connect & Thrive offers monthly gender specific support groups, monthly workshops, a transitional processing group for individuals coming to the end of their 2-year period of long-term therapy, a workshop for family members of CSA survivors, moving forward sessions, and peer support training.

Purpose of the Review

In the literature, the meaning of peer support has remained the same while its structure and implementation have been divergent. There are ongoing theoretical considerations, debates and issues surrounding peer support training and implementation for adult survivors of childhood sexual abuse.

This literature review aims to explore peer support development through a comprehensive review of issues relevant to the implementation and facilitation of CSA-specific peer support programming. I will define and describe peer support and its implementation as well as explore

existing peer support initiatives for survivors of sexualized violence to address gaps in research related to the development and implementation of CSA-specific peer support training and programming. Using a feminist trauma-informed lens, I will establish context for the relevance of peer support as an intervention for childhood sexual abuse survivors through a description of childhood sexual abuse, the impacts of such trauma, traditional treatment for adult survivors, and the barriers that survivors face in reaching out. Following a description of the definition, history, values, and models of mental health peer support, I will explore themes related to peer support service delivery for survivors of sexualized violence, specifically childhood sexual abuse, including subpopulations among CSA survivors, cultural considerations, service delivery models, peer support facilitation and the benefits and challenges of peer support implementation. Through a review of the literature on peer support, childhood sexual abuse, and peer support programming for survivors of sexualized violence, I will provide a foundation for the implementation of peer support training and programming for survivors of childhood sexual abuse.

About the Author

I am a lived experience researcher, social worker, therapist, consultant, advocate, author, and artist with a vested interest in the growth of trauma-informed, anti-oppressive peer support and other forms of lived experience leadership. As I immersed myself in the literature, I reflected on the testimonies of my peers as well as my own experiences as a survivor of multiple forms of gender-based violence who has been engaged in local and international peer support initiatives in the counter-sexual exploitation movement since before the professionalization of peer support in Manitoba.

Methodology and Limitations

This review was completed alongside the development of the Connect & Thrive program at Heartwood Healing Centre and was informed by informal consultations with staff and participants. Literature was provided by Heartwood Healing Centre as well as located in the University of Manitoba Library Databases and Google scholar.

Informal Consultations

Consultations conducted were very informal. Feedback was received through individual and group meetings following presentations made to all levels of staff throughout the organization including administrative staff, clinical staff, and leadership. Emerging data from feedback offered by participants of the piloted peer support training and peer support groups were also included in the review.

Literature Review

Literature was provided by Heartwood Healing Centre as well as located in databases (UM Library databases and Google Scholar) using the terms childhood sexual abuse and peer support. The searches were refined with the query string of lived experience, experiential, peer support, childhood sexual abuse, and childhood sexual abuse survivor. I later added sexual abuse, sexual assault, sexual violence, CSEC, sexual exploitation, mutual support, social support, and treatment which were terms taken from keywords identified in relevant papers. Articles that did not provide a comprehensive framework for understanding the impact and treatment of childhood sexual trauma, provide context to the origination and development of peer support, or offer insight into peer support programming for survivors of sexualized violence were removed.

Reviewing the literature was a heuristic process where I relied on tacit knowledge to direct literature selection. I leaned towards qualitative studies that included the voices, perspectives, or experiences of lived experience service users and service providers. In response to emerging data and periods of incubation, I reviewed an article about peer support supervision offered by the Canadian Mental Health Association's Centre for Excellence in Peer Support (2019) and explored the theoretical underpinnings of the use of self-disclosure as it is described in the literature. The strong, feminist values that have permeated the spirit of Heartwood Healing Centre since its inception led me to material that provided introductory insight into how self-disclosure in peer support aligns with feminist therapy. The inclusion of peer support as a framework aligned with the values of Heartwood Healing Centre as a trauma-informed organization. In recognition of the overlap in experiences of gender-based violence, the role of trauma in childhood sexual abuse, and the indiscriminate nature of childhood sexual abuse, I felt it important to include sources that offered insight into trauma-informed peer support for

various communities that addressed multiple forms of gender-based violence. Literature content included Canadian statistics on Indigenous peoples, sexual abuse, sexual assault, family violence, victimization, and sexual exploitation. Canadian and international studies were drawn to explore the impacts of child abuse, childhood sexual abuse, and trauma; trauma-informed peer support, sexual exploitation peer support, sexual assault and domestic violence peer support, and mental health peer support; and feminist therapy and peer support supervision.

Research revealed that there is very little literature on peer support for survivors of sexualized violence and even less specific to the experience of CSA. Of the 40 sources reviewed, 23 were Canadian sources, four (4) of which were based in Manitoba. Eleven (11) of the sources were related to the history, implementation, and facilitation of peer support. Four (4) sources were directly related to peer support for addictions and mental health including a large study with a sample population of over 600 Canadians and a study that focussed on peer support supervision. Six (6) sources were related to peer support for sexual violence survivors. Of those six (6), one (1) was conducted in the UK, where peer support has been in operation since the 1800s, offering the perspective of six (6) experienced non-peer practitioners that support peer programming, two (2) were Canadian, two (2) were specific to childhood sexual abuse/sexual exploitation, and two (2) were focussed on peer support for trauma survivors. The sources on peer support for trauma survivors were peer-informed and trauma-informed and one (1) focussed on the perspectives of peer workers with over 150 hours of training (including theory, practice, and supervision).

Excluding sources on Canadian statistics, there were 29 sources on sexual violence. Ten were Canadian and five (5) were directly related to peer support. Eighteen (18) sources were specific to CSA with seven (7) of those sources focused on child sexual exploitation. Of the sources related to childhood sexual abuse, three (3) focussed on the male experience. Three (3) sources focused on trauma-informed practice, one of which was a Canadian peer-informed handbook on service delivery to CSA survivors. The other two (2) included information on the impacts of trauma on various cultures and subpopulations, one of which was Canadian and the other gathered information on best practices from over 45 trauma-informed agencies that serve trauma survivors, including four (4) agencies that served a culturally specific populations (Indigenous, Latino, African American, and Asian).

Sources that were drawn on for information related to the relevance of peer support for survivors of CSA included Canadian statistics as well as literature that examined the relationship between CSA and substance use in women, the relationship between CSA and mental health, the nature and pattern of CSA by Canadian school staff members, a global comparative report on the nature of childhood sexual abuse, systemic reviews of sexual abuse and sexual assault, best practices working with survivors of sexual exploitation, a review of global reports of child abuse from 2000-2017, and the impact of and treatment among male survivors.

Canadian statistics were drawn from seven (7) sources and included information on reported child abuse and neglect, impacts of family violence and the consequences of family violence against children, Canadians who self-reported experiencing victimization before 15 years of age, reported incidences of online childhood sexual abuse, and the rates of abuse and violence experienced by Indigenous communities in Canada. Limitations to these sources lie with the understanding that these statistics are pulled from reported cases of victimization and that sexual victimization is vastly underreported. In addition, despite information related to these reports, these statistics were not specifically focused on childhood sexual abuse.

Sources used to address emerging themes were related to feminist self-disclosure and peer support supervision. Two (2) documents were used to explore the use of self-disclosure - one in which #Wetoo disclosure among survivors of sexual violence was described. This source was limited by its focus on cisgender survivors. A complimentary article, focused on peers recovering from eating disorders rather than sexualized violence, offered in-depth insight into the advantages and disadvantages of self-disclosure by recovered practitioners (de Vos et al., 2015). The latter document does not address reflective practice or evaluation however it offered perspective on issues unique to peer support workers to strengthen effective peer worker supervision.

Guiding Framework

Three (3) documents, Making the Case for Peer Support (Cyr et al., 2016), Engaging Women in Trauma-Informed Peer Support: A Guidebook (Blanch et al., 2012), and A First Step In The Development Of A Program Model For Male Survivors Of Childhood Sexual Abuse: Report Of Relevant Issued (Proulx et al., 2012) were used as a framework for this review.

The second edition of *Making the Case for Peer Support* (Cyr et al., 2016) was commissioned by the MHCC's Service Systems Advisory Committee to offer an in-depth look at Canadian and global peer support for those struggling with mental health or addictions. This extensive study engaged individuals with mental health problems in creating this report. In addition to Canadian and International research, government policies, evaluations, and other "grey" literature, it included focus groups and interviews with over 600 Canadians and surveys completed by 220 Canadians. This report described and advocated for peer support while offering recommendations on its implementation, funding, and support.

Engaging Women in Trauma-Informed Peer Support: A Guidebook (Blanch et al., 2012) was published by the National Center for Trauma-Informed Care. This guidebook is dedicated to the lived experience women who engaged in the research design and evaluation within *SAMHSA's Women, Co-Occurring Disorders and Violence Study (WCDVS)* and contributed to the development and delivery of public education and the provision of service intervention and

support. The guidebook offers comprehensive guidelines and considerations for the implementation of trauma-informed peer support across multiple sub-populations of women.

A First Step in The Development of a Program Model For Male Survivors Of Childhood Sexual Abuse: A Report Of Relevant Issues (Proulx et al, 2012) involved a literature review, interviews, and focus groups that were completed and documented to inform programming for male survivors of childhood sexual abuse. The findings guided the development of Heartwood Healing Centre's male-specific services, the first male-specific service of this kind in Manitoba.

Combined, these documents provide a framework for the implementation and delivery of intentional feminist, trauma-informed, recovery-oriented peer support for survivors of childhood sexual abuse. Additional articles provide context for the progression of mental health peer support, CSA treatment, and considerations for the delivery and implementation of specialized peer support for survivors of sexual trauma.

Childhood Sexual Abuse

Defining Childhood Sexual Abuse

The 1999 *Report of the Consultation on Child Abuse Prevention* (World Health Organization) defines childhood sexual abuse as "the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society". *Preventing, and Responding to, Sexual Exploitation, Abuse and Harassment (2017)*, defines sexual abuse as "the actual or threatened physical intrusion of a sexual nature, whether by force or under unequal or coercive conditions. Sexual exploitation and abuse include sexual relations with a child (18-years-old or younger), in any context (United Nations, 2017)."

In 2018, The Canadian Centre for Child Protection conducted a study identifying 750 Canadian incidences of sexual abuse within K-12 schools since 1998. As noted in this study, CSA can occur through contact and non-contact. Contact involves direct sexual contact with a child whereas examples of non-contact sexual offenses include activities such as watching a sexual act, being invited, lured, or groomed for sexual contact, or being exposed to sexual material (Canadian Centre for Child Protection, 2018).

Sexual exploitation, previously treated as a criminal act, was recognized as an act of child sexual abuse by law in Canada (Province of Manitoba – Families, n.d.) and has recently begun to be identified as such in the United States (Hickle & Roe-Sepowitz, 2014). In Canada, adults can be charged with sexual exploitation for sexual activity with minors under Section 153 (1) of the Criminal Code (MacKay, 2017). Sexual exploitation occurs when a child is offered drugs, sex, food, shelter, money, or other basic needs in exchange for the performance of a sexual act (Goodman & Laurence, 2014; Province of Manitoba – Families, n.d.). Research demonstrates that survivors of sex trafficking often report experiencing sexual abuse as children (Goodman & Laurence, 2009; Hickle & Roe-Sepowitz, 2014).

Prevalence of Childhood Sexual Abuse

People of all ages with a variety of cultural, vocational, educational, marital, and socioeconomic statuses experience sexual abuse as children (Schachter et al., 2008). A study that measured the worldwide prevalence of child maltreatment using self-reporting measures found that before reaching the age of 18, up to 20% of girls and 14% of boys would experience sexual assault (Moody et al., 2018). A 2014 survey of victimization revealed that about 2.4 million Canadians reported experiencing sexual assault before the age of 15 (Canadian Centre for Child Protection, 2018). Given that only 5% of sexual assaults in Canada are reported and online exploitation and abuse have been on the rise since the pandemic arrived in 2020, it is likely that this number is much higher (Government of Canada, 2020; Perreault, 2014). The rates of police-

reported cybercrime incidents and online child pornography in 2020 increased by over 30% over a period of 1 year and 6 years, consecutively (Government of Canada, 2020). Online child sexual exploitation and abuse in Canada includes pornography, sexting, sextortion, grooming and luring, live streaming of a child being sexually abused, and made-to-order content (Government of Canada, 2020). From 2014 to 2020, luring was the most reported (77%) online sexual offense against children with an identified victim. Over two-thirds of child pornography incidents involved creating or distributing it while almost one-third (32%) involved possessing or accessing it (Government of Canada, 2020).

The Indigenous Experience in Canada

Although only 4% of Canada's 33 million people are Indigenous (Cyr et al., 2016), Indigenous people are sexually assaulted at more than three (3) times the rate of non-Indigenous people (Perreault, 2014; Nolin et al., 2020). The magnitude of this statement speaks to the Indigenous experience in Canada.

The legacy of colonization and residential schools has had a pervasive and ongoing egregious effect on Indigenous communities (Schacter et al, 2008). Through colonization, Indigenous children were forcibly displaced from their homes and subjected to experiencing and witnessing multiple forms of abuse, including sexual abuse (Nolin et al., 2020; Proulx et al., 2012). The complex trauma of childhood sexual abuse, compounded by historical and intergenerational trauma, has had major consequences on the interpersonal health of Indigenous communities.

The Impacts of Trauma

Childhood sexual abuse is a traumatic experience that can happen to an individual once or multiple times, by one person or by several people (Gregory et al., 2021). Non-contact sexual offenses can be just as traumatic as those that involve contact (Canadian Centre for Child Protection, 2018). *Engaging Women In Trauma-Informed Peer Support: A Guidebook* (Blanch et al., 2012), describes trauma as "an external threat [that] overwhelms a person's coping resources (p.3)." In support of trauma-informed values, the authors are careful to emphasize that trauma is experienced differently by every individual and some people may be impacted by trauma without being conscious of the trauma (Blanch et al., 2012). Individuals may also be impacted by intersectional trauma where more than one form of trauma is experienced (Blanch et al., 2012; Konya et al., 2020; Schachter et al., 2008). Figure 1 shows a few types of trauma that may intersect. The severity of these impacts is influenced by several factors including the individual; the types of abuse; the existence, availability, and quality of supportive relationships; and the environment (Schachter et al., 2008; Sege & Browne, 2017).

Figure 1: Types of Trauma

- Emotional, physical, or sexual abuse in childhood
- Abandonment or neglect (especially for small children)
- Sexual assault
- Domestic violence
- Experiencing or witnessing a violent crime
- Institutional abuse
- Cultural dislocation or sudden loss
- Terrorism, war
- Historical violence against a specific group (as in slavery or genocide)
- Natural disasters
- Grief
- Chronic stressors like racism and poverty
- Accidents
- Medical procedures
- Any situation where one person misuses power over another

Blanch et al., 2012

Attachment and Internal Resources

Research indicates that the areas most impacted by CSA are social supports and internal resources while also asserting that the absence or lack of these protective factors is a strong indicator of possible instability in coping with the impacts of sexual trauma in childhood (Freyd, 1996; Goodman & Laurence, 2014; McCormack & Katalinic, 2016; Proulx et al., 2012). There is a relationship between CSA and insecure attachment (Proulx et al., 2012). This may be because children are most likely to be abused by someone they know. Almost three-fourths (74%) of the 750 incidences of CSA reported in Canadian schools involved contact and between 30% to 40% of Canadian sexual assault victims were abused by a family member at an average age of 9 years old (Canadian Centre for Child Protection, 2018; Canadian Centre for Justice Statistics, 2002; Trocmé et al., 2003). On the other hand, the average age of those victimized by non-family members was 12 years old and strangers were noted as the least likely perpetrators of sexual assault (Canadian Centre for Justice Statistics, 2002; Perreault, 2014).

When someone a child trusts and depends on abuses them it leads to a perception of the world as unsafe and themselves as untrustworthy. Freyd (1996) calls this "betrayal trauma." The disruption of emotional safety inhibits the ability to establish and maintain relationships (Blanch et al.,2012; Freyd, 1996; McCormack & Katalinic, 2016). Frustrated internal boundaries and difficulties identifying and expressing personal needs can lead to developing learned

helplessness and internalizing self-blame as shame (Blanch et al., 2012; McCormack & Katalinic, 2016). Betrayal trauma changes a survivor's way of thinking, their emotional experience, regulation capabilities, how they perceive themselves and others, and how they make sense of the world around them (Freyd, 1996; McCormack & Katalinic, 2016). Difficulties with memory, organization, and decision-making have been noted in those with a history of abuse (Proulx et al., 2012; Sege & Brown, 2017). The impacts of trauma can be pervasive and ongoing, affecting all aspects of the self, and varying in severity.

Figure 2: Factors That Can Increase the Risk of Insecure Attachment

- Male victim and perpetrator.
- Abuse by family.
- Ongoing, enduring, frequent, and severe abuse.
- Young age of victim.
- Lack of social support.

Altman, 2007

Although men and women process trauma differently based on issues related to attachment and identity, the literature is clear that both genders have difficulties with trust and intimacy in relationships as a result of CSA (Blanch et al., 2012; Nolin et al., 2020; Proulx et al., 2012; Wheatley, n.d.). Proulx et al. (2012) point to studies that indicate there are relationships between the occurrence of CSA and insecure attachments, post-traumatic stress disorder, personality disorders, and sexual behaviors among survivors. Figure 2 shows several factors that can increase the risk of insecure attachment among survivors of childhood sexual abuse.

Responses to trauma impact how an individual sees, conceives of, and talks to and about themselves in relation to their experience of victimization (Nolin et al., 2020; Proulx et al.,2012; Schachter et al., 2008). Following the terror and helplessness of experiencing childhood sexual abuse, survivors are plagued by shame, guilt, blame, anger, powerlessness, grief, betrayal, low self-esteem, and more (Proulx et al., 2012). Consequently, how they define themselves can become reliant on and reinforced by the perceptions and attitudes of others (Nolin et al., 2020; Proulx et al., 2012). Lack of identity, low self-esteem, and dissatisfactory social support systems contribute to creating the conditions for developing compulsive coping habits among survivors of childhood sexual abuse.

Compulsive Coping

The developing brain is injured by trauma in childhood in the same way that physical trauma injuries the body (Goodman & Laurence, 2009; Blanch et al., 2012; Sege & Browne, 2017; Proulx et al., 2012). These injuries contribute to mental health challenges, early death, suicide, and

compulsive coping through behaviors such as drinking, drug use, and risky sexual activity (Blanch et al., 2012; Gregory et al., 2021; Wheatley, n.d.).

Compulsive coping behaviors are strategies that victims of CSA rely on to help them survive the magnitude of the negative thoughts and emotions that have invaded their lives (Blanch et al., 2012). When responding to compulsive coping it is critical to recognize these behaviors as coping strategies and prioritize the importance of being non-judgmental while supporting survivors in establishing a repertoire of new coping skills to draw from. (Blanch et al., 2012; Sege & Browne, 2017; Wheatley, n.d.).

A study designed to allow CSA survivors to collaborate in influencing the delivery of health care led to the publication of a handbook intended to help Canadians who have no specialized training and limited experience working with survivors of CSA to be sensitive to their needs and the other types of interpersonal violence they may experience (Schachter et al., 2008). The handbook emphasizes that attempts to "fix" survivors can be experienced as paternalistic, isolating, and disempowering. "Healing from abuse involves re-empowerment and reconnection with self and others" (Schachter et al., 2008). It takes place within the context of safe and supportive relationships in which secure attachment can be modeled and experienced (Blanch et al., 2012; Schachter et al., 2008).

Self Harm

Self harm and addiction are two types of compulsive coping strategies highlighted by the literature (Blanch et al., 2012; Nolin et al., 2020; Proulx et al., 2012; Schachter et al., 2008; Wheatley, n.d.). Self-harming behavior stems from the need to manage the mental and emotional pain. That is another compulsive coping strategy survivors may use to manage extreme and overwhelming feelings (Blanch et al., 2012). Self-harm, also called self-injury or self-inflicted, is another compulsive coping strategy survivors may use to manage extreme and overwhelming feelings (Blanch et al., 2012). It involves cutting, punching, hitting, burning, or other intentional acts of harm to the body in areas such as the arms, legs, or abdomen (Blanch et al., 2012; Schachter et al., 2008). Self-harm is an expression of pain that can be misunderstood as a suicide attempt and as a result is more frequently met with judgment, dismissal, or paternalism than other compulsive coping behavior (Blanch et al., 2012). Unsupportive terms used by clinical staff to refer to self-harm include self-mutilation, self-abuse, and para-suicidality (Blanch et al., 2012). Suicidality is a risk for all trauma survivors, not just those who self-harm, and service providers need to know how to identify and respond to the warning signs so that space can be created to offer information, resources, and support with decision-making when necessary (Wheatley, n.d.).

In the context of peer support, Blanch et al. (2012) recommends prioritizing the creation of mutual relationships in which understanding the role of trauma within self-harming behaviors can shift the focus of service providers from fixing, stopping, or controlling compulsive coping

behaviors to becoming curious about the need that the behaviors are meeting for the individual. The authors insist that self-harm meets the needs of survivors in a myriad of ways. Service providers must be willing to build nonjudgmental relationships in which they encourage survivors to name the experience in their own way, engage in co-reflection with survivors to expand their awareness of the needs being met by the behavior, and explore future options for coping and recovery together (Blanch et al., 2012). Figure 3 shows some of the ways that women have reported using self-harm.

Figure 3: Ways That Women Have Reported Using Self-Harm

- To stop feeling pain.
- To calm myself.
- To make sure I am actually alive.
- To stop flashbacks or drown out voices.
- To go away, numb out, disappear.
- To ground myself, bring me back to reality.
- To punish myself.
- To talk to myself, get in touch with myself.
- To enter my own world.

Blanch et al., 2012

Addiction

Survivors of CSA may turn to substances as a coping mechanism. Phillips et al. (2015) point to a study of African American males that found higher rates of tobacco, alcohol, marijuana, cocaine, hallucinogens, and other such substance use among those who had survived childhood sexual abuse. Substance abuse can lead to other compulsive behaviors related to work, sex, and risk-taking (Nolin et al., 2020). Shalaby (2019) provided evidence that increased social support positively impacts one's motivation to recover from substance abuse. The Stages of Change, Motivational Interviewing, and Harm Reduction are the three (3) most common models of change within the addictions field and can be applied to support multiple areas of recovery from CSA such as health behaviors, eating patterns, and aggressive behavior (Proulx et al., 2012). These models of change fit within a recovery philosophy orientation, a core aspect of the success of peer support interventions. Further information on the recovery philosophy and its relationship to peer support is discussed later in this review. In the context of a trauma-informed approach to substance use, Phillips et al (2015) highlight a shift to harm reduction in which progressive contracts that honor and support the recovery goals of survivors are used instead of the system-imposed recovery goals and rules. This requires a "low barrier approach"

that can empathize with and respond to addictions related traumatic experiences. In peer support, these principles of engagement apply to supporting many aspects of the survivors' recovery including, or especially, in the area of mental health.

Mental Health

A 2002 survey revealed that over a 12-month period, more than 10 % of Canadians were impacted by mood, anxiety, or substance dependence conditions. Thirty-seven percent (37%) of these people reached out for professional help and 21% of the people that reached out felt that their needs were not met (Cyr et al., 2016).

Although there is minimal national Canadian data on the relationship between CSA and mental health, several sources within the literature suggest that trauma is a root cause of physical and mental health problems (Cyr et al., 2016; Hickle & Roe-Sepowitz, 2014; Lyon et al., 2015; Schachter et al., 2008). Other sources noted by Cyr et al. (2016) suggest that additional causes of mental health problems are inequality, deculturation, youth, and community fragmentation.

Literature related to CSA in general (Schacter et al., 2008), among males (Augusta-Scott, T., 2020; Nolin et al., 2020; Proulx et al., 2012), and within sexual exploitation (Hickle & Roe-Sepowitz, 2014) pointed to anxiety, depression, post-traumatic stress disorder, dissociative disorder, and suicide as common mental health challenges. Figure 4 lists some of the emotional and mental health consequences of childhood sexual abuse noted in the literature. Experiences within the mental health system can be traumatizing for survivors and have led to the recognition within mental health and addiction services that a shift toward trauma-informed care is necessary (Blanch et al., 2012; Cyr et al., 2016; Schacter et al., 2008; Shalaby et al., 2019).

Figure 4: Emotional & Mental Health Consequences of Experiencing CSA

- Emotional numbing
- Anger/hostility
- Passivity or aggression
- Need to please others
- Shame
- Guilt
- Hopelessness
- Low self-esteem
- Post-traumatic stress disorder
- Bipolar disorder
- Withdrawal
- Emotional dysregulation
- Flashbacks
- Dissociative identity disorder
- Hypervigilance
- Anxiety
- Increased suicide risk
- Fear
- Inability to trust
- Isolation, paranoid ideation
- Eating disorders
- Antisocial personality disorders
- Borderline personality disorder
- Somatoform disorder

Hickle & Roe-Sepowitz, 2014; Lyon et al., Nolin et al., 2020; Proulx et al., 2012; Schachter et al., 2008

Physical Health

There are also physical health consequences related to traumatic experiences such as childhood sexual abuse. Sexual health problems related to CSA include sexually transmitted infections such as Hepatitis B and C and HIV (Hickle & Roe-Sepowitz, 2014; Proulx, 2012). This can be related to experiencing sexual exploitation as well as later risky sexual behaviors (Hickle & Roe-Sepowitz, 2014; Proulx, 2012). Examples of how mental health impacts physical health can be found in the link between depression, insomnia, and coronary heart disease (Proulx et al., 2012). CSA survivors may also experience eating disorders (Proulx et al., 2012) and malnutrition (Hickle & Roe-Sepowitz, 2014). In addition, compulsive coping behaviors and mental health problems can contribute to physical health challenges. For example, compulsive coping such as substance use can lower immunity to disease and infection (Proulx et al., 2012).

In recognition of the multitude of mental and emotional challenges survivors face as a result of experiencing childhood sexual abuse, survivors need to have access to treatments that will counter negative identity formation, foster physical wellbeing, role model the emotional safety and interdependence of secure attachment, and encourage the identification and expression of personal needs.

Trauma Treatment

There is a lack of research on evidence-based treatment interventions for adult survivors of childhood sexual trauma (McCormack & Katalinic, 2016). Current treatments include individual and group counseling that address several issues such as eating disorders, grief and loss, stalking, sexual exploitation, sex trafficking, and surviving suicide (Phillips et al., 2015).

Mainstream Modalities

Models of treatment often used with adult survivors are Cognitive Behavioral Therapy (CBT), Dialectical Behavior Therapy (DBT), Exposure Therapy, Eye Movement Desensitization and Reprocessing (EMDR), Patient-Centered Therapy, Emotion-Focussed Therapy, Solution-Focussed Therapy, Mindfulness, Somatic Experiencing Therapy, Self-Regulation Therapy, and Sensorimotor Therapy (Blanch et al., 2012; McCormack & Katalinic, 2016; Phillips et al., 2015; Proulx et al., 2012).

Treatments for adult survivors have traditionally focused on supporting the survivor in managing their symptoms of post-traumatic stress however, due to the negative identity formation caused by complex trauma, post-traumatic stress-targeted treatments have been observed to have little effect on overall psychological functioning for adult survivors of childhood trauma (Freyd, 1996; McCormack & Katalinic, 2016). In the United Kingdom, a review published on non-pharmacological interventions for Post-Traumatic Stress Disorder (PTSD) revealed that, although helpful to a point, these interventions do little to support the additional physical, social, and emotional needs of trauma survivors (Gregory et al. 2021). McCormack & Katalinic (2016) suggest that although research points to trauma-focused Cognitive Behavioral Therapy (tf-CBT), and Eye Movement Desensitization and Reprocessing (EMDR) as the gold standard treatment for treating PTSD symptoms, these therapies are not proven to impact participants' sense of connection, quality of life, or emotional distress (McCormack & Katalinic, 2016). McCormack & Katalinic (2016) noted that studies have shown that the type of treatment modality chosen has little effect on the quality or quantity of improvements experienced by participants. The common experience, regardless of modality, is that of having space held for you to be seen, heard, and validated, all of which are experiences that occur within a relationship. This suggests that it is the quality of relationship developed that contributes to improvements experienced.

Furthermore, trauma survivors and individuals with mental illness have reported experiencing invalidating and traumatic abuse within mental health services where the medical model is adhered to (Blanch et al., 2012; Cyr et al., 2016; Phillips et al., 2015). The medical model emphasizes pathology and symptom reduction and focuses on the objective and impersonal evaluation and monitoring of symptoms (McCormack & Katalinic, 2016; Shalaby et al., 2019). Many of my lived experience peers in the CSA sector share how this reductionist approach

dehumanizes survivors and adds to their experiences of objectification. They disclose an internalization of shame that stems from a focus on what is "wrong" with them rather than on identifying and emphasizing root causes or the strengths with which they have supported their coping and resilience. Participants involved in psychiatric and mental health services felt that services often mirrored "the authority and power that had kept them at risk during childhood" (McCormack & Katalinic, 2016, p. 1035) and found formal services more inhibiting than any other supportive service (Cyr et al., 2016). It is likely that this is due, in large part, to the lack of trauma-informed practice within these settings. When highlighting the need for trauma-informed services, Blanch et al. (2012) explains, "Natural responses to threat can lead to patterns of relating to others that can be mislabeled in behavioral health settings or other systems. Staff may not be aware of the impact of trauma on survivors and may harm survivors by reinforcing their sense of powerlessness" (p.48).

Trauma Informed/Trauma Specific Modalities

Trauma-informed interventions are committed to understanding the mechanics and impacts of trauma and promote shame resilience through conversations and activities that "bring understanding to traumatic experiences rather than simply targeting posttraumatic stress symptoms" (McCormack & Katalinic, 2016 p. 1024). To provide quality care it is crucial for those who support trauma survivors to understand the impacts of trauma. Without this knowledge, compulsive coping habits and mental illness can be misinterpreted and left untreated. Blanch et al. (2012) highlighted this when they described how the behaviors associated with intimate partner violence (IPV) can be dismissed as 'mental illness'. Trauma-informed treatment is holistic and collaborative with emphasis on client-therapist partnership; co-creating safety plans with survivors; and including cultural, art-based, and wellness programming (Klinic Community Health Centre, 2008; Phillips et al., 2015; Proulx et al., 2012). This format prioritizes the voice and choice of survivors and honors the dominant themes in recovery that emerged in *Making the Case for Peer Support* (Cyr et al., 2016): the importance of recognizing people's agency, resilience, and resourcefulness and supporting their engagement in relationships or roles that added to positive perceptions, thoughts, and feelings about themselves. Failure to address these themes within program development and implementation can exacerbate the existing barriers that CSA survivors face in seeking support. Click on the links in Figure 5 to learn more about various trauma specific therapeutic models.

Figure 5: Links to Trauma-Specific Therapeutic Models

Trauma Recovery and Empowerment Model (TREM)

- https://www.cebc4cw.org/program/trauma-recovery-and-empowerment-model/detailed
- https://pubmed.ncbi.nlm.nih.gov/12474935/

Trauma Focused Cognitive Behavioural Therapy (CBT)

- https://www.samhsa.gov/resource/dbhis/tf-cbt-web-web-based-learning-course-trauma-focused-cbt
- https://www.samhsa.gov/resource/dbhis/trauma-focused-cognitive-behavioral-therapy-tf-cbt

Seeking Safety Model

- https://www.treatment-innovations.org/seeking-safety.html

Eye Movement Desensitization and Reprocessing (EMDR)

- https://www.apa.org/ptsd-guideline/treatments/eye-movement-reprocessing

Dialectical Behaviour Therapy (DBT)

- https://www.camh.ca/en/health-info/mental-illness-and-addiction-index/dialectical-behaviour-therapy

Dr. Judith Herman's Phases of Trauma Recovery

- https://trauma-informed.ca/recovery/phases-of-trauma-recovery/

Adapted from Phillips et al., 2015

Barriers to Seeking Treatment

In addition to wrestling with shame, worthlessness, disconnection, and powerlessness that stem from CSA, survivors experience many personal, relational, social, and cultural barriers to asking for help (Proulx et al., 2012; Schachter et al.; 2008; Wheatley, n.d.). Silenced by internalized myths and stereotypes, most survivors fear not being believed, being blamed for their abuse, or being punished by their abuser if they disclose (Schachter et al., 2008; Wheatley, n.d.). Disclosing to a peer who has had similar experiences can create a sense of safety and reduce shame. The research of McCormack & Katalinic (2016), expressly challenges the traditional medical model for adult survivors of childhood trauma in favor of a person-centered approach where "those who know" intentionally co-reflect with a focus on recovery, dignity, and acceptance.

Peer support is a holistic and collaborative model of intervention that highlights the voice and choice of participants while honoring existing strengths, resources, and resilience (Phillips et al., 2015). It is more commonly offered to those with medical conditions, addictions, and mental health but there are specialized peer support services that exist (Mead & McNeil, 2006). Survivors of sexual abuse and assault represent a diverse group with significant health needs, and peer led group-based interventions have positive psychological and physical impacts that offer evidence of the feasibility of such interventions for CSA survivors (Konya et al., 2020).

Peer Support

What is Peer Support?

Peer support is a globally growing paradigm that has been practiced in the United Kingdom, Canada, New Zealand, France, and the Netherlands (Shalaby et al., 2019). At its core, peer support is a hope-focused supportive relationship between people on a mutual journey of self-discovery, self-acceptance, and self-love who have survived similar experiences and are willing to learn from one another.

Within mental health and addictions services, peer support is described as a non-clinical social service provided by peers that humanizes treatment through "building relationships based on mutuality, shared power and respect" and supporting social and personal change (Shalaby, 2019, p.37). In this context, a peer is defined as someone with similar life experiences who can deeply empathize and can offer insights and encouragement (Mead & MacNeil, 2006; Shalaby, 2019). Mental health and addictions peer support has been offered within groups that serve people with shared lived experiences of mental illness, addiction, criminal justice involvement, older adults, youth and teens, medically and socially disadvantaged subgroups, persons with disabilities, and families across the world, including low and middle-income countries (Shalaby et al., 2019).

Among the literature on peer support for survivors of childhood sexual abuse, including sexual exploitation and sexual assault, peer support was defined as a non-hierarchal dynamic and flexible values-based approach that can be used in any setting to support the recovery and wellbeing of people from diverse backgrounds (Blanch et al., 2012; Phillips et al., 2019).

Within services for adult survivors of trauma, a peer is described as someone with a trauma history who supports others in understanding and re-authoring their trauma story through a process of relationship building, storytelling, sharing information and resources, and respecting the participant's right to lead their recovery process (McCormack & Katalinic, 2016; Phillips et al., 2019). Peer services for adult survivors of trauma have been offered through mainstream behavioral health programs, housing programs, the justice system, domestic violence shelters, resource centers and human trafficking and sexual exploitation support services (Blanch et al., 2012).

Cyr et al. (2006) claims that peer support for mental health and addictions promotes social inclusion and societal integration for individuals while re-engaging society in supporting individual and community resilience. For those who have survived sexual trauma, peer support has led to strengthened social functioning and quality of life (Gregory et al., 2021). Social action is a significant value for both mental health and trauma-informed peer support services (Blanch et al., 2012; Cyr et al., 2016). In their guide for trauma-informed peer support, Blanch et al.

(2012) take care to highlight how social action can benefit trauma survivors as an instrument for the reclamation of personal power that builds trust and cohesion within a community while channeling anger into action and transforming feelings of helplessness into agency. For trauma survivors, social action promotes recovery.

The literature recognizes the value of trauma-informed practices within peer support programming. Phillips et al. (2019) describe peer support relationships in which peers share their experiences, offer encouragement, share community resources, help explore options, believe in their peers, honor commitments they make to peers, acknowledge the feelings and opinions of peers, and encourage peers to do things for themselves. The intent of the relationship is for the parties to tap into their embodied, tacit wisdom and exchange knowledge in ways that foster connection through validation, normalization, and hope. Mead & MacNeil (2006) describe this as choosing "to say what we see (our perspective), what we feel, and what we need to build a connection" instead of evaluating each other (p.36). These principles of relationship fortify the core principle of the success of peer support- authentic relationships that provide the emotional safety to explore and grow from life experiences.

History of Peer Support

The history of peer support extends from the pre-colonial era to today. Cyr et al. (2016) suggest that we are in the third wave of three (3) major eras of peer support. This neglects to include the precolonial period and peer support in the 18th century and so I propose five (5) waves of peer support. An overview of these waves is shown on a timeline in Figure 6 and explained in the sections below.

First Wave

Before colonialism, Indigenous communities across the world practiced peer support. Many Indigenous communities viewed recovery as an ongoing, life-long process of noticing imbalance and regaining equilibrium (Hart, 2005; Nolin et al., 2020). Through sharing life stories, teachings, and reflections within sharing circles, ceremonies, and sweats, Elders held space for healing, learning, and connection (Cyr et al., 2016; Nolin et al., 2020). Western peer support mirrors these practices in their use of peer self-disclosure to teach and support as well as their engagement in arts-based activities such as singing, drumming, and crafts (Cyr et al., 2016).

Second Wave

Peer support also existed in Eurocentric societies in France, England, and Germany in the 18th and 19th centuries (Shalaby, 2019). The first known peer support service for mental health was the Lunatic French Society in England in 1845 (Cyr et al., 2016).

Third Wave

Making the Case for Peer Support (Cyr et al., 2016) references a wave in the 1930s with the establishment of 12-step programs such as Alcoholics Anonymous and Recovery International. Some of the earlier peer support groups were suspicious of leaders and organizations and refused funding from the government so that they could maintain the operation of a consensus-based model that avoided the hierarchal structure of managers, staff, and volunteer boards (Cyr et al., 2016).

Fourth Wave

Rooted in the desire for self-determination, the next wave started in the 1970s following a wave of unrest in which patients of mental health services rallied together to protest negative treatment due to limitations and inadequacies of the system (Blanch et al., 2012; Cyr et al., 2016; Mead & MacNeil, 2006). For example, women who were in abusive situations were considered over-emotional and dramatic and had higher rates of prescriptions for addictive medications (Blanch et al., 2012). It was around this time that The Vancouver Mental Patients Association established the first Canadian peer support service.

FIGURE 6: HISTORY OF PEER SUPPORT

Fifth Wave

The final wave of peer support, which we are said to currently be in began in the 1990s with the unfolding of the recovery philosophy and integration of peer support as a formal service within the mainstream mental health system (Cyr et al., 2016; Shalaby et al., 2019). The training and certification of peer support providers became critical to facilitating acceptance of peer support within mental health in Canada (Cyr et al., 2016). In 1997, The Mental Health Services Act of New Brunswick included a preamble that supported "less dependence on formal systems of care" and expressed the value of peer contributions to mental health (Cyr et al., 2016). This statement contributed to the growth of peer support in Canada.

Ontario, British Columbia, New Brunswick, and Québec have experienced the greatest

growth in Canadian peer support services in policy, funding allocations, and workforce development (Cyr et al., 2016). Canadian peer support programs have included various approaches, models, and styles of service delivery. A summary of the components of peer support programs in Canada is shown in Figure 7. Peer support continues to grow and diversify to meet the needs of specialized populations (Cyr et al., 2016). Suggested peer support roles for the future have included community health workers, peer whole health coaches, peer wellness coaches, and peer navigators (Shalaby et al., 2019). Cyr et al (2016) ask the question: "At what point along the continuum of helping relationship does the peer worker transition into a paraprofessional role?" (p.27).

Peer Support Delivery Methods

There are many ways to deliver peer support to trauma survivors and those with mental health challenges. Peer support groups can be focussed on activity, education, recovery, or a combination of each. Activity-focused peer support such as going to a film, volunteering, or participating in social activism together encourages cohesion, purpose, and belonging in groups. (Blanch et al., 2012). Education-focused peer support centers around topics of shared interest to the participants and engagement in reflective discussion (Blanch et al., 2012). Examples provided in the literature are study groups, book clubs, and discussing trauma recovery material (Blanch et al., 2012). Recovery-focused groups may be based on principles of 12-step programs, Recovery International, Double Trouble, and other models (Cyr et al., 2012).

Peer support groups can include but are not limited to, storytelling, listening, psychoeducation, tutoring, mentoring, activism, and advocacy, and can be delivered in-person, over the phone, or through the

Figure 7: Summary of the Components of Peer Support Programs in Canada

- A holistic and integrated approach to business development.
- Employability and mental health self-management.
- One-to-one coaching supplemented by group learning.
- Flexible, self-paced, self-directed, and participant driven timelines.
- A graduated approach to achievement of long-term goals.
- Public education and media.
- Advocacy.
- Education for people with mood disorders
- The opportunity to learn from peers to give and get support.
- Support to find food, clothing, and other essentials.
- Advocacy.
- Service co-ordination and referral.
- Education for members.
- Social and recreational opportunities.
- Support for consumers and survivors in contact with criminal justice.
- Harm reduction for drugs and alcohol.
- Community support.
- Gaining Autonomy with Medication (GAM) approach.
- A recovery clearing house.
- A leadership network of consumers/ survivors.
- Self-help recovery education.
- Recovery education for mainstream allies.
- Like Minds: Peer support education.
- Showings and discussions on Extra Ordinary People — an anti-discrimination documentary.

Cyr et al., 2016, p88-90

internet (Gregory et al., 2021). This section will explore some common methods in more detail.

Drop- in Peer Support

Drop-in peer support groups appear to have better outcomes among participants than other types of peer support groups. In an experimental study on peer-run services that took place in the United States between 1998 and 2002, three (3) types of peer support (drop-ins, mutual support, and education/advocacy) were examined by a research team that included lived experience and was led by a self-identified survivor (Cyr et al., 2016). Although improvements in quality of life, empowerment, hope, social justice, recovery, and social acceptance were evident for all participants of peer support, the greatest improvements were demonstrated by those who attended drop-in groups (Campbell, 2005). There is a gap in the literature about the efficacy of drop-in peer support groups for survivors of CSA. Further research is necessary to determine what method of service delivery is most effective for this population.

Mentoring

Mentoring, a core tenet of peer support, occurs informally in all peer settings but can also be done on an individual, formalized basis. Formal mentoring involves connecting peers in different stages of life and recovery to allow for role-modeling, co-reflection, and mutual growth (Goodwin & Patton, 2009). This approach to peer support is often offered to those who are new in recovery (Goodwin & Patton, 2009).

Online Peer Support

Internet-based peer support is an emerging method of peer support delivery that is worthy of mention. It can be conducted through videoconferencing, interactive websites, mobile technology such as texting, social media sites, bulletin boards, or emails (Cyr et al., 2016; Shalaby et al., 2019). It is most noted within peer support services for mental health, addictions, and trauma for its accessibility (Blanch et al, 2012; Cyr et al., 2016; Goodwin & Patton, 2009; Shalaby et al., 2019) and can be offered on its own or in conjunction with regular in-person meetings (Goodwin & Patton, 2009).

Online peer support increases accessibility. Shalaby et al. (2019) explain that participants are most likely to reach out in times of crisis. Blanch et al. (2012) suggests that accessing support remotely may decrease the discomfort of engaging in a new social environment. Although not everyone, especially people of certain ethnicities or income levels, have access to or uses the internet, research notes that online peer support can increase accessibility for those with disabilities, mobility challenges, or those who are living in isolated communities (Cyr et al., 2016; Shalaby et al., 2019; Goodwin & Patton, 2009). Goodwin & Patton (2019) suggest that participants accessing online peer support may experience anonymity, safety, and convenience in seeking support.

Concerns about online peer support noted in the literature revolved around connection and safety. Goodwin & Patton (2009) describe limitations to the depth of emotional support that can be established, the barriers to screening, the possibility of misrepresentation by attendees, and the potential for exchanging misinformation. However, Shalaby et al. (2019) cited studies that found online peer support was associated with improvements in mental health, medical self-management skills, quality of life, and the generation of hope and confidence in older adults with severe mental illnesses or chronic health conditions. It is believed that online peer support will continue to grow (Cyr et al., 2016).

Continuum of Organizational Engagement

The type of service delivery methods relies heavily on the level of organizational engagement as well as the values, mandate, and support of the organizations that they are engaged with (Cyr et al., 2016). Although this report does not focus on all levels of organizational engagement, I will briefly describe each for greater context and understanding of the diversity and flexibility of peer support.

The continuum of organizational engagement refers to the level of decision-making and governance a peer has within programming as well as the level of reciprocity, mutuality, and direct service that peer service providers are supported in providing to peer support recipients (Cyr et al., 2016; Mead & MacNeil, 2006). *Making the Case for Peer Support* (Cyr et al., 2016) identified four (4) frameworks for mental health peer support that overlap within peer-led services, peer-run services, and peer-informed services (Cyr et al., 2016). These services can be offered through mutual support or formal service provision by peers within independent, peer-operated organizations, grassroots self-help services, community services, or mainstream mental health organizations (Cyr et al., 2016).

Categorization of Peer Services

The authors of Supervising Peer Workers: A Toolkit for Implementing and Supporting Successful Peer Staff Roles in Mainstream Mental Health and Addiction Organizations (Phillips et al., 2019) state that peers may be engaged in peer support, self-help groups, or social enterprises. Peer-led, peer-informed, and peer-run are the three (3) main categorizations related to the engagement of peers within peer support services.

Peer-led services are often developed, coordinated, and facilitated by peers. At this level of organizational engagement, peers do not have true decision-making or governance authority within the organization or program (Cyr et al., 2016).

Peer-informed services, like peer-led services, are developed by, or in collaboration with, lived experience peers (Canadian Women's Foundation, 2014; Clan Mothers Healing Village, 2020; Cyr et al., 2016; Drabble, 2019). However, these peers may not be involved in the coordination

or facilitation of these services (Clan Mothers Healing Village, 2020; Cyr et al., 2016). As with peer-led services, these peers do not have true decision-making or governance authority within the organization or program (Cyr et al., 2016).

Peer-run services often involve independent operation by peers with full decision-making and governance authority within the organization. At a minimum, Blanch et al. (2012) shares, trauma-informed peer-run services are "governed by a majority peer board and receive government funding and/or private funding (p.16)." Within self-help groups (the purest form of peer-run services), peers have full decision-making and governance authority. Services are developed for peers, by peers, to meet self-defined needs and may occur in homes or public community spaces (Blanch et al., 2016; Cyr et al., 2016). Beyond self-help groups, independent peer-run organizations are emerging within non-profit and for-profit social sectors (Cyr et al., 2016). There are functional differences between peer-run services for mental health and peer-run services developed for other health and social conditions. Mental health services focus on advocacy and support whereas other services concentrate on emotional, informational, and assessment functions (Cyr et al., 2016).

Peer support services can be offered within independent, peer-operated organizations, grassroots self-help services, community services, or mainstream mental health organizations. The primary focus of this report will rest primarily on peer support services within the mainstream community and mental health organizations.

Mainstream Organizational Engagement

Mainstream mental health and addiction services are everywhere. Phillips et al. (2019) outline hospitals, primary care centers, community mental health organizations, treatment centers, as well as almost any non-profit or government service as some of the many systems that exist within mainstream health and addictions services. The best peer support initiatives were reported to take place in "small, non-profit, community or peer-driven agencies with a flat hierarchy and consensus-inclusive decision making (Cyr et al., 2016, p.74)". Peer support continues to adapt, transform, and evolve to meet the specific needs of diverse groups and in doing so has allowed for the emergent potential for new roles within peer support such as community health workers, peer whole health coaches, peer wellness coaches, and peer navigators (Cyr et al., 2016; Shalaby et al., 2019). Peer support efficacy appears to rely on the continuum of organizational engagement that peers are involved in. In *The Benefits and Mechanisms of Psychiatric Illnesses*, Moran (2012) described peer staff added as traditional services and peer staff delivering structured curricula as having better results than peers in existing clinical roles.

A peer can be engaged in mainstream services by working *for* them or working *with* them (Cyr et al., 2016). Working *for* mainstream organizations involves varying degrees of peer

partnership in which fiduciary responsibility lies with the organization. Control is shared and hybrid groups, where non-peer service providers have a significant and often dominant role, are provided (Cyr et al., 2016).

A vital component that is often absent or underemphasized within professional services offered by mainstream organizations is the empowered decision-making of service users (Segal & Silverman, 2002). This dynamic repeats itself within mainstream peer support services and extends beyond the service user to the peer provider. Those who work with mainstream organizations are sometimes called peer specialists or contractors that are hired as advisors, consultants, partnership liaisons, and peer support trainers or facilitators (Cyr et al., 2016). These positions are not open to any applicant and the essential requisite to working *with* mainstream organizations in this way is the willingness and ability to be straightforward and authentic in your self-identification and self-disclosure as a peer (Cyr et al., 2016). Studies suggest that peer workers and peer specialists both fall onto a continuum of lived experience leadership in which peer specialists have mastered the art of peer support through years of experience; education; and strengthened self-advocacy, self-insight, and self-care practices (Cyr et al., 2016; Stewart et al., 2022). In *Making the Case for Peer Support* (2016), respondents advised that peer specialists working inside mainstream agencies were made more vulnerable to alienation resulting from power imbalances and philosophical differences when they worked alone in a team of professionals (Cyr et al., 2016). This supports the suggestion by trauma-informed peer support researchers that peers in mainstream settings are confronted with opposition and obstacles in preserving the values of peer support due to misaligned organizational mandates and professional values or standards (Blanch et al., 2012). See Figure 8 for examples of inappropriate tasks that do not align with peer support values.

Figure 8: Appropriate vs. Inappropriate Tasks for Peer Support Workers	
Tasks Appropriate for a Peer Worker	**Tasks Not Appropriate for a Peer Worker**
The peer worker facilitates a group on self-care during which the peer worker shares their own strategies as well as missteps or what didn't work for them in a way that normalizes the importance of trying new things.	The peer worker is part of a staff compliment to a therapy group but does not use their lived experience as a means of relating group content to the participants.
The peer worker meets one-to-one with someone to discuss harm reduction strategies. The peer worker shares how in their recovery they found making safer choices to be scary and uncomfortable at first, validating the person's uncertainty about changing behaviours.	The peer worker is asked to hand out harm reduction supplies but not encouraged to discuss their own lived experience with substance use.
The peer worker is asked to drive a participant they work with to a doctor's appointment. On the drive to the doctor's appointment the peer worker and the participant discuss communicating with the doctor about medication side effects. The peer worker shares their lived experience of communicating with doctors about medication concerns.	The peer worker is asked to drive a participant to a doctor's appointment and wait in the parking lot. The peer worker does not know the individual and there is no intended ongoing connection between the participant and peer worker.
The peer worker leads a mindfulness group, drawing from their personal knowledge and interest in mindfulness practice. The peer worker discusses the role that mindfulness plays in their recovery.	The peer worker's program does not provide after-hours support to individuals. The peer worker is asked to check-in with a participant on the weekend because the peer worker and participant live in the same apartment building.
Taken from Supervising Peer Workers Toolkit (Phillips et al., 2019)	

Peer Support Models

The two (2) main models of peer support noted in the literature are Intentional Peer Support (IPS) and the Wellness Recovery Action Plan (WRAP). Both are commonly used models within peer support programming in Canada and around the world (Cyr et al., 2016; Shalaby, 2019). Researchers describe IPS as a theoretically grounded, trauma-informed philosophy and methodology that redefines the helping relationship as one of mutual learning and growth (Blanch et al., 2012; Cyr et al., 2016; Shalaby et al., 2019). WRAP is a self-monitoring tool designed to support symptom reduction, management, or elimination (Cyr et al., 2016). Other practice methodologies used with peer support are PACE (Personal assistance and community existence) recovery programs, recovery education curricula, self-stigma workshops, and user-led research projects (Cyr et al., 2016, p.55). Additional practices such as Cognitive Behaviour Therapy, mindfulness, and meditation can be incorporated into peer support programming as well (Cyr et al., 2016).

Where WRAP focusses on symptom management, IPS concentrates on social support. The theoretical and philosophical underpinnings of IPS align with feminist, trauma-informed values that promote recovery and resilience. As such, the philosophy, tasks, and principles of Intentional Peer Support will be used as the framework for exploring the values identified within other models of peer support.

Intentional Peer Support (IPS)

Intentional Peer Support (IPS) is one of Canada's most used peer support models and promotes trauma-informed and transformative relationship-building (Mead, 2014). It is underpinned by the recovery philosophy which emerged in the late 1980s in response to the grassroots ex-patient movement of the 1970s (Mead, 2014). Within peer support, recovery is a value shared by mental health and sexual abuse and assault initiatives (Cyr et al., 2016; Konya et al., 2020).

The growth of the recovery-oriented movement included three (3) major developments: an interest in the experience of recovery from service providers to service users, the increased use of peer supporters, and the change to a bio-psychosocial-spiritual model of personal growth (de Vos et al., 2015). In contrast to the medical model, this treats mental health holistically as a continuum of wellness, rather than pathologized, evaluated, and monitored as an illness (Cyr et al., 2016; Gregory et al., 2021). It prioritizes hope, self-determination, autonomy, and decision-making while acknowledging people are the experts and primary contributors of their own recovery (Cyr et al., 2016). Table 1, as presented in *Making the Case for Peer Support* (Cyr. Et al., 2016), compares tradition and recovery-based services. Recovery is both a journey and a destination for peers. It is the process of defining what wellness and recovery means on a personal level and then nurturing that wellbeing while learning how to live from a place of self-acceptance, self-examination, and self-adjustment (Cyr et al., 2016).

Table 1: Traditional vs. Recovery-Based Services			
		Traditional Services	**Recovery-Based Services**
Continuum →			
Beliefs	Views of mental health problems and illnesses	Pathology No meaning in mental health problems or illnesses	Crisis of being Full human experience
	Philosophy	Maintenance Paternalism	Recovery Self-determination
	Language	Focus is on language that is: • Medical • Objective • "They"	More focus on language that is: • Personal • Subjective • "We"
People	Service users	Passive recipients	Active agents and participants
	Families	Unsupported and grieving	Supported and supporting
	Workforce	Mainly medical Expert authorities	Diverse workforce incl. peers Collaborators
	Communities	Fearful and discriminatory	Accepting and inclusive
Services	Main service types	Drugs and hospitals	Board range of therapies, peer support, recovery education, housing, education and employment, support and advocacy
	Service cultures	Authoritarian Segregation from society	Participatory Inclusion in society
	Service settings	Hospitals and clinics	Community, home-based, and online services
Outcomes	Social networks	Service community	Natural community
	Housing	Hospitals, group homes, and other residential services	Own home
	Work	Pre-vocational services Sheltered workshops Unemployment	Real work for real pay A valued contribution to society
Taken from Making the Case for Peer Support, Cyr et al., 2016			

Peer support values, established by peers and researchers over time, guide the work of peer support providers (Cyr et. al., 2016). However, the underlying contributions and values of peer support that are inherent to, and likely adapted from, Indigenous peer support practices embedded within their culture have been omitted throughout this process. Further research exploring the parallels between the values, actions, governance, and outcomes of contemporary and pre-colonial peer support activities is required.

The values of IPS, encompassed by its principles, are related the tasks of connection, mutuality, worldview, and moving towards (Mead, 2014). It's three (3) guiding principles are learning and growing, caring for relationships, and hope-based relationships (Mead, 2014). The tasks of IPS and its principles are interwoven and overlapping. They are not linear in their delivery and do not fit neatly into one category because peer support is a fluid and dynamic process.

Principles of Intentional Peer Support

Learning and Growing

Learning and growing involves a commitment to discovery, learning from one another, and using differences as an opportunity to do so (Mead, 2014). Learning and growing is reflected by mental health peer support movements in *Making the Case For Peer Support* (Cyr et al., 2016) through valuing experiential knowledge, honouring the right to make mistakes, recognizing and valuing differences; encouraging independence and respect, consciousness raising, and critical learning. Mead & MacNeil (2006) describe critical learning as a process of co-reflection in which experiences are deconstructed and re-authored together, exposing the other person to a different perspective and new ways of thinking that allows new solutions to be identified. Critical learning is a process of examining, evolving, and expanding one's worldview through shared experiential knowledge that facilitates other ways of knowing. It is a critical aspect of the recovery process that allows for re-naming experiences, personal re-identification, and the re-authoring of trauma narratives.

Caring for Relationships

Caring for relationships involves nurturing communication, connection, respect, and dignity and finding ways to navigate discomfort in relationships (Mead, 2014). Research on sexual abuse and sexual assault peer support emphasizes the importance of integrity and trust in relationships with peers (Konya et al., 2020). Peer support providers have a responsibility to model peer support through an intentional practice of its principles and values. Although the concept of responsibility is unique to the principle of caring for relationships within peer support, caring for relationships encompasses all the values of peer support.

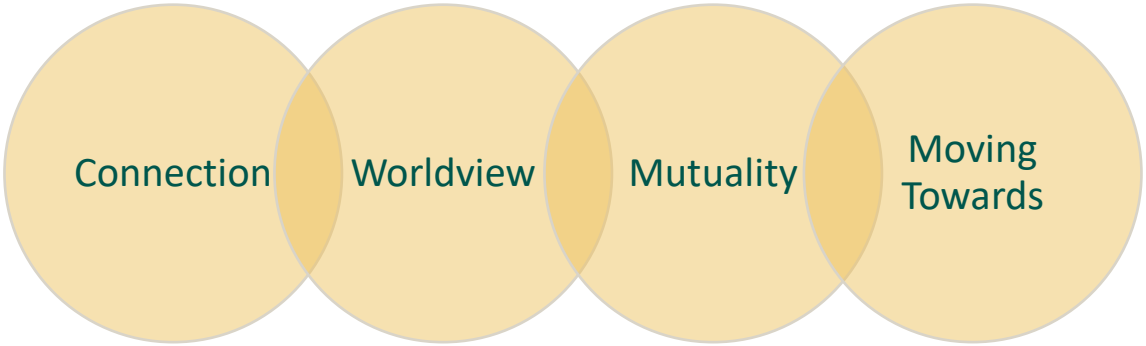
Hope-based Relationship

Hope-based relationships involve meeting each other where they are at, building trust over time, and exploring options for the future (Mead, 2014). The literature on peer support for mental health echoes this principle through values such as "respecting the rhythm of everyone," "empowerment" and "dignity" (Cyr et al., 2016). A hope-based value shared within sexual abuse and sexual assault peer support is the call to accept a person for who they are (Konya et al., 2020).

Tasks of Intentional Peer Support

Mead (2014) identifies four (4) tasks of IPS that guide service delivery connection, worldview, mutuality and moving towards (Figure 9). Attention to self-disclosure and the use of language are key practices in each of these tasks. In this section, a description of the values and purpose of each task and key practices in applying them will be discussed.

Figure 9: Tasks of Intentional Peer Support



Connection

The first task of IPS is connection, where peers focus on relationships by relating to one another's stories, pursuing shared interests, and navigating conflict to maintain a connection (Mead, 2014). Mental health peer support initiatives describe this with values such as social support and community identity, whereas trauma-informed peer support describes this as fostering appreciation between women (Cyr et al., 2016; Blanch et al., 2012). A review of sexual abuse and sexual assault peer support highlighted the significance of authenticity in peer service providers (Konya et al., 2020).

Worldview

The second task of IPS is worldview, where peers foster connection through openness to diversity and differences, questioning assumptions, and listening for understanding and discovery (Mead, 2014). In trauma-informed peer support, this is reflected through values that promote learning rather than problem-solving and respecting people's choices about how to describe their experience (Blanch et al., 2012). Empowering language is a key component of the worldview task.

Mutuality

The third task of IPS is mutuality, where peers share power and responsibility by holding space for each other and inviting engagement and participation (Mead, 2014). Mutuality is considered a key value for mental health, addiction, sexual abuse and assault, and trauma-informed peer support services. It embodies values that reinforce self-determination, are reciprocal, encourage sharing vulnerabilities and strengths, finding value in each other's support, and foster choice, including the voluntary use of peer support (Blanch et al., 2012; Cyr et al., 2016; Konya et al., 2020, Mead, 2014, Mead & MacNeil, 2006). Mutuality invites connection, sets the stage for worldview, and creates a foundation for moving towards.

Moving Towards

The fourth task of IPS is moving towards, where peers focus on co-creation, inspiration, and building a vision of the relationships and community that they want in their future. Values within peer support for mental health and addictions that support this task are focusing on strengths as opposed to weaknesses, addressing stigma and discrimination, and co-creating a limitless vision of hope (Cyr et al., 2016). Literature on sexual abuse and sexual assault peer support describes this as supporting the move towards wellness (Konya et al., 2020). Moving towards has a synergistic relationship with a connection that is intensified when authentic mutuality exists. Social action fits well with this task but it can also be accomplished through dialogue and arts-based or body-based activities (tools that may be useful for those who communicate with the body-based language of action).

Key Practices of Peer Support Delivery

Self-disclosure and mindful use of language are key practices in paving the way for connection, worldview, mutuality, and moving towards. For example, an important aspect of connection is the use of self-disclosure in peer relationships. Research demonstrates that experiential self-disclosure creates connection through demonstrations of empathy, trustworthiness, compassion, acceptance, and increased openness in sharing personal experiences (DeVos et al., 2015). This reduces power imbalances related to roles, humanizes peer providers, normalizes peer experiences, and role models peer support values of non-hierarchy. However, trauma survivors have learned to be alert to insincerity and pretense. Superficial sharing, absence of vulnerability, transparency, and authenticity will not clear the way for lasting and effective peer connections.

Lasting and effective peer connections rely on each person feeling seen and heard in the relationship. It is important to take time to understand how one another sees the world. Mental health and trauma-informed peer support researchers agree that language influences and communicates worldview (Blanch et al., 2012; Mead & MacNeil, 2006). For this reason, shifting language to talk about experiences instead of symptoms, exploring other worldviews, and being mindful of how language can hold us back in our recovery is encouraged and expected (Mead & MacNeil, 2006). These practices support mutuality and moving towards as well. Language with a non-clinical focus allows for greater connection between peers and exploration of the whole self rather than just the problem-in-self while honoring the unique and variable ways in which individuals experience their symptoms (Blanch et al., 2012). Recovered professionals reported that self-disclosure supported fast rapport-building and deep, insightful conversations that led to greater appreciation and understanding of worldviews as well as stronger knowledge of how to engage in the recovery of others (DeVos et al., 2015).

Everyday language creates a space for individuals to identify themselves beyond their victimization, facilitate community-based relationships rather than helping relationships, and

promote contextual understanding of individuals (Blanch et al., 2012). Within trauma-informed peer support, peers must be conscious that people may communicate through their actions and body language when they are not able to speak about their trauma (Blanch et al., 2012). Peers are encouraged to make space for that pain by using empowering, everyday language that supports all four (4) tasks in those moments.

Benefits and Challenges of Peer Support

Benefits

Peer support has many benefits. Peer support group participants experience a sense of validation from the self-disclosure of people who have experienced similar trauma (Konya et al., 2020). Peer support encourages authenticity; supports the identification and communication of thoughts, feelings, and needs; and engages peers in a practice of remaining mindful, self-compassionate, and hope oriented. It strengthens survivor's ability to identify when to step away or when to use supports and honor their story through owning their truth (Blanch et al., 2012; Cyr et al., 2016; Mead & McNeil, 2006; McCormack & Katalinic, 2016; Shalaby et al., 2019). Peer support can also help survivors identify, access, or navigate services and practitioners that engage in trauma-informed, sensitive practice with survivors of sexual trauma (Gregory, 2021; Wheatley, n.d.).

In their exploration of thirteen specialized peer support initiatives for survivors of sexual violence in Ontario, Goodwin & Patton (2009), found that peer support benefited survivors in many ways that could be measured in terms of symptom relief, recovery time, life expectancy, functioning, and psychological well-being. Benefits included empathy, confidence, interpersonal competence, and shame resilience. Recovery-oriented storytelling between peers increases social networks; encourages self-discovery; stimulates hope through role modeling; and expands knowledge of resources, strategies, and skills through shared experience and expertise (Goodwin & Patton, 2009). An article aimed at identifying the benefits and challenges experienced by participants of peer support initiatives for survivors of sexual trauma and abuse found that through hearing other people were able to adapt to the reality of their abuse, re-organize their sense of self, and re-conceptualize their core beliefs (Konya et al., 2020). Participants experienced greater identification, expression, tolerance, and self-regulation of their emotions and reported improvements in mental and physical health including exercising more and losing weight; enhanced harm reduction and coping practices; an increased ability to identify and address self-harming behaviors; strengthened self-esteem, self-respect, and self-care; healthier personal, social, and family relationships; and better parenting skills (Konya et al., 2020).

When peer support programs are implemented in alignment with peer support values, organizations, peer providers, peer members, and their community benefit from a return to

grassroots social and political empowerment that compliments existing health and social services; counters stigma; transforms services; promotes recovery and leadership; and improves social, emotional, mental, physical, and spiritual health (Blanch et al., 2012; Cyr et al., 2016; Gregory et al., 2021; Hickle & Roe-Sepowitz, 2014; Konya et al., 2021; Phillips et al., 2015). Peer support may be particularly beneficial for survivors of sexual violence and abuse. Goodwin & Patton (2009) state that "recovery takes place when physical and emotional safety exist in relationship [meaning] social relationships can be a source of healing (p.104)". Professionals working with sexual violence survivors have described peer support as potentially supportive environments where people have opportunities to develop friendships, share their experiences with others who understand, and create communities of admiration, support, and unconditional positive regard (Gregory et al, 2021, Konya et al., 2020). One youth member of a peer support group for survivors of sexual exploitation shared "I learned how to open up more and to share stuff I never told my therapist (Hickle & Roe-Sepowitz, 2014, p.108)". As participants experience increased safety and connection, they shared more intimate experiences of abuse, breaking the silence and expressing feelings in a process of reframing and normalizing what they had previously perceived as evidence of being irreparably damaged or abnormal (Hickle & Roe-Sepowitz, 2014; Konya et al., 2010). Furthermore, taking on meaningful roles and witnessing one another's recovery from a position of mutual vulnerability changed how peers viewed themselves and others, leading to increased self-respect, assertiveness, and boundary setting (Goodwin & Patton, 2009; Konya et al., 2020). These participants described being able to see their strengths, resources, and worth and gaining the strength and skill to challenge or walk away from abusive behavior. As peers evolve in their recovery, they may also become invested in contributing to the recovery community through working, providing outreach and advocacy, training others, engaging in anti-oppression and anti-racism, and promoting social change (Phillips et al., 2015). Several studies reported that survivors are emerging as leaders in their communities (Goodwin & Patton, 2009; Konya et al., 202; Phillips et al., 2015).

Challenges

There is a growing body of evidence that peer support can increase confidence, self-esteem, social networks, and a sense of community, in addition to leading to future employment however, challenges exist when it is embedded within existing services (Blanch et al., 2012; Cyr et al., 2016; Gregory et al., 2021; Mead & MacNeil, 2006; Phillips et al., 2019).

Self-disclosure and role modeling are implicit in the peer support role. Peer workers can have multiple roles within the community as service users, friends, staff, and volunteers. In many of these relationships, their traumatic history may be pre-disclosed by the nature and title of their role which are both inseparable, and necessary, to the role of peer support providers (McCormack & Katalinic, 2016). The blurred identity and relational lines of the peer support

role have led to questions about whether professionalizing the role is best for peer support promotion or attending to individual wellbeing (Shalaby et al., 2019).

Another challenge is the high risk of isolation for peer workers in mainstream organizations (Cyr et al., 2016). The authenticity and candor of peer workers can create discomfort for other staff, but it is vital to create spaces for peer workers where they feel safe to be themselves, ask for what they need, and practice self-care (Cyr et al. 2016; Philips et al., 2019; Wheatley, n.d.). Helping other staff understand peer support, building a relationship with the peer worker, supporting the peer worker in clarifying their needs or boundaries, and letting others know when the peer worker is having an "off" day or in need of support are some of the ways that this can be accomplished (Philips et al., 2019). When integrating into the mainstream mental health labor force, barriers include peers' past negative experiences with services affecting their current role as providers; feeling stigmatized or not treated as equals by non-peer colleagues; negotiating blurred boundaries; dual roles as providers and patients; and lack of consensus and policies on confidentiality and self-disclosure (Cyr et al., 2016). Challenges noted by a study that explored the risks and benefits of peer support work for survivors of sexualized violence were leadership, burnout, irregular attendance, low membership, dominating or controlling members, keeping the space safe or comfortable for members, misguided or inaccurate information shared among members, intense emotions that can become overwhelming for other group members, and being unwelcoming towards others (Goodwin & Patton, 2009). There is also the risk of going too deep or attempting therapy in groups, which is strongly discouraged due to the potential for interpersonal or intrapersonal conflict related to triggers or frustration with one another's a healing process among peers of varying stages of recovery (Goodwin & Patton, 2009). In my experience, burnout and compassion fatigue can be triggered in peers in the CSA sector who work to maintain the balance between being open to taboo topics and mindful of the potential to go "too deep" while simultaneously managing their exposure to the traumatic content without access to personal support or time for self-care.

Peer supporters who work in hierarchical settings experience unique challenges with program elements that may cause re-traumatization (Blanch et al., 2012). If the practices of their organization create unequal power, "peer supporters may encounter challenges in creating mutual relationships based on authentic, personal experience where power is shared" (Blanch et al., 2012, p.64). Researchers note that peer support principles sometimes conflict with ideas about what helping relationships are in traditional human service systems. Although peers are acknowledged for their insight into program development, decision-making often remains the privilege of non-peer staff (Gregory et al., 2021). Additionally, peers may be directed to take on tasks that conflict with peer support values (Blanch et al., 2012; Mead & MacNeil, 2006; Phillips et al., 2019). Peers without organizational support have difficulty opening up about conflict and refusing inappropriate duties. For example, there have been times in my career that I, or other

peers, have unsuccessfully addressed management of trauma-informed, feminist programs about the harmful practices that peer clients have disclosed and sought support with. These discussions were thwarted by management with a dismissiveness that was not conducive to creating safe spaces to explore or refine peer support practices. In fact, it is a practice in epistemic justice which I briefly define on page eighty-six of this review. To facilitate organizational support for the values of peer support, the creation of spaces where continuous open discussions about peer support duties, values, principles, conflicts, and concerns can take place is required (Phillips et al., 2019). Peer supporters need to navigate multiple viewpoints about recovery, peer support, and trauma while trying to help their organizations change their values and beliefs about healing and recovery (Blanch et al., 2012.)

Making the Case for Peer Support (Cyr et al., 2016) stresses the importance of management teams working in a spirit of partnership with peer workers, ensuring they feel respected. Trauma-informed supervision that is aware of the degree of emotional labor and risks of re-traumatization to the peer provider is a key element in establishing safety for peer providers (Blanch et al., 2012). Studies recommend that before implementing peer support programming, new policies and procedures that actively support peer support roles should be created to prevent role confusion and promote a team environment (Blanch et al., 2012).

Considerations for Developing a CSA Peer Support Program

Peer support for people experiencing mental illness has gained support in recent years but there is little evidence that peer support is also used for survivors of sexual abuse and assault (Konya et al., 2020). When considering the implementation of peer support for survivors of childhood sexual abuse, it is important to consider the relationship between CSA and the unique life stage, identity, and cultural factors of the population being served.

Childhood sexual abuse occurs at an alarming rate across the world, affecting males and females of all races, classes, and abilities. More than half of Canada's sexual violence victims are children (Government of Canada, 2001). Although there are similarities across populations, childhood sexual abuse is experienced differently within subcultures. Considering the worldview, cultural values, and discriminatory experiences of participants is key to creating spaces that welcome multiple worldviews.

Sub-Cultures Within Childhood Sexual Abuse

When offering peer support, it is important to understand, and adapt service provision to, how CSA may have impacted the circumstances, experiences, and needs of the populations being served. This section will review the unique sub-cultural circumstances and experiences of CSA among varying life stages and identities.

Life Stage

The following section will explore youth, including those experiencing sexual exploitation, parents, families, and elders.

Youth

Blanch et al. (2012) describes insecure attachments, relationship avoidance, and powerlessness as the consequences of experiencing trauma in the younger years while teen survivors may be susceptible to violence, date rape, and manipulation in relationships. According to *Making the Case for Peer Support* (Cyr et al., 2016), lived experience roles are critical to Canadian youth accessing support. This is important to understand because young people are least likely to reach out for help even though they are more impacted (Cyr et al.).

According to Hickle & Roe-Sepowitz (2014), group work is significantly effective among adolescents. In a review of ten (10) studies that examined the use of group work for girls who were sexually abused, Avinger & Jones (2007) found that group work provided a place where adolescents facing a sense of hopelessness changed perceptions about themselves and others. Group activity provides an opportunity for adolescents to engage in self-disclosure, receive affirmation from peers, and reduce isolation (Olson-McBride & Page, 2012).

Suggested activities for peer support for youth include counseling, advocacy, mindfulness groups, outings in the community (Phillips et al., 2015), and practical resources such as safe dating handouts (Blanch et al., 2012).

Sexual Exploitation

"Human trafficking is the fastest-growing criminal industry in the world" (Blanch et al., 2012)

Some youth experience CSA through sexual exploitation. According to Seshia (2005), more than half of sexually exploited women in Winnipeg were sexually exploited (80%) or sexually abused (52%) as children. Historically, victims of sexual exploitation were criminalized and stigmatized due to the perception that they were there by choice (Hickle & Roe-Sepowitz, 2014).

Neuropsychiatrist Bruce Perry (2006) describes the impacts of sexual exploitation by describing how trauma affects the "wiring" of the brain. As patterns of dysfunction are repeatedly experienced throughout development, the brain fails to detect these patterns as unusual and instead interprets them as normal. Our behavior is guided by how the brain detects these patterns (Perry, 2006). Perry (2006) also states that "As victims of commercial sexual exploitation regularly experience lifelong trauma, particularly childhood sexual abuse and neglect, some of the prevalent patterns that become normative are violence as a means of communication, deep worthlessness, distrust of people in positions of power and help, and a belief that the body is an object to be hurt" (p.79).

Youth who have been sexually exploited often do not reach out for help. In some circumstances, their families may have been threatened or they may not have the language to talk about their experiences (Goodman & Laurence, 2014). In other circumstances, they may perceive their traffickers as a family by choice or intimate partners, impeding their ability to recognize their exploitation (Goodman & Laurence, 2014). The trauma bond that forms can enable traffickers to manipulate, isolate, and abuse their victims for years or decades (Goodman & Laurence, 2014). Victims of sexual exploitation carry shame, trauma, and stigma with them throughout their lives (Goodman & Laurence, 2014). Hickle and Roe-Sepowitz (2014) noted that this stigma can appear in peer support groups as survivors compare their experiences with sexual exploitation using the standards of the sex trade culture that they have been conditioned to live by. These researchers share how facilitators in their study managed this by creating a space to understand and identify the commonalities present in their

experiences through discussions that were relatable to everyone such as emotional abuse or secrecy.

According to Goodman & Laurence (2014), beneficial services for survivors of sexual exploitation include basic needs, housing, medical care, counseling, substance use treatment, educational and vocational support, intensive case management, and healthy adult relationships and mentoring. The authors describe the model that drives the peer-based services of *Girls Education & Mentoring Services* (GEMS), an organization that has served victims of sexual exploitation since 1998, as a best practice. The GEMS victim, survivor, leader model "incorporates a variety of evidence-based practices and concepts built on two foundational principles - survivor leadership and transformational relationships which are gender-responsive, trauma-informed, strengths-based, culturally competent, developmentally grounded, and social justice oriented" (Goodman & Laurence, 2014, p.87). GEMS uses the Stages of Change model to tailor support to the needs of members and incorporate survivor input and leadership to ensure responsive services and programs. The program draws on peer support, mentoring, and role modeling to cultivate a family-like atmosphere and offers a member-identified approach to empowering the self-determination of members. Staff advocate on behalf of their participants, offers financial incentives to address barriers to engagement, and, where possible, use evidence-based programming (Goodman & Laurence, 2014).

Parents

As a parent who is a survivor of CSA, the actions of children can be triggering (Blanch et al., 2012). Part of a larger study aimed at developing an evidence base for trauma-informed services for survivors of gender-based violence recommends supporting the parent-child attachment (ARC model); providing services to survivors and their children at the same time; recognition of neonatal effects of trauma throughout life, traditional cultural ceremonies for families and communities; supporting the variant needs of pregnant women; and employing clinical models such as structural family therapy, dyadic play, and creative art therapy (Phillips et al., 2015).

Families

Participants of the *National Inquiry into Missing and Murdered Indigenous Women and Girls* identified family unity as central to the safety and well-being of individual Indigenous women, girls, and 2SLGBTQQIA people (Government of Canada: Public Services and Procurement Canada, 2013). Adults with or without children can also be affected by their families. Proulx et al. (2012) noted that for CSA survivors depression is more likely a result of dysfunctional or unsupportive communication with families. The same is true of mental health. Even when a family is trying to be supportive, they can still exacerbate the shame and stigma that survivors experience (Shalaby et al., 2019).

There is a paucity of research related to peer support for families of survivors of childhood sexual abuse. However, studies on mental health peer support demonstrate that 29 to 60% of caregivers who support someone with a mental illness experience significant psychological distress (Shalaby et al., 2019). Moral support was perceived as a substantial motivating attendance factor for relatives who are ill (Shalaby et al., 2019). Peer support involving families in India, Australia, Uganda, and Nepal offers information, produces positive results, and shows promise as clinical alternatives (Shalaby et al., 2019).

Elders

There is little evidence in the literature of peer support programming for the elderly in Canada (Cyr et al., 2016; Shalaby et al., 2019). Shalaby (2019) stated peer support for elders is effective in improving general and physical health, social functioning, depression parameters, and social support satisfaction, especially in socially isolated low-income older adults. The lack of peer support initiatives for the elderly, despite the rising numbers and needs of this population, was noted as a concern by researchers (Cyr et al., 2016).

Sexual Orientation, Gender Identity, and Expression

The following section will explore females, males, and 2SLGBTQQIA people.

Women

Western socialization of females increases their risk of traumatization and institutional invalidation. Women often face intersecting oppression and live with ongoing violence yet their symptoms of trauma are often dismissed as a mental illness in settings focused on the medical model of diagnosis and illness (Blanch et al., 2012). Females are socialized throughout their life development to believe that their value lies in their presentation to males as attractive, youthful, and innocent (Schachter et al., 2008). According to Schacter et al. (2008), normative female socialization conditions females to be submissive and may encourage accepting blame for negative adult interactions. Women and girls are more likely to experience abuse by those they know and trust, leading to difficulty developing meaningful relationships. “Sexual abuse may leave a girl believing that her sole value is as a sexual object” which can cause females to struggle with their femininity and sexuality (Proulx et al., 2012, p.19).

Blanch et al. (2012) explain that many traumatized women have been conditioned to be dependent and helpless or have learned to fight to survive. Hormones and situational stressors can trigger old feelings and memories (Blanch et al., 2012). Peer support providers support women with getting through these times by focusing on their strengths and survival skills (Blanch et al., 2012).

Men

According to Nolin et al. (2020), approximately 16% of Canadian men have been sexually abused as children. Males experience sexual abuse at a younger age than females, often

through physical force or intimidation by someone outside of the family and the absence of a father figure has been noted as a vulnerability factor in the sexual abuse of males (Proulx et al., 2012). There are two (2) pervasive myths about the rarity of CSA and the severity of its impacts on males that function as a barrier for men in disclosing their abuse and its legitimization as a problem (Proulx et al., 2012; Schachter et al., 2008). According to Proulx et al (2012), male disclosures are less likely to be believed and more likely to be ridiculed or minimized (Proulx et al., 2012). Schachter (2008) insists that the myth that males are not at risk and are inherently equipped to protect themselves as a by-product of their sex reinforces this issue and promotes the internalization of responsibility for their abuse.

Nolin et al. (2012) describe how the pleasure and arousal males may experience related to grooming and sex can cause them to internalize blame for their victimization. Men who have been abused by a woman are more likely to be promiscuous, sexually exploitive, and engage in risky and compulsive sexual behavior (Nolin et al., 2020). Sexual abuse can lead to confusion about sexual orientation and undermine confidence in their masculinity leading to hypermasculine behavior, addictions, aggression and violence, risky and aggressive sexual behavior, self-injury, a fear of abusing children, mistrust and discomfort with women, or involvement with the justice system. (Proulx et al., 2012; Nolin et al., 2020).

Studies have found that childhood sexual abuse is correlated with the mental health of male survivors (Proulx et al., 2012; Schachter et al., 2008). Nolin et al. (2020) share that, “for many males, anger is an emotional outlet for vulnerable emotions, such as fear, hurt and shame. The male gender role does not allow them to show these emotions, so they convert them into anger, which makes them feel more powerful and is acceptable within the male gender role” (p16). Men who are abused as children may experience shame, guilt, self-blame, feelings of violation, being “damaged goods”, anger, fear, guilt, shame, a sense of powerlessness, hopelessness, lack of control, a sense of betrayal, feelings of loss and grief, difficulties describing and expressing emotion, dissociation, avoidance, and anger (Augusta-Scott, 2020; Nolin et al., 2020; Proulx et al., 2012).

2SLGBTQQIA

A report commissioned by the Mental Health Commission of Canada (Cyr et al., 2016) highlighted the strong overlapping connections between mental health difficulties and queer identity when advocating for mental health and addiction peer support for this population.

According to the authors of *Engaging Women In Trauma-Informed Peer Support: A Guidebook* (Blanch et al., 2012), people who are two-spirited, lesbian, gay, bisexual, transgendered, intersex, or questioning can be targets of social discrimination, social and systemic marginalization, or violence stemming from societal fear and misinformation about sexual orientation. A handbook developed collaboratively with CSA survivors’ states that the self-perception and self-talk of survivors that are in same-sex relationships are often negatively

impacted by these experiences (Schacter et al., 2008). This can lead to compulsive coping behaviors such as substance use and eating disorders (Blanch et al., 2012).

Disabilities

A review of literature by the authors of the *Handbook On Sensitive Practice For Health Care Practitioners: Lessons From Adult Survivors Of Childhood Sexual Abuse* (Schachter et al., 2008) found that there is a higher risk of neglect and physical or sexual maltreatment among children with disabilities. Within Canadian mental health and addictions peer support programming researchers have emphasized that, despite the high rates of mental health among people with disabilities, there are barriers to experiencing the benefits of peer support. For example, peers may not understand the disability experience and accessibility to peer support information and venues are limited (Cyr et al., 2016).

Incarceration

Given the relationship between trauma, compulsive coping, and justice involvement, it is pertinent to note that peer support within criminal justice or forensic mental health services is nominal (Cyr et al., 2016; Nolin et al., 2020). Participants of the *National Inquiry Into Missing and Murdered Indigenous Women and Girls* state that the Canadian justice system does not reflect Indigenous culture or ways of restoration. They suggest redefining the justice system in terms of Indigenous laws and values of generosity, accountability, safety, caring, and responsibility to community (Government of Canada: Public Services and Procurement Canada, 2013). They recommend improved law enforcement practices, crime prevention, support for victims and survivors, restorative justice projects, revitalization of Indigenous laws, and rehabilitation and reintegration support (Government of Canada: Public Services and Procurement Canada, 2013). Nolin et al. (2020), in their development of a healing program for male survivors of childhood sexual abuse, suggest that recidivism will occur if the opportunity to heal from trauma is not provided while incarcerated.

Cultural Sensitivity & Humility

This section will explore how CSA is impacted by colonial, historical, and immigration-related trauma and explores culturally based practices that can be incorporated to support cultural sensitivity and humility.

It is essential to be sensitive to the various perceptions of faith, spirituality, and culture. Religious and spiritual practices can be tied to cultural identity (Blanch et al., 2012). For some, acts of spirituality can involve music, nature, art, fasting, acts of service, or prayer (Blanch et al., 2012; Nolin et al., 2020). For others, it may involve none of these. Spiritually oriented communities can be supportive in recovery, but they may also be harmful due to conditional acceptance, judgment, and stigma related to mental illness and compulsive coping behaviors (Blanch et al., 2012). The topics of faith, spirituality, and culture can be a source of peace or discontent for survivors, depending on the experiences of the survivor (Blanch et al., 2012). Some survivors may have been victimized by religious leaders or other trusted spiritual or cultural leaders and communities (Blanch et al., 2012; Nolin et al., 2022; Schachter, 2008). Trauma-informed researchers note that, although the childhood sexual abuse occurs in religious and spiritual communities, there is still a long history of religious and spiritual recovery practices, many of which are now called alternative coping strategies or relaxation exercises (Blanch et al., 2012).

Some people experience discomfort with these conversations, but peer supporters must practice remaining open to the beliefs of others and the meaning they find in their suffering with the intention of helping them discover the practices that are the most meaningful and healing to them (Blanch et al., 2012). Exploring these aspects of recovery can contribute to wellness and the creation of a culturally sensitive space where survivors can understand, accept, and grow from their past trauma (Blanch et al., 2012).

As part of peer support's connection and worldview tasks, it is important to understand the cultural history and perspectives of those being supported. This requires a commitment from the organization to support cultural sensitivity. Figure 10 shows examples of ways organizations can commit to cultural sensitivity. In Canada, colonial trauma, historical trauma, and immigration-related trauma compounds trauma related to CSA.

Figure 10: Examples of Organizational Commitment to Cultural Sensitivity

Cultural Competency Initiatives

- Committees
- Cultural competency training, including LGTQQI2S+
- Bilingual and bicultural staff
- Written materials and signage in common languages spoken by survivors
- Bilingual volunteers
- Language access lines
- Video phones for survivors who are deaf or hard of hearing
- Program wide language learning classes for staff
- Translators and interpreters who understood trauma
- Support for interpreters in managing their trauma responses
- Staff training on working with interpreters
- Culturally representation
- Ongoing trainees on issues important to the community
- Collaboration with Allied Partners
- Mission statements reflective of value and vision
- Cross cultural partnerships with local organizations
- Education and trainings to local agencies on the cultural background and experience of survivors
- Emphasizes choice at all times

Community Support

- Informal peer networks
- Resource sharing
- Programs where elders mentor younger survivors
- Wellness activities
- Social gatherings
- Provide community education
- Participate in ongoing prevention, advocacy, and social justice work

Community Feedback

- Identify gaps in services or unmet needs
- Engage youth elders and community leaders

Culturally Resonant Services

- Attention to how food is prepared
- Languages used
- Culturally based learning styles in teaching styles

Blanch et al., 2012; Phillips et al., 2015

Colonial Trauma

Indigenous people living in Canada experiences three (3) times more sexual violence than other Canadians (Perreault, 2014; Nolin et al., 2020). This is a result of the legacy of trauma, abuse, sexual oppression, and domination that colonization and residential schools ushered into Canada. In many Indigenous cultures, women and children were viewed as sacred (Nolin et al., 2020). This was disrupted by a system of colonialism that undermined the egalitarian, matriarchal values of Indigenous people while imposing patriarchal laws that demoted women to the voiceless (voteless) property of men and the state with no rights to their children or other property (Nolin et al., 2020). Through residential schools, Indigenous children experienced spiritual, emotional, physical, sexual, and mental abuse by priests, nuns, and other clergy staff members (Nolin et al., 2020; Schachter et al., 2008). The residential school experiences continue to affect survivors and Indigenous communities, collectively, and individually. These effects include distrust of others, aggression, isolation, and coping behaviors such as alcohol and drug abuse, past and ongoing physical and sexual abuse, low self-esteem, and suicide (Nolin et al., 2020; Schachter et al., 2008). Forty-two percent (42%) of non-Indigenous people in Canada have experienced a sexual or physical assault (Perreault, 2022). Among Indigenous people this number rises. Sixty one percent (61%) of First Nations people, 64% of Métis people, and 51% of Inuit people reported experiencing at least one sexual or physical assault in their lifetime. (Perreault, 2022). Furthermore, Indigenous CSA survivors in Canada reported nine (9) times more criminal victimization as adults than non-Indigenous CSA survivors (Heidinger, 2022).

Indigenous cultures revolved around values of community, generosity, and the interconnectedness of all things to the Creator (Nolin et al., 2020). Researchers on Indigenous survivors of CSA explain that “healing is a cultural practice that involves working to improve well-being in the face of challenges, trauma, difficulties, sorrow, and distress. It involves a balance of all aspects of the self, but begins with the spiritual” (Nolin et al., 2020, p.21).

Culturally based programming includes groupwork (Nolin et al., 2020). Peer support is a healing practice that relies on social support grounded in values of community, generosity, and interconnectedness. Social support (community) can reduce stigma and shame related to colonial trauma however it is crucial for such approaches to focus on strengths, generosity, and the importance of each person's contribution to the wellbeing of community, humanity, nature, spirit, and the universe (interconnectedness) (Nolin et al., 2020). Focussing on these aspects can help to counter the internalized racism and negative concepts of self and the community that colonialism has perpetrated (Nolin et al., 2020). This focus fosters an appreciation of the richness, depth, strength, and resilience of both them and their communities (Nolin et al., 2020).

Historical Trauma

Maria Yellow Horse Brave Heart defines historical trauma as "cumulative emotional and psychological wounding over the lifespan and across generations emanating from massive group trauma" (Blanch et. al, 2012 p.26). Historical trauma has been experienced by Indigenous peoples across North America, families of Holocaust survivors, and descendants of enslaved Africans, to name a few (Blanch et al., 2012). It is essential to understand the connection between structural racism, historical trauma, health disparities, and high rates of interpersonal violence within communities when delivering trauma-informed services (Blanch et al., 2012; Phillips et al., 2015). This includes understanding how forms of trauma intersect in the lives of survivors collectively as well as individually (Phillips et al., 2015). In their study involving 45 trauma-informed programs, 19 of which were culturally based or refugee-directed, Phillips et al. (2015) share how “in one program, women who previously participated in a group for survivors have emerged as leaders in providing outreach on historical trauma, healthy relationships, and domestic and sexual violence” (p.16). Trauma-informed researchers in gender-based violence services recommend that services designed to attend to the impacts of historical trauma include culturally based practices, foster women’s matriarchal relationships, and support survivors to understand the effects of historical trauma on family functioning (Phillips et al., 2015).

Immigration-related trauma

Cultural dislocation often affects refugees, immigrants, and other displaced people with greater trauma than they experienced in their countries of origin (Blanch et al., 2012). Researchers insist that access to peer support groups and other opportunities to build relationships is pertinent to the social learning, connection, and belonging of those experiencing immigration-related trauma (Phillips et al., 2015). The National Centre for Domestic Violence, Trauma & Mental Health’s report on promising trauma-informed practices for survivors of gender-based violence noted that the effects of wrestling with trauma are compounded by lack of access to resources; fear of deportation; language barriers; isolation from family, community, and culture: and lack of information and understanding about their legal status or rights (Phillips et al., 2015). Research suggests that these survivors are best supported through outreach, advocacy, and education on their legal rights, immigration status, immigration laws, and support with immigration documentation, including personal identification (Phillips et al., 2015).

Incorporating Culturally Based Practices

Cultural considerations are a critical factor in the delivery of peer support services. The Indigenous origins of peer support are reflected in the beliefs of the peer support community. Phillips (2019) shares that “Peer support is grounded in the belief that everyone has personal

medicine and works in collaboration with traditional medicine" (p.14). However, racialized communities often have invalidating experiences within the medical system, their own communities, and from peers belonging to dominant cultural groups (Cyr et al., 2016). Furthermore, different cultural values can act as a barrier. Blanch et al. (2012) states the cultural significance of group identity can be a big part of the relationship between one's individual story and the story of the group. Hence, the individualism of western values can deter people from attending (Blanch et al., 2012; Cyr et al., 2016). The peer support movement has recognized that it does not represent racialized service users and must develop race equality, anti-discriminatory, and culturally responsive practices (Cyr et al., 2016). Although the literature did not specify the need for peer support workers to share the ethnic or cultural background of the peers they serve, it did strongly recommend the incorporation of cultural practices and, in Manitoba, recommended the engagement of Elders (Nolin et al., 2020; Phillips et al., 2019).

Cultural practices are central to healing in many cultures. Nolin et al. (2020) assert that healing experiences that use cultural approaches are integrated better, increase positive emotions and resilience, decrease suicide rates, increase responsibility to others, and reduce substance use and abuse. Challenging assumptions about culture and transforming the group to match the wellness beliefs and practices of those being supported is key to culturally responsive healing (Blanch et al., 2012).

According to participants of the National Inquiry, First Nation, Métis, and Inuit communities of Canada view access to culture as a fundamental right, basic need, and an essential priority to reduce risks of violence and support well-being (Government of Canada: Public Services and Procurement Canada, 2013). Culturally informed organizations are guided in their work through turning to the land, languages, and cultural teachings as sources of strength, healing, and guidance. New models for mental health and healing must be developed in ways that acknowledge the relationship between physical and mental wellbeing, community ties, and the safety of Indigenous women, girls, and 2SLGBTQQIA individuals (Government of Canada: Public Services and Procurement Canada, 2013).

National researchers recommend the inclusion of traditional and culturally based practices and the intergenerational sharing of cultural knowledge by Elders in peer support (Government of Canada: Public Services and Procurement Canada, 2013; Phillips et al., 2019). In Manitoba, researchers echo these recommendations, asserting that Indigenous teachings, ceremonies, and Elder or knowledge keepers be included in group healing sessions (Nolin et al., 2020). Figure 11 identifies some ways to involve Elders when including culture in peer support and encouraging peers to explore their history.

Figure 11: Ways to Involve Elders

- Teachings on origins, history, and traditional beliefs
- Rights of passage for life cycle events
- Traditional art, music, dance, and crafts
- Traditional healing practices and medicines
- Spiritual or religious practices
- Sharing language

Nolin et al., 2020; Phillips et al., 2015

The medicine wheel was also noted as a significant Indigenous healing tool. The medicine wheel highlights a balance between intellectual, emotional, spiritual, and physical wellbeing (Schachter et al, 2008). In relation to the Indigenous concept of this balance, researchers speak of an inner balance and an outer balance, sharing that inner balance is about self-understanding and acceptance of vulnerability whereas outer balance is described as connection and peace with others that stems from empathy, compassion, and consideration for the healing journey that all human beings are on (Nolin et al., 2020).

Recommendations for Implementation of a CSA Peer Support Program

Many people have felt harmed by the mental health system and are hesitant to engage with it (Cyr et al., 2016; Schacter et al., 2008; Shalaby et al., 2019). Peer support workers can function as a bridge between survivors and traditional services. In this exploration of the implementation and facilitation of peer support for survivors of childhood sexual abuse, the models of service delivery used, recruitment and intake, and facilitation were important considerations. A trauma-informed approach is necessary for this population. In alignment with this approach two (2) major themes emerged: organizational support and peer provider wellness. Organizational support and peer provider wellness are the foundation of quality peer support provision for survivors of childhood sexual abuse. In these next sections, I will discuss current service delivery models, participant recruitment, effective peer support facilitation, organizational support, and peer provider wellness followed by recommendations related to the implementation of CSA.

Service Delivery Models

Survivors need a specific space to talk about their sexual abuse despite other treatments available for addictions, mental health, and compulsive coping behaviors (Hickle & Roe-Sepowitz, 2014). Service delivery models determine the quality of the space survivors are invited to engage in. Among survivors of childhood sexual abuse, including sexual exploitation, trauma can lead to disconnection and feelings of guilt and shame (Blanch et al., 2012; Hickle & Roe-Sepowitz, 2014). These messages are often supported by societal attitudes that support rape culture and impose responsibility for victimization on the survivor (Blanch et al., 2012; Hickle & Roe-Sepowitz, 2014). They become internalized, affecting self-image and self-worth. It is imperative for services to recognize that sexual abuse impacts many aspects of people's lives (Gregory et al., 2021). For this reason, trauma-informed and sensitive practices play a crucial role in creating a space for the safety, connection, and recovery of survivors of childhood sexual abuse. Two (2) models in the literature, the trauma-informed model and Sensitive Practice, offer a framework for the delivery of services intended for survivors of childhood sexual abuse and other experiences of interpersonal violence.

Trauma-Informed Model

Trauma-informed peer support is a relationship between survivors that promotes reconnection by creating a space for them to discover their voice, own their story, and speak their truth in the reclamation of their personal power (Blanch et al., 2012, Proulx et al., 2012). This approach fosters compassionate self-knowledge, self-awareness, and a redefinition of self beyond the trauma experience (Proulx et al., 2012).

Trauma-informed practices recognize trauma as the root of mental illness and compulsive coping behaviors, shifting the focus of treatment from "what is wrong with you" to "what happened to you" (Blanch et al., 2012; Proulx et al., 2012; Wheatley, n.d.). Significant elements of trauma-informed practice include an emphasis on viewing and interacting with the individual holistically, recognizing systemic and structural relationships with trauma, and non-pathologizing attitudes that perceive individuals as injured rather than damaged (Proulx et al., 2012). With an emphasis on safety, choice, trustworthiness, collaboration, empowerment, support, resilience, self-care, and self-healing, trauma-informed approaches promote an understanding of trauma, a broader perspective of its impacts on identity and functioning, and honest self-expression (Blanch et al., 2012; Proulx et al., 2020). Figure 12 provides examples of recommended trauma-informed practices.

Figure 12: Recommended Trauma-Informed Practices

- Ongoing conversations with survivors.
- Ongoing conversation at all levels.
- Independent evaluation of programs, facilities, and policies.
- Staff support during organizational shifts - regular time for staff to process, change, technical assistance, giving staff time to consider new ways of working with survivors.
- Integrating celebrations, arts, and traditional health and healing practices.
- Understand the language and reasons behind differing professional philosophies.
- Staff from partnering organizations need to get to know each other, both as individuals and as professionals.

Phillips et al., 2015

In the context of peer support, trauma-informed services create space to acknowledge and make sense of the impacts of trauma on survivors' lives (Blanch et al., 2012; Gregory et al., 2021). In a study aimed at identifying the components of trauma-informed services that positively impacted survivors, core values of the trauma-informed approach were identified as a trauma-responsive environment grounded in trusting relationships; listening to the lived experience of survivor staff and community about what helps to support their individual safety, health, and wellbeing; and educating survivors and staff on the impacts of trauma (Phillips et al., 2015). Working from a survivor-defined perspective contributes to an environment of emotional and physical safety that avoids stigma and traumatization for all. Education on the impacts of trauma increases awareness of triggers and normalizes trauma responses among staff and survivors (Phillips et al., 2015). Examples of specific models used to support trauma education and awareness within organizations are The Sanctuary Model or Risking Connection.

Sensitive Practice

Sensitive Practice aligns with trauma-informed approaches. *The Handbook on Sensitive Practice for Health Care Practitioner: Lessons from Adult Survivors of Childhood Sexual Abuse* (Schacter et al., 2008) was developed collaboratively with CSA survivors to help Canadians who support this population "be sensitive to the needs of adult survivors of childhood sexual abuse and other types of interpersonal violence" (p.1). The principles of Sensitive Practice include respect, time pressure, information-sharing, rapport, sharing control, boundaries, mutual learning, understanding of nonlinear healing, and demonstrating an understanding of sexual abuse (Schacter et al., 2008). The Umbrella of Safety depicts these principles working together to provide a web of trauma-informed service (Figure 13).

Figure 13: Umbrella of Safety

Schacter et al., 2008

Respect

Respect is noted as a key practice. Survivors often feel diminished as human beings and may be sensitive to any sign of disrespect because of how the abuse they experienced may have undermined their boundaries and autonomy (Schacter et al., 2008). A component of respectful practice includes sensitivity to time pressure because not having enough time inhibits survivors' sense of safety by making them feel hurried, depersonalized, and devalued (Schachter et al., 2008). Taking time with survivors instead of rushing through an agenda is a valuable relationship-building technique that makes survivors feel heard. Many survivors involved in the study that informed *The Handbook on Sensitive Practice For Health Care Practitioner: Lessons*

From Adult Survivors of Childhood Sexual Abuse (Schacter et al., 2008) said that being accepted and heard by health care practitioners helped them feel respected.

Rapport

Developing rapport requires empathy, warmth, and compassion. When these qualities are present in-service relationships with survivors, it promotes safety, cooperation, and communication in the relationship whereas a lack of respect and insensitivity to time pressure can negatively affect rapport with survivors (Schacter et al., 2008).

Taking Time

High numbers of participants and the participant-led nature of peer support can prevent facilitators with an agenda for the session from having the time to complete the topic. Researchers suggest that topics be extended over more than one session to address these constraints on time (Nolin et al., 2020). This respects the principle of taking time in Sensitive Practice.

Information Sharing

Information-sharing supports a sense of physical and emotional safety. When survivors are told what to expect on an ongoing basis, it helps soothe anxiety and prevent triggers (Schacter et al., 2008). Seeking ongoing feedback about survivors' reactions and needs is another way to share information (Schacter et al., 2008).

Sharing Control

Information-sharing acknowledges the agency of survivors and encourages them to share control of the treatment process. It creates an opportunity for survivors to voice their needs despite the power differentials in the relationship (Schachter et al., 2008). Sharing control is vital in supporting the development of healthy boundaries.

Respecting Boundaries

Sexual victimization in childhood violates one's bodily autonomy, their trust for authority, and perpetuates the belief that one's needs are inconsequential (Schachter et al., 2008). The authors of Sensitive Practice insist that being sensitive to and respectful of personal boundaries reinforce survivors worth and their right to have their needs heard and met (Schachter et al., 2008). This supports the lifelong process of establishing, re-establishing, and maintaining boundaries that is a staple of healing from abuse (Schachter et al., 2008).

Mutual Learning

Mutual learning is also essential to Sensitive Practice. Survivors develop a better understanding of the impacts of trauma, greater agency within their recovery, improved boundaries and support service providers to understand the impacts of interpersonal violence and ways to work effectively with survivors (Schachter et al., 2008).

Understanding Nonlinear Healing

Understanding nonlinear healing demonstrates an understanding of sexual abuse and promotes respect, rapport, taking time, information sharing, sharing control, respecting boundaries, and mutual learning. Survivors who participated in the study repeatedly highlighted that "healing/recovery from childhood sexual abuse is not a linear process" (Schachter et al., 2008, p.22). They found that regular check-ins, flexibility and adaptation to treatment, and understanding and compassionate responses to the variation within the healing process create greater interpersonal safety and stronger therapeutic alliances (Schachter et al., 2008).

Demonstration and Understanding of Interpersonal Violence

The final principle of Sensitive Practice is the demonstration and understanding of interpersonal violence through things like gender-inclusive signage and information such as posters and pamphlets (Bennet et al., 2022; Schachter et al., 2008). When survivors see evidence that the organization understands interpersonal violence, it can help them become more comfortable in raising the issue of their own experience (Schachter et al., 2008).

Together, the nine (9) principles of Sensitive Practice act as peer-informed guidelines for providing trauma-informed services for survivors of childhood sexual abuse. All aspects of program operation and service delivery benefit from the principles of trauma-informed service and Sensitive Practice, from organizational culture and staff management to member recruitment and intake to group facilitation and evaluation

Participant Recruitment

Peer support programming for survivors of childhood trauma such as sexual abuse emphasizes the need for safety and connection to be at the forefront of decision-making beginning with recruitment and intake (Goodwin & Patton,2009; Gregory et al., 2021; Hickle & Roe-Sepowitz, 2014; Phillips et al., 2015; Proulx et al., 2012). Although recruitment efforts mostly rely on word of mouth, Figure 14 shows examples of how they can also take the form of public education, organizational partnering, and public advertisements (Goodwin & Patton, 2009). An in-depth exploratory study in the UK, where peer support has been delivered since 1845 explored how highly experienced professionals perceived victim-survivor services such as peer support and found that ongoing contact with survivors as early in the process as possible and throughout the waiting period was invaluable (Gregory et al., 2021).

Figure 14: Recruitment Methods

- Most rely on word of mouth
- Public education: Some initiatives have developed a roster of individuals who engage in public speaking about their experiences and healing process
- Partnering with organizations to attract new members
- Newspapers, online social network, posters, websites, and fax
- List on self-help or peer support databases.

Goodwin & Patton, 2009

Participant Intake and Screening

Despite the desire to be open to all, researchers emphasize that the absence of adequate screening and assessment processes within peer support for CSA survivors puts group leaders, peer leaders, and peers at risk of harm (Goodwin & Patton, 2009; Gregory et al., 2021; Phillips et al., 2015). Goodwin & Patton (2009) explored the benefits, risks, and challenges of peer support for survivors of sexual violence among 13 specialized peer support initiatives in Ontario with a focus on creating safety throughout service implementation and delivery processes.

They found that it is critical to ensure people are ready for a group and a "good fit" (Goodwin & Patton, 2009, p.107). Figure 15 displays a range of potential exclusionary criteria to consider when screening potential participants (Goodwin & Patton, 2009; Proulx et al., 2012). Foregoing these considerations can violate the principles of trauma-informed Sensitive Practice by ignoring the various stages of nonlinear healing and putting members at greater risk of stigma and re-traumatization. Specific intake practices ensure that a group culture without stigma can be achieved (Gregory et al., 2021; Hickle & Roe-Sepowitz, 2014).

Figure 15: Potential Exclusionary Criteria for Participants

- Sexually abusive towards children as an adult
- Active addiction, if unable to attend sober
- Domineering, disrespectful, uncommitted
- Cannot follow group rules or abide by structure.
- Instability
- Severe violence
- Severe mental health challenges

Goodwin & Patton, 2009; Proulx et al., 2012

Screening and assessment are important aspects of fostering safe peer support spaces to fit the stage of recovery of participants and avoid re-traumatization (Goodwin and Patton, 2009; Gregory et al., 2021; Phillips et al., 2015; Thomson et al., 2011; Hickle & Roe-Sepowitz, 2014). Intake and screening processes that are trauma-informed, non-intrusive and reduce experiences of rejection are recommended for survivors of CSA. (Blanch et al., 2012; Phillips et al., 2015, Hickle & Roe-Sepowitz, 2014). Relationship-building, informed decision-making and voluntary consent are essential elements of trauma-informed practice. According to Phillips et al. (2015) and Hickle & Roe-Sepowitz (2014), best practices in trauma-informed programming include information sessions or "discovery groups" in which programs introduce programming and allow survivors to understand the purpose of the group, participate in the discussion, ask questions, and make informed decisions about their voluntary participation (Phillips et al., 2015, Hickle & Roe-Sepowitz, 2014). This allows individuals to learn more about the eligibility criteria, topics, purpose, boundaries, structure, and any available alternative programming, creating space for agency and self-determination in self-assessment and decision-making before the intake process.

There are ways to conduct non-intrusive assessments and provide services that meet the needs of those in various recovery stages. For example, a large residential treatment facility in Massachusetts for adolescent girls called ACT (Acknowledge, Commit, Transform) established admission criteria that required potential clients to identify as sexual exploitation survivors who are ready for change (Thomson et al., 2011). Those who did not yet meet the program's admission criteria were referred to a psychoeducational group, called My Life My Choice, where survivors met other survivors, learned about the exploitation experience, developed a common language to describe these experiences, began to self-identify as a survivor of sexual exploitation, and increased receptivity and progress in treatment (Thomson et al., 2011). This met the needs of survivors along the continuum of recovery and reduced the experience of rejection for those who were not a fit for the primary peer support program.

According to the literature, success in creating safety and connection within peer support relies as heavily on the expertise of the peer facilitator and high-quality support as it does on group member "fit" (Gregory et al., 2021; Phillips et al., 2019). For this reason, screening may be even more important in the hiring of peer support facilitation staff than it is in the admission of participants.

Facilitator Selection

Lived experience, training and expertise, and cultural humility are important factors in the selection of peer support facilitators. Many peer support groups for CSA limit facilitation to survivors and only allow professionals to attend as guest speakers (Goodwin & Patton, 2009; Gregory et al., 2021). This is because facilitators with lived experience are better able to build rapport, make authentic connections, and influence other peers as a role model (Goodwin &

Patton, 2009; Gregory et al., 2021). In a study intended to guide the development of programming for male survivors of childhood sexual abuse, it was important to participants that their treatment was facilitated by someone with lived experience, as well as education, training, and professional development in CSA (Proulx et al., 2012). For these men, gender was not as important in a facilitator as lived experience, caring, compassion, authenticity, and understanding (Proulx et al., 2012). Hickle & Roe-Sepowitz (2014) stress that peer support facilitators must also be able to manage peer relationships before they go into a peer-led setting because it can be quite damaging otherwise. Studies indicate that the facilitation of peer support for survivors of sexual violence requires trained and qualified lived experience facilitators that are well-versed, comfortable exploring issues related to sexual violence, and able to manage peer relationships (Goodwin & Patton, 2009; Gregory et al., 2021; Hickle & Roe-Sepowitz, 2014). Additionally, the importance of supporting peer leaders in their roles suggests that a balanced co-facilitation team is often best. Some studies advocate for two (2) facilitators where only one (1) facilitator is a survivor (Hickle & Roe-Sepowitz, 2014; Proulx et al., 2012).

In Canada, the selection of a facilitator may also be an exercise in cultural humility for organizations who engage Elders in facilitation (Nolin et al., 2020). Elders can serve as role models of healing and connect recovery from childhood sexual abuse to Indigenous ceremonies and teachings (Nolin et al., 2020). Research recommends that Elders invited to peer support initiatives are familiar and comfortable with the topic, non-judgmental, caring, and respect the principles of mino-pimatisiwin (Hart, 2005; Nolin et al., 2020). Mino-pimatisiwin (the good-life) is guided by core Cree values and grounded in the key Medicine Wheel concepts of wholeness, balance, relationships, harmony, growth, and healing (Charmaz, 2017; Wilson et al., 2019). It challenges Western individualism through a focus on collective, communal, relational, traditional, and contextual ways of knowing (Charmaz, 2017; Wilson et al., 2019). This approach is person-centred within a collective community. It emphasizes that, although on different journeys, all human lives are sacred, purposeful, of value, and on a path to living the good life – a life of physical, emotional, mental, and spiritual centeredness. Engaging Elders as facilitators creates opportunities for cultural humility through learning, growing and being guided in the healing ceremonies, customs, and wisdom of Indigenous traditions.

Effective Peer Support Facilitation

Effective peer support facilitation involves practices that create and maintain safety and connection within the group. *Opening the Circle's Guidelines for Peer Support* (Wheatley, n.d.) recommend regular check-ins and meeting people where they're at with empathy because these validating experiences can promote trust and foster connection. Check-ins and check-outs are common transitioning peer support practices that achieve these goals. Opening each session with a check-in allows participants to clear the mental clutter of their day while reconnecting with their peers and getting settled into the room for group. Closing sessions with

a check-out is a transition point where residual comments, concerns, and reflections can be aired before returning to daily life (Nolin et al., 2020). This next section will address other elements of peer support facilitation that are critical to establishing safety and connection when facilitating peer support including sharing power, ongoing emotional safety, and communication.

Sharing Power

Sharing power is an egalitarian, trauma-informed, decolonizing practice. Sharing power involves mutual relationships where there are no "leaders" (Blanch et al., 2012). This includes being equally accountable to one another in relationships, understanding the impacts of stigma related to labels and mental health, creating space for the voices of all members, and being conscious that participants should be the ones making decisions about the activities and discussions they participate in (Blanch et al., 2012). When power is not equally shared, the self-determination and agency of the "other" can be undermined through controlling behaviors that use blame, shame, guilt, obligation, silent treatment, constant correction, a sense of entitlement, and the minimization and justification of said behavior (Wheatley, n.d.). Supporting survivors to acknowledge and embrace their personal power, strengths, and resiliency buffers the risk of fostering codependency or hero-worship (Wheatley, n.d.).

Sharing power is a trauma-informed value. Being trauma-informed means being aware of the power imbalances that exist within peer relationships, how participants may be experiencing this, and ways in which you "may be reinforcing helplessness and shame… and eliciting the survival responses of fight, flight, or freeze" (Blanch et al., 2012, p.48). Peer support facilitators must become aware of their unconscious biases and any privilege associated with their social status that may be experienced as, or lead to, the discrimination of those with which they work (Blanch et al., 2012).

Sharing power is a decolonizing practice. Creating a space where individuals of any culture or religion feel welcomed can be accomplished by staying sensitive to the potential history of religious traumatization among survivors, making space for all spiritual perspectives, refraining from promoting one belief or practice over another, and encouraging participants to decide for themselves which conversations and activities they wish to be a part of (Blanch et al., 2012). Peer supporters should stay open and curious about someone else's culture and experiences and develop a habit of checking in with the person they are supporting to see if their assumptions or knowledge about a cultural group are relevant to her life experience (Blanch et al., 2012).

Ongoing Emotional Safety

There are various elements of establishing ongoing emotional safety including authentic self-disclosure, distress tolerance, stigma reduction, and boundary setting within peer support

(Goodwin and Patton, 2009; Gregory et al., 2021; Hickle & Roe-Sepowitz, 2014; Mead & MacNeil, 2006). This section will discuss how safety is defined and applied to support these elements of ongoing emotional safety.

Safety is defined in two (2) contradicting ways, the traditional pathologizing assessment of the medical model and the ongoing navigation of boundaries within the recovery model. Both models of safety are core components of peer support facilitation. The founders of Intentional Peer Support and Wellness and Recovery Action Planning disagree with the medical model of safety that relies on risk assessment, stating that safety most often occurs within mutually responsible and trusting relationships that offer unconditional acceptance, validation, and shared vulnerability (Mead & MacNeil, 2006). However, assessing risk is necessary to establishing safety in peer support for survivors of childhood sexual abuse because individuals interested in acting as peers may not have a history of CSA, may have a history of abusive behavior, or may have difficulty abiding by structure and rules such as attending groups sober (Goodwin & Patton, 2009).

Once established, safety can be maintained through a relational process of honesty and transparency while sharing risk, navigating boundaries, and negotiating conflict (Mead & MacNeil, 2006). Mead & MacNeil (2006) describe this process as confronting our relationship with internal and external power through an exploration of how losing, abusing, and balancing power affects experiences of trust and connection, responses to relational threats, and ways to navigate these experiences in relationships. Ongoing emotional safety planning can take place alongside these conversations. Planning for emotional safety involves trauma-informed processes of sharing information about trauma and coping skills, identifying threats to wellness such as triggers and stressors, and supporting survivors in identifying their internal and external resources (Phillips et al., 2015).

Authentic Self Disclosure

Establishing emotionally safe settings for authentic self-disclosure is a key aspect of peer support for peer providers and participants. There are conflicting views on establishing safety in relation to the impact of self-disclosure. Some peer support professionals believe that peer support does not offer adequate boundaries for survivors of sexual violence and abuse and suggest that professional oversight is necessary to avoid harmful safety breaches (Gregory et al., 2021). However, fears that peer providers are fragile and vulnerable to re-traumatization have been countered with points related to the resilience of survivors and the opportunities for vicarious resilience and post-traumatic growth that are present (Blanch et al., 2012; Gregory et al., 2021). An emotionally safe setting for self-disclosure includes clear boundaries, having an outlet for processing emotions, sitting with distress, and mitigating stigma (Bennet et al., 2022; Blanch et al., 2012; de Vos, 2015; Wheatley, n.d.).

Distress Toleration

The ability to tolerate distress is an important factor in establishing emotional safety. *Engaging Women in Trauma-Informed Peer Support: A Guidebook* (Blanch et al., 2012) insists that honest, direct, and compassionate communication is a critical requirement of peer support as is being willing to talk about the tough stuff. The authors insist that avoiding triggering topics can shut women down, teach them to suppress their stories, and prevent them from accessing their inner resiliency. The ability to sit with distress and provide an outlet for processing emotions are other essential elements of emotional safety (Blanch et al., 2012). Trauma-informed peer support researchers describe how the strong emotions that can come hand in hand with peer support conversations can be expressed behaviorally, if shut down (Blanch et al., 2012). Medical settings and other systems have misdiagnosed these responses to trauma. Staff that are not aware of how distress is impacting them may reinforce feelings of powerlessness in others (Blanch et al., 2012). Sitting with distress, rather than shutting it down, sends the message that the individual has the capacity to survive however, it is also necessary to provide an outlet to process these emotions. Participants of Putting the Pieces Together, a group intervention for teens who have experienced sexual exploitation, confirmed that the use of written and creative activities to support engagement in difficult topics assisted in preventing emotional overwhelm (Hickle & Roe-Sepowitz, 2014). Art-based and other activities are often used within trauma-informed peer support programming (Blanch et al., 2012).

Stigma Reduction

Stigma is another factor that can lead to distress within groups due to its potential for breeding lateral violence. Mitigating stigma is a critical factor in establishing emotional safety as a platform for connection, validation, and self-disclosure. The stigma that emerges within the group setting has the potential to disrupt safety and connection among peers and, therefore, the efficacy of peer support (Cyr et al., 2016; Hickle & Roe-Sepowitz, 2014). Skilled peer support providers navigate stigma by guiding the group's attention to broader topics that are likely to be shared experiences (lack of internal safety, difficulties identifying emotions, etcetera) (Hickle & Roe-Sepowitz, 2014). This approach to mitigating stigma draws focus away from differences and moves the group towards connection, understanding, validation and normalization.

Boundary Setting

Boundaries are necessary for creating emotional safety in peer support for CSA survivors as well. This is grounded in the understanding that sexual violence is a violation of boundaries that commonly results in interpersonal difficulties, challenges in identifying needs and establishing boundaries, and difficulties in navigating conflict assertively (Blanch et al.,2012; Freyd, 1996; McCormack & Katalinic, 2016, Schacter et al., 2008). Several studies on peer support for survivors of sexual violence and abuse highlight the importance of establishing ground rules to

create and maintain a foundation for safety in peer relationships (Goodwin & Patton, 2009; Hickle & Roe-Sepowitz, 2014; Proulx et al., 2012; Wheatley, n.d.). Although these guidelines will differ among peer support groups, they are necessary in creating healthy interpersonal dynamics that offer a structure for survivors to discuss, explore, and re-establish personal boundaries (Goodwin & Patton, 2009; Proulx et al., 2012). The establishment and maintenance of boundaries can be supported by having a clear program plan that includes role descriptions, expected outcomes, and ground rules that establish group norms and clearly communicate the consequences for boundary violations (Goodwin & Patton, 2009; Hickle & Roe-Sepowitz, 2014). Ground rules in CSA programming should center around confidentiality, boundaries, intimidation, sharing space, attendance, sobriety, and the right to participate without speaking (Proulx et al., 2012). While some groups limit discussions as a safeguard, others do not (Goodwin & Patton, 2009). Goodwin & Patton (2009) offer examples of ground rules within peer support for survivors of sexual violence including taking turns, respect, sobriety, gossip, reasons a non-member might be allowed to attend, discussion content, and limitations to discussion. Reviewing and confirming agreement with the ground rules, with the understanding that the ground rules may need to be continually reassessed, is necessary preparatory work for establishing safety that supports both definitions of safety (Proulx et al, 2012; Wheatley, n.d.). Doing so establishes the basis for ongoing respectful communication, shared power, supportive group dynamics, and appropriate self-disclosure.

Communication

Building connection with curiosity, validation, and appropriate self-disclosure are key communication practices in peer support (Mead & MacNeil, 2006). A critical element of the responsibility of a peer provider is to role-model, listen, encourage, offer guidance, and explore options without assessing, evaluating, or judging the peers in their community (Mead & MacNeil, 2006; Wheatley, n.d.). In a study that identified issues relevant to male survivors of childhood sexual abuse, essential traits for working with them included non-judgment, compassion, honesty, empathy, and respect (Proulx et al., 2012). In *Opening the Circle's Guidelines for Peer Support*, Wheatley (n.d.) describes communication in peer support as transforming biases, being present together through difficult moments, and non-judgmental listening that honors the individual's right to express themselves without advice. This includes listening to the characteristics of trauma being shared by others. While sharing the details of traumatic experiences is not required, survivors often want to explore trauma stories that include the traumatic event itself, its meaning, and how it has affected their lives (Blanch et al., 2012). An attitude of curiosity supports them in this part of their healing process.

Curiosity

Curiosity is the key to connecting with others and encouraging co-reflection (Blanch et al., 2012). It builds connection, creates space, and contributes to people feeling seen and heard.

Curiosity about yourself is important when becoming open to the worldview of others (Wheatley, n.d.). When we are curious about ourselves, it becomes easier to become curious about others. Asking questions to understand the experience of others allows us to learn what experiences, beliefs, thoughts, and values may be shared as survivors of CSA despite differing worldviews (Blanch et al., 2012; Mead & MacNeil, 2006; Wheatley, n.d.). Researchers suggest beginning peer conversations with questions like, “What does this particular story mean about you?”, “How does this story explain who you are?”, or “How were you able to survive?” However, they are careful to note that asking a survivor "What happened to you?" and remaining silent is not enough to a create safe space, communicate respect, and build trust (Blanch et al., 2012). Instead, one must listen attentively with both compassion and curiosity (Blanch et al., 2012).

Validation

Validation of disclosures foster connection and emotional safety. A systematic review of peer support for sexualized violence found that participants reported that the attention and acceptance of the group made them feel as though they mattered (Konya et al., 2020). In many cases survivors have not been able to acknowledge their own strengths, resilience, or resources. A strength-based model that notices, and draws attention to, even the smallest act of survival is an act of validation that can create a platform for survivors to reconstruct their perceptions of themselves as victims (Blanch et al., 2012). While demonstrating the connection that exists within shared experiences of recovery, the self-disclosure of peer support providers can also act as a method of validation.

Appropriate Self Disclosure

As part of the process of offering validation and connection within an emotionally safe setting, it is necessary to understand the purpose, advantages, disadvantages, and ethical use of self-disclosure.

Appropriate self-disclosure involves using your lived experience to establish a connection while maintaining emotional safety (de Vos, 2015). The experiential knowledge (lived experience) of peers, shared through common values and storytelling that relates to shared experiences of recovery, is central to peer support (Konya et al., 2020; Mead & MacNeil, 2006). Storytelling is a global form of cultural expression that reveals the distinctive and shared experiences of one another; offers teachings to learn from; and models the identification and articulation of feelings, thoughts, experiences, coping, and resources (Blanch et al., 2012; Hickle & Roe-Sepowitz, 2014). Self-disclosure through storytelling can include talking about personal experiences with other systems including criticisms, referrals, helpful practices, or programs; myths and stereotypes that have affected their experience; and sharing personal coping skills and strategies while encouraging others to honor their own (Blanch et al., 2012; Konya et al., 2020; Wheatley n. d). Recovered therapists describe appropriate self-disclosure as sharing

personal feelings or experiences; giving specific examples of challenges, solutions, losses, successes, and failures from their own lives; and adapting advice and tips to fit the patient's need (de Vos, 2015).

For survivors of sexualized violence, therapeutic modalities that require experiential knowledge of the treatment afford unique opportunities for therapists to make #WeToo statements and the disclosure of the therapist's own experience of recovery may strengthen the therapeutic relationship, helping clients feel more comfortable asking questions about survivorship (Bennet et al., 2022).

Research has demonstrated that self-disclosure in peer support has benefits for survivors of sexualized violence. Appropriate self-disclosure is a valuable clinical tool that creates safety and connection in relationship-building and normalizes experiences that survivors are processing as trauma survivors. An environment of emotional safety for survivors of sexual violence can be achieved by requesting permission to share a story or offer feedback, remaining mindful that the reason for self-disclosure is to connect, normalize, validate, or offer a new perspective related to their experience (Wheatley, n.d.). There are several signs that peers are being positively impacted by self-disclosure.

The most significant benefit of self-disclosure is that it promotes safety and connection (Blanch et al., 2012; Gregory et al., 2021). Experiencing safety and connection fosters a sense of being heard and respected (Hickle & Roe-Sepowitz, 2014). In their study on the aspects of trauma-informed services that positively impact trauma survivors, Philips et al. (2015) note **"**When survivors feel respected as individuals, believed, and can be open and honest with staff members without feeling judged, they experience feeling more empowered and hopeful and develop meaningful relationships with staff, making it likely that they will return to the program again if they need to" (p.22).

Appropriate self-disclosure through storytelling is a clinically valuable tool in relationship-building with survivors of sexualized violence. Research demonstrates that lived experience self-disclosure creates a connection that is empathic, trusting, validating, and shame reducing (DeVos et al., 2015). It normalizes and validates experiences within recovery, offers different versions of recovery that are possible, and strengthens the recovery knowledge and experience of the peer community (Bennett et al., 2022; Blanch et al., 2012; de Vos et al., 2015, Mead & MacNeil, 2006). In turn, participants respond with increased openness and personal sharing (DeVos et al., 2015).

Appropriate self-disclosure can help others process their experience and identity as a trauma survivor. According to a study that explored key stakeholders' perceptions of peer support for sexual violence, peer support is grounded in building connections, normalizing emotions, and inspiration from witnessing another victim-survivor become "the hero of their own life journey"

(Gregory et al., 2021). Self-disclosure normalizes psychiatric diagnosis, compulsive coping experiences, and structural oppression like incarceration, homelessness, or poverty; offers new coping skills; and presents alternate perspectives on shared fears and barriers in recovery through role-modelling, authenticity, and open dialogue (Blanch et al., 2012; Hickle & Roe-Sepowitz, 2014; Wheatley, n.d.). It also helps survivors identify areas where they are held back in their recovery and recognize their worth (Wheatley, n.d.).

There are several signs that peers are being positively impacted by self-disclosure. Signs that peers are relating to self-disclosure and experiencing safety, connection, validation, or normalization include pronounced nodding; crying; affirmations of feeling seen; and visible relaxation in their body, face, posture, or tone (de Vos et al., 2015). Signs that they are feeling safe and connected enough to be more open are increased eye contact, personal sharing, and questions. When peers share personal stories in peer support they become hopeful again, they experience less fear and shame, and they feel relieved because they are no longer the "only one" (DeVos et al., 2015).

Self-disclosure has potential disadvantages to peers and peer providers as well. Among peers, self-disclosure can make others feel misunderstood (de Vos et al., 2015). This happens when a connection isn't made between the self-disclosure and the experience that prompted it. Others feel like their experience is "worse" than the disclosure made or they look for other ways their experience may be different (de Vos et al., 2015). Reported disadvantages of self-disclosure experienced by recovered professionals were increased risk of making assumptions, feeling too committed or responsible to others, and working too hard (de Vos et al., 2015). The ethical use of self-disclosure can buffer these risks.

For the safe and ethical use of self-disclosure, the emotional safety of peer providers must also be considered. The honest communication and authenticity of peer workers, as well as the ability to practice self-awareness and self-reflection in their recovery, are directly related to the efficacy of self-disclosure in peer support (Konya et al., 2020; Bennet et al., 2020; de Vos et al., 2015).

Organizations can support emotionally safe spaces for peer providers through role clarity and consultation opportunities. Currently, there is very little in the literature that refers to policies or procedures surrounding how peer providers should respond to and be supported in managing concerning disclosures within the peer relationship. Further research on organizational standards for peer disclosures in peer support is recommended.

Peer providers need direction in responding to peer disclosures. Self-disclosure often invites disclosure. However, there is a duty to report self-harm and suicide under certain circumstances as well as disclosures of child abuse. As part of role clarity, peers need clarity about the limits of their role, whom to report concerns to, and when to report concerns. It is

also important to offer regular reminders of the limitations of confidentiality (Wheatley, n.d.). Currently, there is very little in the literature that refers to policies or procedures surrounding how peer providers should respond to and be supported in managing concerning disclosures within the peer relationship. Further research on organizational standards for peer disclosures in peer support is recommended.

Consultation opportunities support emotional safety among peer providers as well. The safe and ethical use of self-disclosure of peer providers requires that they know their limits, honor their needs and model self-care by setting and enforcing boundaries (Blanch et al., 2012). For the safe and ethical use of self-disclosure among trained recovered therapists, matters needed to be openly discussed with colleagues including within the multidisciplinary consultations (de Vos et al., 2015). It is clear that given the degree of organizational support needed by trained and experienced clinical professionals with recovery experiences peer providers who have less training and experience require even stronger organizational support to ensure the success of peer support initiatives through regular debriefing and co-reflection that encourages their ongoing recovery while engaging in such emotional vulnerability.

Self- Disclosure & Feminist Therapy

Within therapeutic medical models of service delivery, self-disclosure is dissuaded in favor of maintaining objectivity in the client-patient relationship. However, this method of maintaining objectivity counters the peer support tasks of connection, mutuality, and worldview. Some therapists have observed that clinical objectivity, which can present as emotional distance, is less important to therapeutic efficacy than developing normalizing connections and a validating and empowering rapport (Proulx et al., 2012).

Feminist therapists and researchers oppose the resistance to therapist self-disclosure. A study using the Feminist Self-Disclosure Scale as a guiding framework to explore the benefits of therapist self-disclosure about the #MeToo movement argues that #WeToo disclosure aligns with each core factor of feminist self-disclosure and can "help empower clients through knowledge sharing, rewriting narrative, and encouraging the client to conceptualize what their own survivorship might look like (Bennet et al., 2022, p.104)." The authors of the study also speculate that current perceptions of sexual assault are patriarchally informed and "…the implicit assumption that a #WeToo disclosure is subversive or inappropriate is related to the fact that survivorship and recovery is not [seen as] possible" (Bennet et al., 2022, p.122). The authors believe that feminist self-disclosure is central in supporting clients to connect with and integrate their experience in recovery (Bennet et al., 2022). They question who benefits from withholding shared lived experience:

"Who stands to benefit when … both therapists and clients, understand sexual assault as an off-limits topic for mutual connection? How many systems of power and oppression stand to benefit when we are convinced that we are more professional, more effective, and more evidence-based when we keep that aspect of our shared experience private? Regardless of an individual therapist's professional perspective on evidence-based practices and their necessity for so-called good or effective therapy, what is evidence if not a strengthened body of information to support that a lived experience is valid? A #WeToo statement is at the heart of supporting our clients in seeing their own experiences as reality, as legitimate, and as survivable. These questions speak to the heart of the original "me too" movement, which focused on "me too" self-disclosure as a means of connecting and supporting Black women by not allowing sexual violence to stay protected (Bennet et al., 2022, p.112)."

In their exploration of ways in which feminist therapists approach self- disclosure, including ethical considerations and recommended practices, the authors of **#**Wetoo: Feminist therapist self-disclosure of sexual violence survivorship in a #Metoo era (Bennett et al., 2022) reference a study by de Vos et al. (2015) that focuses on therapist self-disclosure. Although the participants for this study were drawn from the field of eating disorders, it offers invaluable insight into the use of self-disclosure by recovered therapists. This cross-sectional qualitative study was based on a questionnaire provided to 205 patients (response rate 57%) and 26 recovered therapists (response rate 75%) that explored the advantages and disadvantages of using lived experience

Figure 16: Client Views of Therapist Self-Disclosure of Experiential Knowledge

<u>Benefits</u>

- Client feels heard and recognized.
- Therapeutic safety.
- Therapist has enhanced knowledge and insight of recovery.
- Therapist is authentic, open, honest, and accessible.
- Client feels increased hope for recovery.

<u>Disadvantages</u>

- Client may make negative comparisons to the therapist.
- Therapist may become too personal with client.

de Vos, J.A., Netten, C., & Noordenbos, G. (2015)

in therapy. According to the results of the questionnaire among patients, 97% reported advantages to experiential self-disclosure while 11% reported disadvantages to experiential disclosure. Figure 16 shares client views about the self disclosure of experiential knowledge. Among recovered therapists, 100% reported positive reactions to experiential self-disclosure while 35% reported negative reactions to experiential self-disclosure. However, among that 35%, there were no themes that repeated themselves more than three (3) times, indicating that there were no common negative reactions among this sample.

Figure 17 shares therapist views about the self disclosure of experiential knowledge. The most important finding in this study was that the experiential disclosure by recovered professionals was viewed as a credible goal-specific therapeutic intervention increases understanding of recovery, strengthens rapport, and increases client motivation (de Vos et al., 2015).

Figure 17: Recovered Therapist Views of Self-Disclosing Experiential Knowledge

Content
- Do not share specific details about therapist symptoms (46%)
- Do not tell very intimate or personal things (19%)

Safe Use Requirements
- Self insight and self-care (62%)
- Training guidance and support (54%)
- Consider purpose and how it can help client (31%)
- Safe work environment (27%)
- Length and strength of recovery (15%)

Therapeutic Goals
- Insight into recovery process (2%)
- Connection (2%)
- Activating or motivating client (27%)

Benefits
- Can establish a relationship based on cooperation and trust (46%)
- Relationship is based on equality (19%)
- Enhances knowledge and insight (54%)
- Offers positive role modeling (35%)
- Demonstrates high empathy (15%)

Changes Within Client Experience
- Feeling recognized and heard (77%)
- Shame reduction (54%)
- Increased hope (42%)
- Increased trust (38%)
- Increased openness and honesty (27%)
- Increased motivation to change (23%)

Disadvantages
- Potential projection or identification (81%)
- Potential over involvement or concern with the client (50%)

Positive Client Reactions
- Demonstrating recognition and understanding (100%)
- Becoming more open (31%)
- Having reactions related to hope (19%)

Negative Client Reactions
- No themes emerged more than 4 or more times (35%)

de Vos, J.A., Netten, C., & Noordenbos, G. (2015)

According to feminist therapists, “several specialized therapeutic modalities require the therapist to experience the treatment modality firsthand and self-disclosure is encouraged and

accepted as responsible and therapeutic in many settings, including eating disorder recovery, 2SLGBTQQIA-related trauma and experience, and severe mental illness (Bennet et al., 2022, p.110). Dedicated to the core principles of empowerment and advocacy, feminist self-disclosure is promoted as a means of developing rapport founded on connections that demonstrate therapist responsiveness, validate and normalize the recovery experience, and share aspects of survivor identity (Bennet et al., 2022). This includes consideration of the inherent balance of power in the room, the potential for emotional reversal, and whether the self-disclosure prioritizes therapeutic goals (Bennet et al., 2022). The therapeutic goals of peer support are individual and collective empowerment through connection, safety, normalization, and role modeling (Blanch et al., 2012; Cyr et al., 2016; Goodwin & Patton, 2009; Hickle & Roe-Sepowitz, McCormack & Katalinic, 2016; Mead & MacNeil, 2006; Shalaby, 2019). In peer support, it is the shared experiences within the relationship that promotes connection, fosters mutuality, encourages worldview, and models moving towards recovery.

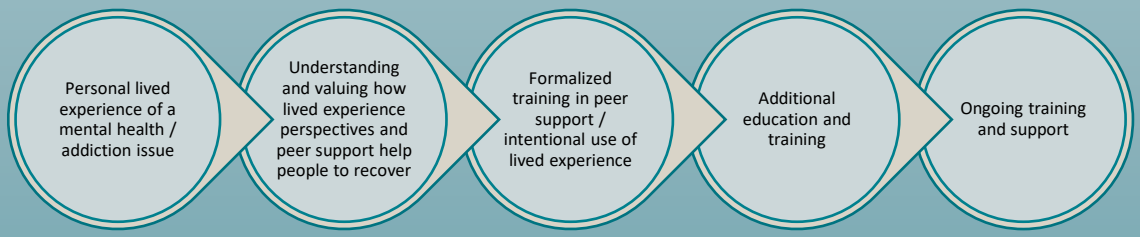
Organizational Support

Peer support work is a practice of continuous relational vulnerability and mindfulness. It stems from an intimate conscious knowledge of trauma and recovery that has been and is continually lived, learned, and navigated. Throughout the literature, the necessity of organizational support for peer support values, principles, and practices during the implementation and operation of peer support programming is highlighted as key to the successful implementation, facilitation, operation, and training of peer support programming within mainstream health services. In a study involving the staff, program managers, advocates, associate directors, and executive directors of 45 trauma-informed programs, it was noted that “A trauma-informed relational environment creates and sustains emotional safety; encourages respectful and caring connections; focuses on strengths and resilience; and supports clarity, consistency, transparency, and choice” (Phillips et al., 2015, p.4).

The implementation of peer support for those who have experienced sexual violence must start at the organizational level by creating safety and connection for peer providers within the organization through staff training, co-reflection, and application of mutuality, connection, worldview, and moving towards. Some ways to begin doing this are prioritizing role clarity with clear duties, deliverables, deadlines, and reporting procedures; informal social connections within the organization; peer inclusion in decision-making; offering affirming performance feedback; supporting the peer in navigating professional interpersonal challenges through guided self-reflection, discussion, guidance, and intervention when necessary; genuine relationships rooted in mutual vulnerability; and regularly checking in on peer provider wellness, safety, and connection in the role (Blanch et al., 2012; Goodwin & Patton, 2009; Hickle & Roe-Sepowitz, 2014; McMackin & La Fratta, 2021; Phillips et al., 2019).

The components involved in organizational support for the values of peer support are highlighted in Figure 18. This section will offer examples of organizational support within successful peer initiatives and highlight three (3) critical areas of organizational support in peer support for CSA survivors.

Figure 18: Organizational Support for Peer Support



Successful peer initiatives include organizational support that prioritizes peer support principles and honors the emotional labor of peer providers through the personal and professional empowerment of the peer staff and members. "Organizations that promoted a non-hierarchal sense of community and opportunities for sharing or telling life stories and artistic expression were highlighted as having had the most significant improvements in quality of life, empowerment, hope, social justice, recovery, and social acceptance measured within a competent well-being scale (Campbell, 2005 in Cyr et al., 2016, p.29)".

Sprang et al. (2018) outlined several interventions that have been implemented (online and in-person) to support employee wellness and resilience in response to risks of secondary traumatic stress including low impact debriefing, organizational policies related to continuous STS monitoring, practitioner self-help groups, workshops, and instructions for employees to support STS intervention. In fact, the article emphasizes organizational support and psychological and physical workplace safety as a best practice in prevention and intervention of indirect trauma, highlighting studies that prove the efficacy of trauma-informed training, evidence-based practices, and reflective processing-oriented supervision in supporting resilience factors such as emotional awareness; emotional regulation; healthy coping skills, compassion; social support; and finding meaning, purpose, and hope in one's experiences. (Sprang et al., 2018). Important components of organizational support worth noting when considering peer support for CSA survivors include organizational culture, peer training, and peer supervision.

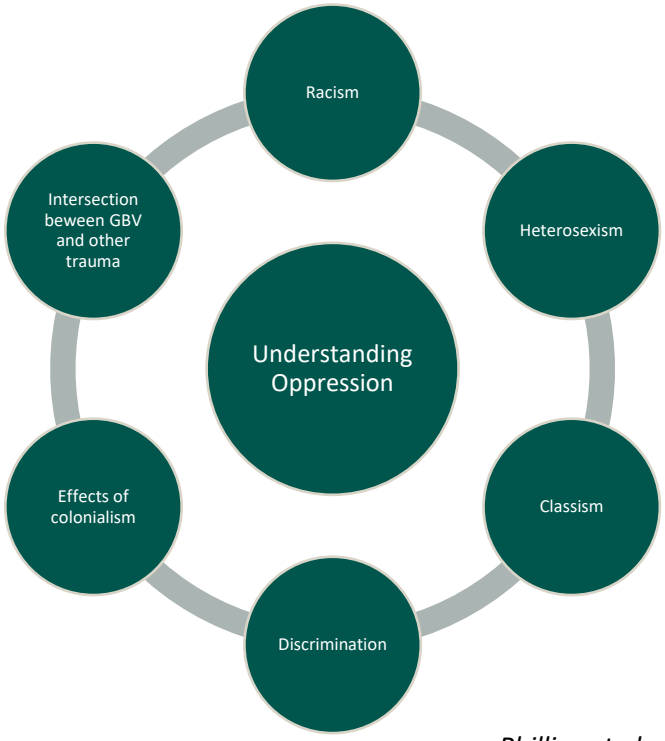
Organizational Culture

Two (2) significant and dependent factors related to a supportive organizational culture are addressing ongoing oppression and incorporating survivor values and worldviews (Phillips et al.,

2015). Ongoing oppression occurs as epistemic injustice in the workplace. Due to efficiency and cost-effectiveness, some clinicians who have supported survivors of sexualized violence have expressed concerns that perceptions of peer support as "cheap labor" can reduce job security for mainstream professionals (Cyr et al., 2016; Gregory et al., 2019; Hickle & Roe-Sepowitz, 2014; Shalaby et al., 2019). Additionally, studies have demonstrated epistemic injustice experienced by peer support workers who face discrimination, prejudice, marginalization, lack of understanding, lack of welcome, feeling dominated by professionals who do not understand the value of their work, and exclusion by co-workers and other professionals while also adapting to the transition from service user to service providers (Cyr et al., 20166; Shalaby et al., 2019). Epistemic injustice is described as a leg of oppression related to one's identity that includes unequal access and opportunity to both give and receive knowledge as well as damaged credibility and being minimized as a credible source of knowledge (Johnstone, 2020).

One way to address oppression in the workplace is by incorporating survivor values and worldviews within the organization. Addressing oppression when working with communities impacted by trauma involves learning about multiple experiences of oppression and how they impact interactions with systemic supports and resources and then using this knowledge to transform service delivery, systems, policy, and social change work through ongoing system change and training for professionals to develop the skills to work in and in partnership with peer provider (Cyr et al., 2016; Phillips et al., 2015). The multiple experiences of oppression are shown in Figure 19.

Figure 19: Understanding Multiple Experiences of Oppression

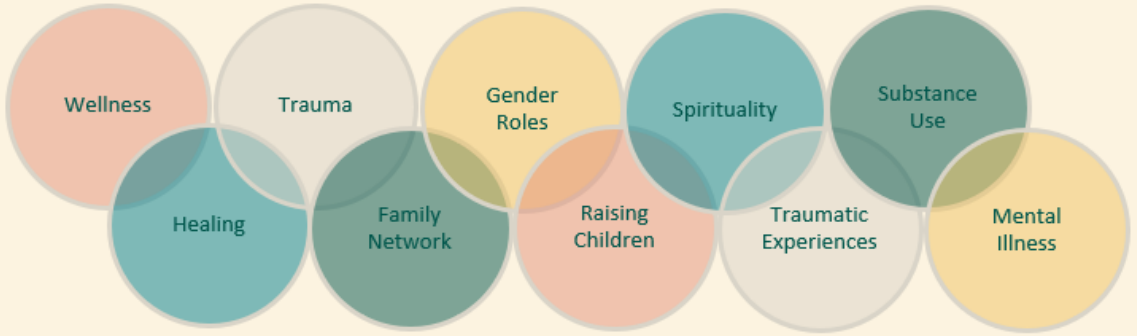


Phillips et al., 2015

On an organizational level, components of survivor worldview and values include a vast number of areas of their lives (Phillips et al., 2015). Organizations must be willing and able to spend the time necessary to understand how this worldview and values impacts survivor

experiences, practices, and beliefs (Phillips et al., 2015). The many potential components of a survivors worldview is displayed in Figure 20.

Figure 20: Components of Survivor Worldview



Phillips et al., 2015

Peer Training

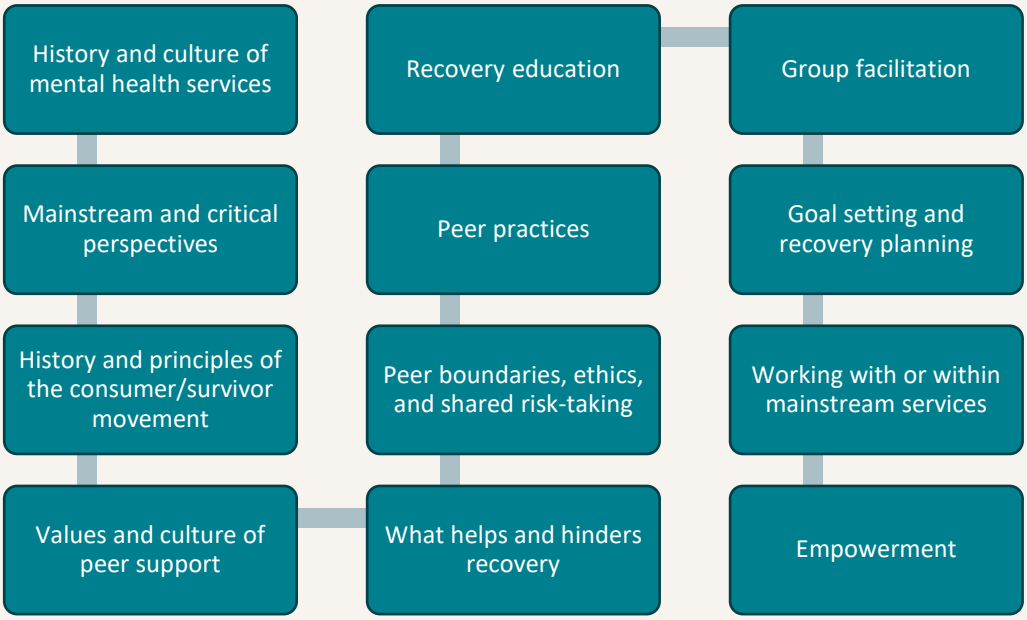
There are many ways that peer training can be designed and delivered. Some training topics are unique to peer support while others may be interpreted and taught differently based on the recovery population it is meant to serve and the purpose of the peer support programming (Cyr et al., 2016). The spectrum of training topics is presented in Figure 21. Training manuals can be standardized or customized, but critics of standardized manuals suggest that there are consequences of imposing mainstream services through the adaptation of recovery language and the professionalization of the recovery process, including the recovery of peer providers (Cyr et al., 2016). Regardless of the design and delivery style chosen, all training for peers should apply directly to peer support and include group facilitation (Goodwin & Patton, 2009).

Peer training can address organizational misalignment with peer values. Depending on the organizational culture, some agencies do not align with peer support values. This reinforces the need to garner support for peer values and relationships through the adequate training of all staff, both peers and non-peers (Blanch et al., 2012; Goodwin & Patton, 2009; Konya et al., 2020; Philips et al., 2019). In a study by Goodwin & Patton (2009), peer support groups that functioned the best had extensively trained members or staff.

Peer training can also disrupt peer provider role isolation. Some peer workers have felt uncomfortable and excluded when they have attended mainstream training (Cy et al., 2016). To address the sense of isolation and exclusion that peer workers experience within mainstream training and employment, researchers recommend an ongoing connection to a community of

other peer workers as well as learning from seasoned peer workers to maintain the integrity of peer support. (Phillips et al., 2019; Konya et al., 2020; Wheatley, n.d).

Figure 21: Spectrum of Training Topics for Peer Support Initiatives



Cyr et al., 2016, p.75; Goodwin & Patton, 2009

Peer Supervision

Responding to trends in mainstream mental health and addictions peer work, the Ontario Centre for Excellence in Peer Support developed *Supervising Peer Workers: A Toolkit for Implementing and Supporting Successful Peer Staff Roles in Mainstream Mental Health and Addiction Organizations* (Phillips et al., 2019) to provide resources that will build capacity for effectively supervising peer workers by reflecting on issues unique to peer support workers. Figure 22 provides an example of three trends in mainstream mental health and addiction work that this toolkit addresses. These trends can be found in organizations engaging women in trauma-informed peer support as well (Blanch et al., 2012)). Goodwin & Patton (2009) insist that peer support for survivors of sexual violence must "consider strategies to ensure that these services can be both successful and safe for all those concerned (p.12)". This section will introduce four (4) principles of peer support supervision and recommended supervision content and supervisory experience. The benefit of experienced peer and alternative supervisory methods more in line with the feminist, anti-oppressive values and egalitarian relationships of peer support will also be explored.

Figure 22: Three Trends in Mainstream Mental Health and Addiction Peer Work

- Peer worker roles tend to be implemented haphazardly and without full organizational support.
- Peer workers tend to struggle with a lack of role clarity.
- Peer workers struggle with isolation and role strain, especially when they are the only peer worker in their organization, which is often the case.

Phillips et al., 2019

Supervising Peer Workers: A Toolkit for Implementing and Supporting Successful Peer Staff Roles in Mainstream Mental Health and Addiction Organizations (Phillips et al., 2019) refers to four (4) key principles of peer support that must be fostered: recovery skills (related to personal growth and leadership), recovery identity (involving holistic wellness, acceptance, belonging, and hope for their future), recovery communities (safe, supported, recovery-oriented spaces where one can contribute as an equal), and recovery relationships (rooted in mutual growth, validation, connection, normalization, and cultural safety). The content of supervision with peer workers should focus on "supporting the peer worker's reflective practice, setting professional goals, and maintaining workplace wellness" (Phillips et al., 2019, p.5). Findings from a study providing insight into the use of self-disclosure by recovered therapists asserted that self-insight, regular self-care, a safe work environment, supervision, training, and support are important elements of supporting service providers with lived experience in developing a professional use-of-self style that integrates their personal history and identity (De Vos et al., 2015). It is also necessary for supporting the wellness plans and coping strategies of peer workers.

Philips et al. (2019) note that peer workers are often situated in inter-disciplinary teams supervised by professionals in social work, medicine, therapy, or other allied health disciplines but it is also important to have a supervisor that has experience with peer support roles, a basic knowledge of supervision practices, and is a passionate advocate for peer roles. In a study of peer support for managing work-related stress, supervisors that communicated approachability, availability, positive regard, and acceptance fostered positive supervisory experience where negative supervisory experiences were categorized as unapproachable, poor managers that lacked attunement. Notably, participants noted that distress from negative supervisory relationships was partly buffered by peer support relationships (Agarwal et al., 2019).

As well as contributing to resilient practice, effective supervision promotes quality services and staff retention (Phillips et al., 2019). Supervisors play a critical role in addressing challenges that peer workers face such as low wages, lack of resources, ineffective supervision, inadequate

training, staff resistance, and conflicting feelings about peer support or towards peer workers (Konya et al., 2020; Philips et al., 2019).

The focus on feminist, anti-oppressive values and egalitarian relationships in peer support suggests that non-traditional forms of supervision are better suited to support the peer support role. In supervision, employees' application of values, knowledge, and skills are monitored, assessed, and discussed (Tsui et al., 2017). It is critical to ensuring quality service to clients as well as professional development and job satisfaction among employees (Tsui et al., 2017). However, the supervisory experience is traditionally a hierarchal, managerial process of accountability that can be oppressive in nature (Tsui et al., 2017). Researchers suggest that an integrated approach to organisational learning can support employees by providing multiple supervisory and support initiatives while ensuring the administrative, educational, and supportive roles of supervision are fulfilled (Tsui et al., 2017; Wenger & Snyder, 1999).

In *Making the Case for Peer Support* (Cyr et al., 2016), the authors emphasize the importance of management teams working in partnership with peer workers and making them feel respected. Peer support workers that may not understand workplace politics or lines of power could benefit from professional development and mentorship however, for true learning to be achieved, safe relationships where peer providers feel respected must be established (Cyr et al., 2016). Tsui et al. (2017) believes that "human service organisations need to develop systems that integrate and enhance staff development and establish communities of practice through integrative approaches which include consultation, mentoring, and coaching" (p. 2416). Consultation, mentoring, and coaching can compliment the supervisory process by offering instruction, feedback, and support in employee learning and development that is not aligned with managerial values (Goodwin & Patton, 2009; Tsui et al., 2017). Consultation involves professional advice related to organizational transitions and challenges or training that is offered to agency staff and management by an external expert (Tsui et al., 2017). Coaching and mentoring are similar in that they both provide guidance to less experienced employees (Tsui et al., 2017). The key difference is that, where mentors must have discipline-related experience in the role as the mentee is developing, coaches do not (Tsui et al., 2017). Mentors share knowledge based on their similar backgrounds and needs and coaches draw on solution-focused techniques to meet goals; foster growth, learning, and development; and improve or acquire skills (Tsui et al., 2017). According to Wenger & Snyder (1999), supervision can be an integral part of a community of practice for organisational learning. The authors believe that organisations should integrate supervision with mentoring, consulting, and coaching through the development of communities of practice that foster practitioner growth, development, and knowledge (Wenger & Snider, 1999).

Making Space for Vicarious Trauma

It is important to make space for vicarious trauma among peer support providers. This can be done through debriefing, reflective practice, and a strong positive supervisory relationship. Vicarious trauma can affect individuals who support trauma survivors and those who have a history of trauma may struggle to believe that they are worthy of self-care (Blanch et al., 2012; McCormack & Katalinic, 2016; Proulx et al., 2012; Wheatley, n.d.). Like peers, peer workers need support in honoring their needs, setting boundaries, and practicing self-care (Blanch et al., 2012; Wheatley, n.d.). There may even be times that they will need someone to cover their shift or duties while they address personal feelings of being unsafe or uncomfortable (Wheatley, n.d.).

Debriefing and reflective practice are critical because they can help supervisors learn about their supervisee while helping peer workers increase awareness of when they are getting caught up in the emotions of the person they are supporting and identify what they need for themselves to stay well (Phillips et al., 2019; Wheatley, n.d.). A peer worker in a study by McCormack & Katalinic (2016) shared her experience of personal and professional growth as a peer provider, explaining "It's not about having to fix myself or change myself, it's about chipping away the fear-based crap that I was wrapped up in before (p.1030)."

Supervisors have an opportunity to strengthen their relationship with supervisees via feminist self-disclosure that centers around their personal and professional learning experiences (Bennet et al., 2022). Such disclosures may validate; normalize; or provide tools, resources, or strategies for the learning of the supervisee (Bennet et al., 2022). Supervisors can support peer provider wellness by creating opportunities to prioritize and role model practicing self-care individually and as a team. It is during these times that the relational environment for peer support can be co-created.

Peer Provider Wellness

A relational environment for peer support is essential to peer provider wellness. It is important for the work setting to be a place of safety and connection where peer providers can experience support for their ongoing recovery and professional growth. When a child is a victim of sexual violence it interferes with their ability to experience emotional safety, practice the vulnerability necessary to establish and maintain authentic relationships, and assert the boundaries required to ensure their wellness (Blanch et al.,2012; Freyd, 1996; McCormack & Katalinic, 2016). These barriers to interpersonal and intrapersonal wellness follow survivors of sexualized violence into their adult years. For some survivors of childhood sexual abuse, their trauma is compounded by other experiences of abuse that may lead to an even greater severity of traumatic symptomology. Depending on the nature of their relationship with the systems in their lives, as well as the length and strength of the individual's social supports and recovery

experiences, their recovery experiences outside of work may not always be positive. In addition, the inherent self-disclosure of their role leaves them open to judgment by others whose lives they know little about. This, combined with the long-term impacts of childhood sexual abuse, can create additional stressors in their recovery so it is important they feel supported in their work.

As one can imagine, seeking support for one's wellness requires a great deal of vulnerability and insecurity. When working with survivors, healing is about being seen, validated, being recognized for who and what you are, and being recognized for what you survived to tell (Blanch et al., 2012). This requires that a safe and accepting space exists where stories can be told (Blanch et al., 2012). The importance of this becomes clear when one understands the role that ongoing trauma recovery, sharing experiential knowledge, and reducing the risks of indirect trauma plays in the wellness and recovery of peer support providers. This section will explore these components of peer provider wellness.

Ongoing Trauma Recovery

Ongoing recovery is a primary factor in the wellness of peer providers. Organizations must understand that the nonlinear nature of healing and the invasive impact of trauma exposure applies to employees with histories of sexual abuse as well as clients identified as survivors. These staff members may also be impacted by more than one form of trauma (Blanch et al., 2012; Schachter et al., 2008). Healing from the consequences of CSA is an ongoing process. Those with lived experience who work in the field of sexual violence face several personal and professional stressors that contribute to their vulnerability to compassion fatigue, vicarious trauma, and burnout (indirect trauma) including a personal history of trauma and barriers in attending to their self-care and accessing treatment (Agarwal et al., 2019; Delker, 2019; Goodwin & Patton, 2009; McMackin & LaFratta, 2021; Pirelli et al., 2020). The ongoing recovery of peer providers is impacted by multiple factors including the non-linear nature of healing and recovery from short-term and long-term impacts of CSA, the relationship between personal and professional stressors, the personal protective factors of peer providers, barriers in accessing or activating protective factors, and the importance of supported self-reflection and self-care. This section will discuss these factors in further detail.

Recovery from childhood sexual abuse is nonlinear and ongoing. Survivors of CSA experience a plethora of long-term and short-term consequences that affect every aspect of their emotional, social, mental, spiritual, and physical health and wellness. The consequences include feelings of guilt, blame, anger, powerlessness, grief, betrayal, helplessness, and shame; insecure attachment; low self-esteem; incarceration, frustrated internal boundaries; difficulties identifying and expressing personal needs; intergenerational trauma; difficulties with trust and intimacy in relationships; ongoing experiences physical, emotional, and sexual abuse; mental health challenges such as anxiety, depression, post-traumatic stress disorder, and dissociative

disorder; memory, organization, and decision-making difficulties; and disconnection from culture, spirituality, or faith (Augusta-Scott, 2020; Blanch et al., 2012; Freyd, 1996; Gregory et al., 2021; Hickle & Roe-Sepowitz, 2014; McCormack & Katalinic, 2016; Nolin et al., 2020; Phillips et al., 2015; Proulx et al., 2012). Lack of identity, low self-esteem, and dissatisfactory social support systems contribute to creating the conditions for developing compulsive coping habits among survivors of childhood sexual abuse (Blanch et al., 2012; Nolin et al., 2020; Proulx et al., 2012; Schachter et al., 2008). Compulsive coping strategies, used by survivors to manage the overwhelming thoughts and emotions that accompany the short and long-term consequences of childhood sexual abuse, can have negative impacts on physical health such as lowered immunity to disease and infection, sexual health problems, insomnia, eating disorders, and malnutrition (Blanch et al., 2012; Cyr et al., 2016; Gregory et al.,2021; Hickle & Roe-Sepowitz, 2014; Proulx et al., 2012).

There is a relationship between personal and professional stressors. In an article exploring a trauma-informed framework for work-related trauma-informed interventions, McMackin & LaFratta (2021) stated that "in the same way that one's work experiences affect one's personal life, stresses with one's personal life may spill over into one's professional life" (p.34). I have witnessed how balancing the stressors of everyday life, responsibilities to family, and the tasks that support ongoing recovery can challenge wellness and recovery, especially during periods of transition, loss, or adversity. A personal history of trauma can foster post traumatic growth (Frey et al., 2017, McCormack & Katalinic, 2016). However, when combined with highly empathic professional relationships and ongoing triggers at work from exposure to traumatic content through the disclosure of peer clients, a traumatic history can also increase peer support providers' risks of experiencing the consequences of indirect trauma (Adams et al., 2006; Cunningham, 2003; McCormack & Katalinic, 2016).

Personal protective factors can act as a buffer against indirect trauma. Peer support providers have several potential personal protective factors at play such as self-compassion, emotional intelligence, and regulation skills (Pirelli et al., 2020). These can act as buffers for the risks of burnout and compassion fatigue while coping with humor mitigates the risks of compassion fatigue and vicarious trauma (Pirelli et al., 2020). McMackin & LaFratta (2021) outline personal resources and interventions that can strength peer support provider resiliency after work hours: leaving "work at work", relaxing, experiencing success, growth or mastery in an unrelated area, and autonomy and personal agency over their recreational time (McMackin & LaFratta, 2021). Accessing self-care and treatment are also important protective factors (Blanch et al., 2012; Delker, 2019; McMackin & LaFratta, 2021; Pirellli et al., 2020).

There are barriers to self care and accessing treatment. Barriers to accessing psychotherapeutic treatment include fear of stigma, discomfort sharing their difficulties, restrictions on time and money, the need to travel to protect their confidentiality and fear of

the response of those in authority, including regulatory bodies (Pirelli et al., 2020). Barriers to self-care and self-compassion include the need for self-approval and feelings of shame that created powerful internal barriers to prioritizing self-care (Delker, 2019) Given the instinct of sexual abuse survivors to push past mental and emotional barriers, McCormack & Katalinic (2016) describe peer providers' experience of burnout as at odds with the survivor instinct that is so central to their identities, making it difficult to ask for help. One participant described this internal battle as a "struggle with the fact that I do matter because I didn't matter before (McCormack & Katalinic, 2016, p.1032)." Other barriers to self-care include an inability or unwillingness to prioritize it due to lack of time, energy, resources, or support with family responsibilities (Delker, 2019). Difficulty identifying personal needs, setting limits with others, and presently engaging in recreation are also barriers to self-care (Delker, 2019). Some individuals self-treat (Pirelli et al., 2020).

Importance of self-reflection and self care. Finding ways to support peer providers in self-reflection and self-care is a recommended practice within peer support for CSA survivors (Dutton et al., 2017; Goodwin & Patton, 2009; McCormack & Katalinic, 2016; Phillips et al., 2019). Without a supportive outlet, the frustrated internal boundaries and difficulties identifying and expressing personal needs that are long-term impacts of developmental sexual violence can resurface, triggering old feelings of helplessness and the internalization of self-blame as shame (Blanch et al., 2012; McCormack & Katalinic, 2016). This can have detrimental effects on lived experience leaders' wellness and recovery, and therefore, is important to create spaces for peer workers where they feel safe to be themselves, ask for what they need, and practice self-care (Philips et al., 2019). Goodwin & Patton (2009) recommend encouraging self-care through group self-care practices in the workplace such as relaxation, meditation, or grounding exercises, limiting certain topic discussions, sharing leadership, and discussions about what can be done to facilitate wellness as a group together as well as individually after group.

Sharing Experiential Knowledge

Peer support is a relevant, meaningful, and effective service with many benefits that stem from sharing experiential knowledge. Sharing experiential knowledge is an integral practice that permeates the peer support role however, it can create vulnerability to indirect trauma through experiences of epistemic justice and fostering the increased trust, rapport, and disclosure of those they support. Peer support can be offered to survivors of childhood sexual abuse but, when implementing peer support for survivors of sexualized violence, consideration must be given to the inherent nature of sharing experiential knowledge through self-disclosure within peer support and its relationship to indirect trauma. In this section, I will describe experiential knowledge, discuss how peer support is rooted in self-identification and self-disclosure, and

explore two (2) factors related to self-disclosure that increase lived experience staff vulnerability to indirect trauma.

Peer support centers around the experiential knowledge of peer providers and the peer community. There is a marked difference between academic knowledge and experiential knowledge (de Vos et al., 2015). In a study on the experience, benefits, and challenges of self-disclosure among recovered therapists who supported individuals with eating disorders, recovered therapists reported that experiential knowledge is embodied and includes the emotional social and spiritual aspects of the recovery experience making it inherent and extensive wisdom and gained through trial and error that is easier to use, understand, remember, and apply (de Vos et al., 2015). In comparison to this, academic knowledge is cerebral, literary, routine and scripted making it feel prescribed, foreign, reliant on thought, and easily forgotten (de Vos et al., 2015). The relationship between self-and role modeling is described as “the living example” and role modeling vulnerability (de Vos et al., 2015).

Self-disclosure in the form of identification as a survivor of a traumatic history is embedded within the peer support provider role. As a lived experience peer support participant, researcher, peer provider, and consultant, the experience of myself and many of my peers is that, within mainstream organizations, self-disclosure is a key component of peer support provider employment. It begins from the time of application for the role. Over the years, I have had the privilege and honor of recruiting, hiring, and training peers for peer initiatives. Throughout the onboarding process, within the application and in the interview, details of their traumatic history and their recovery experiences are shared including their triggers, social supports, coping skills, and other intimate details. Many times, this interview involves sharing difficult truths while sitting across a desk from two (2) or more authority figures with whom the peer support provider has little to no relationship and who are assessing your value to their organization. Once hired, based on their job title or the nature of their role as peer providers, their history of trauma is often known by peers, staff members, community members, or other collaborating professionals without being directly shared by the peer support provider. Additionally, as part of their recovery plan, details of their traumatic history and recovery experiences are a huge part of their personal lives. Although there is no research that speaks directly to this, I believe that the combination of being an “open book” in so many areas of their lives and communities, experiencing epistemic injustice in the workplace, and empathizing with the trauma-intensive disclosures of participants can increase the risks of indirect trauma, especially without adequate and appropriate supports and resources.

Two (2) factors related to self-disclosure that increase the risk of peer provider’s experiencing indirect trauma are epistemic injustice and increased trauma exposure through participant disclosures (Cyr et al., 20166; de Vos et al., 2015; Phillips et al., 2015; Shalaby et al., 2019). Given their history of trauma, its long-term impacts, as well as the self-disclosure and

vulnerability implicit in their role, peer providers face a great risk of epistemic injustice (Cyr et al., 2016; Shalaby et al., 2019). Epistemic injustice is described as an oppressive form of prejudice about one's credibility as a knower based on their identity (Johnstone, 2020). This happens in the form of unequal access and opportunity to both give and receive knowledge, damaged credibility, and being minimized as a credible source of knowledge (Johnstone, 2020). Epistemic injustice is closely tied to institutional invalidation. Institutional invalidation is the experience of being treated as though your experience is invalid and you do not know what you know (Stewart et al., 2022). Lived experience staff describe epistemic violence in terms of being included in environments where their expertise is invalidated through minimal decision-making power, pathologization of their resistance to oppressive policies and practices, delegitimized concerns, and people in authority dictating and defining what is true for them (Stewart et al., 2022). In my experience, peer providers have had their traumatic histories used to counter and negate their efforts at advocacy. For example, in one agency I know of, a team of three managers seated across the room from one peer provider suggested that the peer providers' recent advocacy for trauma-informed services for a participant stemmed from unresolved trauma then, without further discussion or follow-up, dismissed her concerns and recommendations with the statement "Everyone has trauma". Epistemic injustice heightens the risk of burnout and indirect trauma. This point is illustrated in the qualitative grounded theory study introduced by *Making the Case for Peer Support* where a participant shares how the "emotional labor" of their role resulted in role strain and blurred boundaries when they were undervalued by their non-peer coworkers who treat them more like patients than professionals (Cyr et al., 2016). In my experience with the peer community, this can be the case regardless of the years of experience, education, or recovery of the peer provider. Burnout, which can be exacerbated by these types of microaggressions fuelled by epistemic injustice, is related to inadequate organizational support and unsafe spaces for co-reflective dialogue (Cyr et al., 20166; Philips et al., 2019; Shalaby et al., 2019). It increases one's vulnerability to indirect trauma and is a significant concern for peer providers (Blanch et al., 2012; Cyr et al., 2016; McCormack & Katalinic, 2016).

Sharing experiential knowledge builds a unique rapport with others that often invites greater degrees of intimate and trauma-intensive disclosure (Bennet et al., 2012; de Vos et al., 2015; Hickle & Roe-Sepowitz, 2014; Wheatley, n.d.). Indirect trauma is the result of exposure to trauma such as hearing, reading, witnessing, or supporting difficult client stories and is considered an occupational hazard in helping professions such as social work (Branson, 2019; Ben-Porat et al., 2020; Harr & Moore, 2011; Knight, 2013; Nikischer, 2018; Vandeusen, 2016). With greater exposure to traumatic disclosures, there is greater vulnerability to transference, countertransference, and projection. Vulnerability to transference, countertransference, and projection, heightened by ongoing self-disclosure, can increase the risks of indirect trauma (Branson, 2019; Knight, 2013). The psychological, emotional, and cognitive consequences of

indirect trauma among practicing professionals have been well-documented. This includes feelings of helplessness, irritability, depression, decreased self-esteem, mistrust, a distorted perception of self and the world, intrusive and recurring thoughts, decreased empathy, a disrupted sense of safety, and difficulties in personal and professional relationships (Branson, 2019; Harr & Moore, 2011; Ben-Porat et al.,2020; Nikischer, 2018; Vandeusen, 2016). Two (2) forms of indirect trauma highlighted in the literature on peer support for survivors of sexualized violence are compassion fatigue and vicarious trauma (Cyr et al., 2016; Frey et al., 2017; Knight, 2013; McCormack & Katalinic, 2016; Pirelli et al., 2020). Although vicarious trauma is noted as more severe than compassion fatigue, the symptoms of both mirror those found in traumatized individuals (Branson, 2019; Knight, 2013; McCormack & Katalinic, 2016). In both cases, it is caused by empathic exposure and responsiveness to trauma. Vicarious trauma is an internal transformation that chronically and pervasively impacts one's worldview leading to a growing trauma-induced perception that the world is not safe, no one can be trusted, and one must be always on guard (Branson, 2019; Knight, 2013; McCormack & Katalinic, 2016). Compassion fatigue is described as a feeling of helplessness and a loss of ability to empathize with clients due to reexperiencing the traumatic events of survivors (Knight, 2013; McCormack & Katalinic, 2016). Research notes that inexperience with trauma work, high exposure to trauma survivors, and a personal history of trauma increases the risks of indirect trauma (Adams et al., 2006; Cunningham, 2003; McCormack & Katalinic, 2016).

Reducing the Risks of Indirect Trauma

Recommended practices for supporting well-being and reducing the risks of experiencing vicarious trauma and burnout closely center around organizational support (Phillips et al., 2015). Organizational support can encourage the development and maintenance of personal characteristics that promote resilience among lived experience staff (Frey et al., 2017; Sprang et al., 2018). A review of the theory, research, practice, and policies related to vicarious resilience in sexual assault and domestic violence advocates, that included two hundred twenty-two surveys, found that although a personal history of trauma may increase vulnerability to indirect trauma, there is evidence that organizational support could promote vicarious resilience (Frey et al., 2017). The foundation of effective, safe, and healthy peer support lies within the capacity of the organization to support the professional growth, emotional safety, and ongoing recovery of its peer support staff.

For peer support to maintain efficacy, the health and wellness of peer providers must be supported. Peer support has proven to improve social skills and social networks, coping skills, psychiatric symptoms, quality of life, self-esteem, life satisfaction, community engagement, goal setting, personal responsibility, hope, purpose, empowerment, and knowledge of mental health while simultaneously reducing isolation, shame, stigma, distress, hospitalization, and other crises (Blanch et al., 2012; Cyr et al., 2016; Shalaby et al., 2019). Supporting the

professional growth, emotional safety, and ongoing recovery of peer support staff supports them in their commitment to establishing and maintaining safety and connection in relationships with others by reducing the risks and impacts of indirect trauma. Recommendations for supporting the professional growth, emotional safety and ongoing recovery of peer support staff include improved supervision and peer relations, prevention programming, improved peer networking, staff relations, employee reflexivity and self-care, an environment that encourages relational authenticity, a positive work-life balance and knowledge of the risks and protective strategies related to indirect trauma (Delker, 2019; Frey et al., 2017; McMackin & LaFratta, 2021; Phillips et al., 2019; Pirelli et al., 2020). This section will introduce how organizational support can reduce the impact of indirect trauma among peer providers and honor the professional growth, emotional safety, and ongoing recovery of peer providers through trauma-informed onboarding, training, and supervision.

Onboarding

Trauma-informed onboarding promotes emotional safety, ongoing recovery, and professional growth. It allows participants to be fully informed of the risks and benefits of peer work while establishing co-reflective relationships from the onset. It involves informed consent and shared risk-taking which are necessary practices when engaging peer providers in the CSA sector (McCormack & Katalinic, 2016). Highly trained peer support facilitators in McCormack & Katalinic's (2016) study on residential peer support for CSA survivors highlighted the importance of informed engagement. They explained that "engaging with a conscious willingness to continue to heal, and thus be triggered indefinitely, was necessary" (McCormack & Katalinic, 2016, p.1033). Participants of the study spoke about how some negative aspects of the program contributed to positive outcomes. For example, the inevitability of ongoing triggers related to old beliefs and internalized messages that diminished self-worth resurfaced for facilitators during times of high stress. Ongoing self-reflection, self-care, and self-compassion is essential to effective role modeling and further personal growth (McCormack & Katalinic, 2016). Trauma-informed onboarding prepares peer providers for these responsibilities.

Training

Training can support professional growth and emotional safety. Training with a focus on coping strategies have been noted as protective factors in relation to compassion fatigue and vicarious trauma (Pirelli et al., 2020). Frey et al. (2017) recommend informed practices such as trauma education and shared power to counter the barriers to compassion satisfaction (poor wages, safety issues, lack of supervision, etc.). Training that supports professional growth and emotional safety includes information about egalitarian relationships; shared power; vicarious trauma and resilience; and nurturing an environment of safety to nurture transparency,

curiosity, safety, insight, authenticity, and mutual sharing related to conflict, stressors, concerns, and challenges (Frey et al., 2017).

Supervision

Co-reflection supports professional growth and ongoing recovery. Consultation and supervision with a focus on coping strategies are protective factors for compassion fatigue and vicarious trauma (Pirelli et al., 2020). However, the relational environment is critical to developing a supportive, respectful space for the support-seeking self-disclosure of peers (Phillips et al., 2015; de Vos et al., 2015). Supervision and consultation also support co-reflection (Blanch et al., 2012; Konya et al., 2020; Phillips et al., 2019). Regardless of who is facilitating supervisory discussions, a relationally safe environment is needed to foster the communication, honesty, and accountability necessary for co-reflection.

A recommended practice within peer support for CSA survivors is to support peer providers in self-reflection and self-care (Dutton et al., 2017; Goodwin & Patton, 2009; McCormack & Katalinic, 2016; Phillips et al., 2019). Peer providers need to know how to identify and respond to the warning signs of indirect trauma or relapses in their mental wellness and compulsive coping behaviors. McCormack & Katalinic (2016) describe a process of supporting participant and facilitator wellness through a reciprocal model of care where participants received healing opportunities and facilitators were provided with ongoing reflective professional and personal growth opportunities. In some cases, external supervisors and consultants may be employed to support this reflection. (Frey et al., 2017, Tsui et al., 2017). When organizations offer spaces where peer providers are offered information, resources, and support with decision-making, those same peer providers can develop these skills personally and then model them professionally through storytelling and role modeling.

Conclusion

Peer support is an effective, relational approach to supporting survivors of childhood sexual trauma that has tremendously positive impacts on the quality of life, wellness, and recovery of its members (Blanch et al., 2012; Cyr et al., 2016; Gregory et al. 2021; McCormack & Katalinic, 2016; Shalaby et al., 2019). Peer support is cost-effective; compliments traditional treatment; and has a plethora of mental, social, emotional, and physical benefits to its members (Cyr et al., 2016; Goodwin & Patton, 2009; Gregory et al., 2021; Hickle & Roe-Sepowitz, 2014; Konya et al., 2020). Although the advantages of peer support are vast, it does not come without challenges. Organizational support is paramount to the success of peer support within mainstream organizations and the investment required to experience the full value of lived experience leadership. Peer providers need training, connection to other peer workers, continued professional development, and regular peer supervision (Blanch et al., 2012; Goodwin & Patton, 2009; Konya et al., 2020; Philips et al., 2019). In order for hosting organizations to implement peer support that is true to its nature, they must be willing to undergo cultural transformation that eliminates hierarchal relationships and disempowering language; centers inclusion and respect; revolves around survivor-defined health and recovery; supports the safe and ethical use of self-disclosure; recognizes the perceived misuse of power within working relationships as potentially re-traumatizing; supports critical learning from a place of self-examination, self-adjustment, and self acceptance; engages all staff (peer and non-peer) in the practices and values of peer support; and develops race equality, anti-discriminatory, and culturally responsive practices (Blanch et al., 2012; Cyr et al., 2016; Frey et al., 2017; Nolin et al.,2020; Phillips et al., 2015; Phillips et al., 2019; Pirelli et al., 2020; Sprang et al., 2018). With strong organizational support, peer support can transform individuals, organizations, communities, and cultures while strengthening the leadership capacity of lived experience service providers.

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