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Recovery and Chronic Pain: Acceptance ≠ Giving Up

Lauren Hollrah, Psy.D.

Chronic pain can be a debilitating experience. Pain that lasts for years or decades interrupts life in such a way that it seems like it controls everything. It does not fit neatly into the pace of our modern world, nor with many of the "quick fix" attitudes that have become prevalent. According to the dominant medical culture, doctor and patient alike want the cure that will bring back the former way of life. Frequently, the thought is "if only I can find the right specialist, get the right diagnosis, or be given the right pill, injection, surgery or other procedure, then I can be relieved of this pain once and for all." Unfortunately, that is rarely the case and dealing with chronic pain is a life-long process focused on recovery and management rather than the elimination of all pain. Typically, patients will enter into the "medical merry-go-round" with their health care providers. For some, the repeated cycle of hope and later disappointment eventually leads to a downward spiral into feelings of depression, discouragement, and hopelessness. For others, the issue of blame enters into the doctor-patient interaction. In all cases, there can be distrust with the medical system in general.

In our Functional Restoration Pain Program we pursue a different approach to chronic pain. This approach is called "self-management" and represents an alternative or supplement to medical management. Unlike medical management, which relies solely on healthcare professionals, prescribed drugs, and passive medical procedures, self-management places responsibility for day-to-day pain management back on the patient. It requires acknowledgement of pain and reclaiming ownership of one's body to pursue healthy means of managing pain. While not opposed to medical management, self-management aims at creating a healthier balance between self-reliance, and dependence on professionals. Self-management is aimed at helping maintain a sense of personal control, dignity, and self-respect despite having chronic pain and disability. Self-management approaches to chronic pain are also meant to be flexible and adaptable to individual needs.

Many patients with chronic pain will eventually hear a doctor say, "There's not much more we can do for you. You're just going to have to live with your pain." The message, "you'll have to live with your pain" is not comforting at all. It can conjure up thoughts of passive suffering, "biting the bullet," and joylessly enduring your fate. The self-management approach is not about passively enduring, it's about taking active control of life and really living. A better concept is **living despite the pain**. It's about making the most of life despite having a chronic pain condition. That is the recovery process.

Recovery Update

is a collaboration by providers within the Veterans Health Administration, as well as mental health providers and recovery resources in the community. This periodic newsletter is intended to disseminate Psychosocial Recovery (PSR) information, news and developments. If you would like to contribute to Recovery Update or have questions regarding this publication, please contact:

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Lauren Hollrah, Psy.D. is a Clinical Pain Psychologist in the Pain Clinic at the VA Puget Sound Health Care System. She earned her doctoral degree in Clinical Psychology from Pacific University. She completed her pre-doctoral internship at the Northampton VAMC in Northampton, MA and her residency at a multidisciplinary pain management clinic, Progressive Rehabilitation Associates in Portland, OR.

Dr. Hollrah specializes in the behavioral treatment of chronic pain and the psychological issues that arise from chronic health conditions. Her professional interests include the development of Functional Restoration Programs, utilization of chronic illness management skills like mindfulness, stress management, and instilling hope for reengaging in an active and vital life.

Advances in the Early Intervention of Psychosis

Michelle Friedman-Yakoobian, Ph.D.

This article originally appeared in the Spring 2011 issue of NAMI Beginnings (Issue 18). It has been re-printed with permission from Dr. Friedman-Yakoobian and NAMI. For further resources regarding early psychosis, a full archive featuring all issues of NAMI Beginnings is available at www2.nami.org/beginnings.

In the first month of starting college, Xavier* was taken to the emergency room by the police after he was found wandering aimlessly around his university campus without shoes. He was muttering to himself about “mind tricks” being played on him by the government and university officials. To many people, this appeared to come out of the blue. However, in reality, this moment had been years in the making. In ninth grade, Xavier experienced periods when he felt different—as if he was living in a dream. He started feeling overwhelmed at school and his grades slipped from As to Cs. By eleventh grade, he frequently caught himself getting confused about whether something he dreamed about had actually happened. He also found himself feeling like his friends were scheming against him and could somehow tell what he was thinking even though he knew that is not possible. He began spending less and less time with his friends. By his senior year, Xavier’s parents had to struggle with him daily to go to school. Xavier met with his school’s counselor who assumed he was depressed. However, she also had a sinking feeling that perhaps he was developing psychosis. She never discussed these concerns with Xavier or his family because she felt that mentioning psychosis when she was not sure about it would be unduly stigmatizing to him.

Prodrome to Psychosis

Contrary to popular belief, psychosis does not come out of the blue. Typically, a young adult will experience several months or years of milder symptoms that cause challenges with school and social functioning. This period of time is known as the “prodrome to psychosis.” However, the signs of prodrome to psychosis are usually difficult to recognize and may be misunderstood as signs of depression, drug or alcohol abuse, late-onset attention deficit/hyperactivity disorder (ADHD) or even a normal phase of adolescence. It is not until a young person develops clear signs of a first psychotic break (such as in the story of Xavier above) that the symptoms are clearly recognized.

* This story is a fictionalized account similar to the stories of a number of young adults who have experienced a first psychotic episode and who have been seen at the Center for Early Detection, Assessment and Response to Risk.

About the Author:



Michelle Friedman-Yakoobian, Ph.D. is a Licensed Clinical Psychologist and an Instructor in Psychiatry at Harvard Medical School, at the Massachusetts Mental Health Center Public Psychiatry Division of the Beth Israel Deaconess Medical Center. Dr. Friedman-Yakoobian is the Clinical Director of the Center for Early Detection, Assessment, and Response to Risk (CEDAR Clinic), a clinic devoted to early detection, intervention, and prevention of psychotic disorders. Dr. Friedman-Yakoobian’s research and clinical interests are focused on the development and implementation of effective psychosocial interventions for individuals experiencing psychosis (or signs of risk) and their families. Previously, Dr. Friedman-Yakoobian developed a family intervention designed to help clients and families learn strategies for overcoming cognitive deficits related to psychosis. Currently, she is developing and studying a new cognitive remediation program for young people at clinical high risk for psychosis that combines elements of Cognitive Enhancement Therapy and Acceptance and Commitment Therapy. She has written journal articles about her work and regularly presents at colleges, hospitals and community youth agencies to raise awareness about new advances in early detection and treatment of early signs of psychosis. She authored *Everything You Need to Know about Schizophrenia* (The Rosen Publishing Group, 2000), a book for teenagers about schizophrenia.



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Early Intervention Clinics

As studies find that developmentally sensitive, specialized early interventions lead to better outcomes for young adults living with schizophrenia, a movement toward even *earlier* intervention has evolved. That is, efforts have been made to identify young adults who are experiencing symptoms that may be part of the prodrome to psychosis. The idea is to provide early treatment to help young adults stay on track with their lives and to try to prevent full-blown psychosis from developing. This work was pioneered by Dr. Patrick McGorry and colleagues in Australia, then spread to the United Kingdom and some other countries and has now slowly become available in some areas of the United States—mostly in locations that are associated with academic medical centers (see the table, U.S. Clinics for Youth at Risk for Psychosis, on page 5 for a list of U.S. clinics)

In Boston, this has led to the development of the Center for Early Detection, Assessment and Response to Risk (CEDAR). CEDAR is affiliated with the Beth Israel Deaconess Medical Center and the Massachusetts Mental Health Center and is funded by the Sydney R. Baer Foundation and the Massachusetts Department of Mental Health. The goal of CEDAR is to connect with young adults like Xavier early on—when they are still able to recognize that their thinking is changing— rather than wait until symptoms become more fixed and disabling. In order to reach young people during this early stage, CEDAR provides free out-reach trainings to community youth agencies, including schools (middle school, high school and college), primary care settings, community clinics, emergency rooms and youth groups to get the word out about the CEDAR program. CEDAR staff members are available to provide expert consultation and evaluation on whether a young adult may be at risk for psychosis. Young adults who are identified as at-risk are offered supports, including family education, school/work counseling and support, cognitive behavioral therapy and in some cases, low doses of medication to help them get back on track with their lives.

CEDAR is one of less than 20 programs in the United States that specializes in identifying and treating young adults who are showing signs of risk for psychosis.

Research on the Risk for Psychosis

Currently, the largest study of risk for psychosis in North America is the North American Prodrome Longitudinal Study (NAPLS), which includes eight sites across the United States and Canada. These sites work together to better understand what happens in the brain when psychosis begins. Another primary goal of the NAPLS study is to learn how to best distinguish individuals who are truly at risk for developing psychosis from those who are experiencing similar symptoms but are not going to develop psychosis. Some smaller studies in the United States and from around the world have also been investigating the treatments that may be most effective for helping young people at risk for psychosis. More research needs to be done before firm conclusions can be made about what treatments work. Although early studies have shown some support for the following:

- cognitive behavioral therapy;
- omega-3 fatty acid supplements;
- intensive community care with family psychoeducation; and
- low-dose antipsychotic medications.



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Future Considerations

Currently, individuals who are showing signs of risk for psychosis can have a hard time getting treatment because their symptoms may not meet criteria for any specific mental illness in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*. There is a proposal to add “psychosis risk syndrome” to the upcoming fifth edition of the manual, although it is not without some controversy. Those in favor note that this new category would lead to greater awareness about the early signs of psychosis, would make it easier to justify reimbursement of treatment by insurance companies and would help to prevent the progression of mental illness. Those opposed have noted concerns about false diagnoses. That is, most people who are experiencing symptoms that would meet criteria for the psychosis risk syndrome may not go on to develop psychosis and could be unnecessarily exposed to stigma or medication side effects.

Do's and Don'ts for Talking with Someone Who May Be at Risk for Psychosis

Do...

1. Spend time with the person and keep lines of communication open. It is easiest to express your concerns in a helpful, non-threatening way when you maintain regular contact and communication. Even if the young adult has been withdrawing from you, continue to invite him or her to join you for dinner, go for a walk or talk on the phone, but also be willing to take no for an answer if the young adult is not up for it.
2. Express your concerns. Be open and honest as much as possible. In a gentle, non-judging way, let the young adult know that you have noticed that he or she seems to be going through a tough time or seems to be experiencing changes and that you are available to listen and help when he or she is ready to talk about it.
3. Let the young adult know he or she is not alone. Between 4-17 percent of young adults report experiencing sub-clinical (mild), psychotic-like symptoms. These experiences are not rare and there could be a number of reasons why they occur. Letting the young adult know that you are familiar with what he or she is going through and that he or she is not alone can be very reassuring.
4. Let the person know that there is hope and practical help available. Clarify what the young adult may want to gain from seeking help. Balance talking about what the young adult wants and what you

think would be helpful. Both medical and psychological therapies (for the individual and his/her family) can help to reduce symptoms, distress and daily difficulties associated with clinical risk.

5. Be patient and avoid pushing too hard. When you first express your concerns, the young adult may not want to talk about it. Let the young adult know that you respect his or her privacy—but are available to talk and share information about potentially helpful resources when he or she is ready. Then keep the lines of communication open with the young adult so he or she can warm up to the idea of talking with you about his or her concerns.

Don't...

1. Ignore changes in functioning or recurrent odd behavior as being “just a phase” or “teenagers being teenagers.” Contrary to popular belief, research has found that it is not typical for adolescence to be a time of significant turmoil and distress. While increases in privacy concerns are common, it is not typical for teenagers to refuse contact with friends for long periods of time or to withdraw significantly from family relationships. If you know a young adult who has recently begun to withdraw from others, behave oddly and/or struggle at school and with friends, it is important to offer support and help. There can be a number of reasons why this can be happening. A careful assessment can help the

young adult (and you) better understand what is going on and what types of services and supports can help. Ignoring early warning signs delays early treatment, which has the best chance of being effective.

2. Act as if you are giving dreadful news when talking about risk for psychosis. There is a lot we now know about treating psychosis and there is much hope for recovery—especially when it is treated early. Talking with the young adult about risk can provide an important opportunity for the young adult to better understand what is happening to him or her and to get effective treatment that can prevent further distress and negative changes in functioning. If you are comfortable talking directly about the symptoms and daily difficulties as treatable, the young adult will often take your lead and feel reassured. Using everyday language such as “stress” and “changes in experiences or functioning” is also helpful in normalizing the young adult's experiences.
3. Push too hard or argue with the young adult if he or she denies that anything is wrong. If the young adult denies experiencing challenges or refuses to talk with you about your concerns, respect his or her privacy and let him or her know that you are there to help if and when he or she wants to talk. You might gently describe some specific behavioral changes that you have noticed (e.g., “I have noticed that, since December, you

have been spending a lot of time in your room, your grades have gone down and you have been wearing sunglasses most of the time. I know that a lot of young adults can experience stress during their senior year of high school and sometimes it can help to talk to someone about it. I am here if you decide you want to talk”).

4. Do not give up and do not forget to take care of yourself in the process. The young adult may seem more interested in engaging in treatment at some points in time more than others. Steps forward may often be followed by steps backwards as well. To help a young adult get into treatment and stick with it, you may have to try several times and even enlist the help of other family members and friends. Keep a sense of priorities and avoid “sweating the small stuff.” Focus your efforts on the important activities and tasks that matter the most in the long run (e.g., school, well-being/safety and relationships) and not so much on the smaller things (e.g., keeping a room clean). Keep your perspective. The young adult did not choose to have these difficulties. Rather, he or she is currently being challenged by a significant change in functioning that may be due to a neurodevelopmental process or disorder. Lastly, maintain your own positive daily routines and keep in touch with your best supports to recharge your batteries. You cannot help the young adult if you are not caring for yourself first. 

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U.S. Clinics for Youth at Risk for Psychosis		
LOCATION	NAME OF CLINIC	DETAILS
California		
Los Angeles	The Staglin Music Festival Center for the Assessment and Prevention of Prodromal States	Provides assessment and treatment for youth at risk or in first episode of psychosis aged 12-35.
Sacramento	Early Diagnosis and Preventative Treatment	Provides assessment and treatment for youth at risk or in first episode of psychosis aged 12-30.
San Diego	Cognitive Assessment and Risk Evaluation	Provides assessment and treatment for youth at risk aged 12-30.
San Francisco	Prodrome Assessment Research and Treatment Program	Provides assessment and treatment for youth at risk aged 12-35.
Connecticut		
New Haven/Hartford	Prevention Through Risk Identification Management and Education	Provides assessment and treatment for youth at risk aged 12-40.
Georgia		
Atlanta	Development and Mental Health Project	Provides research-based evaluations for youth at risk aged 13-30.
Illinois		
Chicago	First Episode Psychosis Program	Provides assessment and treatment for youth experiencing early stages of psychotic symptoms aged 15-40.
Maine		
Portland	Portland Identification and Early Referral Program	Provides assessment and clinical services for youth at risk aged 12-25.
Massachusetts		
Boston	Center for Early Detection, Assessment and Response to Risk	Provides assessment and treatment for youth at risk aged 14-30.
Michigan		
Detroit	Services for the Treatment in Early Psychoses	Provides assessment and treatment for youth at risk or in first episode of psychosis aged 12-50.
Ypsilanti	Michigan Prevents Prodromal Progression	Provides assessment and treatment for youth at risk aged 12-25.
New Mexico		
Bernalillo County	Early Assessment and Resource Linkage for Youth	Provides assessment and treatment for youth aged 12-25.
New York		
Manhattan	Center of Prevention and Evaluation	Provides assessment and treatment for youth at risk aged 12-35.
Long Island	Recognition and Prevention	Provides assessment and treatment for youth at risk aged 12-22.
North Carolina		
Chapel Hill	Outreach and Support Intervention Services	Provides assessment and treatment for youth at risk or experiencing early psychosis aged 16-36.
Pennsylvania		
Pittsburgh	Services for Treatment in Early Psychoses	Provides assessment and treatment for youth at risk and in first episode of psychosis aged 12-50.



Art Therapy in Recovery from PTSD

Lisa Giovanetti, ATR-BC, LPCC

Often, trauma is not stored in the verbal centers of the brain; it can be hard to access language to share our experience. In Art Therapy, images and metaphor help us express and connect with emotions, especially when feeling stuck and/or numb.

The process of making art can be a release and offer a safe venue to externalize intense and uncomfortable feelings and thoughts. It can also can be a side door around the defenses, which in civilian life can impede growth and healing.

Art Therapy helps Veterans engage in creative problem solving—developing the ability to see options and new perspectives—a skill that can be impaired by trauma.

Common questions we get asked about art therapy in PTSD work include:

Do I have to be an artist or good at art to do Art Therapy?

No. In fact, Veterans who have never engaged in art-making often experience the most significant benefits of having an additional method of communication. In Art Therapy, our motto is: *“Art for expression, not for perfection.”*

Is this an art class or lesson?

No. Art Therapy treatment, similar to traditional talk therapy, targets mental health symptoms and recovery. Treatment takes the form of closed therapy sessions that use the creative process to explore symptoms and healing. Both one-on-one and group sessions are facilitated by registered art therapists, with extensive training in mental health treatment.

Will the art therapist analyze my art?

No. The art therapist is there to assist you in processing and learning from the art. The goal is for the Veteran to approach his/her own art with curiosity and non-judgmental inquiry in order to gain insight and foster self-awareness

How do I learn more about Art Therapy services?

Talk to your care team to see if there are registered art therapists offering services at your VA. Additionally, here are some resources highlighting art therapy services in trauma work at the national level:

[Discovering Art and Healing at the VA](http://www.operationwearehere.com/ArtTherapy.html)

<http://www.operationwearehere.com/ArtTherapy.html>

About the Author:



Lisa Giovanetti, ATR-BC, LPCC

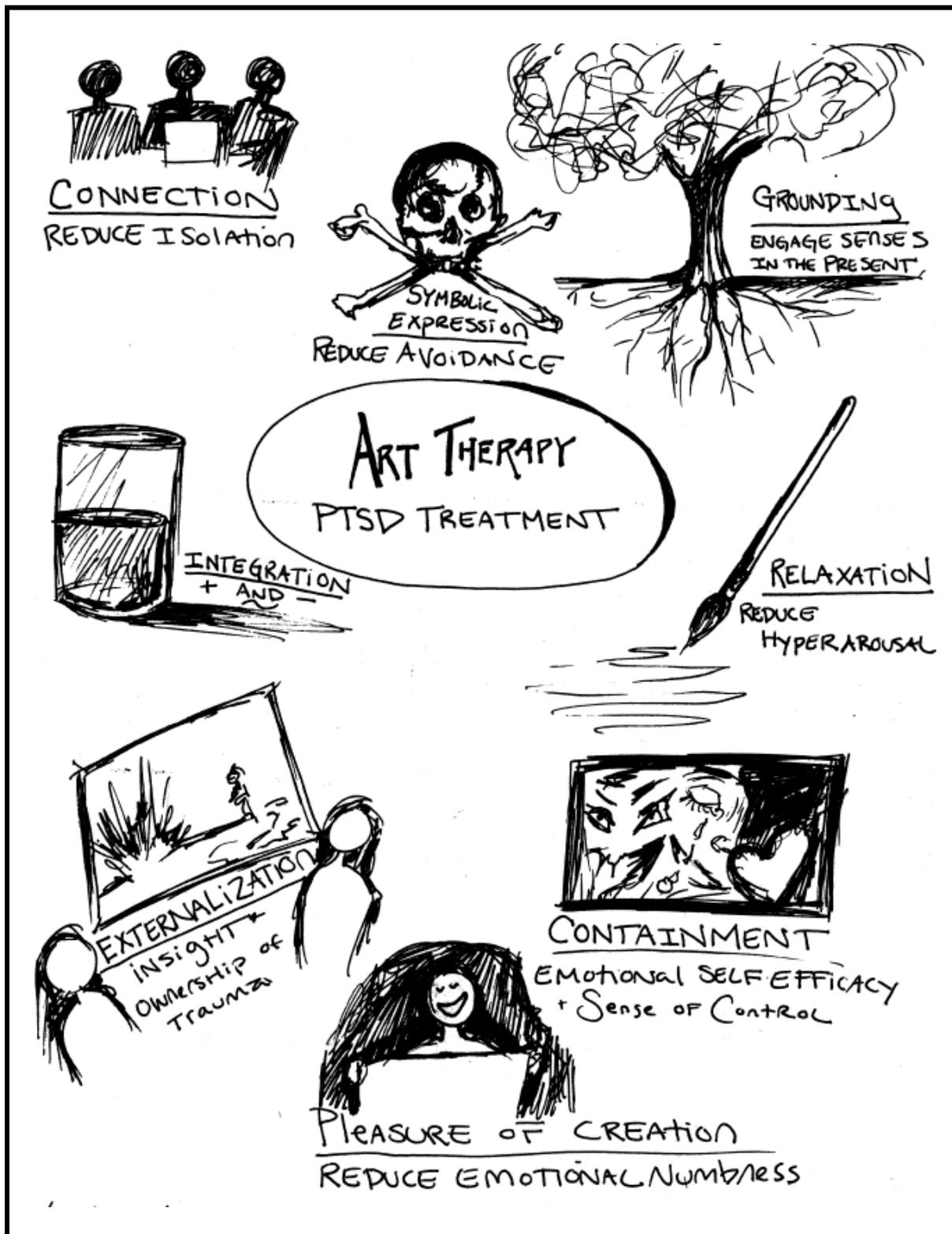
Is an Art Therapist and member of the PTSD Outpatient Clinical Team at the VA Palo Alto Health Care System (Menlo Park Division). She has a Master’s Degree in Expressive Therapies with focus on Art Therapy and Mental Health Counseling and specializes in the use of creativity to support healing and growth in mental health and trauma recovery. Ms.

Giovanetti has experience working as a clinician in groups homes/therapeutic day schools for children as well as in a community based day rehabilitation program for adults with SMI. She began working at the VA in acute inpatient psychiatry in 2013.



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Recovery Reminders

Kristin Gayle, Ph.D.

- Do I respect the Veteran’s goals even if I disagree?
- Am I focusing on making the Veteran’s life more meaningful (as opposed to only symptom reduction)?
- Is the Veteran an active and equal partner in the treatment planning process?
- How might the Veteran feel if he/she read what I wrote about him/her?
- How can I help this Veteran develop a meaningful community support network?
- Am I treating this Veteran the way I would want to be treated if I suffered from the same illness?

Ask a Veteran

We asked Veterans from the Ralph H. Johnson VAMC in Charleston, South Carolina:

“What advice would you give someone who is just starting in their recovery journey?”

Here’s what they said:

- “Share your own experiences with others at the PRRC and other programs, that helps your own personal recovery. Sticking to what you say you are going to do.”
- “Take advantage of any programs that the VA offers. Get back out into the community. Join a support group. Establish a daily routine. Get off the couch and out of the house. Do things! Exercise and eat right. Be kind to yourself and take good care yourself. You are important!”
- “Once you have come a ways and have found a connection between the direction you want to go, find a pace that you can maintain from day to day. Following that pace that you have set for your self as time goes on you will begin to see your recovery journey take shape!”
- “Hang in there and stay with it, the PRRC can help you—the lectures, discussions, handouts, the support really can help. Hold on and don’t let go - Don’t give up so easy! You can start believing in yourself, you get more confidence — you can get more out of life — you have to hang in there.”
- “The biggest advice I can give is to be “strong” and “positive”. The only way recovery can begin is to “want” it, and this is difficult but a very vital requirement. The advantages of those requirements allow for a positive attitude, the ability to continue to build a positive environment will allow the positive and strong to continue to grow— creating positive reactions that continue on a path of success.”



Recovery Reminders is a recurring section in Recovery Update, in which providers suggest considerations or questions that clinicians may wish to ask themselves when working with consumers to ensure recovery-oriented care.

This edition of Recovery Reminders features contributions from:

- Kristin Gayle, Ph.D.
SMI Services Director

VA Puget Sound Health Care System,
American Lake Division



Ask a Veteran is a recurring section in Recovery Update, in which Veterans are asked questions about their path to recovery. This issue of Ask a Veteran features responses from veterans at the Ralph H. Johnson VAMC in Charleston, SC.



Zen and the Art of Peer Support:

Chuck Sanchez

If the title above sounds familiar, it is. I stole it. Well, I paraphrased it. Robert M. Pirsig wrote a book entitled *Zen and the Art of Motorcycle Maintenance* in 1974. I remember reading it while standing watch over the engineering plant onboard the USS Pioneer MCM-9. This book dealt some with motorcycle maintenance and even less with actual Zen, but was interesting to me as it explored the metaphysics of values and quality. As the book concludes, (spoiler alert), the narrator, reaches the West Coast of the United States by motorcycle with his son riding on the back the entire way. He arranges transportation home back East for his son, and Pirsig becomes an inpatient in a psychiatric program, having fallen victim to his philosophical meanderings.

As I read the book I empathized with the kind of madness or exhausted insanity that too many philosophical musings can create. I can remember as a child, around 9 or 10 having a congregation in my head trying to figure out whether or not life had any inherent meaning. And if it didn't, how then did I know apathy, or harming others, or a nihilistic anarchy wasn't the way to go? On the other hand, how could it have meaning when everything around me seemed to occur by chance? I didn't buy into Einstein's thinking, it looked to me like God was playing dice with the universe. These are haunting thoughts for a 10 year old to be burdened with. I experienced these thoughts and others like them frequently and they felt intrusive. All I really wanted to do was play baseball. In high-school as the bullying started, I struggled, as do most of us I have discovered, to carve a niche for myself. I found solace in creating music. I was fairly good at it, and understood it. The answers were easier. I still struggled with the difficult questions and intrusive thoughts, but they only haunted me at night when I was tired and wanted to sleep. No big deal I thought.

It wasn't too long into my first go at college that I wanted to die. At night I would hope that I didn't wake up the next morning. I wanted a break from the constant mental chatter. Most of it by this time wasn't very nice or encouraging. I had always wanted to travel, and be busy, the Navy sounded perfect.

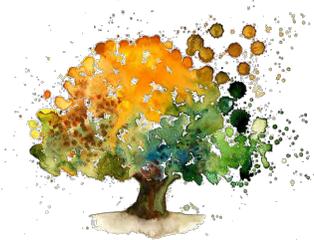
It was perfect too. With one exception, I had to bring myself. I had experiences that were unrivaled anywhere else and was afforded the gift of reinventing myself. All of the old racing thoughts were there, but luckily I wasn't required to sleep. In fact sleep was discouraged, so I could stay busy and exhausted. My mind only bothered me sometimes.

After six years I got out of the Navy, went back to college, graduated, and decided that marriage and family would help. Things got bad again.

Somewhere along the way I found a process to quiet my mind through mindfulness meditation. At various times I have been in therapy learning to process the hurt, fear and sadness that I helped create. I still struggle with these emotions and racing thoughts sometimes. My wife is a tough lady for supporting me, and my kids don't have a perfect father. But it doesn't seem like anybody else's kids do either.

I worked for the VA for about 10 years before becoming a Peer Support Specialist, and I was very nervous about 3 years ago as I briefly described the role of a Peer Specialist to the entire staff of the outpatient clinic where I work. Many of whom probably weren't aware of my mental health struggles. I was admitting to about 200 folks that I had been diagnosed with a mental illness, was in recovery and helping and supporting others to learn and embrace skills that I had to learn and embrace to have a life that was meaningful to me. Getting through that gracefully is a testament to the recovery tools I still use, as I share my story with others, in groups, one-on-one, or in newsletter articles. However I do it, I must continue to breathe and be present giving my emotions the space they crave. I have to practice what got me here, to stay here. Sometimes I make the mistake of thinking I have it licked. These are the times that life takes me down a peg. But, it's all grist for the mill isn't it?

"... I was very nervous about 3 years ago as I briefly described the role of a Peer Specialist to the entire staff of the outpatient clinic where I work. Many of whom probably weren't aware of my mental health struggles. I was admitting to about 200 folks that I had been diagnosed with a mental illness, was in recovery and helping and supporting others to learn and embrace skills that I had to learn and embrace to have a life that was meaningful to me. "



About the Author:

Charles (Chuck) Sanchez is a Peer Support Specialist working at the Daytona Beach VA in the PRRC. Along with facilitating groups and doing individual sessions Chuck started a music group at the PRRC in 2012. The group explores ways to use music for personal recovery by learning to play instruments, performing or just listening. The group performs at PRRC events and has played in the community while auditioning to play in the Daytona Beach Recovery Month celebration.

