Bridging the Gap With Peer Support
Patricia’s Recovery Story

The current commentary describes the life of an individual living with multiple psychiatric, substance use, and domestic violence problems, escaping an abusive situation, and obtaining help. Her story includes the help she received from peer support services and her rise to peer support specialist. A brief review of the advantages and barriers to peer support is also included.

BACKGROUND
In the “Joint Commission Top Standards Compliance Issues for 2010” (2011), health care providers are required to develop a plan for care, treatment, or services that reflect the assessed needs, strengths, and limitations of the individual served. Self-Management and Recovery Training (SMART) is an evidence-based recovery model (Gilliver, 2010). The four-point model emphasizes building and maintaining motivation; coping with urges; managing thoughts, feelings, and behaviors; and living a balanced life. Dr. Gerstein, its founder, claims that this model is effective in achieving recovery from addiction. SMART recovery has been in existence since 1994 (SMART Recovery, 2017). A list of providers can be found on the SMART recovery website (access http://www.smartrecovery.org).

Peer support services are a growing part of mental health care. These services encompass an evidence-based practice, reimbursable model recognized by the Centers for Medicare & Medicaid Services (Canady, 2015; Daniels et al., 2013). Peer support is showing great promise in facilitating recovery (Repper & Carter, 2011). More than 60% of individuals working for recovery services are peers (Porter, 2011). Duties and tasks specific to peer support specialists include empowering consumers, promoting consumers’ educational growth, and supporting personal development (Crane, Lepicki, & Krudsen, 2016). Peer support services involve individuals in recovery from mental illness who offer encouragement, hope, and support to individuals in similar situations (Walker & Bryant, 2013).

In Congressional briefings (Canady, 2015), consumers and experts advocated for the use of peer support services to improve recovery and lessen the cost of care. Peers go through training and receive certification to become members of a treatment team to stand alongside, augment, and enhance services. Mental health services are inadequate in 85% of counties (Canady, 2015). Peer support services may help fill the gap in this vulnerable population.

ADVANTAGES OF PEER SUPPORT SERVICES
The literature reveals that peer support services can lead to a decrease in inpatient psychiatric admissions among individuals with whom they work (Repper & Carter, 2011). Advantages for the peer support specialist include friendly relationships with peers, staff, and increased wellness resulting from working (Walker & Bryant, 2013). Peer support recipients experience increased wellness and social acceptance (Walker & Bryant, 2013). Bracke, Christiaens, and Verhaeghe (2008) found that providing peer support was beneficial to the individual providing the care. Peer support workers are in a good position to “navigate primary care services by aiding in the transition from specialist care to community living while preventing and reducing relapses and rehospitalization” (Tellez & Kidd, 2015, p. 84). Peer support services are less expensive and effective at reducing hospital stays and helping individuals achieve and maintain wellness (Canady, 2015). Myrick and del Vecchio (2016) established that “peer support services have the potential to increase access to recovery-oriented services for people with mental and substance use disorders served by the public behavioral health care system” (p. 197).

BARRIERS TO PEER SUPPORT SERVICES
The key barrier to the practice of peer support services is obtaining adequate and ongoing funding (Tellez & Kidd, 2015). Myrick and del Vecchio (2016) also agree that financing and workforce challenges exist. Peer support workers may experience non-peer staff prejudice and discrimination, low pay, undesirable working hours, and difficulty managing the transition from “patient” to peer support worker (Walker & Bryant, 2013). Challenges may also include supervision, training, and management of all involved (Repper & Carter, 2011). Role ambiguity may be a challenge because
of the overlapping responsibility between peer support specialists and case managers, including aspects of each role that promote consumers’ development, wellness and recovery, administrative tasks, and care coordination activities (Crane et al., 2016). In a New Zealand study, Scott et al. (2011), as cited by Tellez and Kidd (2015), found participants in their research indicated that peer support workers had a “tentative place” (p. 86). Regardless of barriers, with self-management and recovery training, participants can decide if they have a problem and build their motivation to change. The story of one such individual is presented.

PATRICIA’S STORY

During my 60 years of life, I have been diagnosed with multiple mental and physical illnesses. I did not keep records of the diagnoses or names of medications I received. I did not want to be bothered. But I remember that for many years I was treated for bipolar I and II, then manic depression, uncontrolled anxiety, panic attacks, and schizophrenia in addition to substance use problems. I was prescribed a variety of medications including antidepressant agents, lithium, and antipsychotic and anti-anxiety agents. After many years of taking these medications, I began experiencing negative side effects, including liver failure and kidney problems.

These side effects resulted in more physician visits and, later in life, I was diagnosed with posttraumatic stress disorder (PTSD), anxiety, and depression.

During office visits, physicians told me that I must continue taking the prescribed medications for the rest of my life. Sometimes it was a handful (24 pills) at a time, which also included several vitamin pills. Often, I felt like a zombie. Psychiatrists had given up on me, saying that recovery was not a possibility and my life was limited. Well, I would like to say the physicians and other professionals were wrong.

Childhood in New York

My life began on June 12, 1956. I was the product of fetal alcohol syndrome and the last of 19 children. I lived in a small town called Bayside in Queens, New York. When I was 5 years old, one of my siblings was murdered, leaving behind two small children. My mother got custody of the two children. Since age 5, I helped care for them while still attending school and graduating in 1975. At age 19, I joined the U.S. Army. Approximately 9 months after enrolling, my mother had a major stroke, and I had to return home to care for her and my two nephews. My older siblings had left home. They promised to help with our disabled mother and sister’s two children, but I found myself carrying the load.

Both of my parents had severe alcohol addiction, and this had been an ongoing issue for most of my life. My father was separated from my mother. He lived across the street in a boarding house but was not permitted to return to live in the same household because of domestic violence toward my mother and his alcoholism. I was not able to have much of a normal childhood, and I began to experience depression. My symptoms included anxiety, decreased self-esteem, hopelessness, sleeplessness, difficulty focusing, and increased suicidal thoughts. In coping with these feelings, I began to follow my parents and drink alcohol.

My first visit to a professional was to a medical physician. When I started talking about what was going on with me, I was told that I needed to see a psychiatrist. After the first psychiatric visit, I was prescribed an antidepressant medication. This medication worked for a while, but eventually I began to relapse. I returned for a second visit and was given two more medications. In the years to come, I continued to experience anxiety, suicidal thoughts, hopelessness, and helplessness. I began to mix medications with addictive drinking. In my lifetime, I have attempted suicide three times. One was by drinking until I became unconscious. Another time I overdosed on pills. The third time it was by closing the garage door and turning on the engine to die of carbon monoxide poisoning. I was admitted to inpatient psychiatric units each time, and my medications were increased. I have been admitted at least 11 times for psychiatric inpatient treatment in my lifetime. During these admissions, diagnosis and medication changes occurred, followed by many years of outpatient therapy.

There were times when I was able to focus. I took college courses and found employment. I studied to be a private duty nurse. I was able to support myself and have an improved quality of life. My life began to look hopeful. I worked for the Long Island Jewish Medical Center. There, at age 27, I met the man of my dreams. He was a patient I was helping in the hospital. He was a nuclear engineer, well-respected and decent. He was 32 years older than me, but that did not matter. We fell in love, got married, and had two beautiful children (a daughter and son). We were married for 15 years. Less than 2 weeks after the birth of our son, my husband had an open-heart surgery and passed away.

Move to Florida

In 1990, 2 weeks after my husband’s funeral, I moved to Citrus County,
Florida. I started the construction of our new home in a 14-acre lot my husband and I had previously planned. My husband had left sufficient money for building the house and for our future needs. After the construction had been completed, I moved into our new home with my two children. A few months later, I began feeling the symptoms of depression. I became bored and lonely. To engage myself in activities, I joined the Mary Kay® cosmetics business. I also spent time as an independent consultant for skin care. These ventures did not bring in a lot of money, but it kept me engaged. Meanwhile, in New York, my mother died in 1992, and my father passed away 5 years later. One nephew died of drinking complications, and the other nephew was placed in a nursing home.

During this time, I met the second love of my life, who was 5 years older than me. This new man served in the Vietnam War. He was a decorated soldier and ex-prisoner of war. We got married and were blessed with a son. Everything seemed to be perfect. We were one big happy family. A few years later, our youngest son was diagnosed with Asperger’s syndrome. One day, we were returning home from a doctor’s appointment for our youngest son. On the way home, my son was crying because of a reaction to an injection he had received. My husband, who was driving the car, pulled off the highway and got out of the car. He left our son and me in the car and started walking 10 miles home. I drove my son home, and my husband never spoke about the incident again. I knew something was wrong. I found out later from one of his Army friends that my husband had been hospitalized for PTSD. A child’s cry probably triggered his PTSD symptoms. This incident was just the beginning of a journey to hell. I felt that everything I tried to do was sabotaged. I realized the danger my two older children were in and sent them to Michigan to live with relatives and for their schooling. They are very intelligent, and the move was successful.

My second husband had an explosive personality. I have gone through physical, emotional, and financial abuse. He would lift the television and throw it across the room. He shot me in my buttocks and shoulder. I had to have hip replacement surgery and ended up in a wheelchair. He would hit me on my face and eyes with his gun. Whenever I planned to leave, he would threaten to kill our son and me. He used our money for marijuana and cars and spent lavishly. He introduced me to marijuana. Prior to that, I was only drinking alcohol. My life began to fall apart again. With all the medical bills and substance use habits, all the money from my previous husbands’ savings vanished.

Once again, I started getting sick, and not just with mental illness, but medical problems including fibromyalgia, hypertension, cancer, and hip replacement. While I was recovering from my last surgery, I was again assaulted by my husband. This was the last straw. I was determined to leave as soon as I was able to get some strength. After I had recovered, I asked my husband to help me buy a ticket to visit my other two children in Michigan. He bought the ticket. I left Florida as fast as I could to safety and recovery. By now, my youngest child was 17, and although he had Asperger’s syndrome, he was high-functioning and doing well independently.

It was time to take care of myself. Away from the abuse of approximately 22 years, I knew I had a better chance of getting well and that my life was not limited. I moved to Kalamazoo, Michigan, not only to be close to my two children but also to search for sanity. My second husband and I got divorced 6 months after I moved to Michigan.

Despite being away from an abusive situation, I had many rounds of depression and many more medical problems, which came with more prescription medications. All this time, physicians had told me that I needed to get well, but I was never shown how to get well. During my last admission to the Borgess Medical Center psychiatric unit for mental illness, the therapist told me, “The way you are is because you don’t like yourself.” This was very upsetting to me. My physician told me that I was a nice person, but “you should never come back to the mental ward again.” He said that the problem was with my thinking.

I left the hospital that day wondering if what they had said was true. Could I change the way I was thinking? If I change my way of thinking, could I feel and act differently? One of the therapists mentioned checking out the peer support center. Four days later, I went to the Recovery Institute of Southwest Michigan. My life changed for the better. I have been free of medications for mental illness since I left Borgess Medical Center 5 years ago.

**Psychiatrists had given up on me, saying that recovery was not a possibility and my life was limited.... The physicians and other professionals were wrong.**
Peer Support Center

I was skeptical at first but determined to give my life another chance. I thought, “My organs are breaking down, and I’m dying anyway.” The people at the center were friendly and nonjudgmental. I started attending the center daily, just to see if this was a good fit for me. I began to get involved with many activities, became a member, and attended all support groups they offered. As I started making changes to my life, my growth and support for my recovery expanded. I was able to identify with peers who had similar life experiences. I found that I could talk with peers who would listen and not be judgmental. I got the support, education, and wellness that I needed from the peer support center. The center used the SMART recovery model. They emphasized its four core principles—building and maintaining motivation; coping with urges; managing thoughts, feelings, and behaviors; and living a balanced life. I was determined that this path was right for me. I began focusing on my strengths, and not my weaknesses. I no longer had to rely on medications for my mental illness, but the support was still necessary.

As a participant at the peer support center, I realized that supporting others who are struggling and listening to them is something I could do to help. During one of the groups, I heard about a training program at the local community college. I attended a peer support training course at the Kalamazoo Valley Community College and took the certification examination from the State of Michigan. This was the beginning of a new career: an individual recovering from mental illness helping others with mental illness. One year after I first set foot at the center, they offered me a job.

Rise to Peer Support Specialist

I have been a part of the Recovery Institute staff since 2012. They have been adding responsibilities, which I love. These responsibilities include Certified Peer Support Specialist, Recovery Coach, SMART Facilitator, and Recovery Oriented Data Action Network team member. I am also trained in trauma-informed care, and I fill outreach roles at the Community Mental Health Access Center and Kalamazoo Psychiatric Hospital (KPH). Often, I am called to the psychiatric inpatient unit at KPH to plan aftercare peer support services for patients ready to be discharged to the community.

I recognize that my overall role at the Recovery Institute is to help those who are seeking recovery. I do this by walking the bridge with peers and members who are traveling from hopeless to hopeful. I want to be the role model they can follow. My goal is to educate individuals who I work one-on-one with and provide them with the tools they need to seek recovery on their own. I recognize what it means to live a life of trauma and pain—mentally, emotionally, and physically. I see great power in the relating of one peer to another because it is important not to feel alone. When I share my story with peers, I remind them that if they want something enough, recovery or otherwise, and if they believe in it, they can make it happen.

I model my life of recovery by being an example for others by taking care of myself first and being ready to assist others. My goal as a peer support individual is to help reduce stigma, advocate by being the voice for those who need to be heard, educate, and help others so they may be empowered and lead the life they desire. I help peers by earning their trust, being nonjudgmental and open-minded, being available, and giving the respect and dignity they deserve. I tell my peers about the stigma I faced, such as being called “crazy.” As a woman of color (I am half-black and half-Irish), there were only selective places I could go to socialize. This was especially noticeable in Florida; however, I did not feel this in New York or Michigan. No one wanted to listen to me. I lived through this entire stigma.

My duties as a peer support specialist involve telling peers that change is possible, and so is recovery, for anyone who is willing. I tell them that a diagnosis should not define who they are, and I educate them about their rights.

Working as peer support staff is not a high paying job and it does not have the perks others may enjoy. Some individuals with lived experience may not be satisfied with working in the mental health field. However, I feel very positive about working with individuals who are struggling. I have found that sharing my life challenges and believing that everyone has the ability to recover are some of my best accomplishments in life.

Conclusion

My life has been full of significant experiences, some treasured and some tragic, and all together they have led me to the life I lead today. At one particular turning point, I found myself existing in suffering. Before I moved to Michigan, I was holding on waiting for my husband to die. I was losing myself. I decided I had to go, which took a lot of courage and determination. I gathered the strength to get on a plane from Florida to Michigan. This same strength lives inside of me today. Recovery has allowed me this freedom.

These days I spend my leisure time listening to music, cooking, creating artwork, and checking in with my loved ones. I find my greatest joy in being a mom to my grown children and being available to them. This is my gift from recovery. My goal is to be known for my work as a role model for recovery and help individuals find hope for their lives. I want to continue to give back to the community by
Commentary

making a difference in helping others change their lives. I was able to think about my mental illness differently. I had the willingness to change; therefore, I accepted what was wrong, surrounded myself with a good support system, and sought permanent lifestyle changes. With all these things in place, I could adapt, overcome many obstacles, have a new and more positive insight about my life, and realize that recovery is possible.

REFERENCES


Sam Abraham, DHA, MS, RN

Patricia Perez

Dr. Abraham is Assistant Professor of Nursing, Bethel College School of Nursing, Mishawaka, Indiana; and Ms. Perez is Certified Peer Support Specialist, Recovery Coach, Self-Management for Addiction Recovery Treatment Facilitator, and Recovery Oriented Data Action Network team member, and is also trained in Trauma-Informed Care and fills outreach roles at the Community Mental Health Access Center and Kalamazoo Psychiatric Hospital, Kalamazoo, Michigan.

The authors have disclosed no potential conflicts of interest, financial or otherwise.

The authors acknowledge Merline Abraham and Rebecca Huizenga for proofreading and offering valuable comments.

Address correspondence to Sam Abraham, DHA, MS, RN, Assistant Professor of Nursing, Bethel College School of Nursing, 1001 Bethel Circle, Mishawaka, IN 46545; e-mail: abrahams383@att.net.

Received: June 6, 2017
Accepted: August 22, 2017
doi:10.3928/02793695-20171027-01

JOURNAL OF PSYCHOSOCIAL NURSING • VOL. 56, NO. 3, 2018 11