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Exploring the Dual Role of Consumer and Provider in Substance Use Peer Support Workers

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This is to certify that the doctoral dissertation by

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Walden University
2020

Abstract

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Abstract

Peer support is built upon the premise that shared life experiences will benefit both the helper and the receiver. In the substance abuse field, this relationship has been linked to an increase in practical knowledge, empowerment, hope, and community connectedness. However, the research on peer support is primarily geared toward the effectiveness of the intervention for the consumer. Less is known about the role of this relationship in the recovery of the workers themselves. The purpose of this generic qualitative study was to explore the experience of recovery in substance abuse peer support workers. A recovery framework and the helper therapy principle were used as conceptual frameworks. Semi structured interviews were conducted with 10 individuals who are currently employed as peer support workers in community-based roles. Data were analyzed utilizing a 6-phase thematic analysis to identify themes and patterns in the data and interpret these themes in relation to the study. Five themes were identified from the data: (a) by helping others we help ourselves, (b) self-care makes the role of peer support worker sustainable, (c) connection through shared experience, (d) extension of the personal recovery process, and (e) peer support in a system of care. This study furthers knowledge regarding the benefits and risks for peer workers and provides suggestions for effective support of this role including increased supervision, the presence of peer support networks, and training on the acuity the challenging situations peers may encounter. This study can help guide training development and create positive social change for peer support workers as this role becomes increasingly widespread.

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Dedication

I would like to dedicate this dissertation to the 10 participants in this study who so generously allowed me into their lives and openly shared their insights and experiences of substance abuse recovery.

Acknowledgments

First, I would like to express my deepest thanks to my patient and supportive chair, Dr. Silvia Bigatti. She has not only supported me through my dissertation journey, but she has been my biggest cheerleader and motivator during each and every challenge along the way. Thank you to my committee member, Dr. Marcus who constantly pushed me to do my best. I am grateful for her honest feedback, as much as the red lines and deletions were hard to see at times, they were always paired with encouragement and ways to improve. I am truly a better scholar and researcher because of the never-ending support of my committee.

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Chapter 1: Introduction to the Study

Introduction

Peer support work has been long recognized as a resource for patients with medical conditions and has expanded into behavioral health fields, playing an increasingly visible and more formalized role in care across a variety of practice settings (Mendoza, Resko, Wohlert & Baldwin, 2016; Tracy, Guzman & Burton, 2014). In the field of behavioral health, peer support has been defined as a system of giving and receiving help based on the principle of shared responsibility and mutual agreement (Substance Abuse and Mental Health Services Administration [SAMHSA], 2015). Peer support workers provide an opportunity for individuals to receive nonclinical support from those who have a shared lived experience and firsthand knowledge of addiction and recovery (Bassuk, Hanson, Greene, Richard & Laudet, 2016). This movement aligns itself well with the value of shared experience that is seen in the mutual aid programs such as Alcoholic Anonymous and sets the stage for more formal helping opportunities for peers in substance abuse recovery.

Peer support workers are individuals who have achieved and sustained their recovery goals and provide support to an individual who is in a more acute stage of substance abuse. Peer support workers through formal but nonclinical roles, assist in service provision and connection-building across a multitude of life domains (Bassuk et al., 2016; Jacobson, Trojanowski, & Dewa, 2012). Researchers have found that peer support workers had a positive impact on behavioral health with improvements that were equal to or greater than those provided by non-peer professionals (Bassuk et al, 2016;

Davidson et al., 2010; Reif et al., 2014). An increased understanding of the dual role of consumer and provider of services from the perspective of a peer support worker provides insight into this unique experience of personal substance abuse recovery and can be utilized to inform future training of peer support workers and improve support services for peer workers in the field of addiction and recovery.

This chapter presents the background of the study, including literature noting the increase in the use of peer support workers in behavioral health and the contributions as well as challenges of the dual role. The problem statement, purpose of the study, and research questions are discussed. The nature of the study, conceptual framework, and potential significance of the research are presented along with relevant key terms and limitations to the present study.

Background

Peer support is a well-known phenomenon and has been seen in many different practice arenas both in informal and formal roles. This intervention has been used to address prevention, health, health promotion, and intervention support (MacLellan, Surey, Abubakar & Stagg, 2015). Peer-based methods have been implemented in the medical field to assist individuals who are experiencing chronic conditions including asthma, diabetes, cardiac issues, extensive burns, HIV, smoking cessation, and cancer treatments and screenings (Fisher et al., 2015). Peer-based approaches have also been used in acute situations such as bereavement, trauma, parenting issues, maternal health, childhood malnutrition, breastfeeding, and bullying. The use of peer support in substance

abuse recovery is a newer application and one that has shown great potential despite the lack of rigorous research.

Individuals in recovery have a long history of providing support to one another through mutual aid and self-help models as well as other informal roles. The value of this role has been attributed to the natural disposition of individuals to be drawn to similarities and opportunities to share experiences and provide support to one another (Faulker, 2017; Penny 2018). The concept of peer provided support has gained increased visibility in the field of behavioral health as the value of shared experiences and modeling recovery has become more widely accepted. Peer support workers provide a wide range of roles in a variety of service settings and models including mental health, substance abuse, criminal justice, crisis intervention, veterans' affairs, family support, and mutual aid.

Peers support draws on the shared lived experience of substance abuse and recovery as the key component of this intervention. Peer support workers use their lived experiences as a catalyst for the development of a working alliance to assist other individuals (Solomon, 2004). In many cases, peer support workers also provide the unique experience of having transitioned from consumer to peer worker which can empower individuals who are pursuing their own recovery (Mendoza et al., 2016). Experiential knowledge, insight, and encouragement allows peer support workers to create a bridge from active substance use to recovery and community involvement.

Peer support services have recently become more common in the field of substance abuse treatment and recovery-based efforts. This has taken the form of standalone services, as a part of treatment programs, and as part of a continuum of care

(Davidson et al., 2010; Pandtridge et al, 2016; Reif et al., 2014). These workers have many functions including coaching, role modeling, connecting to community-based supports and facilitating community integration, providing advocacy, assisting with life skill development, and encouraging adherence to and completion of treatment with the goal of guiding the recipient to long-term recovery leading to sustained quality of life (Jacobson, Trojanowski, & Dewa, 2012; Mendoza et al., 2016; Scanlon, Hancock & Honey, 2017). Researchers found that peer support workers reported increased knowledge of support services, active engagement in recovery-based services, increased social acceptance, and additional financial resources due to decreased barriers to employment (Bailie & Tickle, 2015; Dugdale, Elison, Davies, Ward & Dalton, 2016).The benefits that consumers have reported demonstrate the importance of continued exploration of effectiveness and the impact of the role of peer support worker. Studies have predominantly focused on outcomes related to the recipient of services while the peer support worker's experience of this dual role has not been well studied.

In the field of substance abuse, peer support workers have served to assist individuals who seek long-term substance use disorder (SUD) recovery. This has been accomplished through a supportive and reciprocal relationship that seeks to help the individual both initiate and maintain recovery in addition to increasing quality of life and community engagement (Laudet & Humphreys, 2013). SAMHSA has included peer support as an integral component of recovery from SUDs and research has shown that recovery is stronger in individuals who have strong support networks (SAMHSA, 2015). Peer support workers provide access to support networks and recovery resources because

of their direct personal experiences, and these can become an integral part of the consumer's ongoing support network.

In sum, prior research has found that peer support workers provide essential services to people in recovery (Bailie & Tickle, 2016; Dugdale et al, 2017; SAMHSA, 2015; Tracy et al, 2011). Peer support workers have demonstrated resilience, adaptability, and investment in helping other individuals in recovery. However, several authors have pointed out that an understanding of what this dual role means to the peer support workers' personal recovery process has yet to be fully explored. Bailie and Tickle reviewed 11 qualitative studies and found consistent evidence of the value of the peer support worker to the organization and the worker despite the poor quality of most studies, and clearly identified the need for substantive qualitative studies to better understand how workers' personal recovery may be affected.

Problem Statement

As their name suggests, peer support workers are in recovery from substance abuse themselves. While it is widely recognized that they have a positive impact on recipients of their services, it is not clear how providing these services affects their own recovery (Bassuk et al., 2016; Reif et al., 2014). However, some studies have shown that peer support workers reported increased knowledge of support services, active engagement in recovery-based services, increased social acceptance, and additional financial resources (Bailie& Tickle, 2015; Dugdale et al., 2016). They also experienced greater self-identity, increased exposure to skills and resources, as well as connectedness to supports (Dugdale et al., 2016; Reif et al., 2014). However, there are also concerns

related to boundaries of these roles, threats to the peers' personal recovery, lack of acceptance of peer support by the greater recovery community, and how having to identify themselves as being in recovery may impact their occupational trajectory (Bailie & Tickle, 2015; Dugdale et al., 2017; van Melick, McCartney, & Best, 2013). There are both potential benefits and harms that can come from being in the role of peer support worker. Therefore, a better understanding of this dual role will contribute to the scientific and professional communities' understanding of support workers' recovery experience.

While these studies have pointed out the value of peer-support services, they have also indicated a gap in the research related to the role of peer support workers and the influence of this role on their personal recovery. For example, Tracy et al (2011) conducted a clinical trial and found that the addition of a peer support worker to post-treatment protocols improved compliance in patients posttreatment. They also found through a short self-report survey that peer support workers perceived personal benefits (Tracy et al., 2011). Bailie and Tickle (2016) reviewed 10 qualitative articles and found mostly positive benefits and some potential risks of this dual role. Both sets of authors concluded that more high-quality studies of the peer support worker experience are needed, particularly qualitative studies that more specifically "explore PSWs' conceptualization of recovery and its relationship with PSW" (Bailie & Tickle, 2016, p.61).

Purpose of the Study

The purpose of this generic qualitative study was to explore the peer support worker's experience of the dual role of consumer and provider of services in substance

abuse recovery using a basic qualitative approach. This phenomenon of interest was the dual role of the experience of helping others in recovery and as well as experiencing their own personal recovery. There is some research indicating that the incorporation of peer support workers in the recovery components of treatment has a positive impact on the consumer (Alberta, Ploski, & Carlson, 2012; Bassuk, et al., 2016; Davidson et al., 2010, Reif et al., 2014). Research has also identified potential contributions and risks to the personal recovery of the peer support worker; however, this study adds knowledge to fill the gap of how the peer support worker experiences this dual role of provider and consumer of services.

Research Questions

How do peer support workers experience the dual role of consumer and provider of services in substance abuse recovery?

Conceptual Framework for the Study

The recovery model and helper therapy principles were utilized to provide the conceptual frameworks for the study. The recovery model was incorporated to provide the foundation for understanding the process of recovery while the helper therapy principle was used to explain the role of shared life experience in peer support as well as to provide the recognition of the potential influence that helping has on the peer support worker. I have used these frameworks, which are explained in detail in Chapter 2, to inform the research design and assist in the development of relevant research questions as they create a context for the exploration of the dual role of peer support workers.

The field of substance abuse has long struggled with defining and describing recovery from addiction. Initial models were abstracted from the methods used to diagnosis, treat and manage diseases, and there still remains an advocacy for disease models of addiction that locates the cause and treatment of addiction in the brain (Heather, et al., 2018). More recent models have emphasized a biopsychosocial model which conceptualizes addiction as sourced in biological, psychological, and social functions. Researchers and theorists described brain dysfunction, cognitive processing and social milieu as creating the risk for recreational use to turn to addiction (Dodge, Krantz & Kenny, 2010; MacKillop & Ray, 2017). These models view addiction and recovery through the lens of medical or health care "treatment" or "management".

Contemporary conceptualizations of addiction use the terminology *recovery framework* to (a) describe the chronic nature of addiction, (b) recognize that recovery is process rather than a destination, and (c) diminish the focus on finding a "cure" (Dodge, Krantz & Kenny, 2010, Laudet, 2011; SAMHSA, 2015). Ceasing substance use is not the end goal in the recovery model, rather it is instead the vehicle by which negative symptoms can decrease and an individual's quality of life can improve (Laudet, 2011). As such, this study incorporated a framework of recovery to guide the development of the data collection tools and analysis plan.

The helper therapy principle has long been acknowledged in the world of addiction recovery, particularly through the mutual aid models of self-help programs such as Alcoholics Anonymous (A.A.) where individuals with substantial recovery provide support and encouragement to an individual who is at an earlier point in the recovery

journey (Pagano, Post, & Johnson, 2011). This principle is based on the concept that helping someone with a shared life experience also benefits the helper due to increasing the personal commitment to recovery, developing an identity as a helper, and the increased social status due to participation in this role (Reissman, 1965). In fact, this principle purports that it is in fact the helper that receives the greatest benefit due to their investment in the system and identification as a helper while demonstrating the visibility of a voluntary lifestyle of recovery across all dimensions of recovery (Reissman, 1965). The helper therapy principle ties directly into the role of shared life experience in peer support and the concept that mutuality, shared responsibility and decision making are key factors in the success of these relationships (SAMSHA, 2015; Scanlon, Hancock & Honey, 2017; Walsh, McMillan, Stewart & Wheeler, 2018). This principle was used to support the current study in recognition that the exploration of peer support work should include the experiences of the individuals providing the help not just the way the recipient experiences the help. As such, I used it to conceptualize the research questions. The concepts identified were also used to develop interview questions and guide the research plan. In Chapter 2, I discuss in further detail the recovery framework and the helper therapy principle.

Nature of the Study

This study used a generic qualitative approach to explore how peer support workers experience the dual role or peer worker and consumer of services. A generic qualitative approach does not claim fidelity to an accepted philosophical viewpoint, therefore creating a methodology that allows for the construction of knowledge via the

interaction between the researcher and participants (Kennedy, 2016). The existing research regarding peer support workers has primarily focused on the intervention itself and the experience of the individuals receiving services (consumers), not the experience of the peer support worker (Bailie & Tickle, 2016; Tracy et al., 2011). I used a generic qualitative approach to build off of this prior knowledge on peer support workers, which allowed for the interpretive description of the phenomenon of interest: the peer support worker's dual role of the experience of helping others in recovery as well as experiencing their own personal recovery (Percy, Kostere, & Kostere, 2015).

As the area of inquiry was in the peer worker role itself and how it was experienced (Percy, Kostere & Kostere, 2015), a generic qualitative was the best fit for the current study. The current study allowed me to explore any commonalities in these experiences among peer support workers including their ideas, opinions, and reflections on the role of peer support worker (Caelli, Roy & Mill, 2003; Liu, 2016). This inquiry moved beyond what can be easily quantified and explored the lived experiences of the peer support workers, making a qualitative model the best option.

The use of a generic qualitative approach allowed for broad insight into this phenomenon and provided the ability to use the data collected to guide the interpretation rather than drawing inferences from existing theories of recovery (Kahlke, 2014; Thomas, 2016). A generic qualitative approach was appropriate as I sought to understand the actual experiences of the participants, the meaning that they attribute to their experiences as well as the manner in which these experiences have produced transformation in their perspectives (Merriam, 2009). A generic qualitative approach

facilitated exploration of what the role of peer support worker brought to the workers themselves and their personal substance abuse recovery.

This study used a criterion sampling approach, augmented with snowball referral sampling, to explore the experience of recovery through the role of peer support worker and sought to discover how they interpret these experiences and the meaning attributed to them in the context of their recovery. The selection of participants was completed with a criterion sampling approach to identify peer support workers living in Massachusetts who were actively providing paid nonclinical support in community settings to individuals in early recovery from substance abuse. A snowball approach was applied by asking each respondent if they knew a peer support worker who may be interested in participation. Individual semi structured interviews were conducted with 10 peer support workers that specifically sought to uncover the actual experiences of participation as a peer support worker, what these experiences meant to the participants, as well as the transformational nature of the experiences in terms of their views of their own personal recovery. The use of a generic qualitative approach allowed for the exploration of these concepts as they emerged rather than being guided by specific philosophic assumptions (Kahlke, 2014). I also used a six-phase thematic analysis approach, as described by Braun and Clarke (2016), to identify themes and patterns in the data with a flexible and data driven approach. This allowed me to explore commonalities in the experiences among peer support workers, moving beyond what can be easily quantified and looking at the opinions, ideas, and reflections of the peer support workers.

Definitions of Key Terms

I used the following key terms throughout this study:

Addiction: a chronic brain disease that can be connected to a genetic pre-disposition, environmental influence as well as behavior manifestations (U.S. Department of Health and Human Services, 1995). It is characterized by obsessive-compulsive behaviors, an inability to stop or control use, and continued use despite adverse consequences (American Society of Addiction Medicine, 2011).

Consumer: individuals who are receiving peer support to assist with their recovery from substance abuse.

Peer Support Worker: individuals who have achieved and sustained their behavioral goals and that through nonclinical, formal roles assist in service provision and connection-building across a multitude of life domains (Bassuk et al., 2016; Jacobson, Trojanowski, & Dewa, 2012).The present study will focus on paid peer support workers in the field of substance abuse.

Recovery: a course of change and development during which individuals seek to develop increased health and wellness, live a self-directed lifestyle and strive to reach their full potential (SAMHSA, 2015)

Substance Use Disorders: a group of cognitive, behavioral, and physiological symptoms due to a change in brain circuitry that follows a pathological pattern of behaviors that encompass impaired control, social impairment, hazardous use and the presence of pharmacological changes that include tolerance and withdrawal (American Psychiatric Association, 2013).

Assumptions

In this study, I assumed that the insights gained from peer support workers regarding their experience of recovery and their role of peer support worker would provide valuable information about this increasingly visible intervention. The peer support workers were assumed to be willing to answer questions honestly and to share an accurate representation of their experience of recovery as a peer support worker. Further, it was assumed that the questions selected for the interviews would provide adequate insight into this experience and that saturation would be reached. It was also assumed that my use of well-regarded methodological strategies (described in Chapter 3) would minimize the risk of bias in the design of the questions, the interview process, and data analysis and interpretation.

Scope and Delimitations

The research sample was limited to peer support workers living in Massachusetts who were actively engaged in formal roles providing peer support. Peer support workers engage in a wide variety of formal and informal support roles, this research sample was limited to peer support workers who are engaging in a paid formal role providing services to at least one individual attempting to sustain recovery from substance abuse. The study was limited to participants who identified a period of personal recovery of 1 year or more and who had engaged in a role of peer support worker for a minimum of 6 months allowing for the development of their role as provider of services. All participants self-reported stable recovery with the understanding that any active substance abuse would result in exclusion from the study.

The study was limited to individuals who were providing support while living in the community and did not include individuals who were living in residential facilities for addiction recovery or in inpatient hospitals. Individuals providing voluntary support such as mutual aid were not included. The research was limited to individuals who were 21 years of age or older due to the developmental issues that may accompany younger participants that are outside of the scope of the current study and to facilitate participation from individuals who had substantive experiences with addiction and recovery. Participation was limited by the request for an in-depth interview that discloses recovery status and experiences and the request for audio taping to ensure that accurate rich data was obtained. While this created the risk that some peer support workers may have chosen not to participate in the study, I did not experience this during recruitment. There were two peer support workers who expressed interest in participation but did not follow through with scheduled times to talk about the study. Sample selection for this study does not lend itself to widespread generalizability to peer support workers.

I considered both self-determination theory and social cognitive theory as conceptual frameworks for this study. Self-determination theory supports the concept that individuals will strive through inherent tendencies to meet their needs and that with the right environmental influence that they will be able to do so effectively (Mancini, 2008). This brings forth the recognition that while individuals have intrinsic motivation, recovery requires that external and environmental factors are considered in achieving the optimal conditions for recovery (Mancini, 2008). While peer support has been correlated to increased self-determination and positive recovery outcomes (Jones, Corrigan, James,

Parker & Larson, 2013), this study explored the experience of helping in recovery making the helper therapy principle a more appropriate choice. Social cognitive theory purports that the individual, the environment, and behavior interact and that the beliefs and expectations that an individual holds dictate how they make interpretations (Bandura, 1999). This theory identifies that an individual's beliefs and expectations influence self-efficacy and self-regulatory processes (Bandura, 1999). This is particularly useful in substance abuse research as an individual's expectations about their substance use and their ability to change that behavior are critical to success in the recovery process. However, in the current study the goal was to explore how peer support workers experience their dual roles of helper and consumer not the factors driving their behaviors, therefore this theory was not used.

Limitations

The selection of participants was done using criterion sampling and snowball approaches to identify peer support workers living in Massachusetts who were actively providing paid nonclinical support in community settings to individuals in early recovery from substance abuse. Transferability defines the extent to which the current research can be utilized by other researchers in their proposed settings. While the primary focus of qualitative research is on the experiences of the participants, efforts to attain transferability will be utilized in the proposed study (Shenton, 2004). The sampling process in the present study was limited to individuals who were in paid positions, in the state of Massachusetts, who opted in to participation in the study, which makes transferability to the broader population of peer support workers limited. However, to

increase transferability, I have provided a detailed description of the information provided by the participants and the research procedures including data analysis so that the reader can determine the relevance to themselves and their context of reference (Moser & Korstjens, 2018). The detail of information provided should allow the reader to make appropriate judgements regarding whether the present study is one that can relate to their setting or research.

I used in-depth interviews to gain firsthand knowledge of peer support workers experience of the dual role of provider and consumer of substance abuse services. The stigma associated with substance abuse and the sensitive nature of personal disclosures could have resulted in socially desired interview responses rather than more truthful responses. In order to prevent this from occurring, participants were provided with inclusion criteria, a description of the nature of the study, and the requirements of a participant to aid in their decision as to whether they wanted to opt-in to participate. They were also provided with an informed consent that detailed the nature and purpose of the study, the commitment that was being requested of them, their right to withhold any information that they were not comfortable sharing, and the option to withdraw from the study at any time with their records being destroyed. Therefore, it is reasonable to assume that the participants who chose to participate provided accurate responses and were willing to openly share their experiences, as was also observed in the candid nature of responses to interview questions.

Another potential concern about the proposed study was the concept of dependability. Dependability refers to the way the study can be replicated (Pandey &

Patnaik, 2014) and requires a clear and detailed account of the steps taken in the current study (Morrow, 2005). In this study, I used a comprehensive audit trail that provided a detailed account of all research processes and documented emerging data and analysis to safeguard against this concern (Morrow, 2005). The audit trail also included a description of decision making, emergence of findings and the process of data management which allows for ease of review of the analysis and codes to ensure that they flow from the data (Korstjens & Moser, 2018). I used consistent recruitment, data collection and data recording procedures for all study participants.

Bias often arises in studies such as this one and because I have experience with the concepts of recovery in my role as a psychotherapist, I needed to manage any preconceptions in order to prevent these assumptions from influencing the study outcomes. My awareness of possible assumptions and bias aided in mediating the possibility of researcher influence as well allowed for mindfulness of my behaviors during interviews and communication with participants. A reflexive journal was used throughout the entirety of the study serves as a record of my experiences, reactions, and awareness of any assumptions that emerge throughout the research process. I also used reflexive notes for documentation of the aspects of the interview that seemed noteworthy to me as well as the subjective responses that I had to the participants (Korstjens & Moser, 2018).

Due to the stigma associated with substance abuse recovery and the emphasis on experiential knowledge, the information about my certification and experience working in alcohol and drug counseling was provided to participants in order to establish rapport

and transparency in the research process. While experience with substance abuse and recovery may increase rapport building, there is also the risk of leading participant responses and interpreting answers in the light of my previous professional experiences. As a result, I used content and methodological experts to review interview questions developed for presuppositions. In order to safeguard against bias, I did not recruit from agencies in which I have had professional collaborations in the community. I also did not include any peer support workers who I have encountered in either a personal, professional role or as a client in the past.

Significance

The use of peers engaging in mutual aid is a concept that has been a part of addiction recovery for many years, however, the introduction of a peer as having a professional role is new and the implementation has been growing rapidly, with a limited understanding of the impact on the peer's personal recovery (Dugdale et al., 2016). The results of this study contribute to the literature on peer support workers' experiences through the exploration of how their work occurs in the context of their personal recovery stories, including physical, psychological, social and community benefits. This is an under-researched area of addiction interventions.

The results of this study also enhance the understanding of the benefits and the risks for the peer support workers. This dual role of consumer and provider of services is unique from other professional roles and therefore the field would benefit from a better understanding of the workers' perspectives (Bailie & Tickle, 2015; Reif et al., 2014). Increased knowledge about the experience of peer support workers may contribute to the

development of support and training for peer support workers and may influence social change in the field of addictions and recovery.

Summary

This chapter introduced this qualitative study which explored the dual roles of peer support workers in the context of their own personal recovery. It also provided background information regarding the history of peer support workers in the medical and behavioral health fields. The incorporation of peer support workers into the field of substance use recovery was presented and the emphasis on shared experiences as a catalyst for rapport building and support was introduced. Research has been conducted that indicated that peer support workers have a positive impact on the consumer, as well as the contributions and risk to the personal recovery of the peer support worker (Bailie & Tickle, 2015). This chapter also identified the lack of published research exploring the experience of personal recovery for peer support workers. In Chapter 2, a detailed review and analysis of academic and professional literature is provided to identify what is already known about the experiences of peer support workers.

Chapter 2: Literature Review

Introduction

Helping one another is a phenomenon that can be seen throughout history in a multitude of informal roles and more recently in more formal roles. Peer support has been defined by SAMHSA as a system of giving and receiving nonclinical support based upon the principle of shared experiences, responsibility, and cooperation (SAMHSA, 2015). Peer support has been empirically associated with positive behavioral health outcomes for individuals in recovery including influencing substance use, recovery outcomes, and improvements across a multitude of life domains (Bassuk et al., 2016; Reif et al., 2014). While evidence exists regarding the benefits to the consumer receiving the support, it is not clear how providing these services affects the recovery experience of the peer support worker (Bassuk et al., 2016; Reif et al., 2014). Given the widespread use of peer support workers in the field of behavioral health and the increased visibility of peer support workers in formal roles and practice settings, it is crucial to conduct research that explores the experiences of personal recovery for these workers (Bailie & Tickle, 2015; Mendonza et al., 2016). This study focused on peer support workers who were hired to provide nonclinical support to individuals in recovery from substance abuse with the purpose of exploring the dual roles of peer support workers in the context of their own personal recovery.

The following literature review explores the application of peer support workers into the medical and behavioral health fields, current conceptualizations of peer support workers in substance use recovery, as well as the potential contributions and risks to

personal recovery for the peer worker. An understanding of the experience of recovery through the peer support workers' role allowed for a greater understanding of how this role exists within the context of their personal recovery stories, including physical, psychological, social and community benefits (Bassuk et al., 2016; Reif et al, 2014). A greater knowledge base regarding the risks and benefits for peer support workers through the dual role of consumer and provider sets the stage for the development of training and support programs for these workers as they continue to be integrated into the field of addictions and recovery.

Literature Search Strategy

The literature included in this review was searched through the use of electronic databases available at Walden University and Assumption College including Academic Search Premier, Psycharticles, Psychinfo, ERIC, SocIndex, Worldcat, and Proquest. Searches were also conducted via Google Scholar, relevant texts, and through the Internet for government publications and websites. This search included peer reviewed journal articles, scholarly books, firsthand accounts, government publications, and information from nonprofit organizations as well as task forces. Key words that were used include *peer assisted recovery, peer support workers, peer support services, peer mentoring for substance abuse, recovery coach, recovery support services, peer led interventions, peer delivered/provided services, peer recovery specialists, informed supporters, paid peer support, consumer operated services, peer based recovery, recovery programs, recovery action plans, peer support, peer mentors, mentorship, peer provided services, recovery,*

recovery models, helper therapy principle, mutual aid, mutual support, intentional peer support, and *recovery outcomes.*

Conceptual Frameworks

The main purpose of this study was to explore how peer support workers experience their dual role of consumer and helper. The experience of recovery will be interpreted through the lens of the role of peer support worker. In order to fully explore this phenomenon, a recovery framework and the helper therapy principle are used. The recovery framework recognizes that individuals do not become cured from their addiction; addiction is chronic in nature and recovery occurs on a continuum (Dodge, Krantz & Kenny, 2010, Laudet, 2011, SAMHSA, 2015). The helper therapy principle is based on the concept that helping an individual through a shared life experience also benefits the helper by increasing personal commitment to recovery, developing an identity as a helper, and the increased social status due to identification as a helper (Reissman, 1965). Both approaches create a context for the exploration of how peer support workers experience the relationship between this role and their personal recovery.

Recovery Framework

Recovery has taken on many definitions with some purporting that it includes a full cessation of specific behaviors and others only requiring an improvement in functioning. SAMHSA (2019) defines recovery as "a process of change through which people improve their health and wellness, live self-directed lives, and strive to reach their full potential" (Para. 3). This definition supports the recognition that recovery is not an end result and instead is a fluid process under which complete remission is not a

necessary component or outcome, allowing for multiple pathways to recovery (Dodge, Krantz, & Kenny, 2010; SAMHSA, 2015, van Melick, McCartney & Best, 2013). This construct is built upon the developing landscape of addiction and recovery research and policy.

The field of substance abuse has long struggled with defining and describing recovery from addiction. Initial models were developed based upon the traditional medical values of diagnosing, treating, and managing a disease with the goal of symptom reduction and improvement in functioning (Ostrow & Adams, 2012). The disease model calls for professional oversight and a problem-solving approach that identifies the biological underpinnings of the development of addiction in the brain (Hammer et al., 2014; Heather et al., 2018). There remains an advocacy for this model as it removes the stigma and moral arguments about substance abuse and focuses on objective medicine and treatments (Buckman, Skinner & Illes, 2010; Hammer et al., 2013). The disease model has received criticism for not considering the psychological, social, and environmental influences of addiction and recovery (Buckman, Skinner & Illes, 2010). The emergence of more holistic models have attempted to address these concerns.

The emergency of subsequent frameworks have emphasized the biopsychosocial aspects of addiction, identifying biological changes from abstinence as well as mental health and social improvements (Dodge, Krantz & Kenny, 2010). The biopsychosocial model sought to combine biological underpinnings with an understanding of the social and psychological factors that influence substance use behaviors (Becona, 2018). This model helped to provide insight into why individuals with substance abuse addiction

continued to feel ill and struggle after a medical intervention and to bring attention to the fact that not all individuals who utilized substances became addicted (Becona, 2018). This integration of biological, psychological, and social factors allows for a multi-faceted approach to the diagnosis and treatment of addiction and expanded the previous conceptualizations of recovery.

While the biopsychosocial model assisted in the movement away from an acute care model to one that viewed addiction as a chronic condition, there were many criticisms of its limitations. These limitations include the lack of attention paid to the influence that providers can have on outcomes of patients and a lack of inclusion of the subjective aspects of addiction recovery including personal experiences and spirituality (Benning, 2015). While this model attempted to produce explanations for the aspects of addiction that cannot be explained through the medical disease model, its usefulness in clinical settings was limited by the lack of well-defined factors (Benning, 2015). These concerns have led to a greater emphasis on the need to better understand and conceptualize recovery in addiction.

Both the disease model and the biopsychosocial model have attempted to decrease the stigma associated with addiction by providing explanations for substance abuse and addiction. However, the outcome of the implementation of these models may have been an increase in stigma as individuals who continued substance abuse despite participation in traditional treatment interventions were not well understood (Heather et al., 2018). A recovery framework has directed attention to the subjective nature of addiction and has allowed for the recognition that the outcome, recovery, is not a cure for SUDs, but rather

involves consistent management through the development of recovery supports and resources (van Melick, McCartney, & Best, 2013).While traditional frameworks have emphasized symptom reduction or cures, a recovery framework emphasizes the restoration of life goals, hopes, and the recognition that all lives have meaning and can have fulfillment (Davidson et. al., 2009; Laudet& Humphreys, 2013). A recovery framework seeks to build upon this recovery capital in individuals, which is the quantity and quality of internal and external resources that an individual can draw upon to initiate and sustain long-term recovery (Davidson et. al., 2010; van Melick, McCartney & Best, 2013). Through this model, individuals are able to be viewed with an inclusion of their strengths rather than emphasis on their symptoms or presenting problems. A recovery framework allows for not only improvements in major life domains, but it also allows for the recognition that resilience can be built throughout this process. According to Bellack and Drapalski (2012), a recovery framework can counteract the impact of negative life experiences and negative stigma that can be found in traditional care models. This is particularly true when the expectations related to recovery emphasize the engagement in a fulfilling life rather than in a cure since many individuals can experience life satisfaction in the presence of continued challenges (Ostrow & Adams, 2012). The focus on the individual's personally valued goals creates a recovery approach that is more inclusive and responsive to individual choices and fosters independence (Ahmed et al., 2015). Further, recovery attitudes can serve as protective factors for addressing stressors and challenges that present themselves in the lives of individuals and act as buffers against the influence of negative life events (Ahmed et al., 2015). The use of the recovery

framework in the present study supports the goal of exploring peer support workers' experiences, ideas, and beliefs about their personal recovery and the way in which they find meaning and connection to their role as peer support worker.

This theory has been evaluated in contemporary mental health and substance abuse research to evaluate the effectiveness of peer support as an intervention for individuals who are seeking recovery and to explore the role of helping in recovery for a peer support worker. Individuals who identified themselves as being in recovery were found to have support networks that had a larger proportion of individuals in recovery than actively using when compared to those in active treatment (Best, McKitterick, Beswick & Savic, 2015). These findings also included an increase in formal and informal supports as well as resources for sustained recovery (Best et al., 2015). Ahmed and colleagues (2015) found that the extent to which peer support workers adopted a recovery philosophy was predictive of the impact of stress on functioning and symptomology. This points to the possibility of a recovery framework positively influencing psychosocial aspects of a peer support worker's life (Ahmed et. al., 2015). This also supports research that has identified the medical model as a barrier for peer support workers who were not regarded by professionals in the same manner as non-peer providers (Clossey, Gillen, Frankel & Hernandez, 2016). The acceptance and identification of recovery as a framework and philosophy allows for flexibility in the definition which may be linked to increased positive reports from those who incorporate a recovery approach.

The types of support provided under a recovery model and how they should best be provided have gotten attention in substance abuse research. Pantridge and colleagues (2016) utilized a recovery-oriented model to garner information about the best timing for different types of peer support to achieve maximum benefits for consumers and to extend the current research knowledge beyond support in treatment settings. The authors found that engagement from a peer support worker had the ability to lengthen treatment engagement and to increase recovery resources (Pantridge et al., 2016). When combined with research that found that a large number of peer support workers report that they have relapsed while in this role, and the success that they reported in utilizing resources and strategies for recovery (Ahmed et al., 2015), the utilization of recovery models that build individual recovery capital can be viewed as essential parts of this process.

There have also been some concerns related to the way the recovery model has been implemented. Neale, Nettleton, and Pickering (2013) cautioned that the use of a recovery model that claims individuals in recovery can return to a fully functioning role in society quickly have been reported to increases the number of individuals that report entering recovery in a manner that was not long enough to create lasting change. They also found that through the decision-making process individuals who were actively using heroin benefitted from consulting with other individuals who had experienced heroin addiction and recovery (Neale, Nettleton and Pickering, 2013). This points to the recognition that recovery is a fluid and individualized process and that shared experience and connection play an important part in this process for individuals with substance abuse issues.

The present study utilized a recovery framework to explore the way peer support workers experience their dual role of consumer and helper. It provides the flexibility to recognize that recovery is not a destination and rather can be looked at as an outcome fueled by positive recovery beliefs and attitudes (Ahmed et al., 2015). The ability to view recovery as a life-long journey allowed for the recognition that peer support workers experience may be influenced by the experiences that they have and their perceived quality of life. A recovery framework allowed for flexibility in exploring how the peer support worker's experience recovery and the recognition that this may vary from individual to individual.

Helper Therapy Principle

The helper therapy principle was introduced by Frank Reissman (1965). The principle purports that engaging in the process of being a helper for an individual with a similar issue has significant benefits for the helper. Helpers often engage with individuals who are experiencing symptoms that are more acute or severe than their own and in doing so may experience a further reduction in their own problems (Davidson, Chinman, Sells, & Rowe, 2006; Pagano, Post & Johnson 2010; Reissman, 1965). In fact, Reissman (1997) believed that it is the helper that has the greatest benefit from this relationship, with claims that giving help is the best way to help oneself. Reissman developed this principle through his observations of the structure of the A.A. program, recognizing that as individuals learned to help others they were continuing to be exposed to information that could be applied to themselves (Pagano, Post & Johnson, 2010; Reissman, 1965). This continued exposure to recovery activities coupled with the

increase in positive emotional states through the act of helping can directly influence personal recovery.

The motivation for helping has been linked by many to an interest in promoting self-healing and increasing positive emotions. The act of giving help is viewed as being one of the critical ways in which individuals help themselves and promote their own therapeutic healing (Reissman, 1990). Not only is engaging in helping believed to be rehabilitative in nature, it can increase the effectiveness of the helpers in this role, making them more skilled and developed helpers (Reissman, 1965). The role of helper also increases the investment in the overall recovery system and connectedness to community agencies and stakeholders, thereby placing the helpers in the role of stakeholder for larger scale recovery outcomes (Reissman, 1965). This shift in perspective moves the helper from the self-reference that is emphasized in recovery to a view that includes the broader recovery community and social networks.

The helper theory principle has been supported in studies examining benefits like an improved sense of self and feelings of self-worth related to the valuable role of being able to make a difference in the life of another person (Cronise, Teixeira, Rogers & Harrington, 2016; Skovolt, 1974). Recovery benefits include an increased perception of stability in their own recovery and an increased commitment to personal recovery (Cronise et al., 2016; Reissman, 1965; Skovolt, 1974). Helpers were also found to have improved self-image in relation to their importance to others and the increased social status from participation in this role (Skovolt, 1974). It has also been suggested that the role of helper allows for an individual to master life roles to which they may not have

exposure otherwise. These life roles include maintaining meaningful employment, engagement in ongoing services and opportunities for the development of interpersonal relationships (Ahmed et al., 2015). These benefits are consistent with the recognition that helping facilitates improvements in overall health and quality of life. This principle applies to peer support workers, in that by helping, they report experiencing many personal benefits and enhancements to their personal recovery.

The helper therapy principle has been widely recognized in many behavioral health arenas including chronic illness, mental health, hospitals, smoking cessation programs, youth mentoring, prison systems, veteran programs, and more. In the world of addiction recovery, mutual aid models, particularly self-help programs such as A.A., have incorporated the component of service as the cornerstone to long-term success (Pagano, Post & Johnson, 2011). The 12th step in A.A. emphasizes the helping of individuals who are new to the recovery journey with the recognition that the insight of already having traveled the journey will build a bridge for those just starting out (A. A. World Services, 2001). It also identifies the limitless rewards of being able to help another individual through a process that has been traveled.

There have been several studies that have identified the benefits of helping for both the helper and the recipient and a growing body of literature shows that providing help is more beneficial than receiving it. Benefits of helping have included reduced distress, improved health as well as promoting longevity and personal well-being (Krause, 2016).Pagano and colleagues (2004) reported that 40% of individuals who were helping others remained sober in a 1 year follow up, compared to 20% of a cohort that

was not engaged in the helping process. These examples demonstrate that helpers experience healing when they help another individual who is living with the same situation. Mendoza and colleagues (2016) explore recovery as a "function of connection" (p. 147) and recognize that the vehicle for recovery is engagement in meaningful relationships with others. Smith and colleagues (2016), in a small pilot study, found that the engagement of a concerned significant other (CSO), invited to participate in the treatment process with the client, and who also experienced substance use, led to an increase in days abstinent and a decrease in the number of reported days of binge drinking for both the peer and the client. While the current body of literature is small, it demonstrates promise for the future of this increasingly visible role, making the need to understand the relationship between peer support worker and personal recovery crucial.

Peer Support Workers

The work of peer support has had a widespread reach in terms of settings, the nature of the relationship, and level of integration into existing services. Peers work as support in diverse settings, among varying age groups, with a multitude of uses and purposes including providing support for physical health outcomes, homelessness, chronic pain, supported employment, mental health, and substance use. In addition to these settings, the use of peers is promising in other settings such as forensic environments where individuals are likely to experience mental health and substance use issues (Chapman, Blash, Mayer & Spetz, 2018). Although the present study focuses on peer support workers for SUD, I will briefly summarize the work done by peer support

workers in other major areas because they preceded and informed the SUD field and the application in SUD is a newer and less documented phenomenon.

Mental Health

Peer support has been visible in the mental health arena for many years. This has taken the form of naturally occurring social supports, consumer run programs, and in formal employment roles such as the peer support worker (Davidson, Chinman, Sells & Rowe, 2006; Repper & Carter, 2011). The evidence regarding effectiveness has been variable and ranges from specific outcome benefits, to no benefits, or even a decrease in overall functioning (Castellanos, Capo, Valderrama, Jean-Francois & Luna, 2018;Llyod-Evans et al., 2014). Many studies have found that there is not a significant difference between care as usual and the use of peer support workers on traditional mental health outcomes (Cabassa, Camacho, Velez-Grau & Stefancic, 2017;Castellanos et al., 2018; Davidson, Simpson et. al., 2014). Yet when targeting specific recovery-based measures such as self-management (Cabassa et al., 2017), social support, and practical strategies, outcomes that included a peer support intervention were better (Proudfoot et al., 2012). Overall, the evidence indicates that peer support work is at a minimum equal in value to that of traditional care models that utilize professionally trained staff at higher costs (Doughty & Tse, 2011; Repper & Carter, 2011). The benefit of receiving peer support is shown in the practical aspects of recovery, including navigating social and community expectations, such as employment and housing (Doughty & Tse, 2011), and connection to community support networks (Proudfoot et al., 2012). The shared experience as a

means to form rapport makes this intervention more practical and easier to receive than formal interventions.

The benefits of peer support workers for individuals with mental illness include increased time between hospital admissions, empowerment, increased self-esteem, increased self-management of symptoms, reductions in experiences of stigma, and the experience of hope (Pitts et. al, 2013; Miyamoto & Sono; 2012; Repper& Carter, 2011). Peer support in mental health has reduced the isolation of individuals with mental illness and has demonstrated the strength of identifying with others of similar experiences as a normalizing factor (Cabral, Strother, Muhr, Sefton & Savage, 2014; Walker & Bryant, 2013). Peer support has also been an integral part of self-management interventions where the use of lived experiences can be combined with skill building to increase the capacity for disease management (Cabassa et. al., 2017; Davidson et al., 2012). These outcomes are different than the traditional measures of efficacy that include reductions in symptomology and instead target individual satisfaction and quality of life. Peer support workers in the mental health field, while experiencing benefits in line with the helper therapy principle, have also reported challenges to being in this role. This will be explored in the coming section on potential risks and benefits to the peer support worker.

Veterans

The use of formal peer support with the veteran population has been long established, built upon the understanding that a shared lived experience would increase participation and improve outcomes. Veteran to veteran peer support shows a connection between the favorable manner in which peer support is viewed and attitudes toward

recovery for this population (Jain, McLean, Adler & Rosen, 2016). The value that veterans place on the support from another veteran has been not only noted but has also reduced PTSD symptoms, highlighting the importance of social bonds in the recovery process (Jain et. al., 2016; Laffaye, Cavella, Drescher & Rosen, 2008; Resnick & Rosenheck, 2008). While the effectiveness of peer support continues to have mixed reviews with this population, evidence suggests that there is no difference between a peer provided intervention and an intervention that is provided by a professional through the usual treatment modalities (Eisen et al., 2012; Resnick & Rosenheck, 2008; Tracy et al., 2011). Tracy and colleagues (2011) reported increased post-discharge participation in community-based interventions when peer support was incorporated into the treatment modality. There is evidence to suggest that veterans who have been employed as peer support workers have benefitted from the role of helping, including reports of increased job satisfaction, improvements mental health, and perception of quality of life (Chang, Mueller, Resnick, Osatuke & Eisen, 2016; Eisen et al., 2015). The Veterans Administration's alignment with the recovery framework has increased the visibility and favorability of this intervention by veterans and demonstrated the mutual benefit to both the helper and the consumer.

Health Care

In the medical field, peers have provided support for individuals who are trying to manage a variety of chronic conditions. This has historically included support to individuals experiencing cancer (Campbell, Phaneuf & Deane, 2008; Hoey, Ieropoli, White & Jefford, 2008) and chronic illness (Embuldeniya et al., 2013; MacLellan et al.,

2015; Proudfoot et al.; 2012), including diabetes (Heisler, Vijan, Makki & Piette, 2010). Peer support workers provide practical knowledge that assists in the real-world management of the illness (Proudfoot et al., 2012). Peer support workers, through having managed their own illness, instill confidence that persistence and treatment compliance can provide desired results (Proudfoot et al., 2012). Peer support workers are readily able to address the psychosocial impact of the illness through shared experiences of frustrations and to normalize the experience of individuals new to recovery (Proudfoot et al., 2012). In some cases, peers were able to share information and experiences that led to problem identification, an increased understanding of their medical experiences, and increased information about their condition (Campbell, Phaneuf & Deane, 2008). This research has increased knowledge about the way a peer support worker can utilize a shared narrative to engage with hard to reach populations.

Substance Use

While formal roles for peers in the substance abuse field did not appear until the 2000s, informal peer support has had a significant presence starting much earlier. Peer support workers have been identified as having positive contributions to treatment retention and recovery outcomes of individuals with active SUDs both in paid and unpaid roles (Laudet & Humphreys, 2013; Pantridge et al., 2016). These improvements included decreased substance use, fewer re-admissions to hospitals, as well as increased participation in services after discharge (Bassuk et al., 2016; Reif et al., 2014). Turpin and Shier (2017) found that peer support provided a unique and different perspective than that of professionals thereby strengthening traditional services. Peers that have received

this service report increased confidence (Pantridge et al., 2016), increased self-esteem, and a greater understanding of the practical issues of navigating recovery (Turpin & Shier, 2017), including increased coping skills, and increased hope that recovery is possible (Cabral et. al., 2014). Bassuk and colleagues (2016) conducted a meta-analysis and found that peer support workers had a beneficial impact on substance abuse outcomes. The reciprocal nature of the relationship between peer and consumer allows for the working alliance to increase outcomes in many life domains.

The cornerstone of the peer support relationship is the shared lived experience of addiction as well as experiential knowledge of the recovery process. This shared narrative enhances hope that long-term recovery is sustainable and increases motivation for engagement in recovery-based activities therefore enhancing recovery capital (Boisvert, Martin, Grosek & Claire, 2008; Davidson et al., 2010; Bailie & Tickle, 2014). The real-world knowledge of addiction and recovery has allowed peer support workers to provide effective psychosocial supports and life skills as brokers between the community and the individual in early recovery (Doukas, 2015). Peer support workers provide a unique perspective from that found in traditional intervention models that use professionals.

Conceptualizations of Peer Support Workers in Substance Use Recovery

The recognition of the value of peers in behavioral health has been long established and has taken many forms including mutual aid, peer-based support groups, peer run housing programs, peer clubhouses, and the employment of individuals in recovery in paid service provision roles. Throughout history, there is substantial evidence for the support that peers have provided to one another through informal and

more recently formal roles (Faulker, 2017). While the use of individuals in recovery as peer helpers is not a new concept, it is one that is quickly gaining visibility and acceptance in the continuum of recovery services as an evidence-based practice (Daniels, Ashendon, Goodale & Stevens, 2016; Davidson et al., 2010). The recognition of the value of peer support workers in the substance use field is a more recent phenomenon than in other fields.

Peer support as a resource for individuals experiencing substance abuse issues has historically had widespread recognition in the form of mutual aid. Current conceptualizations have taken the form of naturally occurring or informal peer support, peer run programs, as well as the employment of peers as providers of services, either in traditional or standalone services (Davidson et al., 2012; Solomon, 2004). One of the frequently identified differences amongst these roles is the distribution of power in these relationships and the direct roles that are assumed by the peer support worker (Davidson et al., 2012). For the purposes of this study, only peer support provided as a paid employee in the substance use field were explored.

Informal/Naturally Occurring Peer Support

Through the use of informal or naturally occurring supports individuals engage in the sharing of resources and mutual collaboration. In this type of peer support, the relationship is based on reciprocity without the clearly defined roles of helper and receiver of services (Moura, Sledge, Sells, Lawless &Davidson, 2014), rather a common need is identified (Solomon, 2004). Among the first to recognize the benefit of informal peer support in substance use recovery were the 12 step mutual aid groups such as A.A.,

which emphasize a nonprofessional approach to recovery by identifying oneself as an alcoholic (Kelly &Yeterian, 2011), the identification of a shared narrative, and an emphasis on citizenship and social reciprocity as critical components of long-term recovery (Ostrow & Adams, 2012). Much of the effectiveness of this type of support is the ability for it to be sustainable over a long period of time, in a manner that is conducive to its participants, and the development of a social support network (Kelly &Yeterian, 2011). A.A. established the role of sponsor to create an investment in the recovery of another individual which would in turn simultaneously enhance their own personal recovery (Gross, 2010). While the emphasis in A.A. is on the informal role of mutual aid from nonprofessional peers, the structure of the program and meetings is formal and orderly.

A.A. has been attributed to increases in recovery outcomes for individuals in recovery from alcoholism. While A.A. has been long accepted as a meaningful pathway to recovery, it is now recognized that identification as a member of A.A. is not the critical component to its success. In fact, regularly attending A.A. meetings, the development of a home group to regularly attend, and the formation of recovery relationships, particularly with a sponsor, have been identified as the core of recovery maintenance (Zenmore, Subbaraman &Tonigan, 2013). Additionally, engagement in activities such as community service, being engaged in the A.A. network, and reading of A.A. literature have also been identified as activities that increase recovery outcomes (Zenmore, Subbaraman & Tonigan, 2013). The widespread acceptance of informal helping through A.A. opened the door for many other mutual aid programs to be established.

Narcotics Anonymous (N.A.) emerged as an extension of A.A. that attempted to emphasize the unique challenges of individuals who experienced an addiction to drugs. The emphasis of this mutual aid group was the development of the personality trait of addiction (Peyton, 1985) and purports that members are powerless over the addiction process (White, Budnick & Pickard, 2013) which differed from A.A.'s emphasis on alcoholism. While continuing the groundwork laid by A.A., N.A. also emphasized the role of sponsorship with the belief that there would be a mutual benefit to an interdependent relationship immersed in recovery activities and spiritual transformation (Peyrot, 1985; White, Budnick & Pickard, 2013). N.A. also utilizes a 12-step model to help individuals with drug addictions to repair the damage that addiction has caused in their lives with members most notably identifying improved family relationships and social connections as the benefits of participation (N.A. World Services, 2013). N.A. expanded the reach of mutual aid by creating an atmosphere where individuals who were struggling with drug addiction could find support and encouragement.

In the United States, mutual aid groups continue to be one of the most recognized and sought-after resources for alcohol and addiction problems. In its conception, these meetings were held in people's homes, churches, and libraries. It is only in the last several years that these meetings have been held in spaces that are occupied by traditional service programs(Chamberlain& Rogers, 1990) and have been incorporated as components of formal treatment as well as aftercare recommendations with results indicating that this combination can lead to increased recovery outcomes (Kelly & Yeterian, 2011). Current incorporation of self-help programs such as N. A. into formal

treatment has been linked to increased treatment retention by way of social supports that facilitate changing views regarding self and knowledge about the recovery process (Jalali, Moradi, Dehghan, Merzai & Alikhani, 2019). Mutual aid groups have provided a recognition that recovery can be achieved without professional treatment and outside of conventional healthcare settings, opening up possibilities for alternative pathways to recovery. However, the increased incorporation into formal treatment has facilitated the recognition that the combination of informal and formal supports has the potential to increase recovery outcomes far greater than either approach alone and supports the need to explore the role of peer support as a vehicle to recovery.

Peer-Run or Operated Programs

The idea that peers can play an important role in the delivery of services can also be seen in peer run programs. Peer run programs have traditionally existed outside of the formal treatment system and were created and run by peers with the goal of establishing peer support through both naturally occurring and staff supported interactions (Brown et. al., 2008). These have taken the form of clubhouses, sober living programs, drop-in centers, crisis services, vocational and employment services, and community-based peer support services (Solomon, 2004). While these types of services often vary in terms of their make-up and services provided, the commonality is that they are run and controlled by individuals who identify as being in recovery (Solomon, 2004).Through this model, the community is believed to play an integral role in the recovery process with the peer support worker influencing program operation and community inclusion.

One of the common types of peer operated programs takes the form of recovery housing. Based on the premise that many individuals recovering from SUDs need to make changes to an unhealthy living environment, recovery housing options provide a supportive environment that is peer driven and focuses on recovery activities (Humphreys &Lembke, 2014). Two of the most popular forms include half-way houses that support a transition from intensive treatment to community reintegration (Polcin, Korcha, Bond & Galloway, 2010) and sober houses in which the residents are responsible for not only the structure of the environment but also pay rent and expenses (Humphreys &Lembke, 2014). Polcin and colleagues (2010) identified reduction in stressors and increased maintenance of recovery in individuals who resided in peer run sober living environments. Often individuals in the early stages of recovery lack a strong sober support network and need to make changes to their environments in order to maintain sobriety. Support from peers allows these individuals to begin to establish support networks that can strengthen their recovery and assist with many of the stressors and triggers for relapse (Reif et al., 2014).

Peer Support Workers as Employees

Peer support workers are individuals who are hired into the role and are paid to provide non-clinical support to individuals whose recovery is not as far along. This has taken the form of peer support services both as standalone services and as part of a formal treatment process (Davidson et. al., 2012).The role of peer support worker includes activities such as mentoring, coaching, being a role model, connecting to natural community-based supports and resources, facilitating community reintegration,

advocacy, coping skill development, and the encouragement of treatment adherence and completion (Laudet& Humphreys, 2013; Mendoza et al., 2016; White & Evans, 2014). Due to the recent increase in the use of peer support workers in formal roles an understanding of the role itself as well as the impact on the peer support worker have not been thoroughly explored.

Peer support workers in this category are tasked with using their experiences as expertise from which they can assist another in navigating the system, providing a bridge between professionals and clients (Reif et al., 2014). While the experience of substance abuse recovery is a critical component, it must be combined with the ability to utilize this expertise effectively to guide others. Peer support workers have been engaged as part of a formal treatment team and as a means to support a transition from treatment with an emphasis on community goals such as housing, employment, and linkages with naturally occurring recovery supports (Gagne, Finch, Myrick & Davis, 2018). Peer support workers are in a formal role, therefore, they will often be engaged in identification of goals for the client and the assistance in connecting to community resources to meet these goals (Reif et al., 2014). Although in other fields this role has been historically difficult to generalize as the expectations and utilization has varied greatly (Cabral et al. 2014), in the substance abuse field there is a clear delineation between treatment and mutual aid, however, treatment has historically been provided by clinical professionals (Myrick & del Vecchio, 2016). This can create confusion with how to conceptualize the role of peer support worker and may lead to the viewing of the worker as not being a part of the treatment team or not as a professional role.

While the employment of peer support workers in the substance abuse field continues to rapidly expand, the majority of the literature that currently exists focuses on their role in mental health creating generalizations that may not consider the unique attributes of substance abuse recovery. This trend is likely due to the disparity in states' adoption of payment avenues for peer support workers. While 41 states had established payment for mental health peer support workers by 2016, only 11 states had established payment for SUD peer support workers (Gagne et al., 2018; Kaufman, Kuhn & Stevens-Manser, 2016). It is noted that the need for peer support workers is on the rise as President Trump declared the opioid crisis a national health emergency in 2017 and a significant increase in the application of peer support workers in the treatment of SUDs was recommended (Madras, 2018).

Potential Contributions and Risks to Personal Recovery for Peer Support Workers

It is widely recognized that there are positive and unique benefits from peer support services for individuals with active SUDs, however, less is known about the impact on the peer support workers themselves of providing these services. It has been assumed that the peer support worker also receives a benefit from helping another person with their addiction, as evidence has shown in the mutual aid models and through the application of the helper therapy principle(Pagano, Post & Johnson, 2011; Reif et al., 2014, Reissman, 1965).Yet there have also been concerns about the potential risks with Moura and colleagues (2014) identifying that the intensity of this relationship creates the potential for both benefits and risks to the peer support worker.

Potential Benefits to the Peer Support Worker

Helping has been found to be directly related to improve health and sense of life satisfaction. Peer support workers have been recognized for their resilience, flexibility, and adaptability, as well as the investment that they make in the struggles of another individual (Doukas, 2015). The peer support workers themselves have reported many benefits from this role including increased confidence in their recovery, increased self-esteem, and a sense of control over their illness (Bailie& Tickle, 2015; Cronise, et al., 2016). The role of peer support worker has been reported to provide ongoing structure, responsibility, and purpose in the lives of the peer worker (Dugdale et al., 2016; Moura et al., 2014). Peer support workers have reported increased job satisfaction and personal satisfaction from being in a role of helping others (Cronise et al., 2016). Peer support workers experience a positive shift in the view of themselves as well as how they are perceived by others.

Peers with sustained recovery are often looked upon as role models by individuals who are in early stages of recovery. Peer support workers have also been seen as role models by non-peer staff, particularly around strategies to create working alliances, and providing information about the real-world experiences of recovery (Cabral et al., 2014). Bailie and Tickle (2015) found that being a role model motivated the peer support worker to engage in the practices that they were teaching, thereby enhancing personal recovery and immersion in recovery-oriented activities. The validation that comes from the individuals that they help, coworkers, and other members of their support system further strengthens their sense of purpose and recognition of their recovery (Mead & MacNeil,

2006). The transition from service recipient to peer support worker has also been found to assist the peer worker in shifting their identity from a service user with a self-reference to an individual with sustained recovery that can make a meaningful contribution to the behavioral health system (Dugdale et al., 2016). These contributions are directly linked to participation in important life domains and improve recovery capital.

This transition in role allows for a decrease in some of the negative emotions and experiences that are frequently reported by individuals who struggle with addiction. For example, peer support workers reported a decrease in the experience of stigma in the transition from identification as an individual who is in active addiction to being employed and recognized by what they have to offer to others (Dugdale et al., 2016). Peers have also reported that through this role they were able to sustain long term recovery (Dugdale et al., 2016; Tracy et al., 2011). This includes the development of additional skills that support remaining substance free (Doukas, 2015), staying closely connected to treatment providers and informal supports (Jacobson, Trojanowski, & Dewa, 2012), which facilitates the engagement in recovery-oriented activities (Doukas, 2015), as well as developing a larger social support network (Dugdale et al., 2016). These support networks were believed to be beneficial to the peer worker should they begin to struggle with their own recovery (Dugdale et al., 2015). The role of peer worker not only strengthens recovery supports but also allows for the fulfillment of major social responsibilities.

The role of peer support worker has allowed for the employment of individuals who may have otherwise not found meaningful employment. In returning to gainful

employment, peer support workers are less likely to need to depend on systems such as Social Security and state assistance programs (Salzer et al., 2013). Individuals with SUD have many obstacles in relation to obtaining and maintaining employment and have a lack of access to formal employment training despite the recognition that this is an integral part of positive lifestyle outcomes (Room, 1998). The ability to be a contributing member of the labor market is beneficial, however, it is the development of work experience and the psychological benefits of employment that contribute to sustained recovery outcomes (Salzer et al., 2013). Through paid employment as peer support workers, individuals can not only contribute to society but to further their recognition of the control that they have over their future and develop autonomy. Peer support workers are individuals who have a period of recovery from active substance abuse behaviors, however, it is also important to remember that the amount of time sober is not the most important indicator of successful recovery.

Peer support workers have established strategies to maintain recovery and utilize resources effectively, however, the potential for relapse is also a natural part of the recovery experience. Evidence suggested that while there have been concerns voiced regarding the potential for triggering a relapse in the peer support worker, workers have a greater understanding of the negative consequences of relapse in their lives (Dugdale et al., 2016). Further, their increased immersion in recovery activities has been reported to increase the support network and resources available to the peer support worker (Dugdale et al., 2016; Tracy et al., 2011). The role of peer support worker can be seen as facilitating the recovery journey of these workers, however, these studies suggest that

safeguards such as formal training and ongoing supervision and support, should be implemented to ensure that harm does not come from participation in this role.

Challenges to the Role of Peer Support Worker

Concerns have been raised in the research that peer workers are tasked with being both a provider and a receiver of services and that this can add stressors to the recovery process of the peer worker. This shift in roles has been correlated to experiences of role confusion and discrimination when one of the defining qualifications for employment is self-identification of personal recovery status (Moran et al., 2013; Walsh et al., 2018). The perpetuation of stigma through the label of expert by experience may set the stage for inequity of status (Alberta, Ploski& Carlson, 2012) as well as a lack of credibility in the role of peer worker (Vandewalle et al., 2016). Peer support workers have reported a lack of equality between themselves and their non-peer colleagues (Walker & Bryant, 2013), concerns related to being accepted by coworkers (Doughty &Tse, 2011), as well as feelings of stigma and discrimination from non-peers and leadership (Chapman et al., 2018; Cronise et al., 2016). This negative view of the peer role by non-peer staff may be directly related to the lack of role clarity and the lack of information regarding the differences between peer and non peer roles.

Peer support workers regularly report a significant difference in their compensation and the value placed on their work by others, creating challenges to this role. These challenges including lower salaries and fewer work hours available than for non-peer counterparts in similar roles (Chapman et al, 2018; Cronise et al., 2016; Walker & Bryant, 2013).A national survey of peer support worker compensation found peer

workers to be paid significantly less than other health professionals and to have barriers to full-time employment (Daniels et al., 2016). The career trajectory of a peer support worker appears linear as behavioral health organizations do not appear to have opportunities for career advancement (Chapman et al., 2018; Daniels et al., 2016, Gagne et al., 2018). This may discourage individuals from entering the role of peer support worker due to the lack of opportunities for upward mobility as well as the potential for this role to decrease future employment opportunities (Sherba, Coxe, Gersper & Linley, 2018; Walsh et al., 2018). The identification as an individual in recovery may be the one of the critical components of the role of peer support worker, however, it can create barriers when seeking employment outside of this role due to stigma and discrimination from potential employers.

Peer support workers have been reported to be at greater risk than other mental health professionals for the personalization of the client's successes and failures. This has been attributed to the use of shared experience to influence the outcomes of individuals in recovery (Ahmed et al., 2015; Moura et al., 2014).There is concern that the role of peer worker will increase the pressure to maintain personal sobriety (Moura et. al, 2014), which can create added stressors for the peer support worker (Ahmed et al., 2015). Concerns related to the potential for being triggered or relapse of the peer support worker have been raised due to the immersion in work that is directly related to their own personal experiences and illness (Ahmed et al., 2015; Walsh et al., 2018). It is also unclear as to how a peer support worker will experience having to resume personal treatment should relapse occur (Chinman, Shoai & Cohen, 2010). The recovery

framework recognizes that relapse is a part of the process and that recovery exists on a continuum, however, more information is needed as to the experience of the peer support worker in this dual role.

Summary

Peer support and helping one another is not a new concept, however, the introduction of paid peer support workers is quickly increasing in visibility as a substance abuse intervention. There is considerable research on the use of peer support workers in the mental health field, however, the number of studies conducted on peer support for substance abuse is much smaller. Much of the research on peer support workers in the substance abuse field has focused on the intervention itself and the influence on the recipient's recovery. There are a small number of studies that have looked at the experiences of peer support workers and have identified potential contributions and risk factors for personal recovery including increased self-esteem, a sense of purpose (Bailie & Tickle, 2015), as well as the impact of stigma (Walker & Bryant, 2013), and lowered opportunities for advancement (Walsh et al., 2018). This research has been conducted on small samples and has helped to identify the need to understand how peer support workers experience the relationship between this role and their personal recovery. A generic qualitative study helps fill this gap by allowing for a greater understanding of the peers' perspectives and experiences and reveals common themes to better understand the peer support worker recovery experience. I have incorporated the recovery framework and the helper therapy principle which have provided the context by which to understand the concepts of recovery and the experiences of the peer support workers. The following

chapter provides the rationale for utilizing a generic qualitative approach, the procedures utilized, and the ethical processes proposed for the exploration of the experience of peer support workers.

Chapter 3: Research Method

Introduction

The purpose of this generic qualitative study was to explore the peer support worker's experience of the dual role of consumer and provider of services in the context of their personal recovery. For the purpose of this study, a peer support worker is an individual who is paid to provide nonclinical support services to an individual in early recovery from substance abuse. In this study I have inquired about the participants' perspectives of their personal recovery while acting in the role of paid peer worker. This chapter includes the research questions, research design and rationale, the role of the researcher, the methodology, as well as issues of trustworthiness and relevant ethical considerations.

Research Design and Rationale

Research Question

How do peer support workers experience the dual role of consumer and provider of services in the context of personal substance abuse recovery?

Research Design

The central phenomenon of the study was to explore how peer support workers experience their dual roles and their personal recovery from substance abuse. I chose a generic qualitative approach for this study to allow for the exploration of the experiences and meaning of personal recovery from the perspective of the peer support workers themselves. This approach looks at the subjective experience of the participants, the meaning that they attribute to these experiences as well as the way these experiences have

produced transformation in their perspectives (Liu, 2016; Merriam, 2009). A generic qualitative approach allowed for the consideration of the way peer support workers interpret their role and how it shapes their view of their own recovery (Kennedy, 2016). While peer support workers have previous experience with recovery, the manner in which it is experienced with the introduction of the role of peer support worker was the focus of this inquiry.

A generic qualitative approach facilitated exploration of what the role of peer support worker brought to the worker themselves and their personal substance abuse recovery. As the area of inquiry was the peer worker role itself, and how it was experienced (Percy, Kostere & Kostere, 2015), a generic qualitative was the best fit for the current study. The current study allowed me to explore any commonalities in these experiences among peer support workers including their ideas, opinions, and reflections on the role of peer support worker (Caelli, Roy & Mill, 2003; Liu, 2016). This approach allowed the themes to emerge from the raw data of the interviews (Thomas, 2006). This inquiry moves beyond what can be easily quantified and explored the lived experiences of the peer support workers, making a qualitative model the best option.

Other qualitative approaches were considered, particularly phenomenological, case study, and narrative approaches. While a phenomenological approach seeks to understand the lived experiences of the participants in a pre-reflective manner (Percy, Kostere & Kostere, 2015), and while that is in line with a great deal of recovery research, I sought to explore the actual experiences of peer support workers and how these experiences shaped their view of their personal recovery. Phenomenology was not chosen

as the experience being studied is external to the individual experiencing it rather than looking at the internal processing of the participant (Kennedy, 2016). A narrative approach was considered due to the ability to explore the perspective of the participant; however, the broad exploration of life experiences did not lend itself to the research as it does not address the narrower experience of a peer support workers. A case study approach was also considered as it provides an in depth look at a participant's experience, however, the focus is on one individual, in their context, and utilizes multiple data collection options to create this depiction (Johansson, 2003). This study sought to look at the experiences of peer support workers and how the context in which they work and live may vary.

Role of the Researcher

My role as the researcher was to oversee all aspects of the study from the conceptualization and design of the study, the review of the literature to frame and guide the study, through the collection and interpretation of the data and reporting of the results. This included the development of the interview questions, identification of participants, as well as conducting the interviews, and analyzing the data. I am not a participant in the study and used participant interviews for data collection.

While I have experience with the concepts of recovery through the role of a psychotherapist, I am not presently, nor have I ever been a peer support worker. My experience in working with individuals who have experienced substance abuse issues had the potential to influence the research process. To safeguard against this, I engaged in ongoing self-reflection and reflexive practices. I managed any preconceptions and focus

solely on the participants' experiences and incorporated the use of reflexivity. A reflexive journal was used throughout the entirety of the study and serves as a record of my experiences, reactions, and assumptions that emerge through the research process. The use of reflexive notes allowed for documentation of the aspects of the interview that were noted by me as well as the subjective responses that I had to the participants (Korstjens & Moser, 2018).

Due to the stigma associated with substance abuse recovery and the emphasis on experiential knowledge, the information about my certification and experience in alcohol and drug counseling was disclosed with the goal of establishing rapport and transparency in the research process. While experience with substance abuse and recovery may increase rapport building there was also the risk of leading participant responses and interpreting answers in the light of my previous professional experiences. As a result, I sought support from content and methodological experts to review interview questions developed for presuppositions. In order to safeguard against bias, I did not recruit from agencies in which I have had professional collaborations in the community. I also did not include any peer support workers that I have encountered in a personal role, professional role, or as a client in the past.

In addition to these precautions, other methods were utilized to ensure the trustworthiness of this qualitative analysis. Prior to conducting the interviews, all participants were provided with informed consent detailing the voluntary nature and the purpose of the study, their right to withhold any information that they were not comfortable sharing, their right to terminate from the study at any point in time with their

records being destroyed, the manner in which data was utilized and stored, as well as how the participant's privacy is be safeguarded.

Methodology

Participant Selection

The selection of participants was done utilizing a criterion sampling approach to identify peer support workers living in Massachusetts who were actively providing nonclinical support to individuals in early recovery from substance abuse. I utilized a snowball referral sampling to ensure an adequate number of participants to reach saturation.

Population. In order to be considered as a potential participant, a peer support worker needed to meet the following criteria:

- Participants had to be from Massachusetts. While peer support has received funding approval at the federal level, states have authority as to how to structure and implement peer support worker roles. This allowed for greater similarities in roles.
- Participants had to be 21 years of age or older.
- Participants had to be currently in formal paid peer support worker roles.
- Participants had an identified period of personal recovery of no less than 12 months and reported that their recovery was stable at the time of participation.
- Participants must have worked as a peer support worker for individuals recovering from substance abuse for no less than 6 months.

- Participants needed to be available for interviews either in person, via Facetime, Zoom, or Skype.
- Participants could not know the researcher.

Participants were excluded from the study if they have any active substance abuse at the onset of the study. All participants were asked to self-identify current substance abuse activity as an exclusion.

Sampling Strategy and Sample Size

A combination of criterion sampling and snowball/referral sampling was used to identify peer support workers and invite them to participate in the study. Criterion sampling was appropriate as there are predetermined criteria that participants needed to meet in order to be included in the study that are integral to the inquiry at hand (Moser &Korstjens, 2018), and this was employed at specific sites, as described below. The connected nature of substance abuse recovery makes snowball/referral sampling also an appropriate choice as individuals who are peer support workers are likely to know other peer support workers. Referral sampling has been found to be effective in situations where the stigmatization of the phenomenon being studied may prevent participants from responding to advertisement (Robinson, 2014). The stigma associated with the role of peer support worker has been identified as a potential detriment to the role and thus should be considered here. Participants were asked if they know other peer support workers whom they would like to invite to participate in the study which resulted in four referrals, three of which opted in to participation.

Qualitative inquiry takes an in depth look at the phenomenon of interest often creating smaller sample sizes and personal interaction between the researcher and participant. While there are recommendations regarding suggested sample size, these have received much debate and variation (Vasileiou, Barnett, Thorpe & Young, 2018) as factors such as access to participants, setting in which research is conducted, selection criteria, homogeneity of the participants, and quality of data collected influence the process (Moser & Korstjens, 2018). Saturation, the point at which no new data is being revealed, is the most common measure of sample size appropriateness in qualitative research(Guest, Bunce & Johnson, 2006; Saunders et al., 2018) and purported as the gold standard by many researchers (Guest et al., 2006). Mason (2010) explained saturation as the point in which additional research yields diminishing returns making it a gradual process rather than a moment in time. It is possible that saturation can be approximated, in that when new data is incorporated, it does not provide additional relevant themes or meaning units about the phenomenon in question. In the present study, saturation was accepted when additional interviews no longer provided additional understanding of the experiences of a peer support worker and the influence of this role on their personal recovery.

This study reached saturation at 10 participants which is within the established suggestions that presently exist for qualitative inquiry of this nature. While Guest and colleagues (2006) found that 12 interviews were sufficient to achieve thematic saturation, other researchers have suggested 20-30 when considering the use of a semi-structured interview (Creswell, 1998; Morse, 2000; Patton, 2002). It is believed enough data was

gathered to explore how peer support workers experience personal recovery and the influence of this role on these experiences.

Participant Recruitment

In order to recruit participants for the study, I contacted agencies that employ peer support workers to work with individuals who are in early recovery from substance abuse in the state of Massachusetts. I shared with them the nature of the study and asked if I could provide information to be shared with peer support workers and send an email that can be disseminated to their peer workers. I also asked if they had Facebook pages or LinkedIn pages where I could post a brief description of the study to gain interested participants. I also contacted the state certification body to inquiry about ways in which information could be disseminated to past and present recovery coach candidates. While certification is not a requirement of this role in the state of Massachusetts presently, this in addition to direct agency contact helped to yield an appropriate sample size. I have not identified these organizations in my final dissertation to ensure participant confidentiality. I also connected with public forums that include peer support workers and posted the brief description of the study to promote participation interest. Once interviews began, peer support workers were asked to pass on information about the study to peer support workers who may be appropriate for participation.

Interested individuals contacted me via email or telephone at which point I explained the criteria for the study and what I was looking for from participants. If they had contacted me via email, I sent them a request to schedule a time to talk with them on the telephone. During these initial conversations, I asked potential participants to opt in

to the study based on the inclusion and exclusion criteria, gave an explanation of the purpose of the study, the requirements of participants, as well as the commitment that was being requested of them. I provided participants with informed consent forms and a summary with pertinent study information to assist in decision making. While interview questions were not provided directly to the participants prior to the beginning of the study, I informed them of the topic of the interview; how their role as peer support worker influences their personal recovery.

Once eligibility criteria were determined and the participant agreed to participate, telephone and zoom interviews were scheduled depending upon the participant's preference and availability. I reviewed informed consent with participants on the telephone and a signed consent form was submitted to the researcher for inclusion in the study via secure fax or email prior to the interview being conducted. I conducted all of the interviews allotting 60 to 90-minute for each interview. This time period did not include the 10 to15 minute initial study overview and orientation and review of informed consent that occurred prior to the recorded interview session, nor did it include the debrief and wrap up that occurred after all of the interview questions were answered.

An interview debrief included a review of how data would be stored and used in the context of the research study, participants were reminded of the transcript summary review, which will take approximately 20-30 minutes and asked if they knew of anyone that would be an appropriate candidate for the study. A follow-up appointment was scheduled once transcript summaries were completed to give participants time to review the transcripts and elicit feedback (Shenton, 2004). All attempts were made to have this

follow-up occur within 2 weeks of the initial interview, with 1 week being the preference so that the conversation was easier to recall. This was delayed in a few cases due to the coronavirus complications in the state of Massachusetts. Participants were given a flyer and study summary to provide to other potential participants as well as my contact information. Additional interested individuals then contacted me in the same manner as the other participants. Participants were provided with a 1-2-page summary of the research results, in everyday language, at the conclusion of the study. This was disseminated via email based on participant expressed preference.

Instrumentation

Generic qualitative research lends itself well to the semi-structured interview process to gather information about the experiences of participants. For this study, I have developed a semi-structured interview guide consistent with a generic qualitative approach (see Appendix A), allowing for the exploration of the subjective experiences of the peer support workers (Liu, 2016) as well as follow-up probes to elicit participants' experiences with personal recovery in greater detail, the meaning that recovery has for them, and what the role of peer support worker contributes to this experience. The interview guide was developed through the lens of a recovery framework and the helper therapy principle where the focus was the experiences of the peer support worker in the context of their personal recovery. During the interview, participants were encouraged to share their experiences, opinions, and beliefs about their role as a peer support worker as well as their own personal recovery. Participants were also given time to expand on the primary questions and to add information that they felt was pertinent to share,

recognizing that they are the experts in the recovery experience and may offer information that was not previously considered.

Interview questions were developed from the key concepts that were identified in the literature review frameworks as well as concepts central to substance abuse recovery (Brod, Tesler & Christensen, 2009).These include recovery as occurring on a continuum (Laudet, 2011), that helping often benefits the helper as well as the recipient (Pagano, Post & Johnson, 2010), and that there are positive and negative consequences associated with the role of peer support worker (Bailie& Tickle, 2015). Although all questions were asked in every interview, prompts were used at my discretion to foster greater exploration of the experiences of peer support workers. The interview guide included interview questions and probes, additional general probes were used, at the discretion of the interviewer, such as "Can you give me an example of that?" or "Can you tell me more about that?"

Researcher Developed Instrument

In order to ensure content validity, I developed the interview guide through the lens of a recovery framework and the helper therapy principle where the focus was the experiences of the peer support worker in the context of their personal recovery. Interview questions were developed from the common themes that have emerged during the literature review, conceptual frameworks, as well as concepts central to substance abuse recovery (Brod, Tesler& Christensen, 2009). I prepared a draft interview guide that was shared with committee members to ensure flow, the use of clear open-ended questions, and aided in the elimination of the use jargon and the reduction of any undue

influence of the researcher (Patrick et. al., 2011). The nature of semi-structured interviews lend itself well to a thorough and rich exploration of the subjective experiences of the peer support workers.

Procedures for Recruitment, Participation and Data Collection

After obtaining IRB approval from Walden University (approval number 01-07-02-0136562), I began the process of recruitment of participants by contacting public agencies and forums that either employ or certify peer support workers and those that have informal connections to paid peer support workers. Once interviews began, I asked participants for referrals of peer support workers that may be interested in and appropriate for inclusion in the study. I scheduled and conducted interviews with interested peer support workers who opted to participate, met selection criteria and provide informed consent.

Interviews were conducted via Zoom or Telephone at the request of the study participants. All participants were offered a variety of locations that offer privacy based upon participant location. This included private rooms in at the Worcester Public Library and a willingness to travel to the participant's location. However, all peer support workers opted for virtual methods.

I interviewed all of the participants using the semi-structured interview guide and allotted 60-90 minutes for the interview itself. An additional 10-15 minutes was allotted for the initial introductions, study overview, review of informed consent and time for participant debriefing and wrap up. At the conclusion of the interview, I provided

participants with a flyer to give to other peer support workers that may be interested in the study to assist in the recruitment of an adequate number of study participants.

In addition to the audio recordings, field notes were taken during the interview to complement and capture the essence of the data. Participants were provided with a $20.00 Amazon gift card as a thank you for participating in the study prior to participation so any pressure to continue participation was minimized. Field notes were reviewed after each session and when necessary converted into a fuller more comprehensive account of the interview. All interviews were transcribed verbatim at which point participants were contacted and asked to review a summary of transcript of the interview for accuracy through the process of member checking.

Data Analysis Plan

I utilized a semi structured interview format with an interview guide that was developed to explore how peer support workers experience their dual role of consumer and provider of services in the context of their own personal recovery. All interviews were audio recorded, and a reflexive journal was utilized to document the aspects of the interview that are noted. I utilized a thematic analysis approach as defined by Braun and Clarke (2006) to identify themes and patterns in the data and make sense of these themes in relation to the current research study. A thematic analysis lends itself well to a generic qualitative study due to the flexibility and emergence of themes from the data (Maguire & Delahunt, 2017). Thematic analysis allowed for the peer support workers to construct the meaning of the experience and allowed the researcher to identify themes across peer support worker experiences (Saldana, 2016). It is particularly appropriate for this study

that sought to develop themes from the interview data to explore the relationship between the peer support worker role and substance abuse recovery as experienced by the workers.

I utilized a thematic analysis following the 6-phase method of thematic analysis as recommended by Braun and Clarke (2006). The first phase, familiarizing with the data occurred by reading each participant's transcript to the audio recording to increase familiarity and understanding of the participant interviews. The second phase included taking the data from each transcript and creating an initial coding to identify patterns in the data and establish preliminary categories that I found pertinent to the present study. The third phase was to search for themes in the initial codes with all codes that are relevant to the research question being incorporated into a theme. A thematic map as recommended by Braun and Clark (2006) was utilized to allow for a visual depiction of the themes and helped facilitate the identification of relationships between themes. Subsequent steps included reviewing and defining themes in order to ensure that they are representative of the data set as a whole. A qualitative analysis software program, NVivo12 was utilized to assist in data organization and to assist with the coding process, however, a manual coding process was also be conducted.

Issues of Trustworthiness

Trustworthiness in qualitative research involves looking at the level of rigor, justification for the research, and confidence that exists in the quality of the research conducted (Shenton, 2004). Strategies have been identified to ensure the trustworthiness

of qualitative research specifically targeting credibility, transferability, dependability and objectivity (Lincoln & Guba, 1985).

Credibility

Credibility refers to the confidence that can be placed in the results of the study to reflect the phenomenon of inquiry and has been likened to internal validity in quantitative studies (Shenton, 2004). Credibility is ensured in the present study using recruitment methods that promote honesty in participants including a clear description of the study, its voluntary nature, and the commitment being requested. During the semi-structured interview, participants were encouraged to answer honestly and openly while being given permission to not disclose anything that they did not feel comfortable talking about. All participants had the informed consent process explained to them as well, including the protection of their personal information and any limits to their confidentiality.

One of the most common ways in which credibility can be established in a qualitative study is by member checking. Member checks have been purported to increase credibility by highlighting possible researcher bias (Lincoln & Guba, 1985), identifying potential misinterpretation of the message conveyed by the participant (Shenton, 2004), as well as providing opportunities for clarification and provision of additional information (Hadi & Cross, 2015). The present study included audio recordings of all participant interviews. These recordings were transcribed verbatim and participants were asked to review a summary of the interview transcript. They were presented the option to review the transcripts as well should they prefer. These options allowed the participant to review what they have said and identify if the words that they

have chosen were in fact reflective of what they had intended to convey (Shenton, 2004). The member checking process also helped me capture the true voices of the participants (Candela, 2019). Participants also had the option to add information that corrects or further clarifies the points that they were trying to make.

Transferability

Transferability describes the extent to which the current research can be utilized by other researchers in other settings. While this is not the primary focus of qualitative research that is concerned with the experiences of the participants itself, there are way in which this can be attained in a study (Shenton, 2004). The present study provided a detailed description of the information provided by the participants and the research procedures including data analysis so that the reader can determine the relevance to themselves and their context of reference (Moser & Korstjens, 2018). The use of this level of description allowed for a thorough review by the dissertation committee. The detail of information provided also allows the reader to make appropriate judgements regarding whether the present study is one that can relate to their setting.

Dependability

Dependability refers to the way the study can be replicated. This process requires a clear and detailed account of the steps taken in the current study (Morrow, 2005). This was safeguarded using a detailed audit trail that provides a detailed account of all research processes, emerging data and analysis (Morrow, 2005). The present study used consistent recruitment, data collection and data recording procedures for all participants in the study.

Confirmability

Confirmability refers to the way the subjectivity of the researcher is managed so that it does not influence the results of the study and the results produced will be from the perspective of the participants(Korstjens & Moser, 2018). In the present study, the use of an audit trail as well as reflexivity, particularly the use of a reflective journal, assists in this process (Shenton, 2004). The participants were also provided with a summary of the interview to review for accuracy which assisted in ensuring that the data captured is the subjective experience of the peer support worker.

Ethical Procedures

This study follows federal regulations and IRB guidelines and I sought IRB approval prior to the data collection process to ensure the protection of all participants. Individuals who are employed as substance abuse peer support workers were invited to participate in the present study. This population does not meet the criteria for a vulnerable population, however, the role of stigma in substance abuse recovery was included in all stages of decision making to safeguard study participants. Participants are selected utilizing participation criteria and exclusions. The voluntary nature and purpose of the study, limits to confidentiality, as well as protection of data were provided and explained via the study's informed consent form. This included the participants' right to discontinue their involvement in the study at any time during the process. While inclusion criteria specify that participants will demonstrate stability in their personal recovery as evidenced by a minimum of 1 year of sobriety, it is important to take into consideration the potential for triggers when engaging in personal disclosure. Therefore,

participants were given information regarding how to find local resources should they experience distress, including the Massachusetts helpline that has 24-hour access to immediate referral support and information.

While identification as a peer support worker is not an ethical concern, disclosure by participants about the clients that they work with would be. Therefore, I informed participants at the beginning of the study that they should not reveal identifying information about the individuals that they work with and that the focus of the study is on their personal experiences in this dual role. In order to further protect confidentiality, participants were assigned numeric codes that were utilized for all data storage. I did not include information regarding the agencies or forums that were used for recruitment in order to further safeguard privacy. All physical data was kept in a locked file cabinet in my office and all electronic data is be stored with password protection. All documents will be destroyed 5 years after the completion of the study. Participants were provided with informed consent both verbally and in writing and required to acknowledge their agreement in writing prior to being included in the study.

Summary

This study utilized a generic qualitative research design to explore how peer support workers experience the role of peer worker and their own personal recovery. Peer support workers were recruited from agencies and certification bodies in Massachusetts utilizing criterion sampling. Snowball sampling was also utilized to ensure saturation of data. The purpose of the study was to identify the experiences, beliefs and opinions that peer support workers have about this dual role in the context of

their own personal recovery. This was accomplished using semi-structured interviews and thematic analysis. Procedures for data analysis, study rigor and ethical concerns have been addressed. Chapter 4 expands upon this to include a detailed account of the data collection and analysis procedures as well as the results of the study.

Chapter 4: Results

Introduction

The purpose of this qualitative research study was to explore the peer support worker's experience of the dual role of consumer and provider of services in substance abuse recovery. The central research question was: How do peer support workers experience the dual role of consumer and provider of services in substance abuse recovery? A basic qualitative approach was used to develop and collect information from participant interviews and thematic analysis was used to analyze the data. The setting and pertinent demographics are discussed in this chapter followed by data collection, analysis of data from participant interviews and transcripts, and results.

Setting

As described in Chapter 3, participants were peer support workers working in the state of Massachusetts. After participants consented to the interview process, appointments were scheduled for interviews. Participants were given the option to engage in face to face, telephone, Facetime, Zoom, or Skype interviews based upon their preference and availability. All interviews were conducted either via Zoom or over the telephone. There were no substantial variations from the originally planned procedures.

Demographics

The participants in the study were recruited through social media posts as well as information given to local agencies that train and employ recovery coaches for dissemination. Initial participants were asked to share information about the study with other peer support workers who may be interested in participation. Peer support workers

who were interested reached out via email or telephone and a discussion was held explaining the criteria for the study, its purpose, as well as the requirements and commitment being requested of them. All participants were over 21 years of age, in recovery from substance misuse, and employed in paid formal roles as peer support workers for more than 6 months. All participants reported sobriety of greater than 12 months at the time of the interview. All interested participants were prescreened to ensure that they met inclusion criteria for the study.

Participants who opted in to participate included three females and seven males. Basic demographic data collected was length of time they have worked as a peer support worker and the type of setting that they work in. Of the 10 participants, three work primarily in a hospital setting, one reported being split between an Emergency Department and a program in the community, and six worked for community organizations. Two of the respondents worked for the same hospital.

Table 1

Participant Demographics

	Gender	Length of time as PSW	Work setting
P1	M	3 years	Hospital
P2	M	5 years	Community
P3	F	5 years	Community
P4	F	4 years	Hospital
P5	M	3 years	Hospital
P6	M	10 years	Community
P7	M	3 years	Community
P8	F	10 months	Community
P9	M	20 years	Community/Hospital
P10	M	6 years	Community

Data Collection

Recruitment for the study occurred as described in Chapter 3, beginning on January 8, 2020 after IRB approval. Recruitment commenced via email distribution of a brief study description to organizations in Massachusetts that employ or train recovery coaches. In addition, posts describing the study were made on social media via LinkedIn and Facebook pages such as Recovery in Massachusetts asking interested participants to contact me for more information about participation. In addition to my recruitment efforts, snowball referral sampling was incorporated, with all participants being asked to share information about the study, via a flier that was provided to them, to any peer support workers who they thought may be interested in participation. Three respondents were recruited through snowball referral and did not work for the same agency as the individual who referred them. Recruitment of participants ended in March of 2020.

Response rates to recruitment attempts were approximately one to two people per week with 13 individuals reaching out to me via email or telephone in response to the invitation to be interviewed. I set up a time to review the criteria and informed consent form with all interested individuals and scheduled a time to interview those that opted in and met selection criteria. I emailed the informed consent forms and study description to all interested individuals prior to the telephone call and then signed consent forms were returned via email by the individuals that participated in the interviews. Ten participants were interviewed either via Zoom video conferencing or over the telephone with none of the participants electing for a face-to-face interview. All interviews lasted approximately one hour, with a range from 33 to 79 minutes, not including the brief introduction of

myself and the study at the beginning and the debrief and discussion of next steps at the end. All interviews were audio-recorded using iPhone voice memos and Zoom to prevent any unforeseen loss of data. I took notes during the interviews, and again when I read the transcripts later. My notes included any emotional or personal reactions, reflections, and perceptions relating to the participants' responses to interview questions or follow-up probes, as well as responses that stood out to me. I did not encounter any unusual circumstances during the interview process; however, I did not anticipate that so many of the participants would have requested virtual interviews.

I stored all digital recordings on my password protected laptop computer and transferred any recordings from my cell phone to my laptop at the conclusion of the interview. All interviews were transcribed and then I read the transcription while listening to the audio to ensure accuracy. The transcription files were password protected then uploaded to NVivo on my password protected laptop and print copies were stored in a locked filing cabinet in my home office. All identifiable information was removed from the transcription, and participant names were substituted with numerical coding (P1-P10).

After the completion of transcription, I engaged participants in member checking. Each participant was emailed a summary of their interview and asked to review the summary to ensure that inaccuracies or misinterpretations were resolved. I also invited participants to share any additional information that they felt would be pertinent to the study. There were no variations in data collection methods from what was proposed in chapter 3.

Data Analysis

This generic qualitative study utilized thematic analysis to identify themes across the experiences of peer support workers of their dual role of consumer and provider of recovery services. I utilized a 6-phase thematic analysis process as recommended by Clarke and Braun (2018). This method was chosen as it allows for a reflexive and recursive approach through which the peer support workers' meaning of their experience can be captured and utilized to identify themes across the data (Clarke & Braun, 2018; Saldana, 2016).

Data analysis began in the first phase, familiarizing with the data, which involved a careful review of each verbatim transcript several times while listening to the audio recordings (Braun & Clarke, 2013). This allowed for both immersion in the data but also further reviewing the transcripts for accuracy. During the first phase, I made notes in my research journal of the items and concepts that initially caught my attention including possible connections across the data, application to the research questions, and to the conceptual frameworks (Braun & Clarke, 2013; Braun, et al, 2018). This allowed for reflection on what I am bringing to the data as a researcher and the salience of these notations to my own personal belief system and identification (Braun & Clarke, 2013). Engagement in reflexivity at this point allowed me to pay attention to these factors during analysis so that the focus of the analysis remained on the participants' meanings and experiences and not on any pre-judgments that I may have made. My notes taken during the interviews were also reviewed during this time

The second phase of data analysis, generating initial codes, included taking the data from each transcript and creating an initial code to identify patterns in the data and establish preliminary categories that I found pertinent to the present study. This phase begins the systematic portion of engagement with the data (Braun, Clarke, Hayfield, & Terry, 2018). I began this process by initially hand-coding the transcripts, with each transcript being coded individually, line by line, before moving on to the next. Hand coding was an important step as it helped me to continue to familiarize myself with the participants' experiences. Then, I uploaded all the interview transcripts into NVivo 12 for further analysis. I conducted another round of manual coding using NVivo and compared my paper codes to the codes generated with the software which allowed me to ensure that I remained consistent in my coding process. I gave equal attention to all of the interview transcripts to ensure that repeated patterns could be identified and that as many codes as possible were developed (Braun & Clarke, 2013).

All coding was completed in an inductive manner, allowing the codes to be generated from the data without predetermined categories or codes. While I had some initial ideas about the codes that may emerge during phase two, such as internalizing failures, helping helps the helper, and engagement in self-care, that resonated during phase one, those were recognized and put aside at this point to allow for the participant transcripts to guide the coding process. Codes were developed both at the semantic and at latent levels of the data. Overall, 75 codes were established during this phase of analysis. Once the codes were identified, the interview transcripts were again reviewed to identify all instances where the codes appeared in the data and to incorporate these

pieces of the data into the codes. At this point, notes made during the interview and transcription process were reviewed to look for concepts that may not have been included in the coding process but had resonated during the interview process. Lastly, I identified codes that overlapped or were too similar in nature and combined or renamed them to highlight the concept being captured by the code.

In Phase three, search for themes, identification of the patterns of meaning across the data begins using the developed codes in Phase 2 and allows for the integration of larger pieces of the data (Clarke & Braun, 2013). I initially reviewed the codes that were similar and integrated them into meaningful clusters along with their corresponding data (Braun, Clarke, Hayfield & Terry, 2018). To fully explore the research question, I then looked at the generated codes with the specific lens of the dual roles: the peer support workers' experience of helping others and their experience of their own personal recovery. All codes that were relevant to the research question were incorporated into candidate themes with seven themes and two subthemes identified at this phase. A thematic map, as recommended by Braun and Clarke (2013) was used to depict the themes and to aid in identifying the relationships between the themes (see Figure 1). All themes that did not have a central construct, relation to the research question, or substantial data to support them were discarded at this point.

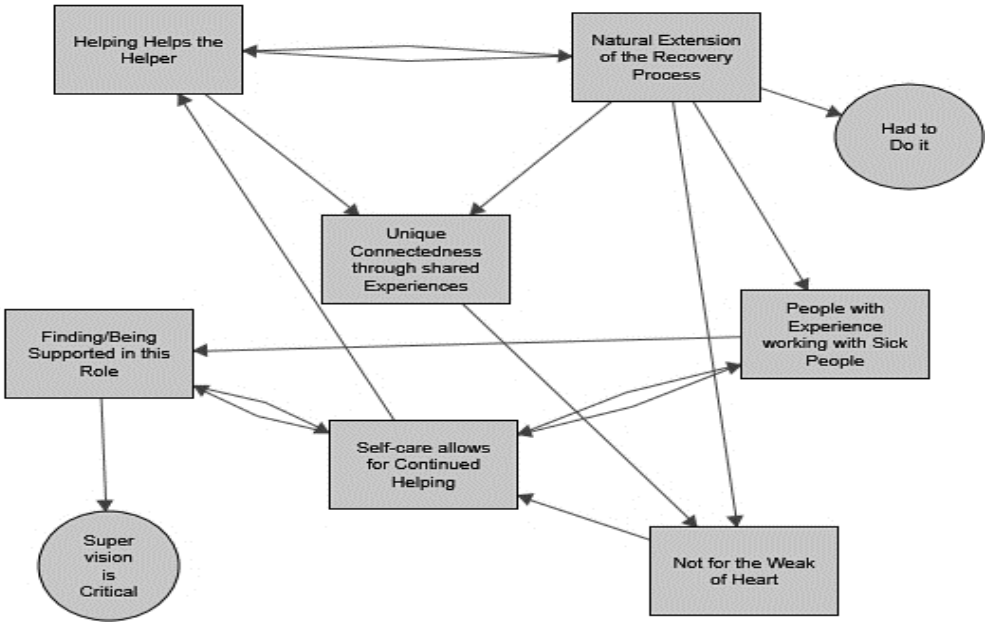

*Figure 1.*Thematic map of candidate themes, subthemes and the relationships.

Phase 4, reviewing themes, involves reviewing and revising candidate themes to ensure that the themes are representative of the data and to clarify the breadth and scope of the candidate themes (Braun et al., 2018). Following the recommendations of Braun and colleagues (2018), the revision process took place in two steps. First, I began by reviewing all the coded and collated data and ensuring that the candidate themes work well in relation to the data. Then I considered the candidate themes in relation to the entire data set by re-reading the uncoded transcripts to ensure that the themes were representative of the data set in relation to the research question (Braun & Clarke, 2006). I coded any information at this phase that stood out and was not coded in the first two rounds and included it in the relevant theme. I also utilized my research journal to make note of concepts that stood out to me while reviewing the data.

During Phase 4, I collapsed the candidate theme of people with experience working with sick people into the candidate theme of unique connectedness through shared experience. I also discarded the candidate theme of not for the weak of heart. While this candidate theme spoke to the intensity of the role reported by the peer support workers and the challenges that were voiced, it was more representative of their recommendations as to qualities of a peer support worker and not representative of the intensity that they experienced personally in the role. I believe that this intensity is captured better under the candidate theme self-care allows for continued helping and have included it there. After reviewing and refining the candidate themes, five distinct themes persisted that are cohesive and represent the data and the overall story in a meaningful way. Another thematic map was created at this stage (see Figure 2) to allow for continued visualization of the analysis process.

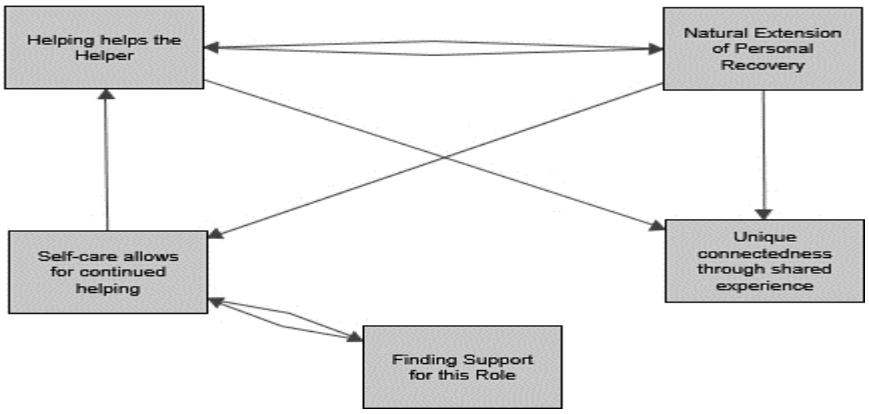

*Figure 2.*Thematic map of revised candidate themes.

As depicted in Figure 2, I found, during Phase 4, that there were relationships between the themes that is important to note. First helping helps the helper has a

bidirectional relationship with natural extension of personal recovery in the continued to connection the community resources and recovery activities which was highlighted by the peer workers as assisting their ongoing recovery. Self-care was identified as having a bidirectional relationship with support for the role of PSS due to reports from peer workers that they often had to advocate for the support they needed and to be encouraged to engage in self-care by supervisors and support systems. Many of the peer workers identified their personal recovery activities as part of their self-care creating a relationship between personal recovery activities and self-care. The peer support workers explained that engaging in self-care is what makes the role sustainable and helps them to be effective in it, depicted a connection between self-care and the help that the PSS receives from their role.

Phase 5, defining themes, includes the naming and defining of all themes to identify what is distinct about them. At this phase, I reviewed all the themes and gave each one a definition that identified its relationship to the data and the research question. I paid attention to the story represented in each theme and how that story related to the overall story that emerged from the data. Then I revised the names of the themes to clearly identify the data that is captured by the theme and the essence of the theme. The themes that were refined at this stage are a) by helping others, we help ourselves b) self-care makes the role of PSS sustainable, c) connection through shared experience, d) extension of the recovery process, and e) peer support in a system of care.

Phase 6, involved writing the analysis report which is included in the results section of this chapter. In this written analysis, the themes are presented and interwoven

with excerpts from the transcripts that illustrate the elements and central concepts of the themes. These themes represented the perspectives as presented by the peer workers interviewed.

Discrepancy in Experiences/Cases

Variations in data sometimes occurred because of the differences in work settings between a hospital environment and a community setting. For example, in hospital settings peer support workers reported that they were engaging individuals who did not ask for help and in some cases, who had recently overdosed, whereas in community settings referrals often came from individuals who were residing in the community or through other community referral sources. This difference can influence the experience of the ability to engage with participants, differences in styles of approach, as well as feelings of accomplishment, or success in the role of peer support worker. P3 who has worked in the community several years for an agency and independently identified the significance of the individual wanting to engage in services "you really have to be seeking recovery or recovery to benefit from a recovery coach and most of them, that is not where they were." The differences in perspective between peer support workers in both settings was apparent, P3 expressed that the emergency room model is "more an opportunistic intervention, you know interventional, not as long term, but they're a really key part of the building a community that does serve the person long term." However, despite differences in perceptions of the practice settings, there was consensus as to the value of peer support workers in any setting.

Variations also occurred in the data based on funding sources for the PSS service. For example, community-based providers reported difficulties related to being able to service participants based on insurance or grant requirements, whereas hospital-based employees did not voice this barrier. Community based providers also reported a difficult time connecting individuals with other providers when they could not service them based on insurance limitations.

All participants reported that their work as a peer support worker was an extension of their personal recovery and most of the participants viewed it as a meaningful and satisfying role. However, P1 reported that the role was not what he had expected and that he felt that it was more of a "low-grade case management" position. P1 was unique in that he had held many existing positions in the field and his present position working with individuals who are involved with the court due to drug related incidents. P1's differing view from the others can be related to discomfort with the informal nature of the PSS role and the less formal boundaries than he experiences in his full-time employment.

I work in a very professional, very high structure, boundary driven boundaries driven into my brain atmosphere. And here I am in a car right with myself and maybe a girl who's 4 to7 days sober. That breaks all my ethics. (P1)

This view of the role differed from the other participants who expressed the value of being in an informal role as a peer support worker. While P1 did believe that it was similar to the role that he played as a sponsor in A.A., which is an informal mutual aid role, he reported that the informal nature of the role made him uncomfortable at times and

that he found himself in situations that conflicted with his ethical training “I didn’t feel comfortable at all, these were situations I had to try to get myself out of.”

Further, all participants have been through peer support worker (recovery coach academy) training except for P1 who started before the training was regularly recommended and widely available. He reported that he had been through extensive professional training for his current role on ethics, boundaries, and professional behaviors. This type of training presents different expectations than the less formal expectations of the peer support worker training. For example, P6 describes the boundaries that they are taught in the peer support worker trainings as being fluid

As a recovery coach, you know, our boundaries are very fluid. And it all boils down to, don't sleep with your clients. Don't take your clients home and, you know, don't do drugs with your clients. And other than that, you know, it's a it's a case by case basis. You know, we tend to let them know a little more about us than a clinician would let them know because we're building a relationship for them that's probably going to go on for a little while.

While P1 has experienced the dual role of consumer and provider of services, his position in a more structured environment seems to parallel some of the apprehension that other service providers have regarding this role as reported by many of the study participants. He was the only participant who reported apprehension for the role and its utilization while also describing the importance of shared lived experience.

Evidence of Trustworthiness

Several strategies were identified in Chapter 3 to address the trustworthiness of this research study and the findings. These strategies included credibility, transferability, dependability, and confirmability. These strategies helped to establish rigor, justify the research, and establish confidence in the quality of research findings (Shenton, 2004).

To establish credibility of the study, I recruited participants via criterion and snowball sampling. All interested participants that contacted me were provided with a description of the study, engaged in a telephone call where the purpose of the study, the participation process, and its voluntary nature were explained to them. All participants were encouraged to answer the interview questions honestly and were told that they only had to disclose information that they were comfortable talking about. I explained the informed consent process including how their information would be protected, stored, and disposed of, as well as the limits to confidentiality.

I also utilized member checking to establish credibility in the study. I began by writing summaries of the interviews from the transcripts and audio recordings, sending them to all participants, and asking them to provide feedback on the accuracy of the summary via a follow-up meeting as originally planned. If they were unable to do so, feedback was also accepted via email. I encouraged participants to identify any misrepresentation of their message and to clarify or provide information in any instances where they deemed appropriate. I informed all participants that they could read the entire transcript if they would prefer. The member checking process allowed me to ensure that I was capturing the essence of the participants' messages and their intended meaning

while also ensuring that any of my personal interpretations or beliefs about recovery were not influencing the research process. Of the 10 summaries sent out, I received feedback from six that reported that they were comfortable with the representation of their voices. The other four did not respond to my request for follow-up.

Transferability, the extent to which the current research can be utilized by researchers in other settings, was established using detailed reporting. While transferability is not the primary goal of this research study as the emphasis was on the experiences of the peer support workers (Shenton, 2004), I have provided a detailed account of the information provided by the participants, a succinct description of the research procedures, and a step-by-step explanation of data analysis process using thematic analysis. This detailed depiction of the research process will allow the audience to identify the relatability of this study to their setting.

To ensure dependability in the present study, I recorded a detailed audit trail that provides a comprehensive account of my research processes, emerging data, and the data analysis process. My verbatim transcriptions, memos describing my coding process, and reflexive journal serve as an audit trail of the research process (Shenton, 2004; Patton, 2002). I also used recruitment strategies that were consistent with what was established in Chapter 3, engaged in consistent methods of data collection, and recoded all data in the same manner for all study participants. I utilized the semi-structured interview guide with all participants, asking all participants the same questions, and I allotted the same amount of time for each interview. In the audit trail, I also included the codes and themes

developed with the use of NVivo 12 software as well as the audio recordings of the interviews.

Confirmability was established so that my subjective experiences and interpretations did not influence the research results and to ensure that the results produced were from the perspective of the peer support workers (Korstiens & Moser, 2018). The use of a detailed audit trail and the implementation of an ongoing reflexive journal were integral to ensuring that I did not allow my personal experiences or bias to interfere with the research process and to allow my conceptual lens to be visible to the reader (Korstiens & Moser, 2018; Ortlipp, 2008). The use of interview summaries that were reviewed for accuracy by the peer support workers further ensured that the perspective that was captured was their voice.

Results

The study explored how peer support workers experience the dual role of consumer and provider of services. All participants responded to questions about their experiences as a peer support worker and how they experienced their own personal recovery. Five major themes were developed through data analysis and include:

1) By helping others, we help ourselves

2) Self-care makes the role of PSS sustainable

3) Connection through shared experience

4) Extension of the recovery process

5) Peer support in a system of care.

Theme 1: By Helping Others, We Help Ourselves

The peer support workers described the role of helping another individual who is in an early stage of recovery as a meaningful and rewarding experience on many levels including having a positive influence on their personal recovery, keeping them connected to communities of support, providing opportunities to be of service to others, being able to pay forward what has been given to them, and a sense of accomplishment in being a part of the recovery of another individual. While all participants spoke to the benefits that they received from helping another individual who is in an earlier stage of recovery, many warned about the need to separate personal recovery activities from the role of being a peer support worker.

While the participants in the current study did not enter the role of peer support worker to benefit themselves, many reported that being in the role helped to maintain their personal recovery. P10 reported that it is a reminder of his past "I don't want to repeat what they're going through right now…It's always a reminder, the starting all over again, the low self-esteems, I don't want to do that again." The reminder of the suffering and challenges that they faced while struggling with substance abuse and recovery served not only as a connection point for relationship building but also helped to keep the memories of those struggles fresh which enhanced their own commitment to recovery, P1 shared that he believes that this reminder coupled with helping others is the reason that he was initially able to maintain sobriety "I think that's the reason why I stayed sober for the first 13 or 14 years because I wasn't working any recovery program. I was working with others. "He further explained that at times when he was not actively

working a recovery program that the exposure to the firsthand struggles caused by substance abuse and the act of helping were enough motivation to maintain sobriety.P6 also shared that working as a peer support worker "keeps me sober." P7 shared that when talking with an individual whose situation mirrors a place he has been, it serves as a reminder "oh man, I forgot all about that. "Many peer support workers in the present study reported that the key to preventing relapse in the face of this intense role is to ensure that peer support workers have a long enough period of stable recovery prior to being hired into the position and that they continue to focus on their own recovery (P1, P3, P4, P9, P10).

Beyond serving as a reminder of the negative impact of substance abuse on their lives, many of the peers interviewed shared that the reciprocal nature of the relationship helped to them to experience "boomerang joy" (P5). P5 shared that while it is extremely rewarding to be able to "change someone's quality of life for even a minute," there is also the benefit from interactions with the individuals receiving support.

but the same way someone's personal experience can help you. One day I was having a low day, my son's had ear infections, it was just stressful and I used to be everything you could think of homeless, hungry, infected with hepatitis and now none of that is true….so that boomerang joy is like when a guy I knew texted me from the hospital and he remembered me from years ago…and was like holy crap, I knew you, now look at you.

The role of helping others has changed the way many of the peer support workers not only view the recovery process but also their own personal recovery. P1, P3 and P8 shared that getting a firsthand look at the many pathways to recovery helped them to be

more accepting. "It just like makes me open to other people and really more accepting of my own process, um, and it not having to be such a straight and perfect line" (P3). P1 reported that he must work hard to believe that A.A./N.A. is not the only way and to be openminded. He shared that being a peer support worker has helped him to "not force my own beliefs on them, letting them have a different approach." Many individuals in recovery subscribe to a 12-step program model and these programs have a fairly prescribed process with strong views about less traditional approaches and a firm confidence in the efficacy of the model. The peer workers interviewed experienced a change in their perceptions of recovery and of themselves, creating an avenue through which other individuals in early recovery can be empowered to choose whatever path is most effective for them.

I have a huge repertoire of like of seeing what it looks like for other people um and allowing myself to be more open for myself to be in a different path than they are. You know, like I used to be it's like, 12 steps, 12 steps, it has to be 12 steps, have to go to meetings, you have to have a sponsor, and you have to do this and you have to do that. And um I've just watched so many people over time have a broader pathway than that and maybe even go to 12 steps for a while and then step away and do other things and allowed me the freedom to explore for myself. (P3)

The increased openness described by many of the peer support workers included becoming comfortable with the idea of harm reduction and recognizing that abstinence may not be a path that everyone will follow. P4, P5, P6 and P7 all shared that part of allowing individuals to find a path that they are willing to explore involves being

comfortable with harm reduction and the recognition that it could save lives. In creating space for the opportunity of multiple pathways to recovery, the perspective that one holds about their own personal recovery can shift, allowing for increased acceptance of their own recovery journey.

The role of peer support worker also serves as a facilitator for self-forgiveness and healing for some peer support workers.

> Helping people helps you, you know? It helps. It reminds you, it helps you stay focused on your own recovery, um, makes you feel better. You know, there's like a lot of years of bad feelings to get over when you first get sober. So anything that makes you feel better is OK in my book. (P6)

In addition to being a reminder and a catalyst to personal growth, P7 explored how the continued connectedness to recovery networks and communities through this role can enhance personal recovery and prevent the isolation that can be experienced by individuals in recovery:

> I'm building relationships with people. It's forcing me to remain in contact with the community around me. A lot of times myself and most other people suffering from substance use disorders, they'll isolate from the world around themselves. It's pretty easy to do. (P7)

He reports that this connectedness ensures that he continues to work on the behaviors and addiction that "exists right below the surface." P9 reported that being a peer support worker enhanced his feelings of acceptance and worth in the recovery community "it

really makes me feel a part of the community, the recovery community, too, that what we do matters."

Being a peer support worker provided the opportunity to be of service to others and to be able to give back the compassion and guidance that at one point had been given to them. While several also reported that helping is what was expected of them and a huge part of what they have been taught to do through recovery connections such as AA/NA, where helping others is a significant component, others reported that there were individuals who stood out as helping to set the course toward a recovery lifestyle. P5 explained his perspective "you've got to give it away to keep it." P6 also shared

That's the way I got sober and drilled by sponsors and drilled by mentors. And, you know, it's it's all about the helping that it's you know, the helping it is what helps you stay sober…So, you know, the simple fact of helping somebody should, you know, always boost your recovery.

Many of the peer support workers interviewed recounted their pathways into recovery with numerous attempts at sobriety and relapses and some identified key individuals who helped them reach a turning point in their recovery and presented a solution to the elusive promise of rehabilitation and a life beyond addiction. P8 shared that

Helping is a way to give back what was freely given to me…that was my experience when I was new in recovery and kind of struggling with like how am I ever going to get my daughter back? And I had, I found a woman who shared her experience and had custody of her son and was happy and in recovery. And so it made me feel like it was possible. So I just hope by sharing my experience that I can be that for somebody else.

P9 Shared that it is an amazing feeling to be able to make a difference in the life of another person in the same way he feels that it was given to him.

I'm bulletproof when I leave there because I feel like I've, I've made a difference in that one person's life, like someone did that for me. This director of this Quincy Recovery Center did that for me 30 years ago in 1984, and it changed my life. So I know that that, you know, where there's breath, there's hope.

P9 shared that helping other parents who are struggling with children who have addiction and being able to be there for them in a time of uncertainty helps him to be able to do something, while also experiencing his own personal struggles with the heroin addiction of his son.

As a parent, you know, you're waiting for that phone to ring. And I know how brutal that is. So. Being able to be part of a healing with parents that come in and, you know, they almost lost their child or they lost their child. Like, you know what I mean? Going into a room with a guy wailing. I'll never forget the scream of people that lose their child. The scream is like, you never forget it. And consoling them when they may be beating themself up. "Why didn't I answer the phone this time?" You know, and, you know, that's a whole other thing that comes with this, the devastating effects of the children and parents left behind by these children dying, you know. So, when it ... I could be of help... when I could be a part of anything that has to do with, you know, if you get... if you get one success. That's somebody’s child that didn't have to die of this thing.

P8 also shared that the application of skills is fluid between what she manages in her personal life with family that struggle with addiction and the way she engages with the individuals that she providers peer support.

Several peer support workers shared that seeing individuals in desperate situations and providing help was the facilitator in their ongoing sobriety and all of the peer support workers drew a parallel between their role as a helper and continued personal recovery. Yet they also cautioned that personal recovery and the role of helping must be viewed as separate for long-term success. The need for this separation is described in Theme 2.

Theme 2: Self-care Makes the Role of PSS Sustainable

A common concern expressed by participants was the need to be vigilant with one's own self-care in order for the role of peer support worker to be sustainable on a long-term basis. The peer support workers interviewed explained that there is a need to be present in their personal lives, to establish and maintain effective boundaries, and to ensure ongoing attention to their personal recovery. Self-care was identified as being a preventative measure against burnout and other challenges in the role of peer support worker as well as assisting in the management of crossover into one's personal life.

Several of the peer support workers described the intensity of working with individuals in early recovery as one of the challenging parts of the role and purported that it requires ongoing self-care to handle effectively. When asked what one of the hardest parts of the role is, P10 explained that it is "dealing with the different personalities, early in recovery." P1 shared that it is the desperation and true understanding of the depths of another's pain that can be heavy to carry.

> It's hard. People are desperate and, you know, you don't want to see people, they're in so much pain. Even though they, you know, nobody wants to destroy their lives right…but they're in so much pain and they can't stop it…I know the feeling and I hate seeing people suffering like that. Yea it sucks…I've been suicidal because of my drug and alcohol use and I've been suicidal because of not having recovery. So, I can identify with being desperate and, you know, and just seeing people in those situations. I know, I know where they're at pain wise. I know how the pain is

Peer support workers benefit from engagement in ongoing self-reflection and awareness building to be able to recognize the impact of helping on their own well-being as P10 described the work as "not for the weak of heart. "Having self-awareness decreases the risks posed by the acuity level of the individuals that the peer support worker is engaged with on a daily basis. "There's always there that challenge of being around, you know, people that are all doing the same things that you used to do" (P6).

P7 shared that self-care helps to prevent burnout making continuation in this role possible: "We focus on self-care, you know, and you're gonna be no good to anybody if you're burnt out, of course I don't want that on my conscious." P9 also shared the importance of self-care "Take little mental breaks for yourself. Pray before during and after, um yea, take care of yourself so that you have something to bring to the table."

Self-care issues were also raised when describing patient deaths and relapse. "It's really hard when you're working with somebody and you know they're using when they leave the coffee shop you're at and you know they are going to go out and potentially

die" (P8). P2 explained that while there is a sense of purpose in helping others "I help some, some people die." Both P2 and P4 understood that losing someone to opioid overdose is part of the process but that does not negate the painful nature of the experience. "I've had a hard time with it…it is painful for me and um, this is why we have to take good care of ourselves" (P4).

P6 shared that it is important to have an awareness of your own potential to be triggered.

> You have to be very aware that, you know, I mean, if you're somebody that's given to you know having triggers or any form of PTSD, you need to make yourself, be honest with yourself and keep yourself very self-aware because you're working with people and some of them are still sick individuals.

P3 expressed the need for self-awareness about when you need self-care:

One of the challenges is like I need to be well and sometimes I don't know how well I am or how not well…I can only give away what I have. I can't give away something I don't have.

Several peer support workers identified that it is important for a peer support worker to recognize that the outcome is not their responsibility. P3 stated "the individual outcomes aren't my responsibility, so I don't get attached to them, it's not about me." P4 expands upon this by sharing the importance of recognizing and allowing individuals to be in the stage of change that they present in "and that's um very difficult, unless you understand that it's not my job to take care of their recovery, I can meet them where they are, but they have to do the work." P1 echoed this sentiment "So I think the greatest

thing that I get out of this is just trying to plan some seeds now, so that maybe later on they're going to be ready for what's out there for them."P3 and P5 also explained that it can be useful to recognize what your goals are for your role as a peer worker. "I say to even change somebody's quality of life for one second" (P5). "I'm just here. I've been placed here to be of service for whatever duration of time and I just try to believe that I've had an impact on someone…If I have given them a glimpse of hope" (P3).

Other peer support workers identified strategies such as remembering the positive times that they shared with their participants as a strategy to handle difficult outcomes and manage stress:

I try to remember a lot of times there's some sort of humor, or some sort of laughing, there's some sort of bond that's created. And I try to think of that stuff and just think to myself that we shared these good laughs, those good times that this person may not have had if, you know, if anything I was able to give them a good laugh, period. (P7)

The ability to have boundaries or separation between work and home and be present in one's own life was a construct that was identified by the peer support workers interviewed. P6, P7, P8, and P9 described the role as having the potential to becoming all-consuming and shared the need to instill self-boundaries to prevent it from taking away from their personal lives. "If you don't shut it down, it could become a 24/7 thing. We have to say whoa wait a minute. Turn off the phone, be present in your own life, walk the dog, talk to your girlfriend" (P9). P6 shared that this can be particularly challenging for peer workers who are just entering the field.

It's hard early on because we're always busy, crises happen for recoverees all hours of the day and night. Um you learn to keep your phones to a regular hour. You learn to check your own behaviors and keep an eye on yourself. I mean, you used to be early on, you were almost never off. Seems like you're on the clock all the time and that just does not work. It just does not work, you're either going to burnout or you're going to start making judgment mistakes.

The informal nature of the role of peer worker creates a dynamic where boundaries are fluid and while there are some concrete boundaries that exist the majority of the boundaries are created by the peer support worker "kind of case by case" (P7). "You have to remember that no is a complete sentence. You can get taken advantage of by people" (P5). P1 shared the discomfort that he encountered at times when placed in situations that he was unsure of and that went against the formal training he had received in other roles in his life.

Now if I had them in my car, like that was probably the first time I've ever done something like that. I remember having to go pick somebody up to take them to a meeting and I was like, fuck, like, I can't do this. It's just so awkward. You know what I mean? I don't feel safe…uh, it makes me sick to my stomach.

Many of the participants work and participate in recovery activities such as self-help groups in the communities in which they are also providing services creating the potential for even more crossover into their personal lives by encountering individuals that they are currently working with or have worked with in the past.

I can't be too specific about the stuff that I share, like I will tell someone I'm married, I'll tell someone I have kids. I won't tell them where I live. I'll tell someone I got to meetings in Worcester, you know, maybe I'll tell them where I'm going because that doesn't matter, anybody can see me at a meeting. (P1)

P8 shared how strict boundaries in the community in which she lives helps to protect her ultimately.

I have to protect myself or else I'm never going to be able to help anybody else. So, for example, if I see someone out in the community, I'm not going to ignore them if they come up and say hi. But if they try to start talking to me about something work related I just let them know that I'm not in the office right now, they have my number, they can give me a call in the morning.

P8 explained the importance of this for her in her role of PSS

If I become too invested outside of work hours, I think it lends itself to like burnout and overextending myself and like not only am I in recovery, but I also have three children. I have a family. So like I have to keep some of myself secret in order to give to my children and my family who depend on me.

P5 also shared that self-care and boundaries allows him to continue to be present for his family and to find balance rather than allowing the intensity of the work to take all his energy.

Part of my recovery is my family and if I've been dealing with people all day and complex cases it's like when they talk about what level are you at? Is your gas tank empty? Sometimes giving so much of yourself, because of the nature of your peer role,

at the end of the day you can come home empty and you may react to your family that way.

The participants illustrated the importance of continued engagement in personal recovery activities (P1, P3, P4, P5, P6, P7, P8) Participants also explained that even though there is a benefit to the peer support worker by helping others, working as a peer support worker should not be viewed as self-care.

I have to remember that recovery coaching is not my self-care, it's not my own personal recovery…because a lot of times people get tripped up that way. You think that you are helping people daily but you're also getting stressed out. It's both of those things. (P5)

All of the peer support workers in the present study agreed that a critical part of self-care is continuing to emphasize their own personal recovery in their lives and to not allow their work to become a replacement for what keeps their recovery stable. "I have to be diligent with my own recovery, like if I'm gonna work with people, I have to take care of myself right" (P1)? The role of helper and of expert by experience was identified by peer support workers as having the potential to create complacency in their personal recovery with all of the peer workers mentioning the need to figure out what will help to provide self-care and recovery support. "I have to treat my disease, which is going to meetings, doing writing, knowing then to reach out and all that. You know, speak with my sponsor, got to therapy, and stuff that I do for my recovery" (P4).

Many of the peer support workers understood the importance of having a community that they could rely on to support them. P6 identified that colleagues play a key role in helping the role be sustainable "Being honest with myself and keeping close

to my colleagues that all do the same things so that we can kind of check on each other." P3 shared the power of her recovery network in helping her restore her energy and maintain balance. "I have a huge group of women…they're all these amazing, incredible, powerful women filled with grace and love. I just need to go hang out with them and like my faith in humanity and everything is restored."

All of the peer support workers interviewed shared the importance of self-care and the need to recognize what it is that helps them to find balance and "fill up my cup" (P3, P5). They shared that this is a crucial aspect of continuing to be effective in the helping relationship. They also stressed the importance of self-care in the form of self-boundaries, self-awareness, and continuing to work their own recovery programs.

Theme 3: Connection Through Shared Experience

The very cornerstone of the peer relationship is the unique ability to relate to individuals in early recovery due to the shared lived experience. This experience was reported to aid in the establishment of relationships, rapport building, and breaking down barriers that can be experienced in traditional provider/patient relationships. The peer support workers interviewed believe that there is always a connection point and that their personal understanding of the cycle of addiction, the role and normalization of relapse in the recovery process, and the suffering that substance abuse can cause creates a relationship of trust and facilitation of hope. Self-disclosure was identified as a catalyst to establishing a peer relationship and is integrated into the helping process.

The peer workers interviewed expressed that the connection that they build with their participants is built on the unique commonality of substance abuse that created a

common bond from which a helping relationship could be established (P1, P8). This connection was described as authentic and powerful by many of the peer support workers. P3 explained

being able to share because of my own journey and them sharing something with me and just like having those moments where you're both like 'whoa' like having a genuine really powerful moment of hope or grace or whatever it is.

In fact, the shared lived experienced was explained as creating relationships and bonds between individuals that would otherwise not have connected.

We have something in common, right? We can talk about it and only you and I can relate to it or other people in that situation, right? We come from two different words where we have one major common illness that's linking us together, that the symptoms are very similar. No matter what. I could have a successful job and a good career and that person could be homeless, but I have more in common with that person that I probably do with my wife. (P1)

P5 shared that a common expression that he hears in AA is "we're a type of people that would typically not mix but together, we're unified on a common ground."

The peer support workers interviewed shared that there is always a connection point whether the individual is struggling with drug or alcohol abuse(P1, P5). "I've been to the shoe store, I don't have the same size, I don't wear your shoes, but I've been there" (P5).

So it's a commonality that just kind of brings down barriers very quickly and allows you to really feel comfortable and connected to someone who you may not have otherwise had anything in common with at all (P1).

The connection point was identified by many of the peer workers as being the suffering and the destruction that substance abuse has brought into their lives (P1, P3, P5, P6, P9). P5 talked about how the suffering helps with being relatable "I know what it's like when you're in your lowest point. You know where it's like you're damned if you do, you're damned if you don't." P9 describes the connection he feels when he can see the pain in an individual's eyes "I can identify with the feeling, when I look in their eyes, I know that terror, that hopelessness that they have." P9 expressed that he feels that his experience of pain makes him able to truly relate "If I didn't have all that lived experience, what would I know about pain and relapse?" Being able to share these experiences with an individual who is experiencing them in the moment was reported by the peer workers as being a powerful connection point. "So I think being able to share my experience of losing custody of my daughter always brings me so much closer…because it's a hard thing you can't really fathom until you've gone through it" (P8).

Another connection point that the peer workers highlighted as powerful is the strain experienced in provider/patient relationships after a disclosure of substance abuse. P6 explained that many peer support workers have also experienced these challenges: You've had these adversarial relationships with your own PCP or with a psychiatrist, or with doctors that you met in detox or nurses you met in the emergency room and you

come to have this attitude that they don't know shit. They treat me like shit, I can't stand them. We need to help change that narrative quick.

The peer support workers interviewed shared that their role helps to break down the walls that exist between providers and individuals with SUD and improve communication in these relationships (P5, P6, P7, P8, P2). For example, P8 shared, because I don't have a lot of trust in my world. Like, a lot of people broke my trust, especially in the medical field. So, I think the more that I show people that I'm just like another human being that makes a connection better.

P5 expressed that not only are barriers broken down but that individuals can begin to see that providers can work on their behalf, stating:

> but the good thing is that they get to see that there are people working on their behalf, not against them. Or maybe that they have that perceived understanding that the doctors just think I'm a junky and I'm like no, they let me work here.

Other peer support workers explained that even when they do not disclose that they are in recovery, the shared language from self-help meetings and recovery meetings and way of discussing it can serve to create a sense of understanding. "I know the language and they can pick that up" (P10).

Many peer support workers reported that they felt that sharing that they were in recovery was something that they needed to do to earn trust and be effective in their role (P1,P2, P5, P6, P8). P8 shared,

> I think its key for our role, being able to personally disclose my experience, what my experience has been like, what my pathway to recovery looked like, because I

> think it just breaks down walls. I know from my experience of being in the treatment world it's really hard to connect with people who aren't disclosing.

P1 and P5, working in hospital environments expressed that they needed to disclose their recovery status as quickly as possible, creating a scenario that resembled "sales", and trying to make recovery as attractive as possible.

P3 shared that the understanding of feeling as if others had given up and no longer believed in her ability to achieve recovery due to her multiple attempts at recovery helped in her relatability and also motivated her to want to for another what she did not have.

> I found that it's irresistible to genuinely care about and believe in somebody that everybody else has thrown away. That was kind of the added value. I was out there for over two decades and I tried every method of treatment many times over…there were many times that people did not believe that I could get better. So that's near and dear to my heart, no matter how bad you think someone is, if they're alive, they have a chance of recovery.

Other peer workers explained that one of the unique traits that they bring to the table is never losing hope in an individua's ability to recovery (P3, P5). "You might think he's unworkable, but I don't" (P5).

The peer support workers interviewed believe that they are able to be uniquely helpful due to the ability to share about their personal lives and to provide non-judgmental support (P4, P7). "You know, dude I can't judge you on that, I've done something similar" (P7). The peer support workers also explained that there is a sense of compassion and empathy that they can draw on that is unique to the shared lived

experience and is a valuable part of this helping relationship (P10). This was noted by the peer workers as being particularly important when talking about Medication Assisted Therapies (MAT) with participants due to the stigma associated with it (P4, P9). P4 and P9 explained that they make a significant effort to create safe spaces to talk about MAT and to decrease the stigma that individuals experience when talking about this in recovery communities.

While many of the peers shared experiences of how sharing their personal journey through substance abuse and recovery assisted in relationship building, the idea of creating hope was expressed by all the peer support workers. P5 expressed "it's sharing that hope, it's like a walking, talking hope shop." P7 explained that it is providing a picture of how life can change via recovery and to demonstrate what that can look like "we're able to offer, the then and now possibility, you know, that you can be, I was this and now I'm not." P4 expands on this by explaining that even if an individual is not ready to make a change that peer support workers embody what the future can look like when they are "we can be an example of, you know, when you're ready, maybe not now."

The peer support workers in this study explained that it is important to recognize the boundaries of self-disclosure and to frame this sharing in the context of the helping relationship (P6, P7). P7 described his sharing as giving examples of things that helped him or to identify commonalities but does not elaborate on many of the details of his experiences unless asked.

> I don't want to make it about me. It's not my issue about my problem that I try to portray. I give them examples of where I've been in my life and where I am today. I don't go on and on about being homeless, but if somebody asks, I'll throw that down there. I try not to just say hey this is my story, I find that does very little.

The peer workers described how they skillfully weave their lived experience into the support services that they provide. "I mean there's absolutely no sense in just sitting down and regurgitating your whole experience…what's that gonna do for anybody? We definitely are trained well to make sharing your experience useful" (P6). P3 uses her story to relate when others are sharing with her "I've found that when I have somebody describing something that's happening, I can say wow I really relate to that…I also use scenarios in my life to say this is a choice I made in a similar scenario."

As described by all the peer support workers interviewed, the shared lived experience is a crucial aspect of creating a connection and rapport building. The ability to be understood is an important aspect of being able to trust providers and build rapport. As was explored in Theme 2, there is the need to be cognizant of the way sharing personal experiences can influence the nature of the relationship. As P3 explains "there's always the risk, you know, of developing a deeper relationship with recoverees. That can be a slippery slope," There is also the need for awareness related to a role that is often built from personal recovery experiences. As all of the peers interviewed in the current study explained that becoming a peer support worker was an extension of recovery practices that were engaged in.

Theme 4: Extension of the Recovery Process

Helping others is a cornerstone of many substance abuse recovery communities and mutual aid groups. An important aspect of the peer support role is the ability to connect individuals to recovery networks or support systems that provide resources to maintain recovery. Many of the peer support workers interviewed did not begin the process of helping others via becoming a peer support worker, they had been involved in personal recovery activities where the expectation or opportunity to help was present and in many cases expected. The experiential knowledge in the role of helper comes from the peer support worker's behaviors and experiences while abusing substances, the process of becoming sober, and developing stability in long-term recovery.

None of the peer support workers identified having sought out this role but rather they were introduced to the idea by someone in their recovery network that asked them to consider it, creating an organic path between personal recovery and being a peer support worker. P9 shared "it wasn't even a choice. It was almost like it was…it was fluid. I started helping people and taking people to detoxes and then they hired me." P8 shared that her doctor at a routine visit told her that they had a position that she would be perfect for. "So I kind of felt like, the stars aligned, and God works in mysterious ways." For P5, while someone in a treatment facility mentioned he should apply for a job as a peer support worker, it was his engagement in the self-help fellowship that facilitated the crossover when someone mentioned the job opening to him. "It turns out I had already known all of these people, it's funny the crossovers, because these people are professionals, but we all go to the 12-step fellowship" (P5).

Many of the peers interviewed felt that being a peer support worker was a natural extension of the help that they engaged in with their mutual aid groups and recovery communities (P1, P2, P3, P6, P7, P8). “It feels very natural, like at first I was like they’re going to pay me to do this? It just kind of comes really natural” (P8). P7 describes the role of peer workers as “like a big brother type of situation.” P1 described the role as a continuation of the work that he was already doing as a sponsor in the self-help community.

> It seemed like a perfect situation to me. I’m a person in recovery. I go to meetings. I like that type of stuff. I believe in that type of self-help process. I believe in the evidence behind it. So, for me, I’m always trying to help people.

In other cases, employment as a peer support worker was described as a calling or a responsibility.

> I had experienced so much abuse and then I went into my own addiction and alcoholism. I knew what it took to get any peace and recovery from that and when I heard guys that had grown up in similar situations as I, I was like oh my god, I have a responsibility. (P9)

P4 shared that she realized that this role “was a way for me to give back.” Further she explained that it is not simply about giving back but contributing to the recognition that recovery matters and peer support is a critical and valuable tool.

The peer support workers interviewed highlighted that the role of PSS keeps them connected to a recovery community beyond the connection they might have maintained without this role (P6, P9). “It really makes me feel part of a community, the recovery

community" (P9). Other peer support workers shared that the relationships that they build with their participants can last an extended period and that the open-ended nature of this relationship lends itself to a lack of formal termination.

> It's kind of an open-ended thing, for as long as it's necessary. I see people around that I've had as recoverees at other places I've worked, and we still have that same sort of relationship when we run into each other. (P6)

P7 explained that his can also lead to an informal termination as the individual is integrated into community supports and becomes more of an equal peer and to some a friend.

> The comfort level that people that you're working with end up having, sometimes we've ended up discharging people from our services because we've become legitimate friends with them.

Peer support workers can provide support through a lens of understanding the challenges that can be faced in the recovery process. In fact, many of the peers interviewed explained that their own recovery was a very long and chaotic journey and believe that this positions them to be more empathic and to believe in the recovery potential of all individuals (P3, P4, P5, P9). "I think that one of the things that helps my perspective is the same way you assume it failed, you assume recovery" (P5). P3 explained that it positions the peer worker uniquely to believe that every individual that they encounter is capable of recovery. "You have to believe in recovery. You have to believe that recovery is possible for every single person you work with" (P3).

All of the peer support workers that were interviewed talked about the need for sustained recovery and training as critical elements to becoming a peer worker but cautioned that personal recovery should not be the only precursor to being a peer worker. They shared that there is a tendency for individuals to believe that because they are personally in recovery that they can help others (P1, P3, P9, P10).

> Just because you're in recovery doesn't mean you can do this job. I've seen it time and time again where someone will start working during recovery and that doesn't translate into job skills…they don't have the proper job training or education. They think that because they are in recovery that they know everything about it. (P10)

P9 shared explained that most organizations do not require significant periods of recovery to be a recovery coach and that this can create unnecessary risks and take away from one's own personal recovery "I'm not a fan of somebody that has less than a few years clean time getting into this and putting the focus on other people and then they die. Fuck that." P1, P9 and P10 further reported feeling as if there is an immense pressure to build a workforce as quickly as possible, particularly in the climate of the opioid epidemic, and expressed concern that it should not be done at the expense of choosing candidates who can be effective. "Soldiers are needed but make sure that their own recovery is on point before they start trying to heal other people" (P9). P10 recommended that peer support workers should not be considered for employment "unless they have three or four years clean and I think it's a good thing to bring some maturity to the job, like over 25 because you're dealing with an average age of over 30."

P8 also shared that while the role of peer worker is built upon the personal recovery process that it is not meant to be folded into one's own recovery as was discussed in theme 2, making it important to recognize where it should not crossover. "I would never sponsor someone that I work with." This is a sentiment that was exchosed by many of the peer workers in this study.

Theme 5: Peer Support in a System of Care

While is it widely accepted that there is significant value in the role of peer support worker, it has not been conceptualized as a stand-alone position, but rather one that is integrated into a system of care. A common experience shared by the peer support workers in this study was the challenges in establishing credibility of the roll, frustrations in managing systematic barriers, and a lack of clear understanding by outsiders as to what the role is meant to entail. The peer support workers shared that while initially the role was met with skepticism, that they have experienced a shift in this view, and a resulting decrease in stigma surrounding substance abuse treatment. Further, peer support workers noted the importance of ongoing supervision for this role with some of the peer workers expressing concern that their supervisors are not in recovery.

Several of the peer support workers interviewed work in hospital settings on teams with doctors, social workers, nurses, etc. while other workers are employed in community agencies either as a standalone service or to enhance existing services provided by the organization. "We work alongside a lot of people in our other programs and help them with things that maybe their counselors and case managers aren't able to help them with, so much more like a personal role" (P7). Regardless of the practice

setting, all the peer support workers explained that they work within a continuum of care with the goal of enhancing engagement in treatment and recovery-based activities. Many times, this engagement takes the form of engagement with medical and mental health providers.

Many of the peer support workers interviewed expressed that a major challenge to being effective in their role is directly related to the challenges that exist systematically (P3, P8, P9).

> Whether it's the child welfare system, the Department of Transitional Assistance and Housing, there's just a lot of systems that I really feel like are not built to support these people…I think that's been the hardest part of my job is like I can do the best possible work that I can but if they're engulfed in these systems that aren't working for them, then sometimes it can feel like is my work even worth it. (P8)

P3 experiences the system as outdated and controlled by insurance. "We can make the best plans in the world, but the system lets people down a lot. A lot of times people just can't get housing, transportation, jobs, psychiatrists. There's such an extreme shortage of psych care." P9 shared that working in an emergency room can create challenges for individuals who are trying to get into detox or treatment programs. "Once they know they're in the hospital now, the alarms go off. Do they have medication? can you fax over the release that they can discharge? Are they physically healthy?"

Peer support workers talked about the disparities that exists for individuals needing treatment based on access to health insurance and the quality of the insurance

policy (P1, P2, P3, P4, P7, P9). Some peer workers struggled with not being able to help all individuals seeking help due to insurance restrictions (P7). They explained that it creates barriers for individuals seeking help and inequality in the type of treatment that is received which they have experienced leading to decreased engagement in long-term recovery and an increase recidivism rates (P3, P4, P9, P10). P9 shared his experience of

> continually sending somebody for a spin dry, I call it, five to seven-day detox and then they hit the street and we're wondering why we don't have such a high success rate? Well it takes a lot longer than that to change anything…If you have Tufts Health plan, I can actually get the into a log nicer facility that can be longer term that has access to further treatment. I mean getting the drugs and alcohol out of your body is a beautiful thing for a week, but then what?...If folks aren't off the streets long enough to heal their spirit and mental health, they continually fall, go to detox, come back to the ER. There's a continual flow of wounded warriors coming into the emergency departments.

P10 explained that with the current concerns related to public health and the coronavirus that these challenges have only increased as the availability of already limited beds becomes even smaller.

> Usually it's a four to five-week process from beginning to end. But now in our current situation with the covid19, a lot of halfway houses have closed their doors and are not taking in new clients…it's like if you came in here homeless, you're going to end up leaving and still be homeless. The only difference is you won't

> be addicted to drugs and alcohol, but if you're going back to being homeless, the changes of you picking up again are real big.

Several of the peer workers interviewed explained that in their work environment peer support often did not exist before them and that it took time for them to feel that providers appreciated the value of the shared lived experience (P3, P5, P6, P8). "We were the new kids on the block. It wasn't always so easy" (P5). "There were a lot of counselors who were just saying it's stupid, it's a paid sponsor and all the crap you hear about recovery coaching, so we were up against that" (P3). Many of the peer support workers expressed pride in being able to see such a transformation in the way in which lived experience is valued (P3, P4, P5, P6). "I think it's being honored more now because people are seeing the effects that coaches have in the field. So we're getting more respect" (P9). P6 also shared about this change

> I've watched it change over the past 10 years. Early on, you almost felt like you were a kid that was allowed by his father to go out and use the lawnmower for the first time, but you knew your father was lurking right around the corner.

Others explained that it is very rewarding to have medical professionals ask their opinion and consult with them, recognizing their lived experience as creating an expertise rather than being dismissed due to a lack of credentials (P5, P9). "My favorite part is reducing that stigma; warm handshakes with doctors that say hey what do you think? And they value my opinion. And it's noticeable and you can track it, the doctors will call me" (P5).

Some of the peer support workers shared that they were met with skepticism and that they continue at times to experience practitioners who are distrustful of the

effectiveness of this role (P4). “They’re not really sure about us. It was really slow in the making and now we’re four years later….and it’s not as smooth sailing as we would like it to be” (P4). P5 expressed that he believes that the lack of understanding of the role may be creating a fear reaction that peer workers are trying to take the jobs of existing practitioners or that the role may replace formal treatment providers. He also expressed that it may be that changing cultures can still be challenging in some settings. “A lot of people are kind of stoic and stuck in their old ways when we’re just trying to help. That can be difficult.”

Yet despite the experience of skepticism, the peer support workers believe that they can often serve as a bridge between individuals who are in active addiction and their practitioners. “They took a Hippocratic oath to treat people fairly, kindly. But sometimes people in the throes of addiction are not so nice” (P5). Peer support workers, through their shared lived experience, believe that they can be more tolerant and empathic during these times, taking the actions for what they are rather than personalizing the behaviors (P5, P6). P5 expressed that he has found that he can serve as a reminder for practitioners that relapse is a part of addiction and is able to decrease the negative perception of individuals who represent for treatment repeatedly.

> I just try to remind them that I wasn’t a one and done. I didn’t just go to treatment once and then like here I am. No, like I was a mess, I was in and out and that is a valuable part of our collaboration.

P6 shared that one of the rewarding aspects is seeing a change in practitioners from when he was struggling with his own addiction.

I remember a lot of how I got treated when I was out there running and gunning and I was hitting the emergency rooms and putting up with aversion from doctors and nurses and people who didn't want to deal with ya and in wearing out our PCPs because they didn't want to deal with you. The recovery coaching movement has brough somebody into the mix that is helping people understand a little bit. Seeing attitudes change in PCP offices and in the mental health field has been a good part of it.

The peer support workers interviewed shared that they have seen significant improvements in many of their participants including enhanced treatment compliance, attendance at appointments, and improved long-term patient outcomes. P3 shared that the ability to integrate a service into the community in which an individual lives allows for support in practicing skills that have been built in a treatment setting.

> We like try to fix people within this highly controlled environment and it doesn't work. They say go home and repeat all of the things we taught you in this little box and it's just unrealistic and it's not practical…having recovery community organizations and coaches out in the environments in which individuals hang out, a lot of people wouldn't have followed through to go see us but seeing us at meetings and at recovery programs makes it integrated.

P7 explained the difference between seeing an individual in a treatment environment and being able to meet with the on a more personal level. "In the emergency department, they wouldn't tell you if your coats on fire, but when they get you in your car and you pick them up cigarettes and you take him to a treatment and you make a friend" (P9). The peer support workers interviewed shared that the informal

nature of the relationship with individuals in early recovery allows them the freedom to engage individuals in ways that practitioners may not be able to do (P1, P4, P5, P9).

Almost all of the peer support workers interviewed repeatedly used the phrase "stay in your lane" and when asked what that meant, shared that the phrase describes the need to recognize the scope of practice of a peer support worker and where they fit into the larger system of care (P5, P6, P7). P6 shared his perspective "Our job is to remove barriers and advocate…You don't mess with people's meds. We're not fixing their trauma, we can't. We can be sensitive to it…that's for the clinical realm" (P6). P7 explains that it also involves not stirring people towards one choice or another but rather guiding them towards healthier options. "We just try to guide them into making a choice that will be more health that the choice they were previously going to make and help people look into things they're willing to do."

While the role of peer support worker operates within a system of care and often within a community organization that has many different types of programs, the peer workers interviewed expressed concern over expectations that do not mesh with the informal nature of the intervention (P3, P7, P8). P7 shard that outside agencies can be unclear on what the role of a peer worker is and expect things from the peer workers that are outside of the intention of the role.

> Sometimes like we work with different probation departments and their people would test positive for marijuana, they don't understand the role that we're providing. We don't say you can't smoke marijuana, we may try to say if you smoke a joint, you're gonna test positive and you're gonna violate…we try to

> influence them into adhering to the stipulation that you have, but we're not going to be reporting to you. That's a big thing because sometimes they want you to report to them and we really try to avoid situations like that. I really try to explain that we'll help find a route to recovery…where they'll be in a place where they can adhere to your stipulations.

Others explained that there is increased pressure for measurable outcomes particularly from grant funders and insurance companies are looking for a return on their investment (P3, P4, P5, P8). Yet these demands for measurable outcomes was reported by the peer support workers contradict how they perceive their role and the informal nature of a coaching relationship (P3, P6, P8).

> I get it on their end, measurable goals, quantifiable, they want outcomes to show that our money is worth spending…It's really hard to quantify like quality of life. It's really hard to quantify, yea I show up for my appointments. It's really hard to quantify I have a better relationship with my daughter. (P3)

Many of the recovery coaches expressed an understanding of why measurable outcomes are sought after, yet they also expressed confusion regarding how improved functioning is expected to be quantified (P3, P6).

> A lot of times it's something as simple as you've had a recoveree who didn't come out of his hours or wash his hair for 6 months and now he's coming out of his house with clean hair, going to the doctors and coming to meet you for coffee. Your measurables are different with everybody. And the rest of it is just like

> looking at a person with your own eyes and seeing that, you know what? This guy is way better than he was at this time last year. (P6)

P6 shared his belief that if peer support workers are afforded the necessary time to build relationships with individuals struggling with addiction that the outcomes would become obvious. "You will see that your patients are doing better, you have to grow to trust the process" (P6). Some of the peers explained that the role works because of the trust that they are able to build as peers and that documentation at a more formal level could increase rather than decrease the barriers that exist for the individuals that they work with (P6, P8). While the peer support workers interviewed advocated for increased latitude in their role (P3, P5, P7, P9),they expressed concern that this is not possible due to the expensive nature of this service and systematic expectations (P3).

All of the peers interviewed expressed the desire to maintain fidelity to the coaching models that they were trained in there was concern voiced regarding the expectations that are being set forth for peer workers and the compensation that they will receive when employed (P1, P3).

> They just keep raising the bar, but we're not gonna pay them to get that education. We're gonna keep raising this bar and get more and more defined and restricted and still want to pay you 13 bucks an hour and give you no benefits. (P3)

The peer workers interviewed expressed that while they understand there is a need to improve upon the role and increase its understanding, they expressed concern that changes will occur without their consultation or input (P3, P8). Lastly, peer workers expressed the need for ongoing support, supervision, and continuing education for

workers in this role as well as the importance of self-advocacy when it comes to getting this need met (P4, P6).

> I definitely think advocating for the support you need as a recovery coach is very important. I've had to do a lot of self-advocacy because the role is so new to where I work…you know going to other support groups with other recovery coaches, which is something I've advocated for on work time. (P8)

Supervision was described by the peer workers as an avenue for recovery coaches to have support for the peer role and to be able to receive support around some of the more challenging aspects of the role (P6). P1 and P6 shared that many peer workers have not held other jobs and identified a need to include job skills in initial and ongoing trainings. P1 also explained that a lot of the skills that you need in the role of peer support worker are learned through the actual work, making supervision during decision making an important piece of success in this role. "The only way to really teach this stuff is on the job right? Yes, you should do the training but when it's the first time in somebody's life that they've ever even tried to do this, they need supervision" (P1). Some of the peer support workers shared that their supervisors were not in recovery or that they had met supervisors who had not served in the role of peer support worker (P1, P3, P6, P8). They expressed concern about whether or not this will create the most effective supervision model for a role built upon shared lived experience (P3, P6, P8).

While the role of peer support worker in a system of care is still be developed and enhanced in Massachusetts, the peer support workers interviewed in this study are experiencing a shift in acceptance and support for their role. The movement that

currently exists to formalize this role and to establish greater guidelines for reimbursement may increase the barriers for both the peer worker and the individual that they are trying to service. Many of the peers interviewed reported that they hope their perspectives will be incorporating into the decision making.

Summary

In this study, I sought to answer the research question how do peer support workers experience the dual role of consumer and provider of services in substance abuse recovery? The five themes that developed from the interviews were a) by helping others we help ourselves, b) self-care makes the role of peer support worker sustainable, c) connection through shared experience, d) extension of the personal recover process, e) peer support in a system of care. All of the peer support workers interviewed explained that the opportunity presented itself through their personal recovery efforts and that it felt like a natural and fluid extension of this process. The peer support workers interviewed in this study shared that the role of helping was greatly beneficial to themselves and their own personal recovery but also cautioned that it is not meant to replace the recovery efforts that it was derived from.

There were many challenges outlined by peer workers including the acuity levels of the individuals that they were working with, recidivism, and the death of a patient, making the need to engage in self-care critical to success in this role. Peer support work is built upon a shared lived experience that the peer workers in this study recognized as a true understanding and connection through suffering and struggles to maintain recovery.

They explained that there is a connection that is created by living through addiction that is unique and extends across all walks of life and contextual situations.

The development of peer support was as a way to recognize the value of shared lived experience and has been integrated into many systems of care since its inception. While the peer support workers in the present study all reported experiences of apprehension from providers and other professionals, many have seen significant shifts in how they are viewed and the value of experiential knowledge. Many also reported seeing a change in how providers view substance abuse and recidivism due to their ability to set an example of what a recovered individual can look like. This allows the peer to serve as a model of hope for the individual struggling with active addiction but also a viewpoint into what recovery can look like for practitioners who may struggle to see beyond a current addicted state.

In Chapter 5, I discuss the interpretation of the results while considering the literature and conceptual frameworks and analyze findings. A review of the limitations of the study and recommendations for future research is provided. Implications for social change are discussed and conclusions are provided.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this qualitative research study was to explore the peer support worker's experience of the dual role of consumer and provider of services in substance abuse recovery. A generic qualitative approach was chosen to facilitate an exploration of what the role of peer support worker brought to the worker themselves and their personal substance abuse recovery. A generic qualitative approach was appropriate as I sought to understand the actual experiences of the participants, the meaning that they attribute to their experiences as well as the manner in which these experiences have produced transformation in their perspectives. This chapter includes an analysis of major findings as related to research on the experience of peer support workers and a discussion of the connections of this study to the conceptual frameworks presented in Chapter 2. This chapter also includes a discussion of the limitations of the study, recommendations for future research, implications for social change, and conclusions.

Peer support workers are increasingly being employed in formal roles yet an understanding of the role, how it is experienced by the peer worker, and the impact on their personal recovery have not been thoroughly explored. This study helped fill a gap in the literature regarding what this dual role means to the peer support workers' personal recovery process. The results of this study contribute to the literature on peer support workers' experiences in creating a more sophisticated understanding of how their work occurs in the context of their personal recovery stories, including physical, psychological, social and community benefits. This study allowed me to explore commonalities in these

experiences among peer support workers including their ideas, opinions, and reflections on the role of peer support worker. This is an under-researched area of addiction interventions. The results of this study also enhance the understanding of the benefits and the risks for the peer support workers from the perspective of the peer workers themselves. Studies have predominantly focused on outcomes related to the recipient of services while the peer support worker's experience of this dual role has not been well studied.

Semi structured interviews were conducted with 10 participants who were employed as paid peer support workers in hospital settings or community organizations. I analyzed the data using 6-phase thematic analysis, as recommended by Braun and Clarke (2018), to identify themes across the experiences of peer support workers of their dual role of consumer and provider of recovery services. The qualitative data analysis revealed 5 major themes: (a) by helping others we help ourselves, (b) self-care makes the role of PSS sustainable, (c) connection through shared experience, (d) extension of the recovery process, and (c) peer support in a system of care.

Theme 1, By Helping Others We Help Ourselves, revealed that while peer support workers did not seek out this role for personal gain, there were benefits to the peer worker on many levels, including benefits to their personal recovery such as serving as reminder of the damage active addiction can cause, keeping them connected to recovery communities, and allowing them to give back what had freely been given to them. While all of the peer support workers experienced personal benefits, they also warned about the

need to separate the helping relationship from their own personal recovery activities and to remain vigilant with their personal recovery.

Theme 2, Self-Care Makes the Role of PSS Sustainable, centered on the recognition that while there are many rewards and benefits to serving in this role for the PSS, that it is one that can be intense, challenging, and lead to burnout if self-care is not made a priority. The peer support workers interviewed explained that in order to be effective as a peer worker on a long-term basis, there is a need to establish and maintain effective boundaries and to be present in their personal lives while safeguarding against their peer role crossing over too much into their personal lives. The informal nature of the peer role and flexibility in service delivery can increase the emotional impact, making self-care an important component.

Theme 3, Connection through Shared Experience, illustrated the unique connection between individuals who have struggled with substance abuse and its role as a catalyst for relationship development. The shared experience serves as a connection point for individuals that would not otherwise have had anything in common, creating bonds that would not have otherwise existed. The role of peer support worker allows the peer to serve as a model of what recovery can look like and provide hope for individuals who are earlier in their recovery journey.

Theme 4, Extension of Personal Recovery, illuminated the fluid nature of the peer support worker role, with all of the peer workers interviewed reporting that they did not seek out the role, rather it was recommended to them. The peer workers described the role as feeling natural and highlighted their first-hand knowledge of the addiction and

recovery process and connection to community resources as important aspects of the helping process. Of particular importance, for all of the peer support workers, was the need to establish stable personal recovery prior to beginning work in this role.

Last, theme 5, Peer Support in a System of Care, represents the experiences of being a peer support worker within a system of care. A common experience shared by the peer support workers in this study was the challenges in establishing credibility of the roll, frustrations in managing systematic barriers, and a lack of clear understanding by outsiders as to what the role is meant to entail. The peer support workers shared that while initially the role was met with skepticism, that they have experienced a shift how they are viewed by providers as well as increased acceptance of individuals who seek treatment of substance abuse issues.

Interpretation of Findings

This phenomenon of interest guiding the study was the dual role; i.e., the experience of helping others in recovery and as well as experiencing their own personal recovery. The findings of this study reflect the perspectives of 10 peer support workers who were employed in hospital settings and community organizations. Two of the peer support workers interviewed had experience in both settings.

Conceptual Frameworks

The results of this study were strongly consistent with the recovery framework (Davidson et al., 2009) and the helper therapy principle (Reissman, 1965) as presented in Chapter 2. These two theories created a context for the exploration of how peer support

workers experience the relationship between the role of peer worker and their personal recovery. They also shed light on the meaning that they make of these experiences.

The recovery framework provides a foundation for understanding the continuum on which an individual's recovery exists, with the measurement of success being improved functioning, rather than the permanent cessation of substance use. It acknowledges the chronic nature of addiction and the fluid manner in which recovery occurs often on multiple pathways as defined by the individual seeking change (Dodge, Krantz, & Kenny, 2010; SAMHSA, 2015; van Melick, McCartney & Best, 2013). SAMHSA (2019) defined recovery as "a process of change through which people improve their health and wellness, live self-directed lives and strive to reach their full potential (Para 3)." Further, this model seeks to help individuals restore the goals they had for their lives and to recognize the potential that still exists for them (Davidson et al., 2009; Laudet& Humphreys, 2013). This model has been believed to be able to counteract the negative experiences that are often reported in traditional care environments (Bellack & Drapalski, 2012) and refocus the outcomes to goals that are important to the individual thereby promoting independence (Ahmed et al., 2015).

The findings of this study are consistent with the recovery framework. The peer support workers interviewed consistently recounted personal recovery journeys that were chaotic and full of struggles, aligning with the recovery model concept that engagement in treatment does not, nor should it, ensure that an individual will not experience future struggles (Becona, 2018). Further, many of the peers specifically identified the need to believe that recovery is possible for every individual that you work with no matter how

many times they have relapsed (P3, P5, P6, P7, P9). "If they're alive, they have a chance of recovery" (P3). P9 explained that someone held onto that belief for him and that changed his life, "so I know that that, you know, where there's breath, there's hope." The peer support workers highlighted how their own recognition of the cycle of addiction, normalization of relapse, and understanding of the nonlinear path that recovery can take for many individuals positions them to be uniquely empathic, nonjudgmental, and increased the ease of rapport building.

The participants consistently reported the need to allow the individuals that they work with the freedom to find a recovery path that worked for them even if it did not align with the beliefs of the peer worker. Nine of the peer support workers interviewed engage in abstinence-based recovery and several reported that they worked for organizations that did not support harm reduction models. The peer workers shared the belief that for recovery to be effective, it must be based on the goals of the individuals (Ahmed et al., 2015). The peer workers also identified the need to recognize multiple pathways to recovery and to help individuals explore any path they choose rather than pushing them toward the path the peer worker has taken. For many of the peer workers this involved widening their beliefs regarding what recovery can look like and embracing multiple pathways to recovery including harm reduction. Not only did this create a shift in views of recovery for the peer support workers but it also led to an increase acceptance of the journey that their personal recovery had taken.

Ahmed and Colleagues (2015) asserted that the degree to which a peer worker operated from a recovery framework was predictive of the impact that the stress from the

role could have on functioning. The peer support workers interviewed all described their work from a recovery framework, one built from their own foundation and understanding from recovery support networks. The peer workers consistently emphasized the importance of self-care for themselves, recognizing that there needed to be a separation between their personal recovery and the role of peer worker. As previously mentioned in Chapter 4, many of the peers identified the need to depersonalize the recovery journey of the individuals that they work with and recognize that they are not responsible for another individual's recovery (P1, P3, P5). The involvement in their own personal recovery activities as well as the fluid nature in which the peer support worker role presented itself from their recovery networks, uniquely positions the peer worker to incorporate the tenets of the recovery model.

The descriptions of the helping relationship in the context of the peer worker's personal recovery journey were consistent with the Helper Therapy Principle, which states that by helping an individual with similar issues, that the helper also benefits (Reissman, 1965). In fact, it was purported that the helper may get the greatest benefit from the relationship, making helping a significant manner by which one can help themselves (Reissman, 1997) and promote their own therapeutic healing (Reissman, 1990). While none of the peer support workers in the present study sought out to personally benefit from their role as a helper, many did report experiencing benefits. These personal to their recovery included the maintenance of connection to communities of support, providing an opportunity to be of service to others, paying forward what was

once given to them, and the sense of accomplishment in being a part of the recovery journey of another individual.

Reissman (1990) illustrated that helping others was important in the healing process, which he found to be consistent with the tenets of A.A. Cronise and colleagues (2016) found that the biggest reward reported by peer providers was helping others followed closely by strengthening their own recovery. The participants in the present study repeatedly shared that they were taught early on in their personal recovery journeys that helping others and being of service would not only help them but was also an expectation (P1, P3, P5, P6, P9). P5 shared "that's what they mean when they say you got to give it away to keep it…maybe if you are lucky you get to be a servant." This is a message that the peer workers in the present study internalized from the helper therapy principle.

Many peer workers shared that being able to see firsthand the suffering and destruction that substance abuse was causing in the lives of their clients served as a reminder of what they do not want to return to (P1, P6, P7, P10). The helper therapy principle also purports that the continued exposure to recovery networks and principles connects helpers to their own personal recovery (Pagano, Post, & Johnson, 2010; Reissman, 1965). This is consistent with the findings of the present study (P4, P6, P7, P9). "It makes me feel a part of the community, the recovery community" (P9).

Consistent with previous literature on the helper therapy principle and peer support work, the participants in the present study reported increased feelings of self-worth due to being in this role as well (Cronise et al, 2016; Skovolt, 1974). The peer

workers in the present study shared processes of self-forgiveness and improved positive self-regard of their own journey as a consequence of their involvement with others(P1, P3, P6). The findings from this study were also in line with Skovholt's (1974) explanation of the improved self-image that can occur when a peer worker is in a role of expert by experience and this role is recognized as valuable to others.

Previous Literature

As described in Chapter 2, peer support has a long-established place in the substance abuse recovery field starting with mutual aid programs such as A.A. and developing into more formal helping roles for peers in substance abuse recovery. Consistent with the findings of Mendoza and colleagues (2016), the participants in the present study identified the process of becoming a peer worker as natural evolution from their own personal recovery journeys rather than an opportunity that they sought out themselves. This can shed light on their views related to the role as well.

Reif and colleagues (2014) identified that a shared lived experience allows the peer worker to utilize their personal experiences in recovery to assist others positions the peer worker to serve as a bridge between providers and individuals in recovery. The bridge served two functions: to cover gaps in service delivery due to mistrust in providers and to show providers that recovery is in fact possible (P3, P5, P6, P7). "I've got an MRN number, I've got an MSN number for jail. I've been all over. And not all drug addicts die…try not to lose hope in your patients…so I just try to remind them of that" (P5). The peer workers in the present study serve as models of what recovery can look like, in the face of recidivism and multiple treatment attempts.

As I described in Chapter 2, previous research on the experiences of peer support workers, although limited and primarily focused on the mental health field, has identified other potential contributions and risks to the personal recovery of the peer support worker. This was consistent with findings from the present study where contributions and stressors of the dual role of peer support worker and consumer of services were recognized. Participants described the overlap and the need for each role to be viewed as a separate aspect of life.

Peer support workers have reported benefits including increased confidence, improvements in self-esteem and a greater sense of control over their recovery and illness (Bailie& Tickle, 2015; Cronise et al., 2016). The peer workers in the present study identified feeling proud when they are regarded as having something to offer by providers or as an "expert by experience" (Dugdale et al., 2016; Mead & MacNeil, 2006; Moura et al., 2014). This sense of pride and purpose was reported in the context of seeing a decrease in the stigma associated with substance abuse and recidivism from providers (P4, P5, P6, P7) as well as a true appreciation for the role that they are able to play in helping individuals who are in early recovery. The peers identified their contribution to the field of substance abuse recovery as unique and meaningful P9 excitedly shared a proud moment:

> How's this, the president, the CEO of Cambridge Hospital coming up behind you and saying what a blessing you are. They had me speak at a black-tie event with like two hundred dollars a plate the first year that I did this. I mean, or doctors coming up to me and asking me, what do you think?

Prior research found that peer support workers had a greater understanding of the negative consequences of substance abuse in their lives and were more likely to remain connected to recovery networkers and stay alert to the risks of their own recovery (Ahmed et al., 2015; Dugdale et al., 2016; Walsh et al., 2018). These findings were echoed by the peer workers in the present study who felt that seeing the challenges and suffering caused by substance abuse served as a constant reminder of lives that they did not want to return to. While participants in this study did not in every case connect the recovery activities in the work realm to their personal lives, all of the peer workers identified the need to remain vigilant to their own personal recovery in order to be effective in a helping role. "When people are working with people who are actively using, that can be a pretty uneasy situation for a lot of people in recovery" (P7).

The results from the present study do not support concerns from previous research regarding the stigma associated with self-identifying as a person in recovery, lack of mobility options (Chapman et al., 2018; Daniels et al., 2016; Gagne et al., 2018), nor did they feel discouraged to enter the role based on the inequities that exist (Sherba et al., 2018; Walsh et al., 2018). Many of the peer support workers in the present study identified the low-wages and concerns about long-term funding allowing for fidelity to the peer worker model. However, the ability to contribute positively to the substance abuse field superseded the poor pay, as P6 noted, "we don't get paid shit."

Limitations of the Study

As described in Chapter 1, limitations to the current study include participant selection, sample size, and the self-report of stability in personal recovery by the peer

support workers. I utilized a criterion sampling approach to select peer support workers to participate in the study. This criterion included the need to be employed in Massachusetts to provide paid peer support in non-residential settings to individuals in early recovery from substance abuse. which makes generalizability to the broader population of peer support workers limited.

Snowball sampling was also utilized in the current study to ensure adequate sample size was obtained and saturation was reached. I did this by asking each peer support worker if they knew any other peer workers who may be interested in participating in the study. The peer workers were then asked to provide the information about the study to interested participants and to have them contact me if they were interested in participating. Of the 10 participants interviewed, two participants reached out to me regarding participation in the study after being referred by a peer support worker that had already completed the interview. It is possible that by the nature of being associated with one another that the participants may have experiences that are similar in ways that may differ from the broader peer support worker population. Perhaps these respondents are more connected to networks of peer workers than other peer support workers may be. While saturation appears to have been reached with 10 participants in the present study, due to the purpose of this study being to explore how peer support workers experienced their dual role of provider and consumer of services, a larger sample with a greater geographic consideration may have revealed additional insights.

While there is concern in qualitative studies of this nature about participant comfortability in sharing openly and the possibility of responses leaning toward socially

desired answers, all participants were provided with the information regarding the sensitive nature of the interview prior to participation. Further, all participants were provided with informed consent that detailed the nature and purpose of the study, the commitment that was being asked of them, and the right to not share any information that they did not feel comfortable being included in the study. I also explained that the participants could withdraw at any point during the study and asked the peer workers to opt into participation. One peer support worker did not decide to opt in after making several inquiries about the process of the study. Therefore, it can reasonably be assumed from their decision to participate and the depth of their personal interviews that the peer support workers interviewed for the current study were willing to honestly share their experiences.

Bias can arise in studies such as this one and since I have experience with the concepts of recovery in my role as a psychotherapist and professor, I needed to manage any preconceptions in order to prevent these assumptions from influencing the study outcomes. The awareness of possible assumptions and bias aided in mediating the possibility of researcher influence and allowed for mindfulness of my behaviors during interviews and communication with participants. A reflexive journal utilized throughout the entirety of the study serves as a record of my experiences, reactions, and awareness of any assumptions that emerge throughout the research process. I also utilized reflexive notes for documentation of the aspects of the interview that seemed noteworthy to me as well as the subjective responses that I had to the participants (Korstjens & Moser, 2018). Finally, to safeguard against bias, I did not recruit from agencies in which I have had

professional collaborations in past or present roles. I also did not include any peer support workers that I have encountered in either a personal, professional role, or as a client in the past.

In an effort to maximize transferability, I have provided a detailed description of the information provided by the participants and the research procedures including data analysis so that the reader can determine the relevance to themselves and their context of reference (Moser & Korstjens, 2018). The detail of information provided will allow the reader to make appropriate judgements regarding whether the present study is one that can relate to their setting or research. In addition, the situation of the current results to previous literature provide linkages to other contexts to which this study may be applicable. To increase dependability, all of the interviews were audio recorded and transcribed verbatim. Further, as described in Chapter 4, I implemented member checking by providing summaries of the transcripts to all study participants and asking for their feedback and any additions or corrections that they would like to see.

Recommendations

As previously mentioned, all the peer support workers are from the state of Massachusetts. Massachusetts is a state that has a formal recovery coach academy and is working on a process by which credentialing can occur for coaches. It is recommended that similar studies be conducted in other locations to understand potential similarities and differences in results where the peer support worker model is not as well supported.

This study highlighted the improvements in integration of peer support workers in systems of care and the way they are regarded by other professionals in the field. Yet

there still remains some confusion that they have experienced regarding how they are integrated into a larger system of care as well as the specific role that they play. While the peer support workers in the present study all strongly identified the need to understand their scope of practice and to not extend beyond that, many shared concerns that community stakeholders do not understand the role as well. Future research into the specific ways peers have been most successfully integrated into and the roles that they play in those systems may help to solidify the understanding of these roles on a larger scale.

Almost all of the peer support workers interviewed identified the need for sustained recovery prior to engagement in this role. While the peers interviewed for the current study had varied lengths of time in recovery, they all claimed that they had taken the time to build a solid recovery program prior to engaging in the role of peer support worker. Many of the peer workers pointed to individuals working in the field who did not have enough time in recovery and the ineffective nature of the service when provided in that circumstance. While a limitation of the current study was the self-reliance on the participant to identify as having stable recovery, future research that could identify clearer indicators of stable recovery and screen participants in that manner. A quantitative study that looks at the relationship between the stability of the peer support worker's recovery and the success of the peer relationship could help to explore this.

While all of the peer support workers in the present study had an average of 6 years of employment as a peer support worker, their actual span of experiences was 10 months to 20 years of employment. There were no discrepancies that stood out in their

experiences related to length of employment, however, future studies could seek to utilize a longitudinal approach to qualitatively explore the experiences of the peer support worker over the course of their employment to see if their subjective experiences of their role and/or its relation to their personal recovery changes over time.

All of the peer workers interviewed in the present study described some of the biggest challenges as being the acuity of the individuals that they encounter, the participants' readiness to change, the intensity of the role, and participant death. They cautioned about the need to watch for burnout in oneself and to engage in self-care to prevent burnout. Further, all the peer support workers illustrated the importance of supervision and support systems in this role to provide guidance and assist with self-care. This is consistent with previous studies that suggested the need for safeguards to ensure that harm does not come to the peer worker from serving in such an intense role (Dugdale et al., 2016; Tracy et al., 2011). Future quantitative studies could look at the relationship between supervision, perceived social support, and burnout in peer support workers. Such research could lead to an understanding of the role that supervision and social support play in peer worker burnout.

Implications

Implications for Social Change

The use of peer support workers in the field of substance use has been rapidly gaining popularity. While previous research has established that there are benefits to the participant from engaging with a peer worker, the exploration of how this role is experienced by the peer and the intersection with their personal recovery has received

less attention (Dugdale et al., 2016). The results of this qualitative study provide insight into the how peer support workers experience the dual role of provider and consumer of abuse services. The participants in the current study identified areas in which they felt that their role could be better supported through the use of supervision, peer networks, and education of practitioner as to the role of the peer worker and the boundaries of this role.

This study identifies some areas in which peer support workers can be better supported in their role including supervision by individuals with experience in recovery, ongoing training on how to manage individuals with high acuity, as well as support in effectively handling the relapse of a patient, or potentially more challenging, patient death. The peer support workers interviewed in the current study illustrated the use of coping skills to manage these challenges faced in the role of peer worker, however, all cautioned new workers to ensure that they did not personalize participant outcomes and identified situations in which they saw peer workers be ineffective or experience distress as a result. This study highlights the crucial role of ongoing training and support for individuals whose role it is to use their shared lived experience as the catalyst for promoting change in others. Peer training programs, while becoming increasingly popular would benefit from an emphasis on recidivism, patient death due to overdose, and ongoing dialogue with peer workers regarding challenges that they are facing in the field.

The present study identified the peer support worker role as a natural evolution from their own personal recovery journey, and all of the peer workers identified individuals who suggested the role to them. This illustration of the fluid progression

from a participant in their personal recovery into the peer role can be utilized to design training and support programs that recognize that the role of employee may not be one that the peer has a strong skillset in. "The population that are coming into this field are sometimes people who are six months sober, who've never had a job in their life" (P1). While the role of peer worker has its own unique challenges, the need to assess the job readiness skills of peer workers may assist new peer workers who also are new to the workforce, further complicating the issues that they face.

This study utilized a qualitative approach to explore the lived experiences of peer support workers in the dual role of provider and consumer of services. All the peers interviewed reported engagement in personal recovery activities that allowed for comfortability in sharing personal details about themselves and their recovery such as engaging with self-help communities and participating in treatment modalities. This study produced rich data that should encourage continued qualitative research with this population to further explore the needs and experiences of peer support workers.

Conclusion

Peer support has widely been identified as being a useful service for individuals who are struggling with a host of issue including psychiatric issues, homelessness, medical diagnoses, returning from combat, and substance abuse which was the focus of the current study. Serving in a dual role as receiver and provider of services is no easy task yet the individuals in the current study find themselves poised to make a difference. Peer support stood out as being a natural evolving role out of personal recovery which makes this unique from many individuals who have traditionally sought careers and

employment. The present study participants identified that helping others is a benefit to both their recovery and their personal lives, while recognizing the toll that the intensity of this role can take, making self-care of the utmost important.

A shared lived experience is the catalyst for building rapport and positions peers to not only connect but to find commonalities that may be greater than what exists in their day to day relationships with family and friends. However, this is only the beginning of the skills that are essential in making this role successful for both the peer worker and the individuals that they are seeking to help. The participants in this study highlighted the need for pre-employment and ongoing training for peer support workers that focuses on setting effective boundaries, self-care, as well as the importance of ongoing supervision from individuals who understand the challenges that peers face in both the day to day aspects of the role and when faced with patient relapse or death. If peer support workers are not provided with adequate training and support there is a very real possibility of ineffective peer help as well as burnout for the peer worker themselves.

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Appendix A: Interview Guide

Interview Questions and Prompts

1. How long have you been a peer support worker?
2. Can you tell me about a typical day as a peer support worker?
    - What are some of the key tasks you do?
    - What is the best part about what you do? Can you give me an example?
    - What is the hardest part? Can you give me an example?
3. What motivated you to become a peer support worker?
    - Was there a specific experience?
    - What did that experience mean to you in continuing in this role?
    - What makes this work meaningful to you?
4. What type of workplace(s) have you provided peer support services in?
    - How would you describe your relationship with your supervisor(s)?
    - How would you describe your relationship with the other employees?
    - How have you experienced support of your role from other professionals in your workplace?
        - Have you had any apprehensions or concerns from the others in your workplace?
5. What is it like to provide support to others who are in recovery?
    - Can you give me an example of how your personal recovery experience was meaningful to someone that you have worked with?
    - How was that sharing meaningful to you?
6. How do you define recovery for yourself?
    - What is most important to you for a recovery lifestyle?
    - Is there anything else that is important?
7. How does being a peer support worker show up in your own recovery?
    - What is the biggest benefit to your recovery?
        - What is another benefit?
    - What is the biggest challenge to your recovery?
        - Another challenge?
    - What is hardest part about being a peer support worker?
        - What else is hard about it?
    - What is the greatest benefit that you experience?
        - Is there another benefit?
8. Tell me about how you connect your role as a peer support worker and your own recovery?
9. What advice would you give to a new peer support worker that is just starting?
10. Is there anything else you'd like to share that would help me understand your experience?
11. Do you know of any other individuals who are employed as peer support workers that might be willing to participate in this study?