2023

Stress and Coping Among SUD Certified Peer Recovery Specialists

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This is to certify that the doctoral dissertation by

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has been found to be complete and satisfactory in all respects,
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Walden University
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Abstract

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MSN, University of Virginia, 1992

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Dissertation Submitted in Partial Fulfillment

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Abstract

Certified Peer Recovery Specialists (CPRSs) are individuals with lived experience in the successful recovery of substance use or mental health disorders. CPRSs provide services for individuals seeking or enrolled in substance use disorder (SUD) recovery, provide mentoring and coaching, service and resource connections and lead recovery groups but, the job of a CPRS can have beneficial and detrimental impacts on the CPRS's personal recovery. The purpose of this quantitative study, guided by Lazarus's theory of coping and stress, was to determine whether there is (a) a relationship in stress and coping effectiveness among CPRSs, (b) a difference in the level of stress and coping among SUD CPRSs with 5 or more years in personal recovery and SUD CPRSs with less than 5 years in personal recovery, and (c) a difference in the level of stress and coping among SUD CPRSs with 5 or more years of employment as a SUD CPRS compared to SUD CPRSs with less than 5 years of employment. Data were collected from 141 participants using the Ways of Coping Questionnaire and Work Stress Scale. Results from my study demonstrated that there is a difference in stress and coping between CPRSs with 5 or more years of personal recovery with a small effect, but there was no relationship in the level of stress and coping among SUD CPRSs. Future studies are needed on identifying benefits of stress and coping training among SUD CPRSs, testing the relationship between years of employment as a CPRS and stress and coping, and a quasi-experimental design with sufficient sample size to determine the effect of stress and coping training. The results show the need for CPRS training to focus on known stressors and provide positive coping strategies which affect positive social change.

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Dedication

This study is dedicated to all those who have experienced a substance use disorder.

Acknowledgments

I wish to extend my deep gratitude to Dr. Leslie Hussey, my committee chair, for her tireless support and guidance and to Dr. Mary M. Martin for her recommendations.

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Chapter 1: Introduction to the Study

Certified Peer Recovery Specialists (CPRSs) are individuals with lived experience in the successful recovery of substance use or mental health disorders (Substance Abuse and Mental Health Services Administration [SAMHSA], 2018). Personal recovery time varies, and research shows that the length of personal recovery impacts successful coping (Kelly et al., 2018). CPRSs are employed within integrated healthcare teams, hospitals, emergency departments, crisis teams, in-patient, and out-patient treatment centers, medication-assisted treatment (MAT) centers, the criminal justice system, recovery communities and within a growing array of other sites or centers (Bardwell et al., 2018; Goedel et al., 2019; Kulik & Shah, 2016; Pfeiffer et al., 2020; Watson et al., 2020; Waye et al., 2019). Many articles are found in the literature on the wide range of services CPRSs provide, and there is a small amount of literature on job stress that CPRSs experience. However, there is only sparse research into the impact of providing peer recovery services on the CPRSs themselves and the ways that CPRSs cope with this stress (Bassuk et al., 2016). I investigated job-related stress CPRSs experience and coping processes based on length of time in personal recovery.

Background

CPRSs became a part of the U.S. behavioral health workforce during the 1980s and since that time have provided an ever-expanding array of services in a growing number of service sites. CPRSs provide services for individuals seeking or enrolled in substance use disorder (SUD) recovery, provide mentoring and coaching, service and resource connections, lead recovery groups, and help build community through a variety

of roles. There is growing research that indicates the job of a CPRS can have beneficial and detrimental impacts to one CPRS's personal recovery and require a variety of coping strategies to be a professional delivering harm reduction services, as well as a client consuming harm reduction services, within the same agency (Bailie & Tickle, 2015; Wilson et al., 2018).

CPRSs are deployed within integrated healthcare teams, hospitals, emergency departments, crisis teams, in-patient, and out-patient treatment centers, medication-assisted treatment (MAT) centers, the criminal justice system, recovery communities and within a growing array of other sites or centers (Bardwell et al., 2018; Goedel et al., 2019; Kulik & Shah, 2016; Pfeiffer et al., 2020; Watson et al., 2020; Waye et al., 2019). More than 24,000 CPRS are employed across the United States (University of Chicago, 2021). In 2019, according to the University of Michigan, an estimated 6,806 facilities out of a total of 12,074 offering substance use treatment provide peer services. Of these, transitional housing or halfway houses utilize the largest percentage of peer services (77%), detoxification facilities (60%,) and substance abuse treatment facilities (57%).

CPRS qualifications vary by state (Copeland Center, 2021). For example, Virginia and New Hampshire have established a state-endorsed certification process while Alaska has not. Only two states, South Dakota, and Vermont, do not offer a statewide peer support credential and each state offering the statewide credential requires specialized training (an average of 50 hours) for an individual to become a CPRS. States also vary in whether they differentiate between Mental Health Peer Support Specialists and Substance use Peer Support Specialists. Educational, personal, and professional

requirements vary widely by state although most states require a high school education or GED, lived experience with mental illness or substance abuse, and 1–2 years' experience in their recovery (Virginia Department of Behavioral Health & Developmental Services, n.d.; University of Michigan Behavioral Health Workforce Research Center, 2019.). Nationally, Mental Health America has established the National Certified Peer Specialist Certification program (NCPS) and the Association for Addiction Professionals has established the National Certified Peer Recovery Support Specialist Certification program (NCPRSS). Neither are substitutes for state certifications and are not yet required, though the goal is to move toward a national certification program.

An international rise in the use of CPRSs is seen within SUD services despite continuing role challenges (Gagne et al., 2018; Wilson et al., 2018). Among the challenges CPRSs face is microaggression, lack of respect as a member of the professional team, unclear guidelines related to CPRSs' use of agency relapse prevention resources, varying definitions and expectations of recovery, unclear reporting structures, managing dual relationships, having difficult conversations, competing priorities, taking responsibility for others as well as self-care, addressing stigma, and leadership development (Ahmed et al., 2013; Almeida et al., 2020; Chudzicka-Czupala & Zalewska-Lunkiewica, 2020; Firmin et al., 2020; Forchuk et al., 2020; Kuhn et al., 2015; Jenkins et al., 2020; Park, 2016; Shalaby, 2020; Wilson et al., 2018). Bassuk et al. (2016) conducted a systematic review of peer-delivered recovery support services for addictions in the United States. They found general evidence that CPRSs are effective within recovery programs and provide a wide range of services with varying degrees of

supervision in many different settings. They recommended further research into types of peer support services, effectiveness, skill level, and population types. Chapman et al. (2018) reviewed the U.S. CPRS workforce changes since 2016 and identified the varied settings in which CPRSs provide services, including ambulatory clinics, Department of Corrections facilities and city/county jails, housing programs, and mental health facilities. Medicaid reimbursement for CPRS services was identified as an essential revenue source. Chapman et al. revealed the challenges and benefits that the CPRS role entails, which showed that each state sets its criteria for certification as a CPRS and that CPRSs have low wages, limited career opportunities, and may lack the potential requirement of workplace accommodations for the CPRS to maintain their personal recovery. Wilson et al. (2018) conducted a study to identify challenges peer workers face in Ottawa, Canada, which identified conflicting identities, performance pressure at work, access to support services, and a common definition of recovery.

Problem Statement

CPRS services promote improved outcomes within the SUD population, but there are also continued challenges inherent in the role (Ahmed et al., 2013; Almeida et al., 2020; Chudzicka-Czupala & Zalewska-Lunkiewica, 2020; Firmin et al., 2020; Forchuk et al., 2020; Jenkins et al., 2020; Kuhn et al., 2015). As CPRS roles have expanded, addiction recovery is also being redefined to focus on the evolving nature of recovery rather than its endpoint. SAMHSA (2018) revised their definition of *recovery* to "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential" (p. 3). Notably, the words

"abstinence" and "sobriety" are removed from this new definition. This marks a change in medical and personal expectations of recovery. Following SAMHSA's revision of recovery, Borkman et al. (2016) published a participatory research process with those in recovery that yielded items to measure recovery from the lived experience perspective and resulted in items such as "freedom from feeling physically sick because of my drinking or using" rather than "abstaining from drinking or using drugs" and harm reduction items such as "non-problematic alcohol or drug use" rather than "no longer use alcohol or drugs" (p. 1123).

There is growing research that indicates the job of a CPRS can have beneficial and detrimental impacts on the CPRS's recovery and require a variety of coping strategies to be a professional delivering harm reduction services, as well as a client consuming harm reduction services, within the same agency (Bailie & Tickle, 2015; Wilson et al., 2018). According to the National Harm Reduction Coalition (2020), harm reduction involves realistic tactics and plans a set of practical strategies and ideas to reduce negative consequences of drug use. Harm reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs. Harm reduction was first discussed internationally in England in 1990 as a mechanism to reduce risk of HIV transmission (Erickson et al., 1997) and has evolved to include a variety of services thought to be based on what recovery is. Depending upon the definition of recovery, geographical location of employment, and administrative policies, a CPRS could be employed and use sick time to cover an absence or late arrival to work due to a "slip" that resulted in drug use. Wilson et al. (2018) studied challenges CPRSs

faces and found that CPRS have a dual self-image as a peer worker working in a harm reduction service and as a person who uses drugs and requires access to harm reduction services such as needle exchange programs. CPRSs reported reluctance to report personal use of harm reduction services to their supervisor. Results showed that administrators of harm reduction programs that employ CPRSs need to identify situations that could present potential harm to the CPRS.

Gagne et al. (2018) found that CPRSs are employed in a variety of settings, the most common being within integrated healthcare teams, crisis service teams, mediation-assisted treatment programs, criminal justice settings, employment programs, and community treatment teams. Forty states provide certification training programs for mental health peer support specialists, and 13 states provide certification training programs for SUD peer recovery coaches. State certification training programs predominantly require the applicant to have personal experience with a mental health illness, SUD, or both. National certification programs have been developed for CPRSs, such as the one from the Association for Addiction Professionals, which require 1000 hours of volunteer or paid field work, 1 year of recovery, 125 hours of approved education, and a passing score on the Nationally Certified Peer Recovery Support Specialist exam. The benefit of national certification is that it is not state career mobility for the CPRS. The researchers also found that CPRSs do experience prejudice from other staff, role conflict, and role ambiguity (Gagne et al., 2018).

Although CPRSs in some roles are assigned to a team, they can also be in positions with autonomy. Many CPRSs work for free-standing recovery centers that

function independently of primary care providers and SUD treatment and recovery providers, while others work in mobile services based out of emergency departments. In British Columbia, mobile units are staffed with CPRSs to provide supervised drug consumption to reduce overdose deaths (Merna et al., 2019). A systematic review of CPRS services in the United States (Bassuk et al., 2016) identified services provided on a one-to-one basis, within groups, and on college campuses. These service types and locations supported avenues for CPRS to engage with their clients where the client needs them, and can put the CPRS into cirsumstances in which they experience difficulty with boundaries and triggers that could lead to the re-emergence of their own mental health symptoms or drug use behaviors (Bailie & Tickle, 2015).

Many employers of CPRSs support the concept of harm reduction and chronic disease management as part of their definition of recovery (Bailie & Tickle, 2015; Bassuk et al., 2016; Eddie et al., 2019; Ezell et al., 2021; Merna et al., 2019; Wilson et al., 2018). Principles of harm reduction and chronic disease management are based upon the belief that recovery is a journey that varies among individuals and may include periodic use of illicit or illegal substances. Programs directors are encouraged to support CPRSs using harm reduction services of the programs by which they are employed. This results in CPRSs that, at times, cope by using the substances to which they were previously addicted on a one-time or very short-term basis. Wilson et al. (2018) identified an increasing need for the CPRS to continually develop coping skills.

Workplace and job-related tension create juxtapositions in which CPRSs face crises and emergencies which they could be dealing with on their own for some time. It is

of vital importance that the inclusion of time and resources for CPRSs in maintaining their own recovery goals are available (Chapman et al., 2018). A CPRS can be in any phase of their recovery, from 18 months to 30 years (Chapman et al., 2018). For this reason, the coping strategies for a CPRS in the earlier years of their recovery may be different than those with long-term recovery. There is a scant amount of data that described the experience of stress and coping among CPRSs within the MH population however there were no current studies found that identify the processes used by CPRS within the SUD population for stress and coping. Dugdale et al. (2016) conducted a qualitative study of CPRSs to explore the therapeutic impact of the CPRS role on their own recovery from SUD. The findings revealed that the CPRS role helped (a) to build confidence for CPRSs in their own ability to continue their recovery journey, (b) to provide structure in the lives of CPRSs, (c) to help CPRSs develop a new self-identity, and (d) to support CPRSs in sustaining their own personal recovery. Lapidos et al. (2018) conducted a state-wide survey study of CPRSs in the state of Michigan for (a) the roles CPRS are employed within, (b) services provided by CPRS, and (c) CPRS self-perception of job skills and financial well-being. Results revealed 42% of the respondents said nonpeer staff had received education or training on the role of a CPRS. Other studies found that CPRSs overall reported high satisfaction in their role (Chang et al., 2016; Lapidos et al., 2018). However, no studies have been identified through this literature review that evaluate the stress and coping among CPRSs. Shumway et al. (2014) found that coping is a significant characteristic of long-term recovery. Jafari et al. (2010) found that coping skills training during recovery improved relapse and recovery rates, yet

coping skills training is not a requirement for treatment programs nor assessed for in the CPRS exam. A recent publication provided strong recommendations to include coping skills training within treatment and recovery programs (Sudhir, 2018). The minimum personal recovery time eligibility requirement for the CPRS certification exam is 12 months. Given the coping difficulties a CPRS may have, it is feasible that coping with stress may continue to be a strain once in the CPRS role.

CPRSs may have, or have suffered, stressors just as those who chose not to become a CPRS. Coping strategies are a key factor in how individuals come to experience addiction and recovery (Jafari et al., 2010). Further, stress and the real or perceived lack of internal and external resources to effectively cope with stress often lead to relapse. Daily life for those in recovery includes self-care practices such as prayer or other mindfulness practices, sober routines that help build self-esteem, journaling, meetings, and other activities that help the individual maintain focus upon their recovery (Brand, 2017; Narcotics Anonymous, 2012a; Narcotics Anonymous, 2012b) and build their recovery capital (Vilsaint et al., 2017). As these daily practices gain traction and self-reliance grows, the desire to help others will emerge and for some leads to volunteering personal time to help others in recovery. For those wanting to continue helping others, they will seek employment as a peer recovery support worker or CPRS. Along this pathway to employment, these individuals gain experience in sharing their recovery stories (Parker & Uraine, n.d.) and honed their self-care practices, learned, and implemented coping strategies to deal with stress.

While findings in the scholarly literature related to long-term recovery (e.g., greater than 12 months) are scant, there is growing evidence that quality of life and psychological distress vary, especially within the first several years of recovery (Kelly et al., 2018), that recovery does not always mean total freedom from use of drugs (Borkman et al., 2016), and that recovery usually takes multiple attempts (Kelly et al., 2019). All the while, individuals gain resources that help them cope with physiological, emotional, and cognitive, and physical changes associated not using drugs (Vilsaint et al., 2017).

Individuals in recovery learn coping through a variety of sources, including treatment programs, outpatient after-care programs, 12-step programs, sponsors, peer support, counseling, family, and friends. Almeida et al. (2020) conducted a study to identify employment challenges experienced by CPRSs and found that 100% of the respondents identified self-care as the most important training needed.

According to Lazarus and Folkman's (1984) transactional theory of stress and coping, coping is a process that begins with a stressful event. In the process of coping, the individual appraises their resources to cope with the event, and based on their initial appraisal, the individual utilizes a coping strategy based on the belief of their internal and external resources. Lazarus and Folkman (1984) defined three coping processes: problem-focused coping, emotion-focused coping, and reframing. Problem-focused coping and reframing result in positive emotions, which can then build the individual's future coping capacity, skills, and nimbleness in what many refer to in the literature as adaptive coping (Folkman, 1997; Lazarus, 1966, 1991, 1999; Lazarus & Folkman 1984).

Emotion-focused coping can lead to unresolved emotions, which require a continued state of coping.

Coping and coping strategies among the addiction population in recovery have been discussed in the literature (Adan et al., 2017; Blanchard et al., 2019; Cavicchioli et al., 2019; Marceau et al., 2018). Coping effectiveness has been studied in the HIV population (Chesney et al., 1996, 2003), spinal cord injury population (Kennedy et al., 2005, 2015), and the chronic heart failure population (Bose et al., 2016) among others. There was a gap in the literature on coping with stress and coping effectiveness within the SUD CPRS population.

Purpose of the Study

The purposes of this quantitative study were to determine if there is (a) a relationship in stress and coping effectiveness among CPRS, (b) a difference in level of stress and coping among SUD CPRSs with 5 or more years in personal recovery and SUD CPRSs with less than 5 years in personal recovery, and (c) a difference in the level of stress and coping among SUD CPRSs with 5 or more years of employment as a SUD CPRS compared to an SUD CPRSs with less than 5 years of employment.

Research Questions and Hypotheses

Research Question 1: What is the relationship between the level of stress and coping among SUD CPRSs?

$H0_1$ - There is no relationship between the level of stress and coping among SUD CPRSs.

*H*A$_1$ - There is a relationship between the level of stress and coping among SUD CPRSs.

Research Question 2: What is the difference in the level of stress and coping between SUD CPRSs with 5 or more years in personal recovery and SUD CPRSs with less than 5 years in personal recovery?

*H*0$_2$ - There is no difference in the level of stress and coping among SUD CPRSs with 5 or more years in personal recovery and SUD CPRS with less than 5 years in personal recovery.

*H*A$_2$ - There is a difference in the level of stress and coping among SUD CPRSs with 5 or more years in personal recovery and SUD CPRSs with less than 5 years in personal recovery.

Research Question 3: What is the difference in the level of stress and coping among SUD CPRSs with 5 or more years of employment as an SUD CPRS compared to SUD CPRSs with less than 5 years of employment.

*H*0$_3$ - There is no difference in the level of stress and coping among SUD CPRSs with 5 or more years of employment as an SUD CPRS compared to SUD CPRSs with less than 5 years of employment.

*H*A$_3$ - There is a difference in the level of stress and coping among SUD CPRSs with 5 or more years of employment as an SUD CPRS compared to SUD CPRSs with less than 5 years of employment.

The data were analyzed using SPSS quantitative research multiple regression, comparative analysis, and independent *t*-test statistical methods. I used two survey

instruments to measure coping: the Ways of Coping Questionnaire (Folkman & Lazarus, 1988b) and the Work Stress Scale (Steinisch et al., 2013).

Theoretical Framework

Lazarus's (1966) theory of coping and stress guided my study. This theory originated from Lazarus's interest in understanding the process of coping and the relationships between the individual, their environment, and how they managed stressful events. Lazarus, through his coping and stress model, defined *coping* as a fluid process that exists between an individual, their environment, and their appraisal of their resources to cope with events. *Stress*, according to Lazarus, is a post-appraisal state and occurs only when the individual appraises the event as one that taxes their resources. Folkman and Greer (2000) elaborated on this definition, and defined coping as an ongoing, fluid process between the person and their environment that consists of a primary and secondary appraisal, generates emotion, and leads to one of three outcomes: (a) a positive psychological state, (b) distress, or (c) reframing.

Following a primary appraisal, the individual utilized either problem-focused or emotion-focused coping (Folkman & Greer, 2000). Problem-focused coping relates to cognitive processes and behavior used to manage the stressful event and results in a favorable resolution with positive emotion (Folkman, 1977). Conversely, emotion-focused coping leads to an unfavorable resolution and continued coping. Distress and coping continue until the person can reframe the event into a positive event positively (Folkman & Greer, 2000). Meaning-based coping involves reframing an unresolved event to create positive emotion and end the coping process (Folkman & Greer, 2000).

Meaning-based coping includes four processes: “positive reappraisal, revised goals, spiritual beliefs, and positive events” (Folkman, 1977, p. 1212).

These processes represent the ability to arrive at a new understanding of how the event was positive, rather than negative (Folkman, 1977). The more control a person feels they have over the outcome of the stressful event, the more frequently they use problem-focused coping (Lazarus & Lazarus, 2006). Conversely, the less control a person feels they must influence the outcome of the stressful event positively, the greater the emotion-focused coping. This implies that self-efficacy is related to coping. Problem-focused coping has been studied within a variety of populations; however, scarce evidence exists on how problem-focused and meaning-based coping can impact self-management within the SUD recovery population (Folkman, 1977; Harris et al., 2011; Lazarus, 1966). According to Helmreich (2017), the literature describes a well-defined relationship between coping and resilience, positive emotions, self-esteem, self-efficacy, social support, cognitive flexibility (including positive reappraisal and acceptance) and, religiosity or spirituality or “religious coping.”

Lazarus’s (1966) theory of stress and coping describes the process of coping and demonstrates that when an individual finds themselves in a stressful situation, they make an appraisal of their past experiences in dealing with similar situations. Based upon the individual’s experience, negative or positive emotions will be generated, and the individual will feel either positively or negatively about their ability to cope successfully with the current situation. If the individual can cope effectively with the current event, the individual may be able to resolve any negative feelings, which enhance their future view

and emotion generation of the same situation. However, if the individual is not able to cope with the current situation in a manner that results in positive emotions, then the individual will continue to cope with that situation until they can resolve it (Lazarus & Folkman, 1984). More detail on Lazarus' theory of coping and stress will be presented in Chapter 2.

Nature of the Study

I conducted a quantitative descriptive correlation approach (Creswell & Creswell, 2018) using multiple regression for Research Question 1 and multivariate analysis of variance (MANOVA) for Research Questions 2 and 3 to analyze the data (Creswell & Creswell, 2018; Gribbons & Herman, 1996). I administered the Ways of Coping Questionnaire (Folkman & Lazarus, 1988b) and the Work Stress Scale (Steinisch et al., 2013) to CPRSs. I used SPSS (Version 28) to analyze the results. Key study variables included coping and stress. I collected data through online methods such as email, websites, and social media platforms.

Definitions

Coping: Coping is a fluid process that exists between an individual, their environment, and their appraisal of their resources to cope with events (Lazarus & Lazarus, 2006).

Stress : Stress is a post-appraisal state and occurs only when the individual appraises the event as one that taxes their resources to resolve an event (Lazarus & Lazarus, 2006).

SUD Certified Peer Recovery Specialist: SUD CPRS is a role filled by individuals with lived experience within the SUD or mental health field (MHA, 2021). Within this study, the term will be used exclusively to refer to those CPRSs within the SUD field, unless otherwise noted.

Personal recovery: Personal recovery is a life-long process and commitment through which an individual actively engages in strategies to manage their addiction and risk of using drugs again (McLellan et al., 2007) Within this study, personal recovery refers to the CPRS's recovery from using substances to cope with stress.

Triggers: Triggers are internal or external events that function as a stimulus to the individual and result in a craving response. Triggers have been identified as key elements in the development of the craving response for individuals in recovery. (Asensio et al., 2020)

Peer providers: Peer providers draw from their own experiences of disability (e.g., addiction), along with training and professional support, to provide services like counseling and coaching to people with the same type of disability(Administration for Community Living, 2021)

Peer support worker: Peer support workers are individuals in recovery from a mental health condition, SUD, or both. They provide strength-based services to those in earlier stages of recovery from the same condition (SAMHSA, 2018).

Lived experience: Lived experience refers to first-hand personal experience with the challenges of mental health or SUD. The word *lived* is used to differentiate from others who may have experience working with mental health and substance use

conditions but have not personally lived through those challenges (San Mateo County Health, 2021)

Internalized stigma: Internalized stigma can include self-negative feelings, maladapted behaviors, changes in self-identity, attribution of stereotypes resulting from an individual's experiences, and perceptions or anticipation of negative social reactions based on their illness. (Livingston & Boyd, 2010).

Assumptions

This study was based upon the assumption that CPRSs will complete the survey instruments using their own experience in full disclosure and truthfully, A second assumption was that the participants desire to be effective in their role as a SUD.

Scope and Delimitations

This study was a quantitative survey design. I considered conducting a qualitative design; however, I did not choose a qualitative study due to potential barriers to completing personal interviews. Lazarus and Folkman's theory of transactional coping and stress was selected because of the focus on the process of coping and the identification of varying types of coping (e.g., problem-focused, emotion-focused, and reframing). Other models I considered included the health belief model (Hochbaum & Rosenstock, 1950), the self-efficacy theory (Bandura, 1995), and the theory of planned behavior (Ajzen, 1980). I did not choose these theories because they did not provide details of the coping process. I used online surveys to collect data and participants were included in state or national mailing lists that had successfully passed a CPRS exam were contacted to complete the study instruments. Participants were currently working as a

CPRS job within the SUD population and can be from any state within the United States. CPRS can be certified by any approved CPRS program.

Limitations

My study design was a convenience sample, descriptive method. This design has the limitation of a sample that will not be randomly selected (Creswell & Creswell, 2018). Therefore, the findings cannot be generalized, and no casual conclusion can be reached.

A potential challenge for this study was sample size. Conducting online research during a global pandemic may produce an unexpected barrier to obtaining the desired sample size. Efforts were made to secure the needed sample size through networking with peer recovery groups throughout the state of Virginia as well as other states. Videka et al. (2019), on behalf of SAMSHA and HRSA, conducted a national analysis of peer support providers. According to their findings, of all facilities in the United States offering SUD treatment, 56% offer peer services, and of these, 35% offer services provided by peer support specialists or self-help groups. The site maintains a database of peer workers in each state, along with whether peer workers in each state have their own professional network and contact information for the liaison for the network. I recruited from across the United States and contacted all states with a listed statewide peer organization.

The data collection had a time limit, which may be a limiting factor. As with any study conducted for dissertation, I allowed time for as many participants to respond as possible. Given the scope of recruitment planned to include six states, and assuming each state has 360 peer workers, a 5% return rate was projected to produce a sample size of

180. I estimated that this sample size would meet the requirements for power in statistical analysis.

I used online resources to collect data for the study which required internet access for individuals to participate. Internet access was a potential barrier as the participant pool was unknown, and I could not assume that all those who would want to participate had the necessary access to do so.

Significance

There is a national epidemic in opioid SUD, overdose deaths, and suicide rates (National Institute on Drug Abuse, 2023). Stress, and the perceived lack of resources to effectively cope with the stress, often lead to relapse (Jafari et al., 2010). Effective coping is a factor shown to be strongly related to successful recovery (Bradshaw et al., 2014). Exploring the coping strategies and stress of CPRSs can help to identify the recovery support needs of this growing and emerging workforce.

Meaning-based coping includes four processes: “positive reappraisal, revised goals, spiritual beliefs, and positive events” (Folkman, 1977, p. 1217). These four types of coping all have in common the person’s search for “and finding positive meaning” (Folkman, 1977, p. 1215). They also include the person creating a belief, value, or goal that facilitates their ability to arrive at a new understanding of how the event was positive, rather than negative. Often, these steps are defined as finding meaning and are part of the coping process. Folkman revealed that positive states of mind are part of the coping process.

The findings of my study contributed to understanding the correlation between stress and coping among CPRSs. Findings may support CPRSs by informing SUD treatment and recovery employers using CPRSs on how stress and coping impact CPRSs. My findings led to positive social change within the CPRS population and could help to build the body of knowledge for use by localities and states, as the CPRS role is developed across the country.

Summary

In summary, the purpose of this quantitative study was to determine the relationship between stress and coping among SUD Certified Peer Recovery Specialists based on the number of years in personal recovery and the number of years employed as a CPRS. Lazarus and Folkman's theory of transactional stress and coping was used to guide the study, which identifies a process of problem-focused coping that helps an individual effectively deal with stress and a process of emotion-focused coping, that distances the individual from the feelings or perceptions of the stressful event however does not create positive feelings for the individual, as does the use of problem-focused coping processes. Emotion-focused coping includes many strategies usually employed by those before successful and sustained recovery. Problem-focused coping processes include strategies usually employed by those in more stable personal recovery. In Chapter 2, the literature review, theoretical framework, and key variables will be discussed.

Chapter 2: Literature Review

There has been a global proliferation of programs utilizing SUD CPRSs in stressful and potentially triggering work environments. The current development of addiction models indicates that the modality and causative factors in addiction are multiple and related in a complex manner (Asensio et al., 2020). The term *trigger* is used to indicate external or internal events, a "stimulus that elicits a reaction" (American Psychological Association, 2019). The trigger is an event that may elicit cravings and strong desires to use drugs that could lead to relapse (Asensio et al., 2020). Effective management of the CPRS role and employment challenges requires effective coping strategies to navigate work stressors as CPRSs continue their successful recovery amidst supporting others in recovery. Further, CPRS with less personal recovery time or employment time in the role may have less effective coping strategies than those with more time in personal recovery or who have been employed longer in the CPRS role (Ahmed et al., 2013).

Addiction treatment and recovery programs and services are encouraged to support the CPRS through harm reduction services. Harm reduction services are aimed at reducing negative impacts associated with drug use because CPRSs at times cope by using the substances to which they were addicted on a one-time or very short-term basis. Although CPRSs are hired based on their success with their personal recovery, continued skill development in stress and coping may be essential for the these individuals. Depending upon the definition of recovery, geographical location of employment, and administrative policies, a CPRS could be employed and use sick time to cover an absence

or late arrival to work due CPRS stress that led to drug use. In Canada, Wilson et al. (2018) studied challenges CPRSs face. The findings called for clarity around employees (i.e., CPRSs) accessing the same harm reduction services available to the clients they serve.

Although there is evidence to indicate CPRS services promote improved outcomes within the SUD population, there are also continued challenges inherent in the role of CPRS (Ahmed et al., 2013; Almeida et al., 2020; Chudzicka-Czupala & Zalewska-Lunkiewica, 2020; Firmin et al., 2020; Forchuk et al., 2020; Kuhn et al., 2015; Jenkins et al., 2020). Researchers have primarily focused on integration of the role within an existing team or service area, types of services CPRSs provide, or the beneficial outcomes of the services CPRSs provide to their clients (Bassuk, 2016; Chapman, 2018; Cronise, 2016; Daniels, 2017; Ehrlich, 2020; Forchuk, 2020; Gagne, 2018; Goedel, 2019; Greer, 2019; Jack, 2018; Kuhn, 2015; Mancini, 2018; McCarthy, 2019; Pelletier, 2020; Pfeiffer, 2019). There is scant research on CPRS job satisfaction and experience in the CPRS role (Dugdale, 2016; Lapidos, 2018; Lien, 2012; Mowbray, 2021; Scannell, 2020).

Recently, research has begun to focus upon the experiences and challenges CPRSs face within the role and work environment (Almeida, 2020; Jenkins, 2020; Jones, 2019; Scannell, 2020), and a few researchers have focused upon the impact of the role upon personal recovery of the CPRS (Chudzicka-Czupala & Zalewska-Lunkiewica, 2020; Firmin, 2019; Park, 2016; Shalaby, 2020; Wilson, 2018).

Workplace stressors include difficult integration of CPRSs into professional teams, stigma within the work environment, lack of information about the CPRS role

among team members, and the potential and real impact these stressors have upon the personal recovery of the CPRS (Chudzicka-Czupala & Zalewska-Lunkiewica, 2020; Firmin, 2019; Guenzel, 2021; Park, 2016; Shalaby, 2020; Wilson, 2018). Ahmed et al. (2013) found that the more years of personal recovery a CPRS has, the greater coping skills they may have to deal with these stressors effectively.

It is of vital importance that CPRSs have available time and resources to maintain their own recovery goals (Chapman et al., 2018). A CPRS can be in any phase of their own recovery, from 18 months to 30 years (Chapman et al., 2018). Therefore, the coping strategies for a CPRS in the earlier years of their recovery may be different than those who have experienced long-term recovery. Coping is an important characteristic of long-term recovery (Shumway et al., 2014), and there is evidence that coping skills training during recovery improves relapse and recovery rates for the CPRS (Jafari et al., 2010). Further, stress and the real or perceived lack of internal and external resources to effectively cope with stress often lead to relapse. Sudhir (2018) provided strong recommendations to include coping skills training within treatment and recovery programs. However, there are no studies that investigate stress and coping among CPRSs based upon their length of personal recovery time and time employed within the CPRS role.

While there are no findings in the literature related to long-term recovery of CPRS (e.g., greater than 12 months), there is evidence that psychological distress varies among those in recovery, certainly within the first several years of recovery (Kelly et al., 2018), that recovery does not always mean total freedom from misuse of drugs (Borkman

et al., 2016), and that recovery usually takes multiple attempts (Kelly et al., 2019). Individuals in the CPRS role gain resources that help them cope with physiological, emotional, cognitive, and physical changes associated with not using drugs (Vilsaint et al., 2017). Scannell (2020) conducted a qualitative study on the dual role of consumer and provider in substance use peer support workers and provided recommendations for additional support for CPRSs as well as additional training on the acuity of situations they may find themselves in as CPRS.

A gap in the literature exists related to stress and coping among the SUD CPRS population, and research indicates the job of a CPRS may negatively impact the CPRS's recovery. The purposes of this quantitative study were to determine whether there is (a) a relationship in stress and coping effectiveness among CPRSs, (b) a difference in level of stress and coping among SUD CPRS with 5 or more years in personal recovery and SUD CPRSs with less than 5 years in personal recovery, and (c) a difference in the level of stress and coping among SUD CPRSs with 5 or more years of employment as a SUD CPRS compared to SUD CPRSs with less than 5 years of employment.

In this chapter, I discuss Lazarus and Folkman's (1985) transactional theory of stress and coping as it relates to coping strategies influential for CPRS in resolving stressful situations. I reviewed the variables and concepts and present a synthesis of the literature.

Literature Search Strategy

I searched the literature through the Walden University Library using a mixture of search strategies and databases. I first used a combined search of CINAHL, Medline,

PsycInfo, and ScienceDirect using the keywords: *peer recovery support or peer coach or peer counselor or recovery coach AND stress or coping*. I limited the search to 2016 as the start year for peer-reviewed journals (236 results). I then added the Boolean operator AND and the keywords *addiction or substance abuse or drug abuse* (66 results). I removed duplicates and articles unrelated to the topic (11 results). I then searched Psychology Databases Combined Search using the keywords *certified peer recovery specialist* AND *addiction or substance abuse or drug abuse* AND *addiction recovery* (3 results). I removed articles unrelated to the topic (1 result). I searched CINAHL Plus and Medline using *certified peer recovery specialist* AND *work, stress, coping, and stress management* (0 results). I searched CINAHL, Medline, PsycInfo, ScienceDirect using keywords *peer recovery specialists* AND *work stress or job stress or occupational stress* (1 result). I then used the same database and searched *work stress or job stress or occupational stress or workplace stress* AND *peer recovery specialists* (0 results). Next, I searched the same database using *recovery capita*l AND add*iction or substance abuse or drug abuse* (600 results) then limited peer-reviewed scholarly journals published from 2016 forward (368 results). Duplicate and nonrelated articles were removed (16 results). I used the same database and searched *stress and coping theory* (3,011 results), limited peer-reviewed scholarly journals only published 2016 and forward (731 results). I searched in the databases ERIC, SAGE Journals, ScienceDirect, Psychology Databases Combined Search, CINAHL & MEDLINE Combined Search, and the Thoreau Multi-Database using *harm reduction, recovery and addiction, recovery journey and addiction* (15 results). I reviewed articles from all search strategies and removed duplicates.

Theoretical Foundation

Lazarus' transactional model of stress and coping guided my study. Lazarus and colleagues and subsequently Lazarus (1966, 1991, 1999) and Lazarus and Folkman (1984) significantly contributed to the understanding of coping as a psychoanalytic ego psychology process. Lazarus and Folkman identified an important distinction within this theoretical model of coping related to how coping is measured (Lazarus & Folkman, 1984). Folkman and Lazarus (1984) asserted that much of the coping research and measurement has been done defining coping as an individual style, personality trait, or character trait. The transtheoretical model of stress and coping provides a theoretical framework of coping as a dynamic ego process and limits the interpersonal comparisons that are essential for group analysis of coping. Folkman and Lazarus (1984) defined coping as a complicated process employed by an individual that has as its primary functions regulation of stressful emotions and changing the problem the individual is faced with for the better. According to Folkman and Lazarus (1984), coping is not employed by an individual when an event occurs that the person perceives to be inconsequential to them, or not different than other events they have experienced that presented no harm or stress. Coping is only employed by the individual when the event is perceived to present a threat, create stress, or is a challenge. Lazarus and Folkman also characterized three coping strategies that individuals utilize when faced with a threatening, challenging, or stressful event which are problem-focused coping, emotion-focused coping, or reframing.

Lazarus and Folkman (1984) defined problem-focused coping as a process employed by an individual to resolve or define the cause of stress; emotion-focused coping as a process employed by an individual to reduce emotional distress and reframe to change their emotion-focused coping to problem-focused coping. According to Lazarus and Folkman (1984) problem-focused coping might include strategies to identify the cause of stress, creating alternative mechanisms to cope with the stress, and looking inward whereas emotion-focused coping might include strategies such as distancing, avoidance, or minimizing among others.

The process of appraisal is at the core of Lazarus's theory of transactional stress and coping (Lazarus, 1999). Based on this theory, how an individual appraises a situation is associated with how the person views the potential for safety or harm and is coupled with the significance the person associates with the event and what the person determines as processes they can employ to manage the event. The coping process is what the person employs to manage the stress of the event (Lazarus, 1999) which is sometimes referred to as cognitive mediation, or the meanings that develop within a person as they interact with their environment (Lazarus, 1999). According to Lazarus, individuals construct meaning through their relationships with what they are interacting with in their environment. The meaning a person gives to a particular situation or event can determine whether the person finds the event stressful and then appraises the situation. Whether a person construes a situation as a threat to their well-being or one of safety depends upon the confluence of events and meaning the person assigns in any given situation, and these are unique to everyone based upon their past experiences (Lazarus, 1999). Lazarus termed

this process a “transaction,” which occurs during an appraisal. Lazarus pointed out that the results of any one person’s appraisal of a situation is subject to the specific details of that event, and similar events may result in a different or varying appraisal by the same person. Therefore, each situation is unique to the individual, and the appraisal of that unique situation can result in a different emotion or meaning, based on the unique elements of that specific event. In the study of cognition, Lazarus found that emotion, cognition, and motivation all work interdependently, rather than as separate entities.

The primary appraisal is a process used to evaluate whether the situation is relevant to the person’s well-being “and the secondary appraisal is an evaluation of the person’s options and resources for coping with the situation” (Lazarus, 1991, p. 145). An appraisal process is employed by the individual to determine how harmful the situation may be and what coping resources the individual possesses to deal with the situation. Based upon this appraisal, emotions occur when personal meaning is applied to the situation. Temperament, emotional, and individual development contribute to the emotion a person experiences in any given appraisal, and the meaning that emotion attributes to the person’s sense of well-being or harm.

Lazarus and Folkman (1984) asserted that cognitive appraisal and emotion are conjoined, meaning that the emotional response is always mediated by the cognitive appraisal process, can be created at any point in the cognitive appraisal process, and can impact the coping response and feelings of stress. Emotions tend to exist in an unstable or unclear state when the appraisal is largely uncertain, or the individual does not know what emotion they are feeling. Further, opposite emotions or a mixture of emotions can

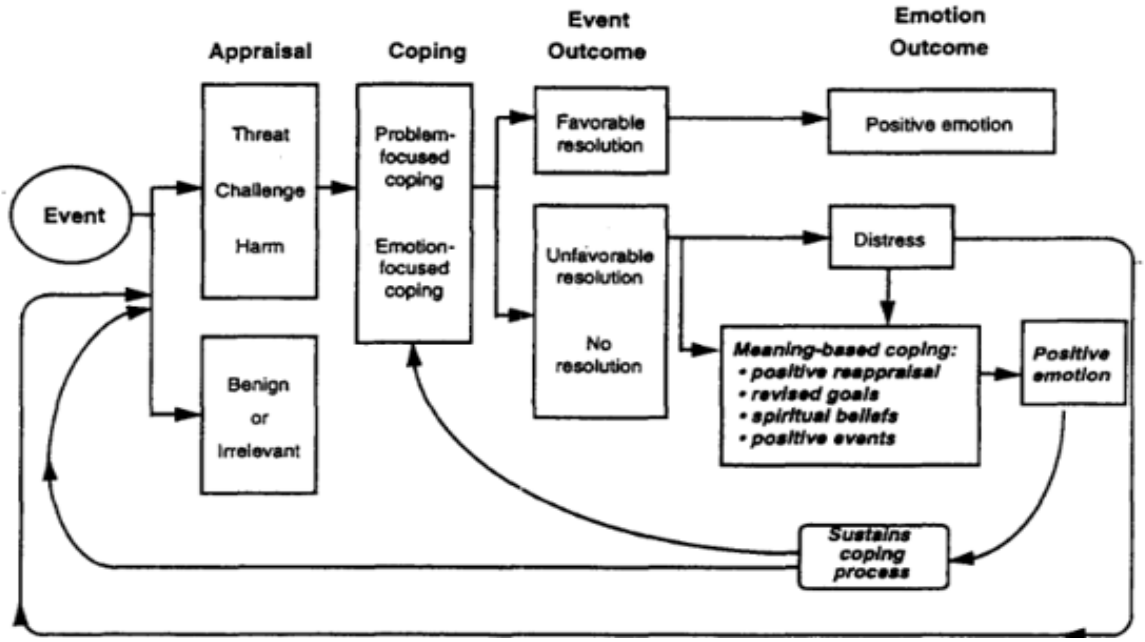
exist all at the same time in this state, and the appraisal a person makes at this time is dependent upon these emotions and what the emotions mean to the individual. Therefore, the coping process is highly dependent upon the emotions a person feels during their appraisal and the meanings the person attaches to those emotions. These interactions then influence how the person appraises a situation and are the basis for the emotions the person feels in that situation.

Coping serves as a mediator of emotion (Folkman & Lazarus, 1988a). Folkman and Lazarus (1988a) conducted a study of 85 married couples ages 26-54 and 161 retired adults with a mean age of 68.9 years of age to determine the extent that various forms of coping-mediated emotion. Folkman and Lazarus (1988a) found that coping processes during a stressful encounter are associated with changes in a variety of emotions; that these changes are seen with both problem and emotion-focused coping processes, and that the emotional changes vary depending upon the type of coping processes. In another study, investigating the impact of daily stress on health and mood, Lazarus and Folkman found a decrease in health and mood as daily hassles increased, especially among those with low self-esteem and unsupportive social relationships (DeLongis et al., 1988).

Lazarus' original transactional model of stress and coping was developed in 1966 and then revised to Folkman's modified theoretical model of the coping process (1977) to incorporate findings that problem-focused coping results in positive emotion and emotion-focused coping results in negative emotion and continued coping until the individual can reframe the event (see Figure 1).

Figure 1

Folkman Modified Theoretical Model of the Coping Process (1977)



From "Positive Psychological States and Coping with Severe Stress," by S. Folkman, 1977, *Social Science & Medicine, 45*(8), p. 1217 (https://doi.org/10.1016/S0277-9536(97)00040-3).

The emotions a CPRS feels as they appraise stressful situations are important to understand within the context of a person in addiction recovery. Jahart and Singh (2020) evaluated the association between emotions and activities of drug users during recovery and found emotional distress and lack of positive emotion played a critical role in relapse. Folkman and Moskowitz (2000, 2004) reported on positive emotions and their supportive influence on widening the range of coping strategies considered by the individual and that build resilience against stress. Christian and Steinhardt (2014) found that among a group of postdoctoral research fellows, positive emotion may enhance resilience directly and indirectly through the mediating role of coping strategies especially through adaptive

coping. Further, resilience moderated the association of stress with trait anxiety and depressive symptoms. Rajaei et al. (2016) found a positive and significant relationship between positive psychological states and problem-focused coping strategies and a negative relationship between hope and relaxation and emotion-focused coping strategies among college students. Hassanbeigi et al. (2013) compared stress and coping among individuals in addiction treatment to those without a history of addiction and found that 2 years prior to beginning substance use, individuals in addiction treatment experienced psychosocial stressors more often than those not in treatment. The treatment group used problem-focused coping methods less often and used emotion-focused coping more often. Hassanbeigi et al. concluded that those who seek treatment from SUD experience greater levels of stress associated with life events and tend to employ emotion-focused coping processes rather than problem-focused coping processes to manage their stress from these events. Wagner et al. (1999) found that in adolescence, emotion-focused coping was more often used by those who had the greatest substance misuse. DeLongis et al. (1988) studied the impact of daily stress on health and mood and found that those with less social support and lower self-esteem were more likely to experience increased psychological and somatic symptoms at the time of and following stressful events than those with high self-esteem and social support. These findings indicated that those with low psychosocial resources were at risk of mood disturbances when their stress levels increased, even if they generally have little stress in their lives.

My study benefited from Lazarus and Folkman's Modified theoretical model of the coping process (1977) in that coping strategies within the addictions population is

more often associated with strategies that are not as effective at resolving stress and thus CPRSs may be more vulnerable to emotions that result in stress. This could result in CPRSs experiencing a negative impact upon their personal recovery, such as stress within the work environment. Lazarus and Folkman's Modified theoretical model of coping (1984) identifies program-focused and emotion-focused coping, which will be useful in addressing my research questions on the relationship between stress and coping. The selected theory related to this study because stress and coping are the focus of this study. The instrument designed by Lazarus and Folkman (1984) to measure stress and coping can identify the type of coping (e.g., problem-focused, or emotion-focused) as well as the types of daily stressors that are experienced and identify work environment stressors with which the individual copes.

Literature Review Related to Key Variables and/or Concepts

Coping

Coping has been studied and described according to two main theoretical approaches: coping based on animal behavior modeling and coping based on psychoanalytic ego psychology (Lazarus & Folkman, 1984). Animal behavior modeling theories describe coping as behavior that is focused on controlling the environment to reduce psychophysiological disturbance. Passive and active coping fall into this category, with the coping acts or behavior focused on reducing sympathetic nervous system responses. The psychoanalytic ego psychology coping theories define coping as a cognitive process that includes behavior and focuses on the individual's perception of their relationship with their environment (Lazarus & Folkman, 1984).

Pfeiffer et al. (2019) found that the new roles for CPRSs require strong and effective crisis management coping skills. To address concerns that the proximity to suicidal patients could create harmful stress for the peer support specialists, the researchers established a safety net for the peer support specialists by providing an in-depth training and ongoing supervision program for the PSS that included weekly group supervision. Using this safety net approach, the researchers found there were no significant negative impacts on PSS. However, Chapman et al. (2018) reported that while CPRS training programs in the four states surveyed included information on the need for peer supervision, interviews with human resource officials found that hiring officials believe that CPRS do not require any additional accommodation than any other employee.

Ahmed et al. (2013) found that the length of personal recovery for a CPRS was associated with different coping skills. CPRSs with less time in personal recovery than other CPRSs had lower scores for social engagement, interpersonal communication, and stigma resistance, and higher scores for social withdrawal. Additionally, CPRSs with less personal recovery time used less effective coping skills such as denial, disengagement, and substance use to cope. Conversely, CPRSs with more time in personal recovery tend to use more effective coping processes such as humor, positive reframing, seeking support, planning, and other problem-focused coping processes. No follow-up studies were found in the literature review. Further, no other studies on stress and coping among SUD Certified Peer Recovery Specialists based on the number of years in personal recovery or employed in the CPRS role were found in the literature.

Firmin et al. (2019) found that 38.3% of CPRSs regularly experienced microaggression. Microaggression is defined as a variety of behaviors resulting from stigma or discrimination, or prejudice (Sue, 2010) which were reported to be negative communication about mental health or the peer support specialist role. The researchers asked respondents to identify how these events made them feel and the types of coping skills they used to respond to microaggressions and found the events created a wide range of negative emotions such as depression, anger, or lack of sense of worth. Participants reported coping with the negative emotions by seeking social support from other peer support specialists or their social networks, professionals such as a therapist, mindfulness practices, or becoming defensive and withdrawn. Others stated microaggression created a hostile work environment and chose to leave their jobs. Firmin et al. (2019) did not indicate if differences in CPRSs coping processes were correlated with time in personal recovery or employment length in the CPRS role. No other studies were found during the literature review on the correlation of time in personal recovery and stress and coping among CPRSs.

Stress

While much of the literature focused on the roles of CPRSs, the types of services they provided, and the benefit to health outcomes their services provided, there are antidotal findings that indicated stress and work-related coping challenges among CPRS. Studies have also reported that CPRSs experience burnout, ambiguity, and role conflict, staff with no training or knowledge of the CPRS role, and pressure to perform or lead. Several studies report on CPRSs job satisfaction. Mowbray et al. (2021) found CPRSs

tend to be satisfied with role clarity and their relationships with professionals and peers. However, the study used convenience sample and roughly 50% of the items on the job satisfaction scale were omitted, thus the psychometrics of the tool are unknown and validity of the findings unclear. Park et al., (2016) found that over time, CPRSs with higher perceptions of self-efficacy in coping and problem-solving skills felt the greatest degree of burnout. Similarly, Gagne et al., (2018) found that peer workers employed in more traditional treatment models experience friction with the integration of their roles. However, these studies did not analyze the amount of time it takes for the CPRS to improve coping processes or experience burnout.

CPRSs collaborate with team members who are not always trained in the CPRS role. Lapidos et al., (2018) found only 42% of the respondents said nonpeer staff had received education or training on the role of a CPRS. Similarly, Jenkins et al. (2020) found that some CPRSs felt fast-tracked into a leadership role they were not ready for due to their own personal recovery needs. Additionally, these CPRSs experienced a loss of social support from their peers when they moved into a leadership role, needed to have difficult conversations with a peer, or when providing constructive criticism with previous peers to be stressful, especially when providing supervision for previous peers during times the peer periodically used drugs to cope. CPRSs in leadership positions also experienced stress when addressing stigma within the workplace.

Recovery

Studies have reported on a variety of job-related factors that can negatively impact CPRSs personal recovery. Bailie and Tickle (2014) found that being a peer

support worker can impact the worker's recovery in both positive and negative ways but did not include an analysis of the number of years employed as a CPRS or the number of years of personal recovery for the study participants. Bassuk et al. (2016) conducted a systematic review of the SUD CPRS literature and found only one mention of the impact of the CPRS role upon the worker, with the finding that CPRSs felt the role helped them in their own recovery but did not include an analysis of the number of years employed as a CPRS or the number of years of personal recovery for the study participants. Chapman et al. (2018) conducted a study of the first 4 US states to implement a peer recovery support services to identify best practices and found that barriers with acceptance of the role and stigma remains a workplace issue, and that individual or group supervision is part of the employment model in all these 4 states but did not include an analysis of the number of years employed as a CPRS or the number of years of personal recovery for the study participants. Similarly, Jones et al. (2019) reported a case study of a peer specialist employed in the mental health community and reported on the stigma experienced by the peer specialist.

Forchuk et al. (2020) found that while peer support workers stated that their role provided them with support that helped in their own recovery, peer workers also found that health care professionals misunderstood their role and belittled peer support workers. Peer workers also reported experiencing stigma within the work environment, at times felt frightened by patient behavior within the group meetings they were expected to be involved with and reported fear of being triggered by patient behavior. Similarly, in a study of peer workers employed in harm reduction programs Wilson et al. (2018) found

CPRSs that used the same harm reduction services provided to their clients for their own personal recovery reported internal emotional conflicts about this behavior and reported they thought their clients were not aware that the CPRS themselves experienced a "bad day." This internal conflict resulted in peer workers being reluctant to discuss their use of harm reduction services with their supervisor and then felt they could not ask for help from their supervisor when they needed help in the maintenance of their own personal recovery.

Peer workers also reported being triggered at times with their clients as clients were talking about their use of drugs (Wilson et al., 2018, p. 363). Wilson et al.'s (2018) study did not include an analysis of the number of years employed as a CPRS or the number of years of personal recovery for the study participants Similarly, Forchuk et al. (2020) found that peer workers were fearful of being triggered to use drugs but did not include an analysis of the number of years employed as a CPRS or the number of years of personal recovery for the study participants. Eddie et al. (2019) found that CPRSs confronted boundary issues in their role but did not include an analysis of the number of years employed as a CPRS or the number of years of personal recovery for the study Even though there have been several studies to examine the CPRS role, there is a dearth of information on the relationship between stress and coping among SUD CPRS based on the number of years in personal recovery and the number of years employed as a CPRS.

Summary and Conclusions

Findings from the literature indicated that CPRS work in stressful environments and that strong crisis management coping skills are essential for the CPRS. Current

training for the role does not include coping skills building. Further, the CPRS may be at risk of feeling stronger or more negative emotion when appraising an event than those who have not misused drugs, potentially leading to more situations being appraised as stressful than non-CPRS staff. This may result in a negative impact on the CPRS's recovery. The negative impact may trigger or cause the CPRS to misuse drugs to cope which could lead to relapse. Stress and coping within this population have not been adequately studied. Moreover, my literature review indicated the job of a CPRS may negatively impact the CPRS's personal recovery. There is a gap in the literature on coping with stress and coping effectiveness within the SUD CPRS population. This study can provide insight into the stress experience and coping processes utilized by CPRSs to cope with that stress related to time in personal time in recovery and the CPRS role.

In Chapter 3, I discuss quantitative study design, methods, and measurement instruments.

Chapter 3: Research Method

The purposes of this quantitative study were to determine whether there is (a) a relationship in stress and coping effectiveness among CPRSs, (b) a difference in level of stress and coping among SUD CPRS with 5 or more years in personal recovery and SUD CPRSs with less than 5 years in personal recovery, and (c) a difference in the level of stress and coping among SUD CPRSs with 5 or more years of employment as a SUD CPRS compared to SUD CPRSs with less than 5 years of employment.. In Chapter 3, I present the study design and rationale, methodology, threats to validity, and ethical procedures.

Research Design and Rationale

Study variables included stress level, coping, years in personal recovery, and length of employment as an SUD CPRS. Two survey instruments were used: the Ways of Coping Questionnaire (Folkman & Lazarus, 1988b) and the Work Stress Scale (Steinisch et al., 2013). I analyzed Research Question 1 using linear regression and Research Question 2 using MANOVA methods. Research Question 3 could not be statistically analyzed as a result of a design error in the demographic survey that did not collect employment years data.

Time constraints with this study design include recruitment time. There were no identified resource constraints. The design was consistent with standard research designs and data were evaluated through SPSS, which is a widely trusted statistical software platform (Frankfort-Nachmias & Leon-Guerrero, 2018).

Methodology

Target Population

The target population was CPRSs within the SUD population. Based on a power analysis, the population size for the study was 158 CPRSs.

Sampling and Sampling Procedures

I used a convenience sampling method to obtain a sample of the target population. Convenience sampling is a nonrandom method commonly used in exploratory research. A convenience sample is often used with non-probabilistic methods and is selected based on the ease of access to participants. I used professional associations that provide mailing, email access, and social media posting sites to CPRSs to distribute the research study announcement, recruitment, and data surveys. I contacted more than 78 organizations across the United States that supported social media platforms that could share my recruitment flyer on their sites. The sample was drawn from completed surveys until the study size required is reached.

Inclusion criteria were: (a) currently/volunteering or within the past year employed or volunteered as a CPRS and (b) having a role of CPRS employment or volunteer that includes the SUD population. Exclusion criteria were (a) not ever employed/volunteered as a CPRS.

Procedures for Recruitment, Participation, and Data Collection

Participants were recruited by email and social media sites. I sent each association an email with the recruitment flyer, requesting the association to send an email to their mailing list and/or post to their social media platform. Participants were able to access the

surveys through a link provided within the recruitment flyer. Participants were also recruited through emails I sent to employers of CPRS, and state based CPRS professional organizations. I enclosed a recruitment flyer with the email, and interested employees were able to respond to the survey anonymously.

The recruitment flyer contained information about my study and a link to the survey via Mind Garden. The link in the recruitment flyer took the individual to the two screening questions which were "1) Are you currently or in the past year volunteering or working as a CPRS?" and "2) Does your role as a CPRS include the substance use disorder population?"

If the individual answered "yes" to both questions, then the next screen advanced to the consent form. If the individual answered "no" to either of the screening questions, the individual was thanked for their time and the screen closed. If individuals decided to participate, there was an informed electronic statement outlining the intent of the study minimizing risk to the participant and ensuring anonymity. If the individual signed the consent form, the screen advanced to the demographic information. After the demographic information (see Appendix A) was completed, the participant would begin the Ways of Coping Questionnaire (Folkman & Lazarus, 1988b), a 66-item instrument scored using a 4-point Likert scale. After completing the Ways of Coping Questionnaire, participants then began the Work Stress Scale (Steinisch et al., 2013), a 12-item instrument scored using a 4-point Likert scale to elicit positive or negative reactions to the statements. The maximum estimated time to complete all 78 items is 20 minutes.

Data were collected anonymously through the online platform Mind Garden (https://www.mindgarden.com). I used the feature that de-links the participants' information from the data, and all responses were anonymous. Data is stored electronically on a secured external device and secure cloud storage. Data is stored on a thumb drive (SanDisk) and external hard drive (Western Digital), to which only I have access. All data storage is password protected. All raw data collected will remain in my possession and will be maintained for 5 years as required by the Walden Institutional Review Board (IRB). No monetary or similar form of compensation was offered.

Instrumentation and Operationalization of Constructs

I administered the Ways of Coping Questionnaire (Folkman & Lazarus, 1988b) and the Work Stress Scale (Steinisch et al., 2013) to CPRSs. I obtained a site license from Mind Garden to use the Ways of Coping Questionnaire (Folkman & Lazarus, 1988b), which was designed to identify the thinking process and steps taken to cope with a specific event. The Ways of Coping Questionnaire contains 66 items using a 4-point Likert scale and has been used widely to measure coping. Folkman and Lazarus (1988b) stated that traditional test–retest measures of reliability and validity are inappropriate for this questionnaire and recommended internal consistency be used to evaluate the reliability and validity. The Ways of Coping Questionnaire has been used in a wide variety of research studies related to stress and coping. Kato (2015) conducted a meta-analysis of frequently used coping scales and found that the Ways of Coping Questionnaire was the second most frequently used scale to measure coping.

The Work Stress Scale (Steinisch et al., 2013) is a 15-item scale and was developed to measure work stress and health outcomes and includes questions related to work-related demands, work-related values, and interpersonal resources. The potential factor-specific sum scores ranged from 4 to 8 for work-related demands, from 5 to 10 for interpersonal resources, and from 3 to 6 for work-related values. The Cronbach's alpha coefficients for these three factors ranged from 0.42 to 0.59. Express permission to use the scale was granted by the authors for education and research purposes.

Operationalization of Concepts

I studied the concept of coping and recovery among the CPRS population. Coping is defined as constantly changing cognitive and behavioral efforts to manage specific external and internal demands that are appraised as taxing or exceeding the resources of the person (Lazarus & Folkman, 1984). Coping was measured by the Ways of Coping Questionnaire. The participants were asked to recall a stressful work event from the past week and answer a series of questions based upon their recall of how they chose to manage the stress of that event. *Recovery* is defined as a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential (SAMHSA, 2018). The Work Stress Scale (Steinisch et al., 2013) was used to measure work related stress and participants were asked to respond to statements regarding work and items that impacted their stress level or coping.

Data Analysis Plan

I analyzed data using SPSS (Version 28). I cleaned the data removing duplicates and any unrelated information and converted them to .sav files and uploaded them into SPSS for analysis. The research questions and hypotheses were as follows:

- Research Question 1: What is the relationship between the level of stress and coping among SUD CPRSs?

  $H0_1$ - There is no relationship between the level of stress and coping among SUD CPRSs.

  HA_1 - There is a relationship between the level of stress and coping among SUD CPRSs.

- Research Question 2: What is the difference in level of stress and coping between SUD CPRSs with 5 or more years in personal recovery and SUD CPRSs with less than 5 years in personal recovery?

  $H0_2$ - There is no difference in level of stress and coping among SUD CPRSs with 5 or more years in personal recovery and SUD CPRSs with less than 5 years in personal recovery.

  HA_2 - There is a difference in level of stress and coping among SUD CPRSs with 5 or more years in personal recovery and SUD CPRSs with less than 5 years in personal recovery.

- Research Question 3: What is the difference in the level of stress and coping among SUD CPRSs with 5 or more years of employment as a SUD CPRS compared to SUD CPRSs with less than 5 years of employment ?

$H0_3$ - There is no difference in the level of stress and coping among SUD CPRS with 5 or more years of employment as a SUD CPRS compared to SUD CPRS with less than 5 years of employment .

HA_3 - There is a difference in the level of stress and coping among SUD CPRS with 5 or more years of employment as a SUD CPRS compared to SUD CPRS with less than 5 years of employment .

I conducted a power analysis for each research question and revealed the following:

- Research Question 1: Using multiple regression and conducting a power analysis at with an error or probability of 0.05, effect size of 0.15, and power of 0.8 and one predictor variable resulted in a sample size of 55.
- Research Question 2: Using MANOVA and conducting a power analysis at with an error or probability of 0.05, effect size of 0.0625, and power of 0.8, two groups, and two response variables resulted in a sample size of 158.
- Research Questions 3: Using MANOVA and conducting a power analysis at with an error or probability of 0.05, effect size of 0.0625, and power of 0.8, two groups, and two response variables, resulted in a sample size of 158.

Threats to Validity

While participants may have had different experiences with substance use and recovery, this is not likely to be a threat to validity as the research questions are focused on coping. Maturation could be a threat to validity as participants have had varying lengths of time in recovery and within the role of a CPRS. I addressed these threats to

validity through the demographic information which asked participants to identify their length of time in the role of a CPRS. Further, the Work Stress Scale (Steinisch et al., 2013) has been included as a survey to measure the participant's job-related stress. Testing was not a threat as participants are tested only one time and not repeatedly. Survey measures were used once for each participant and did not vary between participants; therefore, instrumentation was not an internal threat to validity. Participants were eligible for the study based upon their type of employment, and they were tested once which prevents a statistical regression. The study was not impacted by attrition as this was not an intervention study and participants were surveyed only once; therefore, experimental mortality was not an internal threat to validity. There was no selection-maturation threat. Surveys were administered to the open population of CPRSs regardless of age, gender, ethnic background, and educational status. Participants were asked to complete a brief biographical survey to obtain these demographics to help reduce this threat. Another external threat is lack of understanding on the participant's part regarding survey instructions and procedures. I provided the same instructions to all participants.

Limitations

A limitation of my study was test taker fatigue. To attempt to avoid test taker fatigue, I asked participants to answer only two measures in the questionnaire. Another internal threat included the participants accurate recall of a stressful situation. To minimize this limitation, I limited the selection of an event to recall to the past week. An additional limitation was sample size. Therefore, I recruited within several professional associations that are known to have a national or statewide membership.

Ethical Procedures

I obtained Walden University IRB approval (No. 11-04-22-0053140) prior to the recruitment of any study participants. No individuals were interviewed in this study, all data were collected anonymously via online surveys accessible through a provided link to Mind Garden. Participation in this study was voluntary, and no identifying information was obtained from data collected. Recruitment materials included an introduction and a recruitment flyer. Interested individuals were able to access the study materials via a link provided in the recruitment flyer. The study was based upon the participant completing two surveys with no repeat surveys and no follow-up, so no contact information was obtained for any participant.

I recruited participants online or through email via professional associations, social media sites, and professional networking sites. I attached a recruitment flyer to announcements that described the purpose of the study and that provided a link to Mind Garden where participants anonymously completed a demographic survey, the Ways of Coping Questionnaire, and the Work Stress Scale. Materials used to recruit participants did not collect any personal information. Participant responses will not be shared.

All data werestored on devices that I own and are not accessible by anyone else. I will not share data with anyone, and all data will be maintained in a password-protected off-line file. Any printouts or paper files of the data are maintained in a locked file cabinet to which I only have a key for a period of 5 years, and then destroyed. My completed dissertation does not contain the names of any participants or refer to them in

any identifiable way. I have received no financial reimbursement or payments of any type related to this study and declare that I have no conflicts of interest.

Summary

In this chapter, I have outlined the research design and rationale. Study methodology, including the target population, sampling procedures, recruitment and data collection procedures were described. Operationalization for the variables coping and stress were described. Data handling and ethical procedures were presented. In Chapter 4, I will present the findings of the study.

Chapter 4: Results

Introduction

The purpose of this quantitative study was to determine whether there is (a) a relationship in stress and coping effectiveness among SUD CPRSs, (b) a difference in the level of stress and coping between SUD CPRSs with 5 or more years in personal recovery and SUD CPRSs with less than 5 years in personal recovery, and (c) a difference in the level of stress and coping among SUD CPRS with 5 or more years employment as a SUD CPRS with less than 5 years of employment. Chapter 4 presents the evidence to address the following research questions and test the associated hypotheses:

Research Question 1: What is the relationship in the level of stress and coping among SUD CPRSs?

$H0_1$ - There is no relationship between the level of stress and coping among SUD CPRSs.

HA_1 - There is a relationship in the level of stress and coping among SUD CPRSs.

Research Question 2: What is the difference in level of stress and coping among SUD CPRSs with 5 or more years in personal recovery and SUD CPRSs with less than 5 years in personal recovery?

$H0_2$ - There is no difference between the levels of stress and coping among SUD CPRSs with 5 or more years in personal recovery and SUD CPRSs with less than 5 years in personal recovery.

*H*A$_2$ - There is a difference between the levels of stress and coping among SUD CPRSs with 5 or more years in personal recovery and SUD CPRSs with less than 5 years in personal recovery.

Research Question 3: What is the difference in the level of stress and coping among SUD CPRSs with 5 or more years of employment as a SUD CPRS compared to SUD CPRSs with less than 5 years of employment ?

*H*0$_3$ - There is no difference in the level of stress and coping among SUD CPRSs with 5 or more years of employment as a SUD CPRS compared to SUD CPRSs with less than 5 years of employment.

*H*A$_3$ - There is a difference in the level of stress and coping among SUD CPRSs with 5 or more years of employment as a SUD CPRS compared to SUD CPRSs with less than 5 years of employment.

In Chapter 4, I describe the data collection process and present the results of the statistical analysis of the data, including the demographic characteristics of the respondents, the testing of underlying assumptions, the descriptive statistics for the Ways of Coping Questionnaire and the Work Stress Scale and the testing of the hypotheses.

Data Collection

I collected data for 9 weeks from organizations across the United States with social media platforms that supported CPRS. The target population consisted of CPRSs within the United States. More than 24,000 CPRSs are employed across the United States (University of Chicago, 2021). A total of 76 organizations were contacted and asked to post the recruitment flyer on their social media platform. One agency that had provided a

preliminary agreement to distribute the recruitment flyer was planned as a recruitment site in the data collection plan but did not participate in recruitment, so I sought additional organizations with social media platforms to recruit participants. I screened and cleaned the response data collected from the two questionnaires in a cross-sectional survey prior to conducting the statistical analysis. The total number of respondents in the convenience sample was $N = 141$; however, a few ($n = 13$, 9.2%) of the respondents did not complete all of the items in the questionnaires. After excluding the missing values, the total number of respondents in the convenience sample was $N = 128$.

Results

Demographics

Table 1 summarizes the demographic characteristics of the convenience sample of SUD CPRSs. Most of the participants ($n = 98$, 76.6%) were female. Over half of the participants ($n = 63$, 55.5%) were between the ages of 35 and 54, five were 65 or older, and one was less than 25. More than two thirds of the participants ($n = 95$, 74.2%) had greater than 5 years of personal recovery and more than two thirds of the respondents ($n = 89$, 69.5%) spent 75% to 100% of their time working with SUD clients.

Table 1

Demographic Characteristics of Sample (N = 128)

Categories	*n*	%
Gender		
Male	30	23.4
Female	98	76.6
Age (Years)		
18 to 24	1	0.8
25 to 34	19	14.8
35 to 44	40	31.3
45 to 54	31	24.2
55 to 64	32	25.0
≥ 65	5	3.9
Greater than 5 years personal recovery		
No	33	25.8
Yes	95	74.2
Working with substance disorder clients		
75% to 100%	89	69.5
50% to 74%	26	20.3
25% to 49%	7	7.5
1% to 24%	6	4.7
Never	0	0.0

Testing of Assumptions

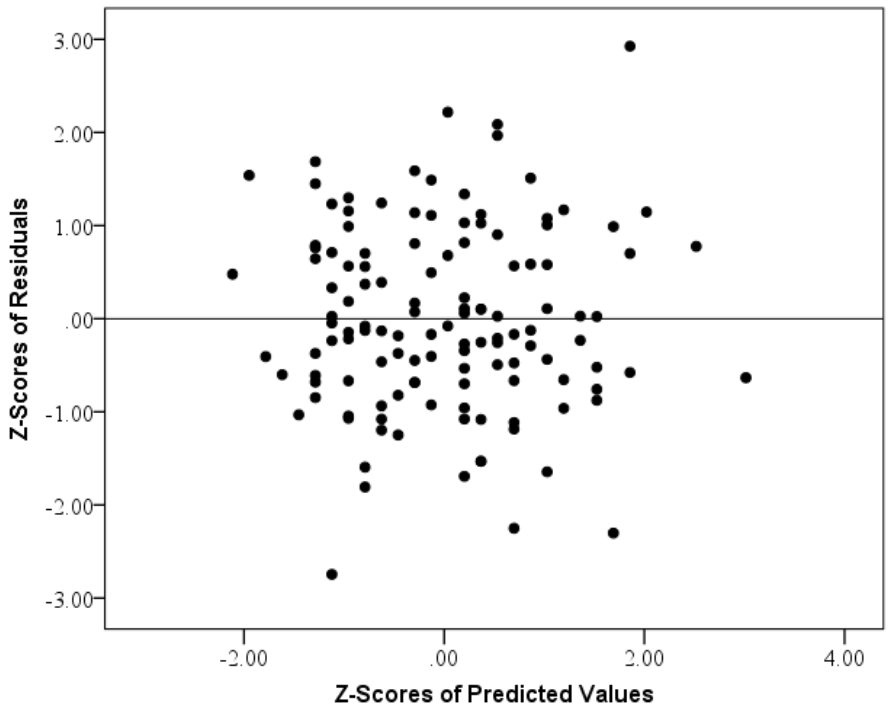
I tested the assumptions of regression analysis and MANOVA. The continuous level variables in regression analysis and MANOVA should theoretically be normally distributed (Creswell & Creswell, 2018). The Shapiro Wilk (S-W) test indicated that the scores for the Ways of Coping Questionnaire were normally distributed; SW (128) = .99, p = .765. The distribution of the scores for the Work Stress Scale were also normally distributed; SW (128) = .98, p = .054.

The residuals (i.e., the differences between the predicted and observed values) should theoretically be normally distributed and contain no outliers (i.e., the maximum Z-

scores of the residuals should ideally be within the expected normal limits of ± 4 standard deviations either size of their mean (zero) value (Creswell & Creswell, 2018). Moreover, the residuals should be homogenous (i.e., randomly distributed either side of their mean (zero) value, with no systematic geometric patterns, such as a line or a triangle (Creswell & Creswell, 2018). The scatterplot in Figure 2 indicates that the assumptions concerning the distributions of the residuals were not violated. No outliers were present, because the maximum Z-score among the standardized residuals was 3.01, and the maximum Z-score among the standardized predicted values was 2.92.

Figure 2

Scatterplot of Standardized Residuals



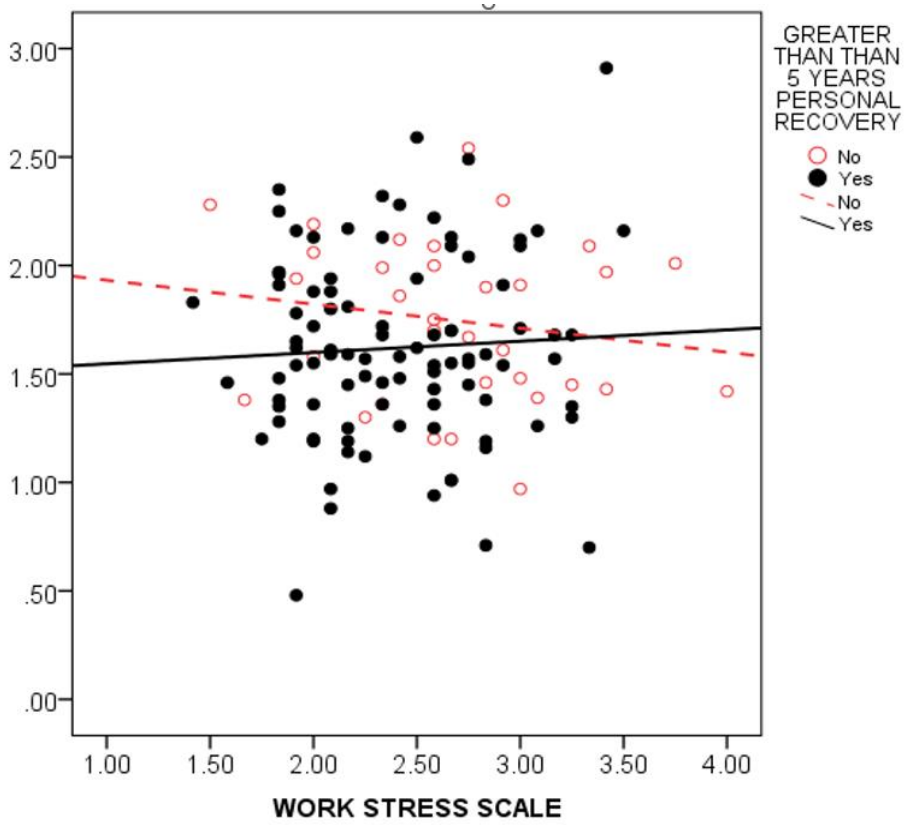
Both regression analysis and ANOVA assumed that the continuous level variables were reliably measured. The internal consistency reliability of the 66 items in the Ways

of Coping Questionnaire was very good (Cronbach's alpha = .91; Folkman & Lazarus, 1988b). The internal consistency reliability of the 12 items in the Work Stress Scale was adequate (Cronbach's alpha = .77; Steinisch et al., 2013).

Both regression analysis and MANOVA assumed that the Work Stress Scale and the Ways of Coping Questionnaire should be linearly related to each other (Creswell & Creswell, 2018). Figure 3 displays a scatterplot fitted with two linear regression lines. One line applies to the SUD CPRS with 5 or more years in personal recovery (n = 95). The other line applies to the SUD CPRS with less than 5 years in personal recovery (n = 33).

Figure 3

Relationship Between Work Stress Scale and Ways of Coping Questionnaire



Visual examination of the scatter of points either side of the almost horizontal linear regression lines in Figure 3 indicated that the Work Stress Scale and the Ways of Coping Questionnaire were not linearly related to each other. I calculated the Pearson's correlation coefficients to estimate the strengths of the bivariate associations. The Work Stress Scale was not significantly correlated with the Ways of Coping Questionnaire for the participants with less than 5 years of personal recovery; Pearson's r (31) = - .17, p = .353. The two scales were also not significantly correlated for the participants with 5 or more years of personal recovery: Pearson's r (93) = .06, p = .592). The assumptions of regression analysis and MANOVA were violated in this model Therefore, predictions and inferences made from this model are impacted and must be considered cautiously (Creswell & Creswell, 2018).

The external validity of the results of the statistical analysis was compromised as the survey data were not collected by random sampling. Drawing generalizations about the population, based on the results derived from a convenience sample is not advised (Creswell & Creswell, 2018). Therefore, the results apply only to the 128 respondents in the sample and not to the entire population of about 24,000 CPRS. The use of convenience sampling also violated the underlying theory that the p-values of inferential test statistics can only be meaningfully interpreted if the empirical data are collected by random sampling (Creswell & Creswell, 2018).

Descriptive Statistics

Table 2 presents the descriptive statistics for the Ways of Coping Questionnaire and the Work Stress Scale.

Table 2

Descriptive Statistics for Ways of Coping Questionnaire and Work Stress Scale

Dependent variable	Greater than 5 years personal recovery	*n*	*M*	*SD*	95% confidence interval	
					Lower	Upper
Work Coping Scale	No	33	1.75	0.38	1.60	1.89
	Yes	95	1.62	0.43	1.54	1.71
Work Stress Scale	No	33	2.69	0.57	2.52	2.86
	Yes	95	2.41	0.46	2.31	2.51

The nonoverlapping 95% confidence intervals between the two mean scores indicated that the mean score for Ways of Coping Questionnaire (M = 1.75) was significantly greater at the .05 level among the participants who did not have greater than 5 years personal recovery experience compared to the mean score (M = 1.62) for those who had more than 5 years personal recovery. The nonoverlapping 95% confidence intervals also indicated that the mean score for the Work Stress Scale (M = 2.69) was significantly greater at the .05 level among the participants who did not have greater than 5 years personal recovery experience compared to the mean score (M = 2.41) for those who had more than 5 years personal recovery.

I conducted a quantitative study to determine whether there is (a) a relationship in stress and coping effectiveness among SUD CPRSs; (b) a difference in the level of stress and coping between SUD CPRS with 5 or more years in personal recovery and SUB CPRSs with less than 5 years in personal recovery; and (c) a difference in the level of stress and coping among SUD CPRSs with 5 or more years employment as a SUD CPRS

with less than 5 years of employment. Results from my statistical analysis of these research questions are presented next.

Research Question 1

The results of linear regression analysis in Table 3 address Research Question 1: What is the relationship in the level of stress and coping among SUD CPRS? The unstandardized regression coefficient (b = 0.023) representing the slope of the regression line was not significantly different from zero (t = .31, p = .757). The 95% confidence intervals [-0.124, 0.170] indicated that the lower and upper limits of the regression coefficient in 95 out of 100 samples captured zero. The effect size (R^2 = .001) indicated that 0.1% of the variance in the Ways of Coping Questionnaire was explained by the Work Stress Scale. Therefore, there was no relationship between stress and coping, and the null hypothesis was retained.

Table 3

Linear Regression Model to Predict Ways of Coping

Predictor	Unstandardized coefficients	*t*	*p*	95% confidence interval for *b*	
	b			Lower	Upper
(Constant)	1.595	8.47	<.001	1.22	1.968
Work Stress Scale	0.023	0.31	.757	-0.124	0.170

Research Question 2

I calculated a MANOVA to address Research Question 2: What is the difference in the levels of stress and coping among SUD CPRSs with 5 or more years in personal recovery and SUD CPRSs with less than 5 years in personal recovery? The multivariate

MANOVA test was statistically significant; Wilk's λ (2, 125) = 0.93, p = .009. Therefore, the null hypothesis is rejected. Although the difference between the two groups of SUD CPRS was statistically significant at the .05 level, the effect size (Eta squared = .07) indicated that 7.3% of the variance in the dependent variables was explained by the years in personal recovery of the CPRS. This effect size was 0.04. Therefore, Eta squared = .07 reflected that the results of MANOVA have limited relevance. The difference between the levels of stress and coping among the two groups of SUD CPRS was too small to draw any definitive conclusions or to make any decisions regarding the effects of the years in personal recovery of SUD CPRS.

Table 4

MANOVA Model

Test statistics		Hypothesis *df*	Error *df*	*p*	Eta Squared
Wilks' lambda	0.93	2	125	.009	.07

Research Question 3

My study design included a MANOVA to address research question 3: What is the difference in the level of stress and coping among SUD CPRS with 5 or more years employment as a SUD CPRS with less than 5 years of employment? Reviewing the data, I discovered an omission in the demographic survey had occurred and a question to obtain data from participants regarding their years of employment as a SUD CPRS was omitted from the survey. Therefore, an analysis for this research question and its associated hypotheses was not feasible.

Summary

The convenience sample consisted of SUD CPRS (n = 128) among which the majority of were female. Over half of the participants were between 35 and 54 years old. Over two thirds of the participants had greater than 5 years personal recovery. Over two thirds of the respondents spent 75% to 100% of their time working with SUD clients.

The dependent variables were reliably measured, normally distributed, and contained no outliers. Both regression analysis and MANOVA assume that the Work Stress Scale and the Ways of Coping Questionnaire are linearly related to each other; however, this assumption was violated. The p values of the test statistics were compromised due to non-random sampling.

The mean score for the Ways of Coping Questionnaire (M = 1.75) was significantly greater at the .05 level among the participants who did not have greater than 5 years personal recovery experience compared to the mean score (M = 1.62) for those who had more than 5 years personal recovery. The mean score for the Work Stress Scale (M = 2.69) was significantly greater at the .05 level among the participants who did not have greater than 5 years personal recovery experience compared to the mean score (M = 2.41) for those who had more than 5 years personal recovery.

Linear regression analysis provided statistical evidence to retain the null hypothesis: H01 - There is no relationship in the level of stress and coping among SUD CPRS. There was insufficient statistical evidence at the .05 level to support the alternative hypothesis. The unstandardized regression coefficient (b = 0.023) representing the slope of the regression line was not significantly different from zero (t = .31, p =

.757). Only 0.1% of the variance in the dependent variable was explained by the independent variable.

The MANOVA multivariate statistics provided the evidence to reject the null hypothesis: *H*02 - There is no difference in level of stress and coping among SUD CPRS with 5 or more years in personal recovery and SUD CPRS with less than 5 years in personal recovery. There was sufficient statistical evidence to support the alternative hypothesis: HA2 - There is a difference in level of stress and coping among SUD CPRS with 5 or more years in personal recovery and SUD CPRS with less than 5 years in personal recovery. Although the difference was statistically significant at the .05 level, the effect size indicated that only 7.3% of the variance in the dependent variables was explained by the years in personal recovery of the SUD CPRS. The small effect size implied that the results of MANOVA had limited practical significance.

The MANOVA for Research Question 3 was not able to be conducted due to an error of omission in the demographic survey. A question to collect data from participants regarding their years of employment as a SUD CPRS was omitted resulting in an absence of data to perform the planned MANOVA.

In Chapter 5, I present a discussion and interpretation of the findings, along with conclusions and recommendations.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purposes of this quantitative study were to determine whether there is (a) a relationship in stress and coping effectiveness among CPRSs, (b) a difference in level of stress and coping among SUD CPRS with 5 or more years in personal recovery and SUD CPRSs with less than 5 years in personal recovery, and (c) a difference in the level of stress and coping among SUD CPRSs with 5 or more years of employment as a SUD CPRS compared to SUD CPRSs with less than 5 years of employment. Based upon my review of the literature, there was a gap in the literature related to stress and coping among the SUD CPRS population. The job of a CPRS may negatively impact the CPRS's personal recovery (Chudzicka-Czupala & Zalewska-Lunkiewica, 2020; Firmin, 2019; Park, 2016; Shalaby, 2020; Wilson, 2018), and I conducted this study to provide further information on whether there was a difference in coping with stress and coping effectiveness within the SUD CPRS population based upon personal recovery. Results showed that there is a difference in level of stress and coping among SUD CPRS with 5 or more years in personal recovery and SUD CPRS with less than 5 years in personal recovery, but the effect was small.

Interpretation of the Findings

Ahmed et al. (2013) found that the more years of personal recovery a CPRS has, the greater coping skills they may have to deal with these stressors effectively. My findings confirmed Ahmed et al.'s findings and extended the knowledge by showing that there is a difference in level of stress and coping among SUD CPRSs with 5 or more

years in personal recovery and SUD CPRSs with less than 5 years in personal recovery. However, my results also showed the effect was small and has limited practical significance (Creswell & Creswell, 2018).

Kelly et al. (2018) reported that there are no findings in the literature related to the long-term recovery of CPRSs (e.g., greater than 12 months), and that there is evidence that psychological distress varies among those in recovery, certainly within the first several years of recovery. My findings support Kelly et al. and extended the knowledge by showing that among those SUD CPRSs who completed the study there is a difference in the level of stress and coping for those who have been employed in the role for 5 or more years from those who have been employed in the role less than 5 years.

Wilson et al. (2018) identified an increasing need for the CPRS to continually develop coping skills. Similarly, my study supports these findings by showing that CPRSs with 5 or more years of personal recovery demonstrated a greater difference with stress and coping. Chapman et al. (2018) found that CPRSs can be in any phase of their own recovery, from 18 months to 30 years, thus the coping strategies for a CPRS in the earlier years of their recovery may be different than those with long-term recovery and that the CPRS needs time and resources to maintain their own recovery goals are available. My study findings support Chapman et al.'s recommendations of including time and resources for the CPRS in maintaining their own recovery goals.

Jafari et al. (2010) found that coping skills training during recovery improved relapse and recovery rates, yet coping skills training is not a requirement for treatment programs nor assessed for in the CPRS exam. My results support the findings of Jafari et

al. by showing that those CPRSs with 5 or more years in personal recovery had a difference in stress and coping. Coping skills training during recovery may improve relapse and recovery rates among CPRSs. Shumway et al. (2014) found that coping is a significant characteristic of long-term recovery. Additionally, Almeida et al. (2020) identified employment challenges experienced by CPRSs and found that 100% of the respondents identified self-care as the most important training needed. My study supports these findings by demonstrating a difference in stress and coping among those CPRSs with 5 or more years in personal recovery.

I could not use a MANOVA for Research Question 3 due to an error of omission in the demographic survey. A question to collect data from participants regarding their years of employment as a SUD CPRS was omitted resulting in no data to perform the planned MANOVA; therefore, this question was not addressed, as planned, within this study.

Folkman and Lazarus (1984) defined coping as a complicated process employed by an individual that has as its primary functions regulation of stressful emotions and changing the problem the individual is faced with for the better. Based on Folkman's and Lazarus's theory, how an individual appraises a situation is associated with how the person views the potential for safety or harm and is coupled with the significance the person associates with the event and what the person determines as processes they can employ to manage the event. According to Lazarus and Folkman (1988a) individuals construct meaning through their relationships with what they are interacting with in their environment. The meaning a person gives to a particular situation or event can determine

whether the person finds the event stressful and then appraises the situation. Whether a person construes a situation as a threat to their well-being or one of safety depends upon the confluence of events and meaning the person assigns in any given situation, and these are unique to everyone based upon their past experiences (Lazarus, 1999). Therefore, each situation is unique to the individual, and the appraisal of that unique situation can result in a different emotion or meaning, based on the unique elements of that specific event My findings support Folkman and Lazarus's (1984) transactional model of stress and coping in that those CPRSs with 5 or more years of personal recovery may have learned to view a greater number of transactions with less harm, greater safety, and less significance. As such, CPRSs may construe fewer transactions as lower threats to their well-being.

Lazarus and Folkman (1984) asserted that cognitive appraisal and emotion are conjoined, meaning that the emotional response is always mediated by the cognitive appraisal process, can be created at any point in the cognitive appraisal process, and can impact the coping response and feelings of stress. Therefore, the coping process is highly dependent upon the emotions a person feels during their appraisal and the meanings the person attaches to those emotions. Jafari et al. (2010) found that coping strategies are a key factor in how individuals come to experience addiction and recovery and that stress and the real or perceived lack of internal and external resources to effectively cope with stress often lead to relapse. My findings support Lazarus and Folkman's (1984) Transactional Model of Stress and Coping and the findings of Jafari et al. in that CPRSs with greater years in personal recovery may have developed more skills in emotional

regulation and are therefore able to cognitively a greater number of transactions in a positive way. Further, CPRSs may have had time to increase their success with reframing events and creating successful coping skills.

Limitations of the Study

My study design was a convenience sample, correlational descriptive method that relied upon CPRSs being available to complete the study. This design has the limitation of a sample that is not randomly selected (Creswell & Creswell, 2018). Therefore, the findings cannot be generalized to the general CPRS population and apply only to the respondents completing the study and do not indicate causality, limiting generalizability of the findings. Based on a power analysis, the population size for this study was 158 CPRS which was not met. I estimated that 180 participants would complete the study. The sample size was 128. I projected a 5% return rate, but the actual return rate was less than 1%. The data collection had a time limit, which may be a limiting factor. As any study conducted for dissertation, I allowed time for as many participants to respond as possible.

I used online resources to collect data for the study, which required internet access for individuals to participate. Internet access was a potential barrier as the participant pool was unknown, and I could not assume that all those who would want to participate had the necessary access.

Recommendations

Effective stress and coping strategies are a known factor in successful personal recovery (Jafari et al., 2010; Sudhir, 2018). Stress management and successful coping

strategies must be available to SUD CPRSs (Sudhir, 2018). I recommend that future studies focus on identifying benefits of stress and coping training among SUD CPRS and on the relationship between years of employment as a CPRS and stress and coping are recommended. Finally, I recommend a quasi-experimental design with sufficient sample size including stress and coping training with a control group.

Implications

Stress among CPRSs has been identified within the literature (Chudzicka-Czupala & Zalewska-Lunkiewica, 2020; Firmin et al., 2020; Guenzel, 2021; Park, 2016; Shalaby, 2020; Wilson, 2018). Coping has been identified as a crucial factor in sustaining positive self-care and recovery for CPRSs (Jafari et al., 2010). My study findings have shown that participants demonstrated a difference in stress and coping among those with 5 or more years of personal recovery. The potential impact for positive social change from my study findings at the societal and policy level are that these findings can be used to guide policy for CPRS coping and stress management training, especially for CPRSs in the first few years of their employment.

Conclusion

CPRSs provide services for individuals seeking or enrolled in SUD recovery, provide mentoring and coaching, service and resource connections, lead recovery groups, and help build community through a variety of roles. I conducted a quantitative study to determine whether there is (a) a relationship in stress and coping effectiveness among SUD CPRSs, (b) a difference in the level of stress and coping between SUD CPRSs with 5 or more years in personal recovery and SUD CPRS with less than 5 years in personal

recovery, and (c) a difference in the level of stress and coping among SUD CPRS with 5 or more years employment as an SUD CPRS with less than 5 years of employment. Results from my study demonstrated that there is a difference in stress and coping between CPRSs that have 5 or more years of personal recovery but had a small effect. My findings provide new information that shows there is a difference in stress and coping among CPRSs based upon years in personal recovery. Lazarus and Folkman (1984) stated that coping is a process that is based upon the appraisal process, pointing to the importance of stress and coping training that teaches the process of an appraisal process that results in resolution of the stress. The results of my study further support literature at the individual level that address the need for CPRS training to address known stressors and provide positive coping strategies. Such training should be focused upon strengthening the benefits that CPRSs provide by implementing personal relapse risk reduction services.

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Appendix A: Demographic Survey

1. What is your gender?

   O - Female
   O - Male
   O - Other (Please Specify) _____

2. Which category below includes your age?

   O --18-24
   O --25-34
   O --35-44
   O --45-54
   O --18-24
   O - Other (Please Specify) _____

3. Which of the following categories best describes your employment status?

   O - Employed, working 40 hours or more per week
   O - Employed, working 1-39 hours or more per week
   O - Volunteering, 40 hours or more per week
   O - Volunteering, 1-39 hours per week
   O - Not employed, looking for work
   O - Not employed, NOT looking for work
   O - Retired
   O - Disabled, not able to work

4. Which of the following best describes your job title?

   O - Certified Peer Recovery Specialist
   O - Peer Recovery Specialist
   O - Peer Recovery Support Specialist
   O - Peer Recovery Coach
   O - Peer Specialist
   O - Other (Please Specify) _____

5. Which of the following categories best describes how often you work with substance use disorder clients?

O - 100% to 75% of my time
O - 74% to 50% of my time
O - 59% to 25% of my time
O - 24% to 1% of my time
O - Never

6. Which category best describes your personal recovery years?
    - 1 Year
    - 2 years
    - 3 years
    - 4 years
    - 5 years or more

7. Which of the following categories best describes the education you have completed?

    O - Completed high school or GED
    O - Completed some college courses
    O - Completed an associate degree
    O - Completed a bachelor's degree
    O - Completed a graduate degree

8. Which of the following categories best describes your annual income?

    O - $1 to $9,999
    O - $10,000 to $19,999
    O - $20 to $29,999
    O - $30,000 or more

9. Which of the following categories best describes your race?

    O - Black or African American
    O - White or Caucasian
    O - Hispanic or Latino
    O - Asian or Asian American
    O - American Indian or Alaska Native
    O - Native Hawaiian or other Pacific Islander
    O - More than one race

10. In what state or U.S. territory do you currently work?

O - Answer choices:

- Alabama
- Alaska
- American Samoa
- Arizona
- Arkansas
- California
- Colorado
- Connecticut
- Delaware
- District of Columbia (DC)
- Florida
- Georgia
- Guam
- Hawaii
- Idaho
- Illinois
- Indiana
- Iowa
- Kansas
- Kentucky
- Louisiana
- Maine
- Maryland
- Massachusetts
- Michigan
- Minnesota
- Mississippi
- Missouri
- Montana
- Nebraska
- Nevada
- New Hampshire
- New Jersey
- New Mexico
- New York
- North Carolina
- North Dakota
- Northern Marianas Islands
- Ohio
- Oklahoma
- Oregon
- Pennsylvania
- Puerto Rico

- Rhode Island
- South Carolina
- South Dakota
- Tennessee
- Texas
- Utah
- Vermont
- Virginia
- Virgin Islands
- Washington
- West Virginia
- Wisconsin
- Wyoming

Web link: https://transform.mindgarden.com/survey/40338/5a9

Appendix B: NAADAC Memorandum of Understanding

44 Canal Center Plaza, Suite 301, Alexandria, VA 22314
Ph: 703.741.7686 • 800.548.0497 Fax: 703.741.7698 • 800.377.1136

Memorandum of Understanding

(MOU) for PhD Candidate Surveys

This PhD Candidate Survey Agreement ("Agreement"), made and effective as of _____, between NAADAC, the Association for Addiction Professionals, and _____("PhD candidate") outlines the below terms and conditions for the distribution of a PhD dissertation-related survey to NAADAC's membership and/or constituents.

Service: NAADAC agrees to send two emails out to either its whole member list or a clearly defined and segmented portion of its email list containing information about the survey (submitted by the PhD candidate) and a link to an online survey (provided by the PhD candidate).

Eligibility: In order to partake in this service by NAADAC, PhD candidate must:

1. Be a current NAADAC member in good standing;
2. Be enrolled in an accredited doctoral program.
3. Obtain approval of dissertation and survey from candidate's University Institutional Review Board.
4. Demonstrate how their academic research is relevant to NAADAC's mission.
5. Agree to share study's results with NAADAC within a timely manner for

NAADAC's use (appropriate credit will be given to the researcher); and

6. Agree to write an article about the survey results and submit to NAADAC for possible publication in *Advances in Addiction & Recovery*.

Payment: PhD candidate shall pay NAADAC a non-refundable $500 service fee to cover NAADAC staff time in the administration of the survey.

Requirements & Procedures:

1. PhD candidate must submit a formal written request to NAADAC with the following items:
    a. Signed Memorandum of Understanding (MOU) for PhD Surveys;
    b. A current resume/curriculum vitae;
    c. A letter addressed to the NAADAC Executive Director from Department Chair on College/University letterhead, evidencing PhD candidate's current enrollment in an accredited doctoral program;
    d. Copy of study's approval by the PhD candidate's College/University Institutional Review Board;
    e. A proposal, no more than five pages, outlining: (1) the purpose of the study; (2) the research questions/hypotheses; (3) explanation as to how research is relevant to NAADAC's Mission; (4) the text of the email to be distributed to NAADAC members and/or constituents; (5) hyperlink to online survey; (6) proposed distribution plan; and (7) intended outcomes.
    f. A copy of the online survey to be administered (in PDF or other format); and
    g. Payment of $500. Payments may be made by check or by credit card.
2. The text of the survey must comply with NAADAC's required terminology, including refraining from using terminology that perpetuates the negative stigmas surrounding those with substance use disorders or living in recovery. Examples of such terminology include but are not limited to:
    - Instead of "addict," use "person with a substance use disorder"
    - Instead of "addicted to X," use "has an X use disorder," "has a serious X use disorder," or "has a substance use disorder involving X" (if more than one substance is involved)
    - Instead of "alcoholic," use "person with an alcohol use disorder"
    - Instead of "drug/substance abuse," use "substance use disorder"
    - Instead of "former addict," use "person in recovery" or "person in long-term recovery"

3. NAADAC staff will review all proposals for appropriate content and distribution plans.
4. Upon approval, NAADAC will contact PhD candidate to agree on any suggested or necessary changes, and proposed distribution and data collection procedures, including:
    a. Member/constituent group(s) survey should be distributed to;
    b. Date and time of distribution;
    c. Due date for survey results back to NAADAC; and
    d. Due date for article on survey results.
5. NAADAC will send survey out to agreed member/constituent group(s) at agreed date and time.
6. PhD candidate will send survey results back to NAADAC within three months of the second email dissemination or by an agreed upon date.
7. PhD candidate will provide an article about the survey results to NAADAC for possible publication in *Advances in Addiction & Recovery* within three months of the second email dissemination or by an agreed upon date. The article must comply with NAADAC's publication guidelines, which can be found at http://www.naadac.org/advancesinaddictionrecovery#Publication_Guidelines. NAADAC reserves the right to amend these guidelines without written notice to PhD candidate.

NAADAC does not guarantee a certain number of survey participants or certain kind of data.

_____

NAADAC Executive Director Signature Date

_____

PhD Candidate Signature Date