SELF-CARE PRACTICES OF FEMALE PEER SUPPORT SPECIALISTS WITH CO-OCCURRING MOOD AND SUBSTANCE USE DISORDERS

by

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DEDICATION

To my mother, Donna M. Olen, and My father- my angel, Michael D. Wohlert, thank you for your unconditional love, instilling in me the value of education, and never expecting anything less than “my best.”

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ABSTRACT

The purpose of this study was to better understand the self-care practices of female peer support specialists (PSS) with co-occurring mood and substance use disorders. The researcher took a qualitative grounded theory approach conducting in-depth semi-structured interviews with ten women employed at peer-run agencies in Maricopa County, Arizona. Data from these interviews were transcribed, then analyzed manually, as well as with NVivo 10.0 software, to identify the key terms, nodes, categories and emergent themes of the participants' experiences. Self-care practices of peer support specialists included accessing personal and professional support networks; maintaining a daily routine to balance the demands of recovery, parenting, and working; taking medications; sleeping; practicing spirituality; participating in service work; eating nutritiously; exercising, and building a sense of coherence. Although a variety of practices were being used and identified as helpful, spirituality was identified as the most important self-care practice to achieve overall wellness. Employment improved the ability for PSSs to practice self-care because they valued the support of their supervisors and coworkers, were reminded of the consequences of not practicing self-care by working with individuals who were unstable, gained knowledge from teaching others, found healing in telling their stories, and reported higher self-esteems from working and helping others. However, participants did identify ways that employment as a PSS could interfere with practicing self-care, such as staff turnover, limited access to supervisors, or being unprepared to work in the field. Several recommendations were suggested as a result of this study, such as the importance of understanding and using effective self-care practices, building personal and professional support networks, and establishing daily routines to balance recovery with personal and professional demands.

CHAPTER ONE: INTRODUCTION

Peer Support Specialists (PSS) have been employed individuals who have worked in professional mental health positions but who also have acknowledged and disclosed they have been in recovery or have been diagnosed with a mental illness and alcohol or drug addiction. Over the past 10 years peer support programs have gained international attention as an adjunct to more traditional mental health and substance use treatment (Galandter, 2000; Trainor, Shepaherd, Boydell, Leff, & Crawford, 1997). Peer support services have been considered a best practice with consistent positive empirical findings for both consumers and peer support specialists (Salzer & MHASP Best Practices Team, 2002). For consumers, peer support programs have had promising outcomes for significantly reducing re-hospitalizations, developing natural supports, and enhancing rehabilitation environments (Landers & Zhou, 2011). In addition, Hodges (2006) reported that individuals who participated in peer support groups were more aware of services and used a greater number of services overall compared to consumers who have not received peer support services. As a result, mental health consumers who have received support from peer support specialists were found to have more timely and appropriate use of crisis services and manifestation of better symptom management, including reduced risk of alcohol or drug relapse.

Specifically, PSSs have provided highly effective and credible services for consumers who have had co-occurring mood and substance use disorders (Mead, Hilton, & Curtis, 2012; Davidson, Chinman, Sells, & Rowe, 1999; Deegan, 1993; Salazar, 2002; Stoneking & McGuffin, 2007). Comorbidity of mood disorders with substance use disorders in the United States has been substantial according to the National Epidemiologic Survey on Alcoholism and Related Conditions (2006). Twenty percent of all persons with current substance use disorders have also

been concurrently diagnosed with at least one mood disorder (Merikangas, et. al., 2007). Co-occurring substance use combined with Major Depressive Disorders was estimated to be as high as 47 % of U.S. adults. Over 61% of individuals living with bipolar disorders also have been diagnosed with substance use disorders and females were at a much greater risk for having co-occurring mood and substance use disorders than males (National Epidemiologic Survey on Alcoholism and Related Conditions, 2005).

The focus of this study was on the self-care practices of female peer support specialists who have been diagnosed with co-occurring mood and substance use disorders, because researchers reported significant associations between gender and co-occurring disorders (Campbell, et al., 2003; & Rounsaville, Dolinsky, Babor, & Meyer, 1987). Hirschfeld, et al., 2003 reported that women with bipolar disorder had a higher risk for alcoholism than men with bipolar disorder. Findings were similar for women diagnosed with Major Depressive Disorder who also had a higher risk for alcoholism than men with Major Depressive Disorder (Covington, 2008). On the other hand, Compton (2003) found that women who received inpatient treatment or long-term outpatient treatment for co-occurring mood and substance use disorders had more positive outcomes than alcohol or drug dependent males with mood disorders. In addition, St. George (2004) reported that women have had better long-term treatment outcomes and were more likely to become peer support specialists. Women who have become peer support specialists and have had co-occurring mood and substance use disorders has been so prevalent that exploration of the benefits and consequences of this type of work has been needed. More specifically, to ensure long-term personal and professional stability understanding the practices that females with self-reported mood and substance use disorders, have been using to maintain their overall wellness could be crucial.

For peer support specialists, the transition from consumer to professional could be therapeutic in itself (Bledsoe, 2008; Davidson, Chinman, Kloos, Weingarten, & Stayner, 1999; Deegan, 1992). Benefits of being a PSS have included (a) increased competence as a result of making an impact on another person's life; (b) a sense of equality developed from giving and taking between herself and others; (c) new personally-relevant knowledge gained while helping; and (d) social approval from the people she has helped, coworkers, and family, thus extending her social support network (Mead & MacNeil, 2004; Solomon, 2004; Williams, Ware, & Donald, 1981). When PSSs began providing services to consumers, the transition could have actually accelerated their own recovery, and even promoted long-term symptom reduction and a decreased risk of relapse (Bledsoe, 2008; Davidson, Chinman, Kloos, Weingarten, & Stayner, 1999; Deegan, 1992). When peer support specialists transitioned from consumer, or helpee, to service provider, or helper, they not only achieved their goal of employment, but also began building a new sense of confidence and purpose (Mead & MacNeil, 2004).

While employment as a peer support specialist could promote recovery over time, the qualifications that enabled PSSs to be so effective and credible could have also made them more fragile and at risk for relapse, such as the following:

- Many peer support specialists were hired to provide services similar to the ones they received during their own mental health care or substance use treatment. Their prior experience may have been an advantage as they have deepened personal insights about these disorders that may have been helpful in a peer support role. On the other hand, working with these disorders could also trigger unwanted or unexpected troublesome memories, emotions, pressures, and consequences (Bledsoe, 2008; Sells, Davidson, Jewell, Falzer, & Rowe, in press).

- The agency from which the worker originally received treatment could become her employer. This could be a double-edged sword that provided similar advantages, as well as, disadvantages. Familiarity with the agency and location could serve as an advantage in not requiring an adjustment period. On the other hand, peer support specialists could have formed a network of functional and dysfunctional caregiver-consumer relationships at the agency that could structure and hinder job performance in new roles and recovery (Bledsoe, 2008). Bledsoe (2008) reported having experienced a loss as she still valued her new coworkers, as "my rehabilitation counselor, my vocational worker, and my case manager" (p. 31), raising questions about where would one fit in, accompanied by feelings of rejection.
- The possibility has existed that peer support specialists could discontinue using the tools for symptom management and relapse prevention that they learned during their treatment, which could have lead to poor job performance or even loss of their jobs. A number of reasons could have existed for this, including job stress, feeling falsely cured by medication causing its discontinuance, family pressure, lack of treatment efficacy, and thoughts such as, "I am cured and could probably now have just one drink," (Laudet, Magura, Vogel, & Knight, 2000, p.476). The peer support worker could have found challenges participating in community support meetings, such as 12-step meetings, in an accessible geographical location, because other program members were now the current consumers of the PSS. This coincidence could have caused awkwardness and confounding behavior for the PSS, clinical team members, and other consumers. When seeking support under these circumstances, a peer support specialist could constantly be asking, "Was this a conflict of interest?"

- Once a PSS has transitioned from client to paid professional, if she has not been sufficiently compensated by her employer, she could experience financial risks. The PSS could become ineligible for governmental services, which could limit her access to medical care, psychiatric medications, and supplemental nutrition assistance (Mead, Hilton, & Curtis, 2012).

Therefore, to balance the demands of the job with ongoing symptoms of mental illness, self-care is critical for PSSs to provide effective services, prevent relapse, and decrease the effects of symptoms of their mental illnesses. Self-care has been the engagement of behaviors that support health and well-being (Lee & Miller, 2013), which have been included in some of the peer support specialists training programs. However, the focus of the training has continued to be on how PSSs could provide care, rather than how they could care for themselves (Stoneking & McGuffin, 2007). If PSSs were unable to practice self-care and maintain wellness, they could be at risk of relapse and could engage in ineffective or unethical practice. The transition from consumer to service provider has been one of great change (Mendoza, 2013), where PSSs have set high expectations for themselves to prove to other consumers and professionals that they were capable of doing the job (Bledsoe, 2008). In such circumstances, the possibility could exist that peer support specialists have experienced a decrease in mental and physical wellness and have been putting themselves at risk for relapse.

Peer support specialists who were not practicing self-care could have become emotionally drained and not have been able to perform at an optimal, or even ethical level. PSSs who have experienced challenges administering their own self-care also could have found difficulties in providing support to others. An example, a peer support specialist could be

assigned to teach consumers about emotional regulation, yet they have been experiencing extreme highs and lows due to triggered or untreated symptoms of their own mood disorders.

Below is an excerpt regarding Professional Responsibility from The American Counseling Association (ACA) *Code of Ethics*, Section C:

"…counselors engage in self-care activities to maintain and promote their emotional, physical, mental, and spiritual well-being to best meet their professional responsibilities," (ACA, 2005, p.9).

Peer support specialists, as well as people in any working environment, should recognize, just as counselors should, that a direct relationship has existed between maintaining self-care practices and delivering an acceptable level of service performance effectiveness. Individuals who have been diagnosed with chronic illnesses, such as bipolar disorder and depression, combined with co-occurring alcohol or drug addiction, could require additional self-management to achieve wellness compared to professionals without a mental illness or history of addiction. PSSs were not only at a similar risk for occupational impairment as other mental health workers, such as counselors, but they also brought with them an extra set of responsibilities by having joined the profession with a self-disclosed mental illness and alcohol or drug addiction that has required extraordinary care.

The relationships between self-care practices and professional counselors' well-being has been thoroughly discussed in the literature (Oser, Biebel, Pullen, & Harp, 2013; Patsiopoulos & Buchanan, 2011; Puig, Baggs, Mixon, Park, Kim, & Lee, 2011; Richards, Campenni, & Muse-Burke, 2010; Savic-Jabrow, 2010; Shapiro & Brown, 2007). However, researchers have not explored how employment as mental health service providers could interfere with the recovery of peer support specialists (Salazar, Schwenk, & Brusilovskiy, 2010; Williams, Ware, & Donald,

1981). Therefore, the purpose of this qualitative study was to explore (a) the types of self-care peer support specialists have been practicing to maintain wellness; (b) the self-care practices that peer support specialists believed to be most important for overall wellness; and (c) how employment has improved or interfered with PSSs abilities to practice self-care.

Research Questions

The following research questions served as a guideline for this study:

1. What self-care practices have female peer support specialists with co-occurring mood and substance use disorders been employing to maintain wellness?
2. What, if any, self-care practices do PSS's believe to be most important for their overall wellness?
3. How do peer support specialists believe that employment improves or interferes with their ability to practice self-care?

Significance of the Study

Peer support specialists should have been adequately trained and equipped with tools to cope with the inevitable personal and professional consequences of co-occurring disorders, as well as, work related stress (Stoneking & McGuffin, 2007). Active maintenance, including effective self-care principles and practices, have been essential for peer support specialists, because psychological and physical health have been the primary tool in their work. Therefore, a substantial need to educate this unique population about the importance of self-care has existed. Knowledge of the recommended practices to improve overall health outcomes, enhance recovery, and ensure long-term employment has been necessary for growth in the fields of mental health and substance use. Curriculum to address job-related stress and recommended self-care practices could ensure psychological and physical health of peer support specialists, which could

ultimately have a direct effect on their ability to help consumers. This research could also benefit peer support specialists, case managers, counselors, and other mental health professionals to better understand the potential risks of job related stress for individuals with co-occurring disorders. Finally, agency directors and clinical supervisors could use the results of this study to understand the unique self-care needs of PSSs, be able to offer continued education and support for employees, and ensure stable, long-term employment.

Findings from this study could be used to modify trainings for new PSSs, and enhance education for current PSSs, PSS supervisors, and agencies that have employed peers. A written summary of this study, along with recommendations for peer training and future research, has been given to the Arizona Department of Behavioral Health Services Peer Training Department and the Maricopa County Regional Behavioral Health Authority. A written summary has also been given to the peers who have participated in this study. Furthermore, the author of this study, on behalf of the National Council on Alcoholism and Drug Dependence, has also written a peer training certification curriculum approved by the Arizona Department of Health Services. I have used this information to update and enhance training curriculum for new peer support specialists, and share knowledge gained with current peer support specialists, peer trainers, and peer support supervisors.

Definition of Terms

For the purpose of this study, key terms have been defined in Appendix A.

Delimitations and Limitations of the Study

The scope of this study has been to understand the self-care practices of female PSSs with co-occurring mood and substance use disorders and how the job roles of the PSSs have improved or interfered with their overall wellness.

Delimitations were boundaries that were set to control the range of a study. Delimitations were created before any investigations were carried out to reduce the amount of time spent in certain areas that could have been seen as unnecessary, and perhaps even unrelated, to the overall study. Delimitations set for this study included (a) research questions; (B) research design, (c) inclusionary and exclusionary criteria for selecting the sample population, and (d) study location.

Limitations of this study, not set by the researcher, included the lack of empirical studies available to understand the self-care practices and benefits or consequences work has had on overall wellness of PSSs. Because information was not available in the literature, the researcher had to review literature on the self-care practices of mental health counselors as framework for exploring the self-care practices of peer support specialists.

CHAPTER TWO: LITERATURE REVIEW

The purpose of this study was to gain a better understanding of the self-care practices of female peer support specialists (PSS) with co-occurring mood and substance use disorders and how work has improved or interfered with their overall wellness. Information has been included in this chapter to familiarize the reader about the history and the roles of the PSSs, provide a brief description of co-occurring mood and substance use disorders, and to provide a basic understanding of the self-care practices of consumers, as well as professionals, in the fields of mental health and substance use. First, a review of literature describing the origins of self-help programs, which were the foundations that peer support programs have been built upon, have been included in this chapter. Second, a description of the transformation of the mental health consumer movement into today's recovery-oriented mental health services has been provided. Third, a current explanation of today's peer support services has been given, which has included how an individual could transition from a consumer to a PSS, as well as the importance of self-care in the role of the peer support specialist. Fourth, brief information has been provided about co-occurring disorders—what they are, and how people rehabilitate.

Information about co-occurring disorders has been provided to give insight about the experiences of individuals who could receive peer support services, have provided peer support services, and the participants' from this study. More specifically, the chapter has included a brief review of how women with co-occurring disorders might become peer support specialists and what the potential risks have been to self-care when women have taken on these new roles. Fifth, included in this chapter, has been a review of literature on the self-care practices of counselors who have worked in similar environments and with similar clients as peer support specialists, because limited information has been available to describe the self-care practices of peer support

specialists. A brief explanation of critical theory and how this researcher has used a critical perspective when exploring the self-care practices of peer support specialists to create change and promote overall wellness has been the conclusion to this chapter. Results from this study have been submitted to the Arizona Department of Behavioral Health as a recommendation to enhance current Peer support specialist training curricula and continued education for PSSs

Brief History of Peer Support Services

Self-Help Programs

The most long-standing work on peer support began in the 1930s by the Oxford Group. A popular religious group, in the United States and Europe, focused on the principles of self-improvement was the Oxford Group. The Oxfords encouraged self-improvement by performing self-inventories, admitting wrongs, making amends, and using prayer and meditation to carry their messages to others (Alcoholics Anonymous, 2012). Originating from similar principles and membership of the Oxford Group, Alcoholics Anonymous (AA) was founded on June 10, 1935, which was the beginning of one of the oldest and most pervasive types of peer support self-help in the world (Alcoholics Anonymous, 2012). The membership in AA, unlike the Oxfords, was exclusive to Alcoholics. Although many peer support specialists could attribute their own recovery to their membership in AA, peers, known as sponsors, were not paid positions and the illness of alcohol or drug addiction was not disclosed except within the membership meetings of AA. A description of the role of the sponsor from The AA General Service Conference Approved Literature was as follows:

> Alcoholics Anonymous began with sponsorship. When Bill W., only a few months sober, was stricken with a powerful urge to drink, this thought came to him: “You need another alcoholic to talk to. You need another alcoholic just as much as he needs you!”

> He found Dr. Bob, who had been trying desperately and unsuccessfully to stop drinking, and out of their common need A.A. was born. The word "sponsor" was not used then; the Twelve Steps had not been written; but Bill carried the message to Dr. Bob, who in turn safeguarded his own sobriety by sponsoring countless other alcoholics. Through sharing, both of our co-founders discovered, their own sober lives could be enriched beyond measure.

By the early 1970's many other self-help groups, such as Narcotics Anonymous, Cocaine Anonymous, Marijuana Anonymous, Gamblers Anonymous, Over-Eaters Anonymous, Schizophrenics Anonymous, Emotions Anonymous, Recovery Inc., and GROW have covered an array of mental health and addiction related problems, and also were formed by peers working to overcome barriers and live a life of meaning, hope, and optimism (GROW, 2010; Solomon, 2004).

The Mental Health Consumer Movement

The concept of peer support services in mental health has not been new. In the 1970s, the Mental Health Consumer Movement was manifested from the traditions of self-help (Davidson, Chinman, Sells, & Rowe, 1999). By 2006, programs and organizations run by and for people with mental illness and their families outnumbered traditional, professionally run, mental health organizations by almost a 2:1 ratio (Goldstrom, Campbell, & Rogers, 2006). In 2007, the President's New Freedom Commission and the Veterans Administration's New Action Agenda supported the growth and use of peer-based interventions for individuals with mental illness. The Center for Medicaid and State Operations (Smith, 2007) continued to reimburse states for peer support services delivered directly to Medicaid beneficiaries with mental health and substance use disorders.

Over the last 15 years, mental health and substance use providers have evolved into a consumer-driven system focused on increasing consumers' abilities to cope with life's challenges rather than just manage their symptoms (Smith, 2007). Consumer-driven services have been mental health and substance use service programs that staff empowered consumers were invested in the planning and maintenance of their own treatment (Solomon, 2004). Service providers have encouraged treatment plans that have been planned "with" individuals diagnosed with mental illness and substance use diagnoses, rather than "for" them (Curtis, Hilton, & Mead, 2001).

Peer Support

Patricia Deegan (1992) has been a pioneer advocate for peer support for people with mental illness. Deegan stated "peer supports with mental illness offer the possibility of recovering" (p.4). Deegan spent over 24 years of her life living with schizophrenia. She has earned a doctoral degree in psychology and has been a role-model and national leader of the Mental Health Consumer Movement (MHCM) in the United States (Davidson, Chinman, Sells, & Rowe, 1999). Peer support services have afforded PSSs the benefits of effectively helping others to acquire an enhanced sense of worth. "When working with mental illness, if we can step outside of the box of the medical model, peers, ourselves, have revealed that environments of health create healthy members and environments of illness create professional mental patients" (Mead, Hilton, & Curtis, 2012, p.6).

To date, peer employees have continued to fill agency positions specifically designed for individuals with a shared mental health or addiction experience or who were hired into a traditional mental health position. Within the mental health system, people in unique positions, such as peer supports, have increased the number of professionals that could provide support to

individuals with psychiatric or substance use disorders. By providing ancillary services to traditional mental health counseling, PSSs offer hope and encouragement through experiential knowledge and mutual empowerment.

Solomon (2004) described the following categories of peer support services: peer self-help groups, peer delivered services, peer run or operated services, and peer employees. Peer self-help groups, as described previously, have been groups such as Alcoholics Anonymous. Self-help groups have been small groups of individuals who voluntary joined together due to a particular illness or disorder and have provided assistance to others with similar disorders for the purpose of bringing about a desired social or personal change (Solomon, 2004). Peer delivered services have been services provided by individuals who have identified themselves as having had a mental illness or addiction, have received mental health or substance use services and have delivered similar services for the primary purpose of helping others with common disorders. Examples of peer delivered services could have included peer run or peer operated services or peers as employees (Solomon, 2004). Peer-run or peer-operated services have been services that have been planned and managed by individuals with mental health or substance use diagnoses. Individuals without mental health or substance use disorders could be engaged in the operations of the program; however, the control of the program has been managed and evaluated by the peer operators themselves (SAMHSA, 1998; Stroul, 1993). Examples of peer run or operated services could include drop-in-centers, clubhouses, crisis services, vocational and employment services, and peer mentor programs (Solomon & Draine, 2001). Peer employees have been individuals who have fulfilled the requirements to serve in designated peer positions, such as case manager aids, peer companions, peer advocates, consumer case managers, peer specialists, or peer counselors and who have publicly identified themselves as a people who have received

mental health or substance use services. Designated peer positions have been adjunctive to traditional mental health services An example could include a peer support specialist who has worked on a clinical team that also included case managers, counselors, and psychiatrists (Solomon, 2004).

The Role of the Peer Support

The role of the PSS in the fields of mental health and substance use has been to assist consumers to achieve levels of wellness characterized by self-management of symptoms, prevention of relapse, elimination of hospitalizations, and assistance with integration into the community (Bledsoe, 2008). Job duties of peer support specialists could be very similar to those of a professional counselor. Similar job duties could include the following: listening to clients and providing validation and feedback, teaching life-skills, discussing symptom management, problem solving, navigating community resources, case management, or documentation. However, what may make peer support specialists so effective and credible is that they have lived with some of the very same disorders as their peers, who were consumers, and therefore could comprehend, empathize, and work with what consumers have been experiencing in a way no others can (Mead, Hilton, & Curtis, 2012). By serving as a role-model of recovery, PSSs have offered camaraderie, fostered the development of prosocial behaviors, encouraged empowerment by offering hope through their own personal journeys, created independence through advocacy, enhanced social support networks, and promoted increased involvement in healthier leisure activities that do not involve alcohol or drugs (Bledsoe, 2008; Min, Whitecraft, Rothbard, & Salzar, 2007). PSSs also have been assigned to the day to day tasks of keeping the program running, such as opening and closing the program facilities, coordinating activities and outings,

tracking consumer attendance, reporting progresses or challenges of consumers, answering phones, and light housekeeping or clerical work (Bledsoe, 2008).

Transition From Consumer to Peer Support Specialist

Although substance use combined with mental illness has been a relapse-prone disorder, comprehensive long-term support, such as provided in 12-step programs and social networks, which included non-using peers, has been associated with positive outcomes (Laudet, Cleland, Magura, Vogel, & Knight, 2004). Many consumers with co-occurring disorders have been assigned to work with PSSs. Peer support specialists have served as role models to assist individuals with co-occurring disorders to improve participation in treatment, better understand their illnesses, extend social networks, integrate into the community, and achieve long-term sobriety. The possibility exists that PSSs have inspired individuals with co-occurring disorders to also want to help others who have had similar challenges. The phenomenon that has occured when a consumer has decided to become a PSS has only recently started to be studied (Mendoza, 2013). However, Cherie Bledsoe (2008) has shared her experience as a mental health consumer and peer support specialist,

> I first came to the program because I felt I had no other option. I stayed because of my peers. They provided me with friendships, safety, comfort and strength. They showed me the ropes. Peer support can be a "win-win" situation for consumers, staff, the agency, and the entire community. . . I think it is important to note, however getting to this place has not been an easy one for me. In fact, it has been a journey of struggles and challenges for almost twenty years. I believe most consumers do not have a goal of becoming a consumer provider. . but my mental illness simply gave me a direction in which to follow. The transition to providing mental health services when I was used to

> receive them was indeed frightening. However, it held a deeper key to my wellness and to the wellness of my peer providers. (p. 24)

Although the transition from consumer to peer support specialist could be a symbol of successful recovery, it could also be a time of fear, confusion, and isolation (Bledsoe, 2008). The possibility could exist that the self-care practices used as consumers were just as important, if not more so, in the roles of PSSs. Not only have PSSs been expected to maintain their own wellness, but they also have been taking on the responsibilities of caring for others (Shapiro, Brown, & Biegal, 2007).

Importance of Self-Care for Peer Support Specialists

For mental health professionals, caring for those who have been emotionally stressed or distressed, have experienced trauma, abuse, or had personality disorders, could be stressful and could impact mental and physical wellness (Carroll, Girly, & Murray, 2008; Murphy & Schoenburn, 1989; Shapiro & Brown, 2007; Shapiro, Brown, & Biegal, 2007). Consequences of stress on helping professionals, especially early in their careers, could lead to the following: increased depression, emotional exhaustion and anxiety, psychosocial isolation, decreased job satisfaction, reduced self-esteem, disrupted personal relationships, loneliness, decreased attention and concentration, and poor decision making (Lee & Miller, 2013; Shapiro, Brown, & Biegal, 2007). Therefore, an increased need could exist for education about self-care in pre-service training programs for counselors (Shapiro, Brown, & Biegal, 2007), nurses, and other healthcare professionals (Peterson, et al., 2008).

Compared to other mental health professionals, peer support specialists could remain just as vulnerable to stress or impairment, if not more so, than others without a previous disability or addiction who have been working in the field. The risks that employment could have for overall

wellness of the PSS could be similar to those of the professional counselor. Although peer support has often been referred to as a practice of mutual support, Davidson, Chinman, Sells, and Rowe (1999) defined peer support as being a one-directional relationship, with one service provider and one consumer, especially for more skilled workers. Unlike mutual support, the asymmetrical relationship between peer support specialist and consumer could be viewed through the context of the counselor-consumer relationship. The counselor-consumer relationship has been intentional and one-directional, rather than reciprocal, such as in a friendship (Davidson, Chinman, Sells, and Rowe, 1999). Shapiro and Brown (2007) noted the importance of self-care in counselor training programs because the job has required counselors to be able to "give" constantly to their consumers. They must be willing to understand consumers' joys, as well as understand their pains, which could lead to increased stress and emotional exhaustion.

Murphy and Schoenborn (1987) reported that counselors with high occupational stress practiced lower levels of self-care, recreation, and social support, despite counselors' efforts to empower consumers to improve physical and psychological health. Researchers have suggested that self-awareness, coping, and balance of occupational and personal demands have been critical to counselor stress management and self-care (Carroll, Girly, & Murray, 2008). Additionally, counselors experienced high caseloads, received minimal supervision, and were assigned many non-counseling duties, such as responding to inquiries and demands from consumers, family members, and other stakeholders. Between meetings with consumers, counselors could experience high demands to follow up with emails, phone calls, and extensive, time-sensitive paperwork (Lee & Miller, 2013). Taking time for self-care during the day could seem counter-intuitive to counselors and PSSs alike. However, practicing self-care not only has been helpful,

but ethical to maintain wellness and to ensure competence at all times. Because peer support specialists have been recognized as role-models and as people in recovery, consumers could expect that PSSs have been properly caring for themselves personally and professionally to prevent relapse.

The need for self-care among PSSs has been acknowledged as important; however, minimal information has been available about the types of self-care PSSs could access to maintain wellness. Additionally, information has been scarce about peer training curricula and how instructors have or have not encouraged self-care or discussed job-related stress (Shapiro, Brown, & Biegal, 2007). Several researchers have called for more research in this area to address the importance of self-care for peer support specialists (Mead, Curtis, and Hilton, 2008; Stoneking & McGuffin, 2007).

Peer Support Training in Arizona

Due to the wide range of benefits, most states have secured Medicaid reimbursement for peer support services in a variety of settings nationwide (Smith, 2007). To be eligible for Medicaid reimbursement, training, continuing education, and supervision standards have been established. Certification has been defined at the state level (Smith, 2007); therefore training requirements have been inconsistent across the nation. On average, approved peer training programs have included 80 hours of hands-on training and classroom coursework (St. George, 2004). Unfortunately, most program instructors have spent less than one hour covering the topic of self-care (International Association of Peer Supporters, 2013). In Arizona, self-care has been one of the 25 required core elements of the approved training curricula. Although training curricula standards have been consistent throughout the state since July 2013 (ADBHS, 2012); the delivery of the content could vary. See Appendix B for the core elements required for

approved peer support training curricula, as described from the Arizona Department of Behavioral Health Provider Manual, Section 9.2: Peer Support/Recovery Support Training, Certification and Supervision Requirements, (ADBHS, 2012).

Currently, peer support in mental health settings have been recognized in the State of Arizona as an evidence-based best practice, and members of the Arizona Board of Behavioral Health have required that all PSSs have earned a G.E.D. or high school diploma, completed a state approved training program, and passed the state certification examination (ADBHS, 2012). According to the International Association of Peer Supporters (2013), thousands of PSSs have been trained to provide valuable support to people faced with mental health and alcohol or drug addiction in a variety of service categories. For the purpose of this study, peer support specialists have been defined as self-identified consumers who have been in recovery from co-occurring mood and substance use disorders, and who have been employed by peer-run programs to provide services to mental health consumers.

Co-occurring Mood and Substance Use Disorders

Just as the field of substance use and mental health treatment has evolved, so has the terminology used to refer to people with both mental health and substance use disorders. The term co-occurring, formerly called dual diagnosis, could refer to the combination of mental health and substance use disorders. The use of this term might suggest that only two disorders have occurred at the same time, when actually multiple disorders could have existed simultaneously (Center for Substance Abuse Treatment, 20005). For the purpose of this study, co-occurring disorders have included only mood and substance use disorders. An understanding of each of these disorders, their prevalence among the general population, hypotheses about why these disorders could be so common, as well as the prevalence and impact co-occurring disorders

have on female peer support specialists could provide a better understanding of the experiences of the participants in this study.

Mood disorders, including Major Depressive Disorder, Dysthymia, and Bipolar Disorder, were the most prevalent Axis I mental disorders (Bradizza, Stasiewics, & Paas, 2006). Primary symptoms of mood disorders could include disturbance in mood, such as inappropriate, exaggerated, or limited range of feelings or emotions (Center for Substance Abuse Treatment, 2005). Symptoms were experienced at such extreme levels that one's ability to eat, sleep, work, or function at home were impaired. Symptoms also resulted in feelings of worthlessness, or even thoughts of suicide (Grant, et al., 2004).

The term substance-use disorder included both substance abuse and substance dependence disorders. Although these disorders had distinct meanings, researchers from the Center for Substance Abuse Treatment (2005) reported that both disorders included the chronic use of alcohol or illicit drugs. The use of alcohol included beer, wine, or hard liquor. Illicit drug use included the use of cannabis, cocaine, amphetamines, ecstasy, hallucinogens, benzodiazepines, heroin, and other opioids, as well as the misuse of prescription drugs (Center for Substance Abuse Treatment, 2005). Persistent use of alcohol or drugs could impact an individual's ability to fulfill roles for which they were responsible, such as employee, student, or parent. Substance use also could result in legal difficulties or social and interpersonal problems (Grant, et al., 2004).

Researchers have referred to co-occurring mood and substance use disorders as having been a more severe, difficult to manage illness than either a mood or a substance use disorder alone (Hasin, Goodwin, Stinson, & Grant, 2005). Consumers with co-occurring disorders often had poorer outcomes than people with only one disorder: higher rates of HIV infection, relapse,

rehospitalizations, suicide risk, considerable disability, poor quality of life, and inadequate treatment (Drake & Noordsy, 2005; Ormel et al., 2008; Saarni et al., 2007). Mood disorders had a lifetime prevalence rate of 20.8 %, and substance use disorders had a lifetime prevalence rate of 14.6%; both were common among the general population (Kessler et al., 2005). In addition to being highly prevalent, mood and substance use disorders have been found to frequently co-occur in individuals (Conway et al, 2006; Kessler et al., 2005b). Almost one-quarter (24.1%) of individuals with mood disorders have used alcohol or drugs to relieve symptoms (Saarni et al., 2007). Both mood and substance use disorders could occur separately or concurrently, and have been prevalent in the general population.

Researchers posited why mood disorders and substance use disorders co-occurred in individuals at a higher than expected rate. One hypothesis, also known as the "self-medication" hypothesis, was that individuals who already had a mood disorder used alcohol or drugs to reduce distressing symptoms (Kraemer et al., 2001). Bolton, Robinson, & Sareen (2008) found that almost one-quarter (24%) of individuals with mood disorders self-medicated with alcohol, illicit drugs, or prescription medications because they could have alleviated tensions, achieved or maintained euphoria, increased energy, and managed symptoms of depression.

Women, in particular, have used self-medication as a form of coping. For many women, co-occurring disorders could have been trauma related, which included having experienced a high prevalence of violence, and physical, emotional, or sexual abuse (Covington, 2008). Ouimette, Kimerling, Shaw, and Moos (2000) reported that many of the substance-using women had experienced sexual or physical abuse. A history of serious traumatic experiences could play a role in a woman's physical and mental health problems (Messina & Grella, 1998). As consumers, female peer support specialists could have completed more intensive treatment

programs to overcome trauma, in addition to their mental health and substance use treatment regimes. This experience could have been a double-edged sword. Female PSS could be better suited to engage a consumer who also had experienced trauma and abuse. However, hearing someone else's traumatic experience could have triggered intense emotional pain for the peer support specialist herself (Covington, 2008). Therefore, female peer support specialists could have additional self-care needs, such as having a strong understanding of their reactions and emotions, and the ability to use techniques, such as grounding and self-soothing (i.e. breathing) to help themselves cope with their traumatic experiences (Covington, 2008).

Over the past two decades researchers and clinicians concluded that traditional and separate services for individuals with co-occurring mental health and substance use disorders were inadequate compared to multidisciplinary teams that included both mental health and substance use specialists (Drake & Noordsy, 1995). Treatment success has been dependent upon timely screening, comprehensive assessment and integrated, client-centered approach (Minkoff, 2000; SAMHSA Report to Congress, 2002). Integration has occurred in both inpatient and outpatient programs. However, inpatient care was often reserved for crisis stabilization, assessment, and linkage with outpatient programs (Drake & Noordsy, 1995). Many programs for co-occurring disorders have existed in outpatient mental health programs and have had a variety of community support services (Horsfall, Cleary, Hunt, & Walter, 2010). Program components have included assessment, case management, individual counseling, group counseling, family education, medication management, money management, housing, vocational services, and peer support services (Drake & Mueser, 2000).

Self-Care

Self-care has consisted of the day-to-day health behaviors that have promoted wellness and could include the integration of the following elements: physical, cognitive, emotional, play, and spiritual (Carroll, Girly, and Murray, 2008; Shapiro, Brown, & Biegal, 2007). Daily behaviors that could promote wellness included exercising, eating healthily, getting a good night's rest, spending time with family and friends for social and leisure activities, scheduling time for vacations, attending church or meeting with a spiritual advisor. Similar elements of self-care could be helpful for individuals with co-occurring disorders; however, they also could require some additional practices, such as taking prescription medications; attending support meetings; contacting a sponsor; meeting with a counselor; writing a daily schedule; or practicing grounding or breathing techniques as they relate directly to symptoms of their mental illness (Shapiro, Brown, & Biegal, 2007). Although self-care practices could be individualized, a persons' wellness, as well as her ability to help others could be dependent on first caring for herself (Lee & Miller, 2013).

In the helping profession, self-care has been not a form of self-indulgence or a personal luxury, but a professional responsibility to those who have been dependent on their care. Researchers have acknowledged that some mental health professionals have been concerned about not being able to care for themselves properly (Manning & Suire, 1996; Nikkel, Smith & Edwards, 2002). Manning and Suire (1996) confirmed that consumers employed as case management aides often feared relapsing into acute mental illness because of job- related stress, and Nikkel, Smith, and Edwards (2002) concluded that an increased level of support was desired by case managers to prevent relapse. Considering the potential risks to recovery and importance of self-care, little information has been available to explore the self-care needs of mental health

professionals, or more specifically, peer support specialists. Some information, although much of it has been outdated, has been written to describe the self-care practices of other mental health professionals, such as counselors. In the next section the focus was on contemporary, empirical studies of the self-care practices of mental health counselors.

Self-Care Practices of Counselors

Self-care practices of mental health counselors, as a means of burnout prevention, has been the focus of the most recent and most closely related literature to self-care practices of peer support specialists. A review of literature about the self-care practices of counselors has been conducted to provide a framework for understanding the self-care practices of peer support specialists. The first search was completed using the keywords *counselors* and *self-care* at the Arizona Health Science Library website.

Literature Search Procedures

A search for published studies on the self-care practices of counselors was conducted using a four-step selection process.

Step 1: The following databases were consulted: PUB MED, Psych INFO, Journal of Counseling and Development, and the Journal of Mental Health Counseling. The literature review was limited to journals written in English and empirical studies published between 2005 and 2014. Studies that included participants, such as psychiatrists, psychotherapists, or specialty counselors, such as school counselors, bereavement counselors, or counselors who work specifically with victims of trauma were eliminated from this review. Education and training has been required for these careers, beyond the scope of a general mental health counselor and well beyond the requirements for a peer support

specialist. Additionally, the job duties of these positions were not similar to the duties of peer support specialist or general mental health counselor.

Step 2*:* Results from Step 1 were eight abstracts from PUB MED, five from PsychINFO, two from the Journal of Counseling and Development, and one from the Journal of Mental Health Counseling.

Step 3*:* 1,910 articles were found using Google Scholar and the same selection criteria as in Step 1. Most articles contained only anecdotal evidence or did not meet search criteria. Only five abstracts fulfilled the article inclusion criteria.

Step 4: The final group of five articles reviewed for this paper consisted of three quantitative studies and two qualitative studies. The participants in all five studies were adults who were currently employed as mental health counselors in the United States and the United Kingdom in a variety of counseling settings. The researcher conducted a narrative comparison of all five articles multiple times to identify the main themes of current self-care practices of mental health counselors to prevent occupational burnout.

Analysis of Studies

To enhance analysis of the studies, information was divided into four themes: support, mindfulness, self-compassion, and self-time. A summary of participants, purpose, research methods, and results of the studies of the self-care practices of counselors has been presented in Table 1. Job burnout was addressed in each study as a potential consequence of not having an effective, established self-care regime. A sufficient level of well-being and the avoidance of burnout was presumed to be the result of effective self-care practices

Table 1

Self-care practices of mental health counselors

Author	Sample	Purpose	Methods	Results
Patsiopoulos & Buchanan, 2011	15 counselors	To explore counselors' experiences of self-directed compassion.	-Narrative Inquiry -Cross-narrative thematic analysis	**Theme 1:Counselors' stance in session** Counselors identified using the following self-care practices: (a) taking a stance of acceptance, (b) taking a stance of not knowing, (c) compassionately attending to inner dialogue, (d) being mindful of present experience, (e) making time for self, and (f) being genuine about one's fallibility. **Theme 2: Workplace relational ways of being** Counselors identified the importance of the following ways of being: (a) participating on a compassionate and caring work team, (b) speaking the truth about self and others. **Theme 3: Finding Balance Through Self-Care Strategies** Counselors reported they found balance through the following strategies: (a) leisure time, (b) solitary time, (c) family time, (d) getting enough sleep, (e) eating nutritionally, (f) exercising, and (g) setting time for creativity.
Puig, et al., 2012	129 mental health professional	To explore the relationship between the dimensions of job burnout and the dimensions of personal wellness.	-Intercorrelation and multivariate regression analyses	When counselors were not afforded opportunities to attend to basic health needs, such as rest, exercise, and nutrition they could experience a decrease in their ability to appropriately manage stress. A safe, pleasant work environment, supervision, and professional peer groups that promoted self-care could led to a decrease in job burnout and an increase in overall wellness.

Table 1 (*continued)*

Self-care practices of mental health counselors

Author	Sample	Purpose	Methods	Results
Oser, Biebel, Pullen, & Harp, 2013	28 Rural and Urban Counselors	To qualitatively analyze and examine the differences between the causes, consequences, and prevention of counselor burnout among rural and urban counselors.	-Focus Groups -Content Analysis	The following themes and subthemes emerged from the analyses: **Causes:** Challenging clients (B), large case load (B), paperwork (B), office politics (R), and low prestige (R); **Consequences:** Poor client care (B), reversing roles (U), clients trying to choose counselor (U), changing jobs (U); and **Prevention:** Coworker support (B), clinical supervision (B), and self-care (B).
Richards, Campenni, & Muse, 2010	148 Mental Health Professionals	To explore the link between self-care by mental health professionals and their general well-being and self-awareness on well-being	-Demographics -7 point Likert Scale used to evaluate self-care -Self-reflection and Insight Scale -Mindfulness Attention Awareness Scale -Schwartz Outcomes Scale-10	Self-care practices had significant effects on well-being, and when self-awareness increased, so did mindfulness, which was a strategy for self-care, and promoted improved wellness.
Savic-Jabrow, 2010	31 Counselors working in private practice	To explore whether or how counselors receive support, and if so from where	-Survey Questionnaire	Support options identified by the participants included massage, personal therapy, monthly support meetings with colleagues, reading, social activities, exercise, and spiritual activities.

U=Urban; R=Rural; B=Both

Theme 1: Support

The following four subthemes were identified as crucial means of support for counselors: (a) supervision, (b) co-workers, (c) support groups, and (d) supportive personal relationships.

Subtheme A: Supervision. Support in the form of supervision on the job has been identified as Subtheme A. Across all studies counselors viewed supervision as a crucial form of self-care and that accessing such support from a variety of sources was an ethical requirement of the job (Oser, Biebel, Pullen, & Harp, 2013; Patsiopoulos & Buchanan, 2011; Puig, et al., 2012; Savic Jabrow, 2010). Savic-Jabrow (2010) explored how and whether counselors received support, and if so from where. Participants believed that the majority of their support should have been received through ongoing supervision meetings provided by their direct clinical supervisor; however supervision was not occurring often as the counselors preferred. Participants in a study conducted by Patsiopoulos and Buchanan (2011) responded similarly to the participants in Savic-Jabrow's study confirming a recommendation that all counselors, regardless of their experiences, should receive supervision.

The most important self-care practice identified by Oser, Biebel, Pullen, and Harp (2013) was clinical supervision. The researchers took a different approach and explored the three themes of burnout to include the causes, consequences, and prevention of burnout by rural and urban communities. For the purpose of this review burnout was defined as physical or emotional exhaustion experienced as a result of the challenges between mental health counselor and client Oser, Biebel, Pullen, and Harp, 2013 & Puig, et al, 2012). All three themes -- causes, consequences, and prevention of burnout -- were identified and were similar among both rural and urban mental health counselors. No significant differences were identified between rural and

urban mental health counselors in that both groups believed that burnout could be prevented with proper self-care and that clinical supervision was a protective factor for burnout.

Unlike other researchers, Oser, Biebel, Pullen, and Harp (2013), explored the challenges with dissatisfaction of supervision. One participant stated "counselors need counseling, but supervisors also need supervision because they burn out too" (p. 22). Oser et al. (2013) recommended that supervisors also receive supervision because the overall report from both rural and urban counselors was that burnout and poor self-care was psychologically contagious and could be passed easily from supervisor to worker and between coworkers. Urban counselors recognized the importance of supervision, but reported that many supervisors no longer understood the system of care and were not as invested in employee self-care. In cases, in which counselors received minimal supervision, they relied heavily on the support of their peers. Mental health counselors reported that they were more likely to be held accountable for their actions or confronted about needing to care for themselves by another coworker rather than their supervisors.

To maintain wellness, counselors need to be afforded the opportunity to take care of themselves in a way that is unique to their own needs. Overall, the need for organizations to nurture opportunities for self-care through supervision was considered an imperative to combat personal and professional strain. Clinical supervisors could serve as a key supports for those struggling to balance self-care with personal and professional demands. At a minimum, group supervision that includes topics for supervisors to address self-care was has been needed. Counselors also valued a safe, comfortable working environment where they could rely on their peers, as well as their supervisors, for support and to hold them accountable for their behaviors.

Subtheme B: Co-workers. Oser, Biebel, Pullen and Harp (2013) identified co-worker support as the second most important self-care practice for both rural and urban counselors. Mutual support between coworkers was one of the most important self-care practices identified across all studies. Mental health counselors reported benefiting from a "sympathetic ear," and another person who has been in the trenches to hold them accountable (p.22). Although adequate supervision was rated as most important for occupational satisfaction and longevity, coworker support was considered the most realistic self-care practice and that a pleasant work environment and social relationship with coworker's could lead to improved wellness.

Oser et al. (2013) stressed the importance of mental health counselors caring for themselves and each other as a pathway to providing quality client care. Compassion for one's self and coworkers created trust within the workplace and included the following: being empowered to be accountable for one's actions and mistakes, asking others to be accountable for their mistakes, and communicating concerns and needs. Patsiopoulos and Buchanan (2011) interviewed 11 participants who all reported that working on a supportive team contributed to the ways they practiced their own self-care. Participants reported that they received support from one another to "let go" when they had reached their limits with a challenging client, during supervision with leadership, or while participating in agency politics (Patsiopoulos & Buchanan, 2011).

Many of the participants in the Savic-Jabrow (2010) study indicated that support from colleagues was important; however, many counselors worked independently in their own practice so they did not have access to this type of support. Nonetheless, participants highly valued support from peers in their field, stating, "…the information and day-to-day support that can be obtained from peers is not to be understated," (p.231). Participants were able to

compensate for their lack of access to daily support by forming local networks or support groups of counselors or other individuals who also spent less time working in a team environment.

Subtheme C: Support Groups. Counselors valued the opportunity to access the local networks of other practitioners on a regular basis, especially for those who were not working in a team setting (Savic-Jabrow, 2010). Many participants received support by attending a monthly group meeting with colleagues as well as by conducting their own supervision and study sessions with one another.

Puig, et al. (2012) recommended that group support be taken into careful consideration within the work setting as a means of preventing burnout as well as to make up for incidents in which a supervisor could not be available. Peer groups also can provide counselors with opportunities to practice wellness strategies, such as meditation, relaxation, or guided imagery techniques during group sessions.

Subtheme D: Personal Relationships. Patsiopolous and Buchanan (2011) and Richards, Campenni, and Muse-Burke (2010) identified the importance of establishing relationships outside of work with people such as a spouse, family members, friends, and community members as it has helped create a healthy balance both on the job and outside of work. A healthy balance might alleviate symptoms of burnout or prevent a person from becoming a workaholic.

Theme 2: Mindfulness

Counselors who valued self-care also may have been able to elicit a more mindful state. Richards, Campenni, and Muse-Burke (2011) described mindfulness as "a state of being, rather than doing" (p. 259). The practice of "mindfulness may facilitate insight, which can be understood as awareness of oneself and one's motives" (Richards, Campenni, & Muse-Burke

(2011), citing Rosenzweig, Reibel, Greeson, & Brainard, 2003; Schmidt, 2004). Without the ability to be mindful one would not recognize the need for self-care. “So, you have to be mindful of when you are tired or burned out or need a vacation” (Oser, Biebel, Pullen & Harp, 2013, p.22).

Mindfulness could provide a sense of grounding and perspective. Being aware of oneself and achieving a state of mindfulness were related directly to experiencing overall growth and wellness.

Mental health counselors discussed various approaches to achieve a state of mindfulness (Patsiopoulus & Buchanan, 2011). The researchers referred to the use of mindfulness as a way of being in counseling and in life in the moment. Approaches to achieve a mindful state included using cognitive-behavioral strategies to manage self-talk, using breath affirmations, imagery, bracketing, perspective talking, and the savoring of successes. Participants explained that mindfulness was necessary when feeling triggered by a difficult client, because it “helped me step back and track my thoughts non-judgmentally in the moment” (p.304).

Puig, et al., (2013) reported the potential connections between mindfulness, a counselor’s well-being, burnout, and treatment efficacy. Puig et al. (2013) expressed the importance of these connections by referring to the ACA Code of Ethics (ACA, 2005, C.2.g, Impairment):

> Counselors must be aware of their own physical, psychological, and/ or emotional problems. . . Counselors must refrain from offering therapeutic services when problems are likely to affect treatment; and counselors are to seek help in dealing with their own problems as they arise.

Richards, Campenni, and Muse-Burke (2010) also concluded that self-care practices had a significant effect on well-being. Self-awareness was defined as knowledge of one’s thoughts,

emotions, and behaviors, whereas mindfulness was a method of maintaining awareness of and attention to oneself. For example, when an individual engaged in self-care activities such as doing yoga, she also could be better able to practice mindfulness (Richards, Campenni, & Muse-Burke, 2010). Therefore, when self-awareness increased, so did mindfulness, which promoted improved wellness.

Theme 3: Self-Compassion

Patsiopoulos and Buchanan (2011) described self-compassion as a self-care construct that could enhance well-being by reducing the effects of job-related stress. One participant in their study described the difference between self-care and self-compassion by stating: "Self-care has been something you can do all the time; self-compassion was almost like an attitude or a perspective that you shift within yourself, which could translate into self-care actions. It's how we treat ourselves" (p. 305).

Patsiopoulos and Buchanan (2011) further described self-compassion by quoting Neff (2003, p. 224):

> Being open to and moved by one's own suffering, experiencing feelings of caring and kindness toward oneself, taking an understanding, nonjudgmental attitude toward one's inadequacies and failures, and recognizing that one's own experience is part of the common human experience...

When working with clients, Patsiopoulos and Buchanan (2011) recommended that counselors accept the "humanness" in themselves and others by recognizing the limits of helping and letting go of high expectations of themselves as a means to address self-care. "I *don't* have to have all the answers. I just need to help the client to become aware, to see that they already

know within themselves" (p.305), which takes some of the pressure off the self-concept of having to be everything to everyone all of the time.

Interestingly, as noted previously under the "support from coworkers," theme, participants in the Patsiopoulos and Buchanan (2011) study reported a similar type of validation needed from supervisors and coworkers to help them "let go," when they reached their limits. Despite efforts to achieve self-acceptance and acceptance of one another among peers, participants continued to describe a sense of powerlessness and frustration from being a part of a "failing system," or working with clients who were "just not ready for change" (p. 304).

Although, Oser, Biebel, Pullen, and Harp (2013) did not inquire directly about self-compassion in their study, themes emerged that were related to emotional exhaustion, depersonalization, and lack of personal accomplishment. Counselors reported feelings of incompetence when working with challenging clients and when they evaluated themselves critically. For example, a rural counselor articulated, "Sometimes you wonder - are my efforts doing anything?" (p. 23). Feeling ineffective or experiencing a lack of personal accomplishments could lead to subsequent burnout. Puig, et al. (2012) confirmed this by concluding that when mental health professionals felt incompetent or unsupported in their job they experienced difficulty in coping with stress appropriately. Puig, et al, (2012) also reported that low self-esteem could lead to complaints about low self-worth, and part of the counselors' responsibilities included feeling competent, so they could help other individuals recognize their self-worth.

Theme 4: Self-Time

Through supervision and leadership, participants reported having an understanding of the importance of finding balance to practice other self-care strategies that were important to overall

wellness. Strategies included having leisure time, solitary time, and family time; getting enough sleep; eating nutritionally; exercising; and having time for creativity (Patsiopoulos & Buchanan, 2011; Puig, et al., 2012). Strategies also included meditation, taking a vacation, and engaging in leisure activities outside of the workday as key elements of self-care (Oser, Biebel, Pullen, & Harp, 2013), especially when job demands were heavy and counselors had an increased need to manage stress. Savic-Jabrow (2010) also recommended self-reflection, personal therapy, social activities, personal activities, massage, walking, reading, Internet engagement, audio and video activities, creative or stimulating activities, or spiritually or culturally replenishing activities. On-the-job activities that could be put in place to ensure self-time included scheduling breaks, ending appointments punctually, allowing oneself to reflect between sessions, allowing oneself to cry when needed, and finding things that were humorous (Buchanan & Patsiopoulos, 2011).

Limitations

Each study included participants who were able to articulate if they were practicing self-care, what practices they were using, and what practices were important for overall wellness. Despite efforts to strengthen each study, such as by using member checks, several limitations to the literature still existed. One concern, in particular, was the potential lack of generalizability of the findings across all studies. Findings may or may not have been representative of other counselors' self-care practices, especially in studies by Patsiopoulos and Buchanan (2011), Puig, et al., (2012), and Savic-Jabrow (2010). The samples did not represent ethnic or racially diverse participants, or an equal balance between genders. For example, in the study by Puig, et al. (2012) 88% of the participants were white females, and demographics of the study by Richards, Campenni, and Muse-Burke (2010) were indicative of the previous study in which 77% of the participants were women and 94% were white. The sample population among all studies was

very similar and possibly not a reflection of the general public. However, the sample could have been reflection of the overall counseling profession and was a reflection of the demographics of the participants in this study. In 2004, researchers from the Substance Abuse and Mental Health Association (SAMHSA) reported that a majority (approximately 90%) of mental health professionals were non-Hispanic White, and 60% of the workforce was female. A better understanding of the current demographics of individuals working in the mental health field could be helpful to further determine if the results of this review have been generalizable.

Richards, Campenni, and Muse-Burke (2010) surveyed 148 participants from the northeastern United States. However, the response rate was poor and could be a significant limitation to the study. Surveys were mailed to 415 potential participants with a return rate of only 35.7%; therefore those who returned the surveys might have been overly self-selected and the differences between individuals who returned surveys and those who did not could not be examined. A similar concern existed for the Savic-Jabrow (2010) study in which support needs of mental health counselors who owned independent private practices was explored in the context of a very low (6%) response rate – (31 of 541) 25 of which (81%) were returned by females. Savic-Jabrow attributed the low response to methodological challenges, or the nature of independent practice. The surveys were sent as an email attachment, which could have required a level of technological competency, and thus decreased the number of surveys returned. In addition to a low response rate, social desirability may also have limited the studies because counselors who help clients increase their general well-being could have been compelled to report participation in self-care activities. Exploring social desirability and expanding the sample to a more diverse group could improve future research.

Focus group participants in the study by Oser, Biebel, Pullen and Harp (2013) were counselors attending a general educational workshop; therefore limits to the generalizability of the study could also exist. Questions were purposely vague and open-ended and focused mostly on burnout. Questions more specific to self-care could have had a greater impact for this research project. Additionally, more rich data could be collected from an individual working within the urban and rural communities, rather than in a one-time focus group held at a workshop. Moving through the community using an ethnographic method could have produced more fruitful data and been an opportunity for the researcher to have critically observed the counselor's working environment and potential occupational stressors (Carspecken, 2006).

Counselors reported the importance of support both on and off the job as necessary in providing effective client services and to prevent burnout. Counselors also stressed the importance of mindfulness, self-compassion, and routinely dedicating time for self for ensuring overall wellness. Information has been needed to better understand the self-care needs of counselors. Self-care practices of counselors have been available only through literature that was anecdotal, outdated, or specific to counselors with specialty training, such as those working with victims of trauma or bereavement. Additionally results reported from studies in this review contained only self-reported data, from small samples, with low participant response rates, which may not reflect the perspectives of the general population.

Peer support specialists have had similar job duties as mental health counselors and have worked with similar populations of clients. However, very limited information has been available to explore the self-care practices of PSSs compared to counselors. The benefits of PSS services for clients have been described in detail in the literature; however, a significant gap exists for understanding the benefits and risks to PSSs who have been employed in the mental

health field. More importantly, research has not been available to describe if and how PSS have been practicing self-care and how employment has helped or interfered with the wellness.

Critical Theory

A critical researcher has been one who has attempted to use her work to form a social or cultural criticism and believed that thought has been fundamentally guided by social and historical power relationships (Carspecken, 1996). Critically oriented research has aligned with the philosophy of peer support, to make public the barriers that have interfered with an individual's ability to make decisions about her life (Quantz, 1992). Carspecken (2006) stated "Criticalists find contemporary society to be unfair, unequal, and overtly oppressive. We do not like it, and we want to change it" (p.4). Kinchloe and McLaren (1994) made critical assumptions that certain groups of people in society have been more privileged than others, and oppression has been reduced between societies when the subordinates have accepted their social status as inevitable. I have believed that PSSs, as well as others who have worked in the mental health field, have not been provided with the proper training and support on the job to practice self-care. PSSs could have been vulnerable to the pressures of the job, overworked by agency directors, taken advantage of clients and coworkers, overexposed to trauma, and have put their mental health at risk for relapse without having been provided with the opportunities to care for oneself. As a counselor and peer support trainer, I have taken a critical look into the practices peer supports have been using to care for themselves and any challenges they have been faced with on the job to ensure their own wellness. I also have explored the similarities and differences between self-care needs and practices of the counselor compared to the peer support specialist. My intention has been to take the knowledge gained from this study and improve peer training curricula around topics of wellness, as well as provide information to supervisors and agencies that could

reduce barriers to practicing self-care and achieving overall wellness for individuals who have worked in the field of mental health. Critical researchers, just like mental health advocates, and even peer support specialists themselves, seek ways through research to promote changes in power, resources, and policy (LeCompte & Schensul, 2011). I believe the results of this study could be used and implemented in training programs, day-to-day practices of peer supports and supervisors, and agency policy is to ensure a safe and more healthy working environment for mental health professionals.

Summary

This chapter has included a review of literature related to Peer Support Specialists, along with a brief description of co-occurring disorders and their prevalence among this population. Peer support has been an evidence-based practice with benefits to both the consumer and PSS. Many individuals could choose to become a PSS because of a positive experience they have had in their own recovery working with a peer, especially for individuals with co-occurring mood and substance use disorders. Despite the positive outcomes for both consumers and PSSs, a closer look needs to be taken at the possible negative impacts employment could have on the ability of PSSs to practice self-care. Self-care practices, such as participating in a social support network or taking time out to decompress from stressful periods have been not only pathways to recovery for individuals with co-occurring disorders, but also an ethical obligation for peer support specialists and counselors alike. Because information about the self-care practices of PSSs has been limited, a closer look at the self-care practices of counselors was taken to provide a framework for understanding self-care in the field of mental health. This researcher has worked in the mental health field for almost 15 years; reviewed research on peer support specialists, peer support services, counselors, and self-care; and has used this information as a guide to take a

critical look at what self-care practices PSSs have been using, what practices were the most important, and how work has interfered with or improved recovery. More specifically, the researcher has believed that the self-care practices of female PSSs with co-occurring mood and substance use disorders should be investigated, as this population could reflect a significant number of PSS working in the field. The self-care needs, just as the treatment needs of women with co-occurring disorders, could be unique compared to others in the field. This researcher has used face-to-face, semi-structured open-ended interview questions to gain in-depth information about the self-care practices of female PSS with co-occurring mood and substance use disorders.

CHAPTER THREE: METHOD

This was an exploratory study of the self-care practices of female peer support specialists (PSS) with co-occurring mood and substance use disorders. This chapter has included a description of the grounded theory approach, the research methods that were used in this study, participant inclusion criteria, and the data collection methods that were followed.

Qualitative Research Design: A Grounded Theory Approach

The primary value of qualitative studies has been to help others understand broad perspective situations that were ambiguous (Eisner, 1991). Unlike the purposes of quantitative studies whose principal value has been to establish facts based on measurement reliability, validation methods typically used in quantitative studies could be a misleading way of evaluating qualitative studies (Stenback, 2001). Well-respected researchers have cited trustworthiness as an accurate criterion to use as a substitute for reliability (Lincoln & Guba, 1985; Maxwell, 1996). This researcher explored individual qualities that were discovered through extended in-person, face-to-face dialogue; thus, qualitative research methods were employed (Creswell, 2009; Pope & Mays, 2006; Yin, 2009). Open-ended, semi-structured questions that were asked within the context of face-to-face interviews between the researcher and each individual participant allowed for in-depth information to be collected, which could not be obtained through the use of quantitative techniques.

Qualitative research procedures used in this study were applied based on the writings of Denzin and Lincoln (2000) who asserted:

> Qualitative research is a situated activity that locates the observer in the world. It consists of a set of interpretive, material practices that make the world visible. These practices transform the world. They turn the world into a series of representations,

> including field notes, interviews, conversation, photographs, recordings, and memos to the self. At this level, qualitative research involves an interpretative naturalistic approach to the world. (p. 3)

A grounded theory approach (Strauss & Corbin, 1990; 1998) – one of several qualitative research techniques typically employed – was used in this study for exploration of empirical data. Grounded theory was chosen as the research method for this study because it has been ideal for exploring integral social relationships and the behaviors of groups in which little exploration has been done (Crooks 2001). Glaser (1978) reported that grounded theory is useful when a researcher needs to get though and beyond conjecture and preconception to the underlying processes of what is going on, so that professionals can intervene with confidence to help resolve the participant's main concerns. The results from this study will come directly from interviews and observations. To the knowledge of this researcher, the self-care practices of PSSs have not yet been explored. The researcher has conducted this study with limited theoretical preconceptions, and has designed the research questions to provide exploration and an understanding of the current self-care needs and practices of female peer support specialists with co-occurring mood disorders. The data that emerged in the study were examined until categories emerged for the purpose of constructing theory (Charmaz, 2006). The process involved deriving general theory based on the perceptions of individuals in the study. Grounded Theory Methods involved systematic and inductive guidelines for collecting and analyzing data (Charmaz, 2000) and constant comparison of data to identify emergent categories (Creswell, 2003).

Participants

Recruitment Procedure

Connection with the gatekeeper. The researcher began recruitment by contacting the Chief Clinical Officers (CCOs) at local peer run behavioral health agencies and invited them to participate in the study. The researcher needed to establish rapport with the CCOs to gain access to participants and information, gain permission from the "gatekeeper" at each agency to make contact with potential participants, and to be accepted by the research population (Gulati, Paterson, Medves, & Luce-Kapler, 2011). All Agency CCOs referred the researcher to an administrative assistant, human resources, or public relations officer to serve as the gatekeeper for reaching participants.

Administration of the invitations. After speaking with the agency gatekeepers, the researcher requested to share hard copies, as well as through email, informational flyers (see Appendix C) with potential participants. All agency gatekeepers requested that the flyers be sent only through email and agreed to forward the flyers to all agency employees. Thus, participants were first recruited by an email distribution of flyers to all staff from the agency gatekeeper. The flyer contained information about the purpose of the research, inclusion criteria, potential risks of participation, and telephone and email contact information for the researcher.

A second sampling technique was used while engaging potential participants. The researcher distributed additional hard copies of the informational flyers to five individuals who were also willing to share the flyers with other potential candidates (Germain, 1993). This referral technique also has been known as snowball sampling because the sample group appears to grow like a rolling snowball. Snowball sampling has been used as a mutual association procedure in which existing study subjects have recruited future subjects from among their

acquaintances. Snowball sampling has helped to build more relationships using peer recommendations to find new participants with a specific range of skills that have been determined to have been useful (Goodman, 1961).

The researcher ensured a diversity of contacts by broadening the initial base of contacts with agency gatekeepers. Rather than recruiting participants from only one agency, the researcher was able to connect with at least six gatekeepers from peer-run agencies in Maricopa County and recruit participants from five of the six agencies.

Screening and selecting the sample pool. Once identified, potential candidates contacted the researcher by telephone and email to indicate an interest in participating in the study. The researcher confirmed the potential participants' preferred future contact method (telephone or email); scheduled the date, time, and location for a face-to -face interview; encouraged the participant to ask questions about the study; and discussed the next steps in the research process. The researcher informed participants during the initial 10 minutes of the interview that she would further orient the participant to the study and conduct a verbal screening process to confirm demographic information and to confirm that participants met all inclusion criteria.

During the face-to-face meeting, this researcher held a 5-minute introduction period for both the researcher and the participant and reviewed the purpose of the study and any potential harm to participants. Individuals who continued to report having an interest in participating completed an Informed Consent Form (see Appendix D) and a screening and demographics questionnaire (see Appendix E). The questionnaire was used as a final confirmation that the participants met the inclusion criteria.

The sampling was directed by confirmation that participants were experts in the area of peer support and co-occurring mood and substance use disorders combined with the researcher's increased understanding of the developing theory (Glaser, 1978). The researcher recruited and scheduled 12 adult participants to be interviewed, however the researcher interviewed only ten participants. One participant declined to participate in the study at the initial face-to-face orientation due to the stress of a recent loss of a family member and after the researcher reminded the participant that she could opt-out at any time, for any reason, as refusal to participate was her right and privilege. Another participant had indicated during the prescreening process that she had been working as a PSS for over one year. However, during the face-to-face interview, the researcher concluded that the participant had been serving in an administrative capacity and did not work directly with clients on a regular basis. The researcher did not include any information from this participant in the final analysis.

Theoretical saturation started to occur by the seventh interview as could be expected to occur (Glaser & Strauss, 1967; Strauss & Corbin, 1998). However, to confirm the results, this researcher conducted interviews and analyzed data collected with all ten participants.

Data Collection Site

Interviews were conducted in private settings of the participants' choosing in Maricopa County, Arizona, which included coffee shops, restaurants, a park, a community college campus, a private room at the Phoenix Public Library, and the courtyard of a participants' apartment complex. Before starting each interview, the researcher inquired about the participants' comfort level of sharing information within the intended location. The researcher reminded the participants that they could choose to discontinue the study or not answer a particular question if they felt uncomfortable at any time during the interview. The researcher ensured that the settings

were sufficiently private to maintain the confidentiality of the participant. After the participant agreed to be recorded, interviews were recorded using a digital voice recorder.

Sampling Approach

Inclusion criteria. Participants qualified as candidates for the study if they were adult females who were between the ages of 30-55 years old and were able to speak and comprehend the English Language. At the time of the interviews, participants also were employed as peer support specialists for at least 12-months in a peer-run program in Maricopa County, AZ. Participants met all of the requirements to be employed as a PSS in Arizona, which included being in possession of a GED or high school diploma, graduation from an approved peer support training program, and successfully passing the certifying examination for peer support specialists in Arizona. All of the women in the study had a self-reported history of a co-occurring mood and substance use disorder (in full remission). Mood disorders could have included Depression, Bipolar Disorder I and II, and Mood Disorders Not Otherwise Specified (NOS), excluding those experiencing intermittent periods of psychosis, such as Mood Disorder with Psychotic Features or Schizoaffective Disorder. Even though the participants had been diagnosed with a substance use disorder, they reported being in full alcohol or drug remission for at least 12- months at the time of the interviews.

Exclusion Criteria. Participants would have been excluded if they demonstrated signs of severe cognitive or psychiatric impairment or were unable to be interviewed due to discomfort with the interviewer, any of the interview procedures, or any of the interview questions.

Human Subject Considerations

Approval was sought from the University of Arizona Department of Education Institutional Review Board Committee (IRB). The committee granted this research project an "exempt" status; thus a full human subjects review was not required. Written informed consent was obtained from participants before commencement of the interviews (see Appendix D). Participants were offered a $20.00 gift card to Target upon completion of the interview. Confidentiality and anonymity were maintained as names were coded and withheld from the final report. Study data, such as demographics questionnaires and recordings, have been kept in a secure password protected computer and will remain there for up to five years. The researcher assured participant anonymity both during the study and in the reporting of research findings.

Investigative Process

Semi-Structured Interview with Open-Ended Questions

The researcher took a semi-structured interview approach using open-ended questions to allow for new ideas to be brought up during the interview as a result of the participants' responses. Open-ended questions were general questions that the researcher asked for two principal reasons. Reja, Manfreda, Hlebec and Vehovar (2003) described these reasons, noting that, "one is to discover the responses that individuals give spontaneously; the other is to avoid the bias that may result from suggesting responses to individuals" (p. 159). In the semi-structured approach, all participants were asked the same open-ended questions to begin the discussion. This has been distinguished from closed question variations that required a participant to make a forced choice among a limited number of responses (McIntyre, 1999). After the participants responded, the researcher may have asked follow-up probing

questions to clarify the researcher's understanding of these responses. The semi-structured approach has been distinguished from the structured interview approach that typically included a rigorous set of identical questions asked of each participant from which the interviewer did not divert.

Pilot interviews were conducted with two peer support specialists who had met the inclusion and exclusion criteria to improve the participant question guide. The original questionnaire contained 35 interview questions and was reduced to 9 interview questions after meeting with the pilot participants. The researcher determined that many of the original semi-structured questions and probes were not directly related to answering the research questions of this study. Based on the results of the pilot interview, this researcher updated the language of the questionnaire to reflect a clearer interview guide that encouraged conversation and thus elicited more rich data.

The researcher collected data by asking questions and following hunches. Care was taken not to lead or force participants into responding to preconceived notions or categories through the imposition of forced choice questioning (Glaser, 1992). Pre-written interview questions were used as a guide to help maintain focus on the interview topics; however, a fluid conversational approach was taken to open the interview to the participant in the context of the discussion topic (see Appendix G). Interviews took approximately 90 minutes, and did not exceed two hours to complete.

Probes were used as part of the interview process to encourage elaboration on specific topics, to obtain more detail, and for clarification of the participants' responses. This researcher encouraged two-way communication and built rapport with participants by using semi-structured

interviews with probes. By being less intrusive, this researcher created space for the individual being interviewed to discuss sensitive issues more easily.

Observation Set

Observation data were compiled from recorded interviews, documents, field notes, and self-memos. Interview recordings were compared with written notes to ensure accuracy of written results. Field notes, taken on location immediately following interviews, contained recorded ideas and reflections from the interviewer. Based on Bogdan and Biklen's (1998) writing, field notes that included tables were developed to explore and understand similarities and differences between the participant responses.

Maxwell (1996) suggested that if "your thoughts are recorded in memos, you can code and file them, just as you do your field notes and interview transcripts, and return to them to develop the ideas further" (p. 12), and identify potential probes for consecutive interviews. Self-memos were written soon after completing the field notes through recorded descriptions, summaries, and reflections about the interview responses. Connections between the interviewer's reflections and the research strategies and techniques were clarified by the use of recorded memos.

Method of Observational Analysis

Explanation Building

All study responses were evaluated using an analytical pattern-matching technique called "explanation building" (Yin, 2009). Interview transcripts, field notes, and self-memos were reviewed and responses were categorized preliminarily until patterns emerged. The objective was to build an explanation about what was being observed by "pattern matching" (p. 141). Yin noted, "To 'explain' a phenomenon is to stipulate a presumed set of causal links about it, or 'how'

or ‘why’ something happened. The causal links may be complex and difficult to measure in any precise manner” (p. 141).

Interview Data Analysis

To assist in pattern identification, interviews were transcribed and entered into a qualitative analysis program by QSR International (2012) called NVivo (Version 10) [Computer software]. This program was used to analyze, reduce, and organize data efficiently into words, frequencies, and high frequency participant responses called nodes, as well as themes and findings. Nodes were reflected recurrent phrases, expressions, and ideas that were common among participant responses. Themes were reflected large patterns or clusters of nodes. Findings were very large patterns and clusters of themes.

The major categories, referred to as Nodes, and additional subcategories, referred to as child nodes, were numerically coded and compared with observational notes to verify category accuracy and observation position within the categories. In the second coding step, category numbers were collapsed and integrated to create fewer, more generalized categories. Core analysis variables emerged through observation comparison that continued until similarities and differences became apparent and new relationships and categories were created. This categorization process was repeated many times until small patterns began to match other similar patterns, at which point major themes emerged. After this organization and categorization process was completed, the major themes were explored in detail, which led to findings.

Participant names, names of the agencies they worked for or attended treatment, as well as any identifying pronouns, were removed in this process to protect confidentiality.

Methodological Considerations

Trustworthiness

To establish the trustworthiness of the study's findings, the challenge was to demonstrate credibility and accuracy, or truth-value (Guba & Lincoln, 1981; Lincoln & Guba, 1985). In Grounded Theory Methodology, credibility has been the discovery of social and psychological processes as perceived by the persons who have experienced them (Guba, 1981). Reflexivity -- the qualitative interviewing technique of examining the research being conducted by the researcher and the relationship between the researcher and the research participants (Creswell & Miller, 2000; Strauss & Corbin, 1998), and member checking were the procedures that were employed to ensure trustworthiness. The researcher implemented reflexivity by recording and disclosing any biases, assumptions, and aspects of this researcher's background that could influence interview questions or interpretation of data. The researcher maintained a journal to specifically record "thoughts, feelings, uncertainties, values, beliefs, and assumptions that surfaced throughout the research process" (Curtin & Fossey, 2007, p. 89). Conclusions regarding strengths or challenges that preconceived beliefs could have brought to the research were included in the final report.

Member checking also provided an opportunity for participants to review and approve particular aspects of the interpretations of the data (Doyle, 2007; Merriam, 1998). Member checking has been a way of finding out if the researchers' theories were congruent with the participants' experiences" (Curtain & Fossey, 2007, p. 92). Each participant assisted the researcher by verbally reviewing the identified patterns or categories of data identified by the researcher from previous discussions between the participant and the researcher. Specifically, during each interview, the researcher summarized the information already collected and then

questioned the participant to determine accuracy allowing the participants to analyze the findings critically and comment on them. The participants either affirmed that the summaries reflected their views, feelings, and experiences, or they clarified these summaries, views, feelings and experiences. Ongoing feedback from the members gave the researcher the ability to correct errors and challenge what were perceived as wrong interpretations (Merriam, 1998). Member checking began during the first interview and was performed with each additional interview.

Member checks were also completed at the conclusion of the study by sharing all of the findings with two of the participants involved. Findings were provided in a written report to all participants, as well as peer support training programs in Maricopa County, Arizona. Findings will provide direction and improvement for self-care practices by peer support specialists, as well as peer-support-training-curriculum in the future.

Internal Credibility.

The internal credibilities of the interview questions were dependent upon the extent to which participant experiences were recorded and analyzed apart from interviewer bias or theoretical knowledge of the themes (Kvale, 1996). The interviewer conveyed a supportive, non-judgmental demeanor throughout the interview process to bolster internal credibility and avoid distorting participant responses. The researcher asked participants to clarify interviewer interpretations and verify the accuracy of all response documentation in a manner that did not reveal interviewer expectations.

Participants validated the recorded observations by demonstrating response context within the larger conversations. According to Kvale (1996), “validation becomes investigation: a continual checking, questioning, and theoretical interpretation of the findings” (p. 289); this manner of continuous validation was performed throughout the study.

Internal reliability.

The researcher compared findings across all of the different sources of documentation, including recordings, notes, and categorizations. Additionally, the researcher consistently asked the participants further questions to elaborate on the original information they furnished to confirm codes developed from previous interviews. The researcher did this to create internally reliable questions because such an approach could ensure expressions of the participants' experiences that could be retold with certainty (Kvale, 1996).

The researcher employed the procedure of having a second review in addition to this researchers' review to increase the likelihood of inter-coder reliability. Inter-coder reliability was used to ensure that reliable codes were being developed. The use of a second reviewer was an attempt to reduce the potential for error or bias that could be generated when only one coder processes voluminous amounts of text-based data (Armstrong, Gosling, Weinman, & Marteau, 1997). The second reviewer was a University professor -- a researcher with a diverse methodological background and an expert in the fields of mental health and substance use. Data were not released to the second rater until the interviews were transcribed and any identifying information, such as the name of participants or name of their employers, had been removed from the transcript. The second rater reviewed the codes that were generated from the first transcribed interview. A review was held after the first interview to improve the initial coder agreement and reduce the amount of coding rounds needed to reach an acceptable level of inter-coder agreement. After the fifth interview was conducted and transcribed the second rater reviewed a random sample of the first raters' codes from all five interviews and both raters met to discuss any discrepancies or problematic codes. Finally, both reviewers independently coded the tenth interview and discussed any discrepancies or problematic codes. Corresponding

modifications were made to create a final data set (Armstrong, Gosling, Weinman, & Marteau, 1997).

Summary

To better understand self-care practices of female peer support specialists (PSS) with co-occurring mood and substance use disorders, the researcher conducted in-depth semi-structured interviews with ten prescreened prospects who met all of the inclusion criteria. The data from these interviews were transcribed, then analyzed manually, as well as with NVivo 10.0 software to identify the key terms, nodes, categories and emergent themes of the participants' experiences so that explanation building could be completed as part of the grounded theory development process**.**

CHAPTER FOUR: RESULTS

The purpose of this study was threefold: (a) to explore the self-care practices of female peer support specialists with co-occurring disorders; (b) to identify and describe which self-care practices, if any, have been most helpful for peer support specialists to achieve wellness; and (c) to investigate how work has improved or interfered with overall wellness of PSSs. Great care was taken by the researcher to consistently use research understandings as they surfaced to improve the data gathering and interpretation processes within this study.

To better understand self-care practices of female peer support specialists (PSS) with co-occurring mood and substance use disorders, the researcher conducted ten interviews with female peer support specialists. The data from these interviews were transcribed, then analyzed manually, as well as with NVivo 10.0 software to identify the key terms, nodes, categories, and emergent themes of the participants' experiences. To ensure trustworthiness, the researcher employed reflexivity and member checks, and employed a second reviewer to ensure inter-coder reliability. Inter-coder agreement was employed on the first, fifth, and last interview. After all corresponding modifications were completed, the agreement rate was 100% on the final data set, with no coding discrepancies.

Participants' Demographic Profile

Ten female peer support specialists were interviewed for this study. Most of the participants reported their ethnic background as being white or Caucasian, except for two of the women. One reported being Hispanic or Latina, and the other woman recorded "other" on her demographic questionnaire. The age of the women in the study ranged from 30 to 55 years old. Four of the women reported that they were single and never married. Three women were married, one was divorced, one was separated, and one reported that she was cohabitating with

another person. Only two of the women did not have children and one had two children, two had three children, two had four children, one had seven children, and one had nine children.

All participants self-reported as having had a co-occurring mood and substance use disorder. Six of the women in the study reported having had a diagnosis of Depression and four of the women reported having been diagnosed with Bipolar Disorder. Multiple drugs of choice were identified by the women to include Alcohol, Methamphetaime (Meth), Cannabis, Cocaine, Valium, and other narcotic medications, such as Vicoden. Six of the women reported that they had been admitted, at least once, to a psychiatric hospital for treatment of their mood disorders and six of the women reported participating in a formal alcohol or drug treatment program. Six of the women were currently taking medications for their psychiatric diagnoses. Eight of the women have participated in a 12-step program, such as AA or Celebrate Recovery, and seven have met with a mental health counselor within the past year.

All participants had currently been working in peer support positions at peer run agencies in Maricopa County, Arizona, and self-reported that they had not used drugs or alcohol for at least one year at the time of the interviews. All of the women received benefits through their employers such as, paid time off and health insurance. The salary range for the PSSs was between $15,000 per year and $49,999 per year. Four of the women reported their annual salary to range from $15,000 to $24,999, four of the women reported earning from $25,000 to $34,999, and two of the women reported earning from $35,000 to $49,000 per year. All of the participants had completed a peer support-training program and held a current certificate from the State of Arizona to be employed as a peer support specialist. As part of the state certification requirements, all of the participants had earned a GED or high school diploma. Two of the women also had a certificate from a trade school, four had taken classes at a community college,

one had an associate's degree, two had a bachelor's degree, and one participant had a master's degree. See Table 2 for additional participant demographic details.

Findings

This section includes the reported self-care practices of female peer support specialists with co-occurring mood and substance-use disorders. As codes were identified and combined, themes emerged in the data. The themes identified have been described below and were organized according to the original research questions.

Question One: What self-care practices have female peer support specialists with co-occurring mood and substance use disorders been employing to maintain wellness?

Overall, two themes were identified for question one. The first theme identified was support both on and off the job and the second theme was maintaining a daily routine as self-care practices for female PSSs. Data reflected that PSSs viewed practicing self-care as a necessary part of their own recovery. "Living Recovery," was a way of life learned when they chose recovery and it spread somewhat naturally into their work lives. See Table 3 for a list of self-care practices reported by the participants**.**

Theme 1: support. The main theme related to self-care practice was having a support person or group of people.

> Whenever I have issues, I call my sponsor, I call my best friend. I have a lot of support. (Participant G)

Table 2

Participant Demographics

Age	Race	Children	Marital Status	Diagnosis	Drugs of Choice	DOA Treatment	Psych Admissions	Medications	Hours of Work	Annual Salary
35 – 39	White	2	Single	Depression	Meth	6	No	Yes	40 + week	15,000-24,999
30-34	White	0	Cohabiting	Bipolar I	Narcotics, Alcohol	0	No	Yes	35 + week	15,000-24,000
50-55	White	0	Single	Bipolar I	Cannabis	0	Yes	Yes	40+ week	25,000-34,999
40-44	White	4	Divorced	Bipolar I	Meth, Cocaine, Alcohol	3	No	Yes	40+ week	35,000-49,999
40-44	White	7	Single	Depression	Meth	1	No	Yes	40+ week	25,000-34,000
30-34	White	3	Single	Bipolar II	Alcohol, Meth, Cocaine	3	Yes	No	35+ week	15,000-24,999
40-44	Hispanic	3	Married	Depression	Meth	0	Yes	No	40+ week	15,000-24,999
40-44	Other	9	Married	Depression	Cocaine	0	Yes	No	40+ week	25,000-34,999
45-49	White	2	Married	Depression	Vicoden, Valium	1	Yes	Yes	35+ week	35,000-49,999
40-44	White	4	Separated	Depression	Alcohol, Meth	1	Yes	Yes	40+ week	25,000-34,999

DOA Treatment= times admitted for substance use treatment; Psych Admissions= psychiatric hospitalization; Medications= currently taking medications for a psychiatric diagnoses

The theme of support has been divided into four subthemes. Subthemes identified were (a) family members or close friends outside of work; (b) a supervisor or coworker; (c) support from a group of individuals who promote recovery, such as, a church fellowship, 12-step group members, or residents within a supportive living community; and (d) counselors.

> Part of my wellness is checking in with people who know my warning signs. (Participant H)

Table 3

Participants Self-Care Practices

Self-care practices	**Number of women using self-care practices** (*n)*
Support person	10
Subthemes: Family or friend	10
Supervisors or coworkers	10
Recovery groups	8
Counselors	7
Maintained a daily routine	8
Subthemes: Took prescribed medications	7
Cleaned and organized living-work space	7
Received ample sleep	6
Balanced tasks of being a single mom	5
Spiritual practices	7
Participated in service work	4
Exercised	4
Nutrition	3
Separated work and home life	3

Subtheme A: family members or close friends. Many of the women had a particular family member, most often a mother or a sister, who experienced the challenges of their mental

illness and addiction with them, as well as the successes of their recovery, and who continued to be of support in their lives.

> I stay in contact with my mom twice a day. If she ever thought I was going that way again [relapse] she would probably put me somewhere. I told her once "please do that." (Participant D)

The person identified by the women was not only someone they enjoyed talking to, but also was "someone who holds me accountable for my actions."

Subtheme B: supervisors and coworkers. All of the women reported that they relied heavily on the support they received at work from their supervisors and coworkers as a means of practicing self-care.

> I really enjoy working on a team. My boss and my coworkers we are there for one another--mostly at work, but when things are not going well outside of work I definitely look to them for support for personal stuff too. I mean, really, we spend most of our day together. I see them more than my own kids. (Participant A)

Subtheme C: recovery groups. Eight of the women attended 12-step meetings and sought support from other members that they identified as their "recovery friends" or "church family." If PSSs could not find people to talk with, then they would go to the nearest AA meeting and take advantage of the fellowship in attendance. Not all of the women were comfortable doing so, unless they could attend a particular group which they had already been established with. Two of the women acknowledged that "going to a meeting" was the "right" self-care practice to report, but since they have been employed as PSSs they do not attend meetings that often anymore.

> Meetings were important in early recovery. I went every single day for over a year. Now, I just don't want to listen to anyone else talk after work, except my kids. I would rather stay home with my kids and the worst is when you actually do go to a meeting and feel like you can't share because a client is there." (Participant E)

Six of the women attended Christian--based meetings, called Celebrate Recovery (CR), and reported they felt most comfortable at CR meetings, rather than a traditional AA meeting.

> Yeah, I was like this is not going to work. But when I went into a church recovery group, there were people more intently working on recovery. I didn't get approached by anybody wanting--or using. (Participant G)

A few of the women who attended celebrate recovery were also part of leadership teams at their churches. They held additional duties, such as chairing meetings or facilitating groups. A requirement of the leadership team was to participate in a monthly leadership meeting and have bi-yearly sessions with the pastor to debrief and discuss personal wellness.

> I think the most valuable thing that has been taught to me was by my pastor. He said, "We love you and we love what you do. You have to remember that when you are running groups and listening to everyone and sucking all this down, and teaching lessons, and caring for this person and that person, each time you are collecting pebbles. And you are setting all of these little pebbles on your shoulders. If you don't get rid of those pebbles, you are going to break. It is going to get too heavy. You can't keep everything. You must let stuff out." (Participant G)

Prior to becoming PSSs, four of the women had graduated from the same substance use treatment program. A requirement of the program was to be a part of an assigned "church team." The women met with their teams several times a week while they were in treatment. The PSSs and church team members held spiritual meetings at church and dinners at each other's homes at least one evening per week. Members of the team were part of their early support systems and continued to be considered a part of their families.

> They have not only been my cheering squad, but my family. They have been in our lives since [child] was only three months old, [child] is eight now. We celebrate Christmas together, they come for birthday parties, [child] calls her grandma. (Participant E)

At the time of the interview, five of the women were living in a supportive housing program for women in recovery from drugs and alcohol. The women had their own homes, but they shared a courtyard with other women in recovery and their children. The women were referred to live in this program upon graduation from a drug or alcohol treatment program. The

women chose to reside in this type of supportive community after treatment, because their rent was subsidized according to their incomes, and they could continue to receive support from other single mothers in recovery. According to the participants, almost half of the residents of this community worked in the mental health field in capacities such as peer support specialists, community outreach specialists, transportation specialists, and halfway house managers. A requirement to be admitted and remain in the community was that each woman maintained employment, paid 30% of her income each month for rent, and continued to stay clean and sober.

> When I left treatment, I knew I had to go somewhere where I was going to have that continuous support of other women that were also single parents, and working a recovery program. I needed to have continuous support and I still find the women here today a big support. If someone is doing something they were not supposed to, another women would be like, "So.. .. .what's going on? What are you up to? Everything alright?" and then they would probably report them for the safety of everyone's recovery in the community. We hold each other accountable. Our kid's fight like brothers and sisters, us women get on each other's nerves, but we often sit outside and talk about how grateful we are to be here and have this type of support, to have jobs, to have our kids back with us, and to have our sobriety. Every time I think of moving from here, I get nervous and say, "Nah, I'm not ready yet." (Participant J)

Subtheme D: counselors. Seven of the women acknowledged seeing a counselor within the past year either for support or medication management.

> I do see a counselor once every three months. That is the only way I can get medication. I don't really use her regularly for support, but I know she is there if I needed her or if I was feeling depressed or anxious. So I would certainly say seeing a counselor is a self-care practice, but our visits are much lower on the list of importance. (Participant C)

Seven of the women referenced accessing counseling services available through their employer by employee assistance programs. Four of the women reported using counseling services through their employers within the past year.

> Right now I am going through counseling. I basically started going through the EAP at work, and decided, yup there is still stuff I need to work on. I need to continue to learn and feel comfortable with boundaries, and I am having a rough

> time deciding if I should let my mom be in my life or not. That is why the EAP is there, so I don't bring this stuff to work with me. (Participant B)

Theme 2: routine. The second theme that emerged related to self-care establishing and maintaining a daily routine or schedule.

> Being able to have a schedule to me is so important, learning how to stick to it is even more important. (Participant B)

Eight of the women reported having a daily routine. One of the women who noted she valued the importance of a daily routine also was resentful because the program staff where she was living required her to turn in her schedule to the staff on a daily basis. She believed that she was independent and did not have challenges keeping the schedule, she should not have to report what she was doing all of the time.

> I would like to be in charge of my own schedule. I basically know--like I don't need a piece of paper to tell me what to do. I know that my things are the same everyday. I go to work; I leave my house at 7:00 am. I get to work by 8:00 am; I come home at 5:00pm. I get my kids and I feed them. I go to bed. I know what days I have appointments, and things like that. So basically I have everything in my head. (Participant F)

This interviewer explored with the participant if the consequences for forgetting or not following her schedule.

> Oh, that would be bad. Things like taking my medications might be forgotten, or at the very worst I would not go to bed on time. I really need my sleep. (Participant F)

Several of the women used tools to assist them with their daily schedules, such as Day-Timers, wall calendars, dry erase boards, phone alarms, and applications on their Smartphones (Apps). Apps that were mentioned were scheduling Apps and Apps with special alarms that would remind them to take their medications or give their children their medications.

Keeping a daily schedule was reported to assist women with remembering to take medications, keeping their home and work spaces cleaned and organized, getting ample sleep,

and balancing the tasks of being a single parent. Seven of the women reported taking psychiatric medications for their mood disorders. These women reported previously that they relied heavily on their daily routines and cues throughout the day to help them remember if they have or have not taken their medications.

> . . .the minute I am off my morning routine is when I will most likely forget to take my pills. (Participant C)

Maintaining a weekly schedule and maintaining a clean and organized home and work environment was reported by seven of the women.

> When my house or workspace is not clean and organized, I feel nervous and out of control. When I was using, everything was disorganized. I didn't care enough to clean my house, I could never find paperwork, things were everywhere. To feel healthy and right, things need to be clean. (Participant C)

Interestingly, the women spoke at length about the strategy of having a clean home and work environment. The women's weekly schedule most often included regularly scheduled time for house cleaning as a self-care practice.

> I don't let my schedule slip. I clean my house every Saturday. That is kind of my thing, its important to me and it is a release of energy. I don't spend the whole day cleaning, but I spend about three to four hours cleaning and focus on a different area to deep clean each Saturday. I have to have a clean environment. (Participant D)

Another woman stated,

> For some reason when I am organizing my house, my mind feels better. You know when you have just cleaned everything, Spring cleaning, and everything is clean, and you are just sitting there like, ah I just want to enjoy this for an hour before anybody touches anything. And I enjoy cleaning, it's not like I am down because I have to clean that day. It's a physical release and then when it's done, everything, including me, just feels good. (Participant I)

Two of the women reported using cleaning as a means to unwind.

> It's that everything is in its place, is in order, and you have got a clear vision for just that little window of time. And usually, by the time I am done, I have worked

> through whatever was bad; or I have taken it out with the trash, because I don't need to deal with it anymore. (Participant F)

> I even have a part-time job where I clean my church. I do janitorial stuff there, and it's funny how god put this job in my life, because it soothes me to clean things. So, I get a lot of time, and feel like I have an extra layer of protection by cleaning the church. I will just go down there and re-focus. I pray and I clean, and then I leave it all at the alter when I have had a really bad day. (Participant G)

Six of the women reported that sleep was important for their overall wellness and that ensuring that they and their children were able to get enough sleep each night was an important self-care practice.

> Good sleep is very important to me, and I won't get it because of symptoms of past trauma if I don't take my medications. So, since sleep is important, medications are important, and a schedule to remind me to do all these things is extra important. (Participant J)

Five of the women reported that they used a daily schedule or routine to balance the tasks required of a single mom.

> We keep a pretty strict schedule. We come home and we are consistent, I have chores, the kids have chores. We do homework and we all have a few quiet minutes for reading and relaxation. We are super organized, in order to get a lot accomplished in a little bit of time each night. (Participant E)

In addition to the primary themes of building support and maintaining a daily routine, there were other self-care practices reported by PSSs. Seven of the women reported participating in spiritual practices such as going to church, prayer, and meditation. Responses related to the theme of spiritual practices have been described in more detail in the answer to question 2. In addition, four other self-care practices were identified by less than half of the participants, which included participating in service work, exercise, nutrition, and being able to separate work and home life.

Four of the women reported that they participated in service work through their churches or in the community whenever possible.

> It feels good to give back and help others, not because it is my job to help that day, because it's my day off and I want to help. I speak to other women in recovery, I work in the nursery at my church, so the other families can have their time with god, and we also pass out water to the homeless in the summer. (Participant D)

Exercise also was reported by four of the women. One woman reported how exercise was important for her and her children.

> We are so busy, and I don't have a car so we don't get to "go" places to exercise. I do try to fit it in, especially on the weekends. For example, there is this large empty parking lot on our way to the bus. The boys and I will start at one end and race to the other end, as a way for us all to get exercise and burn off some energy. (Participant F)

Proper nutrition was mentioned by three of the women during the interviews.

> I know some people think this is crazy, but I do not eat a lot of processed foods. I don't feel good about myself when I eat too much junk and I feel depressed and anxious. Working out at the gym and doing yoga at least 3 times a week also help me feel good about myself. (Participant I)

Setting boundaries between life at home and life at work was also reported by three of the women.

> I try to leave work at work and not bring the problems from the office to my house. When I spend time with my coworkers or we chat on the phone, we have a rule to not talk about work after hours. (Participant A)

In summary, the women in this study used a wide variety of self-care practices, which seemed to have helped them complete the emotional, mental, spiritual, and physical dimensions of their lives. Many of them recognized that achieving balance in all of the dimensions of their lives was important, however they articulated that some practices were much more essential to overall wellness than others.

Question Two: What, if any, self-care practices do PSS's believe to be most important for overall wellness?

Participants were asked to narrow their list of self-care practices to the most important practice for them to maintain wellness. See Table 4 for the list of practices that were identified as most important.

During the interviews, the women were prompted to identify which self-care practice was the most important for their overall wellness. Only one woman reported that having a support person was her most important self-care practice. Two of the women reported that maintaining a daily routine was most important. Previously, the women had reported that if they had maintained a daily routine, then remembering to take their medications and getting enough sleep were less challenging. One woman continued to note that taking her medications as prescribed was her most important self-care practice. The same woman also reported that she had experienced several inpatient psychiatric hospital admissions.

Table 4

Most Important Self-Care Practices

Most important self-care practice	**Number of women reporting practice as most important** (*n*)
Maintained a daily routine or schedule	2
Take medications as prescribed	1
Received ample sleep	1
Support person	1

Interestingly, seven women reported taking medications for their mood disorders, yet only one woman reported taking medications as the most important self-care practice. Only one of the six women reported getting ample sleep as the most important practice of self-care. This woman also acknowledged that having enough sleep was still the most important practice for her. Five of the women interviewed reported that their spirituality was the most important self-care practice to maintain their overall wellness.

> What I need to practice the most is my spirituality. Just taking time out to refocus on something different, something much bigger than myself (Participant D).

The ways women were practicing spirituality varied. When prompted, three of the women referred to prayer as their most important self-care practice.

> I think prayer and meditation and being in constant contact with my higher power are the most important. (Participant H)

Another women spoke of prayer as a means to stay spiritually connected with her higher power.

> My relationship with god. I do not go to church as much as I used to because it is all the way across town, but my faith in god; saying my prayer before I get up in the morning and saying it when I go to bed at night, that is the most important. Being an addict was all about what I wanted, being in recovery is all about being grateful for what I have been blessed with. (Participant J)

Participant G noted "church is definitely the most important."

The interviewer inquired further about which parts of church were more important and she alluded to the idea that being spiritual was not just about going to church, but taking on a new healthy way of living compared to a life of drug use.

> There is no real part. There are a lot of parts that make up church. Church provides structure, because you are living a biblical life and you have a set of guidelines to follow. Church gives me something definitive to stick to. Also, when you have a Christ-centered recovery, you take on the structure of that program and you meet healthy supportive people. So, it's all of that. It is god, it is structure and to know where to turn to when you are confused about what is

> right or what is wrong, and it is having people and something greater than you to support you through the hard times, no matter what. (Participant G)

Question Three: How do peer support specialists believe employment has improved or interfered with their ability to practice self-care?

Employment improves self-care.

All of the women reported that they felt stable in their recovery, as well as in their current PSS positions. They described how employment has helped to improve their overall wellness.

> I really do love my job and sometimes I walk down the hall at work and think, I'm so happy to be here. (Participant A)

Five themes were identified were ways employment improved the self-care practices of PSSs. The themes and number of responses for each theme have been listed in Table 5.

Table 5

Ways Employment Improved Self-Care

Ways employment improved self-care	**Number of responses** *(n)*
Support from supervisors	10
Subtheme: Comfort with disclosing to supervisors	6
Subtheme: Ongoing supervision about self-care	4
Subtheme: Sufficient time off	4
Supportive coworkers	10
Reminded of consequences of not practicing self-care	10
Knowledge gained from teaching others	10
Received support from others by sharing own story	8
Working and helping others improves self-esteem	5

Theme One: support from supervisors. All of the women reported feeling stable in their recovery and stable with their employment as a PSS, because they felt supported to practice self-care both on and off the job. The women highlighted how they have been supported by their supervisors to appropriately care for themselves.

Subtheme A: comfort with disclosing to supervisors. A requirement of the job as a PSS has been to disclose that one has a substance use or mental health diagnosis. The possibility exists that because of their disclosures PSSs have had more opportunities to discuss personal wellness than other mental health workers who have not disclosed having a mental illness or substance use history. Six of the participants indicated that they could have reached out to their supervisors for support when they felt triggered, believed they were experiencing symptoms, or were had been experiencing rough times.

> Its strange, she [supervisor] is only a year older than me, but I feel like she is this wise old woman. It feels good to tell your boss, "Gosh, I'm feeling really bad today," and she closes the door, and sits there next to me for almost an hour and just listens. (Participant I)

Another woman reported that she looked forward to her boss checking on her regularly.

> She is really big on checking in on us. She comes around about once a week, asking us what [we] have done in the last few days to take care of ourselves. She asks how our week was, or if we have anything we need to discuss. She even asks if there was anything that triggered us or that was upsetting. (Participant H)

Three of the women reported that their supervisors were the first people they would turn to if they were feeling as if their wellness were at risk.

> I went to [supervisor] and I said, "This is what I am going through. And I think I need some help from this. I am not bouncing back like I usually do. The meetings are not helping. My sponsor is not helping. Praying for it to go away is not helping. I hurt, and I am not coming back." She was very supportive and even reminded me of the counseling services we have available to us, called an EAP? [Employee Assistance Program] (Participant J)

In fact, two of the women had identified times when their supervisors had recognized they were getting sick before they had any awareness that they were experiencing symptoms.

> It took my boss, who is absolutely amazing, to tell me things like, "I am needed, when you show up you do amazing work. You have been calling out sick a lot and going home early. Your energy is low, but when you are having a good day, things are really good. We need you and if you are having any trouble, I want to help you. I want to continue to work with you." After she said these things I was able to tell her that I was feeling very anxious lately and not sleeping. I knew these were signs of me getting sick, but it was not until I was forced to say them out loud that I really realized how dangerous things were getting. (Participant B)

Subtheme B: ongoing supervision about self-care. Another participant reported that self-care is discussed during her individual supervision sessions and that her supervisor makes a point to continue to address self-care throughout the week with the staff. Four participants from three different agencies shared that they held monthly supervision meetings for PSSs so they could share challenges they have had at work and their plans for self-care.

> So we have these peer support meetings once a month on Wednesday. During the meeting we remind each other why we are all here and do this type of work, because it can be really, really draining. It is a reminder about self-care and like if we are having a hard time saying no or setting a boundary with a client, we share our experiences and it's almost like we support one another and give each other permission and encouragement to do the tough stuff--like setting boundaries. Addicts usually have never been too good with that one. It is a meeting to talk about different ways we can help ourselves and be of support to one another. We also filled out these sheets once about who could be called if we were in a crisis at work, who could take care of us, and who would go pick up our kids. It reminded me of the importance of having these types of conversations with those who support me. We can also vent a bit about "that client" that kind of gets under our skin sometimes. (Participant A)

*Subtheme C: sufficient time off***.** Four of the women reported feeling a sense of safety that time off was available to them to care for themselves without losing pay

> This would have never happened at any of my other jobs. People usually get angry with you when you are sick. I used to work in a hospital and they tell us to not come to work when we are sick out of one side of their mouths, but then you call out sick because you have the flu and they are cursing at you for not coming

> in out of the other side of their mouth. I could have never just called out and said, "I am feeling really depressed today." (Participant I)

In many circumstances, the women reported that their supervisors regularly encouraged them to take time off for self-care.

> A benefit about being a peer is the paid time-off thing and the idea that we can just be open with our boss. If I need to go to the doctor or I need some time to get an authorization to fill a prescription, I just put in a time-off request. Sometimes I am told to take the entire day or a half of the day. Because we are peers, it is just assumed we will need to see a psychiatrist or counselor or doctor. We are allowed to make time for these things. We don't have to keep it a secret about why we need to leave early that day. The paid time-off thing, yeah, its pretty important. (Participant G)

Theme Two: coworkers. All of the women reported having coworkers they could trust, staff cases with, and turn to if they were having a bad day.

> I feel lucky to work on a team. It feels safe to be able to check in with each other sometimes. I have a coworker who sits near me and we know each other's warning signs and are not afraid to call one another out if we see something that just doesn't seem right. I ask her how to work with a certain client and we cover each other's cases if one of us is having a bad day or needs a break. She has even meditated with me in the office one time when my anxiety was really high and I have prayed with her. (Participant H)

Theme Three: reminded of consequences of not practicing self-care. Overall the women did not see themselves as much different from the individuals whom they provided services.

> I could be right there with them in the same spot, one drink or drug away. The people that I serve are my peers. I am just like them in a lot of ways. (Participant E)

The women were able to describe ways that working with their peers has reminded them of the consequences of not practicing self-care.

> And I've learned a lot working at [agency]. I always share with members in my group that just because I am here wearing a badge, I am not better than you. In fact, I continue to learn from you all each day. That is what group is about. We learn and grow from one another. (Participant H)

One participant reported that early in recovery she still had cravings to drink and use drugs, but after working with people who were still using drugs the cravings had stopped.

> But honestly, because I see so many people relapse, it doesn't look desirable to me. I think how could I ever look like that? What was I thinking? I just don't think the same anymore. (Participant D)

Theme Four: knowledge gained from teaching others. Another participant described how working as a peer support has helped her to learn more about her own mental illness and past drug use.

> When I work with other people with bipolar disorder and I learn about their symptoms and their struggles, I think, "Hey I went through that too." I am reminded about symptoms I have experienced, without even realizing they were related to my mental illness. I kind of fell into the job of peer support and was really uncomfortable talking about my mental illness until after I completed peer training. My family believes it is something a person, should just "get over." Hearing about others' struggles validates what I have been through and I learn more about my own recovery from helping them. Basically, I get paid to learn things that help me every day. (Participant F)

Theme Five: received support from others by sharing own story. Eight of the women held value in telling their stories. One woman reported that learning to tell her story in a way that was meaningful and offered hope to others was healing for her and she believed she gained support by sharing her story with others whom she had something in common.

> I remember what it felt like to sit there and want to just run out. So, if I can tell my story and share my experience, just long enough that they will consider giving the program a chance, then I feel good. Maybe they will stay long enough to get the skills they need to be sober and self-sufficient. It gives me the motivation to go on. Because let's face it, sometimes life is hard, especially as a single mom. Every time I spit out just how awful things were back then, I get a little stronger and every time I share my story with another person, I find I have gained another friend who understands me. (Participant J)

Theme Six: working and helping others improves self-esteem. Five of the woman acknowledged that having a job, more specifically, a job that they could "give back what they

once received," helped improve their self-esteem. They reported that self-esteem and self-confidence were vital to their willingness to practice self-care. One woman referred simply to the idea that having a job and feeling productive was helpful for her wellness.

> For a long time I didn't believe I could work. I was collecting disability for several years. I even have a masters degree, but didn't see myself staying healthy long enough to hold down a job. I believed that I could possibly volunteer a few hours a week. So the idea that I get paid every day, to be myself and to help others, is amazing. Each paycheck is like a sticker on my self-esteem chart. So, for a bunch of reasons, going to work each day is one of my self-care practices. (Participant C)

All of the women reported how employment has improved their self-care practices. None of the participants reported feeling triggered or so overwhelmed on the job that they relapsed on drugs or alcohol. In fact, three of the women denied being able to identify any reasons why employment could interfere with their ability to practice self-care.

> I have definitely had frustrating clients. Clients that have cursed me out in front of an entire group. I was frustrated, but nothing has ever been so bad that I felt triggered, or relapsed, or needed to change my meds. (Participant F)

Employment interfered with self-care

Seven out of ten participants highlighted ways that employment has interfered with their ability to practice self-care or how they have witnessed employment interfere with a coworker's ability to practice self-care. Participants' responses to the ways employment, if any, has interfered with their ability to practice self-care have been listed in Table 6.

Despite reports of current well-being, four of the women were able to report how when working for a different agency or under a different supervisor as a PSS, they had moments when self-care was not a priority, due to high staff turnover.

> Before new management took over I was really uncomfortable, the environment had a lot of staff turnover, there was not any teamwork- no back up, and I would have to fill more than one persons case load at a time, because I had to make up for all the other people calling out sick. No one wanted to come there, not the

> staff, not the clients for a little while. I did not even have the opportunity to think about self-care. I was just trying to make it through the day. (Participant H)

Table 6

Ways Employment Interfered With Self-Care

Ways employment interfered with self-care	**Number of responses** *(n)*
Peer support work does not interfere with ability to practice self-care	3
High Staff turnover does not allow for time to practice self-care	3
Limited access to supervisor and coworker support	3
Not ready for PSS-type work	2

Three of the women shared times they felt overwhelmed because they did not have access to supervision. One of the women reported a time when several staff members had quit including her supervisor. She indicated she was filling several staff roles without any supervision. The woman reported she had to take a medical leave of absence, but was able to return to the job after taking a break for three weeks.

> I had even thought about quitting, because it was so overwhelming. I mean panic attack after panic attack. I was asking myself things like, is this something I really want to do? Am I capable of doing this? You know? Then I had to step back and realize that it was not really me; it was others. When I returned they transferred me to a new site. The site was smaller and the supervisor has been very invested in self-care practices and taking a break when we need one... . (Participant C)

Two of the women were able to report times when they observed their coworkers' health being at risk because they were not stable enough with their dual diagnoses to be able to work and practice self-care.

> [Coworker] was just not sober or stable long enough in her own recovery to take on the pain of others. Nowadays some places require that you have been clean for

> a year before they will hire you. I am not so sure this is a bad idea. On the other hand, I am glad [company] did not have that rule when I started. I am not sure where I would have ended up working. (Participant H)

One of the women observed several of her coworkers relapse when she first started her career.

> They were pushed too early in their recovery to care for others. Maybe they just needed a job and thought this is easy and this pays well. There was just too much going on--too much trauma still in their lives that they had not worked through. This was also before there was training and a certification requirement. You just got put on the job to fend for yourself. One girl had an attempt [suicide]. She was hospitalized for a very long time. Requiring training for Peer Supports is good. Maybe people who are not ready will realize it in training, or maybe they can start the job with more tools, so this does not happen. (Participant G)

Another theme was identified from the data that did not directly relate to the research questions, however could be important to mention when discussing the long-term self-care practices of peer support specialists. The topic of career plans was discussed with several of the PSSs. Many of the PSSs did not have any long-term career goals. Some considered going back to school, "some day-maybe," but others reported being content in their current positions. All of the peer support specialists interviewed had been working as a PSS for at least one year. The average time on the job for all 10 interviewees was 2.7 years. One woman had been working as a PSS for over 4 years, but did not believe career advancement was in her best interest.

> It's not because professionally I don't want to grow. I have already been in management. It stressed me out. Understanding this is part of my awareness. I am good where I am at. I don't need to be a case manager, I do not want to be a counselor. I don't need more money, I will just buy cheaper stuff. (Participant G)

Summary

Although PSSs recognized the importance of having boundaries with clients and "leaving work at work," PSSs did not have much separation between the self-care practices used in their personal lives and the self-care practices employed in their professional lives. The combination

of self-care practices learned from recovery and the self-care practices used on the job helped to enhance their wellness rather than interfering with their ability to practice self-care. All ten of the women reported having a supportive person, both on and off the job. Eight women recognized the importance of having a schedule or daily routine to accomplish necessary daily tasks, especially those required of single mothers. A daily routine also ensured opportunities to practice self-care: taking medications and getting enough rest. Overall, the female peer support specialists in this study reported that spirituality was the most important self-care practice, despite themes related to building a support network as a vital practice of self-care.

CHAPTER FIVE: CONCLUSION

Discussion

The purpose of this study was to explore the self-care practices of female peer support specialists with co-occurring mood and substance use disorders. In this chapter, overarching conclusions for each question, relationships of the findings to the literature, and recommendations for future research studies have been included.

Question One: What self-care practices have female peer support specialists with co-occurring mood and substance use disorders been employing to maintain wellness?

Peer support specialists in this study are using a variety of self-care practices. Frequently used practices include accessing personal and professional support and establishing and maintaining a daily routine.

Women value using both personal and professional supports as one of their self-care practices. Personal support could come from a family member, friend, or people in recovery, such as 12-step members, church fellowships, a 12-step sponsor, or a mental health counselor. Access to a healthy support network is a strategy for women in recovery, as researchers have attributed causes of drug abuse and failed attempts at substance use treatment to the inability to establish a healthy support system (Abott & Kerr, 1995; Covington, 1999).

As part of their substance use treatment regime, all of the women have participated in a 12-step program to build a personal support network outside their treatment setting. Many of the women report that they have not been currently participating in a traditional 12-step program, yet they still believe 12-step support is important to mention as a self-care practice. Peers have identified 12-step meetings as no longer being helpful because they have been too difficult to fit into their schedules as single, working mothers; they no longer feel like “listening to people’s

problems" after they leave work; or they do not believe meetings are a safe place to share information if their clients also are in attendance. Many of the women do attend Celebrate Recovery, because they value a more spiritual approach to 12-step programing and their children also can attend the program with them. Interestingly, the women report not wanting to go to 12-step meetings any more because they might run into clients outside of work. While at work, they report that being around people in early recovery reminds them of the importance of practicing self-care. Perhaps the lack of attendance by PSSs at traditional 12-step meetings, but the need to continue to report 12-step meetings as a self-care practice, alludes to the idea that closed 12-step meetings, specifically for PSSs could be of value. To take the idea a step further, meeting attendance could improve if closed 12-step meetings and reliable childcare were simultaneously available for female PSSs.

The use of professional support among peer support specialists is consistent with reports from mental health counselors from the literature (Oser, Biebel, Pullen, & Harp, 2013; Patsiopoulos & Buchanan, 2011; Puig, et al, 2012; Savic-Jabrow, 2010). A differences between the support received by PSSs and counselors are that many counselors reported not having enough supports on the job, especially from their supervisors (Oser, Biebel, Pullen, & Harp, 2013), and that they needed to rely on supports from their coworkers (Savic-Jabrow, 2010). Whereas most PSSs report feeling supported on the job by their supervisors as well as their coworkers. In fact, in some circumstances, the observation and confrontation by a supervisor that afforded the PSS insight into increased mental health symptoms or relapse-prone behaviors they had been displaying. PSSs also reported that they had a close coworker who they believed would confront them if they noticed any changes in behavior. In several circumstances, the PSSs had shared their warning signs with coworkers and had a mutual agreement to observe one

another for potential mental health or relapse concerns. The importance of support for women with co-occurring disorders has been well documented (Curtis-Boles & Jenkins-Monroe, 2000; Davis &DeNitto, 1998; Kissin, Svikis, Morgan, &Huang, 2001; Majer, Jason, Ferrari, Venable, & Olsen, 2002), and PSSs are hired because they have a co-occurring disorder, rather than in spite of it. Therefore, the ability to openly share symptoms experienced from co-occurring disorders to supervisors and coworkers, as well as the support received on the job to practice self-care, could improve the mental health of peer support specialists and the longevity of their careers.

Peer Support Specialists benefit by having an established daily routine both personally and professionally to accomplish activities of daily living required as people in recovery, single mothers, and professionals. PSSs reported that following a daily routine led to an improved sense of accomplishment, an improved sense of self-worth, and decreased stress. Routine ensures time for other important recovery activities, such as taking medications, time for prayer or meditation, and getting ample sleep. For single moms, routine is necessary to ensure children get to school on time, complete homework, participate in extra-curricular activities, are well nourished, and get ample sleep (Duquaine-Watson, 2007). Similar results were found by Arevela, Prado, and Amaro (2007) who have reported that women in recovery from substance use are more likely to cope positively with daily stressors and maintain good physical and psychological health if they have a strong *sense of coherence* (SOC). SOC has a positive influence on health and occurs when an individual is self-assured and views her environment as manageable and meaningful. In short, women with SOC feel greater self-confidence when operating within a structured and predictable environment (Antonsky, 1987).

SOC is considered to be an emotional or cognitive tool that helps individuals bring order

into their lives by increasing capacity to believe in their competence to accomplish goals, structure their lives, and face challenges regardless of how difficult they seem (Bothmer & Fridlund, 2003). For individuals with mental health and substance use disorders, improved SOC has been associated with better ability to cope with stressful life situations (Langland, Wahl, Kristofferson, Nortvedt, and Hanestad, 2007), improved life satisfaction, fewer psychosocial consequences of substance use, and improved chances of long-term recovery (Bandura, Gorczyca, Tomalczyk & Matysiakiewics, 2000).

Although the terms used in the literature have been different, the importance of SOC as a self-care practice is similar to counselors' reports of the importance of self-compassion (Oser, Biebel, Pullen, & Harp, 2013; Patsiopolous & Buchanan, 2000; Puig, et al, 2012). People with co-occurring disorders have used SOC as a construct to maintain structure and use positive self-talk, to work through stressful situations (Bandura, Gorczyca, Tomalczyk & Matysiakiewics, 2000; Mowbray, Moxley, & Collins, 1998). Counselors refer to self-compassion as a construct to reduce job-related stress by using self-discipline, validation, and self-acceptance to improve feelings of self-worth and thus continue to be able to help others recognize their own self-worth.

Researchers have confirmed that one of the benefits of working as a PSS is that by effectively helping others, PSS are afforded an enhanced sense of coherence (Davidson, Chinman, Sells, and Rowe,1999; Mowbray, Moxley, & Collins, 1998; Powell, Yeaton, Hill, & Silk, 2001; Salazar & Shear, 2002; Sherman & Porter, 1991; Solomon, 2004). Experiencing meaning in ones' life, caring for oneself, thinking positively, and following a daily routine to reduce stress and improve quality of life are important self-care practices for PSSs, as well as counselors, which lead to a strong sense of coherence.

SOC is critical to the long-term success of PSSs, because understanding self-care

practices and having the confidence to access tools for self-care have been identified as significant methods to reduce stress. Stress reduction could be a practice in the overall wellness of female peer support specialists with co-occurring mood and substance use disorders. Stress has been associated with the worsening of chronic diseases such as depression and substance use (Astin, 1997; Bandura, Gorczyca, tomalczyk & Matysiakiewics, 2000; Schure, Christopher, & Christopher, 2008) as well as absenteeism, poor job performance, decreased job satisfaction (Burnard, Edwards, Fothergill, Hannigan & Coyle, 2000), and occupational burnout (Sowa, May, & Niles, 1994).

Question Two: What, if any, self-care practices do PSSs believe to be most important for their overall wellness?

Peer Support Specialists report spirituality as the most important self-care practice to ensure overall wellness. Results have been consistent with those of Arevelo, Prado, & Amaro (2007) who report that spirituality, especially in women, has been associated with improved substance use treatment outcomes. Furthermore, among women spirituality can be a source of support and inner strength by helping to find meaning in situations of extreme stress (Gall, 2006; Tsevat, 2006). Higher levels of spirituality are associated with more adaptive coping responses, higher resilience to stress, a more optimistic life orientation, lower levels of anxiety among recovering women, and greater perceived social supports (Ellision, 1991; Galanter, 1997; Pardini, et al., 2000). Spirituality was not discussed as a self-care practice among counselors. Therefore, the possibility exists that spirituality is a tradition carried over from treatment received for mental illness (Lukoff, 2007), or more likely substance use (Drake & Noordsy, 2005). Spiritual practices are not unique to PSSs who are in recovery from substance use, especially if 12-step programming was part of their treatment regime. The terms “spiritual experience” and “spiritual

awakening," are used numerous times within the Big Book of Alcoholics Anonymous. Four of the 12-steps include the word God, and many members of AA have referred to "unsuspected inner resources" as a power greater than themselves" (pp. 569-570). A recent explorative study about the transition of female PSSs from clients to professionals and spiritual awakenings within their recovery journeys was conducted (Mendoza, 2013).

Interestingly, all ten of the women from this study have reported support in both their personal and professional lives as one of their self-care practices, yet only one person reported having a support person as the most important self-care practice. Many of the women, when prompted to choose the most important self-care practice, relied heavily on the support they received through spiritual connections rather than support received from a family member, friend, counselor, supervisor, or coworker.

The second most important self-care practice identified was maintaining a daily routine or schedule. Researchers have concluded that following a daily routine is crucial to the long-term recovery of individuals with both mood disorders, more specifically bipolar disorder (Frank, Gonzalez, Fagioline, 2006; Frank, et al, 2005), and substance use disorders (Drake & Noordsy, 2005). A daily routine is important because the consistency provides familiarity and comfort (Covington, 1999) by breaking up large tasks such as the ones required to balance recovery, motherhood, and work into well ordered patterns that appear more manageable (Frank, et al, 2005). Adhering to a schedule limits emotions such as boredom and loneliness, which are common relapse triggers (Drake & Noordsy, 2005; Frank, Gonzalez, & Fagioline, 2006; Frank, et al, 2005). More specifically, having daily routines helps women recognize "slips" such as "forgetting to take my meds," (Frank, et al, 2005) and creates normal sleep patterns to prevent insomnia (Frank, Gonzalez, & Fagioline, 2006).

Question Three: How do PSSs believe that employment has improved or interfered with their ability to practice self-care?

Peer support specialists have identified several ways in which employment as a PSS could improve or interfere with their abilities to practice self-care. The primary ways, reported by PSSs, that work improved self-care were due to the support both on and off the job by supervisors and coworkers, the daily reminders received about the consequences of not practicing self-care, and the knowledge gained from teaching others about recovery (Mowbray, Moxley, & Collins, 1998; Solomon, 2004).

Results were consistent with those of Mowbray, Moxley, & Collins's (1998) findings that PSSs experienced more benefits to their recovery from working than risks to their recovery. Participants in this study have been employed as PSSs for at least one year, and consistently reported that working, as a PSS has been helpful in maintaining recovery and practicing professional self-care. Additionally, PSSs reported that employment at peer-run agencies was "safe" because the staff members at all levels of the organization identify as being persons in recovery. Many PSSs reported that working at a peer-run agency allowed them access to supervisor and coworker support directly related to challenges surrounding mental illness and substance use. The ability to access support from supervisors and coworkers also contributed positively to their skill development and personal growth (Mowbray, Moxley, & Collins, 1998).

Working with others in recovery reminded PSSs of the importance of following a routine, taking medications, and using recovery tools, such as a support person or prayer, which increase the likelihood of maintaining sobriety (Solomon, 2004). Working with clients is a regular reminder to the PSSs of how fragile recovery is without consistent self-care and that the difference between providing services and receiving them is "really just one drink or drug away."

These reminders, along with the responsibilities of being seen as a role model, are motivation for the PSS to practice self-care and maintain wellness (Mowbray, Moxley, & Collins, 1998; Powell, Yeaton, Hill, & Silk, 2001; Salazar & Shear, 2002; Sherman & Porter, 1991; Solomon, 2004).

The role of PSS is one of great responsibility. PSSs provide a variety of services such as teaching activities for daily living, group facilitation, emotional support and feedback, and job-skills training. However, this researcher, as well as others **(**Mowbray, Moxley, & Collins, 1998; Solomon, 2004), has concluded that the relationships between peer support specialists and consumers are relationships of mutual support in which both PSSs and consumers experience improved health outcomes. Peer supports identified that they learned more about their own symptoms of mental illness and relapse triggers by teaching others. PSSs reported that by discussing self-care practices during group facilitation or individual sessions with clients, they also learned new ways to care for themselves.

Some PSSs reported circumstances such as poor training, high staff turnover, and being employed prior to being stable with their own mental illness and sobriety, that could have interfered with their ability to practice self-care (Mowbray, Moxley, & Collins, 1998; Solomon, 2004). Counselors also reported that practicing self-care was difficult when the agency had high staff turnover and supervisors and coworkers were either unprepared to do their jobs or were practicing impaired (Oser, Biebel, Pullen and Harp, 2013) However, at the time of this study, none of the PSSs acknowledged facing any of these challenges. Peers identified that they have witnessed similar challenges among coworkers in the past, and while working under previous supervisors. Peers reported that due to a recent push in PSS and peer supervisor training, they were currently feeling supported to practice self-care on the job.

Recommendations and Implications

Recommendations for Peer Support Specialists

Several recommendations are suggested as a result of this study, such as understanding and using effective self-care practices, building personal and professional support networks, and establishing a daily schedule to balance recovery with personal and professional demands.

The peer supports in this study demonstrated a solid understanding of their self-care needs and were able to articulate ways in which they practiced self-care as well as the importance of self-care. Personal awareness of an individual's symptoms, triggers, and stressors could be associated with the ability to achieve mental wellness, maintain sobriety, and maintain employment. Many of the women in this study reported having a mental health and sobriety maintenance plan that they, as well as their support persons, could refer when they were feeling at risk for relapse. Being mindful of how one is feeling, what she is experiencing, and how to access support both on and off the job is imperative for an individual with co-occurring disorders, especially if she is working in jobs that could be emotionally draining, such as any position within the mental health field.

Building and maintaining a support system is vital for peer support specialists. PSSs need individuals to turn when feeling triggered, as well as have individuals who might hold them accountable when displaying symptoms of co-occurring diagnoses or not properly caring for themselves. Peer support specialists could improve employment outcomes by forming local personal and professional support networks. Professional support networks can help PSSs gain new perspectives on challenging clients, develop friendships, normalize fears and anxiety, and support wellness. Many of the participants expressed that once they became employed as a PSS, they felt that AA meetings were no longer safe places to share, especially if their frustrations

were work-related. PSSs might be able to form closed AA meetings, other types of 12-step meetings, or even a job club exclusive to those employed as PSSs. Opportunities for professional dialogue around work-related stress and self-care can connect PSSs so they can normalize and address work with compassion. Professional dialogue can be helpful to promote the long-term well-being for peer support specialists.

Last, daily routine and organization are necessary for PSS to be able to balance both personal and professional obligations, as well as to feel safe, and to ensure opportunities to practice self-care. Using tools such as daily task lists, day planners, Outlook calendars, or Smart Phone applications are helpful to keep up with the demands of recovery, home, and work life.

Recommendations for Supervisors of Peer Support Specialists

The supervisor is in a unique position as an advocate for the agency, the PSS, and the client. Many PSSs identified that the difference between maintaining employment and wellness and discontinuing employment and being at risk for relapse was a result of the quality of supervision and supervisor interventions received. Supervisors should provide consistent supervision; regular staff training, especially on topics surrounding time and stress management; foster a sense of coherence; encourage career growth; and supervisors, themselves, must understand that they also are role-models for PSSs and consumers of self-care.

PSSs benefit from having ongoing supervision, as well as supervisor and coworker support. PSSs must understand who their direct supervisors are, who they should contact if a supervisor is not available, and that open relationships between PSSs and supervisors fosters safety, openness, and personal and professional development. Individual as well as group supervision is crucial to meet the needs of individual PSSs while simultaneously building a collaborative learning environment among all staff members. Clinical supervisors enhance the

quality of client care, improve efficiency of services, and increase workforce satisfaction and retention (Roche, Todd, & O'Connor, 2007).

Supervisors should incorporate time management, stress management, and spirituality into trainings that are comprehensive and teach physical and psychological coping skills. Healthy time and stress management practices may serve as a vehicle for development of resources for occupational stress, burnout, or relapse of PSSs. Support in understanding, as well as participating in, spiritual practices could be resources for combatting stress, burnout, and relapse that are unique to PSSs. By teaching positive work habits, such as organization and time management, PSSs might be more likely to set and adhere to parameters of their work, such as using scheduled time off, taking breaks, setting reasonable deadlines for work completion, and keeping work away from personal time. Professional practices learned on the job could carry over to personal life and reinforce the importance of time management to take medications, ensure enough rest, and to make "time for self," especially during periods of high stress. The development of these skills could help reduce the risk of relapse, as well as the daily wear on well-being that often is experienced in the helping field.

By understanding the concepts of sense of coherence, supervisors also should recognize the importance of staff recognition. Although resilient, many PSSs have come from a background full of unsuccessful work attempts or inability to maintain employment. PSS are now role models of assertive and well-functioning adults who are also having recovery conversations with one another, as well as consumers. Although PSSs themselves have reported the benefits of serving as role models it is likely PSSs, as well as other professionals, might perform at an optimal level if they feel valued, have a high self-esteem, and have a strong sense of coherence. Positive feedback in and out of the supervision setting is important. Regular

recognition for hard work and role specific accomplishments through staff appreciation events could boost self-esteem and nurture movement toward further professional growth. Additionally, assisting PSSs to set career goals and continue their education and promotion also could safeguard against long-term career burnout and further improve the PSSs sense of coherence (Galandter, 2000; Trainor, Shepaherd, Boydell, Leff, & Crawford, 1997).

When prompted, the women in the study denied having any long-term career goals. Data related to long-term career goals were only from the last four interviews. Information was collected in the later interviews, because the theme of not having any career plans other than working as PSSs did not emerge in the first six interviews. One participant admitted to being afraid to take on too much stress, while another had been in a management position previously and did not wish to return to that type of work. Another woman did not like the "carved out," career path at the agency to move to a PSS supervisor or case manager. The participant did not see case management or even becoming a counselor as a "promotion." Researchers have agreed that career success is achieved through extrinsic and intrinsic motivators (Kirchmeyer, 1998; Seibert, Crant, & Kraimer, 1999; Turban & Dougherty, 1994). Extrinsic career outcomes are observable achievements such as salary and promotions. Three of the four PSSs interviewed about this topic denied having an interest in being promoted from their position as PSS, and did not acknowledge any extrinsic motivators. Intrinsic career success is the individual's subjective feelings of accomplishment and satisfaction, or sense of coherence, with her career (Seibert, Crant, & Kraimer, 1999). Although PSSs were confident in their work, they did not state that they were confident to move forward in their careers. Additional information on the career paths of PSSs, which includes success based on an individuals' goals, expectations, and strengths, is needed.

Last, just as PSSs are role models to consumers, PSS supervisors also serve as role models to PSSs as well as consumers. With this understanding, modeling is crucial and supervisors must "walk the talk," by seeking supervision for themselves, participating in continued education, and practicing their own self-care. As role-models, supervisors could unintentionally promote or discourage well-being based on their own professional practices. Understanding what needs to be done to achieve wellness is important, however, actually practicing self-care and balancing personal and professional identities is much more valuable (Wester, Trepal, & Myers, 2009).

Implications for Counseling Practice

Contributions from the research (Oser, Biebel, Pullen, & Harp, 2013; Patsiopoulos & Buchanan, 2011; Puig, et al., 2012; Savic Jabrow, 2010), along with the results from this study, could have several important implications for the field of mental health, and more specifically the counseling profession. What researchers (Oser, Biebel, Pullen, & Harp, 2013; Patsiopoulos & Buchanan, 2011; Puig, et al., 2012; and Savic Jabrow, 2010) was confirmed in this study: professional support through close supervision, deep trust among coworkers, and extensive peer group interaction were key practices for ensuring wellness of individuals working in the mental health field as well as improved client services. Self-care practices may be so critical to preventing burnout that they could never be overemphasized nor taught too prematurely. Additionally, mental health counselor educators could aid in the prevention of professional and personal decline by teaching counselors how to assess burnout potential and negative changes in wellness. Counselor educators also could offer courses about supervision and how to provide support to coworkers who have been approaching and pushing emotional and physical

exhaustion, incompetence, overly negative work environments, devaluation of their clients, and deterioration in their personal lives as detailed by researchers Puig et al. (2012).

Mental health counselor supervisors should be highly attentive to the vulnerabilities of those they supervise, emphasizing the importance of professional and personal wellness. Supervision meetings could include discussions surrounding prevention and career retention. Counselors could be encouraged to complete and share personal wellness plans, such as the Wellness Recovery Action Plan (WRAP) created by Mary Ellen Copeland (1997), as it has been a prerequisite for many PSS training programs. Unlike PSSs who are hired to disclose they have had a mental illness or addiction, counselors could be more likely to keep their past histories or current health needs a secret, thus limiting their access to support. The possibility exists that a counselor will not obtain help until she has already been practicing impaired in fear of being thought of as "less than" or unable to perform the duties of her job. Agencies could have open policies, such as peer run programs to eliminate stigma of counselors needing treatment for themselves, and a plan for intervention and support of impaired counselors.

Recommendations for Future Research

More information is needed to understand the long-term risks and benefits to wellness when employing individuals with co-occurring mood and substance use disorders. Longitudinal studies among peer support specialists, beyond one year post-employment, are necessary to understand the long-term benefits and risks of being employed as a PSS; to understand the experiences of PSSs across a variety of settings and from diverse backgrounds; and to understand and encourage career growth of PSSs.

To better understand the long-term benefits and risks for PSSs on the job as well as practices that have been ineffective in promoting wellness a study should be conducted to

compare those who have maintained employment and overall wellness, with those who have not been able to do so. By exploring the work-related "triggers" for relapse or increased mental health symptoms, especially of those who are no longer able to maintain employment as PSSs, better long-term job support could be provided for PSSs.

The peer support specialists in this study are employed at peer-run agencies where they can openly share their experiences with mental illness and substance use. However, this may or may not be the case for PSSs employed at other agencies, such as agencies that focus on employment services, or where PSSs are members of clinical teams to include case managers, counselors, psychiatrists, and individuals who may or may not be in recovery. To be able to meet the needs of a wider array of individuals working as PSSs, an exploration of the experiences of PSSs employed across all settings is needed. Additionally, researchers also should explore the self-care practices of male PSSs, as well as females, and the self-care practices of individuals from different ethnic backgrounds, as well as individuals with varying diagnoses. For example, studies should include PSSs who have only one diagnosis, or who have other mental health disorders, such as anxiety disorders, psychotic disorders, or post-traumatic stress disorder.

An additional theme emerged related to the long-term career plans, or lack thereof, from the women in the study. The women in the study expressed limited plans for career advancement. The lack of career goals for PSSs has resulted in an expansion of the researchers' thinking about this topic. Only one person was able to articulate considerations for long-term career advancement, and she had concluded that she really did not have any career goals beyond being employed as a PSS. She reported disinterest and concern for her recovery when she considered the options that were available to her, such as case manager, counselor, or supervisor. More information is needed to understand the career paths available to PSSs. A career progression that

is inclusive of the strengths, gifts, and assets people with shared experiences bring to the mental health role could be created from this research. Also, the potential fear of or barriers to career advancement also should be studied.

Last, very few studies have been published that help to understand the self-care practices of PSSs. This study was a small qualitative study. Future researchers should consider expanding upon this study by using quantitative measures to be able to reach a much larger audience and determine how prevalent the self-care practices from this study are in the general population of peer support specialists.

Limitations

The results should be considered in light of several important limitations. The first limitation to this study is the reliance on self-reported data. Self-reported data may be vulnerable to social desirability effects. Self-reported data also could have problems because of over-reporting of self-care practices being used by PSSs. PSSs may have felt pressure to provide answers that reflected that they have been practicing self-care regularly and that employment has improved their wellness because they have been informed that the results of this study would be shared with their employer as well as the governing board of the Arizona Department of Behavioral Health. Self-reported data collection also may be a limitation to this study due to underreporting of symptoms of mental illness and drug use. All participants report being psychiatrically stable and not using drugs or alcohol for at least one year. If this information is inaccurate, the self-care practices in this study might not be effective self-care practices because they have not prevented an increase in psychiatric symptoms or drug or alcohol relapse.

A second limitation to the study is that the sample might not be representative of PSSs working in mental health in other areas of the state or the country. The study includes a very

specific population of females who have been employed at peer-run agencies within Maricopa County and who have self-reported histories of co-occurring mood and substance use disorders. The sample did not include any male participants, women with mental health diagnoses besides mood disorders, PSSs who work on clinical teams, or PSSs who have recently started working in the field. While the use of semi-structured interviews may provide a more in-depth contextual examination of female peer support specialists with co-occurring mood and substance-use disorders, it may also limit generalizability.

A third limitation to this study could be reflexivity. Although this researcher attempted to increase reflexivity throughout the research process by documenting any assumptions, values, sampling decisions, interview questions, or analytic techniques used that could have shaped the research, grounded theorists have been criticized for not satisfactorily addressing questions of reflexivity. Charmaz (2006) reported that observations made from a particular perspective are standpoint-specific, depend on whatever emerges from the field observation, and depend on the observer's position within the research field. Whatever emerges from analysis of a set of data is theoretically informed because all of the analysis has been guided by the questions asked by the researcher.

Last, this researcher has made every effort to understand, record, and reflect potential biases that could have influenced the results of this study. However, researcher bias and subjectivity, especially from a critical orientation, are commonly understood as inevitable when conducting research.

Summary

Mental health workers, such as counselors and peer support specialists, enter the field to make a difference in human lives. More specifically, PSSs hope to make a difference in the lives

of people seeking recovery from mental illness and substance use by sharing their own personal struggles and accomplishments. Feeling effective fuels personal and professional vitality. However, system changes, limited supervision, staff turnover, and the emotional demands of the job also could put PSSs at risk for increased mental health symptoms and substance use relapse. Risks associated with the job can be drastically reduced by consistent and healthy self-care practices by PSSs, as well as support and reinforcement to practice self-care by PSS supervisors.

To better understand the self-care practices of female peer support specialists with co-occurring mood and substance use disorders, this researcher conducted in-depth semi structured interviews with 10 female peer support specialists who have been employed at peer-run agencies in Maricopa County, Arizona, for at least one year. PSSs, more specifically women with co-occurring disorders, report employing a variety of self-care practices. Self-care practices include establishing personal and professional support networks, maintaining a daily routine, and having an improved sense of coherence. Spirituality has been identified as the most important self-care practice. Self-care practices among peer support specialists and counselors were similar, although the identified practices were articulated differently. For example, PSSs identified the importance of recognizing triggers and having an awareness of risks for relapse. Similarly, counselors refer to identifying stressors as achieving a state of mindfulness. Also, PSSs recognize the importance of having a sense of coherence, and counselors describe a similar need, but label it as a having a "sense of self." Perhaps the differences in descriptions of self-care practices has evolved from language learned by PSSs while participating in treatment or recovery programs, or the differences in the descriptions by counselors is more evolved due to advanced education required for their positions.

Unlike PSSs, counselors did not identify spirituality as an important self-care practice. PSSs report that spirituality has been most important for overall wellness. Also, PSSs have not reported feeling at risk for burnout, while counselor burnout has been reported extensively in the literature. In fact, PSSs report that being employed and serving as role models to those who share similar mental health and substance use experiences enhances their recovery and overall wellness. The differences between concerns for burnout among counselors and peer support specialists should be an important consideration for future research.

Both PSSs and counselors care for individuals who are emotionally stressed, have experienced trauma or abuse, or have personality disorders. Both occupations are stressful and are at risk of increased stress, which could lead to impairment of overall wellness if a self-care regime is not established. However, the self-care practices of counselors have been well-studied. Limited information has been available to explore the self-care practices of PSSs, or even the long-term recovery or career benefits and consequences experienced by PSSs. This study is a small beginning for filling the gaps in the literature about peer support specialists. A broader range of research and longitudinal information is needed to enable other professionals and PSSs thmselves to effectively support the long-term recovery and career goals of peer support specialists.

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APPENDIX A

DEFINITION OF TERMS

Bipolar Disorders (Bipolar I Disorder, Bipolar II Disorder, Cyclothymic Disorder, and Bipolar Disorder, Not Otherwise Specified:) Bipolar Disorders have included a history of Manic Episodes, Mixed Episodes, or Hypomanic Episodes, accompanied by the presence of a Major Depressive Episode (DSM-IV-TR, 2000; p. 345).

Consumer: A consumer is a person who has been receiving publicly funded treatment for a mental illness.

Co-occurring Disorder or dual diagnoses: Individuals diagnosed with co-occurring disorders or dual diagnoses have experienced symptoms of both mental illness and alcohol or drug addiction.

Depressive Disorders (Major Depressive Disorder, Dysthymic Disorder, and Depressive Disorder, Not Otherwise Specified): Disorders characterized by one or more Major Depressive Episode(s*)* lasting at least 2 weeks with a depressed mood or loss of interest accompanied by at least four additional symptoms of depression (DSM-IV-TR, 2000).

Mood Disorder: Individuals who have had mood disorders have had a disturbance in mood as the predominant feature as written in the DSM-IV, (2000). For the purpose of this study, mood disorders have been divided into 2 categories: 1) Depressive Disorders and 2) Bipolar Disorders.

Peer-Run Programs: Peer-run programs have been programs that have provided a safe environment for individuals diagnosed with a mental health and or a substance use disorder to participate in psychosocial rehabilitation. Self-identified peers have offered peer social support and recreational activities in an exclusively operated center.

Peer Support Specialist (PSS): A PSS has been a self-identified person who has been in recovery from mental illness, substance use, or both disorders, and who has currently been employed to provide services to other individuals with mental health and substance use disorders. For the purpose of this study, participants will have had co-occurring diagnoses to include mood disorders, and substance use disorders. More specifically, participants will have been employed by a peer-run program and have provided services to mental health consumers.

Self-care: Self-care has been defined as the actions and attitudes that have contributed to the maintenance of well-being and personal health and have promoted human development (Lee & Miller, 2013).

Sense of coherence (SOC): SOC has been considered to have been an emotional or cognitive tool that has helped individuals bring order in to their lives by increasing capacity to believe in their competence to accomplish goals, structure their lives, and face challenges regardless of how difficult they have seemed (Bothmer & Fridlund, 2003).

Substance-Related Disorders: According to the DSM-IV TR (2000) substance-related disorders included disorders related to the taking of drugs or alcohol, side effects of medications, and toxin exposure. For the purpose of this study, participants were individuals who have self-reported being diagnosed as Substance Dependent, and who were in remission. This diagnosis will be referred to as Substance Dependence, in Sustained Full Remission meaning the individual has reported that she has not used any drugs or alcohol for a period of 12 months or longer at the time of interview (DSM-IV-TR, 2000; p. 191-196).

Wellness: Wellness has been the ability of a person to function at their highest physical, mental, emotional, social, and spiritual levels (Mandershceid, 2009).

APPENDIX B

ARIZONA PEER TRAINING CURRICULUM

Minimum Core Elements Required for Peer Support Training Curricula in the State of Arizona

Themes of Required Lessons	**Required Topics**
Concepts of Hope and Recovery	• Instilling the belief that recovery is real and possible • History of recovery and the varied ways that behavioral health issues have been viewed and treated over time and in the present • Knowing and sharing one's story of a recovery journey; how one's story can assist others in many ways • Mind-body-spirit connection and holistic approach to recovery • Overview of the individual service plan and its purpose
Advocacy and Systems Perspective	• Brief overview of behavioral health system infrastructure • Stigma and effective stigma reduction strategies • Organizational change –how to utilize person first language and energize one's agency around recovery, hope, and the value of peer support • Creating a sense of community • Brief overview of advocacy and effective strategies • Familiarization of the Americans with Disabilities Act
Psychiatric Rehabilitation Skills	• Strengths based approach; identifying one's own strengths and helping others identify theirs; • Distinguishing between sympathy and empathy • Learned helplessness; what it is and how to assist others in overcoming its effects • Overview of motivational interviewing; communication skills and active listening • Healing relationships and creating mutual responsibility • Combating negative self-talk; noticing patterns and replacing negative statements about one's self, using one's mind to boost self-esteem and relive stress

	• Group facilitation • Creating a safe and supportive environment, building trust
Professional Responsibilities of Peer Support Employees and Self-care in the workplace	• Ethics and Boundaries • Confidentiality • Mandatory reporting requirements • Understanding common symptoms of mental illness and substance use and orientation to commonly used medications • Documentation and billing and using recovery language throughout documentation • Self-care and use of ongoing supports; dealing with stress in the workplace • Supervision: what should I expect?

Note: Adapted from the Arizona Department of Behavioral Health Provider Manual, Section, 9.2: Peer Support/ Recovery Support Training, Certification and Supervision Requirements (AZDBHS, 2012).

APPENDIX C

RECRUITMENT FLYER

Peer Support Study

The University of Arizona Department of Disability and Psychoeducational Studies is conducting a study about peer support. We hope to learn more about how women who have been diagnosed with a mood disorder and who are in recovery from drugs and alcohol practice self-care once they are employed as a peer support professional.

If you are interested in participating in this study, or have any questions please call (602)451-6444

Study Procedures: Women who are employed as a peer support professional are invited to participate. You will be asked to take part in a 1-2 hour-long interview about your employment experience and how you practice self-care. You will be offered a $20.00 gift card to Target for your time.

Study Benefits and Risks: Peer support staff may gain self-awareness about how and why they chose to seek employment in the helping field. More specifically, participants may gain awareness of self-care practices they are or are not practicing as a professional. They may find satisfaction that their input will be used in the development of training materials. These data will be used to develop training materials for peer support women with co-occurring mood and substance use diagnoses. The possibility exists that talking about personal issues like mental illness, alcohol and drug addiction, and wellness procedures may put participants at risk of emotional distress.

Confidentiality: All information provided during the study will be kept private.

Participation is voluntary. You have the right to refuse to answer particular questions. You also have the right to withdraw your data from the study.

For Questions about the Research, Contact: Beverly Wohlert, Principal Investigator, at (602) 451-6444.

APPENDIX D

INFORMED CONSENT

INFORMATION LETTER (SOCIAL BEHAVIORAL) MINIMAL RISK
UNIVERSITY OF ARIZONA

SELF-CARE PRACTICES OF FEMALE PEER SUPPORT SPECIALISTS WITH CO-OCCURRING MOOD AND SUBSTANCE USE DIAGNOSES

This is a consent form for research participation. It contains important information about this study and what to expect if you decide to participate. Please consider the information carefully. Feel free to discuss the study with your friends and family and to ask questions before making your decision whether or not to participate.

You may or may not benefit as a result of participating in this study. Also, as explained below, your participation may result in unintended or harmful effects for you that may be minor or may be serious, depending on the nature of the research.

RESEARCHERS
Ms. Beverly Wohlert, Principal Investigator: 602-451-6444 (4201 N. 16th St. Ste.140 Phoenix, AZ 85016).

1. **Why is this study being done?**
   This is a study about the self-care practices of female peer support specialists. We hope to learn more about how women in recovery care for themselves once employed as a peer support specialist.

2. **How many people will take part in this study?**
   The researcher will interview 10 female peer support specialists for this study.

3. **What will happen if I take part in this study?**
   You are being asked to participate because you are a female peer support specialist currently employed in the field, and have reported that you have been diagnosed as having a co-occurring mood disorder and substance use disorder. You will be asked a series of questions that will help us understand your experience with alcohol and drug use, your experience working as a peer support specialists, and how you practice self-care.

We are asking for you to allow us to [audiotape (voice record) your responses. The recording(s) will be used for *analysis by the research team only.*

4. **How long will I be in the study?**
   If you decide to volunteer, you will be screened for eligibility for the study. You will be asked to meet with an interviewer for approximately 1-2 hours in a private room at a pre-arranged time. These interviews will be recorded and the interviewer may take additional notes while you are being interviewed.

5. Can I stop being in the study?

Your participation is voluntary. You may refuse to participate in this study. If you decide to take part in the study, you may leave the study at any time. No matter what decision you make, there will be no penalty to you and you will not lose any of your usual benefits. Your decision will not affect your future relationship with The University of Arizona. If you are a student or employee at the University of Arizona, your decision will not affect your grades or employment status.

6. **What risks, side effects or discomforts can I expect from being in the study?**
It is possible that talking about personal issues like mental health experiences and alcohol and drug addiction may put participants at risk of emotional distress.

A risk of taking part in this study is the possibility of a loss of confidentiality or privacy. Loss of privacy means having your personal information shared with someone who is not on the study team and was not supposed to see or know about your information.

7. What benefits can I expect from being in the study?
You may not benefit from participating. However, peer support staff may gain self-awareness about how and why they chose to seek employment in the helping field. More specifically, participants may gain awareness of self-care practices they are or are not practicing as a professional. They may find satisfaction that their input will be used in the development of training materials. This data will be used to develop training materials for peer support women with co-occurring mood and substance use diagnoses.

8. What other choices do I have if I do not take part in the study?
You may choose not to participate without penalty or loss of benefits to which you are otherwise entitled.

9. Will my study-related information be kept confidential?
All information obtained in this study is private. No identifying information will be kept (e.g., name, address, phone number). The results of this research study may be used in reports, presentations, and publications, but the researchers will not identify you. In order to maintain privacy of your records, Beverly Wohlert will assign an alias (different name) to your information.

All data will be stored on a computer, encrypted, and secured with a username and password. Data will be kept secure for 7 years and then it will be destroyed. Electronic files will be inoperable and transcripts will be shredded.

Efforts will be made to keep your study-related information confidential. However, there may be circumstances where this information must be released. For example, personal information regarding your participation in this study may be disclosed if required by state law.

Also, your records may be reviewed by the following groups (as applicable to the research):

- Office for Human Research Protections or other federal, state, or international regulatory agencies
- The University of Arizona Institutional Review Board or Office of Responsible Research Practices
- The sponsor supporting the study, their agents or study monitors

10. What are the costs of taking part in this study?

There are no costs of participating other than time.

11. Will I be paid for taking part in this study?

The incentive to participate is a $20.00 gift card to Target. By law, payments to subjects may be considered taxable income.

12. What happens if I am injured because I took part in this study?

If you suffer an injury from participating in this study, you should seek treatment. The University of Arizona has no funds set aside for the payment of treatment expenses for this study.

13. What are my rights if I take part in this study?

If you choose to participate in the study, you may discontinue participation at any time without penalty or loss of benefits. By signing this form, you do not give up any personal legal rights you may have as a participant in this study.

You will be provided with any new information that develops during the course of the research that may affect your decision whether or not to continue participation in the study.

You may refuse to participate in this study without penalty or loss of benefits to which you are otherwise entitled.

An Institutional Review Board responsible for human subjects research at The University of Arizona reviewed this research project and found it to be acceptable, according to applicable state and federal regulations and University policies designed to protect the rights and welfare of participants in research.

14. Who can answer my questions about the study?

Any questions you have concerning the research study or your participation in the study will be answered as soon as possible. If you have any questions regarding this study, please contact Beverly Wohlert, principal Investigator at (602) 451-6444.

For questions about your rights as a participant in this study or to discuss other study-related concerns or complaints with someone who is not part of the research team, you may contact the Human Subjects Protection Program at 520-626-6721 or online at http://orcr.arizona.edu/hspp.

Signing the consent form

I have read (or someone has read to me) this form, and I am aware that I am being asked to participate in a research study. I have had the opportunity to ask questions and have had them answered to my satisfaction. I am also aware that my responses will be recorded. I voluntarily agree to participate in this study. I am not giving up any legal rights by signing this form. I will be given a copy of this form**.**

Printed name of subject	**Signature of subject**
	AM/PM
	Date and time
Printed name of person authorized to consent for subject (when applicable)	**Signature of person authorized to consent for subject (when applicable)**
	AM/PM
Relationship to the subject	**Date and time**

Investigator/Research Staff

I have explained the research to the participant or the participant's representative before requesting the signature(s) above. There are no blanks in this document. A copy of this form has been given to the participant or to the participant's representative.

Printed name of person obtaining consent	**Signature of person obtaining consent**
	AM/PM

APPENDIX E

SCREENING AND DEMOGRAPHICS QUESTIONNAIRE

1. Do you have a history of a co-occurring mood and substance abuse disorder (in full remission) including Depression, Bipolar Disorder I and II, and Mood Disorders Not Otherwise Specified (NOS)? [yes___no___]
2. Have you been in full alcohol or drug remission for at least 12 months? [yes___no___]
3. Are you currently employed as Peer Support Specialist for at least 12 months in a peer-run program in Maricopa County, AZ? [yes___no___]
4. What is your gender? [male___female___]
5. Were you born between the dates of August 1, 1959 and July 31, 1983; [_____]
6. Have you completed a Peer Support Training Program? [yes___no___]
7. Are you in possession of a GED or high school diploma? [yes___no___]
8. Are you currently in possession of a certificate verifying successful passage of the state peer support certification examination? [yes___no___]
9. Do you speak and comprehend the English language? [yes___no___]
10. What is your 5-digit zip code? [_____]
11. Are you currently experiencing intermittent periods of psychosis, such as Mood Disorder with Psychotic Features or Schizoaffective Disorder? [yes___no___]
12. Are you currently experiencing severe cognitive or psychiatric impairment? [yes___no___]
13. Have you self-reported an alcohol or drug relapse or psychosis within the last 12 months? [yes___no___]

14. On average, how many hours do you work doing peer support each week (circle one)?

Greater than 40 hours per week
Greater than 35 hours per week
Less than 35 hours per week

15. Do you have health insurance? [yes___no___]

16. For the past year, what was **your** average gross income (before taxes), including both reported and unreported income (do not include your partner's income)?

$0 - $4,999
$5,000 - $9,999
$10,000 - $14,999
$15,000 - $24,999
$25,000 - $34,999
$35,000 - $49,999
$50,000 - $74,999
$75,999 - $99,999
$100,000 or more

17. Which of the following best describes your racial or ethnic background? (Circle all that apply)

White or Caucasian
Black or African American
Latina or Hispanic
Asian
Middle Eastern
Native American
Other

18. Do you have children? [yes___no___]

If yes, how many? ____

20. What is your current marital status?

Single, never married
Married
Cohabiting/living together
Separated
Divorced
Widowed

21. How many times have you been in formal treatment for alcohol and drug abuse?

22. Have you ever been admitted to an inpatient psychiatric clinic? Yes or No

23.How many times have you been admitted to a clinical care unit for detox?

24. Are you currently taking any medications to address psychiatric or behavioral health problems? [yes___no___]

25. Do you participate in 12-step programs? [yes___no___]

26. On average, how many per week? Per month?

27. Do you currently participate in any type of group or individualized counseling? [yes___no___]

28. Please include your preferred method of contact for scheduling and follow-up:

Email:_____; Phone:_____

APPENDIX F

INTERVIEW QUESTIONS (PILOT)

1. What is self-care?

2. How would you define wellness?

3. When you were growing up, how were you taught to take care of yourself? Physically? Emotionally?

4. How has your cultural background influenced the way that you de-stress?

5. Reflecting on your past, what experiences led you to become a peer support professional?

6. What training if any, do you have to be a peer support specialist?

7. Do you feel adequately trained? Why or why not? Explain. *What was most helpful on the job? Least helpful?*

8. Describe how you do or do not have the freedom to think and solve problems independently on the job?

9. How would you rate your overall stress level when thinking about your job? (1 none at all -10 high)

10. Describe? (use motivational interviewing)

11. In what ways is your work challenging or difficult?

12. In what ways is your work rewarding?

13. Do you ever find your role as a peer support specialist confusing? Describe.

14. How, would you explain self-care to another peer support specialist?

15. How, if at all, have your experiences in your recovery affected your own self-care?

16. How, it at all, has your professional training influenced your ideas of self-care? Practice of self-care?

17. How if at all, does working with others help or interfere with your own recovery?

18. How do your feelings about yourself influence your ability to manage stress?

19. What do you do to “de-stress” or unwind?

20. How is your method of unwinding different now, as a peer support, from before when you were in recovery?

21. What role do your emotions play in your job? Describe.

22. What role do your emotions play in your overall wellness? Ability to care for yourself?

23. What role, if any, does spirituality play in self-care?

24. How are you supported personally and professionally?

25. In what ways, if any, does your support network influence your self-care?

26. Do you have someone you could turn to if you were experiencing mental health symptoms? Could you turn to your employer?

27. Do you have someone you could turn to if you felt in danger of a relapse? Could you turn to your employer?

28. How do you manage feelings of frustration related to your work? Give examples

29. How do you feel when a client you are working with relapses? What effects does this have on your own recovery?

30. How do you feel when a client is resistant to treatment? What effects does this have on your own recovery?

31. What do you do when you are bored now that you are in recovery?

32. What challenges, if any, do you have with practicing self-care?

33. What, if anything is missing to help you take care of yourself?

34. Do you have a relapse prevention plan? *Is it written or just by memory?*

35. What is your relapse prevention plan currently?

36. What, if any support, does your employer provide in meeting the goals of your relapse prevention plan?

37. Do you face any challenges with following through with your relapse plan?

38. Do you currently participate in individual or group counseling now that you are a peer support worker?

39. Would you be willing to participate in individual or group counseling if you could access those services?

40. Where do you see yourself professionally in 5 years? *Still working in the field?*

APPENDIX G

INTERVIEW QUESTION GUIDE (FINAL)

Section 1

What are current self-care practices?

1. What do you do to take care of yourself?

2. What do you do to "de-stress" or unwind?

3. How, if at all, have experiences from your recovery affected your own self-care?

Section 2

Most important self-care practice for overall wellness.

1. You reported that your self-care practices included _____? (*Clarify and summarize)* What self-care practice do you believe is the MOST important for your overall wellness?

Section 3

How, if at all, does employment improve or interfere with overall wellness?

1. How, if at all, does working as a peer support help or interfere with your own recovery?

2. What challenges, if any, do you have in practicing self-care?

3. How, if at all, has your professional training influenced your ideas about self-care?

4. What support, if any, has your employer provided to encourage practices of self-care?