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Rediscovering Hope: An Empirical Phenomenological Exploration of the Veteran Peer Support Provider Journey through Recovery and Beyond

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Abstract

The purpose of this empirical phenomenological study was to gain an understanding of the experience of United States military veteran peer support providers. Veterans are an at-risk population when it comes to mental illness, substance use, and suicide. Veterans in recovery for mental illness or substance use can become peer support specialists and use their own recovery as a model to help other struggling veterans. However, providing peer services exposes veteran peer providers to the traumatic stories and suffering of their peers. Per the Diagnostic and Statistical Manual 5, such exposure can cause secondary trauma symptoms in the provider. Person-centered theory and empirical phenomenology were combined to conduct semi-structured interviews with 12 veteran peer providers. Overall, participants felt that peer support was an extremely positive experience for themselves and their clients, even considering identified challenges to providing peer services. Secondary trauma was identified as a challenge by all 12 participants. Other challenges reported were stigma, boundaries, self-care, and reaching difficult clients. Even with all the challenges, participants reported that providing peer services had an overwhelmingly positive impact on their lives, providing benefits such as a sense of purpose, reinforcing their own recovery, providing hope for themselves and their clients, creating a sense of camaraderie, and being able to reach difficult clients. These findings demonstrate that peer support results in positive experiences for peer providers, not just the recipients. These lived experiences can be used to enhance research and funding for peer support so that it continues to grow as a field, providing the opportunity for veterans to live beyond their struggles and diagnoses.

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Dedication

This dissertation is dedicated to the late Dr. Barbara Etzel and the late Fran Aspromonte. Both of these brilliant and strong women saw something in me and encouraged me to pursue my education far beyond anything I had ever believed possible.

This dissertation is further dedicated to my children for giving me a purpose beyond myself. Your very existence gave me the strength and courage I needed to pursue a future for myself and for you. Thank you for your sacrifices that helped make all this possible. I promise that every bit of it is for you.

To all my Fisher professors and mentors, spanning three degrees, for their patience, wisdom, and guidance. Thank you for leading with your hearts and by example. I truly believe from the bottom of my heart that Fisher has the best professors this area has to offer. I would especially like to thank my dissertation committee for being incredible humans that just “get” me. Your support made it easy to trust the process.

To my executive mentor, Kyle Heath, thank you for your dedication and example in serving the mission. To the men and women of the United States military, past and present, for defending the rights and freedoms that allowed me to pursue my education and dreams.

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Last but not least, to my late daughter, Doschanelle. I did not cure Cystic Fibrosis as you had asked me to when I first started college, but everything that I do for the rest of my life will have you in it.

Biographical Sketch

Bobbi Smith was born and raised in Canandaigua, New York. Bobbi is a first-generation college student whose strong work ethic came from hardworking, blue-collar parents. Bobbi had many influential teachers in the Canandaigua City School District who taught her the value of education. Bobbi went on to get an associate's degree in human services at Finger Lakes Community College before finally landing at St. John Fisher. At Fisher, Bobbi received a bachelor's in psychology, a master's in science for mental health counseling, and later, an education doctorate in executive leadership.

Bobbi pursued her education while raising five children, three dogs, and three cats. Bobbi has also worked full time for various human services agencies. Most recently, Bobbi has been a crisis responder for the Veterans Crisis Line since July of 2016. Bobbi is also a Certified Peer Support Specialist. Along with working full time, attending school, and raising a family, Bobbi has volunteered at a hospice house in Victor, NY and continues to volunteer for the Humane Society of Wayne County.

Abstract

The purpose of this empirical phenomenological study was to gain an understanding of the experience of United States military veteran peer support providers. Veterans are an at-risk population when it comes to mental illness, substance use, and suicide. Veterans in recovery for mental illness or substance use can become peer support specialists and use their own recovery as a model to help other struggling veterans. However, providing peer services exposes veteran peer providers to the traumatic stories and suffering of their peers. Per the Diagnostic and Statistical Manual 5, such exposure can cause secondary trauma symptoms in the provider. Person-centered theory and empirical phenomenology were combined to conduct semi-structured interviews with 12 veteran peer providers. Overall, participants felt that peer support was an extremely positive experience for themselves and their clients, even considering identified challenges to providing peer services. Secondary trauma was identified as a challenge by all 12 participants. Other challenges reported were stigma, boundaries, self-care, and reaching difficult clients. Even with all the challenges, participants reported that providing peer services had an overwhelmingly positive impact on their lives, providing benefits such as a sense of purpose, reinforcing their own recovery, providing hope for themselves and their clients, creating a sense of camaraderie, and being able to reach difficult clients. These findings demonstrate that peer support results in positive experiences for peer providers, not just the recipients. These lived experiences can be used to enhance research and funding for

peer support so that it continues to grow as a field, providing the opportunity for veterans to live beyond their struggles and diagnoses.

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Chapter 1: Introduction

There is an overwhelming need for mental health care both within the United States and throughout the world (World Health Organization [WHO], 2019). Mental health care exists to treat mental illness and is becoming increasingly known as behavioral health (Substance Abuse and Mental Health Administration [SAMHSA], 2020). SAMHSA (2020) defines behavioral health as promoting mental health, resiliency, and wellbeing. This also includes the treatment of mental health disorders and substance use disorders; as well as providing support to those who experience or are in recovery from these conditions, along with their families and communities (SAMHSA, 2020). Mental illness (also known as disorder) occurs when an individual's cognitive function, emotional regulation, and/or behavior is dysfunctional to the point of clinical significance (The American Psychiatric Association [APA], 2013). Nearly one third of the world's non-fatal disease burden is made up of mental, neurological, and substance use disorders (WHO, 2019). According to WHO (2019), depression is a leading cause of disability that affects more than 264 million individuals across the globe. Mental illnesses can exist comorbidly, meaning that an individual may present with more than one diagnoses (Valderas et al., 2009).

Mental illness is an extreme financial burden, costing the global economy approximately one trillion U.S. dollars a year in productivity due to anxiety and depression (WHO, 2019). People with mental illness are more likely to suffer from chronic health conditions and therefore are more likely to be treated in hospitals and emergency rooms (SAMHSA, 2020). Mental illness takes a toll that is far greater than just productivity and money, it can be a life-or-death situation. People with severe and persistent mental illness die an average of 10 to 20 years earlier than those in the general population (WHO, 2019). Depression is one of the main risk factors for suicide (WHO, 2019). The WHO (2019) reports that approximately 800,000 people die by suicide each year. This is an average of one person dying by suicide every 40 seconds. Globally, suicide is the leading cause of death in individuals who are between 15 and 29 years old (WHO, 2019).

Suicide is also a leading cause of death in the United States (National Institute of Mental Health [NIMH], 2017). Tens of millions of Americans are affected by mental illness each year and it is estimated that only half of these people receive treatment (NIMH, 2017). Certain populations have been found to be at greater risk (NIMH, 2017). United States veterans are an example of a population that is particularly vulnerable to mental illness and suicide (NIMH, 2017; U.S. Department of Veterans Affairs [VA], 2018).

Veterans

A veteran is an individual who has served in any one of the branches of the United States military and received a discharge other than dishonorable (Social Security Administration [SSA], 2017). In the United States, an average of 20 veterans die by suicide each day (NIMH, 2017). Veterans experience post-traumatic stress disorder (PTSD) at a significantly higher rate than the general population (VA, 2018). Trauma can be defined as the exposure to real or threatened death, serious injury, or violence that is sexual in nature (APA, 2013). PTSD is when trauma causes clinically significant symptoms in an individual that can include hypervigilance, avoidance symptoms, flashbacks, nightmares, and mood dysregulation (APA, 2013).

Combat is one factor that contributes to the prevalence of PTSD in veterans. Combat is the exposure to war and no longer needs to be experienced directly (Harding, 2017). For example, drone operators are never physically in war zones but may suffer the effects of engaging in acts such as remotely bombing an area that results in loss of life. Military leaders may also fall into this category by issuing orders that result in loss of life. Combat is not the only cause of PTSD found in veterans. Some PTSD in veterans is due to sexual assault during service (VA, 2018). PTSD rates can vary depending on the service era of the veteran (VA, 2018). Approximately 15 out of 100 Vietnam veterans have been diagnosed with PTSD, compared to 12 out of every 100 Gulf War veterans. Upwards of 20 out of 100 veterans who served in Operation Iraqi Freedom (OIF) and Enduring Freedom (OEF) carry PTSD diagnoses (VA, 2018). Many OIF and OEF veterans are obtaining mental health care, outside of the VA (Harding, 2017). There are many factors contributing to this barrier to care but one significant factor is stigma (Harding, 2017).

Stigma

Stigma is the inappropriate and misinformed association of a diagnosis with something shameful or tainted (El-Badri & Mellsop, 2007; Pescosolido, 2013). People experiencing trauma were once considered to be malingering, or faking (Bonanno, 2004). PTSD has only been recognized as a diagnosable disorder with established symptoms and disturbances to daily functioning since the early 1980s (SAMHSA, 2019; Valent, 2002). However, even with this established set of symptoms, there is still much stigma surrounding mental illness symptoms and diagnoses (Doka, 2002; Hansson et al., 2011; Pescosolido, 2013; Sickel et al., 2019).

A mental illness diagnosis can create many obstacles for patients who have detrimental consequences on quality of life and even physical health (Sickel et al., 2019; Verhaeghe et al., 2008). Stigma has been identified as one of the most prominent challenges for a person living with a mental illness (El-Badri & Mellsop, 2007). Detrimental consequences of stigma have included reduced self-esteem, reduced quality of life, an increase in symptoms, avoidance of seeking treatment, and a decrease in social support and connections (El-Badri & Mellsop, 2007; Sickel et al., 2019; Verhaeghe et al., 2008).

Stigma creates a barrier to care for military veterans (Boyd et al., 2015; Harding, 2017). Veteran vulnerability to the effects of stigma is due to strongly enforced military expectations that service members be strong both physically and mentally (Boyd et al., 2015). Mental illness and help seeking are viewed as weaknesses in the military community (Harding, 2017). Stigma can become internalized, leading to feelings of embarrassment about diagnoses, medications, and other mental health treatments (Boyd et al., 2015; Harding, 2017).

Stigma creates the misconception that a patient somehow has a flawed character, and this can dehumanize the patient in society's view (Pescosolido, 2013). A diagnosis of mental illness can lead to prejudice and discrimination that has even come from mental health staff (Pescosolido, 2013). Hostile stereotypes have been observed between staff and patients in mental health institutions and further enforces internalized stigma for the patient (Pescosolido, 2013). Upon a patient's reentry into the community, it is often difficult for the person to fully reintegrate into society (Pescosolido, 2013).

Deinstitutionalization

Prior to the 1980s, most mental health care in the United States took place in large, state-run institutions (Jones & Gallus, 2016). However, a global shift in policy and practice created the deinstitutionalization movement in which mental health care responsibilities were redirected to local communities (Jones & Gallus, 2016). Deinstitutionalization is a movement that sought to humanize mental health care while decreasing public dependency on state-funded institutions, also known as asylums (Primeau et al., 2013). Over the last 40 to 50 years, deinstitutionalization has created a large need for mental health organizations and providers within communities (Jones & Gallus, 2016).

In 2017, 46.6 million adults in the United States reported living with a mental illness (NIMH, 2019). That translates to one in five Americans potentially in need of behavioral health services within their respective communities. This high level of need, combined with the slow development of community resources in response to deinstitutionalization, has created a strain on human service organizations and providers (Jones & Gallus, 2016; Primeau et al., 2013; Sealy & Whitehead, 2004). This strain is observed as high client to provider ratios and scarce resources for organizations and providers. Sealy and Whitehead (2004) found that the cost of community based psychiatric services in Canada increased by 1,261% (not adjusted for inflation) from 1980-1999. These two decades saw the most rapid period of deinstitutionalization and may be a contributing factor in the sharp increase of costs for community-based services.

The inability of community organizations to respond effectively to the deinstitutionalization movement has led to an increase in the criminalization of people suffering from mental illness (Kim, 2016; Primeau et al., 2013). This has become known as transinstitutionalization, meaning that patients simply moved from one type of institution to another (Primeau et al., 2013). An analysis of transinstitutionalization in Pennsylvania from 1978 to 2010 showed an increased incarceration rate of 6.8% per year that correlated with the decrease in statewide psychiatric hospital beds (Primeau et al., 2013).

The lack of mental health resources and providers is not just a problem in the United States and Canada. Out of the 195 countries in the world, only 139 have mental health policies (Lewis, 2019). Rates of available mental health workers range from below two workers per 100,000 people in low-income countries to over 70 per 100,000 people in high income countries (Lewis, 2019). Even in countries with the highest income, there is a shortage of mental health providers. A national and global mental health crisis is evident. There is an ever-increasing need for mental health providers and services (Lewis, 2019).

Veterans Administration

On July 21, 1930, President Herbert Hoover signed Executive Order 5398 and created the Veterans Administration (VA, 2018). VA's Veterans Health Administration is the largest integrated health care network in the United States, with 1,255 health care facilities serving 9 million enrolled veterans each year. Despite this, many veterans opt for care outside of the VA healthcare system (VA, 2018). Only 17% of OIF/OEF veterans receive VA care (Harding, 2017). There are many barriers to care for veterans both within the VA and without, including but not limited to stigma, PTSD symptoms, and veteran culture (Harding, 2017).

Pairing a veteran with a veteran provider may help to bridge the gap in care by reducing or eliminating stigma and by creating a more equal relationship between provider and client. In 2004, the VA formalized the use of peer providers with the Mental Health Strategic Plan (Jain et al., 2012). The plan called for a large hiring of veterans as peer/mental health paraprofessionals (often referred to as peer support specialists). Since the VA began its peer support initiative, more than 1,000 veteran peer specialists have been placed at VAs across the nation (McCarthy et al., 2019). Peer support services have become available VA-wide as an effort to better engage veterans in care (Jain et al., 2012).

Peer Support

An emerging trend in mental/behavioral health is the addition of the peer support role within organizations (SAMHSA, 2019). A peer support specialist is someone who has recovered from mental illness and/or addiction and then uses their own lived experience, combined with training, to provide intervention services to others (SAMHSA, 2019). The training required is not as rigorous as programs to become licensed mental health providers and differs from state to state (SAMHSA, 2019). Peer support certification does not require a college degree. New York State requires a high school diploma, three letters of recommendation, 18 online courses totaling 50 training hours, and 2,000 supervised hours of field experience (New York Peer Specialist Certification Board, 2019).

Both formal and informal peer roles have emerged at other points in history and across several populations, including diabetics, mothers with post-partum depression, the incarcerated, and HIV patients (Gjerdingen et al., 2013; Warshaw & Edelman, 2019; Watson & Meddings, 2019). Traditionally, the category of mental health providers has included mental health counselors, social workers, psychologists, psychiatric nurses, and psychiatrists, all of which require college degrees. Peer support specialists also go by the titles of peer provider and certified peer specialist or recovery coach (SAMHSA, 2019). There are many differences between peer staff and conventional mental health staff (Davidson et al., 2012). Peer support providers model their own recovery and show themselves going from victim to survivor (Davidson et al., 2012). The peer providers share their experience to model self-care, and they use self-disclosure to build rapport and instill hope (Davidson et al., 2012). This approach is different from the traditional mental health practitioners' lack of self-disclosure and reliance on only clinical skills (Davidson et al., 2012).

Peer support did not become eligible for billing through Medicare and Medicaid until 2014 (SAMHSA, 2019). This emerging role is an attempt at addressing the shortage of mental health providers and services (Travis et al., 2010). Peer support is a low to no cost way to provide social support and improved outcomes for patients with a variety of conditions, including mental illness (Travis et al., 2010). Peer support specialists have had reported high rates of unemployment and salaries falling below $20,000 per year (Ahmed et al., 2015; Travis, et al., 2010).

Peer support services have become increasingly popular in the mental health field over the last three decades (Davidson et al., 2012). However, the emergence of *peer roles* dates to the 18th century (Davidson et al., 2012). Rooted in the moral treatment era in France, an idea emerged that people in recovery from mental illness may be able to help others with severe mental illness (Davidson et al., 2012). People suffering with mental illness have historically faced stigma and discrimination (Davidson et al., 2012). This made it difficult for anyone to believe that people in recovery could ever serve as mental health staff (Davidson et al., 2012).

Jean Baptiste Pussin served as a superintendent at the Bicetre Hospital in Paris during the 1790s even though he was an ex-patient of the same hospital (Davidson et al., 2012). Phillippe Pinel was the chief physician at the time. Pinel began working with Pussin to understand how the hospital had been functioning (Davidson et al., 2012). Common practice among asylum staff at the time was the use of active cruelty to manage the patients (Davidson et al., 2012).

Pussin began hiring as many former patients as possible and Pinel observed that these staff members were well suited for the work because of their predisposition to being gentle, honest, and humane (Davidson et al., 2012). This moral and humane treatment contrasted with common practices at the time and through their work together, Pussin and Pinel were able to decrease and later eliminate the use of shackles and abuse. This is the first documented occurrence of recovered patients going on to occupy formal supportive roles for other mental health patients. However, it is not directly related to the modern peer support movement (Watson & Meddings, 2019).

Formal peer support roles initially began as supportive positions to existing mental health staff. These roles required few skills or competencies. Early studies in the 1990s showed that not only did the peer staff do well in these roles, but there were positive outcomes for the people receiving the support as well. Peer staff have been found to produce better outcomes for difficult to engage clients. Peer services have also been found to decrease hospitalization and inpatient stays as well as decrease substance use across patients with comorbid disorders (Davidson et al., 2012). Peer support has been increasing in popularity since the 1990s. Davidson and colleagues estimated that there were over 10,000 peer support staff in the United States in 2012, and that number was expected to continue climbing. Much research has been done on the impact of emerging peer support on peer recipients but there is little known about the impact these roles have on the peer provider (Davidson et al., 2012).

Secondary Trauma

It is possible that working with peers in distress may trigger a type of distress within the provider called secondary trauma. Pearlman and McIan (1995) defined vicarious trauma, also known as secondary trauma, as a change that happens within a therapist (or other helper) due to empathic engagement while bearing witness to clients' trauma experiences. Working with clients in distress can leave human service professionals vulnerable to secondary trauma (Straussner et al., 2018). Trauma research shows that providers display a range of secondary trauma symptoms that mirror those symptoms seen in primary victims of trauma (Valent, 2002). Symptoms of trauma exposure can include hypervigilance, intrusive thoughts and memories, avoidance of reminders of the event and impairment to functioning (APA, 2016; Bride & Figley, 2009). These symptoms can result in interpersonal and social issues, substance abuse, moral injury, existential crisis, and breakdown of spirituality and belief systems (Valent, 2002). The presence of these symptoms has come to be known as secondary trauma (Boscarino et al., 2010).

Mental health clinicians and other people in the human services field often choose their career based on a deep desire to help (Radey & Figley, 2007). The desire to help is no different for peer support providers. Through their work, behavioral health providers expose themselves to details of horrific events, including reports of violence, death, cruelty, neglect, disaster, and destruction (Pearlman & McIan, 1995). Helping others can be greatly rewarding when there are successful results; however, when the results are deemed strained or worse, helpers may join their clients in suffering (Valent, 2002). Due to the deep psychological connection to their work and because of the demand for empathy, clinicians are extremely vulnerable to secondary trauma (Radey & Figley, 2007). It is likely that this vulnerability also exists within peer providers and furthermore, veteran peer providers.

Veteran peer providers may be particularly prone to relapse given their history. Relapse is one of many concerns that have been expressed by traditional mental health providers and opponents of the peer support movement (Davidson et al., 2012). Relapse is defined as the return of a disease or its symptoms after the disease had apparently been cured (Centers for Disease Control and Prevention [CDC], 2020). It is possible that peer staff may be prone to relapse because of their history, recovery, and the additional burden of disclosing their personal experiences (Davidson et al., 2012). Some traditional mental health practitioners are concerned that if this vulnerability exists, it may leave clients at risk of harm and place additional strain on colleagues (Davidson et al., 2012).

Problem Statement

Peer support workers may be more susceptible to vicarious trauma due to their history of mental illness and/or addiction, combined with the known strain that is placed on mental health workers. Trauma history is found to be one of the leading contributing factors for secondary trauma (Devilly et al., 2009; Robinson-Keilig, 2014). Secondary trauma is a risk factor for increased substance use, and this could potentially lead to relapse in a provider who is in recovery from addiction (SAMHSA, 2019; Valent 2002).

There is some evidence that suggests these fears are unwarranted and that the strain of peer support work is less than the previous strain of poverty, unemployment, and isolation (Davidson et al., 2012). However, at this point, the implications of secondary trauma for peer support workers are unknown. Peer support services are being offered to increasingly more populations across the integrated health setting (SAMHSA, 2019).

Peer support specialists may be in particularly vulnerable positions due to their mental health history and lack of formal training (Esaki & Larkin, 2013; La Mott & Martin, 2019; SAMHSA, 2019). Veteran peer support providers may be at even more risk for relapse and secondary trauma due to their complicated histories and military culture. For these reasons, it is imperative for the health and wellness of veteran peer support workers, their organizations, and the populations that they serve, that the impact of this line of work is examined. Person centered theory provides a strong foundation for a qualitative exploration of the veteran peer provider experience.

Theoretical Rationale

Within the field of mental health, there are many theories or approaches for explaining how mental illness should be viewed and treated (Corey, 2013). Person-centered theory is a humanistic approach to psychotherapy, developed by Carl Rogers, that focuses on individual strengths instead of their pathology (Corey, 2013). The person-centered approach is often referred to as the client-centered approach because its core assumption is that clients can resolve their own issues without direct intervention by the therapist (Corey, 2013). The therapist's attitude and ability to relinquish the role of expert sets the stage for the three necessary therapeutic conditions that are essential to the person-centered approach (Corey, 2013). The core therapeutic conditions are congruence, unconditional positive regard, and accurate empathic understanding (Corey, 2013). Rogers did not create these tenets of person-centered theory, but his application of them was unprecedented (Barrett-Lennard, 1999).

Congruence is also known as genuineness and means that the therapist is authentic while interacting with the client. The therapist's reactions match their feelings, and the counselor serves as a model for the client (Corey, 2013). Unconditional positive regard is when the therapist communicates a deep and genuine caring for their client as a person (Corey, 2013). There is no judgment placed on the client or their behaviors as good or bad. This allows the client to express themselves freely (Corey, 2013). The last condition of accurate empathic understanding involves a deep and nonjudgmental understanding of the client's feelings and reactions (Corey, 2013). Empathy is not to be confused with sympathy or feeling bad for the client.

Person-centered theory was groundbreaking in the 1940s and has held up to the test of time (Barrett-Lennard, 1999). Person-centered theory is still a standalone approach as well as the foundation for many other modern behavioral health interventions such as art therapy, crisis intervention, and motivational interviewing (Corey, 2013). The person-centered approach is at the heart of peer services and informs peer support both in philosophy and practice (SAMHSA, 2019).

The person-centered approach has been applied to working with individuals, groups, and families, all of which can be included in peer services (Corey, 2013; SAMHSA, 2019). Peer support services take the person-centered approach to the next level by reinvesting in the client as a skilled and worthy person that can use their journey to help others (SAMHSA, 2019). Both person-centered theory and peer support services are innovative practices that challenge the status quo by considering the client an expert in their own life and personal growth (Corey, 2013; SAMHSA, 2019).

Person-centered principles are extremely relevant to peer support in the veteran population as that is where Rogers focused a lot of his work. Rogers often expressed his commitment to the war effort during the 1940s and taught simple counseling methods to staff who worked directly with veterans (Barrett-Lennard, 1999). Rogers focused specifically on adjustment problems in returning service members, which is a problem that still plagues the military population to this day (Barrett-Lennard, 1999).

Previous research in the person-centered approach involves in-depth case studies and interviews with the clients (MacLeod & Elliott, 2014; Von Humboldt & Leal, 2015). While quantitative data can and has been gathered, it does not tell the whole story of a client's experience. Qualitative study aligns with the principles set forth by Rogers by seeking to hear the individual's experience from their perspective. Following this philosophy, a qualitative examination of the experiences of veteran peer support providers would allow for a rich understanding of their experience.

Statement of Purpose

The purpose of this study is to gain an understanding of the experiences of veteran peer support providers. This empirical phenomenological inquiry will allow for veteran peer support providers to share their experiences freely and openly. The hope is that this study will highlight challenges and benefits of peer support work for the veteran peer provider.

Research Questions

This study seeks to answer the question: what is the experience of veteran peer support providers? Beyond the overall experience, this study also seeks to answer more specifically, what are the challenges and benefits of providing peer support services and how providing these services impacts the veteran providers' recovery.

Potential Significance of the Study

Veterans are a population that is at increased risk for mental illness, substance use, suicide, and stigma (NIMH, 2017; VA, 2018). Providers in the mental health field are also at risk for developing symptoms of PTSD, substance use, depression, and anxiety (Jenkins et al., 2011; La Mott & Martin, 2019; Martin-Cuellar et al., 2018). Veteran peer support providers fall into both aforementioned categories. Therefore, gaining an understanding of the impact of providing services on veteran peer providers is necessary in order to understand the risks and benefits associated with this work. This study will lay the groundwork for best practices in supporting veteran peer providers. Secondary trauma and resiliency are underrepresented in the literature on veteran peer support providers. It is incredibly important to understand the dynamics of providing peer services for veterans to minimize any risks to the veteran providers while maximizing the benefits of peer support for all involved.

Definitions of Terms

Operational definitions are important in understanding certain terms that may be unique to this research. The following terms and operational definitions were used in this study.

Comorbid Disorders: Multiple, coexisting diseases (Valderas et al., 2009).

Deinstitutionalization: The movement of mental health care from large government run institutions, to community organizations (Jones & Gallus, 2016).

Disenfranchised Grief: The inability to properly express and move through the grieving process (Doka, 2002).

Peer Support Specialist: Peer support exists across many fields and disciplines but for the purposes of behavioral health and this paper, it is defined as someone who recovers from mental illness and/or addiction and then uses their own lived experience, combined with training to provide intervention services to others (SAMHSA, 2019).

Recovery: A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential (SAMHSA, 2019).

Relapse: The return of a disease or symptoms (CDC, 2020).

Resilience factors: Reduces the risk of a disorder occurring (NIMH, 2017).

Risk factors: A variable that makes a disorder more likely to occur (NIMH, 2017).

Secondary Trauma: A change that happens within a therapist (or other helper) due to empathic engagement while bearing witness to clients' trauma experiences (Pearlman & McIan, 1995).

Stigma: An association between a diagnosis or condition and something shameful (El-Badri & Mellsop, 2007; Pescosolido, 2013).

Transinstitutionalization: The process of psychiatric patient's movement from one type of institution to another (Primeau et al., 2013).

Trauma: The exposure to real or threatened death, serious injury, or violence that is sexual in nature. These traumas can occur in one or more ways: direct experiences of the event, witnessing the event as it occurs to others, learning that a loved one experienced a traumatic event, and repeated or extreme exposure to the details of a traumatic event (APA, 2013).

Veteran: A person who served in the military, navy, or air service and who received a discharge other than dishonorable (SSA, 2017).

Chapter Summary

This chapter has provided an overview of peer support in relation to United States military veterans. A deeper exploration of the literature concerning peer support, veterans, and risk factors impacting veterans and mental health providers will paint a bigger picture of why this qualitative inquiry into veteran peer support provider experience is warranted. Chapter 2 is an empirical review of the literature and takes an in-depth approach to veteran culture, trauma types, suicide, and the benefits and challenges of peer support services. Chapter 3 gives an in-depth explanation of the research methodology and design. Chapter 4 presents the results of the study, and Chapter 5 discusses the implications of the research findings. All these sections come together to tell a story about the experience of the veteran peer support provider.

Chapter 2: Review of the Literature

Introduction and Purpose

There are many factors that make veterans a vulnerable population, including trauma history, veteran culture, and stigma (Harding et al., 2017). This vulnerability raises concerns about the impact of secondary trauma on veteran peer support providers. On the other hand, to be a certified peer specialist, one must be successfully in recovery for a period of time, which indicates the presence of resiliency. An in-depth exploration of trauma, peer support, and veteran risk and protective factors will set the stage for an inquiry into the impact of providing peer support services on the veteran population.

In order to examine the benefits and challenges of peer support, a literature review was conducted concerning peer support in both non-veteran and veteran populations. Peer support exists in many fields and can be with or without certification (Watson & Meddings, 2019). This literature review only included peer reviewed empirical articles pertaining to peer support within mental health. Another search requirement was that the peer providers in the studies have formal training or certification. Studies were first gathered that focused exclusively on the need and effectiveness of peer support within mental health in Western countries with established mental health systems. Building upon this evidence, the focus of the literature review search turned to the impact of peer support on peer providers. Lastly, articles that focused on peer support within the United States veteran population were gathered.

Keywords used were “peer support,” “peer services,” “peer providers,” AND “mental health,” “behavioral health,” AND “veterans.” Reference sections of most recent empirical articles were also searched for titles that matched search keywords. Databases that were searched included APApsycnet, SAGE, ESCO, and Google scholar. Articles needed to be less than 10 years old, except Mowbray 1998 because it was identified as a seminal article that was cited by almost every study in this literature review. One other outlying study was included, but under different criteria. McLafferty et al. (2019) did not look at peer support directly, but had a very large sample and were able to demonstrate the importance of quality social supports and networks in buffering veterans against PTSD symptoms. McLafferty et al. (2019) also used several reliable measures that are often used in peer support research. Due to the limited literature that specifically focuses on veteran peer support programs, McLafferty et al. (2019) had too much supporting evidence for the benefits of social networks to exclude from this literature review.

Literature concerning veteran culture, veteran mental health, trauma, secondary trauma, suicide, and grief was also explored. Again, the search requirements were that the articles were less than 10 years old unless an article was cited by multiple researchers. Older articles were included under this condition as seminal work. Due to the United States government controlling and limiting most research on military service members and veterans for reasons of national security, international articles concerning combat veterans were included (Bride & Figley, 2009). International articles added a wider scope to the literature review and demonstrated that combat has long-lasting impacts across all cultures and geographic regions.

Trauma

Trauma can be defined as the exposure to real or threatened death, serious injury, or violence that is sexual in nature (APA, 2013). These traumas can occur in one or more ways; direct experiences of the event, witnessing the event as it occurs to others, learning that a loved one experienced a traumatic event, and repeated or extreme exposure to the details of a traumatic event (APA, 2013). There are many events that are widely recognized as traumatic, such as car accidents, natural disasters, combat, violence, abuse, terrorist attacks, and many more (Kira et al., 2008).

Common psychological and physiological symptoms observed after trauma are sadness, grief, depression, anxiety, dread, horror, fear, rage, shame, intrusive thoughts and imagery, nightmares, flashbacks, numbing, avoidance, and cognitive shifts in views of self and the world (Valent, 2002). These reactions to a trauma can range in severity and may include a temporary interruption in functioning that eventually improves over time or leads to more persistent and severe psychopathology (Bonanno, 2004). The need for early intervention following a trauma has been established since the late 1970s or early 1980s (Valent, 2002).

Adverse Childhood Experiences

Adverse childhood experiences (ACEs) are specific traumas occurring during childhood that include, but are not limited to, maltreatment, poverty, abuse (physical, emotional, or sexual in nature), neglect, having caretakers with a mental illness or substance use disorder, and witnessing domestic violence (Esaki & Larkin, 2013; Lee et al., 2016; McLafferty et al., 2019). The presence of one or more ACEs is a known risk factor for future mental and physical health issues and has even been associated with a shortened lifespan (Evans & Evans, 2019; Lee et al., 2016; McLafferty et al., 2019).

McLafferty et al. (2019) considered adverse childhood experiences to be a factor in the high PTSD rates in veterans. ACEs have been associated with an increased risk of chronic disease, suicidality, risk taking behavior, substance abuse, relationship difficulties, maladaptive beliefs, emotional struggles, personality disorder, depression, and PTSD (Carbrera et al., 2007; Evans & Evans, 2019; Lee et al., 2016; McLafferty et al., 2019).

The increased risk associated with ACEs is thought to come from several factors. Childhood trauma interferes with the process of developing trust and expectations of others (Carbrera et al., 2007). This lack of trust can make it difficult for survivors of childhood trauma to form social networks and coping skills (McLafferty et al., 2019). The presence of ACEs also creates heightened stress sensitivity (McLafferty et al., 2019). With a lack of trust in others and the world, along with a sensitivity to stress, it is only natural that ACEs are thought to exacerbate the impact of any future traumas (McLafferty et al., 2019). Some research suggests that repeat exposure to traumatic life events may lead to a heightened sensitivity and inadequate coping (McLafferty et al., 2019).

Like other dose response trauma theories, it appears that as the number of ACEs increases, so does the likelihood of mental illness (McLafferty et al., 2019). Military veterans with a history of ACEs are more likely to encounter mental health issues post deployment (Carbrera et al., 2007; Lee et al., 2016; McLafferty et al., 2019). McLafferty et al. (2019) surveyed 3,092 military veterans and found that veterans with a history of multiple ACES were 8 times more likely to have a diagnosis of PTSD than veterans without ACEs. Lee et al. (2016) surveyed 3,319 Canadian Armed Forces veterans who had deployed overseas and found a significant association between ACEs and poor mental health outcomes ($p < .001$). Carbrera et al. (2007) found that ACEs and post deployment mental health were significantly and negatively correlated ($p < .001$).

Military veterans are not the only population that are at risk of being impacted by their trauma history. Human service workers and mental health providers with trauma histories are thought to be particularly vulnerable to the effects of secondary trauma (Jenkins et al., 2011; LaMott & Martin, 2019; Martin-Cuellar et al., 2018). La Mott and Martin (2019) used a mixed methods design to examine the impact of ACEs on self-care and compassion outcomes. Several scales and measures were used, including the ACE inventory, and it was found that there was a significant difference in the scores for secondary traumatic stress ($p = .044$), burnout ($p = .004$), and compassion satisfaction ($p = .048$) among the mental health workers with no history of ACEs and those that reported ACEs. The intersection between being a veteran in recovery and providing peer support services could heighten the potential impact of the veteran peer provider's trauma history when exposed to details of their clients' traumas.

Secondary Trauma

The *DSM-5* was printed in 2013 and put into widespread use by practitioners in 2016, replacing the former *DSM-IV-TR* as the diagnostic tool for mental health disorders in the United States (APA, 2013; Horesh, 2016). With this new *DSM-5* came a reconstruction of Criterion A for PTSD to include indirect exposure to trauma (APA, 2013; Horesh, 2016). Furthermore, criterion A4 addresses "repeat and extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties…" (APA, 2013, p. 271).

With this recent inclusion of secondary trauma as a qualifier for a PTSD diagnosis, it begs the question of whether the word secondary is needed any longer when addressing indirect exposure to trauma (Horesh, 2016). A notable gap still exists between the new *DSM* definition and what has been included and studied under the term secondary trauma (Horesh, 2016). For this reason, the term secondary trauma has been and will continue to be used.

Empathy has been highlighted as a significant contributing factor in the development of secondary trauma (Bride & Figley, 2009; Horesh, 2016; Isobel & Angus-Leppan, 2018). Recently, theories about the biological underpinnings of secondary trauma have come to light (Isobel & Angus-Leppan, 2018). Mirror neurons in the brain are activated when a person observes another person experiencing an emotion (Isobel & Angus-Leppan, 2018). These mirror neurons activate areas of the observer's brain as if the person were to be experiencing the emotion themselves (Isobel & Angus-Leppan, 2018). This neural pathway is thought to be responsible for the very empathy and connection that leaves therapists vulnerable to secondary trauma (Isobel & Angus-Leppan, 2018).

Given the recommendation that trauma survivors seek intervention, people employed in the helping field are repeatedly exposed to these details of traumatic events and the suffering of their clients. The impact of exposure to client trauma on the helper has many implications both for the helper and the clients. Beyond trauma, it is widely recognized that people can be secondarily affected by the suffering of others (Valent, 2002). Working with clients in distress can leave mental health workers vulnerable to burnout and vicarious trauma (Straussner et al., 2018).

Approximately 61% of men and 51% of women in the United States have reported experiencing one or more traumatic events over their lifespan (Bride, 2007; SAMHSA, 2019). Roughly 90% of clients receiving behavioral health services in the United States have experienced a trauma (Bride, 2007; Isobel & Angus-Leppan, 2018; SAMHSA, 2019). Combining these statistics, it is implied that about half of behavioral health clinicians have been exposed to trauma as a primary victim and almost all behavioral health clinicians have been exposed to secondary trauma through their clients.

The lifetime prevalence of PTSD in the general population is 7.9% (Bride, 2007; Kilpatrick et al., 2013). While there is no overall agreed upon percentage of clinicians who experience secondary trauma symptoms, several studies have begun to examine just how prevalent secondary trauma may be. One study found that PTSD due to secondary trauma was found in 15% of participating clinicians (Bride, 2007). Another study found that 19.2% of the participating clinicians met all core criteria for a diagnosis of PTSD (Cieslak et al., 2013). It appears that clinicians may be experiencing enough symptoms to qualify a diagnosis of PTSD at a rate that is more than double the general population.

Bride (2007) investigated the prevalence of secondary trauma symptoms in 294 social workers in an unspecified southern state. The number of participants who reported working with traumatized clients was 97.8% (Bride, 2007). Symptoms were measured using the three domains of intrusion, avoidance, and arousal that are seen in PTSD (Bride, 2007). Of the 294 social workers, 70% experienced at least one symptom within the previous week, and 55% met the criteria for at least one symptom domain (Bride, 2007). The most frequently reported symptoms were intrusive thoughts and avoidance of reminders of the client (Bride, 2007).

Cieslak et al. (2013) surveyed 224 clinicians that included counselors, social workers, and psychologists. In order to be included in the study, the clinicians had to have reported secondary exposure to trauma through their clients (Cieslak et al., 2013). The clinicians reported symptoms within the three domains of intrusion (thoughts and imagery) symptoms, arousal (anxious) symptoms, and avoidance (withdrawal, isolation) symptoms (Cieslak et al., 2013). Fifty-seven percent of participants met criteria for the intrusion domain, 35% of participants met criteria for the arousal domain, and 29% met the criteria for the avoidance domain (Cieslak et al., 2013).

Not all evidence supports the existence of secondary or vicarious trauma. Devilly et al. (2009) surveyed 152 mental health professionals in Australia and found that work-related stressors were much more predictive of secondary trauma than exposure to patients' traumatic material. Cieslak et al. (2013) also supported this finding and noted that there was no significant difference between the prevalence of secondary trauma in counselors, social workers, or psychologists. These findings may indicate that it is not so much the exposure to client trauma that contributes to clinician distress as it is heavy caseloads and a lack of resources (Cieslak et al., 2013).

Secondary trauma has not been examined in veteran peer support providers. However, secondary trauma has been studied in veteran spouses, children, and caregivers (Ahmadi, 2011; Bride & Figley, 2009; Pedras & Pereira, 2014). Ahmadi (2011) surveyed 100 Iranian war veterans diagnosed with PTSD, and their spouses. All spouses in the study reported symptoms of PTSD as measured by the Mississippi Scale for Combat Related PTSD (Ahmadi, 2011). The degree of PTSD in the veteran significantly predicted symptoms in the spouse (p =.0001), with 49% of veteran spouses reporting moderate symptoms and 51% reporting severe symptoms (Ahmadi, 2011).

Pedras and Pereira (2014) conducted a mixed methods study to investigate secondary trauma symptoms in 80 adult children of Portuguese war veterans. Symptoms of secondary trauma appeared in 66% of the adult children. Enough symptoms were present in 27.5% to constitute a diagnosis of PTSD while 34% of the veteran offspring showed no symptoms (Pedras & Pereira, 2014). Being exposed to a parent with a mental illness (veteran or not) qualifies as an adverse childhood experience and can lead to lifelong struggles with mental and physical health (Pedras & Pereira, 2014).

Bride and Figley (2009) conducted a rare case study on active duty service members serving as caregivers for wounded soldiers from Iraq and Afghanistan. A lieutenant colonel served as a psychotherapist at the largest military hospital outside of the United States, located on a United States base in Germany (Bride & Figley, 2009). The lieutenant colonel reported that caregivers saw between 30-50 patients a day with a variety of mental and physical wounds. Bride and Figley (2009) define caregivers as medical and behavioral health professionals, volunteers, clergy, parents, spouses, and children of service members and veterans.

The lieutenant colonel reported that staff adopted a laid-back approach in which they allowed wounded soldiers to tell their stories of trauma and injury (Bride & Figley, 2009). Staff at the combat hospital in Germany exhibited and reported extraordinary distress and the lieutenant colonel began to question how long it would be sustainable for staff to absorb such a large amount of secondary trauma. Despite this distress, caregivers often remain committed and reported great satisfaction with their work, indicating that satisfaction and secondary trauma are not mutually exclusive (Bride & Figley, 2009).

Secondary trauma may present a challenge to veteran peer support providers on two fronts. The first area of concern is for veterans as clinicians that will be constantly exposed to the struggles and stories of other veterans. The second area of concern involves the veteran peer provider's history of trauma, whether it includes ACEs, combat, or other factors, the veteran's history and symptoms were enough to constitute a diagnosis. Additional factors such as suicide and veteran culture will contribute to this web of concerns for the veteran peer support provider.

Suicide

Another unique problem that both mental health workers and veterans face is suicide. For mental health providers, the concern is losing a client to suicide. Veterans are already at an increased risk for suicide themselves and must also grapple with the possibility of losing a client to suicide in their role as peer provider. In 2017, 45,390 American adults died by suicide, of which, 6,139 of them were United States veterans (VA, 2019). The suicide rate for veterans was 1.5 times that of non-veteran adults (VA, 2019). Suicides in both the veteran and non-veteran populations have risen every year (VA, 2019).

McAdams and Foster (2000) surveyed 1,000 mental health clinicians and found that nearly a quarter of those practitioners had experienced one or more client suicides. Losing a client to suicide can be devastating for a mental health provider and can become a primary trauma for the clinician (McAdams & Foster, 2000). The loss of a client in this way can lead to grief, feelings of anger, loss of confidence, fear of legal repercussions, and can even impact the clinician financially (Weiner, 2005). On top of these feelings, a clinician may not be able to appropriately express or deal with their grief due to confidentiality concerns, stigma, shame, and policy (Weiner, 2005).

Clinicians may face significant loss in the form of income or employment when they lose a client to suicide (Tsui et al., 2019). Client deaths are often investigated by the agency that employs the clinician to understand what factors led to the suicide (Finlayson & Simmonds, 2019). These psychological autopsies and investigatory practices can be extremely harmful to the clinician, especially when the agency seeks to blame the clinician or use them as a scapegoat to cover up an organizational deficiency (Finlayson & Simmonds, 2019).

Clinicians who have experienced a suicide loss have reported a feeling of responsibility in their client's death (Finlayson & Simmonds, 2019). Mental health workers found to experience the least amount of negative impact after a client death reported that the support of their peers and organizations played an integral role in their ability to move through the grieving process (Finlayson & Simmonds, 2019).

Grief

McAdams and Foster's (2000) finding of almost a quarter of clinicians losing one or more clients to suicide indicates that losing a client to suicide is a very real possibility for mental health clinicians. Client suicide is a unique occupational hazard to this field and its impact on the clinicians deserves further consideration (McAdams & Foster, 2000). The lack of training and preparation for client suicides along with the lack of support and resources following a death, have tremendous impacts on mental health workers (Weiner, 2005).

A disruption in the expression of grief has been defined as *disenfranchised grief* by Keneth Doka (2002), and *stifled grief* by Finlayson and Simmonds (2019). These terms are attempts to capture the inability to properly express and move through the grieving process. The death of a client is often viewed by society as a less significant loss than what is seen in other types of relationships such as family and friends (Doka, 2002). Despite these societal norms, clinician reactions to losing a client to suicide are very similar to such loss in other types of relationships (Finlayson et al., 2013). Insurance companies and employing organizations may prohibit the clinician from attending a client's funeral or speaking with the client's family (Tsui et al., 2019; Weiner, 2005). Not being able to acknowledge such loss can place an incredible strain on clinicians and interrupt their grieving process.

Peer Support

Several common themes emerged from the literature on peer support. Both peer providers and peer support recipients often identified common themes. A multitude of the studies noted that peer support should be supplemental or complementary to traditional mental health services and not completely replace them (Ahmed et al., 2015; Gidugu et al., 2015; Kowalski, 2020). Another common theme was a lack of definitions within the field (Gidugu, et al., 2015). There were many positives found for both recipients and providers of peer support services. The benefits of peer support seem to outweigh any drawbacks; however, peer providers articulated several challenges to providing service.

Definitions of Peer Support

A common theme that emerged among the literature is that both recipients and providers struggled with the definition of peer support and role clarity. Gidugu et al.

(2015) sought to clarify the peer support specialist role along with clarifying what makes peer support effective for the recipient. Some participants were not able to articulate their expectations for peer support (Gidugu et al., 2015; Mowbray et al., 1998). It is established that a main difference between peer support and traditional mental health services is the provider's ability to use their lived experiences with recovery as a model for the recipient (Davidson et al., 2012). However, beyond this point, it is unclear to what degree providers should share and become involved with their clients (Gidugu et al., 2015). Clearer definitions and trainings were suggested as possible solutions to this lack of role clarity (Kowalski, 2020).

Most of the participants (no statistic was given) in a study by Gidugu et al. (2015) reported that they were not familiar with peer support prior to entering their program. Due to the unfamiliarity with peer services, several participants talked about feeling skeptical when they first entered the program. Expectations of the peer support program were quite varied. Some recipients were unsure what to expect, while others were hoping for assistance with daily tasks like shopping and transportation. Others expressed hopes for someone to talk to and provide emotional support (Gidugu et al., 2015).

The peer support job description was so vague that one participant asked a supervisor to provide a description of what her peer specialist could and could not do (Gidugu et al., 2015). Boundaries and self-disclosure were often mentioned as areas of misunderstanding (Gidugu et al., 2015; Mowbray et al., 1998). These blurred boundaries are more than likely a result of poorly defined roles and expectations; however, a study has not been conducted to look at only this correlation. Boundary issues were highlighted by Mowbray et al. (1998) as well as by Gidigu et al. (2015). Gidugu et al. (2015) found that participants reported confusion over boundaries and the peer relationship. It was noted that the boundary confusion may be easily cleared up by better defined roles and job descriptions (Gidugu et al., 2015).

McCarthy et al. (2019) considered the influence of program structure on the peer specialist role. Specifically, McCarthy et al. (2019) wanted to know how a mid-level structured peer support program impacted the peer support experience due to previous research only investigating highly structured or unstructured peer programs. Flexibility was the first theme identified by veterans as an important characteristic of a peer support program (McCarthy et al., 2019). Flexibility allowed the peer specialists to respond to the recipient’s immediate needs and work in more structured content later (McCarthy et al., 2019). Another theme emerged relating to a workbook that was used for the program. Fifteen out of the 20 peer support recipient participants felt that the workbook was helpful and said they would recommend it (McCarthy et al., 2019). However, participants almost unanimously reported that the workbook was not adequate on its own, the true value came from working through the book with a peer specialist.

Themes concerning the unstructured sessions were reduced isolation, community reintegration, and recovery activities (McCarthy et al., 2019). Being accompanied in activities by the peer specialist was again highlighted as the most important factor in these sessions (McCarthy et al., 2019). Both veteran participants and case managers unanimously expressed satisfaction with the peer support specialists, even if they did not necessarily report satisfaction with the program itself. These findings once again stress the peer provider as the instrument of change within treatment programs (McCarthy et al., 2019).

Recipient Experience of Peer Support

The recipient experiences of peer support services were as varied as the expectations (Gidugu et al., 2015). In one study, peer support services were categorized into different activities. The categories were tangible or practical supports, social support, emotional support, mental health treatment support, and goal planning and skills teaching (Gidugu et al., 2015). In another study, effects on peer support specialist's (PSS) lives were categorized as beneficial, meaning that they had a positive impact, or as a cost meaning that the impact was negative (Mowbray et al., 1998). Eleven peer support specialists in Grand Rapids, Michigan were interviewed about their experiences with a peer support program called project WINS. Semi-structured interviews inquired about PSS employment history, activities after leaving WINS, descriptions of activities as a PSS, analysis of WINS experience, effect of WINS on PSS' lives, and recommendations for further PSS and program development (Mowbray et al., 1998).

While McLafferty et al. (2019) did not research peer support itself, they did examine the impact of social support on veterans' mental health. The results of the study by McLafferty et al. (2019) found that veterans experiencing the most adverse childhood experiences were significantly more likely to later have diagnoses of PTSD, major depressive disorder, and generalized anxiety disorder. Once this was established, McLafferty et al. (2019) were able to show that having high quality social networks mediated the effects of adverse childhood experiences when present. However, it was found that veterans with a history of adverse childhood experiences were significantly less likely to have high quality social networks (McLafferty et al., 2019). This association shows how import peer support can be as a buffer between early trauma and the development of mental health disorders in adulthood.

Caddick et al. (2015) explored how combat veterans with PTSD made sense of peer relationships with other veterans. Caddick et al. (2015) wanted to know how a group of combat veterans that belonged to a surfing charity experienced their relationships with other veterans. More specifically, Caddick et al. (2015) were interested in the stories veterans use to make sense of their peer relationships, and how those stories shape the veterans' experiences of subjective and psychological well-being.

Caddick et al.'s (2015) findings very strongly demonstrate how important and powerful a peer relationship has the potential to be, especially within the veteran population. A theme of a collective story emerged from the interviews that was labeled "band of brothers" by Caddick et al. (2015). Sharing a similar background and camaraderie from the military allowed veterans to come together and support each other's journey with PTSD. The collective story also highlighted the intense bond between veterans and informed the name "band of brothers." Even with the intense group bonding, there is room for development of individual identities although it does seem to be formed around the person's place within the group (Caddick et al., 2015). The sense of belonging, acceptance, and normalizing of the suffering of PTSD helped collectively shape these veterans' experiences of well-being.

Gidugu et al. (2015) found the role of shared experience to be a major theme of peer support. This shared experience included a normalizing of psychiatric disability and a sense that they were not alone. Participants reported that they found a sense of comfort and personal connection as well as feelings of hope. Goetter et al. (2018) found that veteran peer outreach coordinators (VPOCs) rated peer support outreach contacts as very feasible with a mean rating of 4.25 out of 5, and very acceptable with a mean rating of 4.63 out of 5 (Goetter et al., 2018). Patient satisfaction with VPOCs was also very high with 94% agreeing or strongly agreeing that the VPOCs helped them to feel more comfortable receiving treatment. Eighty-four percent of participants in treatment moderately or strongly agreed that contact with the VPOC was appreciated and 81% moderately or strongly agreed that the contact helped them to feel more connected to the clinic.

Benefits. Kumar et al. (2019**)** interviewed 29 veterans enrolled in a peer support program through the Palo Alto VA hospital in California. The purpose of the study was to identify the expectations the veterans had for the certified peer specialists running the program, as well as the expectations of the program itself (Kumar et al., 2019). The veterans reported many benefits to receiving the peer support services that included the use of a shared and understood language, the recovery orientation of the program, coping skills, and connectivity (Kumar et al., 2019).

The following five thematic categories emerged: perceived role of the peer support program, supportive experiences of the program, global gains from the program, and limitations to the program and further mental health engagement (Kumar et al., 2019). Two themes emerged about the type of support that veterans receive in the peer support program. Structural support pertains to certain features of the program, such as flexibility and the use of shared language (Kumar et al., 2019). The other theme is emergent support or the supportive experiences that later emerged due to the structural support. Some global gains that were identified were recovery orientation, coping tools, and connectivity. Kumar et al. (2019) synthesized the support themes and global gains of peer support and combined them with traditional evidence-based PTSD treatment to develop a recovery model for peer support program participation

Hundt et al. (2015) gathered veteran perspectives on the potential benefits and drawbacks of peer support for PTSD. Several themes emerged concerning the potential benefits of peer support (Hundt et al., 2015). A quarter of the participants had already experienced peer support in the past and brought positive experiences and a sense of hopefulness. The others had no experience with peer support but reported that it seemed promising. A small amount (exact number not reported) stated that they would be unwilling to participate in peer support and cited social anxiety, difficulty with trust, and hopelessness as reasons they were reluctant (Hundt et al., 2015). Potential benefits of peer support that were identified included social support, sense of purpose and meeting, hope, therapeutic benefits, and linkage to care. Overall, veterans identified few drawbacks to peer support besides the ones listed by those that would be reluctant to attend (Hundt et al., 2015).

On top of benefits and drawbacks, Hundt et al. (2015) noticed some themes in the preferences of veterans concerning peer support services. Almost unanimously, veterans felt that there should be separate peer support groups for combat veterans and military sexual trauma survivors. Most of the veterans were in support of mixed gender groups but felt that the option for a gender-based group was important, especially concerning female military sexual trauma (MST) survivors (Hundt et al., 2015). Most Vietnam veterans were supportive of having veterans from different combat eras in the same group but OEF/OIF veterans disagreed and were more likely to prefer segregated groups by service era (Hundt et al., 2015).

Hundt et al. (2015) also identified veteran recipient's preferred characteristics of the peer provider and preferred topics for discussion in the peer groups. Most participants agreed that the peer provider needed to be a "veteran first; professionals second" (Hundt et al., 2015, p. 854). It was expected that the peer provider be able to use their own recovery and examples as models for the peer services recipients. Preferred topics for groups included traumatic experiences, life goals, and resources (Hundt et al., 2015). These findings indicate that finding the most comfortable fit for peer support may be difficult and that the definition of "peer" may cover a wide array of criteria. These criteria may not be prioritized the same by each person.

Veterans were found to attend more psychotherapy sessions over a 6-month period when they had received outreach contact from a veteran peer outreach coordinator (VPOC) compared to those who had received no contact (Goetter et al., 2018). Concerning treatment engagement, no significant results were found in dropout rates or session totals at the 3-month follow up. However, by the 6-month follow up, participants who had received two peer support contacts had a mean number of sessions ($M = 10.85$) that was almost double the participants who received no peer support contact ($M = 5.47$). The difference was significant ($p = .032$) and indicates that multiple contacts with a peer provider may lead to increased adherence to therapy sessions.

The 6-month dropout rate for the same veteran participants was significantly lower for veterans that received two peer outreach contacts as opposed to veterans that received only one contact or no contact (Goetter et al., 2018). Patients reported high rates of satisfaction with the VPOCs and 94% stated that the peer coordinator made them feel more comfortable with receiving care. Seventy-seven percent of outreach recipients reported the importance of having a veteran they could speak with when needed and 84% felt grateful for the follow-up contact (Goetter et al., 2018).

Ray et al. (2017) designed a study to gain feedback on how peer support could improve an already evidence based cognitive behavioral treatment called Moving Forward for veterans with depression and anxiety. Moving Forward is a computer based cognitive behavioral therapy (cCBT) designed by the VA (Ray et al., 2017). cCBT was designed to support United States military veterans in their transition to civilian life. The cCBT program takes between 4 and 8 weeks and includes exercises, games, video, tools, and self -assessments in a web-based platform (Ray et al., 2017). cCBT is classified by the American Psychological Association (APA) as an empirically supported treatment for depression but it does show high attrition rates, especially when it is used as a stand-alone intervention (Ray et al., 2017).

Twenty-two out of the 24 participants stated that they would use the Moving Forward program and one more participant stated they would use it with a peer support specialist (Ray et al., 2017). Veteran participants identified five primary roles for PSSs in supporting veterans in using Moving Forward. The five roles were emotional support (31% of peer comments concerned this topic), orientation to Moving Forward (28%), technical support (19%), applicability of Moving Forward to problems (12%), and monitor progress/reminders (12%). Preferred methods used by PSSs for delivering activities were grouped into six domains (Ray et al., 2017). The highest percentage of comments were referring to individual meetings with PSS (39%). The other domains for preferred method were group meetings (18%), telephone meetings (16%), email contact (14%), text (8%), and other suggestions including chat (6%).

The results of this study show a preference for a more personal peer support role. Participants also valued help and support with program processes and seem to feel that peer support specialists would be able to increase engagement with the program (Ray et al., 2017). Veterans also identified real-life problems that they would like help addressing with the program. This is consistent with peer support's ability to use one's own recovery as a model to help others in treatment and recovery. There is an indication that even evidence-based treatments can be improved upon with the implementation of peer support services as a complementary treatment (Kumar et al., 2019; Ray et al., 2017).

Challenges. Peer support programs have presented challenges to their recipients as well as benefits (Kumar et al., 2019). The 29 veterans that were receiving peer support services in Palo Alto reported that some of the challenges were due to personal limitations and some challenges were presented by the VA system that provided their care (Kumar et al., 2019). Hundt et al. (2015) found that trust and social anxiety were challenges to recipients accepting peer support services. This finding does not reflect negatively on peer support itself but does demonstrate barriers to treatment.

Overall, not many challenges were identified by peer support recipients (Ahmed et al., 2015; Caddick et al., 2015; Gidugu et al., 2015; Goetter et al, 2018; Hundt et al., 2015; Kumar et al., 2019; Mowbray et al., 1998; Ray et al., 2017). Many benefits were described, and peer support was shown to be complementary to other types of mental health treatment (Goetter et al., 2018). Recipients seemed to value the peer relationship and used it as a model for furthering their recovery (Caddick et al., 2015; Kumar et al., 2019; Ray et al., 2017). With peer providers being in recovery themselves, it is important to now consider the impact of providing those peer services.

Provider Experience of Peer Support

A growing section of the literature considers the impact of peer work on the peer providers. This is a particular area of concern due to the fact that peer providers are in recovery themselves and therefore, may be at risk from such stressful work. The research indicates that there are more benefits than challenges for peer providers. However, common themes emerged in both areas.

A recovery orientation was found to be a large predictor of success in a non-veteran study by Ahmed et al. (2015). The experiences considered included basic roles, and benefits and challenges for the peer specialist (Ahmed et al., 2015). The most profound challenges reported by peer specialists involved rates of employment and salaries (Ahmed et al., 2015). Even though more than 50% of the peer specialist participants had at least some college, 67.9% reported annual income of less than $20,000 (Ahmed et al., 2015). Unemployed participants accounted for 38.3% of the population at the time of the study, and 49.4% of those that were employed, were mostly or very dissatisfied with their financial status. A significant correlation ($r = 0.54$, $p < .0001$) was found between income satisfaction and job satisfaction (Ahmed et al., 2015).

For this reason, Ahmed et al. (2015) compared currently employed peer specialists to currently unemployed peer specialists in the categories of psychopathology, community functioning, and recovery. Significant differences were found between unemployed and employed peer specialists in social engagement ($p = .048$), independence competence ($p = .00$), hope ($p = .047$), and empowerment ($p = .029$), with employed peer specialists functioning higher in each category (Ahmed et al., 2015). Cohen's D results (ranging from .44 to .98) indicate large effect sizes for each significant difference found. Ahmed et al.'s (2015) results indicate that peer workers' employment satisfaction is dependent on their ability to be gainfully employed. The benefits offered by working in peer support may only exist when the provider is actively engaged in employment and making a livable wage while doing so.

Burke et al. (2018) wanted to know how the benefits and costs of providing peer support would be related to levels of empowerment, hope, mental health recovery, and quality of life for the peer providers. Benefits were defined as positive impacts and costs were defined as negative impacts or challenges (Burke et al., 2018). The mean number of personal benefits ($M = 22$, $SD = 3.7$) was much higher than the mean number of personal costs ($M = 7.6$, $SD = 4.9$) from providing peer support services. There were almost twice as many personal benefits found as costs, as evidenced by the cost benefit ratio of .48:.88 (Burke et al., 2018). Additionally, correlation scores were calculated to demonstrate relationships between experiences of providing peer support and quality of life and psychosocial constructs.

Almost all items on the experience of providing peer support survey were highly and significantly intercorrelated, as were psychosocial constructs (Burke et al., 2018). However, the only intersect between the two were found in quality of life which was significantly positively correlated with perceived support in the role (.32), perceived acceptance by mental health team (.41), and perceived team value for peer support (.46). Significant negative correlations were found between total number of personal costs and quality of life (-.40), empowerment (-.35), satisfaction with pay (-.43), satisfaction with career progression (-.49), perceived support in the role (-.37), and overall role satisfaction (-.35). Burke et al. (2018) then used regression analysis to further isolate the impact of the interaction. Quality of life was still found to significantly positively correlate with perceived support in role (p=.007), perceived acceptance by team (p=.007), perceived team value for peer support (p=.002) and negatively correlate with total personal costs (p<.001).

Kowalski et al. (2020) also assessed quality of life of peer providers, along with wellness and recovery. An assessment of recovery capital (ARC) showed overall significant results ($p < .001$). Changes were observed in the expected direction for the World Health Organization Quality of Life Assessment-BEF (WHOQOL-BREF) and the Wellness Assessment but not to a significant degree. However, there was a significant ($p < .001$) and positive relationship between WHOQOL-BREF scores and ARC scores. Higher ARC scores are associated with higher WHOQOL scores and vice versa (Kowalski, 2013).

Several themes emerged from the open-ended questions that reflected both positively and negatively on providing peer services (Kowalski, 2013). Several themes were identified that coincided with previous research. These themes were goals of peer support services, qualities of peer providers, peer services as an alternative to traditional services, a lack of value for peer services, personal growth for peer providers, relapse in recovery, peer provider satisfaction and stress, need for peer services and effectiveness of peer services (Kowalski, 2013). Kowalski (2013) identified five novel themes that had not previously emerged in the literature. These themes were the definition of peer services, professionalism, support for peer services, outcomes of volunteering and justification for peer service

Salzer et al. (2013) found significant (p = .005) differences in changes in certified peer specialist's (CPS) use of case management services, with 69.1% of participants reporting a decrease in services compared to 30.9% reporting an increase in use of services. Significantly (p < .0001) more individuals reported a decrease in frequency of emergency room visits than an increase in emergency room visits. Another significant finding was in the CPS participants that had reported prior hospitalizations. Of the 37 participants with prior hospitalizations, a significant (p < .0001) percentage (83.3%) reported a decrease in hospitalizations compared to the 16.7% that reported an increase in hospitalizations. Dropout rates found by Salzer et al. (2013) also showed a significant (p = .026) difference by the 6-month mark. Participants who received two VPOC contacts had dropout rates (17.39%) that were a third of the dropout rates for participants that received only one VPOC contact (51.11%). These results indicate that peer support may impact dropout rates in a mental health program.

Challenges. Concerns have emerged from the literature concerning the experience of peer support providers. Twenty-three percent of providers in one study experienced an increase in need for behavioral health services (Salzer et al., 2013). Peer support specialists in Grand Rapids, Michigan reported frustrations related to uncooperative clients, along with intimidating home visits, presentations to traditional mental health providers, lack of boundaries, support, and taking their work home with them (Mowbray et al., 1998). For Kemp and Henderson (2012), five major areas emerged as challenges for peer providers. A lack of role clarity, returning to work after a relapse in mental illness, conflicting expectations of time use and workload, self-disclosure, and adequate supervision were the five highest ranked challenges by the peer provider participants (Kemp & Henderson, 2012).

McCarthy et al. (2019) obtained feedback about peer specialists from the peer service recipients, the peer providers themselves, and from traditionally educated and trained case managers that were involved in the program. Three out of eight case managers expressed a concern about boundaries concerning peer support, but this may be a bias due to the general ethical guideline that traditional mental health providers do not self-disclose and maintain strong professional boundaries (McCarthy et al., 2019). All eight of the case managers that were interviewed about peer support and peer providers during the 40 week study, expressed highly positive experiences with the program but one case manager did express concern that the peer specialist may be vulnerable due to working with situations similar to their own (McCarthy et al., 2019).

Benefits. A cost-benefit analysis was conducted, and it was found that peer support providers experience almost twice as many personal benefits as they do costs (Burke et al., 2018). Salzer et al. (2013) noted many benefits for peer providers. These benefits included a significant decrease in hospitalizations while employed as a certified peer specialist, as well as an increase in skills related to recovery and an increase in confidence. Employment related benefits included steady employment and a decrease in dependence on social security (Salzer et al., 2013). Salzer et al.'s (2013) results indicate that working as a certified peer specialist may lead to a decreased need for case management, emergency room visits, and hospitalizations. Salzer et al. (2013) were not alone in quantifying possible benefits of providing peer support services. Similar benefits were noted by Mowbray et al. (1998). The importance of employment was the most frequent theme that emerged, followed closely by gaining specific skills, support found through supervision, positive feedback, a reduction in stigma, and an increased sense of purpose (Mowbray et al., 1998). Burke et al. (2018) found a significant positive correlation between quality of life and perceived support in the role as peer provider.

Providers who had received peer support themselves showed higher quality of life scores and higher recovery scores that their colleagues that never received peer support services (Burke et al., 2018). It has become clear that there are many benefits to peer support for both peer recipient and provider. The challenges that have been highlighted provide an opportunity for further research and development within the field. Considering these findings, it becomes important to examine the methodological designs behind these studies. Methodology can paint a bigger picture about the reliability, validity, dependability, confirmability, and overall credibility of the results being discussed.

Military Culture

Additional factors may become apparent when considering veteran peer support workers (McCarthy et al., 2019). Veterans may experience a stronger sense of camaraderie which could lead to stronger bonds between peer providers and recipients. However, there are factors such as combat exposure, traumatic brain injury from blast exposure, moral injury, military sexual trauma (MST), reintegration challenges with transition to civilian life, and veteran susceptibility to homelessness, substance use, and a higher than average risk for dying by suicide that are unique and specific to the veteran population (Goetter et al., 2018). These factors may leave veteran peer support providers particularly vulnerable when working with similar issues as their own.

United States military service members and veterans constitute their own distinct cultural group (Harding, 2017; Meyer et al., 2016). Those with a military orientation share a language, code of manners, norms of behavior, belief system, dress, and rituals (Harding, 2017; Meyer et al., 2016). Individuals are indoctrinated to military culture through basic training where physical and mental changes occur (Harding, 2017). Rigorous training leads to the formation of the military identity which can become more important than other aspects of identity and often replaces previous cultural beliefs (Meyer et al., 2016). Cultural subgroups are also found within military culture depending on the individual's branch and time of service (Harding, 2017).

Harding (2017) applied The Giger Davidhizar transcultural assessment model to veterans and more specifically, OIF/OEF veterans to demonstrate their distinct treatment needs and preferences as a cultural group. The transcultural assessment model involves six areas of assessment: communication, space, social organization, time, environmental control, and biological variations (Harding, 2017). Using these six areas to assess veteran or military culture, a picture emerges about the special requirements of veterans in receiving care.

Military culture impacts communication with the use of slang, acronyms, and direct and authoritative communication styles (Harding, 2017). There is a clear hierarchy in the military with an emphasis on the collective over the individual and secretiveness over openness. This style of communication can become a barrier to traditional mental health care but may make peer support more appealing. Concerning space and social organization, military culture involves close quarters with minimal privacy and frequent separations and relocations (Harding, 2017). Relationships are based on rank and order and are often described as a second family (Harding, 2017). Providers (veteran or civilian) are often viewed as authority figures and outsiders, creating a barrier of communication and space between veteran and provider. Veterans frequently report feeling best understood by other veterans (Harding, 2017).

The perception of time is also unique in veteran culture (Harding, 2017). Service members and veterans' orientation in the past, present, or future depends on what they are dealing with. Combat requires a present orientation and can lead to a disconnect from the past and future (Harding, 2017). Mission focus requires a preoccupation with future and can lead to increased anxiety and hypervigilance (Harding, 2017). Veterans can often become trapped and consumed by past experiences especially when factors such as moral injury, PTSD, or MST are involved. The past can become so powerful to a veteran that they continue to reexperience it in the form of nightmares and flashbacks (Harding, 2017).

Environmental control involves beliefs about whether the service member has control over situations. Vietnam veterans who were drafted did not choose their fate and were then exposed to combat and trauma (Harding, 2017). The drafting experience is vastly different than a veteran who chose to serve. For OIF/OEF veterans, frequent deployments and exposure to improvised explosive devices (IEDs) can take away any sense of control over one's environment (Harding, 2017).

Biological variations involve ethnic and cultural diversity. The military is composed of individuals from diverse backgrounds; however, service members are predominantly young, White, and male (Harding, 2017). Only 9% of veterans are female and 75% of OIF/OEF veterans are less than 44 years old. OIF/OEF veterans are the most racially diverse group of all service eras but even so, they are predominantly (68.5%) White. OIF/OEF veterans have disproportionately higher rates of PTSD, depression, and substance use disorder (Harding, 2017).

Military culture often acts as a barrier to care for veterans. In 2009, advocates challenged the Pentagon to include PTSD as a qualification for receiving a Purple Heart (Sandel, 2009). The Purple Heart medal is awarded to soldiers who are wounded or killed in battle by enemy action. The Pentagon deemed that veterans suffering from psychological wounds will remain ineligible for the Purple Heart medal that affords its recipients special privileges and prestige at veteran organizations and hospitals (Sandel, 2009). A spokesperson for a veteran's advocacy group stated, "The same culture that demands tough-mindedness also encourages skepticism toward the suggestion that violence of war can hurt the healthiest of minds…" (Sandel, 2009, p. 11). This quote demonstrates the stigma associated with PTSD in military culture.

When considering the veteran population, there has been very little research into the impact of providing peer support on veteran peer support specialists. It is important to consider the best possible ways to support veteran peer support specialists due to their history of trauma and predisposition to PTSD diagnoses (VA, 2018). It seems that no person would be better able to provide that information than the veterans themselves. A qualitative inquiry into the veteran peer specialists' experiences along with challenges and benefits of providing peer support would begin to lay the groundwork for best practices in supporting peer providers.

Post-Traumatic Stress Disorder

There has been a sharp increase in PTSD diagnoses since the beginning of OIF/OEF (Sandel, 2009). More than 300,000 veterans live with PTSD or another mental illness. Some PTSD in veterans is due to sexual assault during service (VA, 2018). PTSD rates can vary depending on the service era of the veteran (VA, 2018). Some research reports that approximately 13% of veterans who served during OIF and OEF have combat-related PTSD symptoms (Jain et al., 2012). However, the VA (2018) breaks it down to approximately 15 out of 100 Vietnam veterans being diagnosed with PTSD, compared to 12 out of every 100 Gulf War veterans, and upwards of 20 out of 100 veterans who served in OIF and OEF.

Implications for Veteran Peer Providers

There is substantial evidence to show that peer support is a valuable supplemental intervention for both non-veteran and veteran populations (Caddick et al., 2015; Gidugu et al., 2019; Hundt et al., 2015; Jain et al., 2012; Kumar et al., 2019; McCarthy et al., 2019; & Ray et al., 2017). Much research has been done on the positive impact of peer support on recipients, but the evidence is mixed on the effects of providing peer support services (Davidson et al., 2012). Furthermore, the impact of providing peer services on veteran peer providers is extremely underrepresented in the literature. There has only been one study conducted concerning military peer providers and secondary trauma and the results overwhelmingly indicated that secondary trauma is a real concern (Bride & Figley, 2009). Considering that United States veterans are already an example of a vulnerable population to mental illness and suicide, veteran peer providers may be more at risk for secondary trauma and/or disruptions in their recovery than other non-veteran peer providers (NIMH, 2017; VA, 2018).

Chapter Summary

Factors such as military culture, trauma, and predisposition to secondary trauma and suicide may leave veteran peer support providers vulnerable to issues in recovery, possibly to the point of relapse. Many benefits of providing peer support services have been identified by peer support providers and these benefits may act as a buffer against relapse for providers. Due to the limited literature concerning veteran peer support provider experience combined with the growing use of veteran peer providers across the nation, an investigation into this experience is needed.

This study hopes to gain an in-depth understanding of the veteran peer support experiences. Careful selection and application of research design and methodology is of utmost importance in obtaining the sought-after information. Chapter 3 provides justification for the proposed qualitative study into veteran peer provider experience as well as gives a detailed outline of proposed research methodology and design. Chapter 3 also covers the privacy and protection of both participants and data.

Chapter 3: Research Design Methodology

Introduction

With the 2004 rollout of the Mental Health Strategic Plan by the VA, a mass hiring of veterans as peer support providers has occurred nationwide (Jain et al., 2012). In 2012, there were an estimated 10,000 peer support staff in the United States and that number was projected to continue climbing (Davidson et al., 2012). According to the Federal Reserve Economic Data (2020), the working age in the United States is currently 15 to 64 years. The youngest Vietnam veterans are turning 63 this year, indicating that current and future peer support programs will be staffed and utilized predominantly by OIF and OEF veterans (VA, 2018). Multiple deployments of OEF/OIF veterans are leading to increasing numbers of PTSD diagnoses (VA, 2018).

Secondary trauma research spans multiple fields and was added to the *DSM-5* in 2013. Current secondary trauma research is predominantly quantitative with the use of scales and questionnaires to gain measurement of the secondary trauma effect (Bride, 2007; Cieslak et al., 2013; Isobel & Angus-Leppan, 2018; Straussner et al., 2018). A small amount of predominantly qualitative research exists on the veteran peer support provider experience (Goetter et al., 2018; Hundt et al., 2015; Kumar et al., 2019; Ray et al., 2017). However, no research has been found that examines secondary trauma in veteran peer support providers.

The focus of this empirical phenomenological study is on the impact of peer support work on veteran peer support providers and their own recoveries. Peer providers are in recovery for their own mental illness diagnoses and there is concern about how this type of work may impact peer providers and their own recovery (SAMHSA, 2019). This study seeks to answer the question: what is the experience of veteran peer support providers? Beyond the overall experience, this study also seeks to answer more specifically, what are the challenges and benefits of providing peer support services and how providing these services impacts the veteran providers' recovery.

The purpose of this study is to gain a rich understanding of the veteran peer support experience that could not be uncovered by quantitative means. An understanding of the veteran peer support provider experience can begin to fill the gap in qualitative research on veteran peer support programs which currently do not include the impact of providing services on veteran peer support providers.

Research Context

Peer support provider experience has been examined in several different organizations across several states' populations (Caddick et al., 2015; Gidugu et al., 2019; Hundt et al., 2015; Jain et al., 2012; Kumar et al., 2019; McCarthy et al., 2019; Ray et al., 2017). However, peer programs within the majority of organizations and communities in the United States are still underrepresented in the literature. When considering the veteran population, there has been very little research into the impact of providing peer support on veteran peer support specialists. It is very important to consider the best possible ways to support veteran peer support specialists due to their history of trauma and predisposition to PTSD diagnoses (VA, 2018). It seems that no person would be better able to provide that information than the veterans themselves. A qualitative inquiry into the veteran peer specialists' experiences will begin to lay the groundwork for best practices in supporting peer providers. A formal protocol for this study has been included in Appendix A.

Methods

Due to research specifically focused on veteran peer support providers not being represented in the literature, a qualitative inquiry was warranted. Qualitative research is a process in which the researcher derives meaning from the participants' shared experiences (Creswell & Creswell, 2018). Brinkmann and Kvale (2015) add that a qualitative interview seeks to reveal the meaning of the participants' experiences prior to scientific explanation. More specifically, qualitative interviews seek knowledge found in everyday language.

Phenomenology is an approach to qualitative research that seeks to uncover the essence of experience (Brinkmann & Kvale, 2015). Phenomenology began as a philosophy founded by Edmund Husserl in 1900 and has evolved ever since (Brinkmann & Kvale, 2015). Phenomenological origins focused on consciousness and experience but have expanded to include human environment, body, and action. Phenomenology is prevalent in qualitative research and falls under the social constructivist lens (Brinkmann & Kvale, 2015; Creswell & Creswell, 2018).

More specifically, empirical phenomenology seeks to obtain descriptions of experiences from participants to lay a foundation for reflective structural analysis (Moustakas, 1994). This structural analysis provides the essence of an experience. There are two descriptive levels in empirical phenomenology (Moustakas, 1994). First, original data is collected through open-ended questions and dialogue. Next, the researcher uses reflective analysis to describe the structures of the participant experience. This process will be discussed in more detail in the analysis portion.

Constructivist researchers pay special attention to specific contexts in which participants work and live to understand participant history and culture (Brinkmann & Kvale, 2015). The understanding of social phenomena from participant perspectives is achieved by participants describing the world as experienced by them (Brinkmann & Kvale, 2015). Open-ended interviews allow the participant space to share their experience while the researcher listens and observes. Interviews eventually become text to be analyzed for themes and meanings (Brinkmann & Kvale, 2015).

Formalized sampling is generally not used in qualitative research (Flick, 2018). Instead, sampling criteria is defined beforehand. The goal is to obtain a representative sample from the larger population being studied to apply the findings to more than just the individual participants (Flick, 2018). There are many methods of sampling and while convenience sampling is often the least desired, it is necessary in some research (Flick, 2018). Convenience sampling focuses on gaining insight into a specific field or issue by recruiting participants from an already specified population (Flick, 2018).

Research Participants

The goal of this study was to recruit 10 to 12 research participants. There were 45 responses of interest to the recruitment advertisement. The first 15 respondents were contacted via email with screening materials and to schedule interviews. The first 12 were chosen for the study with the remaining three selected as replacements in case there were any cancellations. There was one cancellation, and that spot was filled with the first replacement. Of the 12 participants in the study, eight out of 12 (67%) identified as male and four out of 12 (33%) identified as female. Six out of the 12 participants (50%) were African American, 5 out of 12 (42%) were White, and one participant (8%) identified as more than one race. Participant demographics can be viewed in Table 3.1.

All 12 participants met the selection criteria of being United States military veterans with eight (67%) participants being army veterans, two (17%) being air force, one (8%) being a navy veteran and one not identifying a branch. Service era indicates the period in time that military service takes place; however, it does not guarantee that the service member saw combat even if the service era was during a conflict or war. A majority (42%) of this study's participants served during the Gulf War, followed by 25% of participants serving during more than one era (Gulf War and OIF/OEF), 25% of participants served between conflicts, and only one of the participants (8%) served during the Vietnam War.

As per the selection criteria, each participant has been providing peer services for 6 months or more with 75% of participants having provided peer services for 5 or more years, 17% providing peer services for 2 to 4 years, and one participant (8%) provided peer services for more than 6 months but less than 1 year. Participants were all providing peer support services to other veterans but were often also working with trauma and/or mental health and substance use diagnoses.

Participant Recruitment

Due to the small size of the population being recruited, this study first aimed to reach the minimum desired number of participants. Participants were selected in order of response. This study hoped to include and represent the voices of female veterans and people of color with a goal of at least 50% of the sample consisting of women and/or people of color.

Table 3.1

Demographic Information of Participants

Participant	Gender	Race	Branch	Service Era	Time in Peer Support
P1	Male	African American	unknown	Gulf War	2-4 years
P2	Male	African American	Air Force	Between Conflicts	5 or more years
P3	Male	White	Navy	Vietnam	5 or more years
P4	Female	White	Air Force	Gulf War	5 or more years
P5	Male	White and Hispanic	Army	Gulf War and OEF/OIF	5 or more years
P6	Male	African American	Army	Gulf War	5 or more years
P7	Male	White	Army	Gulf War and OEF/OIF	6 mos to 1 year
P8	Female	White	Army	Gulf War	2-4 years
P9	Male	White	Army	Between Conflicts	5 or more years
P10	Female	African American	Army	Between Conflicts	5 or more years
P11	Female	African American	Army	Gulf War and OEF/OIF	5 or more years
P12	Male	African American	Army	Gulf War	5 or more years

Recruitment Process

Convenience sampling was used to recruit veteran peer support providers using the Academy of Peer Sciences monthly e-newsletter. A recruitment advertisement (included in Appendix B) for the study was included in the monthly newsletter. The Academy of Peer Sciences provides the coursework that is used for peer support certification in New York State (New York Peer Specialist Certification Board [NYPSCB], 2019). The advertisement was also shared on the researcher's Facebook page. Interested participants voluntarily contacted the researcher via email or phone to be screened for selection criteria. Once participants met selection criteria, the researcher obtained informed consent, and participants then scheduled a virtual interview with the researcher. At the beginning of the Zoom interview, participants answered a demographic survey and then the interview was conducted. After completing the interview, participants were entered into a drawing to receive a $50.00 Visa gift card that was funded by the researcher. Numbers one through 12 were assigned to represent each participant for the drawing. A random number generator was used and the first number to come up received the gift card.

Instruments Used in Data Collection

Informed consent was provided (included in Appendix C), and participants could withdraw at any time. Participants were given a list of resources to use if the interviews caused any distress (included in Appendix E). The only formal instrument used was a demographic survey (included in Appendix D) created by the researcher to obtain information on gender, race, branch of military served, era of service, and length of time providing peer services.

Semi structured interviews took place virtually on Zoom. Open-ended questions were used to elicit a more conversational tone while encouraging participants to speak freely. The following questions were asked during each interview:

- Tell me about your journey through recovery.
- Did you work with a peer provider during your recovery?
- What made you want to become a peer support specialist?
- How has being a peer support specialist impacted your life?
- How has being a peer support specialist impacted your recovery?
- What are the challenges of being a peer support specialist?
- What are the benefits of being a peer support specialist?

- Tell me about a time that being a peer provider was hard for you.
- Tell me about a time that being a peer provider was rewarding for you.

Probe questions (see Appendix A) were used if the participant was struggling to answer the interview questions. Each participant was interviewed one time. Interviews were scheduled for 1.5 hours but were shorter or longer according to how much the participant wanted to share. While it would have been preferred that participants were interviewed in person, current constraints due to the COVID-19 pandemic required the research to be conducted virtually on Zoom. The use of the Zoom platform includes many automatic privacy and security features including encryption to protect data (Zoom Video Communications, 2019). The virtual meetings were recorded, and recordings were stored on a removable drive that was stored in a locked safe to ensure privacy.

Procedures for Data Analysis

Recordings of the semi structured interviews were transcribed by Zoom. The transcriptions were combined with the recordings to be further analyzed for themes and meanings. Researcher reviewed transcripts and recordings to ensure accuracy and consistency. The researcher then examined the transcripts for meaning.

Moustakas (1994) provides a modified version of van Kaam's method of analysis of phenomenological data. Seven steps are followed to analyze each transcript. Step 1 is listing and preliminary grouping of every relevant statement to the experience, Step 2 is reduction and elimination, Step 3 is clustering and thematizing, Step 4 is final identification of themes and validation, Step 5 is constructing an individual textural description of each participant's experience, Step 6 is constructing an individual structural description for each participant's experience, and Step 7 is combining the textural-structural description of each participant's experience to identify the meanings and essences of that experience (Moustakas, 1994).

Horizonalizing the data attributes occurs in Step 1 and assigns equal value to all initial statements that are listed concerning the topic or question (Moustakas, 1994). Next, meaning units will be identified. During this process, overlapping, vague, or repetitive data will be removed (Moustakas, 1994). Two criteria are used to determine whether data should be included as a horizon of experience. The first requirement for inclusion is that the statement or expression contains a moment of experience that is necessary and sufficient for understanding. The second inclusion requirement is that the expression can be abstracted and labeled. The remaining expressions become known as invariant constituents of the experience (Moustakas, 1994). Invariant constituents are then clustered into themes. Textural and structural descriptions of the phenomena being study will be developed from the themes and the essence of the peer support experience will emerge (Moustakas, 1994). This method was applied to the interview transcripts to organize and identify themes and meanings.

Summary

Empirical phenomenological research seeks to obtain a description of participants' experience of a phenomenon (Moustakas, 1994). This original data is collected through open-ended questions and dialogue but often leaves a question about what the experience means for a participant (Moustakas, 1994). The researcher then engages in a process of reflective analysis to derive underlying structures and meaning of an experience (Moustakas, 1994). Semi-structured interviews with open-ended questions allow the opportunity for the participant to freely describe their experience while also providing some direction to the topics discussed. This type of interviewing also allows for ambiguities to be clarified as they arise through natural dialogue (Moustakas, 1994).

Semi-structured interviews seek to understand themes in the everyday lives of participants (Brinkmann & Kvale, 2015). The themes emerge from the interaction between researcher and participant and are from the participant's point of view. The semi-structured interview is neither open conversation or closed questionnaire and is guided by themes and suggested questions. Interviewing does not follow specific rules or predetermined steps, however, there are general guidelines that have been observed in successful research interviews (Brinkmann & Kvale, 2015).

This qualitative empirical phenomenological inquiry has been designed to extract the essence of the veteran peer provider experience. Semi-structured interviews conducted per the tenets of person-centered theory, combined with data analysis following Moustakas' method of analysis allowed for a rich understanding of the provider experience. Identified themes and direct quotes from the participants are reported in the following section.

Chapter 4: Results

Research Question

The purpose of this empirical phenomenological study was to gain an understanding of the experiences of United States military veteran peer support providers. The research questions were: what is the experience of veteran peer support providers, what are the challenges and benefits of providing peer support services, and how does providing these services impact the veteran providers' recovery? Qualitative data was collected through semi-structured interviews of 12 United States military veteran peer support providers. This chapter organizes and presents findings according to the journey of the veteran peer support provider.

There were nine interview questions that were asked. Each interview question had an additional probing question that was asked at researcher's discretion to elicit a more thorough response. Themes were identified using Moustakas' (1994) method for empirical phenomenological analysis. Themes according to research question can be found in Table 4.1. The research findings are organized in chronological order as they pertain to the peer providers journey through recovery and into peer support.

Data Analysis

The interview transcripts were analyzed following Moustakas' (1994) seven steps for the empirical phenomenological method of analysis to extract the essence of the veteran peer support provider experience. During the first step of analysis the researcher listed any relevant statements pertaining to the experience of veteran peer providers in response to each interview question. Secondly, the researcher used reduction and elimination to remove any redundant statements or statements that were not clearly related to the experience. Horizonalization also took place during this second step and the researcher attributed equal meaning to each statement. For instance, when asked if they were proud of their work as peer support providers, one participant simply stated "yes" while another participant, stated "Yes, I love what I do and I love my veterans." Even though one answer was lengthier than the one-word answer, both answers were given the equal meaning that the participant was proud of their peer support role.

The third step in the empirical phenomenological method is clustering and thematizing. For example, in this step, the researcher grouped statements such as "it's their journey, allow them the consequences of their actions", "knowing when to tap out and take a break, feel like you have to help everyone because you were there, letting people do it on their own" and "not taking ownership of someone else's recovery" into possible themes like "boundaries" for the challenges of being a peer support provider. The next step is identification of themes and validating where the researcher identified major themes. Identified themes are reported in Table 4.1.

The final three steps in the empirical phenomenological method involve constructing textural descriptions, constructing structural descriptions, and then combining the two to extract the essence of the phenomena, in this case, the experience of veteran peer support providers. Textural descriptions are the exact words of participants that the researcher uses to convey a description of the experience. An example of a textural description is when a participant stated that "not having defined roles” was a challenge for peer support providers. This statement can be taken very literally. This same theme was identified in Step 6 but in an inferential manner. Step 6 involves constructing structural descriptions where the researcher considers multiple meanings within a statement. One participant stated that “not being a friend” was a challenge to providing peer support services. There are multiple meanings in this statement such as knowing one’s role and having professional boundaries.

The last step in the empirical phenomenological method of analysis is to merge both textural and structural descriptions to identify the meaning and essence of the experience being researched. Finally, the researcher took measures to obtain inter-rater reliability by having two doctoral students complete Steps 1 through 4 and then comparing each of their results with researcher’s themes. The goal was 80% or higher agreement between researcher and the other students’ identified themes. One transcript demonstrated inter-rater reliability at 84%, while the other transcript compared at 86%.

Table 4.1

Themes by Interview Question

Interview Question	Themes (*subthemes*)
Tell me about your journey through recovery	Diagnosis (*mental illness, substance use, childhood trauma, combat trauma, MST, TBI, comorbid disorders*), Contributing factors (*multiple previous attempts, loss of family ties, court ordered, suicide attempt, hospitalization),* Obstacles (*misdiagnosis, not taking treatment seriously, stigma*)
Did you work with a peer provider during your recovery?	Formally, Informally
What made you want to become a peer support specialist?	Encouragement of others, Already working with peers, Giving back, Better career
How has being a peer support specialist impacted your life?	Rewarding, Positive feelings, Increased quality of life
How has being a peer support specialist impacted your recovery?	Reinforced recovery, Reminder of where they came from
What are the challenges of being a peer support specialist?	Client (*stigma, availability*), Peer provider (*stigma, boundaries, pay, self-care, covid bad supervision, seeing another struggle, secondary trauma, respect for profession*)
What are the benefits of being a peer support specialist?	Purpose, Giving back, Supervision, New perspective, Tools, Camaraderie, Living beyond a diagnosis, Reaching resistant clients, Hope
Tell me about a time that being a peer provider was hard for you.	Clients that do not want help, Client death by suicide, Knowledge harmful treatment, Limited by the system
Tell me about a time that being a peer provider was rewarding for you.	Success stories, Thanks, Connection, Saving lives, Proud (*absolutely, it's complicated*)

Research Findings

Path of the Veteran Peer Provider, Past and Present

Overall, the participants of this study reported that the experience of being a veteran peer provider is positive and rewarding. The participants reported that being a peer provider reinforces their own recoveries and creates hope for themselves and the people they serve. The providers did report challenges, but the challenges did not stop the majority of participants from feeling proud of their work. The essence of the veteran peer provider experience has been captured in two sections: their past lived experience leading to peer support and their current feelings and experiences in their peer provider roles.

Diagnosis. Following the tenet of peer support, participants were asked to share their lived experiences, most specifically, their journeys through recovery. The journeys through recovery covered themes such as diagnoses, obstacles to recovery, and contributing factors to seeking recovery. Seven out of 12 participants (58%) were in recovery for substance use, six out of the 12 participants (50%) reported being in recovery with a mental illness. It is important to note that eight out of the 12 participants (66.7%) reported comorbid disorders, meaning that they reported more than one area of recovery. Six participants (50%) reported combat trauma, two participants (16.7%) reported a history of childhood trauma, two participants (16.7%) reported military sexual trauma, and one participant reported traumatic brain injury. A total of eight out of 12 participants (66.7%) indicated that they had diagnoses prior to serving in the military. Four participants (33%) indicated that the military was solely responsible for their diagnoses, and these were two of the cases of combat trauma and the two cases of military sexual trauma, as these traumas can only occur in a military setting. Eight out of

12 participants (66.7%) stated that their preexisting symptoms were worsened by military service. Table 4.2 presents the diagnoses by participant.

Obstacles to Seeking Treatment. There were three major obstacles to seeking treatment for the veteran peer providers: stigma, misdiagnosis, and not taking treatment seriously. Five out of 12 participants (41.7%) reported stigma as a factor in them not seeking care. One veteran participant shared his experience as a non-commissioned officer in the military, “It was a taboo to be an NCO in the military and have something going wrong.” Another participant described feeling alone with their trauma.

> Many of us, even if it's combat, or any type of trauma really one of the biggest things, especially in the military, I think we're always alone, which I don't know why that's the stigma, because there's millions of us that have served.

One participant shared the stigma of reporting a military sexual assault while enlisted.

> I was infantry so we were surrounded by males, and you know back then it was don’t ask, don’t tell type of situation. So, when I was assaulted, I told no one because I was infantry and that doesn’t happen.

Another participant was even told that they would never hold down a job because of their mental illness, “I was told ‘you can’t do it because you have bipolar and schizoaffective.’”

Half of the participants (50%) reported that they were not successful in treatment until they finally took treatment seriously. One participant shared, “I made a decision that you know this will be the last time, and I think what was different this time, is that I followed all the suggestions that I was given.” Three participants (25%) cited misdiagnosis as a barrier to accepting treatment. A participant shared how they knew something else was wrong but did not challenge their treatment providers.

> I wasn't really being treated for this head injury but I started getting treated for other things. I also developed hyperthyroidism. So, I had a lot of trouble with this third pregnancy, and everything was kind of chalked up to the pregnancy and somewhere inside me I knew it was more than that, but I went along with it.

Seeking Recovery. Several subthemes emerged about what brought the veterans to seek recovery; this overarching theme was labeled contributing factors. Ten out of 12 participants (83.3%) reported multiple attempts at recovery before succeeding. Deployment was a turning point for one participant, causing them to address their mental health and substance use.

> Long story short, I was deployed into a combat zone. I'm a desert storm veteran. I think that was the turning point in my, my substance use and mental health, and what happened. I was exposed to horrific things that I saw when I was over there for 6 months. I saw a lot of stuff, and when I left, I felt different.

One participant shared that they had been in treatment nine times while another stated that they had been hospitalized over 70 times. Another said, “I'm recovering from treatment more than any illness” when talking about how traumatized they felt from the multiple attempts at recovery.

Four participants (33%) reported lost family ties due to their symptoms, ultimately leading them to seek recovery. Three participants (25%) were court ordered to seek treatment, three participants (25%) reported suicide attempts and two participants (16.7%) were hospitalized, ultimately leading to their treatment. A participant shared how they felt when they were finally diagnosed after being incarcerated and using drugs to cope.

> I finally got a diagnosis, they diagnosed me with PTSD, schizophrenia, bipolar disorder and depression. So, and I think at the moment, when that happened, I cried because I think I was relieved, in a way, relieved. It was like an explanation for what I was doing, it was kind of it helps explain my behaviors, help explain how I was feeling. So, from 2010 to 2012, it took years for me to get the right medicine.

Becoming a Peer Support Provider. Once in recovery, common themes emerged pertaining to why the veteran participants became peer providers. Some participants gave more than one reason for becoming a peer support provider. Eight participants (66.7%) reported that they had already been working with veterans in some capacity. Seven participants (58%) reported that they became peer support specialists at the encouragement of others. One participant explained how their wife encouraged them to become a peer specialist.

> I didn't wake up one morning and say I want to be one, but stuff just started happening at the places I was going, and it would always come up, peer support. My wife said you need to be a peer support specialist. She said I'm listening to what he's saying and she said you will be good, be a peer support specialist. And my wife, you know, but now that I'm in it, yes, this is absolutely, this is my niche.

Six participants (50%) reported that they were looking for an opportunity to give back. One participant talked about using their suffering to help others.

> I didn’t want to waste my own suffering. I had done so much work and have learned so many things through my own journey, I just figured that if my wisdom, if it’s okay to call it that, from my lived experience, could be helpful in supporting another individual, that it would be a win-win.

Finally, two participants (16.7%) took an interest in peer support because they were looking for an improved career path.

Participants also shared whether peer support had been part of their own recovery. Exactly half of the participants (50%) reported having worked with a peer specialist during their own recovery. One participant shared their experience “about 12 years into this I met a peer specialist for the first time and for the first time, I had hope that I could actually have a life, that I wasn’t just a disabled patient.” The other half of participants (50%) reported that they had not worked with a peer provider, although some of them expressed wishing they had.

> I really wish that peer support had been around when I first came around, and even in 2009, it wasn't formal in the sense that it is now. You know there were folks that I saw that were working on recovery, but no one was identified as like a peer support specialist to where their job was to help you to focus on your recovery.

Table 4.2

Diagnoses in Veteran Peer Support Providers

Participant	Childhood Trauma	TBI	Mental Illness	Combat Trauma	MST	Substance Use	Comorbid Disorder
P1				X		X	*
P2						X	
P3			X	X		X	*
P4	X	X					*
P5			X	X			*
P6			X			X	*
P7				X			
P8					X		
P9			X	X	X	X	*
P10	X		X			X	*
P11						X	
P12			X	X			*

Present: The Impact of Providing Peer Services. Participants shared how becoming a peer provider has impacted both their lives and their own recoveries. The responses were overwhelmingly positive. Three themes emerged when asked about the impact of being a peer provider on the participants' lives, all of which were beneficial. The three themes were finding the role rewarding, increased quality of life, and reinforcing their own recovery. All 12 participants (100%) used one or more of these themes to reflect how being a peer provider has improved their lives. Eight participants (66.7%) reported finding their role rewarding. One participant shared what the job means to them.

> What I'm doing is not necessarily a job. What I'm doing now is, is like a service, but it's funny that they would pay me for this because what I'm doing with the veterans, I'd do it for free.

Six participants (50%) reported positive feelings about the impact of being a peer provider on their life. One person stated that it has given them "a positive feeling similar to what I thought I found in drugs." Another participant reported, "It has been for me, probably one of the best things that could happen, because, you know, I found my niche and helping others has actually helped myself." Half of the participants (50%) reported an increased quality of life. One participant shared just how much becoming a peer provider has impacted their life.

> My, my role now in my family. My role in my community, my role in society. Everything has changed. I'm, I'm productive, I'm whole, I'm okay with myself. I have no desire to put any drugs or alcohol into my system to help me cope with life and so, it's almost like a fairy tale, and I have to pinch myself because the way that everything has turned out. I'd never thought in my wildest dreams that it would be like this.

Ten out of 12 participants (83.3%) disclosed that being a peer support provider reinforced their own recovery. Five out of 12 participants (41.7%) stated that their role as a peer provider was a reminder of where they had come from. One veteran participant explained how helping other veterans also helps them. "It is beautiful because I share with veterans my recovery story, my story, and it helps me to share my story. Now it may give them hope, but it helps me because I need to know my story."

Benefits. Participants were asked to share the benefits of being peer support providers. Eight themes emerged as benefits to providing peer services. Most prominently, giving back and providing hope were mentioned by seven of the 12 participants (58%). One participant explained the difference between providing help and providing hope.

> I know that I'm there to help those veterans, and I tell everybody, we don't help people. Help is this old lady that's 90 years old, got five bags of groceries, she trying to cross the street, she needs help, but these veterans that I deal with and the people that I work with? They don't need help, they need hope. So, around the hospital, the veterans call me a hope dealer.

Next, six out of 12 participants (50%) reported finding a sense of purpose as a benefit to their peer support role. One veteran participant expressed how sharing their story and pain has become an almost religious experience for them.

> Ours is the only profession I know of that takes the pain and the suffering and the struggle that you have lived and you have learned from, and it turns it into a gift that one can share for the other. Yeah, so that to me is exquisitely poetic, and, and almost religious in, in a way, you know, my suffering is for, for you to choose to gain from.

Four out of 12 participants (33%) mentioned supervision as a benefit. A participant shared how their supervisor makes them feel valuable.

> My supervisor, which she's a, she's a licensed clinical social worker, she said look, okay, you are equivalent to anybody on the staff. You are equivalent, you're not, over, under, you are on an equal basis of authority and importance. So, I have

> a beautiful supervisor who has recognized what I actually bring to the table with my skill set.

Additionally, four of the participants (33%) pointed to finding new tools for recovery as a benefit to the peer provider role. Three out of 12 participants (25%) reported a new perspective as a benefit. One participant shared how they turned pain into motivation, “The stuff that I thought was pain, it was really powerful, but at the time I thought it was pain. Now the stuff is fuel, you know fuel to my spirit.” Three participants (25%) stated that the camaraderie found in peer support was a benefit for them with one veteran saying “I love being around other veterans. It made sense because I am a veteran and I am in recovery.” Two participants (16.7%) found it beneficial to see others improve and two participants(16.7%) found that they could break free of their labels and live beyond a diagnosis, thanks to their peer role. One participant explained what it is like to live beyond their diagnosis.

> Not that I'm cured, but I'm living a productive life, in spite of a diagnosis. I'm still living beyond a diagnosis and so I'm like, I'm the role model for recovery. I'm the role model. I'm the hope that you know, if I can do it, you can do it.

Seven out of 12 participants (58%) talked about being able to reach clients that did not respond to traditional mental health treatment. One participant explained how this is possible and how they aim for collaborative care between all providers.

> I never downplay or discredit any clinician, because I tell all the veterans, this is like a pot of gumbo, and see everything creates this pot of gumbo. It all has a purpose, to make the gumbo taste like it tastes, but everybody got a purpose. Now

> my relationship with the veteran is different than the clinician because the clinician has read about it, has done studies like you're doing, but they've never been in that hole. They don't know how it is to be in the hole and quit. What I'm able to share, and the clinician has something to offer, and I tell veterans all the time, listen, listen to your therapist, listen to the licensed counselor, listen to your psychologist, listen. Listen, they have good information, and it works. They use evidence-based practices, this stuff works, but when it's time to talk about what it’s really like, where, if you haven't been there, you can't adequately explain it or adequately tell somebody how it is. You might even read something, but you don't know, so sometimes the veterans tell me instead.

In order to expand on the benefits of providing peer support, participants were asked to share a time that being a peer provider was rewarding for them. The stories themselves or quotes from participants could not be shared due to the necessity of protecting client privacy. However, four themes emerged from these stories, and they were: hearing a client success story, connection, saving lives, and receiving thanks. Ten out of 12 participants (83%) shared a client success story as their most rewarding experience. One participant shared an experience where they saw someone from their program in public and the person had been clean for a year.

> That moment right there, the way my heart felt, the way my day went after that. That’s something that you know, I don’t care how much you pay me or what you give me, you can’t make me feel that way, knowing that I’m involved in helping people find their way to recovery.

Another participant described how they felt when they hear about a client doing well. "Yeah, it makes me emotional. It makes the hair stand on my hands, and that's it. You can't buy that." Three participants (25%) found the connection to their clients to be a rewarding experience. Two participants (16.7%) told stories where peer services saved the client's life and two participants (16.7%) told stories where they received thanks directly from their client. One participant said, "when people say 'thank you for saving my life,' it's both the most gratifying and the most challenging thing to hear." Lastly, nine of the 12 participants (75%) reported feeling proud of their role as veteran peer support providers. The remaining three participants (25%) feel proud of their role although it was a journey to get to that point. One participant stated that they feel proud for the most part but they "can't vibe with everybody."

Challenges. Participants also identified challenges that they face as peer providers. Most of the challenges identified were concerning the providers, however participants stated there were challenges for the peer support recipients as well. Three out of 12 participants (25%) feel that peer services should be more widely available for anyone who needs them. Ten out of the 12 participants (83%) report mental health stigma as a challenge for both their clients and themselves. One participant discussed stigma as a cultural barrier to care.

> I'm gonna tell you this about Black people and in the Black culture, mental illness is looked at and shunned away. No, no, no, you better not say you got a mental illness. You better not say you could go, you know, in culture, because we, you know, culturally, we just never went to see a psychiatrist or psychologist, you

know they sent you to Big Mama, you know, they sent you to the granddaddy but you never, we never would see a doctor.

Another participant referred to themselves as "just another veteran in recovery" when addressing how they felt they were viewed by traditional mental health professionals. A different participant identified "systems of care in general, how they stigmatize the profession." Yet another participant said "I was still looked at as a person with a mental illness" when explaining their frustration about how they were viewed even after working successfully in their professional peer role.

Eleven out of 12 participants (91.7%) reported feeling that peer specialists are not valued by traditional mental health providers and four of those participants (33%) believe that peer specialists may even be perceived as a threat to traditional mental health care. One participant stated, "being able to have my voice heard professionally, I mean, not only is it hard to hear the things that I hear and then to have my profession disrespected." Seven out of 12 participants (58%) felt that maintaining boundaries was a challenge to being a peer support provider. Additionally, all participants (100%) reported that secondary trauma was a challenge for them, with six of the participants specifically stating that it was a challenge to see other people struggle and three stating that there were triggers for their own symptoms. A veteran participant explained by saying "watching people's lives unravel is really hard." Another participant talked about the impact of secondary trauma and how they cope with it.

That takes, that takes a toll. There's that primary, secondary, and tertiary

> vicarious trauma, and sometimes I'm at home and sometimes I try to, you know, wash it off. Sometimes it works and sometimes it doesn't. Depending on the level of trauma that I'm listening to.

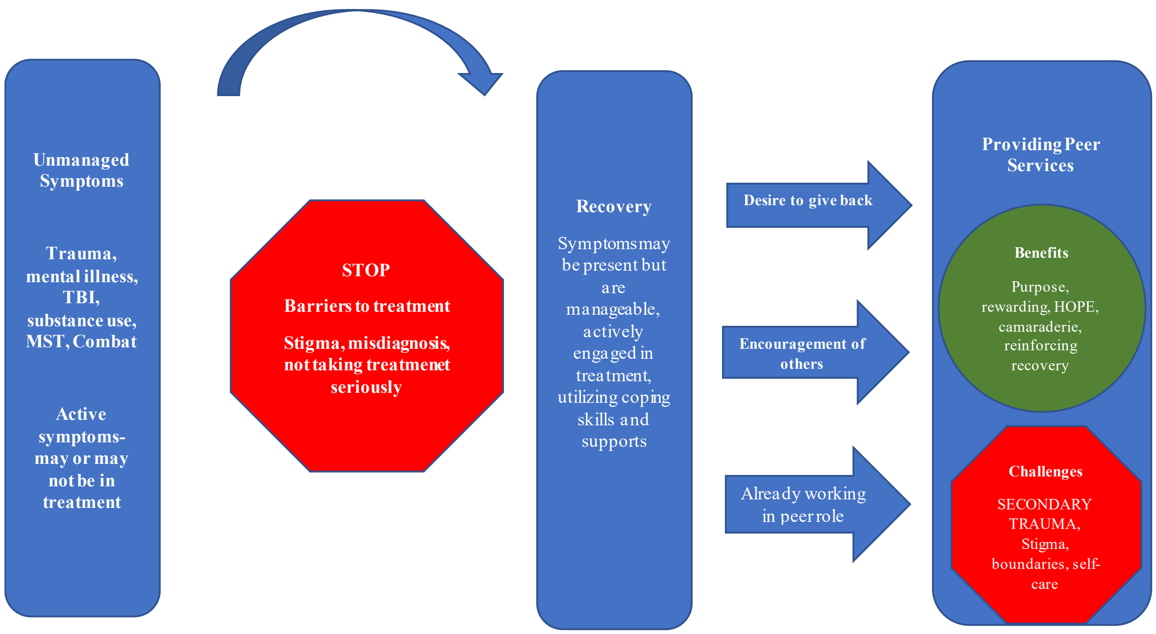
Another veteran put it this way "we meet in this case, veterans where they're at, and so sometimes being in those spaces can be very difficult." Half of the participants reported their own diagnosis and symptoms as a challenge to providing peer support. Four participants reported struggling with self-care.

Fifty percent of participants mentioned pay as a challenge while 25% of participants reported bad supervision to be a challenge and another 25% stated that having unclear roles was a challenge for them. Lastly, two participants (16.7%) talked about the challenge that the COVID-19 pandemic has posed to providing peer services. One participant (.08%) talked about not having met any clients face-to-face since beginning their role as a peer support specialist. This participant stated how difficult video chat can be for engaging and connecting.

To gain a deeper understanding of the challenges faced by veteran peer providers, each participant was asked to share a time their role as a peer provider was hard for them. Each participant shared a story of personal significance, and four themes were identified: clients that did not want help, losing a client to suicide, feeling limited by the system, and observing harmful treatment of the client. Specific quotes and stories could not be shared here due to the need to protect the privacy of peer support recipients. However, four of the participants (33%) talked about clients who did not want help. Three participants (25%) talked about losing a client to suicide. Three participants (25%) told stories where they felt very limited by the system. Two participants (16.7%) talked about having to observe harmful treatment of the client by traditional mental health staff. One participant talked specifically about witnessing a client receive electroshock therapy when the peer provider had had the same treatment and found it not only unhelpful, but harmful.

Figure 4.1

Through Recovery and Beyond: The Journey of a Veteran Peer Support Provider



Note. The path of the veteran peer provider with blue columns representing key milestones. Stop signs indicate challenges and barriers where arrows indicate supporting/contributing factors to moving forward.

Chapter Summary

Capturing the essence of the veteran peer support experience required an examination of the providers' journey from recovery through becoming a peer provider. Figure 1 provides a visual summary of the journey of a veteran peer support provider.

Veterans first told their recovery stories, and their unmanaged symptoms and diagnoses can be seen in the first blue column in Figure 1. The veterans may or may not have been receiving treatment at this point in their journey. The red stop sign represents the barriers to treatment that the participants reported. Stigma, misdiagnosis, and not taking treatment seriously prevented the veteran providers from reaching successful recovery. The blue arrow indicates the ways veterans were able to overcome the barriers to care. Some veterans were motivated by a break down in family ties, legal issues such as incarceration or being court ordered, hospitalization and suicide attempts led to receiving treatment in some participants. Most participants reported that finally taking treatment seriously and following treatment plans is what brought them to successful recovery.

Next, participants shared what brought them from recovery to becoming a peer provider. The three blue arrows demonstrate the influencing factors that brought the participants to providing peer services. Several participants reported a desire to give back, some were encouraged by others, and some participants were already working with fellow veterans in some capacity when they heard about peer support. Once in their peer support roles, the participants shared the challenges and benefits that they have encountered as evidenced by the green circle and red stop sign in the blue peer provider column in Figure 4.1.

Participants reported feeling proud and fulfilled as peer providers, finding hope, reinforced recovery, a sense of purpose and camaraderie in their roles. However, several challenges were also reported. All participants reported secondary trauma as a challenge to providing peer support. Other challenges reported were stigma, boundaries, self-care, and hard to reach clients. These findings indicate that the peer support provider experience is complicated with sometimes conflicting feelings. Providers share a deep connection to their clients and their work but are exposed to secondary trauma and often feel limited by mental health stigma and the system in which they work. These findings present an opportunity to consider the future for the peer support field and the providers working in the field. Chapter 5 will consider these implications for the future of peer support.

Chapter 5: Discussion

Introduction

The purpose of this empirical phenomenological study was to understand the veteran peer provider journey through recovery and beyond. This study sought to answer three research questions: what is the experience of veteran peer support providers, what are the challenges and benefits of providing peer support services, and how does providing these services impact the veteran providers' recovery? Due to the complicated intersections of veteran culture, increased risk factors for veterans, possibility for secondary trauma as a clinician, and the relative newness of peer support services in the veteran population, it is important to gain an understanding of the challenges and benefits to providing peer support. This study was conducted through the lens of the person-centered approach, which creates a safe and comfortable environment for individuals to share their thoughts and feelings. Virtual interviews with 12 veteran peer support providers from across the United States were conducted, analyzed, and findings reported.

Implications of Findings

Consistent with the findings of several peer support studies conducted in non-veteran populations, this study found the peer provider experience to be overwhelmingly positive, despite multiple identified challenges (Ahmed et al., 2015; Burke et al., 2018; Salzer et al., 2013). Challenges such as secondary trauma, mental health stigma, stigma surrounding the profession, boundaries and selfcare, availability of peer services, and clients who do not want help seemed to be mediated by the perceived benefits and positive impacts of peer support such as creating a sense of purpose, offering hope, reinforcing recovery, being able to reach people that traditional by veteran peer providers offer areas for growth, while the buffering strength of the perceived positive impact of peer services on both the providers and recipients demonstrates the necessity of peer support as a complementary service in the mental health field. Furthermore, veteran specific peer support offers a valuable way to reinvest in our military veterans after service while providing renewed sense of purpose and camaraderie that may be lost in the transition to civilian life.

Challenges

Secondary Trauma. One hundred percent of the veteran peer providers in this study reported secondary trauma as a challenge in providing peer support. Secondary trauma is a reaction that occurs in the provider in response to hearing stories of trauma and bearing witness to the suffering of clients (Pearlman & McIan, 1995). The secondary trauma findings of this study are consistent with previous findings in both veteran and non-veteran studies of clinicians exposed to struggling clients and stories of trauma (Bride, 2007; Cieslak et al., 2013; DeVilly et al., 2009). Trauma history of clinician has also been previously shown to increase the chances of secondary trauma symptoms in the clinician (Jenkins et al., 2011; LaMott & Martin, 2019; Martin-Cuellar et al., 2018).

Considering that veterans have an almost threefold occurrence of adverse childhood experiences (ACEs) over the general population, combined with any trauma exposure during service, it makes sense that secondary trauma would be the most prominent challenge for veteran peer support providers (Carbrera et al., 2007; Lee et al., 2016, McLafferty et al., 2019). Surprisingly, this study also found that a quarter of participants reported debilitating secondary trauma in their previous work from which they found relief in their current roles, providing peer support services.

Stigma. Stigma was also seen as a major challenge for the peer providers. Previous studies have shown that stigma can be especially strong in the veteran population, creating internalized negative self-image and an overwhelming barrier to seeking treatment (Harding, 2017; McLafferty et al., 2019). Almost half of the participants in this study pointed to stigma as a challenge in their own recovery and this number doubled when considering participants who reported stigma as a challenge to their current peer provider role. The veteran participants in this study reported feeling that both their mental health and their profession was stigmatized by traditional providers. However, social connection has been shown to have a buffering effect against this internalized stigma (Harding, 2017). Considering that the overall experience of veteran peer providers in this study is positive, it is possible that peer services provide enough social connection and support to overcome the challenge veterans face concerning stigma.

Boundaries and Selfcare. Boundaries and self-care were identified as challenges by veteran peer provider participants in this study. This is consistent with findings in studies of non-veteran peer support providers (McCarthy et al., 2019; Mowbray et al., 1998). Self-care is a very broad and subjective term, however, it has also been identified as an area of need for all providers working in the helping field (Martin-Cuellar et al., 2018). Mindfulness, one type of self-care, has been found to mediate the negative impacts of clinical work (Martin-Cuellar et al., 2018). Previous research indicates that unclear roles within peer support are also a challenge (Gidugu et al., 2015). Unclear roles were mentioned by a small number of participants as a challenge in this study. It is possible that clearly defined job descriptions and roles within peer support would assist with boundary issues.

Availability of Services. Several participants in this study expressed desires to see peer services more widely available across multiple disciplines. They reported the limited availability of peer services as a challenge to reaching everyone that might benefit from peer services. The expression of need for more peer services speaks to the providers' belief in the effectiveness of the services they provide. Peer support has only become part of mainstream mental health care in the last couple of decades (SAMHSA, 2019). In this time, peer support has continued to grow in popularity and recognition as a complementary service to traditional mental health care (Ahmed et al., 2015). As more and more positive outcomes are associated with peer support services, the hope is that stigma surrounding the field will decrease while support in funding, recognition and availability will increase.

Challenging Clients. Several participants talked about recipients who do not want help as one of the challenges of providing peer support. This theme also included recipients who relapsed. Mowbray et al. (1998) reported this challenge as uncooperative clients. In this current study, some of the veteran participants shared that trying to help uncooperative recipients of services caused frustration, anger, sadness, and even triggered some of the veteran peer providers' own symptoms. Interestingly enough, challenging clients were also identified as a benefit in this study. Participants found it most rewarding when they were able to reach these challenging clients.

Benefits

Sense of Purpose. Veteran peer providers in this study shared that their role in peer services have given them a renewed sense of purpose. While this renewed sense of purpose can be important in helping anyone live beyond a diagnosis, it seems to be especially important for veterans. Veteran culture dictates that service members are always committed to a mission (Harding, 2017). This sense of mission and purpose can be lost when veterans try to reacquaint themselves with civilian life. This disconnect from focusing on a mission may contribute to the risk factors and struggles faced by the veteran population. Providing peer services may mediate some of these risk factors.

Hope. Veteran peer providers in this study overwhelmingly reported hope to be a significant benefit of peer services. Most often, the veterans were talking about being able to provide hope to their recipients. However, several participants talked about the reciprocal nature of this hope. The knowledge that they were providing hope for others while living fulfilling lives as functioning members of society, despite their diagnoses, also provided hope to the peer providers themselves.

Reinforcing Recovery. Several participants in this study reported having their own recovery reinforced as a major beneficial impact of their roles as peer support providers. Several avenues were highlighted as the means for reinforcing their own recovery. Many veteran participants discussed having to do as they say, so that they are not being hypocritical when advising their recipients. Some participants also shared that through their training and work with peers and supervisors, they learned new tools and coping skills for their own recovery. Lastly, several participants shared how their clients' stories and struggles remind the providers of where they have been and where they could easily return to.

Reaching Clients Failed by Traditional Mental Health. Several participants in this study reported being able to reach a challenging client as their most rewarding experience as a veteran peer support provider. Previous studies have shown that peer support can reach treatment resistant clients and increase engagement in treatment (Goetter et al., 2018, Kumar et al., 2019). Several peer providers in this study also stated that while there were no peer services available when they were in recovery, they wish there had been. Overwhelmingly, the participants in this study reported needing multiple attempts at recovery before being successful. Perhaps if they had had peer services, their recovery journeys would have been easier. It appears that some element/s of peer support engages clients that are previously resistant to care. These factors could include the hope instilled from seeing an example of someone's success and lived experience, the social support and connection found within peer support, the reinforcement of other recovery tools and skills, or some other unknown factor.

Camaraderie. Much like sense of purpose and mission, camaraderie is a central tenet to military culture. Military veterans have been found to have lower quality social networks than the general population (McLafferty et al., 2019). This lack of social connection post service may be connected to the increased mental health risk factors seen in veterans. It is known that social networks are a protective factor against mental illness (McLafferty et al., 2019). The connection found in peer support has been found to be beneficial for its recipients in both veteran and non-veteran populations (Kumar et al., 2019). The commonly reported benefit of camaraderie reported in this study indicates that the importance of connection translates to the veteran peer provider as well as the recipient.

Limitations

While peer support specialist experience with secondary trauma was a key finding of this study, this was demonstrated by self-report during semi-structured interviews. No assessments or diagnostic criteria was used in this study and no official diagnoses of secondary trauma can be made. Adverse childhood experiences were voluntarily offered by two participants. ACEs have been strongly correlated to military service (McLafferty et al., 2019). ACEs have also been noted as a risk factor in PTSD and mental health symptoms in adults (McLafferty et al., 2019). Specific inquiry about the presence of ACEs was not conducted in this study, so it was not determined whether ACEs existed for the other 10 participants.

The COVID-19 pandemic may have introduced limitations to this study. Due to social distancing, interviews for this study took place virtually. The use of virtual interviews in research studies is largely unprecedented and therefore, the impact is not currently known. Seifi et al. (2020) found that both female and male medical students prefer in-person interviews to virtual interviews. However, the use of virtual interviews did allow the researcher to interview a wider geographical pool of participants than would have been possible in-person.

Recommendations

Recommendations for the future of peer support fall into two categories: recommendations for peer support research and recommendations for peer support as a practice. As an evolving field, more research is needed on peer support in both veteran and non-veteran populations. The findings of this and previous studies indicate that peer support is useful and necessary.

Future Research

Secondary Trauma. Due to 100% of participants in this study reporting secondary trauma as a challenge, future qualitative and quantitative exploration of this phenomena is warranted. Research that focuses explicitly on previous trauma and secondary trauma may provide further insight into the challenges presented to both veteran and non-veteran peer support providers. A quantitative inquiry into the presence and severity of secondary trauma symptoms could shed light on the impact and significance of secondary trauma for peer providers.

Despite the high occurrence of reported secondary trauma, all participants reported feeling fulfilled with their roles. This indicates that aspects of peer support provide a mediating effect over the perceived secondary trauma. The benefits of peer support seem to far outweigh the challenges, not so much in numbers but in the overall perceptions of the experience. While it is difficult to quantify the positive experiences captured in this qualitative study, further investigation of this mediating effect seems warranted.

ACEs. Further investigation into the correlation between ACEs and military service may shed light on explanations for the correlation. To date, it is hypothesized that people with traumatic childhoods are more likely to seek out and join the military to escape their circumstances (McLafferty et al., 2019). Another possibility is that the recruitment process somehow attracts these individuals by offering structure, camaraderie, purpose, and a future, all things that may be lacking for a person with childhood trauma.

Peer Provider's Recovery. Most peer providers in this study reported that their own recovery has been reinforced by their role as a peer specialist. Several participants indicated that this was due to having to "walk the talk" and engage in the same activities they are recommending to their recipients. A quantitative inquiry about peer providers' engagement in treatment may be able to quantify this effect. Veteran peer support providers are underrepresented in current literature and an examination of attended versus missed treatment appointments, hospitalizations, and instances of relapse could give a clearer understanding of how the provider's recovery is improved or reinforced. Overall, more research is needed in all aspects of veteran specific peer support services as veterans constitute their own cultural group (Harding, 2017; Meyer et al., 2016).

Future of Peer Support

Peer Support is Valuable. Previous research has shown how valuable and beneficial peer services are for both veteran and non-veteran recipients. It is apparent from the feedback found in this study that veteran peer providers believe whole-heartedly in their work and reap more benefits than difficulty. Peer support has been found to be an effective complementary service within mental health (Ahmed et al., 2015; Gidugu et al., 2015; Kowalski, 2020). Several participants in this study shared how they encourage their clients to fully engage in all that their mental health treatment has to offer, even though the peer workers also felt that traditional mental health did not value peer support. If this barrier between peer services and traditional mental health services can be broken down, and peer support services can be viewed as collaborative and complementary to traditional treatment, it is possible that many more people can be reached and overcome their obstacles to care.

Given that boundary issues and unclear roles have been consistently identified as challenges to peer providers in both veteran and non-veteran populations, it seems that universalized trainings and job descriptions may be beneficial to the peer support field (Gidugu et al., 2015; Mowbray et al., 1998). While it is important that peer support does not lose the personalization that seems to make it so effective, some standardization within the field may lend itself to more credibility and accountability. A standardized framework for training peer support providers as well as a framework for providing peer support services would give clear guidelines to organizations and their staff. This may reduce challenges concerning boundaries and unclear roles, as well as decrease the stigmatization faced from other mental health providers. This standardization would create a clear niche for peer services and providers within the traditional mental health system. Standardized trainings should include subjects such as boundaries, self-care, secondary trauma, relapse of both providers and clients, and the likelihood of client death by suicide as well as resources for handling a client death.

Reinvesting in Our Veterans. The original purpose behind peer support in mental health was to empower clients to take control of their diagnoses and recoveries. Peer support is about overcoming stigma and limitations to live beyond a diagnosis. The results of this study demonstrate an overwhelmingly positive impact on the veteran providers, indicating that work in peer services have provided purpose and fulfillment. Peer support is an invaluable way to reinvest in our nation's veterans by providing them with renewed mission, purpose, tools, and skills as they navigate and adjust to their lives in the civilian world. Even with this empowerment, stigma was one of the leading challenges that veteran peer providers face. It is recommended that leaders and supervisors within the peer support field acknowledge this stigma and take steps to eliminate it. Education of other fields and the general public about peer support, as well as collaboration in the form of committees and coalitions with traditional mental health providers may help to reduce this stigma.

Conclusion

Veteran peer support providers must navigate their own diagnoses and symptoms while bearing witness to the suffering of others. Previous research in other populations has demonstrated the effectiveness of peer support for its recipients. With veterans constituting their own distinct cultural group, this empirical phenomenological study was designed to extract the veteran peer provider experience from their recovery through current work as peer providers. Examining the veteran peer provider journey in such a way identified challenges and benefits to working in peer services within the context of each provider's history, diagnoses, and recovery.

Overwhelmingly, the findings of this study indicate that providing peer support services is a positive and reciprocal experience for veterans. This nation's veterans offered life and limb to protect their country and they return home after service to disturbingly high rates of unemployment, homelessness, physical and mental health conditions, and suicide (Harding, 2017; VA 2018). The overpoweringly positive feelings about providing peer services found in this and other studies demonstrates how dedicated veterans are to serving their fellow man. As a nation, we owe it to these men and women to not only provide them the best of care by offering peer services to veterans in need but by also offering a career path such as peer services, where veterans can fulfill their need for serving a mission.

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Appendix A

Methodology and Interview Protocol

Recruitment procedures:

1) Recruitment advertisement will be posted on researcher's personal Facebook account and in the peer support e-newsletter. Recruitment advertisement is attachment #7.

2) Interested research candidates will reach out to researcher via the email address or phone number provided on the advertisement to express interest.

3) Interested research candidates that email will receive an email message containing the letter of introduction (attachment #8). Interested candidates that respond via telephone will have the letter of introduction read to them.

4) Interested participants who respond via email will be asked to provide their top three choices for dates and times for a zoom interview.

5) Researcher will respond via email with one of the three dates and times as a scheduled interview. Phone respondents and researcher will select an interview date and time verbally.

6) Researcher will email participant a link for the scheduled zoom interview.

7) On the day of the interview participant will enter zoom through the emailed link.

8) Researcher will read the following introductory statement:
   "My name is Bobbi Smith and I am a doctoral candidate at St John Fisher College. I am going to ask you some questions about your experience as a veteran Peer Support Specialist. I am hoping to use this information to gain an in-depth understanding of the experiences of veteran peer support providers. The interview will take about an hour and a half but more time is available if needed. To begin, we will go over the consent form and I will provide you with a list of mental health resources to use if this interview causes you any emotional discomfort. You can choose to stop at any time by telling me you would like to stop or by clicking the "leave" button on your screen. Next, I will ask you 5 demographic questions about you and your service. Then I will notify you that we are ready to begin recording and will begin with the interview questions. Would you like to proceed with participating in this interview?"

9) Researcher will go over informed consent and participant will sign the form electronically

10) Researcher will explain and provide the list of mental health resources (attachment #10).

11) Researcher will ask the following demographic questions:

1) Do you identify as: male, female, transgender, non-binary, other

2) Do you identify as: Native American or Alaskan Native, Asian, Black or African American, Latinx, Native Hawaiian or other Pacific Islander, White, two or more races, other

3) What branch of the military did you serve? Air Force, Army, Marines, National Guard, Navy, Reserves

4) During which era was your military service? OEF/OIF, Gulf War, Vietnam, Korea, WWII, served between conflicts

5) How long have you provided peer services? 6 months to a year, 2-4 years, 5 or more years

12) Researcher will inform participant that recording will be started and remind participant that the interview can be stopped at any time by participant verbally expressing a desire to stop or by pressing the "leave" button on Zoom.

13) Researcher will ask the following research questions and use probes only if needed:

1) Tell me about your journey through recovery.
   Probe: What helped you decide to recover?
2) Did you work with a peer provider during your recovery?
   Probe: Who were the important people in your recovery?
3) What made you want to become a peer support specialist?
   Probe: How did you hear about peer support?
4) How has being a peer support specialist impacted your life?
   Probe: Do you enjoy working as a peer specialist?
5) How has being a peer support specialist impacted your recovery?
   Probe: How do you separate your peer role from your personal life?
6) What are the challenges of being a peer support specialist?
   Probe: Is there anything you would change about peer support?
7) What are the benefits of being a peer support specialist?
   Probe: Are you proud of your peer role?
8) Tell me about a time that being a peer provider was hard for you.
   Probe: Have you ever had a client that was challenging for you?
9) Tell me about a time that being a peer provider was rewarding for you.
   Probe: Do you ever feel proud of your work as a peer specialist?

Participant will be allowed as much time as needed to answer each question. Probes will only be used if the participant is having a hard time answering the main question.

14) Once interview is complete, researcher will thank participant and explain that they will be entered into a drawing for a $50 Visa card and that the participant receiving the card will be notified via email no later than June 30th, 2021.
15) Participant will exit the zoom meeting and researcher will retrieve the recording of the zoom interview and Zoom's transcription of the audio.

Data Analysis

The transcripts will be analyzed by the reseacher using Moustakas' Empirical Phenomenology method that includes 7 steps for analyzing each transcript. This process will be repeated on several transcripts by another doctoral candidate from researcher's cohort for purposes of inter-rater reliability. An agreement rate of 80% or higher will be considered successful. Moustakas' steps are as follows:

1) Listing and grouping of relevant statements to the experience.

2) Reduction and elimination consist of removing redundant statements and statements that are not clearly related to the experience. This step includes horizonalization which is attributing equal meaning to each statement.

3) Clustering and thematizing consist of grouping statements into possible themes.

4) Identification of themes and validating is when the researcher identifies the major themes.

5) Constructing textual description is when the researcher uses the participants exact words to convey the description of the experiences. This is a very literal description.

6) Constructing structural description is when the researcher considers multiple meanings and perspectives within the descriptions of the experiences.

7) Combining steps 5 and 6 to identify meanings and essence of experiences. Researcher considers literal and implied meanings to best capture the essence of the experiences.

Appendix B

Informed Consent

St. John Fisher College Institutional Review Board

Statement of Informed Consent for Adult Participants

An Empirical Phenomenological Exploration of the Veteran Peer Support Provider Experience

SUMMARY OF KEY INFORMATION:

- You are being asked to be in a research study of the experiences of veteran peer support providers. As with all research studies, participation is voluntary.
- The purpose of this study is gain an understanding of the veteran peer support provider experience and the impact it has on the peer provider's own recovery.
- Approximately 12 people will take part in this study. The results will be used for the completion of a doctoral dissertation.
- If you agree to take part in this study, you will be involved in this study for one 1 ½ hour session.
- If you decide to participate you will complete a brief and anonymous demographic survey and then schedule a 1 ½ hour interview session that will be conducted virtually via Zoom. The session will be scheduled for 1 ½ hours but may take more or less time based on how much you would like to share. This will be a one-time interview.
- Potential risks of participating in this study include possible emotional discomfort due to talking about your recovery and experience. Anticipated minimal risks and/or inconveniences include the length of time of the interviews and being engaged in a virtual environment.
- You may not directly benefit from this research; however, we hope that your participation in the study may lead to a deeper understanding of the veteran peer support provider experience to inform best practices in supporting and treating veteran peer providers.

Click or tap here to enter text.

DETAILED STUDY INFORMATION (some information may be repeated from the summary above):

You are being asked to be in a research study of veteran peer support provider experience. This study is being conducted at virtually on Zoom . This study is being conducted by: Bobbi Smith (student) and Dr. Joshua Fegley (faculty research mentor) in the Executive Leadership at St. John Fisher College.

You were selected as a possible participant because you responded to the study participant recruitment advertisement and you met the criteria of being a united states military veteran and certified peer support specialist that has provided peer support services for at least 6 months.

Please read this consent form and ask any questions you have before agreeing to be in the study.

PROCEDURES:

If you agree to be in this study, you will be asked to do the following:

1) complete a 5 question demographic survey.
2) Participate in one recorded virtual interview via Zoom where you will be asked open ended questions about your experience with recovery and providing peer support services. The interview will be scheduled for 1 ½ hours but more time will be given if needed.
3) After the interview your name will be entered into a drawing for a $50.00 visa gift card.

Recording/transcription is required for participation in this study.

COMPENSATION/INCENTIVES:

You will be entered into a drawing to receive a $50.00 VISA giftcard.

CONFIDENTIALITY:

The records of this study will be kept private and your confidentiality will be protected. In any sort of report the researcher(s) might publish, no identifying information will be included. The only exception to maintaining confidentiality would be if you indicate that there is immediate and serious danger to the health or physical safety of yourself or others. In that case, a professional may have to be contacted. We would always talk to you about this first.]

Identifiable research records will be stored securely and only the researcher(s) will have access to the records. All data will be kept on a removable thumb drive in a locked safe by the investigator(s). All study records with identifiable information, including approved IRB documents, tapes, transcripts, and consent forms, will be destroyed by shredding and/or deleting after 3 years.

Recordings will only be handled by researcher and transcribing service. No identifying information will be connected to the interview transcripts.

The data collected in this study as well as the results of the research can be used for scientific purposes and may be published (in ways that will not reveal who I am). An anonymized version of the data from this study may be made publicly accessible, for example via the Open Science Framework (osf.io), without obtaining additional written consent. The anonymized data can be used for re-analysis but also for additional analyses, by the same or other researchers. The purpose and scope of this secondary use is not foreseeable. Any personal information that could directly identify an individual will be removed before data and results are made public. Personal information will be protected closely so no one will be able to connect individual responses and any other information that identifies an individual. All personally identifying information collected about an individual will be stored separately from all other data.

VOLUNTARY NATURE OF THE STUDY:
Participation in this study is voluntary and requires your informed consent. Your decision whether or not to participate will not affect your current or future relations with St. John Fisher College. If you decide to participate, you are free to skip any question that is asked. You may also withdraw from this study at any time without penalty.

CONTACTS, REFERRALS AND QUESTIONS:
The researchers(s) conducting this study: Bobbi Smith. If you have questions, **you are encouraged** to contact the researcher(s) at 585-694-8465, bjs01060@sjfc.edu. You can also contact researcher's advisor: Dr Joshua Fegley, Dissertation Chair, jfegley@brockport.edu

The Institutional Review Board of St. John Fisher College has reviewed this project. For any concerns regarding this study/or if you feel that your rights as a participant (or the rights of another participant) have been violated or caused you undue distress (physical or emotional distress), please contact the SJFC IRB administrator by phone during normal business hours at (585) 385-8012 or irb@sjfc.edu.

This study has the potential to cause emotional distress. If that happens you can reach out to your healthcare provider or any of the following applicable resources:
Hotlines:
24-hour Veterans Crisis Line/Suicide Prevention Lifeline: call 1-800-273-8255 Press 1 for Veterans, non-veterans listen for prompts for local crisis line
Veterans Crisis Line text option: send a text to 838255 to connect to the Veterans Crisis Line
Safe Helpline for Military Sexual Trauma (MST): 1(888) 734-0760

Websites:
Veteran Make the Connection: www.maketheconnection.net
Veterans Crisis Line: www.veteranscrisisline.net
Alcoholics Anonymous: https://www.aa-meeting.online/
Safe Helpline for Military Sexual Trauma (MST): https://www.safehelpline.org/

LGBTQIA Resource Center: https://lgbtqia.ucdavis.edu/support/hotlines

STATEMENT OF CONSENT:

I am 18 years of age or older. I have read and understood the above information. I consent to voluntarily participate in the study.

Signature:____ Date: ________________

Signature of Investigator:_______________________________ Date: _________________

Retain this section only if applicable:
I agree to be audio recorded/ transcribed _____ Yes _____No If no, I understand that the researcher will allow a 3rd party to transcribe the interview.

I agree to be videorecorded/ transcribed _____Yes _____No If I do not wish to be videotaped, I will inform the researcher, who will instead use only audio recording or transcription.

Signature:____ Date: ________________

Signature of Investigator:_______________________________ Date: _________________

Click or tap here to enter text.

Please keep a copy of this informed consent for your records.

Appendix C

Recruitment Advertisement

Veteran Peer Support Specialists Needed

Participants will be entered into a drawing for a $50.00 Visa gift card

Participants needed for a study about the impact on military veteran providers of providing peer support, and the impact on their own recovery.

SUMMARY: You will be asked to participate in one anonymous zoom interview, lasting approximately 1 1/2 hours. During the interview, you will be asked about your experiences with recovery and providing peer support services.

ELIGIBILITY: Must be a United States military veteran that has at least 6 months experience providing peer support services.

To participate please contact:
Bobbi Smith
585-694-8465
bjs01060@sjfc.edu

Appendix D

Demographic Survey

Demographic Survey for Veteran Peer Providers

Do you identify as:

- Female
- Male
- Transgender
- Non-binary
- Other

Do you identify as:

- Native American or Alaskan Native
- Asian
- Black or African American
- Latinx
- Native Hawaiian or Other Pacific Islander
- White
- Two or more races
- Other

What Branch of the Military did you serve?

- Air Force
- Army
- Marines
- National Guard
- Navy
- Reserves

During which era was your military service?

- OEF/OIF
- Gulf War
- Vietnam
- Korean War
- WWII
- Served between conflicts

How long have you provided peer services?

- 6 months to 1 year
- 1-5 years
- 5 or more years

Appendix E

Resources for participants

Mental Health Resources for research participants

Hotlines:
24-hour Veterans Crisis Line/Suicide Prevention Lifeline: call 1-800-273-8255 Press 1 for Veterans, non-veterans listen for prompts for local crisis line
Veterans Crisis Line text option: send a text to 838255 to connect to the Veterans Crisis Line
Safe Helpline for Military Sexual Trauma (MST): 1(888) 734-0760

Websites:
Veteran Make the Connection: www.maketheconnection.net
Veterans Crisis Line: www.veteranscrisisline.net
Alcoholics Anonymous: https://www.aa-meeting.online/
Safe Helpline for Military Sexual Trauma (MST): https://www.safehelpline.org/
LGBTQIA Resource Center: https://lgbtqia.ucdavis.edu/support/hotlines