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PEER COUNSELLING: AN OUTREACH PROGRAM IN A HOME FOR THE AGED

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Abstract

This paper is an evaluation of the effectiveness of a peer counselling training program in a home for the aged in Victoria, B.C. The goal of the program was to expand the number of helpers available and involve more residents in their self-care. The results indicate that the training model used is an effective method of teaching helping skills to residents of a nursing home.

Résumé

Cet article fait état d'une évaluation de l'efficacité d'un programme de formation en counselling par les pairs dans une maison de retraités située à Victoria en Colombie Britannique. Le but du programme consiste à accroître le nombre d'aidants disponibles et à impliquer davantage de bénéficiaires à prendre soin d'eux-mêmes. Les résultats indiquent que le modèle de formation utilisé constitue une méthode efficace d'enseigner des habiletés d'aide aux résidents d'une maison de retraités.

Our culture defines mental health in terms of social participation (Clark & Anderson, 1979), yet many of the aged in Canadian society are increasingly finding themselves more isolated (France, Note 1). The challenge facing counsellors and service providers for the aged is to provide more effective mental health services in the face of increasing cutbacks and financial restraints. Nowhere is there a greater need than in the multitude of nursing homes mushrooming throughout Canada.

The concept of peer counselling is based on the notion that a person will often seek out a peer when there is a concern, frustration, or a problem. Carr & Saunders (1980) describe a peer counsellor as a person who is willing to listen and talk to others about their thoughts and feelings and who genuinely cares about others. In the nursing home setting, residents are often the first to notice others who are experiencing difficulty. By offering support through listening with understanding, we believed that peer counsellors could foster a therapeutic climate. They could act as a bridge in the helping continuum between those who need help and the professional helpers in the nursing home. The help that the peer counsellors could offer is not only with those in their own social network, but also with those people identified in need of help by friends, neighbors, or professional staff.

Peer Counselling has been widely used in school settings, but its use with the aged has

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been much rarer (McDowell, 1983; McIntyre, Thomas, & Borgen, 1981; Mosher & Sprintall, 1971; Varenthorst, 1974). For the aged, whose social world has decreased and where their degree of social participation is dependent on their proximity to friends, churches, and stores, the peer counselling concept holds a great deal of promise.

The Victoria Project

The purpose of this project was to test the feasibility of implementing a peer counselling training program involving volunteer residents of a nursing home. The underlying assumptions were that: (a) the aged want to help themselves; (b) there is a reserve of talented nursing home residents who want to be helpful; and (c) peer counselling is an effective method of promoting self-help and social interaction.

A 66-bed intermediate care facility was selected for this pilot project. The facility is three years old and houses residents in all three sub-categories of the intermediate level of nursing care. The need for and effects of a program such as peer counselling are difficult to substantiate in a scientific way, nevertheless the project was approached with a view to monitoring various pre-training, training and post-training factors.

Pre-Training Phase

A resident survey was conducted in the facility in order to ascertain existing emotional support practices. Residents were asked a number of questions: (a) whether they had someone to confide in, (b) who that person(s) was, (c) whether they felt residents get a lot of individual attention, (d) whether they felt problems were openly talked about, (e) whether they believed residents had to be careful about what they said to one another. Relevant results of this survey are summarized in Table 1. This was part of a larger study employing a multidimensional assessment procedure (Gallagher & France, 1983).

Table 1

Responses to Pre-program Resident Survey ($n = 32$)

		Yes	No	No Response
1.	Do you have someone to confide in?	75%	25%	0
2.	Do residents get a lot of individual attention?	78%	22%	0
3.	Are residents careful about what they say to one another?	53%	31%	16%
4.	Do staff members spend a lot of time with residents?	66%	22%	12%
5.	Are personal problems openly talked about?	25%	69%	6%
6.	Do residents talk a lot about their fears?	6%	88%	6%
7.	Do residents keep their personal problems to themselves?	72%	19%	9%
8.	Who do you talk to when you have a problem or concern?			
	No-one 22%			
	Staff 18%			
	Family member 40%			
	Friend 20%			
	Another resident 0%			

Of particular interest were the findings that close to a quarter of those interviewed reported that they had no one in whom to confide and no one reported having another resident as a "confidant". A high proportion reported that problems were not openly discussed and saw residents as "keeping problems to themselves". Results of this survey supported the need for a program to enhance the social support network in the home.

Another pre-program activity involved holding group meetings with the staff and residents, carefully explaining the concept of peer counselling. The idea that peer counsellors are not professionals was emphasized and it was explained that they would not be replacing staff but could complement staff activities. One had the sense that some of the staff, particularly the nurses' aide group, were highly skeptical of the value of "talk therapies" and of the ability of any of the residents to perform as helpers. It was important to address their concerns frankly, making no spectacular claims about the possible outcomes of the program.

The third activity of this phase was to select the participants for the training program. We were aided in the selection process by senior staff who recommended residents who had shown an affinity for helping others and who did not have overt emotional problems. Three men and three women were selected, ranging in age from 69 to 96. Hoffman (1983) suggests excluding persons who have strong religious convictions. While two members of this group were very religious, they appeared to be flexible in learning the various counselling techniques and performed as well as or better than the others on the evaluation measures.

Prior to starting the training, an evaluation of each member's counselling skills was carried out in order to measure whether there was any improvement. These measures and the results will be discussed later in the paper.

Table 2

Peer Counselling Training Model for the Aged

	Skill Phase		Number of Sessions
1.	*Communication:* Non-verbal and verbal attending, road blocks, empathic listening, effective questioning, self-disclosure, group process		10
2.	*Life Strategy:* Decision-making, problem-solving, values clarification	) Applied to role) change, illness,) grief, loneliness,) stress, preparation) for dying, family	5
3.	*Helping:* Code of ethics, confidentiality, referrals		5
4.	*Practicum:* In-group and outside group practice under supervision.		10

Training Phase

The training program consisted of 30 weekly classes of one to one and a half hours. The instructional style used kept formal lecturing to a minimum, encouraging role-playing and building on the group members actual experiences. The content of the program followed the training model developed by France and McDowell (1982). It consists of four interrelated phases: communication skills; common age-related life crises; ethics, confidentiality and referrals; and a practicum.

The first phase, communication skills, introduced the learners to six basic strategies for effective counselling. These were non-verbal attending, active listening, empathic

responding, avoiding communication blocking, giving feedback and effective problem-solving. Because attendance was sometimes interrupted by illness of the group members, repetition of the information and practice sessions were found to be necessary.

One of the most difficult problems encountered in this phase was the tendency of the participants to offer premature advice, a problem noted also by Hoffman (1983), who concluded that such advice may be quite helpful. We would advocate that wisdom from a peer counsellor's experience should be offered only after careful identification of the client's problem and in a way that emphasizes the client's responsibility for decision-making.

The second phase of the program was designed to explore issues common to the emotional experience of seniors. Topics included such common life crises as the experience of moving to a nursing home, reductions in self-esteem which may arise from altered roles, and the difficulties of communicating with someone who is confused or withdrawn. Although such problems can seldom be dispelled by simplified solutions, the learners showed an appreciable gain in awareness and sensitivity of these issues as evidenced by their probing questions and sharing of personal experiences. During this phase we also discussed death both as a personal experience and as a threat to friends and family. A guest from the Victoria Association for the Care of the Dying led a discussion on counselling practice in relation to terminal illness.

In the third phase of the training, learners were provided with the essentials of the ethical training imparted to professional counsellors. The imperative nature of confidentiality was emphasized, as was the need to withhold personal value judgements in the counselling process. We also stressed the need to carefully identify situations in which clients might need more skilled professional help than a peer counsellor could give. Local professional services and referral procedures were outlined.

At the conclusion of twenty weeks of formal instruction, students began actual counselling practice with other residents of the nursing home. During a ten-week period, we continued meeting weekly to monitor progress. Initially, other residents seemed reluctant to approach the counsellors for help. The counsellors were encouraged to play down the formal aspects of their role and assume natural ways of approaching residents who seemed lonely or upset. Within three weeks each of the counsellors had made contact with at least one resident. Visits ranged from a single conversation to ongoing involvement.

The participants were enthusiastic about the weekly training sessions. One man said "the role-playing and learning games really helped me see some of the values and biases I had. You couldn't have done that with a lecture". Another noted that he felt he had really learned to put himself in the other resident's shoes. The session on death and dying was particularly well-received. One man noted how helpful it had been to him in talking to his dying friend. In contrast, May, a 69 year old resident said in retrospect that the session on death had helped her realize that she had not yet recovered from caring for her two dying parents and therefore couldn't be very helpful to a dying person just yet. "I realized I couldn't do it. I would just wind up crying".

Evaluation

For each of the six trainees, a tape recorded interview with a trained role player was conducted both before and after the peer counselling training. The subjects also responded in writing to eight brief case studies depicting seniors experiencing stress.

Expert judges rated the empathy levels of both the written and verbal interviews, using Carkhuff's Empathy Rating Scale and the Hill response category system (Carkhuff, 1969; Hill, 1978). From this we calculated the differences in before and after ratings for each subject, as shown in Table 3.

Statistical tests showed that there had been significant improvement in the trainees' use of empathy ($p < .01$).

It is not clear how much of this change was actually related to the peer counselling course itself. Yalom (1975), for example, suggests that just being a member of a therapeutic group will itself increase people's sensitivity, awareness and empathy towards others. Since the size of this group was very small, it would be of value to repeat these measures with a larger sample size.

One year following the training, only one of the original trainees has ceased to

Table 3

Differences in Empathy Rating Before and After Peer Counselling Training[a]

Subject	Difference on Verbal Test[b]	Difference on Written Test[b]
A	+ 1.0	+ 1.0
B	+ .5	+ 1.5
C	+ 1.5	+ 1.0
D	+ 1.0	+ 1.0
E	+ 1.0	+ .5
F	+ 1.0	+ 1.0

a Scale: 1 = poor, 5 = excellent.
b A value of +7.1 is significant at the .001 level.

function in a helper role due to serious illness. Each of the other peer counsellors sees two to four residents on a regular basis and report having had sporadic contacts with between six and 15 additional residents.

The counsellors appear to have benefited personally through their involvement in this project. One senior expressed her views as follows:

> When I was interviewed for the counselling course I was very hesitant. How could I ever do anything like that? At times my own problems seemed to be too much to handle, let alone someone else's. As the course progressed, I found that I could understand myself much better and learned a great deal about other people. I feel now like I really accomplished something that will enable me to help others, which is what the whole thing is all about.

Issues and Questions

The five seniors continue to meet monthly with one of the authors to discuss problems and offer each other support. One of the most difficult aspects of their role is dealing with individuals who have unsolvable problems. As one man said, "You just feel so helpless at times because you know that for some kinds of problems there just aren't any solutions." Gradually they are beginning to recognize the healing effect of empathic listening and are feeling less compelled to "solve" the other residents' problems.

The director of nursing of the home has been extremely pleased with the program. She has been assigning the peer counsellors to visit prospective residents prior to their move to the home and claims that these new residents seem to take much less time to fit in after the move.

Conclusion

The results of this project indicate that peer counselling does offer one method of bringing patients in the home for the aged into the service-providing system. The helping skills taught in the peer counselling training program can help those natural helpers already in the nursing home environment to be more effective. Thus, while the number of patients may increase, peer counselling represents a practical and economical way of increasing the number of mental health services offered.

The peer counsellor role is that of a listener, advocate, and mediator between the patients and the service providers. Peer counsellors know what it is like to be old and a resident of a home. They can assist the professionals in the nursing home in many counselling activities. Evidence indicates that peer counsellors are as accepted in a helping situation by their peers as professionals are and in some cases even more so (Carr & Saunders, 1980). They seem to foster an "us" syndrome instead of the service providers on one side and the residents on the other. Thus, peer counselling can make an important contribution to reducing the well documented phenomena of "institutionalism" (Lieberman, 1971).

The peer counselling training model implemented in this project was an obvious success in enhancing participants helping skills. It also confirms what is currently in the literature (France & McDowell, 1982), that peer counselling participants personally gain by increasing their own intra- and interpersonal skills. All participants in this program experienced increased self satisfaction and wellbeing at the end of the program. In other words, peer counsellors feel useful and enjoy the activities that being helpful brings. A peer counselling program implemented and evaluated at the Victoria home demonstrates the effectiveness of bringing the residents into the helping process in an innovative "outreach" program. Limitations of the study include the small number of trainees and the absence of objective long-term evaluation measures. We conclude however that there are a number of ways that the peer counsellors can serve and it is hoped that this paper will stimulate those working with the aged to consider peer counselling as one method of extending their services.

Reference Note

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