THE MATURING OF PEER COUNSELING

by BERNICE BRATTER & EVELYN FREEMAN

For many years peer counseling has been used in a variety of self-care programs and self-help groups primarily targeted at younger persons who come together for mutual assistance or to overcome a life-disrupting problem (Katz and Bender, 1976). Peer counseling with older adults, unlike traditional self-help groups, frequently includes a professional supervisor/trainer (Bratter and Tuvman, 1980). Over the past two decades, peer-counseling programs for older adults have developed, and their proliferation is easily understood in the context of a rapidly increasing older population that is at high risk for mental illness and emotional disorders. In California, for example, a network of approximately 40 agencies with active peer-counseling programs meets quarterly to share information. This network reports that its peer-counseling programs are significantly affecting their communities by meeting mental health needs, assisting older adults to become more productive, and contributing to the communities' changing views of elders.

Professionals alone will not be sufficient to deal with the growing mental-health needs of older adults for a number of reasons: professional resistance to treating the elderly, high costs of professional services, low Medicare reimbursement for mental health, resistance of older people to the use of mental health services, and an increasingly underfunded mental health system. These issues have been well-addressed by Kastenbaum (1964) and Davis (1986). As early as 1975 Butler wrote that "most older persons never have a chance to obtain mental health services." Ever since the Joint Commission on Mental Health and Illness in the United States published its summary findings in 1961, there has been increasing consensus indicating a great need for trained mental health personnel at the paraprofessional level.

A search of the literature concerning peer counseling for older adults disclosed nothing published prior to 1978 (Alpaugh and Haney, 1978; Becker and Zarit, 1978). In a reviewing of 20 articles published since 1980, the following similarities surfaced among descriptions of the benefits of peer-counseling programs for older adults:

1. Many older people talk more readily to other older people than to professional therapists. "Paraprofessionals are not only less expensive than professionals, but also less threatening to many older people who may be wary of seeking professional help" (Waters et al., 1979).

2. Peer counselors serve as positive models for their clients. Volunteering services to other older people demonstrates the value of productivity for the ones who serve as well as for the ones who receive the services (Sherman, 1981; Hoffman, 1983; Gallagher, 1985; Freeman et al., 1986).

3. Peer counseling benefits both client and counselor. At a time in their lives when older adults might expect their world to become smaller and their satisfactions to lessen, peer counselors find their lives are richer and more stimulating through the experience of training, counseling, and supervision. This factor, in turn, contributes to the counselors' well-being (Gallagher, 1985; Byrd, 1984; Freeman et al., 1986).

4. Peer counselors can, in some circumstances, be more effective in counseling their peers than professionals. "Paraprofessionals have advantages over professionals in that they are often more aware of problems indicative of a particular group or setting than a professional from a different background" (Waters et al., 1979).

Peer-counseling programs often begin because they are a cost-effective means of developing mental health services for older adults, which are often unavailable in a community. Such was the experience of the Santa Monica–based Senior Health and Peer Counseling Center, which began as a health-screening clinic in 1976. It quickly became evident that patients who came in for physical examinations were also struggling with

Senior Health & Peer Counseling Center

Peer counseling training session led by Evelyn Freeman.

depression, anxiety, loneliness, and a full range of mental and emotional disorders. Peer counseling was established at SHPCC in 1978, and since then, 208 counselors have been trained, with 93 still active at this writing. As a result of requests for SHPCC training, a peer-counseling training package, *Peer Counseling for Seniors: A Trainer's Guide*, was published in 1986 (Freeman et al.).

BONDING & GROWTH

Clients and counselors involved in peer counseling meet on an equal plane, thus eliminating the hierarchy that is more likely to exist in professional therapy. This relationship provides the possibility of fewer barriers to overcome and presents a built-in capability for rapport and trust. Sometimes, the fact that the counselor is not a professional but rather another older person with similar life experiences can contribute to this nourishing condition.

The SHPCC training model, an in-depth, 12-week, 24-session program that presents a full range of subjects and interventions suited to the aging population served, emphasizes the significance of personal growth. The value of addressing unfinished personal issues is stressed as a critical part of preparation for counselors. The training presents the belief that one will change when ready and not when anyone else wants that change. A climate is provided during training for developing self-esteem and self-love. As a result of this emphasis on personal growth, a strong bonding takes place among the trainees during the training. Experiencing first-hand the warmth and connectedness established during training, the trainees learn the value of creating that kind of bonding with their clients.

LOW ATTRITION

Peer-counseling programs tend to report low attrition rates for their counselors. The SHPCC model recommends these steps to minimize attrition:

- *Careful interviewing and selection of trainees* is critical to the success of the program. SHPCC uses both a written application and face-to-face interview. After receiving a response to the written application, applicants are interviewed in small groups of four or five by a team of staff members (two or three), including the trainer. This method permits the interviewers to see and hear characteristics not revealed in the written application. Personal qualities such as empathy, respect for others, flexibility, ability to communicate clearly, acceptance of another's world view, interest in others, and warmth are of equal importance.
- *Establishing a clear and firm commitment from trainees* makes it possible to identify those who have potential for longterm volunteering.

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In the written application and during the small-group interview the required commitment to the program is stressed: a minimum of one year's service with a minimum of eight hours weekly. The eight hours include a weekly two-hour group supervision, a monthly in-service meeting, a caseload of three or more clients, record keeping, and travel time.

- *Careful selection of the trainer/supervisor* is integral to the quality and longevity of the program. The trainer's skills, personality, vitality, humor, and motivation to be effective are essential for successful teaching. A trainer conducting classes in a "participatory learning" model exemplifies a nonauthoritarian figure and thus provides an important role model for them as counselors.
- *Training with the belief that change is possible for as long as we live* challenges the myths and stereotypes of aging.
- *The support and good will of the sponsoring agency* is an important element to a successful peer-counseling program. The peer-counseling program must be integrated into the total services of the agency in order to be well accepted by the staff and other volunteers.
- *Satisfaction in the work* is essential to the longevity of the volunteers in the program. The older years have often been seen as a time when most people have already lived what they consider to be their time of productivity. When the possibility of doing something meaningful, useful, and stimulating is presented to them, older adults are eager to participate. An Indian poet said it beautifully:

> I slept and dreamt that life was joy
> I awoke and saw that life was service
> I acted and Behold! Service was joy.
> —Rabinranath Tagore

- *Supervision and the concomitant opportunity for new learning* is a key factor in maintaining the interest of counselors. In the SHPCC model, weekly group supervision is conducted. Here, too, the role of the supervisor is critical in capturing and maintaining the continued involvement of the counselors.

GOALS & FOCUS

The SHPCC model trains counselors to view the goal of the client as the primary goal of counseling. Counselors are also taught that clients are more likely to achieve goals they themselves have initiated, that often "being with" the client is more beneficial than "doing something" for the client, and that attempts at "fixing" rarely solve the problem or resolve the issue for the client. In addition to individual counseling, peer counselors can receive special training in group leadership in order to conduct a variety of groups and, in some instances, to assist mental health professionals in leading their groups. The range of focus for groups includes growth, support for widows and widowers, sexuality, socialization, arts and crafts, self-esteem, pain and stress, drama, arthritis and stroke, as well as special groups for men and for women.

When SHPCC began its peer-counseling program the clients seen were primarily experiencing the losses associated with aging. The goal was to assist older people in maintaining an independent lifestyle for as long as possible. Today peer counsel-

ing includes services to those with more chronic and severe mental disorders. Support from mental health professionals has become essential as peer counselors and professionals often work together in a partnership that benefits clients.

IN VARIOUS SETTINGS

The SHPCC model is being replicated throughout the world. As the program gains exposure, more and more agencies are requesting training and consultation for establishing their own programs. Peer-counseling programs have been successfully developed in urban and rural communities, in the United States, Canada, and Denmark, and with counselors and clients representative of various physical, cultural, religious, economic, and educational backgrounds. The Dallas Lighthouse for the Blind (a field-test site for the SHPCC training manual) is just one example. Portions of the SHPCC manual have been translated into Spanish, and presently two groups of Spanish-speaking peer counselors are active in Los Angeles County.

While much has been written about the value of peer counseling for counselors as well as clients (Kirkpatrick and Patchner, 1978), a paucity of outcome evaluations exists (Gatz et al., 1984), probably in part because many peer counseling programs began in a rather informal manner, serving obvious needs rather than focusing on research or data. Most available information at present consists of descriptions of peer-counseling programs in various settings.

In order to achieve a broader view of peer-counseling programs, we sent a questionnaire to 80 agencies that had purchased the SHPCC training package. One agency in Wisconsin distributed the questionnaire across the state to agencies that had not purchased the manual, and 16 out of our 42 total responses were from these agencies. Nineteen of the 42 agencies that responded were conducting peer-counseling programs, and 18 of these were using the SHPCC trainer's guide. Fifty percent of the total responses were from California, 40 percent were from Wisconsin, and the remainder were from Kentucky, Texas, and British Columbia. A summary of the most interesting responses showed the following:

- Thirty-eight training events were reportedly conducted from 1983 to 1989. The more recent surge in peer counseling is evidenced by figures that show only 2 percent of the training being done in 1983 compared to 33 percent in 1989.
- The range in the number of counselors trained at each agency was from 4 to 99, with a mean of 33. Twenty-two percent of the agencies had trained 53 or more counselors.
- The mean age of the counselors ranged from 49 to 65, with a median age range of 55 to 78. Five percent of the agencies reported counselors between the ages of 94 and 98.
- The mean number of counselors available at each agency was 20, with a median of 17 and a maximum of 60 reported.
- Peer counselors were trained to address a broad range and variety of issues, including mental health problems, from chronic mental illness to depression and loneliness; physical and medical problems, from strokes to Alzheimer's and other forms of dementia, multiple sclerosis, and vision and hearing impairments; concerns of the frail, isolated, institutionalized, and homebound and their caregivers; problems of substance abuse; problems of the ethnic minorities; and concerns related to gender.
- The most common reasons clients seek counseling were reported to be illness and loss (26 percent) and emotional difficulties (24 percent). Thirty one percent cited multiple reasons.
- Half of the agencies reported doing individual counseling, while another 38 percent used various modalities, including work with groups, families, and couples.
- Counselors saw 44 percent of the clients at the agency or a senior center, while 33 percent were seen at home.
- Counselors saw 72 percent of the clients weekly, and 19 percent were seen two to three times a week or as needed.
- Counselors saw 43 percent for one hour, 31 percent for two hours, and 2 percent were seen for three hours. For 12 percent, the time varied according to the needs of the case.
- Length of time clients were seen was reported to be from one to twelve months (22 percent), from three to twelve months and more (19 percent), and for as long as needed (26 percent).
- When asked if clients' needs differed because of ethnicity, education, socioeconomic factors, or other, the highest number of responses cited socioeconomic differences (45 percent), ethnicity (21 percent), and education (26 percent), with the most-cited category for other needs being those with handicaps (7 percent).
- The most commonly used method of evaluating the effectiveness of counseling was with evaluation forms (24 percent), through supervision (33 percent), and through client self-report (14 percent).

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CONCLUSION

When we began our peer-counseling program in 1978, we were unaware of the positive far-reaching impact of peer counseling. The maturing of peer counseling over the past two decades has enabled us to expand our vision. We have come to see that through peer counseling, older people learn to view themselves as worthwhile, valuable citizens and are more likely to be healthier—both mentally and physically. Older people can learn that many of the images of aging are myths and

stereotypes, that they have options, and that, as a group, they can have power.

A trainer from a newly developed peer-counseling program in Eureka, California, wrote to tell us about a recently trained peer counselor, an 80-year-old woman who required a quad cane because of a past stroke. She proudly proclaimed that the training had shown her that even those with physical disabilities have the emotional strength to share with others and that they do not need to stay hidden in the safety of their own environments.

While, as earlier reported, there has been little formal evaluation of peer-counseling programs, there is a seemingly limitless supply of heart-warming stories such as this one. We believe the potential benefits of the peer-counseling movement are still being discovered as more and more programs develop and greater numbers of older citizens blossom with increasing self-esteem, with a beneficial impact on society. ■

Bernice Bratter, M.A., M.F.T., is executive director and Evelyn Freeman, Ph.D., is director of mental health services, both of the Senior Health and Peer Counseling Center, Santa Monica, Calif.

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Ida Schecter, peer counselor, with Lily May Rogers, client.