# THE IMPACT OF PEER COUNSELLOR TRAINING FOR THE AGED ON THE COMMUNICATION OF EMPATHY

by

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## ABSTRACT

Elderly persons are often considered as needing mental health care to cope with the stresses associated with the aging process. Unfortunately, they are often reluctant to request professional help. Peer counsellors who have been trained in counselling techniques are thought to be one way of overcoming this reluctance, thereby providing elderly people with the necessary assistance.

Because little empirical research has been conducted on the efficacy of peer counsellor training programs for the elderly, the present study was conducted to examine one peer counsellor training program with a view to determining whether it provides the means by which seniors can learn to accurately communicate empathy.

Thirty five elderly volunteers from the Victoria Capital Regional District served as subjects. Sixteen subjects served as the experimental group with the remaining nineteen subjects serving as the control group. The experimental group received a 40-hour peer counsellor training course whereas the control group received no training. Pretest and posttest measures of the subject's counselling performance were obtained by assessing the subject's written responses to a counselling questionnaire by means of two rating scales

designed to measure the counsellor's accurate use of empathy in responding to client statements.

Data were analyzed using one-way Analyisis of Variance tests. The ANOVA results indicated a significant treatment effect for those subjects who received the peer counsellor training.

The results of this study indicate that the peer counsellor training program examined was effective in increasing the trainee's accurate use of empathy in responding to the client's statements. This finding is consistent with previous studies examining the effect of peer counsellor training programs on the performance of elderly trainees. The implications of the study are discussed along with the limitations of the study and suggestions for future research.

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# CHAPTER I

## INTRODUCTION

The utilization of peers as counsellors is an idea that is gaining widespread attention and approval throughout North America. One population that seems well suited for peer counselling is the rapidly increasing population of senior citizens. Several studies have indicated that the elderly do not seek professional counselling even when they need help (Schwartz, 1980; Welter, 1978). Reasons given by the elderly range from a reluctance to reveal their private lives and thoughts to associating counselling with the treatment of mental illness. The use of peer counselling is thought to be an effective way to overcome the resistance shown by senior citizens to professional counselling. On the basis of these assumptions, training programs have been established to train senior citizens to become effective peer counsellors. Examples of such training programs are becoming easier to find in the counselling literature (Alpaugh & Haney, 1978; France & McDowell, 1982; France & Gallagher, 1984; Kirkpatrick, 1982; Waters, 1977). Victoria, British Columbia has been the home of several peer counselling programs for the aged. Because Victoria is a city with one of the highest percentages of elderly in its population in North America, it provides researchers and trainers the unique opportunity to involve a large number of retired seniors in programs such as peer counselling. The individual responsible for the growth

of peer counselling for the aged programs in Victoria is Dr. Honore France. The locations in which France has established peer counsellor training programs range from a Community Health Clinic to a Home for the Aged (France, 1986). France's rationale in establishing these programs consists of: (a) there is a need for more effective approaches in helping the increasing aging population in Victoria; (b) the aged want to help themselves; and (c) there is a reserve of talented seniors who desire to be helpful (France, 1986). Much of the rationale behind the use of older volunteers as peer counsellors is based on the view that older people have the desire and motivation to be helpful; but they do not have an appropriate outlet to apply such energies (Pressey & Pressey, 1967). France (1986) has noticed that this is a common theme that recurs throughout the gerontological literature. Peer counselling is thought to be one way of not only providing an appropriate outlet for older volunteers, but as well a way of helping those seniors who need help but are not able or willing to seek professional counselling.

Since these training programs have been relatively recent developments, very little research has been conducted to examine the efficacy of this training. If both the interest in and implementation of such training programs continue to grow at their present rates, there will exist a strong need for researchers to conduct studies to determine if this training is effective.

# CHAPTER II

## REVIEW OF THE LITERATURE

The following review of the literature examines the background, theory and philosophy behind the growth of peer counselling programs for the elderly, and the content of such training courses. Outcome studies that have assessed the effectiveness of peer counsellor training for the elderly are reviewed and finally, empathy is examined as a means of evaluation. The literature reviewed indicates a strong need for controlled research that provides more than the anecdotal reports of the trainees that take peer counsellor training courses for the elderly.

### Background and Philosophy

Peer counselling for the elderly has arisen in response to the underutilization of mental health services by the elderly. Even though seniors have the same propensity towards mental and emotional problems as do other age groups, they either tend not to use mental health services or they wait for longer periods of time before requesting help from mental health services (Eisdorfer & Lawton, 1973). Research has indicated that with proper mental health care a great number of the mental health problems of the elderly can be alleviated if not eliminated (Butler, 1975; Puner, 1974). The major impediment in providing mental health care for the elderly is that most older people will not ask for help with

their mental and emotional problems (Sargent, 1980). Some of the reasons given for this position are that: (a) the elderly are more independent minded which makes them ashamed to ask for help (Buckely, 1977): (b) the elderly have a negative attitude towards professional mental health providers (Welter, 1978); (c) counselling is often associated with the treatment of mental illness (Welter, 1978): and (d) elderly people are generally less able to afford to utilize mental health services that are not covered under third party medical coverage. When these factors are added up, the result is that the elderly make up only 1-5% of the clientele who make use of mental health clinics and private practitioners (Buckely, 1977; Kahn, 1975). One alternative to the traditional kinds of mental health services that the elderly now have is to use the services of peer counsellors. Peer counsellors are senior citizens who undergo counsellor training and then volunteer their time to counsel troubled seniors in their community. Peer counselling is based on the philosophy that counselling skills are human skills and need to be given to as large a number of non-professionals as is possible (Kirkpatrick, 1982). By utilizing the reserve of retired seniors that are motivated to be helpful, peer counselling is providing the aged population with an opportunity to help themselves.

## Theory and Goals

The goals of the peer counsellor are to communicate

effectively with the client, understand the client's experience from a personal frame of reference, and to help the client explore intimate feelings and options in decision making (Alpaugh & Haney, 1978). The theory behind the use of elderly peers as counsellors is that the elderly are more likely to seek help from someone who is not a professional mental health worker and who has had first hand experience with the problems associated with growing old. Some of the problems that are especially relevant to the elderly are health loss, negative self concept and loss of loved ones (Furstenberg, 1985; O'Brien, Johnson & Miller, 1979). Results thus far have shown that not only do clients seem to respond positively to peer counselling but that the peer counsellors themselves seem to gain increased self awareness, self esteem, and feelings of accomplishment from helping others (France & McDowell, 1982; Hurvitz, 1970; Sainer & Zander, 1971).

## Content of training courses

Peer counsellor training programs for seniors typically include a communication phase and a type of inservice/administrative training phase. Training programs increasingly include a practicum phase so that trainees can gain some practical experience in a supervised setting. (See Figure 1 for an example of a 3 part Training Program). Seniors who undergo training in peer counselling typically learn listening and communication skills, steps in problem solving,

information about the normal processes and problems of aging, referral procedures, and confidentiality and ethical issues (Alpaugh & Haney, 1978; Brather & Tuvman, 1980; France & Gallagher, 1984; France, 1986; Priddy & Knisely, 1982). A detailed description of the training program evaluated in this study is provided in Chapter IV.

## Outcome Studies

Although there is a noticeable paucity of outcome research on the effectiveness of peer counselling training for seniors, two studies have shown that peer counsellor training does affect the warmth and empathy level of the peer counsellor trainees (France & Gallagher, 1984; Becker & Zarit,1978). As empathy is considered a core skill in counselling, these findings give some indication that peer counsellor training programs may be effective at increasing the counselling skills of the trainees. Unfortunately, other evidence documenting the effectiveness of such training is virtually non-existent. This paucity of research is believed to exist because peer counsellor training for the elderly is a relatively new idea. Though the program goals of peer counsellor training programs frequently state advantages such as being cost-effective or preventing institutionalization, program evaluations to test these and other program goals do not exist (Gatz & Hileman, 1984; Blanton & Alley, 1981). It would seem that with the constant fear of rising health costs there would be considerable research efforts conducted to

determine if peer counsellor training for the elderly and subsequent peer counsellor training programs actually do aid in the prevention of institutionalization of the elderly. Surprisingly enough very few studies of older people in an independent living status have been reported. This presents a major need in gerontological mental health research as the majority of older people do not live in an institution (Wellman & McCormack, 1984).

Based on an extensive review of the outcome research on peer counselling with older people, Wellman and McCormack (1984) found that very little of the research could even be considered outcome research as it was largely anecdotal. Researchers tended to describe their training programs in great detail with suggestions to readers as to how to establish their own peer counsellor training program. Those who did include an evaluation phase tended to judge the effectiveness of their program based on their own informal observations and on the anecdotal reports of the participants (Wellman & McCormack, 1984). One exception to this lack of controlled research was a study conducted by France and Gallagher (1984). Utilizing a training model designed by France and McDowell (1982) the researchers trained 6 residents of an intermediate care facility in Victoria, British Columbia, to be peer counsellors for older persons.The training program consisted of four phases: Communication skills, Life strategy skills, Helping skills

and a Practicum. The effectiveness of this program was evaluated through an assessment of audiotapes of the subjects both before and after the training. The subjects also completed a written questionnaire which asked them to respond as counsellors to eight written statements that simulated problems that might be experienced by an older client. Verbal and written reponses were evaluated using Carkhuff's Empathy Rating Scale and the Hill Response Category System (Carkhuff, 1969; Hill, 1978). Analysis of the data revealed that there had been significant improvement in the trainee's use of empathy. As there was no control group it is not known how much of the change can be attributed to the peer counsellor training program itself. The small number of subjects used and the fact that the subjects were institutionalized also raises questions as to the validity and generalizability of the findings.

## Empathy

For the purpose of this study empathy is defined as the counsellor's ability to experience and communicate his/her understanding of the other person's experience, that is, to literally put himself in the other persons shoes. Robert Carkhuff (1969),the designer of one of the more prominent scales for assessing empathy, defines empathy in the following fashion:

> Empathy is the key ingredient for helping. Its explicit communication, particularly

> during early phases of helping, is critical. Without an empathic understanding of the helpee's world and his difficulties as he sees them there is no basis for helping (p.173)

Empathy is thought of by many counselling researchers as the most important counselling skill (Dickinson & Truax, 1966; Truax & Carkhuff, 1967; and Carkhuff, 1969).Some researchers have found that this is an especially important skill in the counselling of the elderly (Donran & Mitchell, 1979; Alpaugh & Haney, 1978).

In the context of peer counsellor training it is not surprising that empathy becomes one of the foremost skills taught to trainees. The peer counsellor trainee must learn to use this skill to help their clients to identify their problems and work towards a resolution of such problems. Because of the importance placed on empathy in peer counsellor training programs and in counsellor effectiveness studies, this skill was chosen as the primary skill to be assessed in this study.

## Summary of Literature Review

Peer counselling for the elderly has become a means of bridging the gap between the counselling need of the elderly and the acceptable counselling resources available to them. At the same time, peer counselling provides an outlet for those seniors that have the desire and motivation to be helpful. Peer counsellor training programs typically include a communications phase, an inservice/ administrative training

phase and a practicum.

A review of the limited outcome research on the effectiveness of the peer counsellor training programs for seniors indicated that the training programs do affect the warmth and empathy level of the peer counsellor trainees. Unfortunately, the one study which looked at empathy lacked a control group and used a limited number of subjects.

Empathy was discussed as being one of the most important skills taught in peer counsellor training and therefore an appropriate skill to be assessed in the present study.

# CHAPTER III

## RATIONALE

While there is research to indicate that the elderly only represent 1-5% of the clientele who utilize present mental health services (Buckley, 1977; Kahn, 1975), the evidence to demonstrate that peer counselling is an effective means of compensating for this underutilization is not as obvious. What is even less obvious is evidence to demonstrate that peer counsellor training programs are an effective means of training peer counsellors for the elderly. It seems apparent that in order to justify the continued growth and expenditure for peer counsellor training programs with the elderly, further evidence of the effectiveness of such programs should be made available.

This study was designed to test the hypothesis that there would be an ordered difference in the use of empathy between subjects who have had peer counsellor training and those subjects that have not had peer counsellor training. It was proposed that the use of empathy for those subjects who received the peer counsellor training would be greater than the peer counselling performance for those subjects who did not receive such training.

# CHAPTER IV

# METHOD

## Subjects

The subjects for this study were 35 elderly volunteers between the ages of 55 and 75 years who lived in the Capital Regional District. The volunteers were chosen because of their interest in the concept of peer counselling for the elderly and their interest in becoming personally trained as peer counsellors. Potential subjects were solicited through public informational meetings, mailed brochures, referrals and phonecalls directed to members of senior social service organizations. Approximately half of the subjects were members of the Victoria Gerontological Association. An informational meeting was given to both the members of the Victoria Gerontological Association and the public in which the definition of and rationale for peer counsellor training programmes were presented. At this meeting informational brochures were distributed to those interested in taking the training program (See Appendix A for information given in the brochures). People who were interested in taking the training and who signed up on a list provided were then contacted by telephone and asked to attend an informational/screening session. At the informational/screening session participants attended in groups of six where they were asked questions about their background and why they were interested in the training. At this stage the researcher and program co-

ordinator answered any questions the participants had regarding the course. The major criteria used in deciding if applicants should be accepted were those established by France (1986) The criteria used were: the participants ability to be open and a commitment by the participants to the aims of the programs. In addition participants were screened for any behavioural or distracting behaviours that would detract from the training. Those people who required help were assisted in obtaining professional help. Only one of the participants did not meet this criteria therefore all of the remaining applicants were accepted on the course. Those people who expressed an interest in taking the course, but were for various personal reasons unable to, volunteered to be members of the control group. Other members of the control group were obtained by establishing a list of people who were interested in taking the next peer counsellor training course. The researcher was not able to randomly assign subjects to the control group because the organization that funded the program decided they would allow everyone that was interested in taking the course to take it at this time as long as they met the screening criteria. Since the funding institute did not know when and if they would be able to finance a second training program, they decided it was better to accept all those who were interested in taking the course even though it would entail a larger class size.

## Definition of Terms

### Peer Counsellor

In this study, peer counsellor refers to the older person (age 55 and over) who is trained in peer counselling techniques and the processes and problems of aging so that he/she may provide counselling assistance to his/her peers.

### Peer counselling techniques

Techniques, behavioural traits or qualities that facilitate effective interaction with a client. Such techniques include paraphrasing, reflection of feelings, empathy, active listening, problem solving, confrontation and self disclosure.

### Trainers

For the purpose of this study, trainers were those individuals with experience in organization, counselling and practical communication skills whose task it was to instruct the peer counsellor trainees.

### Empathy

Experiencing and communicating one's understanding of the other person's experience.

### Active listening

Listening carefully to what another person is saying with their verbal and non-verbal behaviour.

### Elderly

For the purpose of this study, elderly persons are defined as men or women 55 years of age and older. This word is used interchangeably with the words senior and aged.

## Instrumentation

### Continuum Center Questionnaire (CCQ)

The Continuum Center Questionnaire (CCQ) was prepared by the Continuum Center, Oakland University, Rochester, Michigan (Ganikos, 1979). The questionnaire was designed to measure the elderly trainee's ability to retain and apply peer counselling skills. In this study it was used as both a pretest and posttest to collect data for assessing the counsellor's ability to apply peer counselling techniques. The instrument consists of five statements that elderly clients might make to a peer counsellor. For each statement the subject is asked to write what they think would be an appropriate and helpful response to the person making the statement. This is a written instrument that was filled out by subjects in both the control group and the experimental group. The primary skill that the CCQ measures is the counsellor's use of empathy or respect for the client and an understanding of the clients "world view". (See Appendix B for a copy of the Continuum Center Questionnaire). The scoring guidelines used to score the CCQ were devised by Alpaugh & Haney (1978) (See Appendix C for a copy of the scoring guidelines).

Carkhuff Empathy Rating Scale (CERS)

The Carkhuff Empathy Rating Scale (CERS) measures empathic understanding in interpersonal processes. The scales range from the lowest level (level 1), in which the counsellor appears to be unaware of even the most obvious surface feelings of the client, to the highest level (level 5), in which the counsellor accurately perceives and relates his or her understanding of the client's deepest feelings. Level 3 indicates the minimal level of facilitative interpersonal functioning. This scale reports rate-rerate reliabilities between r=.80 (Anthony, 1971), and r=.94 (Carkhuff, 1970). The CERS was used as an additional measure to measure the subject responses on the Continuum Center Questionnaire. A copy of the CERS is included in Appendix D.( See Appendix E for an example of the use of the CERS.)

## Scoring Procedures

Scoring procedures for the CERS are included with the description of the instrument in Appendix D. In scoring the CCQ, the subject's responses were rated on a scale of 1-3 (Alpaugh & Haney, 1978). The following standards were used: Level 1 implies that the client is somehow "Not OK". A counsellor who gives a Level 1 response does one or more of the following:

a) She/he does not respect the clients feelings.

b) She/he implies that the client should not be feeling what

she/he is feeling.

c) She/he puts the client down.

d) She/he comes up with quick solutions or advice.

e) She/he responds in a sarcastic, unfeeling manner.

f) She/he shows little respect for the clients world-view.

Level 2

A reponse that shows repect for the client and his/her world-view. A counsellor who gives a level 2 response does the following:

a) She/he responds to the stated feeling or content in an accepting manner.

b) His/her verbal behaviour is attentive to the client.

Level 3

A response which is not only respectful of the client, but also encompasses the client's world-view.

a) Counsellor responds to the stated feelings and notes the undercurrents implicit in the client's statements.

b) Counsellor emphasizes the intensity of the speaker's feelings by words that accent feelings.( See Appendix C)

## Procedure

### Data Collection

Because 16 participants were selected to receive the training the researcher also solicited a similar number of

participants to act as the control group. The control group consisted of seniors who were interested in taking the peer counsellor training but were either unable to spare the time to take this course or were late in registering. Before the training program started, members of both the experimental and control group were given an interview by the researcher to explain the nature of the study. At this time the participants were asked to sign a voluntary consent form informing them of the voluntary nature of their participation, their right to withdraw at any time, and the fact that their individual results would be kept confidential and used for research purposes only ( See Appendix F for a copy of the consent form). Subjects were also given the opportunity to indicate whether they would like to be contacted when the results of the study are available. The researcher then asked the subjects to fill out the Continuum Center Questionnaire. To ensure confidentiality the participants were asked not to fill in their names, but instead to code their papers. Participants were given a number assigned by the researcher who then kept their corresponding names in a confidential place. After the completion of the training program, the same process was repeated for both the experimental and control group.

## The Training Program

The peer counsellor training program that was

investigated in this study is the program designed by France (1985). The training model used stresses the practical and the applied. There are three components to this training program: communication skills, practicum, and inservice training. As indicated in Figure 2, the first two phases of the program consisted of tweenty sessions of 2 hours duration. The inservice training phase is flexible as it can consist of as many sessions as the training program requires.

Phase 1 consisted of communication skills training stressing increased self awareness; development of skills in effective communication; discrimination of the levels of communication and an understanding of when to use communication skills (France, 1986). The sessions dealt with the attending skills, empathy, empathy blocks, questioning, self disclosure, meaning, concreteness, confrontation and problem solving (See Figure 3 for a detailed description of Phase 1).

Phase 2 was the practicum phase. In this phase trainees were given instructions in administrative aspects of the peer counselling process such as ethical considerations and referral techniques. The trainees were then assigned a helpee or client whom they would counsel. The trainees received supervision and further instruction as they continued to meet with other trainees on a weekly basis. These weekly meetings served as an opportunity for the trainees to discuss problems and answer questions (See Figure 4 for a detailed description

of this phase).

The third and final phase of the training program was the inservice training phase. In this phase the peer counsellors were given additional skills and information relevant to the issues and problems common to the elderly population. The number of sessions taught in this phase were flexible and depended on the needs of the trainees. Sessions dealt with health considerations such as nutrition, fitness, first aid and stress management. Sessions also dealt with issues and problems common to the elderly population such as loneliness, bereavement and depression. The inservice phase also made allowance for the inclusion of additional skill training in summarizing, terminating and advanced problem solving.

The method of instruction for the various skills in this training program followed the single skill approach. Counselling skills were taught one at a time with the presentation of the skill by the instructor, followed by the modelling or demonstration of the skill; feedback on the skill by both the instructor and the trainee; and finally, practice by the trainees and additional feedback. In addition, trainees were asked to complete self testing questions and homework assignments based on homework assignments preceeding each skill. (See Figure 5). This teaching approach is based on Ivey's Microcounselling approach (Ivey, 1971).

## Trainers

The trainers for this program consisted of Dr. Honore France and four assistants. Included in this team was a very experienced peer counsellor who was also a senior. The researcher did not assist in any phase of the training program.

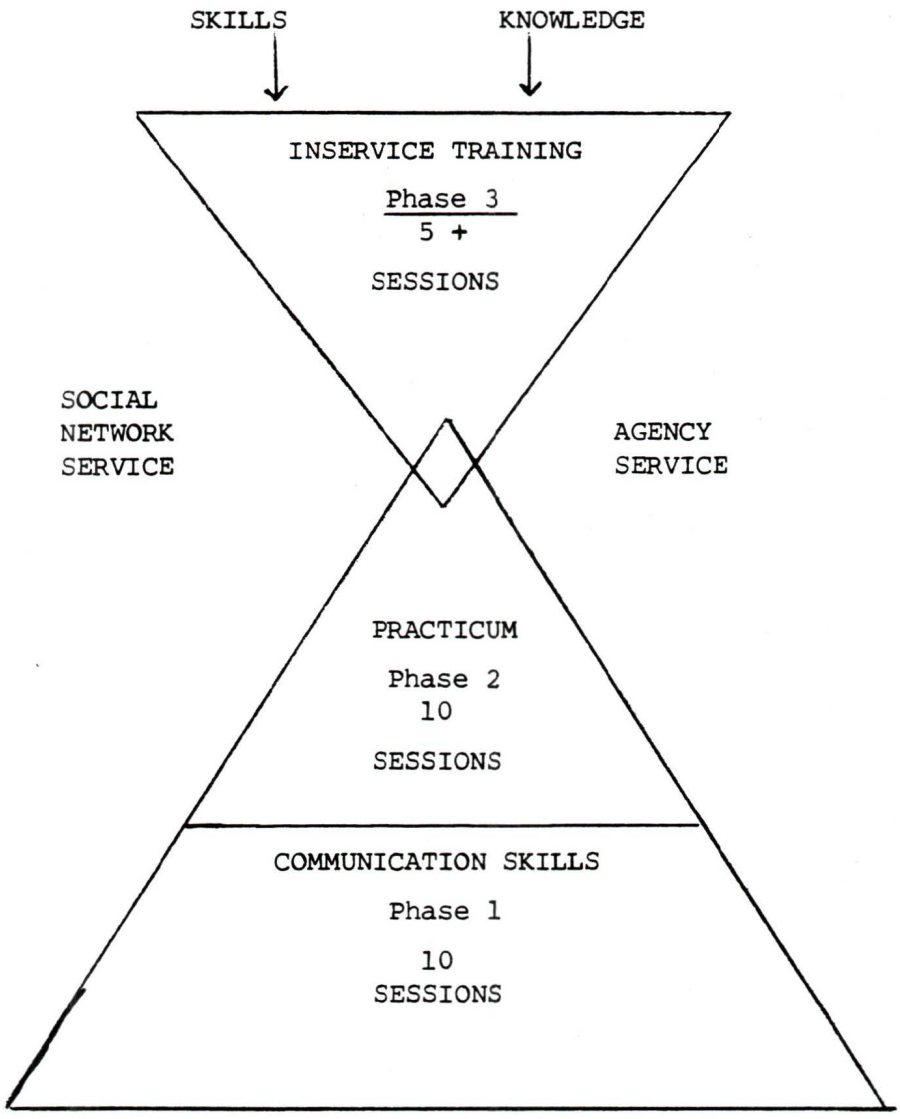
Figure 1

Three Part Peer Counsellor Training Model

| Phase | Content |
|---|---|
| Communications | Attending skills, Empathy, Questioning, Self Disclosure, Confrontation, Problem Solving |
| Inservice/Administrative | Normal processes and problems of aging, Referral procedures, Confidentiality, Ethical Issues |
| Practicum | Supervised practical experience in counselling others. |

Figure 2

Training Model *




* (France, 1986)

Figure 3

Training Program - Phase 1 *

| SESSION | TOPIC | ACTIVITY | T | ACTIVITY | T | ACTIVITY | T |
|---|---|---|---|---|---|---|---|
| 1 | Introduction | 1.1 Lecturette: Training Model | 10 | 1.2 Experiential: Getting acquainted | 40 | 1.3 Lecturette: The helping process | 20 |
| 2 | Attending Skills | 2.1 Experiential: Communication Cues | 25 | 2.2 Discussion: Nonverbal Communication | 25 | 2.3 Experiential: Practice Attending Skills | 50 |
| 3 | Empathy/-Blocks | 3.1 Lecturette: Empathy: Introduction | 15 | 3.2 Model: Empathy | 10 | 3.3 Practice: Empathy | 60 |
| 4 | Empathy and Feedback | 4.1 Lecturette: Empathy: Review | 5 | 4.1 Experiential: Round Robin | 30 | 4.1 Practice: Empathy | 50 |
| 5 | Questioning | 5.1 Experiential: Differences/Similarities | 20 | 5.2 Lecturette: Effective Questioning | 20 | 5.2 Model: Questioning | 10 |
| 6 | Self-Disclosure | 6.1 Experiential: I have to/I choose to | 20 | 6.1 Lecturette: Self-Disclosure | 20 | 6.1 Model: Self-Disclosure | 10 |
| 7 | Meaning | 7.1 Experiential: Something Meaningful | 20 | 7.2 Lecturette: Meaning | 20 | 7.2 Model: Meaning | 10 |
| 8 | Concreteness | 8.1 Experiential: Sharing | 20 | 8.1 Lecturette: Concreteness | 20 | 8.2 Model: Concreteness | 10 |
| 9 | Confrontation | 9.1 Lecturette: Confrontation | 20 | 9.1 Experiential: Self-Confrontation | 20 | 9.1 Model: Confrontation | 10 |
| 10 | Problem-Solving | 10.1 Lecturette: Problem-Solving | 20 | 10.2 Model: Problem-Solving Steps | 15 | 10.2 Practice: Problem-Solving | 65 |

* (France, 1986)

Figure 4

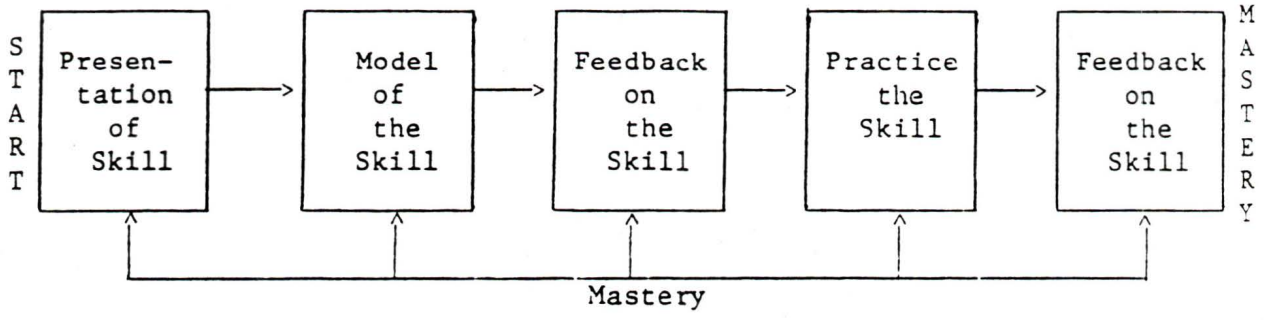
Training Program - Phase 2 *

| SESSION | TOPIC | ACTIVITY | ACTIVITY | ACTIVITY | ACTIVITY |
|---|---|---|---|---|---|
| 11 | Background | 11.1 Experiential: Positive Assets | 11.2 Lecturette: Overview | 11.3 Model: Beginning | 11.3 Practice: Beginning a Relationship |
| 12 | Ethics | 12.1 Lecturette: Guidelines | 12.2 Discussion: Brainstorming | 12.3 Experiential: Dilemmas | |
| 13 | Referral | 13.1 Discussion: Code of Ethics | 13.2 Lecturette: Making Referrals | 13.2 Model: Making Referrals | 13.3 Practice: Making Referrals |
| 14 | Case Study | 14.1 Presentation: Case | 14.2 Model: Case | 14.2 Practice: 1 Case | 14.2 Discussion: Feedback |
| 15 | Case Study | ----------> | ----------> | ----------> | ----------> |
| 16 | Case Study | ----------> | ----------> | ----------> | ----------> |
| 17 | Case Study | ----------> | ----------> | ----------> | ----------> |
| 18 | Case Study | ----------> | ----------> | ----------> | ----------> |
| 19 | Case Study | ----------> | ----------> | ----------> | ----------> |
| 20 | Case Study | ----------> | ----------> | ----------> | ----------> |

* (France, 1986)

Figure 5

Single Skill Model *




* (France, 1986)

## Selection and Training of the Raters

Raters were chosen on the basis of their knowledge of counselling skills and their familiarity with the use of rating scales in conducting research in counselling. For this reason two students were chosen from the Counselling program of the Faculty of Education, University of Victoria. One female student in her second year of her Master of Arts program and a male student who had just completed his Master of Arts degree in Counselling were chosen.

In an effort to ensure maximum interrater reliability, training followed the Systematic Rater Training Model ( Wilson , 1982). This training consisted of 9 steps:

1. Step 1- Raters were given a brief overview of the study and their role.
2. Step 2- The concepts of the rating scales to be used were presented.
3. Step 3- Raters were encouraged to become personally involved in the rating tasks.
4. Step 4- The researcher modeled the target behaviour of the raters.
5. Step 5- The raters individually practiced identifying the attributes to be rated in an effort to reduce evaluation apprehension.
6. Step 6-The raters practiced rating in the presence of the researcher who gave them public feedback following each

trial.

7. Step 7- The raters practiced rating in the presence of the researcher who gave them public feedback only after several samples were rated.

8. Step 8- Raters practiced rating tasks working under the same conditions they would experience when the real ratings were conducted.

9. Step 9- After the raters had rated one half of the data, the data were collected by the researcher and feedback was given to them regarding their individual and collective performance.

## Interrater agreement

Interrater agreements of 89%, 79%, 95%, and 95% were obtained for the pretest CCQ, pretest CERS, posttest CCQ and posttest CERS scores, respectively.

# CHAPTER V

## RESULTS

A series of SPSSX one-way Analysis of Variance tests were conducted to test for the treatment effects on the subjects CCQ and CERS scores. This was done by conducting ANOVA's between experimental and control groups for all pretest and posttest measures. The ANOVA results indicated nonsignificant effects for the pretest scores with significant effects for the posttest scores. Specifically, the ANOVA results indicated nonsignificant effects for the pretest administration of the CCQ: $F(1,34)= .550$, $p<.463$ (See Table 1). Nonsignificant effects were also indicated for the pretest administration of the CERS: $F(1,34)= .805$, $p<.376$ (See Table 2). The ANOVA results did, however, indicate significant treatment effects for the posttest administration of the CCQ: $F(1,31)= 21.082$, $p<.0001$ and for the posttest administration of the CERS: $F(1,31)= 30.103$, $p<.0001$ (See Tables 3 & 4).

Table 5 illustrates the change in the means and standard deviations of the CCQ and CERS ratings for both the pretest and posttest conditions of the Experimental and Control Group. The scores presented represent the pooled empathy scores for 2 raters for each subject. Inspection of the means indicated that subjects in the experimental group received scores higher than the control group on both the postest administration of the CCQ and the CERS. A T test of the

change of the Pretest and Posttest difference scores showed that for both measures the difference of the differences is statistically significant beyond the .001 level. Both Table 5 and Figure 6 indicate that although significant change occured in the mean scores of the experimental group, no significant change was noted in the mean scores of the control group.

An additional analysis of the pretest mean scores of the three subjects that dropped out of the study compared with the pretest mean scores overall was conducted for both the subjects CCQ and CERS scores. Inspection of the means indicates no significant differences.

Table 1

Analysis of Variance of Pretest CCQ by Group

| Source | SS | df | MS | F |
|---|---|---|---|---|
| Between Conditions | 4.89 | 1 | 4.89 | .55a |
| Within Conditions | 293.00 | 33 | 8.88 | |
| Total | 297.89 | 34b | | |

a $p>.25$

b $n = 35$

Table 2

Analysis of Variance of Pretest CERS by Group

| Source | SS | df | MS | f |
|---|---|---|---|---|
| Between Conditions | 12.11 | 1 | 12.11 | .38a |
| Within Conditions | 496.86 | 33 | 15.06 | |
| Total | 508.97 | 34b | | |

a $p>.25$

b $n = 35$

Table 3

Analysis of Variance of Posttest CCQ by Group

| Source | SS | df | MS | f |
|---|---|---|---|---|
| Between Conditions | 472.23 | 1 | 472.23 | 21.08a |
| Within Conditions | 671.99 | 30 | 22.40 | |
| Total | 1144.22 | 31b | | |

a $p<.0001$

b $n = 32$

Table 4

Analysis of Variance of Posttest CERS by Group

| Source | SS | df | MS | F |
|---|---|---|---|---|
| Between Conditions | 1260.40 | 1 | 1260.40 | 30.10a |
| Within Conditions | 1256.07 | 30 | 41.869 | |
| Total | 2516.47 | 31b | | |

a $p<.0001$

b $n = 32$

Table 5a and 5b

Change of Means and Standard Deviations on CCQ and CERS measures of empathy.

Table 5a

Change on CCQ measure of empathy

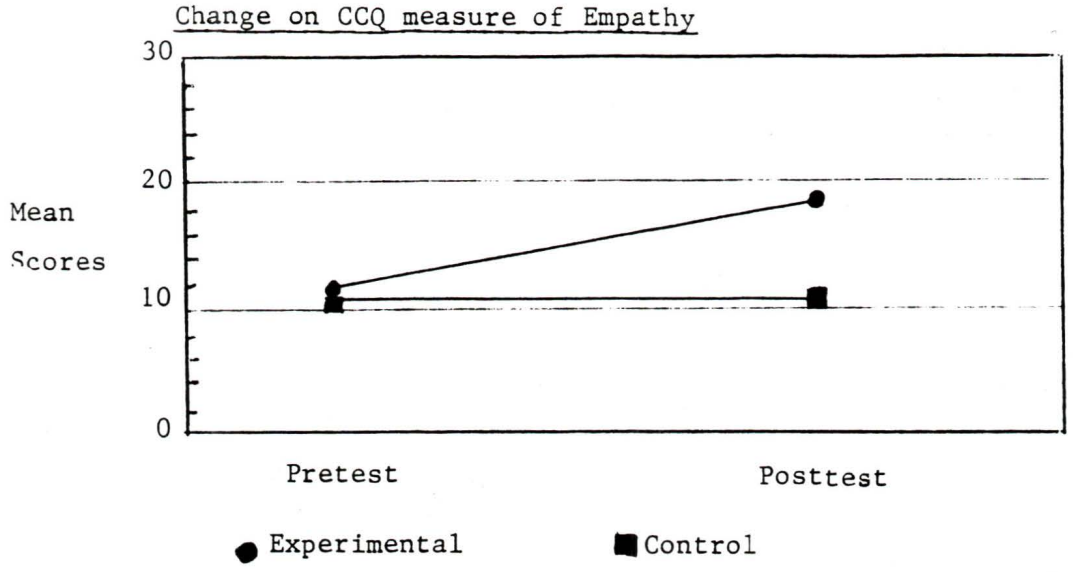
| | | Pretest | Posttest |
|---|---|---|---|
| Experimental | X | 11.75 | 18.93 |
| | SD | 2.93 | 6.17 Control |
| | X | 11.00 | 11.24 |
| | SD | 3.01 | 2.95 |

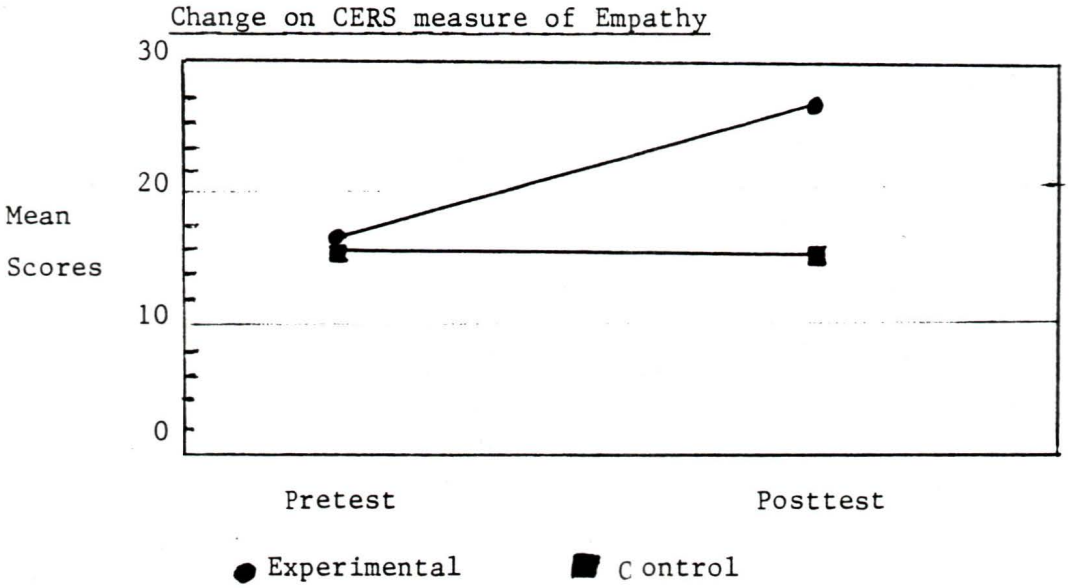
Table 5b Change on CERS measure of empathy

| | | Pretest | Posttest |
|---|---|---|---|
| Experimental | X | 17.81 | 27.40 |
| | SD | 3.06 | 7.73 Control |
| | X | 16.63 | 14.82 |
| | SD | 4.45 | 5.13 |

Figure 6

Changes on Mean Scores of Pretest and Posttest CCQ and CERS measures of Empathy for Experimental and Control Group



# CHAPTER VI

## DISCUSSION

This chapter discusses the results of the study and the conclusions based on those results. The limitations of the study and recommendations for future research are also adressed.

The purpose of this study was to examine one peer counsellor training program and determine whether it provided the means by which seniors could learn to become effective peer counsellors. For the purpose of this study , effectiveness was measured by the trainees' ability to learn and apply the skill of empathy.

An analysis of the results of this study supported the hypothesis that there would be an ordered difference in the use of empathy between subjects who had peer counsellor training and those subjects who did not have the peer counsellor training program.The results also supported the prediction that demonstration of empathy for those subjects who received the peer counsellor training would be greater than for those subjects that did not receive the training. These results are consistent with the findings of France and Gallagher (1984), with the exception that in the present study the Continuum Center Questionnaire was used instead of the Hills Response Category System. Other differences are that the present study utilized a control group and dealt with non-institutionalized elderly and utilized approximately

15 subjects in each group as opposed to only 6. Although there were originally 16 subjects in the experimental group and 19 in the control group, two subjects dropped out of the control group and one subject dropped out of the experimental group leaving 15 in the experimental group and 17 in the control. An analysis of the pretest scores of those subjects who dropped out of the study indicated no significant difference from the scores of the other subjects in the study. These scores were examined to ensure that those subjects who dropped out of the study did not do so because they found the training program/testing to be too difficult or too easy.

One of the major goals of the peer counsellor training program was to teach the elderly trainees to use the skill of empathy. The results of this study indicate that the training program was successful in fulfilling this goal. The present study therefore, lends support to the contention that seniors are capable of learning the core facilitative skills necessary to counsel their peers and that peer counsellor training programs are an effective way to teach these skills to seniors. The implication of the results of this study to the field of counselling is that there now exists further support to the idea that peer counsellor training for seniors is an effective way of enabling seniors themselves, to help bridge the gap between the counselling needs of the elderly and the acceptable counselling resources available to them.

## Limitations

The primary limitation of this study is that there were no observations made of the subject's counselling performance with real clients. Such observations were not conducted because of the time and expense required to use this method. The use of written measuring instruments were thought to not only be faster and less costly, but also less intrusive and more confidential.

A second limitation of this study concerns the sex ratio of the subjects involved in the study. Since there was only one male subject in the experimental group and three in the control group the vast majority of the subjects were female. Although this is somewhat indicative of the female majority in the elderly population (Abrams, 1981), this is still a disproportionately high female sample of the elderly population. One possible explanation for this ratio is that women are more likely then men to participate in a course of this nature.

A third limitation of this study concerns its limited generalizability. Since this study only examined one peer counsellor training program for the elderly, caution must be used in applying it generally to other training programs as they may vary somewhat in their goals and structure. As the idea for peer counsellor training for seniors matures, there will probably be a movement towards standardizing the training courses on either a regional or national basis. Such standardization would simplify the generalizability of future

effectiveness studies.

A fourth limitation of this study is that the study only examined the increase in the trainee's use of empathy. The study did not examine the effect that the peer counsellor graduates have on the clients whom they counsel nor did the study examine questions such as whether peer counselling is an effective way of reducing costly institutionalization of the aged. Such issues will hopefully be addressed in future studies.

A fifth limitation of this study is that the researcher was unable to randomly assign subjects to the different treatment conditions. The experimental and control were therefore different in that the experimental group consisted of those subjects who had the time to take the training program whereas the control group consisted of those subjects who either did not have the time to take the training or were late in registering.

A final limitation of this study is that the recently added phase of the training program entitled "Inservice training" was not evaluated in this study due to time limitations. It is not known whether this final phase would add or detract from the counselling performance of the trainees. As the purpose of the inservice training phase is to familiarize the trainees with the common concerns and issues affecting the older population the addition of this phase should only result in providing more informed and

capable peer counsellors.

## Recommendations for future research

The following recommendations are based upon the findings of this study. The findings of this study have confirmed previous findings that elderly peer counsellor trainees can learn core facilitative skills such as empathy and that peer counsellor training programs seem to be an effective means of training seniors to learn those skills.

Future research investigating the effectiveness of these training programs might use measuring instruments that more closely resemble an actual counselling situation. It would be advantageous if such instruments/methods also tested for the presence of other skills or knowledge that the training program is attempting to teach to the trainees. It might be relatively simple to test for knowledge of the elderly issues and concerns that represent the goal of the inservice phase of the present training program.

It is important to note that the present study only examined the effect which the peer counsellor training had on the elderly trainees. It did not examine the effect that the peer counsellor graduates have on the clients whom they counsel. This is an important need for future research to address.

Although the trainees did improve in facilitative skills such as empathy it is important to look at the long range

effects of this training. Longitudinal and replication studies could be conducted to examine the long term effects, reliability and stability of this training on the trainees. Similar longitudinal and replication studies could also be conducted to examine the long range effects, reliability and stability of peer counselling on the clients who received such counselling.

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# APPENDIX A
## Information provided in Peer Counselling Brochure

## Information contained in peer counselling brochure

PROJECT MOTTO: "The best way to help yourself is to help others"

Rationale

1. There is a need to train more peer helpers (i.e. In Victoria Seniors Serving Seniors and Long Term Care have requested peer counsellor volunteers);
2. It promotes the notion of self help among older people;
3. It brings more older volunteers into the helping continuum; and
4. There is a demand for the training from talented older people who want to be helpful.

How It Works

The peer counselling concept is based on the notion that older people generally seek out other older people for help when they are experiencing frustrations, worries, or other problems. The peer counsellor is someone who is willing to listen and talk to others about their thoughts and feelings and genuinely cares about others. A peer counsellor uses communication skills to facilitate self-exploration, values clarification, and decision making. The peer counsellor can work wihin his/her social network or work within a social agency as a volunteer. For example, a peer counsellor can assist a long term care assessor by doing follow-up visits

with an older person who needs supportor who is fearful or lonely. As a trained volunteer, the peer counsellor knows his/her limitations and is a referral agent. In essence the peer counsellor is a powerful role model who uses the preventative approach.

## Theoretical Base of Peer Counselling With Older People

Logotherapy, developed by Viktor Frankl, is the theoretical basis for the training of older people as peer counsellors. Logotherapy comes from the greek "Logos" denoting meaning, which views the search for meaning as the basic human motivator. This idea is conceptualized by Nietzche: "He who has a why to live for can bear with almost any how". Meaning underlies behaviour, thoughts and feelings. For example, an older person may feel sad, because retirement means a loss of doing something meaningful and productive in life. The effective peer counsellor, using reflection of meaning, explores the value of work before retirement. Afterwards, the peer counsellors help explore ways for achieving meaning and meeting needs in retirement.

## Training Model

The training utilizes an active approach to skill development. The microcounselling approach consists of the following steps: presentation of the skill; modelling of the skill; practicing the skill; feedback on the skill; and doing

homework assignments.

Training Components

Phase 1 -Communication Skill: 10 two hour sessions

Goals: 1. To increase self-awareness;

2. To develop effective helping skills; and

3. To integrate the helping skills into the peer counsellor's unique helping style.

Synopsis: This phase focuses on the skills of non-verbal attending, empathy, effective questioning, self disclosure, reflection of meaning and problem solving. Active learning is emphasized ( i.e. learning by doing as opposed to the didactic approach).

Phase II - Practicum: 10 two hour sessions

Goals: 1. To provide the opportunity to apply the skills by working in a supervised practicum;

2. To develop a code of ethics for working with peers; and

3. To develop the skill of utilizing a computerized information system.

Synopsis: The importance of working within a code of ethics and being a referral agent is stressed, along with continual emphasis on integrating the helping skills in Phase 1. Trainees are assigned someone (helpee) who they will work with under supervision.

# APPENDIX B

## Continuum Center Questionnaire

CONTINUUM CENTER QUESTIONNAIRE

Exercises in Communication*

Name (code name) : _____ Date:_____

The following are five statements which you should assume are made to you by other persons. For each statement, your task is to write what you consider to be an appropriate and helpful response to the person.

1. I retired last year and have nothing to do. I can't go back to work. I don't have enough money to really do what I would like to do, so I just hang around. My wife says I depress her.

WRITE WHAT YOU WOULD SAY.

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2. It seems that everyday I get up, and something else goes wrong. My back aches more, I don't have as much pep as I used to have. Time just drags, just doing the dishes takes half my day.

52 WRITE WHAT YOU WOULD SAY.

---

---

3. My children are all away from home and they stay in

touch, but not very often. My husband died last year, and I am all alone. No one seems to care.

WRITE WHAT YOU WOULD SAY.

---

---

4. My wife and I are having marital problems. I never thought that after 42 years of marriage and five children I could think of getting a divorce; but I'm just not happy anymore.

WRITE WHAT YOU WOULD SAY.

---

---

5. My doctor just told me I have to go into the hospital for a hysterectomy. I'm worried that at my age I won't recover, that I'll never leave the hospital. WRITE WHAT YOU WOULD SAY.

---

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* Continuum Center, Rochester Michigan

(Ganikos, 1979)

# APPENDIX C

## Scoring guidelines for Continuum Center Questionnaire

SCORING GUIDELINES FOR CONTINUUM CENTER QUESTIONNAIRE

LEVEL I

Implies that the client is somehow "not ok". A counselor who gives a level 1 response does one or more of the following:

a) She/he does not respect the client's feelings.

b) She/he implies that the client should not be feeling what she/he is feeling.

c) She/he puts the client down.

d) She/he comes up with quick solutions or advise.

e) She/he responds in a sarcastic, unfeeling manner.

f) She/he shows little respect for the client's world-view.

LEVEL II

Is a response that shows respect for the client and his/her world view. A counselor that gives a level II response does one of the following:

a) She/he responds to the stated feeling or content in an accepting manner.

b) His/her verbal as well as non-vernal behaviour is attentive to the client.

LEVEL III

Is a response that is not only respectful of the client, but also encompasses the client's world-view.

a) Counselor responds to the stated feelings and notes the undercurrents implicit in the client's statements. b)

Counselor emphasizes the intensity of the speaker's feelings by his/her tone of voice, gestures and words which accent feelings.

c) Counselor responds to non-verbal cues from the client.

EXAMPLE

Client: "I don't know. It seems now that Bill has gone there's just nothing to live for. We didn't have that many freinds, and most of the ones we did have passed on. I don't want to be dependant on my daughter. She's got to have a life of her own. I just don't know".

Counselor Response:

Level I : "Why don't you join a Senior Citizen's Club?" Level II: "You must be very lonely."

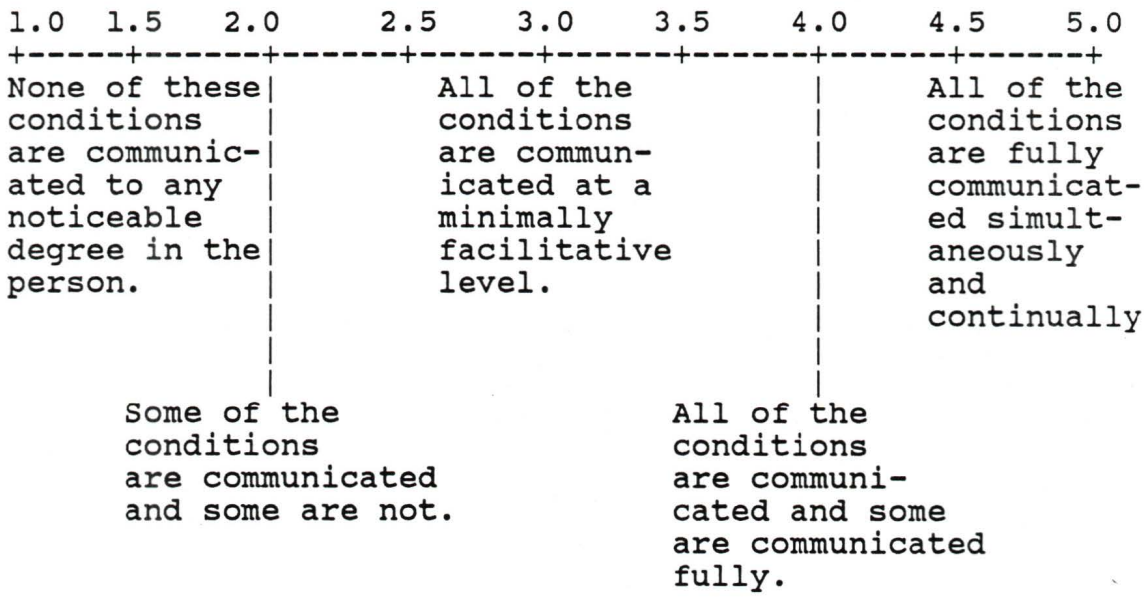
Level III: "You are feeling a great deal of loss from your husband's death. It must be difficult for you to know what to do next."

* (Alpaugh & Haney, 1978)

# APPENDIX D

## Carkhuff Empathy Rating Scale

CARKHUFF EMPATHY RATING SCALE *




* (Carkhuff, 1969)

# APPENDIX E

## Example of the use of the CERS

EXAMPLE OF THE USE OF THE CERS*

Examples of five levels of empathy in response to a client:
Client: I don't know what to do. I've gone over this problem again and again. My husband just dosen't seem to understand that I dont really care anymore. He just keeps trying but it dosen't seem worth bothering with him anymore.

Level 1 Counselor (Subtractive) : That's not a very good way to talk. I think you ought to consider his feelings too.

Level 2 Counselor (Slightly subtractive): Seem's like you've just about given up on him. You dont want to try anymore.

Level 3 Counselor (Basic empathy or interchangeable response): You're discouraged and confused. You've worked over the issues with your husband, but he just dosen't seem to understand. At the moment, you feel he's not worth bothering with. You don't really care.

Level 4 Counselor (Slightly additive): You've gone over the problem with him again and again to the point you don't really care right now. You've tried hard what does this all mean to you?

Level 5 Counselor (Additive): I sense your hurt and confusion and that right now you really don't care anymore. Given what

you've told me, your thoughts and feelings make a lot of sense to me. At the same time, you've had a reason for trying so hard. You've talked about some deep feelings of caring for him in the past. How do you put that together right now with what you are feeling?

* (Ivey, 1983)

# APPENDIX F
# Informed Consent Form

INFORMED CONSENT FORM

I understand that the purpose of this study is to learn more about the effectiveness of peer counsellor training for the elderly.

I understand that I may withdraw my consent and discontinue my participation at any time during the course of this study.

I understand that all of my written or oral responses will remain confidential and will only be used for the purposes of this study.

I wish to give my co-operation as a subject in this study.

SIGNED: _____

DATED: _____

# VITA

Surname: McCormick Given Names: Roderick Michael

Place of Birth: Sudbury, Ontario Date: 31 May, 1959

Educational Institutions Attended, with dates of entering and leaving:

| | |
|---|---|
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| Queens University, Kingston, Ontario | 1980 to 1981 |
| University of Victoria, British Columbia | 1982 to 1986 |

Degrees, Diplomas, Etc., with Dates and Names of Institutions:

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Bachelor of Education, Queens University, 1981

Ontario Teachers Certificate , 1981

British Columbia Teachers Certificate, 1982

Honors and Awards:

N/A

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The Impact of Peer Counsellor Training for the Aged on the Communication of Empathy

Author [redacted]
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Name

June 20, 1986
Date