HOUSTON TRAINING
FOR PEER LEADERS

Peers for Progress
Peer Support Around the World
University of North Carolina at Chapel Hill
Peers for Progress was founded in 2006 to promote peer support as key part of health, health care, and prevention around the world. Our mission is to accelerate the availability of best practices in peer support.

Peers for Progress works to demonstrate the value of peer support, extend the base for such interventions, help establish peer support as an accepted core component of health care, and promote peer support programs and networks on a global scale. We are continually expanding a global network of peer support organizations to address the needs of various chronic diseases, health risks, and other conditions that require ongoing health care and sustained behavior change.

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www.peersforprogress.org
@peers4progress
Part A. Training Overview

- Training Agenda
- Training Objectives & Evaluation

Day 1: Basics and Skill Development

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Details</th>
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<tbody>
<tr>
<td>10:00 – 10:30</td>
<td>Welcome and Introductions</td>
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<tr>
<td>10:30 – 11:30</td>
<td>Diabetes Self-Management Basics</td>
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<tr>
<td>11:30 – 12:15</td>
<td>Overview of Peer Support</td>
<td>- What is Peer Support?</td>
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<td>- Small Group and General Discussion:</td>
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<td>- How do you think you may be helpful as a peer supporter?</td>
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<td>- How peer support fits into overall diabetes management</td>
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<td>- Objectives of the training</td>
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<tr>
<td>12:15 – 1:00</td>
<td>Lunch</td>
<td>- Day in the Life video</td>
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<td>1:00 – 2:15</td>
<td>Program Examples &amp; Guiding Principles of Peer Support</td>
<td>- Program examples</td>
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<td>- Guiding principles in day-to-day work</td>
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<td>- Best practices</td>
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<td>- Q&amp;A</td>
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<tr>
<td>2:15 – 3:30</td>
<td>Communication 101</td>
<td>- Communication 101 - Dos and Don’ts</td>
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<td></td>
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<td>- Basic principles of active listening</td>
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<td>- Several role plays and practice</td>
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<td>- Story Telling – Useful but Tricky (&quot;It’s not about me&quot;)</td>
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<td>3:30 – 4:00</td>
<td>Roles of Peer Support Recap and Conclusion</td>
<td>- Developing Trust and Respect</td>
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<td>- Confidentiality and Personal Privacy</td>
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## Day 2: Peer Support Skill Development

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<tr>
<th>Time</th>
<th>Topic</th>
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<tbody>
<tr>
<td>10:00 – 11:15</td>
<td>Assisting Self-Care Behaviors</td>
<td>▪ Assisting Self-Care Behaviors</td>
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<td>▪ Setting Goals</td>
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<td>▪ Guiding Problem-Solving</td>
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<td>▪ Action planning in a group-based PS setting</td>
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<td>▪ Role Play and Practice</td>
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<tr>
<td>11:15 – 12:00</td>
<td>Providing Emotional Support</td>
<td>▪ Signs of emotional distress/depression</td>
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<td>▪ Referrals for serious mental health needs</td>
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<td>▪ Role Play and Practice</td>
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<tr>
<td>12:00 – 12:45</td>
<td>Lunch</td>
<td>▪ Linkages to local resources</td>
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<td>▪ Houston Facebook group</td>
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<td>▪ Houston Field Guide</td>
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<td>12:45 – 2:15</td>
<td>Supervisors (45 minutes for split-up groups; 45 minutes combined)</td>
<td>▪ Getting started (Group 1 – new to PS)</td>
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<td>▪ Checklist before getting started</td>
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<td>▪ The first month of a program</td>
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<td>▪ Supervision and monitoring</td>
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<td>▪ Documentation and data collection</td>
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<td></td>
<td></td>
<td>▪ Sharing lessons learned and consultation for trouble shooting (Group 2 – experienced)</td>
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<td>▪ Combined groups</td>
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<td>▪ Supervision and backup</td>
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<td>▪ Programmatic action plans - identifying one specific area/step to focus on during the next month</td>
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<td>▪ Discuss how TA, networking might best be arranged going forward</td>
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<td>2:15 – 2:30</td>
<td>Houston Resources</td>
<td>▪ The Peer Supporter’s Best Friend: the Houston Diabetes Resource Center</td>
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<td>2:30 – 3:00</td>
<td>Wrap-up together</td>
<td>▪ Additional information in the training manual</td>
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<td>▪ Resources available from PfP</td>
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<td>▪ What are we going to do next?</td>
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<td>▪ Reflections from the training</td>
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</table>
Training Objectives & Evaluation

The objectives of the training are to teach individuals a) general skills with which they could participate as peer leaders in a peer support program, and b) to find an opportunity to use the skills they have learned through (better) connecting with a stakeholder organization with which they are already affiliated.

For the stakeholder organizations participating in the training, the training also aims to provide some programmatic basics and resources to help start or strengthen a peer support program, as well as to facilitate strategic thinking in terms of identifying concrete next steps for implementation and program development.

The instructional methods include short lectures, group brainstorming and sharing, as well as role-plays. During the process, the trainees will receive feedback on their performance and have opportunities for Q&A.

A Note to You, the Participant: Remember that even after this training, it is normal to feel nervous before getting started with your participants. However, be assured that we do not expect you to have all of the answers or do everything correctly the first time around. During the training, you will also learn about local resources in Houston and get to know organizations that are part of the Houston Peer Support Network. We will also discuss what ongoing networking among trainees and programs might be helpful for continued development of individuals’ skills and peer leader programs. The most important thing is that you are dedicated to continue learning and improving your skills.
Part B. Peer Support Basics

- Definition of Peer Support
- Definition of a Peer Leader
- Guiding Principles

Definition of Peer Support

What is Peer Support?
Peer support is support from a person who has lived experience with diabetes, usually through having diabetes or a close friend or relative with the disease. People who have gone through the same challenges and successes have a unique perspective and understanding of diabetes. These experiences are very valuable for others that may need help with their diabetes.

Peer support is frequent, ongoing, accessible and flexible. It can take many forms – phone calls, text messaging, group meetings, home visits, going for walks together, and even grocery shopping. It complements and enhances other health care services by creating the emotional, social and practical assistance necessary for managing the disease and staying healthy. Peer support works. People get healthier, feel better, feel better about themselves, and stay out of the hospital. It may start with something specific like quitting smoking or managing a disease, but it often spreads to doing lots of things better and gaining greater satisfaction in life. It also provides the personal connection that helps people understand their health and feel they have a good relationship with their doctors and nurses.

Most of all, people like it. Talking with people who care about us and have some good experiences to share can feel pretty good. It feels especially good when it helps us do a better job with some health problem or challenge we face.

Definition of a Peer Leader

A peer leader is a trained non-professional who uses simple listening and problem-solving skills, in combination with learned knowledge and lived experience to assist people with their health concerns. Peer leaders are not healthcare professionals and do not replace existing clinical services. Rather, they provide the personal touch and experience and time to talk with people that are too often hard to find in health care.

Peer leaders help participants figure out how to eat healthy, exercise, take pills, and cope with stress in their daily living with diabetes. As one person with diabetes put it, “The doctors and nurses help me figure out what to do. The peer leader helps me figure out how to do it.” Peer leaders connect participants with healthcare and community resources. They help others stay motivated because healthy behaviors or lifestyle can “get old” for any of us. And sometimes just having someone to listen to their concerns can be a big help for those who need support.
Qualities of a Good Peer Leader

- **Has time** – The Special Advantage of Peer Leaders!
  - Natural ability to build rapport
  - Motivated to help others; caring and compassionate
  - Trustworthy and reliable
  - Open-minded and non-judgmental
- Good listener
- Resourceful
- Flexible but persistent; not pushy!
- Capable of self-directed work
- Able to partner with healthcare professionals and community organizations when needed

Peer Leader Ethics

- Respect individual differences, including choices people make
- Honor diversity in all its forms
- Maintain confidentiality
- Learn as much as possible about the issues that affect your participants
- Only offer information that you are qualified to offer and with the greatest accuracy
- Follow through on your word and promises
- Acknowledge when issues are outside of your scope of practice
- Obligated to report actual or potential harm to participants
- Set boundaries

Guiding Principles

Your effectiveness as a peer leader doesn’t come from “being an expert,” but someone who shares similar life experiences, meets people where “they’re at,” and is available, reliable and resourceful.

Key Skills for an Effective Peer Leader

<table>
<thead>
<tr>
<th>Skill</th>
<th>Description</th>
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<tbody>
<tr>
<td>Building trust and understanding</td>
<td>You are able to know the person and let them get to know you</td>
</tr>
<tr>
<td>Showing availability and reliability</td>
<td>“Being there” for participants is valuable in and of itself – Really, it is the base and core of all good peer support</td>
</tr>
<tr>
<td>Demonstrating empathy</td>
<td>Participants can sense that you have “walked in their shoes”, and you understand their feelings &amp; emotions</td>
</tr>
<tr>
<td>Keeping a contact very light and non-demanding</td>
<td>“Check-ins” not “Check-ups”</td>
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<tr>
<td>Sensitivity and good judgement</td>
<td>Know when to push and know when to back off.</td>
</tr>
<tr>
<td>Facilitating behavior changes</td>
<td>Help participants to identify something they can do and figure out how to try</td>
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</tbody>
</table>
Part C. Building Rapport

- Getting to Know the Person
- Developing Trust and Respect
- Confidentiality and Personal Privacy

Getting to Know the Person

Building rapport begins the moment that you first interact with your participants. In many cases, people just want to know that they are being heard and understood, not just as a person with a disease, but as a whole person.

Ask participants about their hobbies, children, sports, music, or interests to get them to open up. People like to talk about themselves so spend a few minutes to find out what they are proud of and what motivates them to get up in the morning. Along the way, be sure to share a bit of yourself. Especially take the opportunity to point out things you may have in common. In a one-on-one setting, depending on the schedule for your contacts and how quickly the person you are working with enters into talking with you, getting to know them may be the focus of the 2nd or 3rd time you talk, or it may just get included in a number of conversations. In a group setting, it may take a few sessions with ice-breaking activities for the participants to bond.

Example Questions for Making a Connection

- I’d like to get to know more about you. Tell me about yourself. (For some, this may be all you need to say)
- Are you from around here or did you grow up somewhere else?
- How long have you lived in Houston?
- Tell me about your family.
- What things do you like to do?
- What does the doctor tell you about __________?
- What are you doing to __________?
- What are your concerns about your diabetes?
- Living with diabetes is hard for lots of people. What are the ways that it has been hard for you?
### Applications to Different Settings

<table>
<thead>
<tr>
<th>Setting</th>
<th>Description</th>
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<tr>
<td><strong>Face-to-Face Groups</strong></td>
<td>Conducting brief introductions and a simple icebreaker can be helpful for building relationship. In the process, asking participants to work in groups can provide opportunities for them to better know and bond with one and another. You can use questions to energize conversation such as “finding something that you have in common that is not diabetes”, or “telling us about your dream travel destination”. Depending on your participants and your personal style, sometimes you also can use games such as Bingo to facilitate the introductions. Keep in mind that the purpose of a game is to help participants relax, not to embarrass any individuals. Choose any games wisely.</td>
</tr>
<tr>
<td><strong>Individual Contacts</strong></td>
<td>How you make an initial contact will depend a lot on how your work is organized. Someone else may have told the person that you will be contacting them. If so, go ahead and contact them, <em>most likely by phone but perhaps also in person</em> such as at the time of a doctor’s appointment or in a community setting. Let the person know that their doctor or whoever else told them about you felt it would be helpful for them to talk with you. If nobody has told the individual you may be contacting them, start by giving your name and explaining with what clinic or organization you are working. Then tell them you are contacting them about their health or a specific health problem. At this point, politely make sure that you are correct that the person has the problem you are focusing on. Then go ahead and tell them about how you hope you may be helpful to them. Details of how this contact should be worded need to be worked out with the sponsoring organization or program manager.</td>
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<tr>
<td><strong>Online community</strong></td>
<td>Participants join an online peer support community with different needs and various expectation of involvement. Individual stories from peer leaders or other sources can be a good start. Also, common and practical questions can also help generate discussion.</td>
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**Talking about yourself can be tricky**

- Be sure to *keep the focus on the person you are trying to get to know*. Ask yourself how what you are describing can be helpful to someone else.
- When people compare themselves to someone who’s doing really well, they can feel discouraged.
- It is OK to share challenges you’ve faced and how you overcame them.
- “Something similar happened to me” can make the peer leader look naïve or insensitive if the person feels their experience is much more of a problem or much more serious.
Developing Trust and Respect

For some participants to trust you, they may want to connect with you on a personal level. Without some sharing that “all of this is not easy,” it may be difficult to make a meaningful connection. As far as you are comfortable, you can share some of your fears or doubts, especially when they validate the participant’s feelings.

Take care to never rush your participant, as if you only have a certain amount of time to speak with them. Express a genuine interest in every participant, no matter how much some of their attitudes may conflict with yours. Provide the participant with options but don’t push them to do anything they don’t want to.

Confidentiality and Personal Privacy

Guidelines for personal privacy, confidentiality, and handling individual’s information need to be worked out with whatever organization or individual is leading a program. Here are some general thoughts on these very important issues.

Everyone values their personal privacy. As a peer leader, respecting participant privacy is one of your key responsibilities and needs to be taken seriously. Do not assume that your participant’s personal information is known publicly. Unnecessary talking about participants will erode their trust in you and your organization, creating problems for many people. Imagine how you would feel if you were in a support group and heard a leader of some altogether different support group talking critically or just carelessly about some of its members – even if protecting their confidentiality.

If your participant trusts you enough to share personal information, it is a sign of respect to ask for permission before sharing that information with anyone else (family members included). When working in a group setting (face-to-face or virtual), it is important for peer leaders to work with your participants to establish an agreement within a group that can facilitate building respect and protecting privacy.

⚠️ Warning

An area in which people and cultures are very different is in their sense of privacy. Some people are happy to talk about themselves with people they have only just met. Others have a strong sense of privacy and can quickly resent others seeming to want to know too much about them. If you are not familiar with those you are going to be working with, try to find out a little about their general perspectives from other peer leaders or your program manager. And be sensitive to the possibility that your desire to get to know someone may make them feel that you are asking too much.
Part D. Communication 101

- Types of Communication
- Basic Principles of Active Listening
- Sharing Stories
- Responding to Negative Emotions with Empathy
- Roadblocks to Communication

Effective peer support builds upon connection and non-directive support that allows a person to deal with what is important to them at their own pace. The training of communication skills will emphasize:

- **Mindfulness**- Be mindful of what is not being said, or what can’t be said – in relation to what is spoken.
- **How to ask questions** so we can learn more about the person and the situations
- **How to manage interruptions and distractions** during the process of communication

These are the foundation blocks for assisting self-care behaviors and providing emotional support.

Types of Communication

There are three forms of communication - verbal, non-verbal, and para-verbal:

1. **Verbal**: Communication through spoken language
2. **Non-Verbal** - Communication without using spoken language:
   - More powerful messages are often conveyed this way
   - 70-90% of our communication is nonverbal. Examples include:
     - Body language (e.g. folded arms)
     - Eye contact
     - Muscle tension (e.g. taut neck or clenched fists)
     - Mannerisms (e.g. biting nails, fiddling with hair)
     - Proximity (How close were you when talking to another. If too close, we become uncomfortable. This distance varies by culture)
3. **Para-verbal**: Communicating, not by what you say, but how you say it. Examples include:
   - Voice qualities/tone (flat or monotone)
   - Rate of speech (how fast or slow someone talks)
   - Cadence/rhythm of voice
   - Volume
   - Inflections

**Remember:**

- ✓ Communication needs to be specific
- ✓ Don’t assume people know what you’re talking about
- ✓ It’s important to break the big picture into smaller pieces so people can have successes
Active Listening - To understand others first and then to be understood

Active listening is to make a conscious effort to hear not only the words that another person is saying but, more importantly, try to understand the complete message being sent - both the content of the message and the emotions and feelings underlying the message. It helps a peer leader to redirect his/her attention from what to say to how to say things without judgement and to reflect empathy.

Active Listening Steps

- Look at the person, and stop other things you are doing
- Be sincerely interested in what the other person is talking about
- Focus on feelings and emotions
- Ask open-ended questions
- Make reflections (feelings and emotions)
- Be empathetic and non-judgmental
- Be aware of your own feelings and strong opinions, but avoid conveying them

Open-ended questions

Open-ended questions are questions that can’t be answered by “yes” or “no.” They are useful because we get much more information from people and people “own” the information they’re communicating. Generally open-ended questions begin with the following:

- To what extent...
- How often...
- Help me understand...
- What, if any...
- What else...
- Why...
- Tell me more

In comparison, the following terms usually give yes or no responses and very little information:

- Could you?
- Would you?
- Should I?
- Can you?
- Do you?
- Are you?
<table>
<thead>
<tr>
<th>Close-ended Question</th>
<th>Open-ended Question</th>
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<tbody>
<tr>
<td>Are you angry about having diabetes?</td>
<td>What are your thoughts about having diabetes?</td>
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<tr>
<td>Do you inspect your feet every day?</td>
<td>Tell me about your foot care routine.</td>
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**Affirmations**

Affirming is a positive confirmation. When you affirm something that someone has done or said, you are providing them with support and encouragement. This is unbelievably simple, yet most of us forget to do it! Below are some examples of affirming statements:

- “That’s good.”
- “I’m glad you asked that.”
- “You’ve come to the right place.”
- “That’s a great question.”
- “You’re on the right track.”
- “You really seem to have given this a lot of thought.”

**Reflecting Feelings**

Reflecting feelings is an important strategy in active listening because it validates the speaker’s experience so that they feel heard and understood. This skill serves to check your own understanding and to encourage the speaker to continue explaining his/her point of view. You can reflect back the content, thoughts, or feelings that the speaker conveys. However, it is most helpful to focus on the feelings so that speaker knows you are understanding his/her emotions. One way of doing this that is really simple and really effective is to just name the feeling, by saying something like, “you seem . . . (upset/frustrated/sad)” etc.

Reflections often start with:

- “I hear you saying…”
- “It sounds like…”
- “It seems like…”

**Participant**

Every time I leave the house, I have to remember to bring my insulin pen, my meter, some hard candy just in case I have a low. Having diabetes is a full-time job.

**Peer Leader**

*It sounds like you are feeling* a lot of pressure with all the responsibilities you have with your diabetes.

**Summarizing/paraphrasing**

This is where the listener repeats the content and meaning of what the sender says using the same (summarizing) or different words (paraphrasing).
Applications to Different Settings

| Face-to-Face Groups | The same skills for active listening get used in facilitating groups. You can respond to individuals in the group, reflecting their feelings, making affirmations, etc. But in a group, you also turn it to the group: “Who else is having some similar feelings as Ben?” “Alice brings up a good point, let’s talk more about that.” You can also affirm and reflect the group, rather than individuals: Affirmation – “I’m glad you’ve brought up these problems with trying to eat healthy.” Reflection – “A lot of us are talking about how much the day-to-day of diabetes wears us down.” Additionally, think about how you can: • Model the behavior and attitudes you want the group to have • Use encouraging body language and tone of voice • Give positive feedback to group members • Be aware of people’s reactions and feelings, and try to respond appropriately • Ask open-ended questions • Control your own biases • Encourage disagreement, and help the group use it creatively |

| Online community | Similar group facilitation techniques apply to an online community. However, because of the virtual setting, it is hard for peer leaders to detect or predict people’s reactions and feelings. Extra cautions and proactive follow-up through individual messages may be especially helpful. |

Sharing Stories

Storytelling, one of the oldest human traditions, can be personal and inspirational. Through personal and/or someone else’s stories, peer leaders can model/emphasize positive behaviors without being prescriptive, which can stimulate problem-solving and motivate participants in their own self-care. In a group environment, stories can highlight particular recurring themes, helping people to understand the impact of diabetes on those experiencing the illness themselves and their families and friends.

But we have to be careful with this. It can feel really good to tell a lot about your experience to an individual or group. The only caveat is to balance storytelling against oversharing so that you don’t dominate conversations with your own stories. Keep in mind, “How is what I’m about to share really going to help the person/people I’m talking with?”
Responding to Negative Emotions with Empathy

It is common that peer leaders will encounter participants with negative emotions or who bring up challenges to ideas being presented. When you do, remember to use active listening skills to communicate. You can also use a 4-step approach to help redirect their attention to something that participants CAN do:

- **Step 1 – Recognition:** Recognizing feelings and emotions of the person. This is often through a reflection and an open ended question: “Wow, that really is bothering you. Tell me more about it”
- **Step 2 – Affirmation:** Affirm the involvement of the individual: “It’s really important that you are mentioning this. If we don’t talk about difficult stuff, we really can’t get a whole lot done.”
- **Step 3 – Redirection:** Turn the discussion to something that might be helpful. “What do you think might help you deal with this?” “In the past, what’s been helpful when you felt this way?”
- **Step 4 – Refocusing:** Identify one behavior/action that the participant is willing to try

*Please refer to the section on “Providing Emotional Support” for the guiding principles for those with emotional distress/depression.*

Roadblocks to Communication

While there are strategies that can enhance our communication, some factors can hinder communication such as settings, assumptions that a peer leader has, and tones.

**Assumptions to avoid**
- This person ought to change
- This person wants to change
- This person’s health is the prime motivating factor for them
- Now is the right time to consider change
- A tough approach is best

**Inappropriate tones to avoid:**
- **Ordering:** Telling a participant to do something in manner that gives them little or no choice
- **Threatening:** Telling a participant that if their behavior continues, certain negative consequences will happen
- **Preaching:** Telling a participant things they ought to do
- **Criticalping:** Making a negative interpretation of someone’s behavior
- **Advising:** To provide answers to a problem.
• **Diagnosing:** To analyze the other person’s behavior and communicate that you have their behavior figured out.
• **Diverting:** To change the subject and avoid the problem
• **One-upmanship:** To try to “top” the participant’s problem by telling a worse one. (This can often happen among group members. If necessary, point it out and suggest a rule against “one upping each other.”)
• **Kidding / teasing:** To try to avoid talking about the problem by laughing or by distracting the other person.

### Killer Phrases
- Don’t worry, things could be worse
- Cheer up
- What do you have to feel sorry about?
- Don’t think like that
- Think positively
- You have to really want it

### Factors from the external environment to be managed
- Timing & location
- Length of a conversation
- Groupthink
- Disruptive individual behaviors within a group. Please see the table below for examples.

### Facilitation Techniques for Disruptive Individual Behaviors

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<tr>
<th>Behavior</th>
<th>Possible Explanation</th>
<th>Response</th>
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| Overly talkative       | May be well-informed or over-eager            | • Don’t be sarcast
|                        |                                               | • Slow them with challenging questions
|                        |                                               | • Let group manage them
|                        |                                               | • If necessary ask to speak with them after meeting. “You have so much valuable to share, it’s really great. But I think we need you to talk a bit less so that others have more of a chance.” |
| Highly Argumentative   | Combative personality, emotionally charged issue | • Check your temper
|                        |                                               | • Get opinions from others and move on
|                        |                                               | • Talk to them during breaks to gain insight
<p>|                        |                                               | • Use the 4-step approach to negative emotions, outlined above |
| Personality Clash      | Two or more members clash                     | • Note points of disagreement, minimize where possible |</p>
<table>
<thead>
<tr>
<th>Behavior</th>
<th>Description</th>
<th>Response</th>
</tr>
</thead>
</table>
| Obstinate    | Biased regarding topic             | - Throw their view to the group for balance  
- Offer to discuss their issues later  
- Again, use 4-step approach to negative emotions |
| Side Conversation | May be related, may be personal | - Call on individual, repeat last opinion, and ask for their response  
- Stand behind them  
- Reflect that it’s great folks are so eager but ask that we all keep to just one conversation at a time |
| Wrong Comment | Misunderstands topic               | - Handle with care, avoid embarrassing them  
- I see your point, can we reconcile it with... |
| Off Topic    | Hidden agenda, seeks recognition   | - Ask them to remain focused on topic  
- “Yeah, that’s really important and we’ll need to come back to it, but for a few more minutes let’s talk a bit more about....” |
## Part E. Assisting Self-Care Behaviors

<table>
<thead>
<tr>
<th>Myths</th>
<th>Reality</th>
</tr>
</thead>
</table>
| If someone **wants** to do something, they will. If they don’t want to, there is nothing we can do | **We need to engage people in choosing their objectives.**  
**We need to make sure people have the skills they need and a plan that is realistic** |
| If people **feel committed to their goals** and empowered, they will continue to carry out their diabetes management. | **People need skills, not just good intentions**  
**How many of us **really** know what a complex carbohydrate is?**  
**The consequences of self management have to be positive for people to persist** |
| If I **fail** to lose weight or lower my blood sugar, I’m just not able to do this. | **Very few plans work the first time.**  
**More than 50% of all smokers have quit, but most relapsed 2-4 times before they got it right.**  
**Success comes from learning, revising, and persisting** |
| If education is successful, people are able to continue managing their diabetes **without further help** | **We continue behavior because it continues to lead to consequences we value.**  
**Diabetes changes and so do people – we need to revise plans and get help in putting them into place.** |
As illustrated in a General Model of Behavior Change, changing behaviors takes a series of steps for a person to do so. Healthcare professionals can help individuals identify specific objectives to work on. Peer leaders can then assist in making plans specific and solving problems, as well as provide encouragement along the way.

Let's pursue this just a bit more. The doctor or nurse may speak to us once or twice about exercising more or losing some weight. The peer leader has the time and opportunity to talk about it over time, discussing the “two steps forward” as well as the “one steps back” along the way, helping us revise our plans to be successful, or talking us through times when our motivation fades.

### Helping Participants Set Goals

#### Start Small and Celebrate Small Wins
- Broad intentions rarely lead to success.
- Encourage participants to start with something that is specific and which they feel pretty confident they can do.
- Break the big picture into smaller pieces
- Success breeds confidence

#### Working on Individual Goals
- Key to success: **Focus on specific behaviors**
- Don’t be in a hurry to specify a specific goal
- Support the participant in their choice, don’t make it for them

People have to commit to specific goals and then work toward achieving them. Discussing the reasons for achieving a goal may be helpful to build commitment.

<table>
<thead>
<tr>
<th>Broad Intention</th>
<th>Good Objectives (Being Specific)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I would like to exercise more</td>
<td>It would be great if I could walk at least Tuesdays and Thursdays after work and once on the weekends.</td>
</tr>
</tbody>
</table>
Although making specific goals is important, many people aren’t comfortable setting specific goals. That’s OK. Your goal is to help them improve their health, not to change how they like to think about things. What’s important is that the peer leader has not pushed the individual beyond what they were willing to do. Rather, the peer leader has kept a positive tone and recognized the participant’s openness to trying some walking.

It may work to reflect the things the individual has thought about, not to push them to any one thing, but just as recognition that they are thinking about changing.

The same principle applies in the group setting as well. Please see the table below for an example during one-on-one support.

<table>
<thead>
<tr>
<th>Example: Interacting with people who aren't comfortable setting specific goals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Peer Leader:</strong> So, it sounds as though you are willing to try to get more exercise, especially by walking.</td>
</tr>
<tr>
<td>Participant: Yes, I think I’d like to do more of that, especially these nice evenings.</td>
</tr>
<tr>
<td><strong>Peer Leader:</strong> Can you make a specific commitment, say to walking on specific days or at specific times?</td>
</tr>
<tr>
<td>Participant: I don’t know. Let’s just see how it goes.</td>
</tr>
<tr>
<td><strong>Peer Leader:</strong> OK, I understand. You are really thinking hard about this stuff, how exercise might be more helpful, what types might work best for you, ways you might be able to fit it into your schedule. I’ll look forward to hearing more about your thoughts on this next time we get together.</td>
</tr>
</tbody>
</table>

### Helping Participants Plan and Rehearse

Taking exercising as an example, we may think that everybody knows how to do it, but it can be quite complex. Here are the steps to encourage and help move a participant from talking about a specific goal to trying to achieve it:

- Make a plan for the next two weeks (or other time frame but not too much more than a couple of weeks),
- Discuss what may get in the way, and
- Help practice and rehearse.
It turns out there are different ways to practice. The closer to the actual behavior, the better. Here are some ways of practicing, starting with the closest to actual behavior and then getting less close. In the example of exercising here, here are some examples—

- Going for a walk together to practice how long to walk, how to stretch before, and what “brisk walking” is.
- Role playing how to talk to my spouse to encourage me to go for brisk walks after dinner.
- Talking out in detail how to handle a particular challenge – What will you say if this happens? How will you raise the issue?

Remember, the more detailed, the better. However, if someone really does know how to do something, it can be belittling if you push them to rehearse more than they need to. Use your judgement wisely.

This is an example of where groups have real advantages over working with an individual. You can turn the discussion of one member’s plan to the group and pursue brainstorming that will be both energetic and helpful:

- “OK, Joe wants to walk after dinner 3 nights a week.”
- “What may get in the way of this?”
- “What are some specific things Joe can do to keep these from spoiling his plans?”

<table>
<thead>
<tr>
<th>Question</th>
<th>Example Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>What would you like to try to do in the next two weeks? What may get in the way?</td>
<td>I will try to go for brisk walking after dinner every other day. It may be difficult if we eat dinner late, if the weather is bad, or if I fall asleep after dinner.</td>
</tr>
</tbody>
</table>

**Rehearsal – the Secret Sauce**

What do the following important actions have in common: “Ask someone to marry us,” “Ask a boss for a raise,” “Fly an airplane,” “Be an actor in a play,” “Have that conversation with an adolescent child”?

Answer: We rehearse!

Sometimes, people make the mistake of thinking “Oh, I know how to do that. I just have to make up my mind.” Uh oh!

Rehearsal can take two general forms:

1. Role Play: For interactions, like asking a spouse to help us eat a healthier diet.
2. Talking Through Detailed Plan: For detailed tasks, like exercising after work but before dinner.
Role Playing:
- Try switching roles, peer leader or different group members play the individual whose behavior is the focus
- Keep it brief by setting a very specific point in the conversation, e.g., “You’ve asked your husband to cooperate and he responds, ‘But you’re the one with diabetes.’”
- Repeat the role play or different points in the conversation
- Only two kinds of feedback:
  1. “What did Jane do well?”
  2. “What could Jane do more of?”

Talking Through Detailed Plans
- Start with initial phases, and work through the whole sequence, e.g., for exercising after work but before dinner, start with getting off the bus after work and continue through showering before dinner
- Peer leader and/or group members point out problems that may emerge with the plan
- Trouble shooting -- Discuss alternatives, ways to solve the problems
- Repeat this in subsequent meetings to take stock of progress, identify unanticipated challenges that emerged, renew planning,

**Revising a Plan through Problem-Solving**

It is very unusual that plans work very well the first time we try them. Usually something happens that gets in the way and that we had not anticipated. This is where problem solving comes in. In problem solving, we repeat the steps in developing the original plan but now in order to revise it and make it more realistic or effective.

**Problem Solving Steps**
1. Ask the individual what went well and what did not go so well?
2. Discuss what challenges came up and specific ways to address them.
3. Select one method to try
4. Review results
5. Substitute another idea (if the first did not work)

<table>
<thead>
<tr>
<th>Action-Planning in a Group Setting</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Face-to-Face Groups, and Online Community</strong></td>
</tr>
<tr>
<td>- Setting goals: We can encourage individuals to share the specific goals they choose and why they choose these goals.</td>
</tr>
<tr>
<td>- Planning and rehearsing: We can encourage individuals to share ideas about how to address some detailed process questions. For example, “How can we introduce our plans to our families?”</td>
</tr>
<tr>
<td>- Revising plans through problem-solving: We can use the experience of other members to identify challenges that several people encountered, and ways to cope with those challenges</td>
</tr>
</tbody>
</table>
Here’s a more extended approach to Action Planning in a group.

1. Choose an individual with a particular challenge or problem
2. “Pinpoint” the problem as much as possible: where, when, with whom, what specific behavior, e.g., “avoiding rich deserts in the cafeteria at work where I eat lunch with my co-workers and feeling awkward if I don’t join in eating cake or chocolate chip cookies”
3. Ask the group to generate as many ideas as possible for how the individual could change the situation to achieve their objective.
   **Important:** during this brainstorming, the individual whose problem is the focus cannot speak. Otherwise they will tend to discourage creative solutions – “Well that wouldn’t work because…”
4. After the group has generated a large number of possible approaches, the individual whose problem is the focus chooses the one they want to try
5. Discuss how to refine the solution
6. **Rehearse** the solution either with Role Play or Talking Through Detailed Plans
7. At the next meeting, follow-up and perhaps repeat some of the previous steps to help refine the plan

Dealing with “Difficult Participants”

**It’s not your fault if a participant doesn’t change his/her behaviors.** Here are some guiding principles when interacting with participants who show resistance:

- Acknowledge that voicing their resistance reflects their thinking hard about the issues being discussed. The individual who blurts out, “Well, I just don’t think that would work for me” is more engaged than the one who stays silent and answers “Sure” when asked if something makes sense.
- Roll with resistance- Avoid confronting the participant and instead “roll with” the direction the speaker is heading. This technique will often bring the participant back to a balanced or opposite perspective.
- Using similar problem-solving process to help identify something that the individual is willing to try.
- If the person still shows some resistance, the goal will be to provide an alternative perspective/option for them to consider.

<table>
<thead>
<tr>
<th>Example: Rolling with Resistance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant: My wife is constantly telling me to eat healthier, but sometimes she eats worse than me. It makes me not want to change anything at all.</td>
</tr>
<tr>
<td>Peer Leader: That sounds like a tough situation. I don’t blame you for not feeling motivated to make changes.</td>
</tr>
</tbody>
</table>
Responding to Problems that Arise

Lots happens in people’s lives. When problems arise, *it may not be a good time for them to be worried about changing self-care behaviors.* Don’t feel you have to solve the problem or make it better. But you can be a great help in dealing with these problems by “being there” for them:

- Listen, listen, and listen!
- Ask questions if things get silent.
- Affirm the person, but don’t do this too soon – it may come off as minimizing their pain.
- Pay attention and respond to what they seem to want.
Managing diabetes can be stressful. People with diabetes may feel alone or set apart from friends and families because of all the extra work. Studies show that people with diabetes also have a greater risk of depression than people without diabetes. Without getting proper support and care, depression can hinder good diabetes self-care. A peer leader can help recognize some initial signs of emotional distress/depression, provide emotional support, and encourage a participant to seek help.

Spotting depression is the first step. Getting help is the second. Watch for the following phrases when interacting with your participant:

- I'm having trouble getting through the day
- I’m sleeping a lot / I’m not sleeping very much
- I can’t get it together
- It’s hopeless, or I’m hopeless

If your participant has been feeling really sad, blue, or down in the dumps, encourage him/her check for these symptoms:

**Depressive Symptom Checklist**

- **Loss of pleasure** — You no longer take interest in doing things you used to enjoy.
- **Change in sleep patterns** — You have trouble falling asleep, you wake often during the night, or you want to sleep more than usual, including during the day.
- **Early to rise** — You wake up earlier than usual and cannot get back to sleep.
- **Change in appetite** — You eat more or less than you used to, resulting in a quick weight gain or weight loss.
- **Trouble concentrating** — You can't watch a TV program or read an article because other thoughts or feelings get in the way.
- **Loss of energy** — You feel tired all the time.
- **Nervousness** — You always feel so anxious you can't sit still.
- **Guilt** — You feel you "never do anything right" and worry that you are a burden to others.
- **Morning sadness** — You feel worse in the morning than you do the rest of the day.
- **Suicidal thoughts** — You feel you want to die or are thinking about ways to hurt yourself.

If someone has three or more of these symptoms, or if he/she has just one or two but has been feeling bad for two weeks or more, it's time to get help.
Just talking with a peer leader or others in a group can be helpful. But if individuals feel that quite a few of these apply to themselves – especially the last about thoughts of death or suicide – encourage them to seek professional help.

**Referrals:** Seeing their own primary care provider is always a good start. Ask your program manager and see if the organization can help refer the participant to make an appointment with a mental health professional. In some cases, some participants can benefit from having a peer leader accompany them for an office visit. You can offer that when your program’s protocols allow and you also feel comfortable doing so.

### Supporting Your Participants Who are in Distress

These days, we are sometimes too quick to see someone as depressed when their concerns lie more in specific areas of distress. People with diabetes can feel good about themselves and their lives but feel a lot of distress about their diabetes. Based on research in the area*, here are some concerns that get at diabetes distress:

- Feeling overwhelmed by the demands of living with diabetes
- Feeling that I am often failing with my diabetes
- Feeling that diabetes is taking of too much of my mental and physical energy
- Feeling that my doctor doesn’t know enough about diabetes and its care
- Feeling angry, scared or depressed when I think about living with diabetes
- Feeling that friends or family are not supportive enough of my self-care and diabetes care
- Feeling that diabetes controls my life
- Feeling that my doctor doesn’t take my concerns seriously enough
- Feeling that I will end up with long-term complications
- Feeling that my friends and family don’t appreciate how difficult living with diabetes can be
- Not feeling motivated to keep up with my diabetes management

In a group program, it may be helpful to read some of these and ask group members to discuss which may apply to themselves. The discussion should encourage acknowledgement of these as feelings that are sometimes normal for those with diabetes. When group members share these feelings, they are likely to move on to talking about how to put them in perspective or keep them from being too upsetting.

If some of the feelings of distress are pronounced, it may be useful to use the problem solving strategies discussed earlier. For example, pinpoint what are the feelings that “diabetes controls my life” and the circumstances in which they are most troublesome. Then see if the group can come up with some ways of dealing with those feelings.

With individuals, you can be sensitive to the feelings of diabetes distress and encourage expression of these. It can be very helpful for you to acknowledge and accept these as normal and understandable, not “whining” or being weak. Diabetes is distressing and a major contribution of the peer leader is to help the individual recognize that they are not wrong in feeling this way.

<table>
<thead>
<tr>
<th>Principle</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ask</td>
<td>You haven’t seemed yourself lately – is everything OK?</td>
</tr>
<tr>
<td>Listen (Active Listening)</td>
<td>I can hear that the last few weeks have been really terrible for you.</td>
</tr>
<tr>
<td></td>
<td>Please tell me more about it</td>
</tr>
<tr>
<td>Support</td>
<td>• I know it can be hard to talk about this – thanks for trusting me with it.</td>
</tr>
<tr>
<td></td>
<td>• What have you tried to make yourself feel better? Have you thought about seeing your doctor?</td>
</tr>
</tbody>
</table>

Key Points in Providing Emotional Support:
- Don’t underestimate the importance of just “being there”. Contact participants more often if you feel that they need someone to talk to.
- When having a conversation with a participant you are worried about,
  - Take some planning and thought ahead. Identify situations and environment where this participant will be most likely to be attentive as well as at ease.
  - Use “Ask, Listen, and Support” to guide your conversation~
- If a participant situation is “over your head”, bring it to the attention of the program manager, and/or a healthcare professional depending how your work is organized.
Many people with diabetes feel that spirituality, religion, and prayer play an important role in facilitating management of the condition. Praying regularly may be one way a person copes with stress from diabetes or other sources in life. Having faith-based organizations as a setting for peer support program and their leaders and members as peer leaders allows participants’ faith and spirituality to be addressed implicitly in many different aspects of diabetes peer support activities. On the other hand, we also need to pay special attention to several areas when engaging faith-based organizations and their members in peer support:

- It is important to maintain sensitivity to all levels and varieties of spirituality or religious practice within the population/community served so the program can still reach those who may not share the dominant beliefs or practices.

- Peer leaders should not impose a particular spiritual perspective on participants. Especially in a group setting, assuming that all share a particular faith perspective or feel comfortable with a particular ways of expressing their faith may cause distress among those who do not follow the path of the majority.

- Be aware that people may experience added emotional distress if they are led to believe their health problems result from a religious or spiritual failure on their part. Approach these participants with empathy and encourage them to talk to their spiritual friends/mentors for further support and perhaps guidance to resolve that.

- Many with strong faith may feel that their diabetes and their health are “God’s will” or “God’s plan for me” and that trying to change or manage their health is a lack of faith. It may be helpful to raise discussion about accepting God’s will but also recognizing that God has given us health care and the ability to apply it in our daily lives.
Part G. Self-Care, Backup and Support for Peer Leaders

- Common Challenges Faced by Peer Leaders
- Strategies for Self-Care and Getting Support for Peer Leaders

Common Challenges Faced by Peer Leaders
- Unreasonable feelings of responsibility for participant’s progress
- Frustration over participant not performing as well as expected
- Becoming overly involved with participant’s problems
- Giving incorrect information to participants
- Lack of coaching and care-providing experience
- Experiencing difficulties connecting with participants due to cultural, language, age, or socioeconomic differences
- Negative initial perceptions from participants
- Feeling discouraged if participants reject offers of support
- Feeling drained, stressed, or burned out

Here are few strategies for self-care and getting support for yourself:
- **Don’t Work Alone** – The problems people will bring to you are stressful and none of us can know all we need about how to handle them.
  - Connect with other peer leaders to share experience and get support
- Good peer leaders know their own limitations, but are resourceful.
  - Your peer support program should provide peer leaders back-up. Preferably, this should be a number you can call most anytime, ideally 24/7 to get advice or assistance. Turn to the dedicated program contact to seek advice or get questions about details of health problems that you cannot answer.
- **Establish appropriate expectations for your participants**- Remember that you are not competing with or replacing the role of any professional diabetes healthcare personnel. Don’t give your participants any expectation that you have all the answers, only that you’re in this together and you’ll help them find their own solutions to problems.
- **Follow Boundaries** – If your program establishes limits for when and how peer leaders meet with those they help, follow them. If you feel that a participant is taking up too much of your time, making unreasonable requests, or making you feel uncomfortable, bring it to the attention of the program manager or care coordinator.
- **Avoid unnecessary stress**- learn how to say no and take control of your environment to reduce your stress levels.
- Remember that **not everyone is ready to change! But even if they are not ready to change or improve their diabetes management, you can make an important contribution just by being there for them. They just may surprise you!**
- **Find opportunities to gain new knowledge and sharpen your skills** as a peer leader for people with diabetes.
Additional Resources

Diabetes
- American Diabetes Association: diabetes.org
- American Association of Diabetes Educators: https://www.diabeteseducator.org/patient-resources/tip-sheets-and-handouts

Depression

Local Resources
- Houston Diabetes Resource Center https://houstondiabetes.org/