chuť žiť

PEER SUPPORT

Peer support as a form of help for young people with eating disorders

PEER SUPPORT

Peer support as a form of help for young people with eating disorders

Spolufinancované z programu Európskej únie Erasmus+

NIVAM
NÁRODNÝ INŠTITÚT VZDELÁVANIA A MLÁDEŽE

chuť žiť

Anabell

This methodological handbook is part of the project "Youth as part of peer support: New solutions and approaches to addressing eating disorders in young people" under number: 2021-1-SK02-KA210-YOU-000033886 that we are implementing with the support of the European Commission from the Erasmus programme.

---

www.chutzit.sk

Authors:
Mgr. Natália Meliš-Čuga (Tokárová)
Valentína Sedileková
Mgr. Miroslava Takáčová

Professional revision:
Mgr. Vladimíra Osadniková
Mgr. Eva Slezáková
PhDr. Ing. Jana Sladká Ševčíková

Proofreading:
Martina Novotová

Layout:
Lucia Lavríková
Jakub Mikula

Publisher:
EDI Slovensko, oz.
Panenská 23 81103 Bratislava,
IČO: 52257622

ISBN 978 – 80 – 973764 – 3 – 7
EAN 9788097376437

ISBN 978 – 80 – 973764 – 4 – 4
EAN 9788097376444

CONTENTS

CONTENTS

1. INTRODUCTION TO THE PROJECT

This handbook has been produced as part of the project „Youth as part of peer support: New solutions and approaches to address eating disorders in young people (with number: 2021-1-SK02-KA210-YOU-000033886), is implemented in cooperation with EDI Slovensko, o.z. (Chuť žiť) a Centrum Anabell, z. ú., the Czech Republic. The aim of the project is to activate young people with eating disorders so that they can use their experience with the disease for the benefit of their peers.

It is the activation of people with personal experience of mental illness that is one of the modern elements of the prevention (among other things) of the treatment of mental illnesses. That is why both organizations, EDI Slovensko (Chuť žiť) and Centrum Anabell, the Czech Republic, actively work with peer consultants, i.e., people recovered from eating disorders.

In order to engage young people recovering from eating disorders in the process of helping others through work with youth, we needed to create and provide quality education that would prepare them for the challenging stories of their peers, teach them how to safely help their peers, and protect themselves in the process.

The pilot training project was conducted in two runs with female participants aged 20 to 30 years. Subsequently, they completed a short practice, during which they helped peers with eating disorders individually or in a group. Finally, we evaluated education through questionnaires and individual interviews.

In this handbook, we have described the learning design process, its design and the outputs of the evaluation process. The materials can also be used to inspire the development of similar training.

2. TERMS AND ABBREVIATIONS

Youth worker • peer • peer consultant • peer mentor

We see youth workers and youth workers as young people who provide peer support. For the purposes of this guide, we use the terms as synonyms.

Client

For the purposes of this handbook, this term means a young person with an eating disorder.

Relapse

Refers to the reappearance or worsening of symptoms of the disease.

ED

Eating disorder

MD team

Multi-disciplinary team

Chuť žiť

The organization Chuť žiť is equivalent to the name of the organization EDI Slovensko. The organization EDI Slovensko is the legal form of the project Chuť žiť.

3. DEFINITION OF PEER CONSULTANT

A peer consultant is a mental health consultant with personal experience of psychiatric illness and its treatment (Foitová et al, 2014) – in the context of EDI Slovensko (Chuť žiť) we are talking about a person with personal experience with diagnoses of the spectrum of the eating disorders. The peer counsellor uses his/her experience to support other clients and to strengthen their hope for recovery. **They reinforce hope, not just in the sense of empty hope, but in the belief that even with the limitations that can stem from mental illness, a person can live a happy and fulfilling life**. Such persons can be a great inspiration to those who are struggling with their disease. They ate living proof that anyone can be healed. This is also the main message of peer consultants. By using their own story of recovery, the peer gives hope, motivation and support to the client, seeks to focus with them on their strengths, fosters their independence, and takes steps together towards their recovery and empowerment based on this (Foitová et al., 2014). However, the story is not the peer's only working tool, as experience alone does not yet make them a worker in this position. In this chapter, we address the important characteristics, competencies, rights and obligations, as well as the organization's requirements for a peer.

The decision to look at defining peer workers and placing them in multidisciplinary teams was made mainly because of the contribution we see in their work. The peers bring a more human perspective to the diagnosis, pointing to living life to the full even with the limitations that can result from the diagnosis. They are also the bearers of hope in the process of treatment and recovery. They give faith to both their clients and patients and to their families and loved ones. They also have undeniable benefits for the experts and professionals who treat these clients. They bring them closer to the experience of persons with the diagnosis concerned and the effects of their treatments and practices. There are currently several studies and research abroad on the contribution of peer mentors to the treatment of eating disorders in which the impact of col-

laboration with peers on treatment is significant (e.g., Ranzenhofer, Wilhelmy, 2020; Albano, Cardi, 2021; Beveridge, Phillipou, 2019; etc.).

In the context of EDI Slovensko (Chuť žiť) and our project to educate and involve future peer counsellors in working with clients with eating disorders, we perceive the contribution of peers equally. We want to „humanize" diagnoses on the spectrum of eating disorders for the public and professionals, and give faith and hope to our clients. We also see the need to engage young people on issues that directly affect them and the sense of mutual support and inspiration among young people tackling similar issues. After years of restrictions due to the global COVID 19 pandemic, we emphasize the need for socialization, re-establishing contacts and a sense of belonging in society and especially among the youth, who have suffered greatly from quarantines and restrictions in the social sphere.

After defining the role of the peer consultants and their contribution, we focus on how the peers should perform, work, act, etc.

To fulfil their role as peers, those persons should possess certain **personality characteristics**, which we have identified as:

- pleasant, kind manners,
- authenticity, empathy,
- the desire to learn and be educated,
- respect for themselves and the clients,
- high level of self-awareness, insight into one's own experience,
- patience,

- punctuality, responsibility, organisation,
- Openness to new, non-judgemental approaches, acceptance of the different.

In addition to the above personality characteristics, peer mentors should also meet the following **requirements** based on study of foreign literature, experience and practice from abroad (in particular the Czech Republic):

- age: at least 20 years,
- education: at least secondary school (with high school diploma),
- additional education: completion of at least 50 hours of training + additional education is an advantage (e.g., training, courses, motivational interviews, psychological education or other humanities-oriented education, etc.),
- English language (B2 level),
- experience: previous experience as a peer worker is not required, personal experience with the disease and successful treatment is,
- indicatively 2 years after recovery, with the degree of processing of one's own experience and insight into it being a more important factor than the years themselves,
- the ability to talk about their experience and use their story in the client's interest (not to suggest certain paths and styles of treatment, not to be persuasive and not to be invasive),

- being the recipient of professional assistance (in the past – during treatment, or currently),
- good communication skills,
- the ability to listen actively,
- non-directivity,
- pleasant, kind manners,
- belief in healing and moving towards healing,
- openness to the client‘s questions and opinions, or other approaches,
- respect for themselves, the clients and the organisation,
- understanding their competences and boundaries and not overstepping them,
- teamwork (work in a team is a must),
- compliance with the values of the organisation,
- presentation skills,
- be familiar with the different services and help available,
- basic knowledge of medication,
- clean criminal record.

After defining the basic requirements for peer consultants, we worked on defining the competencies that peers should have in the organisation and further build and expand them in their work for the organisation. Peer consultants are not professionals, but they are experts on their own experience of recovery. It is therefore important that they do not act outside their competence, and we consider it important to also define the area that does not fall under the competence of the peers.

Competence of peer consultant:

- Sharing their experience of recovery and using the processed experience and story for motivation, inspiration, hope and support.
- Strengthening motivation and belief in recovery.
- Looking for strengths of the clients and supporting their independence and responsibility.
- Activation of the client.
- Guidance on treatment options.
- Defining the boundaries of cooperation, sharing, support.
- Work on both individual and group level.
- Working in the field, in the client's natural environment, accompanying the client to examinations, eating together, performing other routine activities.
- Bringing new insights into the clients' experience and perspectives on their survival, treatment and health status.

- Supporting a pro-client setting of the team culture and service environment.

- Prevention and education in the field of eating disorders and mental health.

- Lecturing in the field of primary prevention.

- Work with a diagnosis with which the peer has personal experience (in our case, in the organization EDI Slovensko (Chuť žiť) with diagnoses on the spectrum of eating disorders).

What does not fall within the competence of the peer:

- Working outside the multidisciplinary team – working with the clients individually and in groups, but not independently outside multidisciplinary teams.

- Performing psychotherapy, nutritional counselling, social counselling or medical procedures without the necessary education (if the peer has the necessary education for professional work from the above, it is necessary to separate the individual roles – i.e., even if the persons working in the position of peer consultants have education as a nutritional therapist, in the position of peer consultants, they shall stay within the limits of peer competence).

- Conducting crisis intervention.

- Working with the family outside the team of experts.

- Holding the position of case manager, or lead article of the process/case.

- Conducting non-client group meetings (e.g., parent meetings).

In the context of EDI Slovensko (Chuť žiť) the peer consultants will work in the field of eating disorders together with a multidisciplinary team composed of individual professionals (psychotherapist – psychologist, nutritional therapist – nutritional specialist, peer, and others, if any), which is managed by a key worker of the client concerned (the so-called case manager). As part of the cooperation with the clients and the team, the peers will have the following job description, rights and obligations.

Duties of a peer consultant:

- study of work methodology, internal regulations,
- regular checking of the mailbox and replying to mail within 48 hours,
- communication with clients by mail / telephone,
- organising individual and/or group meetings,
- conducting individual and/or group meetings,
- drawing up minutes of meetings and communication with clients,
- participation in evaluation meetings with members of the MD team and the clients,
- co-participation in professional group meetings together with another professional (e.g., meeting with parents),
- cooperation on projects and activities of the organization,
- communication and cooperation with the MD team, coordination of activities, participation in meetings,

- regular team and individual supervisions and interviews,
- presentation of the organization to the public (workshops, trainers, interviews),
- Participation in the prevention and awareness-raising programmes of the organisation,
- participation in mandatory training,
- continuous self-learning and self-study,
- field work, assisting and accompanying the clients,
- participating in the induction of new colleagues.

Obligations of peer consultant:

- active search for post-secondary, continuing education,
- participation in regular interviews and supervisions,
- compliance with methodologies, code of ethics, working hours, confidentiality, GDPR,
- not providing private information, using only work contacts,
- reporting obligation,
- reporting conflicts of interest,
- familiarisation with crisis plans,
- administration (minutes, reports),

- attendance at regular meetings,
- reporting a deterioration in health condition,
- have ready a list of crisis centres and crisis lines that the client might need in the event of a crisis.

Rights of peer consultants:

- refuse a client with whom he or she has a conflict of interest or does not feel competent to provide adequate assistance,
- receive training (e.g., paid time off for training),
- innovate services, come up with ideas,
- choose a convenient time to meet with clients,
- ask colleagues or supervisors for help with a case if it is a situation they do not know how to deal with, it is complicated, new, etc.

3.1 INCLUSION OF A PEER CONSULTANT IN THE MULTIDISCIPLINARY TEAM

While the great contribution of peer mentors lies in their work with the client themselves, since their main tool is their own story of illness and treatment, it is appropriate and necessary for peers to work in collaboration with other professionals and experts. Their perspective is subjective based on their own experience, and they may not have sufficient knowledge and expertise in terms of medicine, psychology and nutritional science to guide clients in their own treatment. Within EDI Slovensko (Chuť žiť) great emphasis is placed on multidisciplinary treatment of eating disorders, therefore it is practically impossible for peer mentors to work with clients independently. The team itself is composed of several experts and specialists who work together during the treatment and use regular revision of procedures in order to adapt the treatment methods as much as possible to the current condition and motivation of the client. The peer complements the team through his or her perspective and experience with the aspects of treatment in question. This provides valuable information for the client, but also for the professionals in the team to whom he or she can explain his or her experience in the different phases of treatment.

In the actual work of the peer mentor, it is important that all team members and the client are aware of the competencies and boundaries of the work of peer consultants. They should not be in the role of other professionals in the team, so we consider it important to define and specify the practical involvement of the peers in the treatment compared to other professionals and specialists working together in the team. Specifically, we offer an overview of the differences with the most commonly encountered professionals in the collaboration – social worker, psychologist – psychotherapist, nutritionist, and psychiatrist.

1. DIFFERENCES BETWEEN DIFFERENT POSITIONS IN A MULTIDISCIPLINARY TEAM

Social worker versus peer

- The social worker accompanies the client and his/her family during the use of services, covers administration, contracts, provides social counselling, not only to people with eating disorders, but also to their relatives who need support and education, etc.; carries out social work – can help arrange disability pensions, orientation in the welfare system.

- The peer performs basic administrative tasks (arranging appointments with the client, reporting), can map the client's situation, go over treatment options with the client, but does not provide social counselling; may also work with the client in the field, but does not carry out social work.

Psychologist – psychotherapist versus peer

- The psychologist focuses on the client's experience, uses diagnostic and psychotherapeutic methods according to his or her abilities and level of education, provides long-term treatment of the client's problems, works individually or in groups, provides client education and an expert view of the eating disorder and its symptoms.

- The peer helps by sharing his/her own experience, very often he/she as a peer consultant does not have or does not use psychotherapeutic training and only uses selected methods according to his/her knowledge, provides support and inspiration and motivational techniques. Offers a view of the diagnosis through his/her eyes and answers the client's questions about his/her experience (within the set boundaries).

Nutritionist versus peer

- A nutritionist deals primarily with **nutrition**, not survival; draws up a menu and a plan for introducing new foods, meals, fear foods, etc.; evaluate the composition, frequency and nutritional aspects of the food.

- Peers deal with **experiences** related to food (fear foods, fear of gaining weight, overeating, etc.), can educate, but do not interfere with the composition of the food /menu, energy intake, do not name caloric values. They work with the particular clients' fear foods and support them in overcoming challenges, but they do not dictate what, when or how – they demonstrate what helped them overcome the challenges and the importance of not getting stuck in comfort. However, they do not give specific nutritional advice and recommendations because they are aware of the individuality of the client.

Psychiatrist versus peer

- The psychiatrist establishes the diagnosis, pharmacotherapy, decides on hospitalization, directs treatment, checks weight, is interested in and assesses the physical health and general health condition of the client.

- The peer does not diagnose, does not comment on the set pharmacotherapy, does not reserve against hospitalization, does not perform medical interventions.

---

2. SPECIFIC COMMUNICATION OF THE PEER CONSULTANT (AS OPPOSED TO OTHER MEMBERS OF THE MULTIDISCIPLINARY TEAM)

- More informality – the peer can suggest the possibility of being on a first-name basis with the client,
- non-directive manner (the peer leads the conversation and frames the conversation always on the topic),
- using active listening methods (mirroring emotions, summarising/paraphrasing),
- informal language: layman's terms, slang, humour (if appropriate),
- the client asks questions – communication is open in both directions (but the peer sets the boundary of comfort in sharing),
- authenticity – adapting the language to one's own needs and character,
- appropriate, non-invasive use of one's own experience depending on the themes the client brings,
- topics are brought by the client; the peer does not have to prepare specific topics and steps that will happen in the meeting.

3. POTENTIAL PROBLEMS

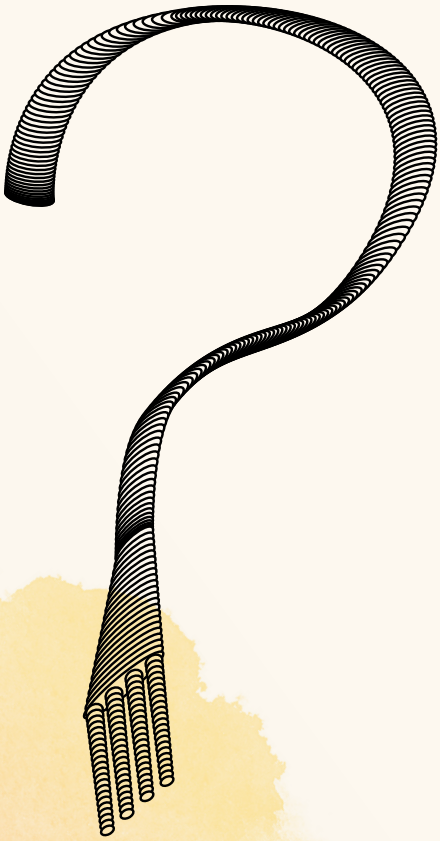
On the peer's side:

- the risk of relapse at work, which includes a number of potential disease triggers or behavioural patterns in the disease,
- lack of self-reflection, insight, communication skills and active listening skills,
- risk of putting yourself in the role of an expert – ("only my view and opinion is the right one"),
- insufficient setting of boundaries of cooperation – falling into the role of a friend, parent, etc.,
- insufficient perception of the limits of one's own competences,
- social media behaviour in terms of posting inappropriate content (risky for people with ED),
- absence from supervision meetings and interviews,
- taking responsibility for the client,
- the problem of talking about yourself, about certain topics,
- low engagement, low effort/willingness to establish contact with clients.

In cooperation between the peer and the MD team:

- teamwork - identifying the place of a peer in the team and participation in meetings, interviews, etc.,
- equal position in the team,
- acceptance of a perspective on the issue drawn from one's own experience,
- unpreparedness of the team - clarification of the role of the peer consultant,
- lack of training,
- a double role in the organisation,
- not sharing important information with the team,
- employment of peers by persons who are former clients of the organization or service,
- previous cooperation, connection of the peer with one of the team members at a different level than the professional worker – peer (e.g., expert – client).

4. INTERVIEW AND SELECTION OF A PEER CONSULTANT



In the previous chapter we discussed the definition of a peer consultant and explained the role, job description, responsibilities and boundaries of the job. Based on these characteristics, we have developed a concept of the interview which consists of several rounds. The very selection of a peer consultant is an important part of the entire process, since during the interview we already define the role and actions of the peer, we examine the motivation of the applicants for this job, but at the same time we leave a lot of space for their own reflection on their competences and abilities. During the interview, there is a space reserved for questions from both the candidates and the organisation. More detailed and longer selection rounds ensure that there is sufficient space for verifying the suitability of a particular candidate for the role of a peer consultant – primarily to avoid damaging the mental health of the candidate, and also to protect the clients of the organisation.

In the first set of questions, we covered basic information about the candidate, work experience, motivation for the position, planned career, and perceptions of the role of a peer consultant and job description.

In the second set of questions, we focused on the candidate's own experience, level of processing and insight, attitudes towards treatment and a recovery-focused approach, and sharing their story publicly.

In the third part of the interview, we tested the candidate's skills, abilities, and competence, using direct questions and behavioural interviewing techniques. Depending on the type of candidate and responses, we have included examples of clients' situations or a short role play – a demonstration of a client's situation with a candidate in the role of peer consultant.

In the fourth part of the interview, we presented in more detail our organisation, vision, work and the role of the peer within the multidisciplinary team and in direct work with the client. If

necessary, we can augment this interview with a second round consisting of additional behavioural interviewing techniques, case studies, and/or examples of written communication with clients.

Ideally, two members of the organisation should be present at the interview to interview the candidate together and observe him/her in specific situations. They then exchange feedback and discuss his/her strengths and weaknesses, suitability for the role of peer consultant and the established multidisciplinary team, alignment with the values of the organisation, etc.

After each interview, it is important to leave enough time for reflection and potential questions to the candidate, as the role of a peer is a specific intervention in a person's privacy in terms of sharing one's own experiences. Persons with a history of eating disorders are also at risk of relapse, so the candidates should be allowed some time after the interview to reflect – how they felt about sharing their experience at the interview, how they can imagine themselves in the role of a peer consultant based on the information from the interview.

1. EXAMPLES OF QUESTIONS AIMED AT FINDING OUT BASIC INFORMATION ABOUT THE CANDIDATE:

Introduce us the person with whom we are sitting here today? / How would you like to introduce yourself?

What impressed you about our job offer and organization? What do you know about EDI Slovensko (Chuť žiť)?

How do you see the role and work of a peer consultant?

Why do you think you would be a good fit for this role?

If you were in a period of active treatment, why would you seek the services of a peer consultant, and what should your peer consultant be like? What would you address or not address with him or her?

Which of your experiences would you use in this work and why?

Why do you think the role of peer consultant is useful and important? What do you think what is the benefit it has for the team and the clients?

What is your motivation to work with people with eating disorders?

What is your vision, what are your work plans for the next five years?

Working in the supporting professions is often demanding, we tend to give ourselves away. How will you guard your boundaries, or how are you guarding them now?

What are your weaknesses? What would you like to work on, what would you like to improve?

Slips and trips naturally occur in treatment and during stabilization. Are you familiar with such conditions? How do you respond then? Do you have any ongoing support/people you can contact?

2. EXAMPLES OF QUESTIONS FOCUSING ON ONE'S OWN EXPERIENCE WITH AND TREATMENT FOR AN EATING DISORDER:

Tell us your story you want to work with as a future peer consultant.

How did you feel about sharing this with us? Can you imagine sharing your experience in this way individually in consultations, in groups or in front of an audience?

What do you see as important in your sharing?

What do you think were the most important moments for you, points in the treatment?

To what end would you like to share parts of your story?

Does anyone know about your experience, e.g., family, neighbourhood? Do you agree that we publish your name and picture on the website and that we communicate with you and your position as a peer – someone with a personal experience with an eating disorder?

3. EXAMPLES OF QUESTIONS TO DETERMINE THE NECESSARY SKILLS, ABILITIES, AND COMPETENCE DEFINED FOR THE WORK OF A PEER CONSULTANT:

What skills (competence) would you use in your work as a peer consultant?

Demonstrate the skills and competences with examples from your life/school/work/experience.

What other skills and competences would you like or need to build and how? (e.g., some specific training, experience, etc.)

Give us an example of when you worked under stress: what did it look like, how did you deal with it, what helped, what impact did it have on your performance and experience, etc.?

Give us an example of how you work in a team versus how you work individually, what you prefer, or what role you typically play in a team.

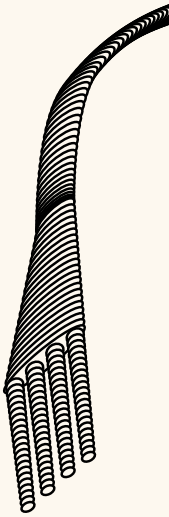
As a peer, what topics would you avoid in a conversation with a client? On the other hand, in which topics do you feel confident?

Do you think that a person can fully recover from an eating disorder? What does recovery from an eating disorder look like?

Where do you see the boundaries of the role of a peer consultant? (Compare for example with a psychologist)

How would you react if a client contacted you via Instagram?

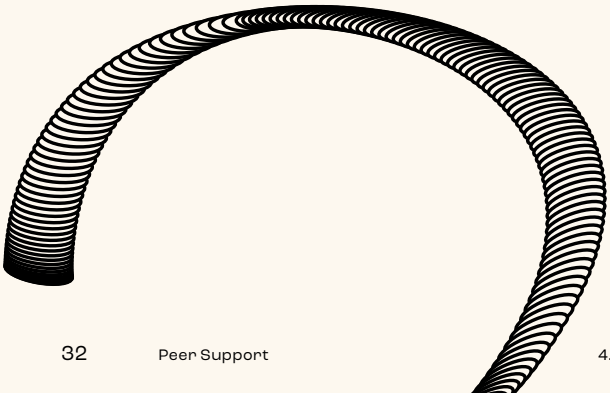
If you were a peer consultant, would you change anything about what you post on social media?



4. EXAMPLES OF QUESTIONS AIMED AT ADDRESSING POTENTIAL PROBLEMS OF A CLIENT:

How would you respond to a client's question or problem with:

- medication and hospitalization,
- the need for nutritional rehabilitation,
- following nutritional trends or special diets,
- movement and sports as part of life?



5. INFORMATION THAT WE WANT TO CONVEY AND SUMMARIZE TO THE CANDIDATE DURING THE INTERVIEW FOR THE POSITION OF PEER CONSULTANT

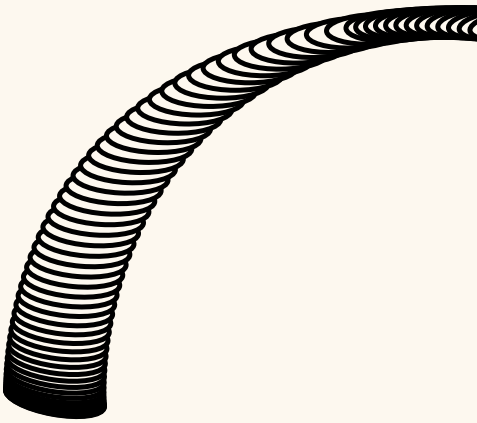
The presentation of organisation and multidisciplinarity.

Explain that peers cannot work alone, that they can only be part of a multidisciplinary team.

Explain the boundaries of the position, describe the job.

Explaining the training we provide in more details.

Presenting the person as a person with personal experience.



END OF INTERVIEW

Recommendation for the candidate to think through and process all the information gathered and encourage them to contact us for further comments and questions.

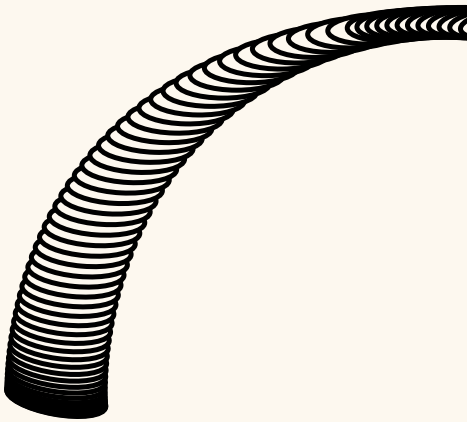
POTENTIAL SECOND ROUND WITH SELECTED CANDIDATES

Candidates who have been successful in the first round and whose skills and competences need to be examined in more detail and/or whom we want to compare with each other on the basis of the tasks in the second round will go forward to the second round of the selection process. For these needs, the second round focuses more practically on exploring their skills and competences by using a client case study, role-playing the peer and client in an interview situation, and creating a response in an email communication with the client.

In the task of working with case studies, the candidate will answer questions such as: “Did this peer act correctly? Where do you see faults in his behaviour and what, on the contrary, do you evaluate positively?”

The role of the candidate's email communication is to create a response to a client’s emergency email in a crisis situation: “What would you write in your reply?”

In the role-playing task, the candidate is in the role of a peer mentor in a session with a client (one of the interviewers) and the task is to react intuitively in the interview in the role of a peer.



INTERVIEWER'S QUESTIONS AFTER THE END OF ROLE PLAYING:

- How did that make you feel? Did anything upset you?

- Where did you feel confident and where did you feel you grope in the dark or have room for improvement?

- Can you now think of other reactions, ways of solving things, etc.?

- How would you proceed if you came across a topic that is beyond your capabilities or competences?

The end of the interview is devoted to the candidate's questions and the possibility to keep a few days' distance to think over possible questions about the role of peer mentors. The aim of the second-round interview of the situation is also to give a more detailed idea of the peer's work, and thus also serves as a tool for the candidate in the decision-making process for the position.

5. TRAINING OF PEER CONSULTANTS

For successful applicants from the interview for the position of peer consultant, we have prepared comprehensive training directly tailored for this position in the multidisciplinary team at EDI Slovensko (Chuť žiť). Our goal was to create an education that prepares young people with their own experience of eating disorder treatment to work with people at different stages of the treatment process.

A peer consultant is often a young person without long-term experience in employment or working with people, especially young people with problems. Therefore, one of the most important tasks of the training course is to prepare future peer consultants so that they do not harm the young person in the process of treatment, but on the contrary – to help and at the same time to be able to cope with this work, to manage the daily stress of working with people and to find their work fulfilling. Education also has a self-discovery dimension – young people have the chance and space to discover and realise what they want to do to help their peers.

As part of the training, we set ourselves the task of broadening the field of information for future peer consultants, but in particular of showing them other competences, methods and techniques that they can use when working with clients in addition to working with their own recovery story. A peer conducts a conversation with a client on a specific topic, and in a long-term partnership, the peer and the client form an intimate relationship that must have boundaries and at the same time be useful on the road to recovery. Given the complexity of this work, it is not possible for peer consultants to have their own story as their only tool. It is also essential to learn how to use this tool correctly for the benefit of the client. Therefore, it is necessary for peers to receive comprehensive information on how to conduct a conversation, how to build and set boundaries in a relationship with clients, or how to communicate with them in a not quite “friendly” way.

At the same time, it is not a prerequisite to have a background in the humanities to work as a peer consultant. It means that even a person who has no experience in communication with clients can become a peer. No other education or training that would adequately prepare young people for the work of a peer consultant is currently available in Slovakia. This is another reason why we see such training as an important part of preparing peer consultants for this job.

The training was prepared by:

- **Natália Meliš-Čuga**
  psychologist, CBT therapist in training and peer consultant (Centrum Anabell, Czech Republic),

- **Valentína Sedileková**
  the founder of the organization and peer consultant (EDI Slovensko (Chuť žiť), Slovak Republic),

- **Miroslava Takáčová**
  psychologist, trainee in psycho dynamic psychotherapy (EDI Slovensko (Chuť žiť), Slovak Republic).

The professional composition of the team of authors of the training allowed us to look at the issue from different points of view, to offer an overview of the theoretical foundations for the work of the helping profession and to introduce the training participants to different types of possible portfolio of clients and clients' situations. The **peer educators** brought a first-hand perspective to the design of the training, focusing in particular on what topics are important and beneficial to future peer consultants, and how this can be communicated to them. They focused on the skills, competences and knowledge they use most in their work in peer support, drawing on their own clients' sit-

uations and practice. **Psychotherapists** in training brought a view from the perspective of the profession. Participants were introduced to the psychological minimum of working with clients – e.g., work with motivation or with a client in crisis; but they also emphasized the importance of psycho hygiene and relaxation techniques.

The development of the training took several weeks and was based on available resources – foreign and domestic methodologies, examples of good practice; completed training for peer counsellors in the Czech Republic, own experience and practice with a portfolio of clients recovering from eating disorders under the guidance of psychologists and peer counsellors.

This is a comprehensive 6- to 7-day training (8 hours each day). The length may vary slightly according to the number of participants. The topic of the work of peer consultants is extensive; there is no other training or specialised field of education that would prepare people to work in this position in Slovakia. We therefore felt it necessary to cover many topics – from the perspective of peer work as such, but also from the perspective of the specifics of eating disorders and peer work with people undergoing treatment for eating disorders. Because of the complexity of the content, we divided the training course into several days, as it would not be possible to cover the individual topics sufficiently in fewer days. We also wanted to give the participants enough space for discussions and questions and to make the training interactive. The training therefore includes a theoretical part and a practical part, i.e., practising the acquired skills when working with clients.

When preparing the training, it was also important to take into account the capacity and energy of both the trainers and the trainees in order to evenly distribute the topics in terms of their difficulty, as well as the breaks between them – including the lunch break and the gap between the two phases of the training. As a result, the whole training lasts 6 to 7 days (de-

pending on the number of participants). In terms of time, the number of participants primarily affects the day on which they present their processed stories. If there were more of them, the training time could be extended by one training day.

We purposely left a gap of several days (about 1 week) between the two phases of training in both runs. On the one hand, the aim was to spread out the training so that the participants would not be overloaded, and on the other hand, to give them enough time to think about any questions and uncertainties that may have arisen in relation to the topics discussed. For us as trainers it was also important to leave a certain gap between the theoretical part (the first 4 to 5 days) and the practical part (the last 2 days). This provided an opportunity to see how the participants learned the skills and knowledge acquired in the exercises (see below).

In order to fulfil our goal – to create an interactive and interesting training – we chose various activities, e.g., short games at the beginning of each day to tune in to the work, various creative activities (drawing, plasticine modelling, etc.), also group work with the use of flip charts and other tools, as well as individual work in the framework of self-discovery exercises.

Since we did the training in two runs, of which the first 4 days during the second run were on-line, we had the opportunity to test how the training works in the on-line space. We adapted all the prepared interactive activities to the on-line space and within the Google Meet platform, through which the training took place, we used various available tools to make the training as varied and enjoyable as possible. The specificity of the on-line space is also the importance of regular breaks

TWO PHASES OF TRAINING:

1. PHASE (4 DAYS):

DAY ONE

The training is aimed at acquiring theoretical knowledge on the topic of eating disorders. The aim is for prospective peer consultants to add theoretical information and knowledge to their own experience of the disease and its treatment, in order to gain a broader context and understanding of the disease and its course, manifestations and treatment. We assume that this information can help future peers to fill information gaps within eating disorder theories and the recovery approach. They can also help to reinforce the insight into the overcome disease or strengthen the argumentative skills when communicating facts, combating myths and prejudices with clients.

Subjects covered:

- History – we offer a brief overview of information on how eating disorders were viewed in the past and how eating disorders were discussed by the experts at that time. This supports the fact that eating disorders are not a modern invention. To support the historical context of the eating disorders, we highlight research milestones that have influenced both the naming and perception of eating disorders as we know them today, and in particular anorexia nervosa and bulimia nervosa. We conduct a discussion with the participants on the topic of the need to know the history of the disease.

- Diagnoses on the spectrum of eating disorders – we go over all diagnoses and disorders found on the spectrum of eating disorders (with primary emphasis on anorexia nervosa, bu-

limia nervosa and the diagnosis of binge eating disorder) and the individual symptoms and causes of their occurrence.

- Comorbidities – we discuss the most common psychiatric comorbidities in eating disorders, such as depression, anxiety, phobias, or borderline personality disorder. The aim is to prepare future peer mentors for the different types of clients they may encounter in practice and to make them aware of the boundaries of their work and knowledge as peer consultants.

- Sports and eating disorders – we highlight both the healthy and unhealthy aspects of sports in illness and during treatment, specifically playing sports during treatment, changing the relationship with sports and regaining the enjoyment of sports. We are particularly concerned with the sporting environment, which is one of the possible risk factors for the development of eating disorders.

- Family – we emphasize the influence and importance of the family in the development and treatment of eating disorders, a shift from the perception of the family as a possible risk factor and environment, to looking at the family as a basic building block of treatment – especially for younger clients. We point out the modern method of treatment called Maudsley approach, its benefits and limitations in our conditions.

- The effects of eating disorders – we look at the individual physical, psychological and behavioural effects of eating disorders on a person to highlight the complexity of the impacts of the disease on a young person's life.

- Myths and stereotypes about eating disorders – we present the most common myths about eating disorders that are known in society with a focus on deconstructing them. Awareness and naming of these myths is important for our peers and potential clients.

- Social networks and eating disorders – we bring an insight into the impact of current social networks on the emergence and development of eating disorders and the importance they play in maintaining myths in society. We also try to make peer mentors aware of what content they are posting on their social networks, and how to recognize the experts from the laymen on the internet.

- The mindset of a person with an eating disorder – we portray the changes in the thinking of a person with an eating disorder, how this mindset is formed and reinforced during the illness, and how it can interfere with treatment.

- The voice of the eating disorder – we use interactive tools to depict the phenomenon of voice of the eating disorder, how it can talk to a person and how to work with the voice of the disease from a peer perspective.

- Food reward system – we draw attention to the use of information from neurobiology on the reward centre in the human brain and its use in working with clients. We show parallels of eating disorders with addictive diseases.

- Compensations – we will discuss possible ways of coping with anxiety and negative thoughts or depressed moods in illness, recognition of compensatory mechanisms in clients and the ability to explain the function of compensations in illness.

- Relaps – we cover the topics of relapse in eating disorders, warning signs and options for working with clients in relapse.

DAY TWO

The training is aimed at acquiring theoretical knowledge on the topic of eating disorders treatment and recovery approach, as well as getting acquainted with the work in the organization EDI Slovensko (Chuť žiť) and in a multidisciplinary team. We emphasize adding information on eating disorders and building on the themes of treatment and recovery. The aim is for peers to gradually focus on healing, the healing process and their role in it as a support worker.

In the second half of the day, we focus on the story as a working tool of a peer consultant, based on the manual from the Centre for Mental Health Development (Foitová et al., 2014).

Subjects covered:

- **Motivation for treatment in a person with an eating disorder** we provide information on the positive and negative motivation of the client; we teach future peers the different stages of the client's motivation and readiness for change and how to work with the client during these stages. We also deal with motivational traps.

- **Forms of help in eating disorder treatment** an overview of the different types of professionals working with clients and their role in the treatment of eating disorders, an overview of the differences between individual specialists and peer.

- **Outpatient treatment versus hospitalization** – advantages and disadvantages of both forms of eating disorder treatment and our position on this issue.
- **Multidisciplinarity in treatment** – the benefit of a comprehensive approach as an advantage; who makes up such a team, how the team works and what its role is.
- **Medication in treatment** – building awareness of what topics and issues around medication peers may encounter at work, leading future peers to neutrality in the field of medication.

- **Recovery approach**
  an explanation of the recovery approach, the optics of recovery and how we perceive it. Peer as a bearer of faith in healing.

- **Functioning in the organization**
  in this section we focus on a more derailed introduction of the organization EDI Slovensko (Chuť žiť), its structure and scope, as well as the project in which the participants are located.

- **Story as a working tool**
  we prepare future peers to process their own stories as a working tool. We have assumed that each peer's story is unique and their experience of illness and recovery is equally unique and unrepeatable. Nevertheless, their journey is inspiring and parts of their story can be very helpful to others on their healing journey. The aim in this part of the training is to make the peers understand that their story is one of their working tools, and therefore it is important to prepare it in advance and prepare it for use so that it focuses primarily on the healing process and on forms of help; on what helped and motivated them. At the same time, it should help them think about how to extract and use individual parts of the story in a conversation with the client, and process the story without the parts they don't want to share. On this day, the story is presented theoretically to the peers as a work tool and they

are given a homework assignment – to write their story at home and then present it to us and the other participants on the fourth day of the training.

- **Writing own story** – sorting through ideas in terms of what peers want to share, what the story should focus on. The structure of the story, the function of the story in peer support.
- **Story as a working tool** – one of the techniques that peers use – how to use it correctly, what to watch out for when using the story.
- **How to share your story with more people** (in front of a group).

DAY THEE

The training is aimed at specifying the position of a peer consultant. The aim of the day is to comprehensively introduce peers to the position, the pitfalls of working with people and the tools to prevent or protect themselves from these pitfalls. In this part of the training, peers are to learn skills and techniques to protect and take care of themselves so that they can do the work of a peer consultant without being overwhelmed by the stories of others.

Subjects covered:

- **The role of a peer consultant in the treatment of eating disorders**
  we define the boundaries of the role of a peer in a team of experts (or in a multidisciplinary team), the skills and competences of a peer and possible work in the field.

- **Relapse in the peer**
  building on the information from the first day about relapse, in this section we focus on building a practical relapse prevention plan, emphasizing trust in the team and the importance of supervision as a way to protect the peer's needs and boundaries.

- **The boundaries of the peer consultant role**
  we define the boundaries of the peer's work, which are sometimes ambiguous and because of the lower formality of the relationship with the client, it is important to learn to guard them. We discuss with prospective peers why it is important to follow them and not to exceed them and leave room for questions.

  - **Burnout syndrome** – what it is, how a peer is at risk of it and how they can protect themselves from it.
  - **"Mother Teresa Syndrome"** – what is it, how to cope when we cannot always save all clients.
  - **Psycho hygiene** – how to take care of yourself and your mental health when working with people.

- **Client crisis in peer support**
  we define what a crisis is, what a client in crisis looks like – how to identify it, what to do in a crisis (psychological first aid and crisis lines and contacts). We also emphasize the importance of knowing how to take care of yourself as a peer after meeting a client in crisis.

  - **Reporting obligation** – we have an obligation to report situations in which clients may be at risk to their health and/or could endanger someone's health, we define the procedure for this obligation.

- **Practical demonstration of relaxation techniques (e.g., autogenic training)**
  relaxation has an important place in the process of eating disorder treatment for many people. Autogenic training was carried out with the trainees, but it is also possible to show them other relaxation techniques. The aim is to introduce them to such a possibility of rest and relaxation and to try the effects of physical relaxation on themselves. The task of the peer is not to guide the client through a relaxation technique, but to be able to explain what it is and to point out the possibility of using a technique to release the tension arising during the treatment.

DAY FOUR

The training focuses on working with story as a working tool. The aim is for the trainees to put their story into a form in which they can present it in front of others and to try sharing their story in front of other people (trainers and other trainees). During this day, participants read their stories while others give feedback on it. The latter in this case consists of emotional feedback (i.e., "What did the listening to the story evoke in me?") and constructive feedback (highlighting the positive parts and suggesting amendments).

After each story and feedback round, a short pause is recommended – in order to process the experience of the next peer reading his/her story, and also to tune the group in to the next story.

After the presentation of all the stories, practising communication with a client follows, using their own experience of their story. Peers and peers are divided into client-peer pairs, or into triplets using the observer role. The challenge is to try to follow up the client's sharing with a part of their story that might be

appropriate in terms of support and motivation. Then they discuss together in the group the feelings and impressions with using their story as a working tool. Future peers leave with the experience of sharing their story, and in the following pause before the second phase of the training, they are asked to reflect for themselves on how they felt in this situation and role.

2. PHASE (2 DAYS)

In these two days, the training is aimed at adding specific practical information to the process of meeting the client and conducting conversation with the client. We build on the knowledge that formed the content of the first four days of training, and also on the experience of sharing their own stories. The greatest emphasis of these two practical days is on rehearsals, which take the form of "role plays", or "skits" involving the peer, the client and – due to the number of participants – also observers. After each role play, it is essential to include feedback from the observers, as well as reflect on the feelings of the peer and client who played their roles. The learning moment is the feedback discussion, where we comment on what worked or didn't work in the conversation; how one could react otherwise; we learn to be here and now with the client. The aim is for peers to put the acquired information, skills and techniques to practical use, while being aware of the complexity of the issues that the client may bring to the meetings. We also tried to introduce peers to the different types of clients they can meet to be prepared for these kinds of situations

Subjects covered:

- **The course of meetings between the peer consultant and the client**
  we introduce to the participants what the cooperation between the peer and the client looks like and how it takes place, the model of cooperation, the frequency of meetings, contact with the client and arranging meetings.

  - **Structure of peer meetings** – how to have a conversation with a client, how to open and close the conversation.
  - **Initial interview** – specifics of the first interview with the client, what to prepare for, what is necessary to tell the client at the first meeting.
  - **Negotiating the goal/order** – specification of the client's treatment goal in view of the capabilities, skills and competences of the peer consultant.
  - **Closing the meeting and ending the collaboration** – the issue of ending the relationship between the peer and the client, possible risks and issues.
  - **Written communication with the client** – Written communication with the client – a form of on-line communication, tips on how to communicate and how to set accessibility boundaries.
  - **Administration of peer consultant** – minutes from peer meetings, which peers should record to maintain the continuity of interviews and meetings, as recorded within a multidisciplinary team of collaborating experts.

- **Interviewing techniques**
  in addition to the story as a working tool and the peer consultant's own personality, we present future peers with conversational and motivational conversational tools that they can use in their meetings with the client. Each technique includes a practical test and an exercise:

- active listening;
- open and closed questions,
- reflection,
- appreciation,
- affirmation.

- **Non-verbal communication**
  why it's important to notice both the client's and the peer's non-verbal speech, what it all means and what it can mean. Working together on a list of things that work and don't work, what they themselves have encountered in the past in consultation with experts, etc.

- **Other techniques that can be used in peer support**
  in this section we have highlighted various other techniques that peers can use in their work. We reminded the participants of the techniques that we introduced to them successively during the individual training days in relation to the theory and topics covered.

  Examples of the techniques mentioned above:

  - decision-making form as a technique,
  - judgement of thoughts,
  - distribution of fear foods by traffic lights,
  - writing a diary in the form of a record of the situation, triggers of discomfort, experienced emotions, thoughts, bodily sensations, behaviour, etc.,
  - imagination of a safe place,
  - method of self-love,
  - formulation of goals using SMART technique,
  - naming of cognitive distortions.

- **Practical demonstrations and practice of interviews**
  As we mentioned when introducing the second phase of the training, the aim of the two days was to link all the knowledge acquired and apply it in practical exercises of conversations

with the clients. Participants took turns in the roles of peer, client and observer, and through practice conversations and feedback from observers, they mastered the work of peer consultants. For rehearsal purposes, on the second day of the second phase of the training, the trainers acted as clients, and we prepared the different role plays and types of clients in advance based on our own experiences. Our intention was to introduce the participants to a wider range of clients and their behaviours during the session.

During the rehearsals in the second phase of the training, we covered the areas of:

- Practising the technique of conversation.
- Practising the initial conversation with the client.
- Practising how to inform the client about the reporting obligation at the first meeting and during the course of the collaboration.
- **Practising work with different types of clients** – the practical training of techniques and skills that the participants have learned during the training takes place in two ways:

  - Participants interact with each other – one has the role of the peer, one has the role of the client, and one has the role of the observer, alternating between each other. They play different situations and try working with the story and technique.
  - Lecturers with participants – trainers take turns in the roles of different types of clients, the role of participants is to be in the role of peer and to react without prior preparation to the situation that the trainer brings as a client – rehearsing techniques, skills, knowledge, working with the story. Others observe, and then reflect.

Types of clients:

- client in opposition,
- motivated client,
- client who brings in peer sessions topics to therapy,
- client crossing the boundaries of a professional relationship,
- client with suicidal thoughts,
- manipulative client,
- client comparing himself/herself with a peer,
- non-communicative client,
- depressed client,
- client heading towards relapse,
- anxious client.

The types of clients described did not come from the official literature, but rather from empiricism, practice, and the subjective naming of the trainers to simplify categorization and rehearsal.

The training also includes **communal dining**, where all the trainees go together with the trainers and trainers to a restaurant for lunch, which is not known in advance. As part of this, we looked at the participants' insight into their illness, their ability to choose a meal from the current menu without prior preparation and knowledge of what would be served, and to eat it in the presence of other people. These situations are a huge challenge for people recovering from eating disorders, and sometimes there may even be a request for the peer to go out to eat with them. For this reason, we decided to include communal dining in the training, bringing future peers closer to the experience of sharing an unexpected meal where they are, to some extent, being watched.

Regular **reflection and feedback** were also an integral part of the training. We consider it essential for a peer counsellor to have self-reflection and insight not only into his or her experience with the disease but also into his or her abilities and possibilities within the peer counselling work. Therefore, quite often during the training there were blocks where we, as trainers, intensively asked the participants how they felt, how they perceived the topic, whether they had any questions or comments, etc. This also encouraged the participants to share, which is an equally essential part of the peer consultant's work.

6. PRACTICE AND EVALUATION OF THE TRAINING, BENEFITS OF THE PROJECT

The evaluation of the training project and the subsequent practice of peer mentors took place in several phases. At the end of each training day, the training itself included a final reflection and feedback on the content and organisation of the day. At the end of the second phase of training, an anonymous feedback questionnaire was sent to all participants. The results of the questionnaire will be presented in a separate subchapter.

The training was followed by a practice for the peer trainees, during which they engaged the knowledge and experience gained during the training and put it into practice. The practice consisted of individual cooperation with the client and also took place in a group form of cooperation in the community centre EDI Slovensko (Chuť žiť). In order to be able to assess the impact of the training on practice, we conducted the evaluation in the form of face-to-face individual interviews with the participants, with each of the trainers separately completing 3 interviews that included questions focused on perceptions of the training itself, the impact of the training on practice and personal life, and an evaluation of the training experience. Evaluation will be the subject of a separate section in this chapter.

6.1 EVALUATION OF THE TRAINING IN THE FORM OF AN ANONYMOUS QUESTIONNAIRE

The whole training was evaluated by questionnaire, which was anonymous. The questionnaire was sent the day after the end of the training, i.e., on the 6th day of the second phase of the training. It consisted of eight questions and was a combination of closed and open questions. The questionnaire was answered by 6 trainees in both Run 1 and Run 2.

6.1.1 QUESTION NO. 1: TO WHAT EXTENT DID THE TRAINING MEET YOUR EXPECTATIONS?

This question was scored on a scale of 1 to 5, with a final score of 97%.

6.1.2 QUESTION NO. 2: PLEASE INDICATE HOW SATISFIED YOU WERE WITH:

- approach by the trainers,
- structure of the training,
- atmosphere of the training,
- overview of the trainers in the subject,
- focus on the topic of eating disorders and the quality of the information provided in the training,
- practical exercises,
- variability of activities,
- usefulness of the training for further practice,
- understanding the position and work of the peer consultant.

This question was evaluated on a scale of satisfaction from 1 – completely dissatisfied to 5 – completely satisfied. All of the above sub-questions were rated as maximum satisfaction by the participants, with one response rated as 4 –satisfied, namely the atmosphere at the training. This was a response from the first run of the training where the atmosphere was affected by a reduction in the number of participants during the training due to illness.

6.1.3 QUESTION NO. 3: PLEASE JUSTIFY YOUR ANSWERS FROM THE TABLE IN MORE DETAIL

This question offered space for free response and verbal commentary on the above items. The participants highlighted in their answers the approach of the trainers, which they perceived as professional and at the same time human and friendly. They appreciated the regular breaks in the training, the structure itself and the connection between theory and practice. The exercises themselves –both individual and group – the relaxation, the degree of creativity of the exercises and the realism of role-playing and drills were rated as particularly beneficial. A safe and comfortable environment for training and chemistry in the group also resonated in the answers. Last but not least, the emphasis on peer psycho hygiene and self-care was appreciated.

6.1.4 QUESTION NO. 4: WHAT DID YOU MISS AND/OR WHAT COULD WE IMPROVE?

This question was open-ended and offered an opportunity to comment on training gaps. Participants in the first run named low participation as a negative, with a recommendation for better communication during the selection process. In addition, no negatives or suggestions for improvement were mentioned. One participant recommended regular relaxation activities at the end of each training day.

6.1.5 QUESTION NO. 5: HOW WOULD YOU RATE THE ORGANIZATION OF THE TRAINING (RECRUITMENT, ORGANIZATIONAL INFO, COMMUNICATION FROM THE ORGANIZER)

This question was rated on a scale of 1 to 5, with 100% satisfaction with the organisation of the training.

6.1.6 QUESTION NO. 6: HOW DID YOU HEAR ABOUT THE TRAINING COURSE:

The question offered a choice of options; social networks (Facebook, Instagram), the website of the organization EDI Slovensko (Chuť žiť) and a recommendation from a friend appeared as communication sources. Three participants received the training as part of their induction into the organisation.

6.1.7 QUESTION NO. 7: WOULD YOU RECOMMEND THIS TRAINING COURSE?

100% of participants answered YES to this question.

6.1.8 QUESTION NO. 8: WHY WOULD YOU (NOT) RECOMMEND US + ANY MESSAGE AT THE END :-)

This question offered space for free response and sharing. Participants highlighted the impact of the training on their personal lives, EDI Slovensko (Chuť žiť) as an inspiring and innovative organization, and the training as a test of readiness and healing. They also appreciated the great experience of an aligned collaborative group, the ability to create an atmosphere of a safe environment, and the importance of training the peer consultant for the specificities of his/her job and position.

6.2 EVALUATION OF TRAINING AND FOLLOW-UP PRACTICE IN THE FORM OF INTERVIEW

Interviews with individual participants were conducted online and lasted between 30 and 45 minutes. Each trainer conducted several separate interviews from which she compiled a qualitative output. The trainers' questions focused on the following areas:

- perception of the training itself over time, pros and cons,
- Perceptions of the impact of training on personal life, assessment of perceived recovery before and after training and practice,
- activities from the training that stuck in minds as personally or professionally beneficial,
- Feelings of cooperation in the training group,

- own psycho-hygiene,

- the benefit of the training in the context of the peer position and practice in the community/peer consultant role, what specifically from the knowledge and experience they have gained and they have used in practice, what they would have appreciated to have heard in the training that was not mentioned/missed in the practice, what other ideas and suggestions they have for the training now that the knowledge has been linked to their practice in the peer consultant position.

The results of the qualitative interviews confirmed satisfaction with the content and course of the training. All participants found the training to be adequate to prepare them for peer consultant work, and were able to apply a number of the skills they had acquired during their placement. As in the questionnaires administered immediately after the training, over time all participants perceived the training as very beneficial, both in terms of the knowledge gained and in terms of their practice as a peer consultant. The practice confirmed their readiness for the role of peer thanks to the theoretical knowledge acquired during the training and the practical exercises that put this knowledge into practice.

The participants evaluated very positively the comprehensiveness of the training, the connection between theory and practice, the variety of topics and activities and the approach of the lecturers. They saw a great benefit of the training in the opportunity to share their own experience, which was reflected across the activities and themes of the training. In terms of the organisation of the training, the participants appreciated the good time distribution and the inclusion of adequately long and frequent pauses necessary for absorbing knowledge and processing the challenging topics that were raised during the training. They preferred face-to-face contact during

training, but at the same time they did not rate the on-line form as negative or less beneficial. In the first group, participants mentioned the difficulty of training days in pairs, as the first run was struggling with attendance issues. There was also a suggestion to train outside of working days and hours, as this would open up the opportunity for employed participants to attend without having to take holidays or other types of time off from their own work. Positive feedback from all participants was the approach and preparation of us lecturers, our involvement in individual activities and role-playing different types of clients and situations from our own practice. The participants also appreciated the composition of the lecturing team, which brought the perspectives of different experts on the issue.

Among the most appreciated activities of the training, the participants named the rehearsals themselves and the involvement of the trainers in the playing of the clients, also the familiarization with the motivational phases for the clients, working with stress and burnout syndrome, self-assessment cake, drawing the voice of the eating disorder, sharing one's own story, lunch together, and autogenic training. In general, the schedule of the group activities and the interactivity of the training, the joint brainstorming on different topics, which brought the elaboration of multiple perspectives and experiences, were very positively evaluated. The opportunity to share feelings, experiences and feedback in a safe training environment was also very positively perceived.

In our interviews with the participants, we also specifically addressed their subjective perceived impact of the training and practice on their personal lives, perceived confidence in their recovery, psycho hygiene, and working in a group with peers with experience of a similar health condition. An anonymously sent scale assessing recovery rates before and after the training showed that all participants experienced an increase in confidence in their recovery by an average of 8%. An average score of 88% was recorded on the scale of feeling recovered before

training, and on the scale of feeling confident in recovery after training and practice, this average score jumped higher, to a figure of 96%. In individual interviews, participants reported that the training raised various themes related to the illness itself and recovery, but did not bring up any negative aspects or the return of thoughts of the disease. They affirmed their distance from the illness and the processing of their own experience, became aware of multiple aspects of illness and recovery, processed the theme of boundaries and anchored themselves in them. Also, one participant gained a better understanding of the mechanisms of lapses and stumbles in healing as a result of the training. We noticed that one participant perceived the topics of the training as particularly difficult, they caused sadness and crying in her every day, but she managed to treat and process them. The issue of treatment was also of interest to us as we devoted a separate section to it in the training and emphasised its importance across the training days. In terms of psycho-hygiene, participants evaluated the benefits of sharing with others, both sharing with loved ones and family and professionally in teams, interviews and supervisions. The topic of psycho-hygiene and boundaries at work was considered by all of them to be particularly important in the training, making them aware of their own boundaries, the need to balance activity and relaxation, or the importance of knowing their stressors. The peer group at the training was perceived by both runs as safe, open and supportive. One participant beautifully highlighted the experience of functioning and sharing in a group of people with the same problem as extremely beneficial and stimulating, and particularly valued the experience of a relationship built on shared experience, which is actually key in peer collaboration with a client. The benefit of the training on the participants' personal and professional lives also came up in the interviews, in terms of using elements of motivational talks in communication with loved ones, or also being able to pick up warning signs in youth at work at the school where one participant works.

The third part and the range of questions to the participants was the perceived benefit of the training on their subsequent practice as a peer. All participants rated the training as necessary and essential for practice, using the knowledge, techniques, and experience gained from the rehearsals and subsequent feedback. From the participants' point of view, the most frequently used in the peer interview was the story itself and its processed parts, then all of them used motivational interviewing techniques, especially active listening and reflection, and also the art of being with the client here and now. Participants appreciated the knowledge of the motivation and readiness of the clients, as well as the knowledge that they do not have to be alone on the situation and they can consult in the team and intervisions afterwards.

Of the techniques, the most frequently used were working with the eating disorder voice and the self-esteem cookie. In addition, each of them also used insights from the sections on psycho hygiene and their own boundaries in sharing information about themselves with the client. When asked what they missed in practice and did not learn in the training itself, they answered that they would definitely appreciate a continuation of the training, which would offer even more techniques on how to work with clients in long-term cooperation, how to interview silent clients, and how to manage a suicidal client. Participants with experience only from the community centre would have appreciated more insight into the work, which involves only one individual consultation without subsequent further cooperation. When asked for any ideas and tips for improvement, the idea of leaving more time in the training to write one's own story, including relaxation exercises each day after the training, offering insight into the work of a nutritional therapist in a multidisciplinary team, and setting up collaborative peer intervisions in the practice were all ideas that came up.

Both forms of educational evaluation were very positive. In the questionnaires and interviews, the participants appreciated the whole training and its contribution both to their practice as a peer consultant and to their personal life. For all of them, the training, its content, and subsequent practice with clients anchored their perception of their own healing and reinforced the need for psycho hygiene and care for their own mental health. The participants also appreciated the approach of us – the trainers, as well as the training environment, where we managed to create a safe environment, which is essential for sharing and peer work. A limitation of the evaluation from our perspective may be the slight difference in the participants' experience of the first and second run, where – as mentioned in the previous chapters – there was a problem with participation in the first run of the training. We also have to take into account that two participants of both runs only experienced the first part of the training and could not participate in the role-play and conversation training days, thus they could not evaluate the comprehensiveness of the preparation for the position included in the training. In the second run of the training, we had to change the format to a combination of on-line and off-line training courses for organizational reasons, but this did not prove to be particularly limiting or influencing the level of experience of the training itself and its content.

7. RISKS OF PEER MENTORING

The actual risks of working as a peer consultant were one of the underlying themes in the construction of the training and education programme. We are aware of the unclear boundaries of the position in a number of ways. One group consists of professional risks, where no specific previous training is required for a peer and it is also sometimes difficult to separate peer competence from other professionals. The second group consists of personality risks, where it can be difficult for the peer to keep the consultation with the client on the borderline of being both informal and in a working relationship. Of course, the boundaries of the peers' own mental health also play a big risk, as they are exposed daily at work to problems that have troubled them for some part of their life and may be potential triggers for relapse. It is for these reasons that we consider it important to prepare peers for their role, and to give them sufficient information through education, rehearsal of situations with clients, and training in the organisation itself.

The Good Practice Handbook of the Centrum Anabell (Jurová, Svabiková, 2021) also lists the personality structure itself as a risk factor for peer work, which is often present in the aetiology of people with eating disorder experience. These include anxiety, rigidity, perfectionism, and obsessive-compulsive traits in anorexia. and emotional lability and impulsivity in bulimia. Many people with eating disorders tend to be perfectionists, or many people with eating disorders are perfectionists, which makes them to be highly motivated and competent employees. Thus, a risk factor from this perspective could be a potential failure to process and learn how to manage these characteristics as part of one's treatment. Therefore, regular team and individual supervision is of great importance for the prevention of this risk, where the peer consultant can address his own work issues, problems and boundaries.

According to the manual on the involvement of peer consultants in treatment prepared by the Centre for Mental Health Prague (Foitová at al., 2016), the setting of the multidisciplinary

team itself, the lack of inclusion of the peer, or the inadequate presentation of the peer's role to other professionals can also be a potential risk. The need for regular team meetings, intervisions and supervisions to ensure quality teamwork is emphasised.

In addition to the basic risk factors listed above, it is also necessary to take into account the variability of various other risks arising from the very nature of the work of the helping professions, the setting of the organisation, the personal individual factors of the workers, etc. In this respect, the benefits of supervisions and interviews are enormous and important too.

7.1 RISK FACTORS ASSOCIATED WITH A TRAINING PROGRAMME FOR PROSPECTIVE PEER CONSULTANTS IN TERMS OF THE PROCESS, DELIVERY AND IMPLEMENTATION OF THE TRAINING

The process of preparing and implementing the training brought awareness of several risks and problems. In selecting candidates for the training programme, as in selecting the peer consultants themselves, there are no fixed rules that the candidate must meet (e.g., defined education in a specific field, specified years of experience, etc.). Thus, the training itself gives room not only for education in the field concerned, but also for learning about the suitability of the job for the candidate, as well as the relevance of the candidate to the organization. Not every candidate and trainee has proven to be suitable for the position of peer. Comorbidity with another mental illness in its active phase was a major risk factor; also, some topics proved to be too vivid and painful during discussions in

the training course. The differences in the previous education and experience of the individual trainees put them in different positions in understanding the content of the training; those with non-humanities backgrounds often needed to go more in-depth and know the basics of the topics. In terms of activity and cooperation of the trainees, another risk was the timing of the training, where the blocks devoted to rehearsals on days 5 and 6 were overwhelming sometimes and treated to more frequent breaks and debriefing after each role play. This factor emerged as a risk factor especially in the first run of the training where only 2 candidates were present on the days devoted to rehearsals and hence were actively engaged throughout the day.

A complication of the training itself was the participation in the first run. The training took place during the warm summer months and holidays, which led to the capacity not being filled (2 people did not show up on the first day of the training). The extreme temperatures also affected the level of activity and mood in the group. In addition, the second half of the first training run was affected by the illness of one of the participants, who had to cancel her participation the day before the start of the training block. Unfortunately, the risk of falling ill during training with a fixed date could not be treated in any way in advance

In the second run of the training in the fall, the capacity was filled, but due to trainers' availability, we took the first block of training on-line. The quality of the training itself and the communication between participants was not affected, and the feedback from both participants and trainers was positive. It has also proven that the training can be carried out even in the case of a worsened pandemic situation. It was possible to use the potential of the on-line space, as well as various tools for effective learning. The second half of the training was face-to-face, so the element of interaction and rehearsal of client situations that could not be authentically transferred to an on-line

format was not lost. Based on this combination of off-line and on-line training, we lost a new colleague from the Czech Centrum Anabell in the second half.

The difference between the training blocks is in their practical and training level: the first block consists mainly of information about the work of the peer and its limits, the second block is focused on practical exercises and grasping the information from the first four days. The division and completion of only the first part of the training is still beneficial for the candidates in terms of their learning, but the training level needs to be extended individually, for example by the presence at the meetings of a more experienced peer consultant of the organisation with the clients.

Other potential risks were addressed by a questionnaire for the participants' feedback, which was sent after the end of the second block of training. Evaluation interviews were also scheduled after the training and practice to provide, among other things, a retrospective look at the potential risks of the program.

The implementation of the training in the organization itself is still a challenge. The issue is the possible reduction of training hours if the capacity of candidates is not filled, as it is neither possible nor feasible to train the programme individually. Another issue is the possible inclusion of a training programme. Its contribution can be both in the process of training a new worker and in the process itself of selecting a new peer consultant.

7.2 RISK FACTORS ASSOCIATED WITH BEING A PEER IN A COMMUNITY CENTRE CHUŤ ŽIŤ (THE ORGANIZATION EDI SLOVENSKO)

After the completion of the training programme, practice followed within the activities of the community centre EDI Slovensko (Chuť žiť). Participants had the opportunity to participate in group activities or individual conversations with visitors to the community centre. Individual peer consultations are time-limited and do not serve to establish long-term cooperation with the clients. Despite this, the risk in individual consultations was establishing the connection between the clients and the peer consultants, especially by asking questions about their stories, which could give the impression of a deeper relationship. The review of the individual meetings and the identification of potential risks were carried out by reading the minutes of the meetings. Peer consultants were advised to limit more cooperation in individual consultation as a precaution to avoid misunderstanding of the function of these consultations.

8.
EVALUATION OF THE PROJECT

8.1 EVALUATION OF THE PROJECT FROM THE POINT OF VIEW OF THE TRAINERS AND COOPERATING ORGANISATIONS

MGR. NATÁLIA MELIS-CUGA (name at birth TOKÁROVÁ) – author of training and methodological manual, peer consultant, psychologist and therapist in training, Centrum Anabell: "Collaborating on the development of the training program has been very rewarding for my professional and personal life. As a peer consultant from Cetrum Anabell, I see a lot of sense in involving peers in the treatment of people with eating disorders and other mental illnesses, I am glad that it will be possible to operate in Slovakia as well. Peer is the bearer of faith in recovery not only for clients, but also in the wider public as part of mental health education. Working together on defining the role of a peer consultant, the creation and implementation of the training and the subsequent writing of this manual brought a greater anchoring in work for me as well We were able to create an accepting and safe environment in both runs of the training, which was beneficial not only for the participants, but also for us as trainers. During the training, we also shared our stories and our own experiences of working with clients. We complemented each other in the training team with varying degrees of education and experience, and worked well both in the development of the training and manual and during the training. After the first run, we incorporated some changes and insights from the training course and additional questions from the participants, such as the need for a minimum of three participants for the play role rehearsals, focus on the meetings with the clients and non-verbal communication. Thus, in the second run, we anchored the composition of the training and individual topics. The question remains as to whether training can be translated into the broader context of peer consultant training without focusing on a specific disease. And also how to use the training to train new peer consultants in the organization EDI Slovensko

(Chuť žiť), where individual peers often start to work, which is not feasible for this format of the training."

VALENTÍNA SEDILEKOVÁ – author of training and methodological manual, peer consultant and director of EDI Slovensko (Chuť žiť): "Working on the development of the training, the training itself and then the communication and cooperation with the young peer or youth workers was also a great benefit for me. A great added value, (not only) for the project itself, was the teamwork – each of us, the trainers, brought a new and different perspective and knowledge from practice to the creation of the training – be it psychological, psychotherapeutic, or from peer support and youth work. Personally, participating in the project helped me to better define the skills and competences of the peer consultant both in the project and in the organisation and to clearly specify the expectations from peer consultants who currently work or in the future will work or volunteer in the organisation. Since we wrote this manual at the end of a joint project, I can say with hindsight that the outputs of the project fulfilled the objectives with which we wrote it. We have been able to create comprehensive training that is useful both for staff working with youth with eating disorders and directly for youth with eating disorders themselves. Even after the end of the project, our goal remains to accredit the training and actively continue with the training. Equally important for the success of the project is the international cooperation with Centrum Anabell, with whom we have created not only a strong partnership, but also a good team, and I believe that our cooperation will also continue after the end of the project."

MGR. MIROSLAVA TAKÁČOVÁ – author of training and methodological manual, psychologist and therapist in training, EDI Slovensko (Chuť žiť): "Collaborating on the development of training for peer consultants has taught me a lot professionally and personally. Valentina and Natalia and I quickly bonded towards a common goal – to create a useful, meaningful and at the same time interesting and interactive training for young

people so that they can help further. This was safely reflected both in the structure and content of the whole training as well as in the experiences and feedback from the participants. It was the first time I had the opportunity to work so closely with peer consultants both as colleagues and as extremely engaged participants in the training. Their experiences with the disease, but above all with the treatment and recovery, are invaluable and inspiring. Their stories have enriched me as a person and as a psychologist working daily with clients with eating disorders. This collaboration has allowed me to better understand the challenge, but also the enormous importance and inspiration of the peer role, in working with people with both eating disorders and other mental illnesses. I am very happy that we have managed to create a successful education that has an impact on the professional and personal lives of its candidates and I believe that the training and work of peer consultants in Slovakia will not only continue, but most importantly will progress."

MGR. EVA SLEZÁKOVÁ, Director of Centrum Anabell, PhDr. Ing. Jana Sladká Ševčíková, Director General of Centrum Anabell: The manual is intended for the process of preparing/educating young people with their own experience of an eating disorder for future work as peer consultants. The manual is clearly divided into several chapters. The first chapter discusses the importance and uniqueness of the role of the peer consultant in the multidisciplinary team of the organization EDI Slovensko (Chuť žiť) focused on supporting young people with eating disorders on their journey to recovery. In particular, the handbook is concerned with defining the personality characteristics and prerequisites of the peer consultants to perform their positions. It emphasises the definition of their skills and competences, duties, rights and comparison with other members of the multidisciplinary team. In our view, these definitions carefully address the high level of security of the peer consultants when interacting with clients and ensure maximum benefit for the clients on their journey to recovery.

The next chapter deals with the selection process for filling a peer consultant position in the organisation. The process is divided into 3 parts and the importance of selection process management is evident in them. It is assumed that a carefully conducted interview with an emphasis on motivation, an attitude to recovery approach, a degree of processing of one's own experience and sharing one's own story is a safety net against possible relapse of the peer consultant.

The largest part of the methodological manual is devoted to the comprehensive training of peer consultants after their admission to the organisation. Professional representation of the team of authors *(Natália Meliš-Čuga – psychologist, CB therapist in training and peer consultant Centrum Anabell, z. ú., the Czech Republic; Valentína Sedileková – the founder of the organization and peer consultant, EDI Slovensko (Chuť žiť), the Slovak Republic; and Miroslava Takáčová – psychologist, trainee in psycho dynamic psychotherapy, works in EDI Slovensko (Chuť žiť), SR)* was brilliantly reflected in the content and layout of the 6-day training for new peer consultants. The training is not based solely on theoretical delivery of information, but is heavily devoted to discussion between trainers and participants. We see that the interactive nature of the training provides the opportunity for both the peer consultant and the organisation to verify that the position is suitable for the worker and thus the worker selection was successful. And also, the opportunity to minimize the threat to the worker in the new position of peer consultant and to increase the relevance and effectiveness of peer consultation for the client in their own recovery process.

Thematically, the training focuses on eating disorders, their history, etiological and clinical definition, and their impacts. Another topic is treatment, motivation for treatment, the recovery process. One whole day of the training is devoted to the position of peer consultants, namely the importance of their role, the boundaries of peers or their relapse. The next two days are devoted to working on the personal stories as a working tool of the peers. Part of the training includes getting feedback from the participants.

In conclusion, the methodological manual addresses the potential risks of the peer consultant position, the risks of the training programme and the question of the implementation of the training programme into the current practice of the organisation. The last chapter is devoted to the comments and insights of the trainers and the authors of the manual and the training programme.

The entire methodological manual fulfils the intended objective of continuously and qualitatively improving the ability of young people to apply their personal experience of an eating disorder to the benefit of their peers who are undergoing a diagnosis from the spectrum of these disorders. We believe that a carefully planned process of working with the person in the peer position from the stage of defining skills, competences and personality characteristics, selecting a suitable candidate through a multi-phase selection interview, and following their acceptance by completing an intensive 6-day training course, is predictive of minimizing the risk of relapse and putting the person in the position at risk of relapse. We are also thinking about strengthening the peers' own resilience and, thanks to this, we expect to achieve a high positive impact for the recovery process of sick people with eating disorders. Based on the experience of our organization, we perceive great potential for the entire MD team and strengthening the philosophy of the recovery principle among other professionals who work with people with eating disorders.

There is no similar material in the Czech Republic or Slovakia that deals in such detail with this specifically defined role of peer consultant. Therefore, we think it could be interesting and useful for other organisations working with people with eating disorders in the form of multidisciplinary teams, including peer consultants. Similarly, feedback from these organizations after pilot testing of this methodology could be interesting and valuable for the organization EDI Slovensko (Chuť žiť)."

9. REFERENCES

Almássyová, G. (2010) “Poruchy príjmu potravy. Etiopatogenéza a princípy liečby.” Bratislava: Lundbeck Slovensko.

Beveridge, J. et al. (2019) “Peer mentoring for eating disorders: Results from the evaluation of a pilot program,” Journal of Eating Disorders, 7(1). Available at: https://doi.org/10.1186/s40337-019-0245-3.

Hromádková, K. (2016) “Začleňování peer konzultanta do pracovního týmu organizace pro duševní zdraví,” FÓRUM SOCIÁLNÍ PRÁCE 2/2016, pp. 51–59.

Jurová, L. and Švábíková, I. (2021) “PŘÍRUČKA DOBRÉ PRAXE v režimu Zotavení.” Brno: Centrum Anabell, z. ú.

Kolektív autorov (Foitová, Z. et al. (2016) “ZAPOJENÍ PEER KONZULTANTŮ DO KOMUNITNÍ A LŮŽKOVÉ PÉČE O DUŠEVNÍ ZDRAVÍ.” Praha: Centrum pro rozvoj péče o duševní zdraví.

Kolektív autorov (Foitová, Z. et al. (2014) “ZAPOJENÍ PEER KONZULTANTŮ DO PÉČE O DUŠEVNÍ ZDRAVÍ”. Praha: Centrum pro rozvoj péče o duševní zdraví.

Kolektív autorov (2019) “Mýty a omyly.” Available at: http://knihovna.anabell.cz/components/com_jshopping/files/demo_products/Myty_a_omyly_2019.pdf.

Kolektív autorov (Špatenková, N. et al. (2017) “Krize a krizová intervence.” Praha: Grada.

Kolektív autorov (Špatenková, N. et al. (2011) “Krizová intervence pro praxi.” Praha: Grada.

Mahlkea, C.I. et. al., (2014) “Peer support in mental health services,” Current Opinion in Psychiatry, pp. 276–281. Available at: https://www.researchgate.net/publication/262580200 (Accessed: May 2022).

Mind collective (2019) “Peer support.” Mind – for better mental health.

Papežová H. (2010) “Spektrum Poruch Příjmu Potravy: Interdisciplinární přístup.” Praha: Grada.

Paulinyiová M. (2013) “Prognostické faktory u pacientok s mentálnou anorexiou.” Bratislava: Lundbeck Slovensko.

Repper, J. and Carter, T. (2011) “A review of the literature on peer support in Mental Health Services,” Journal of Mental Health, 20(4), pp. 392–411. Available at: https://doi.org/10.3109/09638237.2011.583947.

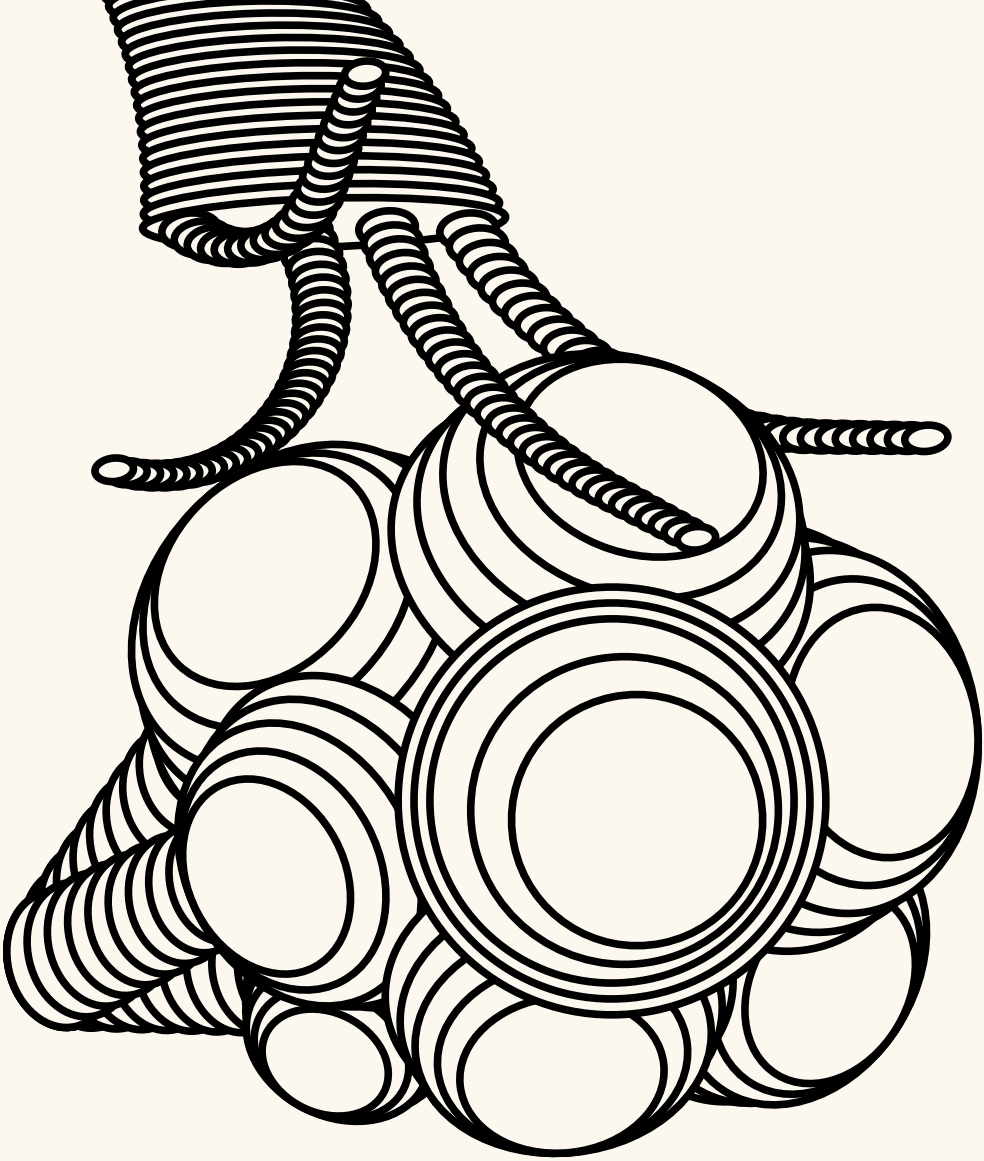
Somogyiová, M., Heretik, A. ml (2015) “Poruchy príjmu potravy na Slovensku a v Čechách: Tematická analýza publikovaných odborných článkov.” PSYCHOLOGIE A JEJÍ KONTEXTY, 6 (1). Available at: https://psychkont.osu.cz/fulltext/2015/Somogyiova–Heretik_2015_1.pdf

Techniky na Zvládanie úzkosti. Centrum emočného zdravia a edukácie. Available at: https://www.emocnezdravie.sk/novinky/techniky–na–zvladanie–uzkosti/ (Accessed: January 18, 2023).

Theinet P. (2011) “Léčba deprese u pacientů s poruchou příjmu potravy.” Psychiatrie pro praxi, 12(3), Available at: https://solen.cz/pdfs/psy/2011/03/05.pdf

YouTube. Available at: https://www.youtube.com/watch?v=FazticI4U2U (Accessed: January 18, 2023).

Záleží na TEBE! Pomoc Existuje. (2022) chcemsazabit.sk. Available at: https://chcemsazabit.sk/ (Accessed: January 18, 2023).



Spolufinancované z programu Európskej únie Erasmus+

NIVAM
NÁRODNÝ INŠTITÚT VZDELÁVANIA A MLÁDEŽE

chuť žiť

Anabell

This methodological handbook is part of the project "Youth as part of peer support: New solutions and approaches to addressing eating disorders in young people" under number: 2021-1-SK02-KA210-YOU-000033886 that we are implementing with the support of the European Commission from the Erasmus programme.

---

www.chutzit.sk