Running head: VOICE-MAIL SUPPORT GROUPS: ASSESSING CONSUMER

SATISFACTION

Voice-Mail Support Groups: Assessing Consumer Satisfaction

John N. Craig

New York University

ABSTRACT

Although group treatment has been shown to be a therapeutically effective and cost-effective form of treatment, a variety of physical, practical, and emotional barriers can prevent individuals from participating. It is hypothesized that support groups conducted via telephone on a time-delayed basis using a specially designed voice-messaging ("voice-mail") system will provide a high level of satisfaction among participants who cannot attend in-person group meetings. Three voice-mail support groups, each consisting of 6-8 geographically isolated caregivers of cancer patients from various parts of the United States, will be conducted over a period of 8 weeks. After the final week of voice-mail interaction, participants will complete questionnaires designed to measure consumer satisfaction. High consumer satisfaction could lead to the further development of a voice-messaging telecommunications system capable of providing support groups via telephone which are inexpensive, convenient, non-threatening, universally accessible, and highly effective.

Voice-Mail Support Groups: Assessing Consumer Satisfaction

Clinicians have long believed group treatment to be a highly effective method of intervention (Yalom, 1995). As Yalom (1995) has pointed out, professionally led therapeutic groups have been used on a widespread basis since World War II to treat an extraordinary variety of conditions: alcoholism, eating disorders, cancer, obesity, depression, panic disorders, schizophrenia, sexual abuse, and a great many more. Northen (1982) has stated that group treatment is the treatment of choice whenever relationship issues are of primary importance.

Clinicians have also long felt that self-help groups—whether leaderless or volunteer-facilitated—can be of extraordinary help to clients (Yalom, 1995). These groups include Alcoholics Anonymous and other 12-step groups. The use of self-help groups is extremely widespread in the United States: It is estimated that more than 15 million Americans seek help in support groups each week (*Newsweek,* 1990).

Although group treatment has been used widely in America since the late 1940s, it has become the focus of new and increasing attention during the past 20 years—and especially during the last decade (Yalom, 1995). At least three factors have been responsible for this surge of interest in group modalities.

First, a significant amount of research—conducted for the most part since 1980—has shown that group treatment is usually extremely effective. It was once widely believed that group treatment was inferior to individual treatment, and this belief has persisted in many circles (MacKenzie, 1995). A decade ago, however Toseland and Siporin (1986) conducted a survey of research studies which had been conducted to measure the effectiveness of group treatment. They found that in all the studies group treatment was shown to be as effective as individual treatment and that in 25% of the studies group treatment proved more effective than individual treatment (Toseland & Siporin, 1986). (These researchers, however, stressed the need for further research in this area.)

A second factor bringing new attention to group treatment in the recent past is the increasingly supported belief that group treatment is highly cost-effective. In their survey, Toseland and Siporin (1986) found that those studies which had examined the cost-effectiveness of groups found them to be more cost-efficient than individual treatment. Some of the studies found individual treatment to cost from two to four times as much as group treatment. In addition, some of these studies indicated that group treatment makes more efficient use of professional staff time. Because managed care organizations have generally accepted as valid the claim that group treatment is very cost-effective, these organizations have moved toward recommending or mandating group treatment in many cases (MacKenzie, 1995). As a result, professional organizations of clinicians who specialize in providing group treatment have swelled their ranks considerably in the past decade, and observers believe the trend will continue (MacKenzie, 1995).

A third reason for the increased interest in group treatment in the past decade has been the impact of a landmark study conducted in the 1980s at Stanford University—a study which demonstrated that group treatment can have a dramatic affect on actual *medical* outcomes. Stanford researchers Spiegel, Kraemer, Bloom, and Gottheil (1989) conducted the study, in which two groups of women diagnosed with terminal metastatic breast cancer received identical medical treatment. The women in one of the groups participated in a weekly professionally led support group; the women in the other group received no such formal psychosocial support. After ten years, statistics gathered in the study revealed that those women participating in the weekly support groups had lived almost twice as long as those not participating (Spiegel et al., 1989).

Thus, groups are perceived as important because they are effective in achieving their psychosocial goals, because they are cost-effective, and because it appears that they may in fact boost one's immune response in certain situations.

Despite these positive characteristics of the group modality, however, a number of barriers effectively prevent a great many an individuals from participating in group treatment. For

example, physical barriers to attendance may exist. Would-be participants may live far from the meeting place of the nearest group available to them. Adolescents, children, and the elderly may lack access to automobiles or other means of transportation required for traveling to and from a meeting place. Those who are sick, frail, disabled, recovering from surgery, or bedridden may also be unable to attend in-person meetings.

Practical considerations can also represent barriers to participation in face-to-face groups. A young mother whose child has a brain tumor may be too preoccupied with caretaking duties to take the time to travel to a support group. In other situations, individuals may find that the kind of group they require is not available in their own area. Such situations are common for those who have a rare disease, or for those who seek a highly specific kind of group—for example, a group for the Spanish-speaking wives of men with prostate cancer.

In addition, emotional barriers such as fear, shame, and embarrassment can prevent individuals from participating in face-to-face group treatment. Individuals with AIDS, rape victims, or men with prostate cancer may feel too ashamed of their situations to attend a face-to-face group. Others may find groups intimidating.

These many barriers to participation in group treatment have, of course, always existed. However, the advent of the new communications technologies—which many observers believe represents the most important change in modern society since the Industrial Revolution (Drucker, 1989)— has recently made possible new ways of delivering group treatment. In the past decade, clinicians have begun to explore ways of using these new technologies to make therapeutic group interactions available to individuals who cannot or will not attend face-to-face groups. Some clinicians have used live telephone conference calls as a forum for support-group communication. Others have used the Internet and other on-line services to conduct computer-based support groups.

Both kinds of groups have allowed individuals to surmount the barriers that previously prevented them from participating in group treatment, and an increasing number of studies have been conducted to explore the effectiveness of these new ways of delivering group

treatment electronically. For example, studies have been conducted on the effectiveness of telephone conference-call groups for people with AIDS and their caregivers (Meier et al., 1995; Rittner & Hammons, 1992; Roffman et al., 1995; Rounds et al., 1991, 1995; Wiener et al., 1993); for those homebound (Stein et al., 1993); and for the visually impaired (Thomas & Urbano, 1993). Studies have also been conducted to evaluate computer-mediated groups. These groups have included patients with breast cancer (Weinberg et al., 1995); survivors of sexual abuse (Finn, 1995; Finn & Lavitt, 1994); and Alzheimer's patients and their family members (Smyth & Harris, 1993; Brennan, Moore, & Smyth, 1992). Although all these studies have shown that technology-based groups have distinct limitations, they have also shown that these groups can be extremely beneficial in a great variety of situations (Galinsky & Schopler, 1997; Foderaro, 1995).

However, although technology-based groups have shown great promise, two factors have effectively prevented their widespread use. In the case of live telephone conference calls, the limiting factor has been the high cost of this technology (Wiener, Spencer, Davidson, & Fair, 1993). The cost of an hour-long conference call is usually above $150 (Wiener, Spencer, Davidson, & Fair, 1993). The limiting factor for on-line groups is the exceedingly small number of individuals today who have access to the Internet. Estimates of the numbers of Americans who have access to the Internet are difficult to make, but most suggest that fewer than 15% of Americans are in fact on-line (The Economist, 1995).

The advent of a relatively new kind of telecommunications vehicle, however, has made possible a completely new kind of technology-based group. In the past five years voice-messaging or "voice-mail" systems have proliferated in the United States because of their rapidly falling cost (Frost & Sullivan, 1993). Voice-messaging is a virtually universally accessible communications technology because it can be accessed using an ordinary telephone. Voice-mail systems are capable of creating a time-delayed verbal interaction among a small group of individuals similar to the interaction created in on-line support groups.

The interaction involves a structured, carefully organized exchange of voice-mail messages instead of a similarly organized exchange of e-mail messages.

Because voice messaging is a relatively new telecommunications forum (Frost & Sullivan, 1993), it is not surprising that its potential uses in social and health-care services are only beginning to be explored. Voice-messaging has recently been shown to be an effective tool for providing communication between parents and teachers (Cameron & Kang, 1997). It has also been used effectively to deliver pre-recorded supportive messages to individuals who are attempting to quit smoking but who have expressed strong resistance to participating in face-to-face smoking-cessation counseling or support groups (Schneider, Schwartz, & Fast, 1995; Jason, McMahon, Salina, Hedeker, Stockton, Dunson, & Kimball, 1995). Voice-messaging has also been successfully used by alcoholics as a method of self-reporting drinking rates via telephone (Searles, Perrine, Mundt, & Helzer, 1995).

The author developed concepts for conducting support groups through voice-messaging systems in the early 1990s and gradually began to test these concepts in a private practice setting. High-functioning individuals responded very favorably over a period of 3-4 years to their involvement in support groups conducted through voice-mail systems. More recently, these concepts have been tested at an outpatient unit of the South Beach Psychiatric Center in New York City. In this situation, outpatients diagnosed with schizophrenic and bipolar disorders and other severe mental illnesses had favorable reactions to their involvement in voice-mail groups conducted on weekends, when the day-treatment clinic was closed.

Voice-mail support groups are in some ways similar to other technology-based groups. However, they have three distinct advantages. First, they are available to virtually anyone who has access to an ordinary telephone. Second, they are inexpensive. Third, they convey the sound and intonation of the human voice, which can be extremely important in many support-group interactions. It is predicted that voice-mail interactions, because they deliver communication via telephone, will share some of the advantages of psychotherapy and other forms of counseling delivered by telephone (Hines, 1994; Haas, Benedict, & Kobos, 1996).

The hypothesis of this study is that participants in three eight-week-long voice-mail support groups conducted for geographically isolated individuals, will react favorably to the supportive group experience delivered to them through this new telecommunications medium.

Method

Participants

Participants will be drawn from the pool of clients referred to the nationwide 800# counseling line of Cancer Care, Inc. in New York. The counseling line receives 50-60 calls per day from callers all over the country—callers requesting information about cancer and its treatment as well as referrals to other agencies. The counseling line regularly receives calls from individuals who are the primary caregivers of cancer patients, have been desirous of joining a support group for caregivers, but have been unable to do so because they have been unable to find such a group in their area. Approximately 18-24 participants will be involved— enough to create three 8-week voice-mail groups consisting of 6-8 participants in each group.

Before deciding to participate in the study, all interested individuals will be informed that they are becoming involved in a research project, that interactions will be taped (though tapes will only be for use by qualified research personnel), and that they will be expected to complete a questionnaire after the group's termination. Participants will be encouraged to identify themselves in the voice-mail interactions by their first names only. Questionnaires will be submitted anonymously by being placed in sealed envelopes and returned to Cancer Care.

Participants will give their written consent to the above stipulations. Questionnaires will be mailed to participants immediately after the end of the final week of their voice-mail support- group interaction.

Design

This study will be conducted using a survey. The survey is divided into five parts and contains 47 questions. The questionnaires will be examined individually and collectively.

Materials

The questionnaire is a modified version of a questionnaire developed by Magen and Glajchen (1995) for use in evaluating in-person support groups at Cancer Care. After the 8-week voice-mail group is completed, all participants will complete the consumer satisfaction questionnaire, which will ask them about their reactions to their experiences in the group.

The first section of the questionnaire will ask for demographic information. The second section will ask questions about the client's other sources of psychosocial support, previous group experience, and "attendance" in the voice-mail group. The third section will consist of questions about the group interaction which evolved during the 8 weeks, such as "Group members helped me to realize that other people experience problems similar to mine." The fourth part of the questionnaire will ask questions specifically about the technological aspects of the group interaction; individuals will respond to statements such as "Because communication from others was recorded on a machine, it felt impersonal and cold," or "The voice-mail system was difficult to understand and operate," or "The time-delayed nature of voice-mail communication enhanced the interaction in some ways." The final section of the questionnaire will contain open-ended questions concerning what the client's favorable or negative reactions to the group interaction and the technology involved.

All of the questions in sections three and four will be answered using a five-point Likert scale using the following ratings: 1 "strongly disagree," 2 "slightly disagree," 3 "slightly agree," 4 "moderately agree" and 5 "strongly agree."

Procedure

The support-group interaction will be conducted as follows.

A Cancer Care social worker will screen each would-be participant via telephone several weeks before any group starts. Two weeks before the start date of a group, all participants will be mailed full instructions for participation. After the start date, each week's interaction will proceed as follows.

Anytime on Sunday, Monday, or Tuesday, each participant in the group will call the system (at whatever time is convenient to him or her), enter a code, hear a welcoming

message from the facilitator, and share his or her concerns (at the tone) in a "sharing message" which will have a specific time limit (approximately 8 minutes). The sharing messages thus delivered will be stored in the system but will not yet be available to group members.

On Wednesday, the group's facilitator will call the system, review the messages, create a new introductory and a final, summarizing message, and issue system commands that will make all messages available to participants.

During the last part of the week (anytime Thursday - Saturday), participants will call the system, enter a code, and listen to: the facilitator's introductory message, the messages of all the other members of the group (one by one), and, finally, the facilitator's final message.

The interaction will continue in this fashion for 8 weeks.

<div align="center">Results</div>

Statistics will be compiled based on the demographic information received. Percentages will be used to analyze "yes" and "no" questions. In section 3 and 4, scores will be summed and totals displayed graphically to indicate overall reactions clearly and concisely. Open-ended questions will be summarized.

<div align="center">Discussion</div>

This study will have a number of limitations. It will involve only individuals who participate because they are geographically isolated. Results may not reflect the assessments of individuals who might have been barred from face-to-face groups by other kinds of circumstances. In addition, questionnaires will probably be returned only by those who remain in the group for the entire 8-week period; generally speaking, those who remain in support groups until their end are usually only those who feel positively about the group experience being delivered. Thus results may be skewed in the direction of a positive response.

Still, reactions to this specific kind of technology-based support group will be useful in determining whether further trials would be worthwhile and in providing information about how any further pilot studies of voice-mail support groups would best be conducted.

References

Brennan, P., Moore, S., & Smyth, K. (1992). Alzheimer's disease caregivers' uses of a computer network. Western Journal of Nursing Research, 14(5), 662-673.

Cameron, C. A., & Kang, L. (1997). Bridging the gap between home and school with voice-mail technology. Journal of Educational Research, 90(3), 182-190.

Drucker, P. (1987). The New Realities. New York: HarperCollins.

Economist, The. (1995, Sept. 30). Telecommunications: The revolution begins at last.

Frost & Sullivan (1993). A review of the voice-messaging industry. Mountain View, CA: Frost & Sullivan, Inc.

Finn, J. (1995). Computer-based self-help groups: A new resource to supplement support groups. In M.J. Galinsky & J.H. Schopler (Eds.), Support groups: Current perspectives on theory and practice (pp. 109-117). Binghamton, NY: Haworth Press.

Finn, J., & Lavitt, M. (1994). Computer-based self-help for survivors of sexual abuse. Social Work with Groups, 17(1/2), 21-47.

Foderaro, L.W. (1995, March 22) I'm O.K. You're O.K. We're on line. New York Times, p. B1.

Galinsky, M. J., & Schopler, J. H. (1997). Connecting group members through telephone and computer groups. Health & Social Work, 22(3), 181-188.

Glajchen, M., & Magen, R. (1995). Evaluating process, outcome, and satisfaction in community-based cancer support groups. Social Work with Groups, 18(1), 27-40.

Haas, L. J., Benedict, J. G., & Kobos, J. C. (1996). Psychotherapy by telephone: Risks and benefits for psychologists and consumers. Professional Psychology, Research and Practice, 27(2), 154-160.

Hines, M. H. (1994). Using the telephone in family therapy. Journal of Marital and Family Therapy, 20(2), 175-184.

Jason, L., McMahon, S., Salina, D., Hedeker, D., Stockton, M., Dunson, K., & Kimball, P. (1995). Assessing a smoking cessation intervention involving groups, incentives, and self-help manuals. Behavior Therapy, 26, 393-408.

MacKenzie, K. R. (1995). Effective use of group therapy in managed care. Washington D.C.: American Psychiatric Press.

Meier, A., Galinsky, M. J., & Rounds, K. A. (1995). Telephone support groups for caregivers of persons with AIDS. In M.J. Galinsky & J.H. Schopler (Eds.), Support groups: Current perspectives on theory and practice (pp. 109-117). Binghamton, NY: Haworth Press.

Newsweek (January, 1990). Help, I need somebody! Support groups in America.

Rittner, B., & Hammons, K. (1992). Telephone group work with people with end-stage AIDS. Social Work with Groups, 15(4), 59-72.

Roffman, R., Beadnell, B., Ryan, R., & Downey, L. (1995). Telephone group counseling in reducing AIDS risk in gay and bisexual males. Journal of Gay and Lesbian Social Services, 2, 145-157.

Rounds, K. A., Galinsky, M. J., & Stevens, L. S. (1991). Linking people with AIDS in rural communities: The telephone group. Social Work, 36(1), 13-18.

Schneider, S. J., Schwartz, M. D., & Fast, J. (1995). Computerized, telephone-based health promotion: I. Smoking cessation program. Computers in Human Behavior, 11(1), 135-148.

Searles, J. S., Perrine, M. W., Mundt, J. C., & Helzer, J. E. (1995). Self-report of drinking using touch-tone telephone: Extending the limits of reliable daily contact. Journal of Studies on Alcohol, 56(4), 375-382

Spiegel, D., Kraemer, H. C., Bloom, J. R., & Gottheil, E. (1989). Effect of Psychosocial treatment on survival of patients with metastatic breast cancer. The Lancet, 75, (888-891).

Springer, A. K. (1991). Telephone family therapy: An untapped resource. <u>Family Therapy,</u>

<u>18</u>(2), 123-128.

Stein, L., Rothman, B., & Nakanishi, M. (1993). The telephone group: Accessing group

service to the homebound. <u>Social Work with Groups, 16</u>(1/2), 203-215.

Toseland, R. W., & Siporin, M. (1986). When to recommend group treatment: A review of the

clinical and the research literature. <u>International Journal of Group Psychotherapy, 36,</u>

43-61.

Weinberg, N., Schmale, J., Uken, J., & Wessel, K. (1995). Computer-mediated support

groups. <u>Social work with Groups, 17</u>(4), 43-54.

Wiener, L.S., Spencer, E.D., Davidson, R., & Fair, C. (1993). National telephone support

groups: A new avenue toward psychosocial support for HIV-infected children and their

families. <u>Social Work with Groups, 16</u>(3), 55-71.

Zhu, S., Stretch, V., Balabanis, M., Rosbrook, B., Sadler, G., & Pierce, J. (1996). Telephone

counseling for smoking cessation: Effects of single-session and multiple-session

interventions. <u>Journal of Consulting and Clinical Psychology, 64,</u> 202-211.

Zimmerman, D. P. (1987). A psychosocial comparison of computer-mediated and face-to-face

language use among severely disturbed adolescents. <u>Adolescence, 22,</u> 827-840.