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Leading Telephone Caregiver Support Groups: A Manual for a Model Psycho educational Program¹

Victoria M. Rizzo²

Ronald W. Toseland³

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² Victoria M. Rizzo is Research Assistant Professor, Institute of Gerontology, School of Social Welfare, University at Albany, State University of New York.

³ Ronald W. Toseland is Professor and Director, Institute of Gerontology, School of Social Welfare, University at Albany, State University of New York, 135 Western Ave, Albany, NY 12222.

Telephone Support Group (TSG) Training Manual

Introduction

In reviews of the literature over the past decade, Toseland and colleagues have pointed out that almost all of the evaluations of caregiver support groups have focused on white, middle class caregivers (see, for example, Toseland & Rossiter, 1989; Toseland & McCallion, 1997; Toseland & Smith, 2001; Toseland, Smith, & McCallion, 2001). Although there has been more attention to minority caregivers in recent studies (see, for example, Gallagher-Thompson et al., 1997), there are still very few reported studies of caregiver support groups that have attempted to reach out to isolated, poor, and minority caregivers. In Toseland's previous studies, and at Senior Services of Albany, Inc., we have encountered many caregivers who could have benefited from attending caregiver support groups, and wanted to do so, but could not because they (1) did not have access to transportation; (2) lived too far from group meetings; (3) could not afford transportation costs; (4) did not feel able to leave the care recipient alone; or (5) did not feel comfortable participating in groups in particular settings for racial/ethnic reasons. Two methods, computer mediated groups and telephone mediated groups, have been proposed to overcome the lack of accessibility of face-to face groups (Toseland & Rivas, 2001). In this training manual, a telephone support group intervention (TSG) designed to reach out to identify, to reach out, and to serve isolated, low income, and minority caregivers of the frail elderly is described. The implementation factors that should be considered when developing and implementing telephone support groups for isolated, low income, and minority caregivers will also be discussed.

The Use of Telephone Groups

Although telephone groups have not been widely used or evaluated, reviews of the

existing literature are very positive about their effectiveness (see Schopler, Galinsky, & Abell, 1997; Schopler, Galinsky, & Abell, 1998; Colon, 1996; Toseland & Rivas, 2001). In addition to increasing access to services, it has been reported that telephone groups reduce stigma, increase privacy, and produce greater levels of self-disclosure, intimacy, and cohesion than face-to-face groups. Because members' identities can be masked and because differences that are not salient to the group are less likely to interfere with interaction, members are more likely to share issues that are taboo in in-person groups. For these reasons, we chose telephone support group intervention as the best way to reach our identified population.

Planning for Telephone Groups

In recent years, technological advances have made it possible to have telephone conversations among a number of individuals. This is often referred to as *teleconferencing* or *making a conference call* (Kelleher & Cross, 1990). Until recently, the use of this technology was largely limited to task group meetings in large group organizations with members who were geographically dispersed. Several pioneering individuals, however, have begun to use the technology to offer counseling, therapy, and support to individuals who have psychosocial concerns. For a review of the literature see Galinsky, Rounds, and Abell (1997) and Schopler, Galinsky, and Abell (1998).

Prior to the preparation of this training manual, two manuals on how to set up and operate telephone groups were available (see Galinsky, Rounds, Montague, & Butowsky, 1993; Bertcher, 1990). In addition, Bertcher is the editor of *Tell a Group Hotline*, an occasional newsletter published through the School of Social Work at the University of Michigan, copies of which can be obtained through the World Wide Web at <http://www->

personal.umich.edu/~bertcher.

Some of the special considerations in setting up a telephone group are (1) teleconferencing capacity in the organizations telephone system of sufficient funds to purchase the service, (2) a speaker phone if there will be more than one leader, (3) teleconferencing equipment, and (4) a willingness of participants to stay on the telephone for a long duration. We have explored the use of hands free headsets for participants, but we found that these are not necessary, and some participants find purchasing the headsets and installing them with existing telephone equipment difficult.

A comprehensive review of the literature revealed 19 studies focused on the use of telephone support groups for people with many types of disability ranging from those with AIDS to those with visual impairments. Although there were few rigorously controlled studies, the results and conclusions of these studies were overwhelmingly positive. As with other virtual groups, telephone groups were reported to have a number of advantages over in-person groups including increased accessibility and convenience, the reduction of stigma, and greater privacy, intimacy and cohesion (for a reviews of these advantages see McKenna & Green, 2002; Galinsky, Schopler, & Abell, 1997; or Smokowski, Galinsky, & Harlow, 2001). Because members' identities are masked and because differences that are not salient to the purposes of the group are less likely to interfere with the interaction, members are more willing to interact with one another and to share issues that are taboo in in-person groups.

At the same time, telephone groups have potential disadvantages. Perhaps the biggest disadvantage is cost, which in 2003 averaged approximately \$60 to conduct a one hour group for eight persons using a low cost internet teleconference provider. One way to overcome the cost

of the teleconferencing is to spend six thousand to ten thousand dollars to purchase a “bridge”, and sufficient telephone lines to run a conference call center. Costs can then be spread over many employees who may use the technology for clinical and administrative purposes. To help defray costs, teleconferencing capabilities can also be rented to other organizations and private practitioners.

Other potential disadvantages of telephone groups include: (1) difficulties in assessing members’ needs and the impact of interactions without the benefit of facial expressions and other non-verbal cues; (2) the difficulty including members with hearing problems; (3) distortions caused by technological difficulties, call waiting, or background noises from other persons in the household; (4) concerns about confidentiality because of lack of privacy within the callers’ households; (5) changes in group dynamics caused by the lack of visual and non-verbal cues; (6) the difficulty of using program activities, flip charts, and other visual media; and (7) expressions of hostility or insensitivity that can sometimes be greater when members are not meeting face-to-face.

Some disadvantages in telephone groups are not inherent in the technology itself but rather in how it is used. For example, telephone groups that last over an hour can lead to fatigue, especially when members are frail (Stein, Rothman, & Nakanishi, 1993; Weiner, Spencer, Davidson, & Fair, 1993). For this reason, and because the amount of time for a telephone conference is often predetermined by arrangements with the teleconference provider, leaders must be vigilant about preparing members properly for the ending of each meeting.

Another disadvantage of telephone groups is that they offer no informal time for members to get together with each other before or after the meeting (Rounds, Galinsky, &

Stevens, 1991). With members' consent, swapping telephone numbers for between-session contact is one solution. In our current research on telephone support groups for caregivers, members have gotten together between meetings, and after the time-limited groups ended over coffee at a diner, or in members' homes.

Because members lack visual cues during telephone meetings, the worker must be particularly attentive to tone of voice, inflection, silences, and other cues such as members becoming less responsive or completely dropping out of the conversation over time. It is also helpful to: (1) have members identify themselves each time they communicate; (2) help members to anticipate frustrations such as missed cues or interruptions during group meeting times while at the same time appreciating the benefits of the medium; (3) prompt members to clarify statements and to give clear feedback to each other; and, (4) check on members' emotional reactions and make these clear to all group members (Galinsky et al., 1997). In general, leaders of telephone groups should plan to be more active than in in-person groups, helping members to communicate effectively without visual cues.

Infrequently, the absence of face-to-face contact can lead to the development of fantasies, which in turn may lead to dissociation from reality, loss of control, and irrational responses (Stein et al., 1993). It can sometimes be difficult to determine whether these responses are the result of disease processes in frail group participants, such as dementia among end-stage AIDS patients, or because of the telephone group itself. Despite these limitations, telephone groups offer a promising alternative to face-to-face groups for frail or isolated individuals. For more information about telephone groups, see Kelleher and Cross (1990), Galinsky, Rounds, Montague, and Butowsky (1993), Kaslyn (1999), and the previously described website

maintained by Bertcher at the University of Michigan.

Our Demonstration Project Experience

Social workers who are planning telephone groups may also want to consider some of the following things that we have learned from our recent experience with implementing a telephone group. We found that participation is more consistent if the leader calls each member of the group rather than having members call into the group using an access code. When members call in, they are more apt to call late, or call from inconvenient locations. If members know they are going to be called at a certain time, our experience suggests that the ability to start a group on time with all the members present is enhanced. The internet provider we used for the project enabled us to set amplification for each caller so that the voices of callers with soft voices could be amplified, and those with loud voices could be softened. However, we still occasionally needed to remind members not to use speaker phones, cordless phones with poor voice quality, and cellular phones, which may go in and out of range during a call.

We also found that although it is good practice for members to identify each other each time they speak, members get to know each others situations and voices quickly. Thus, many times members can identify each other without the need for self-identification after only one or two group sessions. Our experience also suggests that the leader has to take a more active role than in face-to-face groups in directing the action. For example, in an opening go-round, the leader has to indicate who should introduce themselves next because the physical cues that indicate that particular members are next in line to introduce themselves are not present in telephone groups. Similarly, the telephone group leader often has to take a more active role in directing the questions of one group member to the others, and sometimes questions have to be

repeated because members may not have expected to be asked to response to a particular question.

We did not find distractions within group members' home environments to be major problems. Most members were vigilant about explicitly stating that they had to stop their participation for a brief period when they had to deal with an interruption, or a caregiving task that could not be avoided. Individuals also readily let other members know when they returned to the telephone after such an interruption. Overall, participants reported that they enjoyed the telephone groups, and few members experienced any problems with being on the telephone for the hour and fifteen minutes it takes to start and conduct each group session.

The TSG Program

Presently, TSG has been used in a demonstration project funded by the Administration on Aging, and jointly sponsored by the Institute of Gerontology, School of Social Welfare, University at Albany, and Senior Services of Albany, Inc., a non-profit community agency with a long history of serving caregivers of the frail elderly. The intervention model described here has been employed and refined with success in a number of previous face-to-face caregiver support group studies over the past decade (see for example, Toseland et al., 2001; Toseland, Blanchard, & McCallion, 1995; Toseland, 1990). The TSG program is an adaptation of the face-to-face support group model for delivery via telephone using teleconferencing technology.

Teleconferencing Technology

One of the reasons that telephone support groups have not been implemented more regularly is that they can be cost prohibitive. Teleconference equipment is expensive to purchase and the use of teleconferencing services through telephone companies can be expensive when factoring in the cost of the service and the minute rate for each caller, especially if some group members incur long distance calling charges for their group participation. The most basic conference calling arrangement requires all participants to dial into the call using special numbers at a pre-set time. The cost for these conference calls is approximately \$.18 to \$.25 per minute/per person. Providers of this type of conference calling service include but are not limited to Verizon, Interact Conferencing, and Bows Conference Calling. The other common alternative is to have an operator assisted conference call in which a “reservation” is made with the service provider to call a list of people for the conference call on a certain time and day. This more expensive option ranges from approximately \$.27 - \$.36 per minute/per person. Providers

of this type of conference call service include but are not limited to Interact Conferencing, Bows Conference Calling, and Gentner.

Less common is the option of having the moderator/group leader act as the operator and place the calls to the participants from a remote location (i.e., an office) using a web-based teleconference service. This alternative requires the moderator to have simultaneous access to a phone and an internet connection. In 2003, the cost was approximately \$.10 - \$.18 per minute/per call, plus a one time activation fee (\$15) and a monthly subscription fee (\$12.50). Providers of this type of conference call service include The Conference Depot and j2 Global Communications.

Regardless of the type of conference call service provider one uses, there are sure to be technical difficulties because technology in general is rarely free of problems. For example, there may be poor audio quality (limiting the use of portable and cellular telephones by participants can help avoid this difficulty). Sometimes there may be an unexplainable disconnection of the call (the leader can recall all participants when this situation occurs). We recommend that group leaders identify two conference call service providers that they can use in the event that an unsolvable technical difficulty occurs during a telephone group session. The availability of a backup service provider will prevent unnecessary group meeting cancellations due to technical difficulties.

TSG Leader

TSG is designed to be delivered by a masters level social worker with experience in working with chronically ill older adults in senior services or health care settings, and with short-term, psychoeducational group work approaches (Toseland & Rivas, 2001). The social

worker who is selected should be broadly familiar with the theoretical underpinnings of a stress and coping framework, particularly the work of Lazarus and Folkman (1984), and with problem solving casework models such as Reid's (1992) task centered approach. Social workers are the ideal professionals to deliver this intervention because their education focuses on the interaction among bio-psycho-social and environmental aspects of people's lives, and because their practice focuses on the type of care coordination that is typical for this population.

TSG Supervision

Ideally, the TSG leader should receive weekly, ongoing supervision from a masters level social worker with experience in working with chronically ill older adults in senior services or health care settings, and with short-term, psychoeducational group work approaches (Rivas & Toseland, 2001). The telephone groups should be audio-taped for review by the supervisor. Using portions of these audiotapes, the supervisor should provide the group leader with ongoing feedback about his/her group leadership and ability to deliver the intervention as specified in this manual, strategies for keeping the groups focused and on task during sessions, and clinical supervision to address any significant concerns and problems, such as the disclosure of elder abuse, that may arise within the groups during the intervention.

The TSG Sessions

TSG consists of 12 weekly 1-hour and 15 minutes telephone support group meetings. Three components (1) emotion-focused coping, (2) problem solving, and (3) support are included in each TSG meeting.

Emotion-focused Coping Component

The emotion-focused coping component will occur during the first half of each weekly

TSG group meeting. This part of the intervention is based on the Stress Inoculation Training (SIT) developed by Meichenbaum and his colleagues (Meichenbaum, 1977, 1985; Meichenbaum & Cameron, 1983). It has been used successfully in previous caregiver intervention programs (Barusch & Spaid, 1991; Labrecque, et al., 1992; Toseland, et al., 1989c; Zarit, et al., 1987) and with individuals with other chronic health problems (Benjamin, 1989; Blanchard, 1993; Sorbi & Tellegen, 1988). SIT involves multiple strategies such as didactic teaching, relaxation training, cognitive restructuring, self-monitoring, and self-instruction. Instead of teaching a single stress management technique, participants will be exposed to a number of different techniques and instructed to use those techniques that work best for them. Similar to Meichenbaum's (1985) SIT, the stress reduction and coping skills component will be implemented in three major phases including: (1) conceptualization and assessment, (2) skill acquisition and rehearsal, and (3) application and follow-through. The contents of the three phases are distributed over the 12 weekly meetings, incorporating stress management in a flexible and multidimensional approach (Everly, 1989).

Problem-focused Coping Component

Problem-focused coping strategies are introduced and practiced during the second half of each weekly TSG meeting. These strategies have been used in research by Toseland and his colleagues over the last decade (Toseland, 1977, 1990a; 1995; Toseland & Rivas, 2001; Toseland, Sherman, & Bliven, 1981), as well as by other researchers (see, for example, D'Zurilla, 1990). Rather than just discussing problems and ways to cope with them in the abstract, the authors have found that it is important to have group participants take turns focusing on the specific pressing problems that they identify at pretest on the Pressing Problem

Index (PPI).

In the first group session, the leader will describe how the last half hour of each group meeting will be used to help one or two members resolve the pressing problems they articulated at pretest, and any problems that emerge as the group meets. The leader will explain that this will be accomplished by using a 6-step problem-solving model, with several members taking turns each week to present their pressing problems and working to resolve them with the help of fellow group members. Pressing problems that caregivers commonly experience will then be presented to illustrate the types of problems that group members may bring up during group meetings. After this, the 6-step problem-solving model which will be used in each subsequent meeting will be described and included in the Participant Workbook for reference purposes throughout the intervention. The 6 steps are: (1) identifying pressing problems in as specific terms as possible; (2) assessing factors that contribute to the problem and that interfere with its resolution; (3) group generation of alternative problem-solving strategies without evaluation of the suggestions; (4) examination of the advantages and disadvantages of each potential solution; (5) discussion, specification, and cognitive or behavioral rehearsal of the action plan; and (6) monitoring and evaluating the action plan.

During the remaining eleven weekly meetings, members will have an opportunity to work on pressing problems that have not been addressed in previous meetings. Members who have already presented a problem will have a chance to describe their progress in resolving problems and to get feedback from the group and the leader. The previously described problem-solving model will be used to structure the group's interaction during this period. The particular stress reduction or coping skill techniques that members select as potentially most useful to help

them resolve or cope with a pressing problem will be discussed and practiced prior to their use. Over the course of the 12-week group intervention program, each member will get an opportunity to practice problem solving, and to apply the stress reduction and coping skills taught during the first half of the group meetings, to two or three of their own personal pressing problems.

It should be noted that the problem-focused strategies in this component of the intervention will not merely focus on problems. Research by Gallagher and colleagues indicates that some caregivers find an exclusive focus on problems can increase their sense of being overwhelmed instead of enhancing their sense of being in control (Gallagher-Thompson, 1994a; 1994b; Gallagher, Lovett, & Zeiss, 1989). Thus, problem-focused strategies will emphasize turning problems into opportunities for the enhancement of participants' life satisfaction. For example, a problem-focused coping strategy to address over-involvement of the caregiver might consist of arranging for a sitter to come in on a weekly basis while the participant goes to an exercise class, or plays cards with a group of friends.

It should also be noted that problem solving efforts are likely to involve the group leader in case management and case coordination within the senior services center and the local community. For example, a group participant may require assistance gaining access to needed services, or help in communicating with a resource provider. Therefore, it is essential for the TSG group leader to be familiar with the policies, procedures, providers and service structure of the agency under whose auspices the TSG groups are being conducted and to have excellent case management skills. It is also essential for the group leader to be familiar with community resources and services within the agency's service area which are available to TSG participants.

Support Component

Support, the third component of TSG, is to be interwoven throughout the two previously mentioned components of each group meeting. The support component is included because the provision of support by the group leader, and the fostering of mutual aid and support among group members has been found to be among the most helpful aspects of group intervention (Toseland & Rivas, 2001; Toseland & Siporin, 1986; Yalom, 1985). For example, in a study of therapeutic processes in peer-led and professionally led groups for caregivers of the frail elderly, Toseland and colleagues concluded that it was "the opportunity to ventilate pent-up feelings and emotions, the validation of caregiving experiences, the affirmation of coping abilities, the encouragement for continuing to provide care and to cope with the situation, the exploration of alternative caregiving arrangements, the mutual support, and the mutual sharing of information" (Toseland, et al., 1990, p. 279) that were the most helpful therapeutic ingredients of both types of groups. The conceptual framework that underlies the TSG approach to group intervention includes the principle that individuals have inherent coping capacities that can be revitalized by mutual aid and support (see, for example, Wasserman & Danforth, 1988). Thus, the support component of TSG is designed to enable members to sustain and enhance their own coping capacities.

To ensure that the support component is interwoven into each group meeting the leader will facilitate interactions that help group members to: (1) ventilate their feelings and concerns, (2) provide and receive empathic understanding of concerns and problems related to their spouses'/parents' illnesses, (3) share different ways of dealing with problematic caregiving situations, (4) feel hopeful about their situation, (5) play a useful and meaningful role in helping

others in the group with their problems and concerns, and (6) provide peer models that effectively deal with caregiving issues.

When leading TSG groups, the leader should develop a climate of trust, empathy, warmth, and cohesion, where members can disclose their thoughts and feelings, to revitalize their coping capacities, and to be open to advice from their fellow group members. This can be accomplished by highlighting the thoughts, feelings, and experiences that members share in common. The leader will praise members for any assistance they provide to each other, and encourage them to use terms such as "we" and "us" when speaking to the entire group about shared purposes, accomplishments, and experiences.

The leader will help members develop a group identity by starting or ending group meetings with a summary of what has been accomplished in previous meetings and by pointing out what needs to be done. Intra-group conflict, if present, will be reduced by pointing to the commonalities among members, by discussing factors that might account for different perspectives, by helping them consider how different perspectives can contribute to an understanding of their own situation, and by instructing them not to be critical of other perspectives. As the group unfolds, the leader will encourage members to demonstrate their concern, empathy and respect for each other. The leader will reinforce members' rights to express controversial, or emotionally laden thoughts and feelings. Helping the group develop norms of acceptance will do much to deepen members' trust of each other as the group progresses.

Lakin (1988) has found that older persons tend to reveal more in groups than do younger persons. He also found that older group members were more tranquil in their responses to each

other. For example, as compared to younger persons, he found that older group members responded empathically, but less intensely, to emotion-laden revelations made by fellow group members. Therefore, when interweaving the support component of TSG throughout each group meeting, the leader will amplify and highlight subdued responses and help members respond empathically to each other.

Another important role for the leader is to facilitate member-to-member communications. Some members may try to dominate the interaction. Others may try to begin side conversations. The group leader will avoid these situations by discussing expectations for group participation during the first group meeting. The leader will facilitate member-to-member interaction by: (1) acknowledging and praising members who respond empathically to each other, (2) pointing out and highlighting shared thoughts, feelings, and themes, (3) making connections between members' statements, (4) asking members to respond to a particular question in a group go-round, (5) involving individual members or the whole group in an interaction between the leader and a member, (6) suggesting that members speak directly to each other rather than through the leader, (7) asking members to respond to each other, and (8) asking members to elaborate on disclosures that are likely to be of interest to other members of the group. Also, the leader will be encouraged to point out any obstacles to mutual sharing and reciprocal helping among members, and will gently help members confront concerns that they are uncomfortable discussing.

Session Agendas

Meeting 1

The aim of meeting one is to acquaint the caregivers with each other, the group leader and the major concepts of the intervention program.

1. Conference Call Hook-up (15 minutes)

The leader will contact the conference call operator, who will place the conference call. The leader should request to be called first so that s/he can initiate small talk with group members as they are linked into the conference call. The leader should prevent long silences from occurring during the hook-up period. In face-to-face groups, small talk would be initiated as group members arrive and the conference call hook-up time should be treated in this same manner.

2. Introductions (20 minutes)

The first order of business is for the leader and members to introduce themselves. The leader should begin by explaining that it is important for group members to state their first names so that everyone will know who is speaking. The leader should model this by stating his/her name each time she speaks. Some people will initially forget to state their names and the leader should gently remind them to do so when this occurs. The leader should then introduce him/herself. S/he should describe his/her clinical experience and education, particularly as it relates to chronically ill older adults, caregivers, and health care.

Next, members should be asked to introduce themselves. Each member should state his/her name and provide, a brief description of the functional status and health status of his/her spouse, or parent, and any pertinent interests, hobbies, or other positive things s/he does to take

care of himself/herself. During this time, the leader takes attendance using the log provided and s/he may want to jot down notes that will help him/her to identify participants on the phone.

S/he may also want to keep a tally of who speaks throughout the group meeting to ensure that 1) one person is not monopolizing the conversation and 2) other members are not being forgotten.

The group leader can “check-in” with silent members by asking them a question or directing a comment to them.

3. Purpose, Format, and Goals of the Group (10 minutes)

The leader asks members to refer to the Participant Workbook they were given to use during the group sessions. (Each week during the hook-up time the group leader can remind members to have this workbook with them. Those who forgot it then will be able to locate it while the remainder of the members are being linked into the conference call.) The leader asks members to turn to pages 4 and 5 in the workbook, which provides a brief overview of the TSG program and the meeting agendas.

The leader notes that there will be 12 weekly 1-hour and 15 minute group meetings. The leader mentions the three components of the group. He/she also mentions that each session will begin with a very brief review of the previous session, followed by a go-round focusing on what members did between group meetings, and new content on coping skills for that session. The remainder of each session will be used to help members resolve pressing problems using a problem solving model, and helping members to implement new strategies to take care of themselves.

The leader notes that TSG has several goals:

1. To help members develop supportive relationships with other group members.
2. To help members develop and make use of other informal supports such as family and friends.
3. To help members learn more about caregiving resources and skills.
4. To help members take better care of themselves.
5. To help members improve their coping skills.
6. To help members solve problems in providing care.

Caregivers should be invited to describe what they would like to get out of the group.

The leader should ask if there are any questions about the group or the larger research project.

4. House Keeping and Group "Rules" (5 minutes)

House Keeping

The leader should discuss taping of the sessions and its purpose and the group rules.

NOTE TO LEADER: To tape the group, the tape recorder must be telephone record capable.

The tape recorder can be attached to the telephone using the adapter and cord specific to the make of your telephone capable tape recorder. Telephone capable tape recorders can be purchased at most electronics stores.

Group "Rules" (refer members to page 12 in workbook for "Goals, Ground Rules & Tips")

- a. Attendance: Participants will get the most out of the group if they attend each week.

Thus, help participants make a commitment to participate each week. The leader should ask them to: 1) let him/her know if they don't like something, or if they are having trouble attending for any reason; 2) call ahead of time if they can't be available at the scheduled conference call

time; and, 3) write down the leader's telephone number so that they can contact him/her as needed. The leader should also tell members that s/he will need one week's notice if they feel for any reason that they can no longer participate.

b. **Mutual Participation:** It is important that everyone gets an opportunity to participate. There is never enough time in the group for everyone to say all they might like to say. The leader should encourage participation, but if members have a tendency to talk a lot, ask them to limit what they say so that others will have a chance to speak. On the other hand, if members tend to be on the quiet side, ask them to make a special effort to speak up during group go-rounds and other activities that are planned to encourage participation.

c. **Confidentiality:** Ask members to make a commitment to keep things that are said in our group in our group. Ask them not to discuss what is said in group with other non-members of the group. Encourage them to use a phone in a location where others are least likely to listen in, and where they are least likely to be disturbed.

5. Telephone Buddies (15 minutes)

The leader indicates that s/he would like to build a support network within and outside the group. Support is built up in the group by members responding to each other in a helpful, positive fashion. Support can be built up outside the group by having members develop an informal support network between meetings. One way to do this is for members to take responsibility for calling one other member during the week. Members can discuss the group experience, or anything else about the caregiving situation. The idea is to help members form a support network outside the group. The leader will remind individuals that s/he asked them if they wanted to exchange names, telephone numbers, and addresses when they met in the

individual face-to face meetings prior to the beginning of the group intervention so that they might call each other and begin to form a support network. Now, s/he would like to create pairs that can act as telephone buddies in between meetings for the duration of the group sessions.

Prior to the meeting, the group leader should create a list of pairs that includes names and telephone numbers. If there is an uneven number of group participants, a group of three can be created. The group leader assigns the telephone pairs during this group session. First, she asks participants to turn to page 14 in their workbooks where they can write their buddy's name, telephone number and the best time to call. Second she can assign buddies by saying, "Joan (group member), I'd like you and Terry (another group member) to be buddies. Joan can you give Terry your phone number and tell her when it is best for her to call you? Terry write this down in your participant workbook, okay? Then, can you give Joan your phone number and tell her when it is best for her to call you?" The leader will continue in this fashion until everyone in the group has a telephone buddy. She then encourages members to call their buddies at least one time before the next group session.

6. Problem Solving/Taking Time for Oneself (20 minutes)

The leader introduces the problem solving component by describing how half of each group meeting will be used to help one or two members resolve the pressing problems they articulated at pretest, and any problems that emerge as the group meets as well as helping members to identify how to take better care of themselves. The leader asks participants to turn to page 13 in their workbooks and presents a six-step problem-solving model. The six steps are: (1) identifying pressing problems in as specific terms as possible, (2) assessing factors that contribute to the problem and that interfere with its resolution, (3) group generation of

alternative problem-solving strategies without evaluation of the suggestions, (4) examination of the advantages and disadvantages of each potential solution, (5) discussion, specification, and cognitive or behavioral rehearsal of the action plan, and (6) monitoring and evaluating the action plan. The leader goes over the steps using an example of one or more pressing problems, and how to take positive steps to engage in pleasurable activities.

The leader also explains that sometimes it is more effective to focus on taking care of oneself than on the problems one is having with caring for his/her spouse/parent. The leader should explain that in a future group session time will be devoted to discussing how they can take time for themselves.

Using the worksheet on page 14, members should be encouraged to identify one pressing problem that they would like to resolve and how they are presently trying to resolve it for the next group session. They should also be asked to think of one way that they would like to take care of themselves during the week. They should be encouraged to think of ways to take care of themselves that are not already routine or planned (e.g., a hair cut appointment). The leader should explain that many problems are not easily resolved, but can be less noxious if we take time to take care of ourselves.

7. Between Meetings (2 minutes)

The leader reminds group members to call their telephone buddies and complete the problem solving worksheet in their participant workbooks for the next session.

Leader

- a. complete attendance log
- b. label tapes
- c. call office for "supervision"

Meeting 2

The aim of meeting two is to help reassure caregivers that their spouses', or parents', reactions to chronic illness are normal.

1. Conference Call Hook-up (15 minutes)

The leader will contact the conference call operator, who will place the conference call. The leader should request to be called first so that s/he can initiate small talk with group members as they are linked into the conference call. During this time, the leader can check-in with each member to find out if they have their participant workbooks with them. As group members are linked into the conference call, the leader should have them state their names and take attendance.

2. Brief Overview of the First Meeting (5 minutes)

The leader should briefly review the first meeting and ask members if they have any questions.

3. Check-in Progress with Telephone Buddies (10 minutes)

The leader will facilitate a discussion of the telephone buddy conversations conducted during the previous week. Telephone buddies works well for some individuals, but others may need to be encouraged to call, and to have models of conversations they might have. Descriptions of other members' conversations during this discussion can serve as models for members who did not call their partners. A go round or check-in can be used by the leader to help members briefly describe their telephone buddy experiences. The emphasis should be on how these phone calls are helping members build a support network outside the group setting. Members should be encouraged to talk about how this experience is supportive and helpful.

They should also be asked if there were any barriers preventing them from contacting their telephone buddies. The leader should briefly review the telephone buddy list. Members should turn to page 19 in their workbooks and write down the name and telephone number of their buddies as well as the best time to call. Members should be encouraged to contact their telephone buddies at least one time between sessions.

4. Caregivers Reactions to Caring for Their Spouses', or Parents', Illnesses (10 minutes)

Feelings often expressed by caregivers include:

- a. anger
- b. depression
- c. embarrassment
- d. fear
- e. grief
- f. guilt
- g. helplessness
- h. shame
- i. worry
- j. loss of freedom
- k. isolation

Caregivers should be encouraged by the leader to identify their own specific emotional and bodily reactions to stress, and to identify situations that provoke stress and characteristic coping responses. This can be done through a go-round, or through free floating interaction, but in either case each member should be encouraged to participate by using prompts and making

connections among members. The feelings that are discussed can be recorded on a notepad by the leader and the number of members experiencing each feeling can be counted.

Next, the leader should help members to better recognize early signs of stress and their typical cognitive appraisals and coping reactions. To facilitate this learning process, participants should be asked to keep a diary of the stressors they experienced over the course of a week, and their cognitive and behavioral responses to these stressors. A form for this purpose is provided in their workbooks with each session agenda for the remaining sessions. The leader can refer them to the one included with this session on page 17. Practice in recognizing stressors, and in identifying appraisals of stressful situations and resulting coping reactions, will continue in the remaining meetings. The leader should help members to think about when they could realistically make these notes, where the workbook would be placed in their household, and any other details that will help them to make entries.

5. Impact of Chronic Illness (15 minutes)

Members can be referred to page 18 for a brief summary of these coping styles. The leader introduces members to the concepts of stress, appraisal, and coping (Lazarus & Folkman, 1984). Stress is a dynamic state within an individual that results from the individual's interaction with a noxious stimuli or circumstance such as having a chronic illness such as a stroke or severe arthritis. The individual then appraises the noxious stimuli or circumstance, and struggles to manage with the circumstance by coping reactions. Stress occurs if a person's appraisal of a situation results in an evaluation indicating that (a) this situation poses either a challenge, a threat or a loss (primary appraisal), and (b) the available coping resources are not sufficient to obtain a beneficial outcome (secondary appraisal).

The appraisal step is important because it defines the degree and kind of reaction to the stressor. Changing appraisals by some of the strategies to be taught in this group can help to lessen the stress. Learning new strategies can also increase an individual's comfort and control by providing the person with alternatives to limited coping responses that are not working. Individuals' coping skills vary greatly. Moos, and colleagues (Moos, Cronkite, Billings & Finney, 1988) defined the following coping skills:

- a. Active cognitive coping, e.g. "tried to see the positive side of things"
- b. Active behavioral coping, e.g. "tried to find out more about the situation"
- c. Avoidance coping, e.g. "refused to believe that it happened"
- d. Logical analysis, e.g. "considered several alternatives for handling the problem"
- e. Information-seeking, e.g. "talked with a friend about the problem"
- f. problem-solving, e.g. "made a plan of action and followed it"
- g. Affective regulation, e.g. "tried to reduce tension by exercising more"
- h. Emotional discharge, e.g. "let my feelings out somehow"

The leader's task is not to put a label on group members' coping styles. Rather, the focus should be on identifying what caregivers actually do in response to a stressful situation (be as behaviorally specific as possible), how well that works for the individual, and what other, more effective coping strategies might reduce caregivers' stress. Effective coping strategies need to be tailored for each individual's circumstances, and each individual's unique makeup. Therefore, during group meetings we will offer participants a variety of strategies for coping more effectively, and participants can select which ones they feel will be most helpful to them in their day-to-day caregiving.

The leader asks participants to turn to pages 19 and 20, which include the problem solving worksheet. S/he explains that the worksheet can be filled out over the next week based on what they have learned about coping in this session. Using examples, s/he explains how to fill out the worksheet. This worksheet will be used as a homework assignment on a weekly basis and will be discussed during the problem solving part of the group sessions.

6. Problem Solving/Taking Time for Oneself (15 minutes)

The leader asks members if one or two of them want to share the pressing problems or ways to take care of themselves that they identified in their homework assignment for this week. The leader facilitates a group problem solving effort to help these members focus on strategies to resolve pressing problems they articulated at pre-test as well as identifying ways group members can take care of themselves.

7. Between Meetings (5 minutes)

The leader encourages members to call their telephone buddies and complete the problem solving worksheet in their workbooks during the week.

Leader

- a. complete attendance log
- b. label tapes
- c. note any new pressing problems/change goals
- d. call office for "supervision"

Meeting 3

The aim of meeting three is to help participants identify and label their reactions to caregiving.

1. Conference Call Hook-up (15 minutes)

The leader will contact the conference call operator, who will place the conference call. The leader should request to be called first so that s/he can initiate small talk with group members as they are linked into the conference call. During this time, the leader can check-in with each member to find out if they have their participant workbooks with them. As group members are linked into the conference call, the leader should have them state their names and take attendance.

2. Brief Overview of the Second Meeting (5 minutes)

Overview of second meeting, questions.

3. Check-in Progress with Telephone Buddies (5 minutes)

A go round or check-in can be used by the leader to help members briefly describe their telephone buddy experiences. The emphasis should be on how these phone calls are helping members build a support network outside the group setting. Members should be encouraged to talk about how this experience is supportive and helpful. They should also be asked if there were any barriers preventing them from contacting their telephone buddies. The leader should briefly review the telephone buddy list. Members should turn to page 22 in their workbooks and write down the name and telephone number of their buddies as well as the best time to call. Members should be encouraged to contact their telephone buddies at least one time between sessions.

4. Problem Solving/Taking Time for Oneself (25 minutes)

The leader asks members if one or two of them want to share the pressing problems or ways to take care of themselves that they identified in their homework assignment for this week. The leader facilitates a group problem solving effort to help these members focus on strategies to resolve pressing problems they articulated at pre-test as well as identifying ways group members can take care of themselves.

5. Care Recipient's Reactions to Chronic Illness (20 minutes)

The leader can remind individuals that they talked about coping and their reactions to their loved ones illness last week. She can ask members if they completed worksheets regarding coping and their stress reactions. She can encourage them to share what they wrote down ofr thought about from last week.

Next, the leader should describe the common psychological, emotional, and social reactions care recipients have to chronic illness. Common feelings experienced by care recipients include:

- a. anger - at being confined, treated like a child
- b. frustration
- c. depression
- d. embarrassment - about appearances or the needs for assistance resulting from disabilities
- e. fear - of the future, of losing control, of losing independence, role, power
- f. guilt - spoiling the caregiver's life
- g. helplessness
- h. shame - being a burden
- i. isolation

A go-round can be used to give each group member a brief opportunity to discuss their spouse's, or parents', reactions to chronic illness (care recipient-related appraisals), and their spouses', or parents', functional limitations. Caregivers can also briefly discuss their caregiving responsibilities. The leader should mention that in future sessions the focus will be on helping members improve their coping skills and take better care of themselves.

6. Between Meetings (5 minutes)

The leader should ask members to call their telephone buddies during the week. Also, members should be encouraged to complete the homework assignment included with the agenda for this meeting session on pages 22 and 23. The assignment is to identify one effective coping skill they would like to use more often, and one ineffective coping skill they would like to change and to write both down in their workbook.

Leader

- a. complete attendance log
- b. label tapes
- c. note any new pressing problems/change goals
- d. call office for "supervision"

Meeting 4

The aim of meeting four is to reinforce effective coping skills and change ineffective coping skills that caregivers identify.

1. Conference Call Hook-up (15 minutes)

The leader will contact the conference call operator, who will place the conference call. The leader should request to be called first so that s/he can initiate small talk with group members as they are linked into the conference call. During this time, the leader can check-in with each member to find out if they have their participant workbooks with them. As group members are linked into the conference call, the leader should have them state their names and take attendance.

2. Brief Overview of the Third Meeting (5 minutes)

Overview of third meeting, questions, attendance, telephone buddy calls.

3. Coping Skills (25 minutes)

The leader should ask members to recall that their homework assignment was to identify one effective coping skill they would like to use more often, and one ineffective coping skill they would like to change and to write both down in their workbook. The leader should also ask members to take a minute to find their notes on this subject or to take a minute or two to write down in their workbook what they do successfully regarding caretaking, and what they would like to improve. Do a go-round to enable all members to have a chance to briefly describe the coping strategies they have been using to deal with these reactions to their spouses', or parents', chronic illnesses. The leader should help members focus both on what they are doing successfully, and what they would like to change or improve upon.

4. Problem Solving/Taking Time for Oneself (25 minutes)

The leader asks members if one or two of them want to share the pressing problems or ways to take care of themselves that they identified in their homework assignment for this week. The leader facilitates a group problem solving effort to help these members focus on strategies to resolve pressing problems they articulated at pre-test as well as identifying ways group members can take care of themselves.

5. Between Meetings (5 minutes)

The leader should ask members to call their telephone buddies during the week. Participants should also be encouraged to continue to keep a diary of the stressors they experience over the course of the coming week, and their cognitive and behavioral responses to these stressors as well as their progress with resolving the pressing problems they identified at pre-test. A form for this purpose is provided in their workbooks.

Leader

- a. complete attendance log
- b. label tapes
- c. note any new pressing problems/change goals
- d. call office for "supervision"

Meeting 5

The aim of meeting five is to help caregivers understand the importance of informal supports in helping them take care of themselves. It should be pointed out that if caregivers are not healthy, they cannot take care of their spouses, or parents, and if they are emotionally overwhelmed, the care they provide will suffer.

1. Conference Call Hook-up (15 minutes)

The leader will contact the conference call operator, who will place the conference call. The leader should request to be called first so that s/he can initiate small talk with group members as they are linked into the conference call. During this time, the leader can check-in with each member to find out if they have their participant workbooks with them. As group members are linked into the conference call, the leader should have them state their names and take attendance.

2. Brief Overview of the Fourth Meeting (5 minutes)

Overview of fourth meeting, questions, attendance, telephone buddy calls.

3. Check-in About Progress Toward Goals (10 minutes)

The leader should remind group members that each of them have identified goals for problem solving and taking care of themselves that they would like to work on during the group session. A go-round or check-in can be used by the leader to help members briefly describe one pleasurable activity or one coping strategy they are working toward implementing. The emphasis should be on helping participants to focus on the limited goal of doing one new thing in response to the focus on coping skills and taking better care of themselves in the previous meetings. During the go-round members should not be allowed to get stuck on the obstacles to implementing this change. The second part of the meeting focused on problem solving can be used to help a few

members work intensively to overcome obstacles to implementing a particular goal. Members should, however, be encouraged to interact with each other about what kinds of pleasurable activities they have engaged in, and the benefits of these activities.

4. Taking Time for Oneself (20 minutes)

The leader discusses the importance of rest, relaxation, good nutrition, exercise, and maintaining some social/leisure pursuits. The leader facilitates a discussion of what social/leisure activities members currently engage in. The emphasis should be on helping members to consider engaging in a new activity

The leader should make the point that it may be more effective for caregivers to focus on taking care of themselves than on the problems they are having in caring for their spouses or parents. Participants should be encouraged to identify and describe ways in which they take care of themselves through a group go-round, using the journal entries they made during the week. The leader should ask members if they noticed any relationship between their own mood and daily stressful and pleasurable events.

5. Problem Solving Taking Time for Oneself (20 minutes)

The leader asks members if one or two of them want to share the pressing problems or ways to take care of themselves that they identified in their homework assignment for this week. The leader facilitates a group problem solving effort to help these members focus on strategies to resolve pressing problems they articulated at pre-test as well as identifying ways group members can take care of themselves.

6. Between Meetings (5 minutes)

The leader should ask members to call their telephone buddies during the week.

Participants should also be encouraged to continue to keep a diary of the stressors they experience over the course of the coming week, and their cognitive and behavioral responses to these stressors as well as their progress with resolving the pressing problems they identified at pre-test. They should also be encouraged to identify one thing they can do to take care of themselves that involves the use of informal supports. A form for this purpose is provided in their workbooks.

Leader

- a. complete attendance log
- b. label tapes
- c. note any new pressing problems/change goals
- d. call office for "supervision"

Meeting 6

The aim of meeting six is to continue to help caregivers understand the importance of taking care of themselves. It should be pointed out that if caregivers are not healthy, they cannot take care of their spouses, or parents, and if they are emotionally overwhelmed, the care they provide will suffer.

1. Conference Call Hook-up (15 minutes)

The leader will contact the conference call operator, who will place the conference call. The leader should request to be called first so that s/he can initiate small talk with group members as they are linked into the conference call. During this time, the leader can check-in with each member to find out if they have their participant workbooks with them. As group members are linked into the conference call, the leader should have them state their names and take attendance.

2. Brief Overview of the Fifth Meeting (5 minutes)

Overview of fifth meeting, questions, attendance, telephone buddy calls.

3. Check-in About Progress Toward Goals (10 minutes)

The leader should remind group members that each of them have identified goals for problem solving and taking care of themselves that they would like to work on during the group session. A go-round or check-in can be used by the leader to help members briefly describe one pleasurable activity or one coping strategy they are working toward implementing. The emphasis should be on helping participants to focus on the limited goal of doing one new thing in response to the focus on coping skills and taking better care of themselves in the previous meetings. During the go-round members should not be allowed to get stuck on the obstacles to implementing this change. The second part of the meeting focused on problem solving can be used to help a few

members work intensively to overcome obstacles to implementing a particular goal. Members should, however, be encouraged to interact with each other about what kinds of pleasurable activities they have engaged in, and the benefits of these activities.

4. Informal Supports (20 minutes)

The leader should discuss how informal supports such as family members, neighbors, and friends can provide assistance and respite to caregivers. A go-round can be used to help members describe the helpfulness of particular individuals in their informal support networks. Next, each member should be encouraged to think of at least one way to increase informal supports, either by calling on assistance from an additional person, or by asking someone to increase their secondary caregiving activities. The emphasis should be on a specific plan, focused on freeing the caregiver for a designated time so that they can engage in a pleasurable activity, or in some other way reduce caregiving burden for a specified time period. An example is asking a brother or sister to come and sit with the care recipient for a specified time period, to take the care recipient out to lunch etc. so that the caregiver can have a respite from caregiving and engage in a task activity such as shopping or a social activity such as visiting a friend that reduces burden and promotes well-being. Group members should be encouraged to explore new informal supports rather than allowing them to say they already have enough support.

5. Problem Solving/Taking Time for Oneself (20 minutes)

The leader asks members if one or two of them want to share the pressing problems or ways to take care of themselves that they identified in their homework assignment for this week. The leader facilitates a group problem solving effort to help these members focus on strategies to resolve pressing problems they articulated at pre-test as well as identifying ways group members

can take care of themselves.

6. Between Meetings (5 minutes)

The leader should ask members to call their telephone buddies during the week.

Participants should also be encouraged to continue to keep a diary of the stressors they experience over the course of the coming week, and their cognitive and behavioral responses to these

stressors as well as their progress with resolving the pressing problems they identified at pre-test.

They should also be encouraged to identify one thing they can do to take care of themselves. A

form for this purpose is provided in their workbooks.

Leader

- a. complete attendance log
- b. label tapes
- c. note any new pressing problems/change goals
- d. call office for "supervision"

Meeting 7

The aim of meeting seven is to identify formal community supports and resources within the sponsoring senior service center and the larger community that can be used to assist caregivers, and to help them to take better care of themselves.

1. Conference Call Hook-up (15 minutes)

The leader will contact the conference call operator, who will place the conference call. The leader should request to be called first so that s/he can initiate small talk with group members as they are linked into the conference call. During this time, the leader can check-in with each member to find out if they have their participant workbooks with them. As group members are linked into the conference call, the leader should have them state their names and take attendance.

2. Brief Overview of the Sixth Meeting (5 minutes)

Overview of sixth meeting, questions, attendance, telephone buddy calls.

3. Services and Resources (20 minutes)

Services such as home care, respite care, adult day care, telephone reassurance, and emergency response systems, will be described. The leader should present these services as resources that can be used to avoid many of the burdensome aspects of caregiving. NOTE: The leader should locate resource booklets from the sponsoring senior services center and the local communities of the participants. Copies should be mailed to the participants and the leader should mention to them that these will be mailed prior to the next meeting.

After the presentation, participants should be encouraged to discuss their experiences with, and feelings about, using these services. The authors' previous experience suggests that, although group members may not actually use these services, they are comforted by knowing that

these services exist, and can be turned to if needed.

4. Problem Solving/Taking Time for Oneself (25 minutes)

The leader asks members if one or two of them want to share the pressing problems or ways to take care of themselves that they identified in their homework assignment for this week. The leader facilitates a group problem solving effort to help these members focus on strategies to resolve pressing problems they articulated at pre-test as well as identifying ways group members can take care of themselves.

5. Between Meetings (5 minutes)

The leader should ask members to call their partners during the week. Participants should also be encouraged to continue to keep a diary of the stressors they experience over the course of the coming week, and their cognitive and behavioral responses to these stressors as well as their progress with resolving the pressing problems they identified at pre-test. They should also be encouraged to identify one thing they can do to take care of themselves. A form for this purpose is provided in their workbooks.

Leader

- a. complete attendance log
- b. label tapes
- c. note any new pressing problems/change goals
- d. call office for "supervision"

Meeting 8

The aims of meeting eight are to 1) check on the progress participants are making with their identified pressing problems and problem solving and 2) to practice deep breathing exercises in preparation for the introduction of relaxation techniques in the next session.

1. Conference Call Hook-up (15 minutes)

The leader will contact the conference call operator, who will place the conference call. The leader should request to be called first so that s/he can initiate small talk with group members as they are linked into the conference call. During this time, the leader can check-in with each member to find out if they have their participant workbooks with them. As group members are linked into the conference call, the leader should have them state their names and take attendance.

2. Brief Overview of the Seventh Meeting (5 minutes)

Overview of seventh meeting, questions, attendance, telephone buddy calls.

3. Check-in About Progress Toward Goals (15 minutes)

A go-round or check-in can be used by the leader to help members briefly describe one pleasurable activity, or one coping strategy they are working toward implementing. The emphasis should be on helping participants to focus on the limited goal of doing one new thing in response to the focus on coping skills and taking better care of themselves in the previous meetings. During the go-round members should not be allowed to get stuck on the obstacles to implementing this change. The second part of the meeting focused on problem solving can be used to help a few members work intensively to overcome obstacles to implementing a particular goal. Members should, however, be encouraged to interact with each other about what kinds of pleasurable activities they have engaged in, and the benefits of these activities.

4. Deep Breathing (10 minutes)

A deep breathing technique will be introduced and practiced. This technique, which is easily learned, teaches participants an effective strategy to moderate their typical reactions to stress by interrupting their habituated responses, slowing down their cognitive processes, thereby increasing the likelihood that more planned and effective coping reactions will be chosen.

Members will need to be encouraged to sit as comfortably as possible given they will most likely be holding a phone receiver. The leader should ask them to practice this throughout the week.

The procedure:

- a. Sit comfortably, feet flat on the floor, eyes closed.
- b. Tell members that you will be counting 3 deep breaths with them. Members are to breath deeply from the diaphragm so that the lower ribs are going in and out. While breathing, members should focus on their breath going in and out. They can think "I am" while breathing in and "relaxing" when breathing out.
- c. Breath in deeply and exhale. Say "breathe deeply in and out" - continue for 3 breaths.
- d. Ask members to open their eyes and share what they experienced.

5. Problem Solving/Taking care of Oneself (25 minutes)

The leader facilitates a group problem solving effort to help one or two members focus on strategies to resolve pressing problems they articulated at pre-test or that have emerged as the group progresses as well as identifying ways group members are taking care of themselves.

6. Between Meetings (5 minutes)

Members should be encouraged to practice the deep breathing exercise in preparation for the progressive muscle relaxation training in the next session. Directions for the exercise are

included in their workbooks on page 37. The leader should encourage members to call their telephone buddies during the week. Also, members should be encouraged to complete journal entries using the form provided for them in the participant workbook. Ask members if they are having any difficulty filling out the entries

Leader

- a. complete attendance log
- b. label tapes
- c. note any new pressing problems/change goals
- d. call office for "supervision"

Meeting 9

The aim of meeting nine is to introduce relaxation techniques that can be used to counteract the negative effects of strain associated with caregiving.

1. Conference Call Hook-up (15 minutes)

The leader will contact the conference call operator, who will place the conference call. The leader should request to be called first so that s/he can initiate small talk with group members as they are linked into the conference call. During this time, the leader can check-in with each member to find out if they have their participant workbooks with them. As group members are linked into the conference call, the leader should have them state their names and take attendance.

2. Brief Overview of the Eighth Meeting (5 minutes)

Overview of eighth meeting, questions, attendance, telephone buddy calls.

3. Check-in About Progress Toward Goals (10 minutes)

A go-round or check-in can be used by the leader to help members briefly describe their progress toward engaging in one pleasurable activity, or one coping strategy they are working toward implementing. The focus should be on progress since the last meeting, and also the positive results members are experiencing.

4. Deep Breathing (5 minutes)

5. Progressive Muscle Relaxation (15 minutes)

A progressive muscle relaxation (Jacobson, 1978) is introduced and practiced. During the group session, the leader will lead the relaxation exercise. Participants will also be given an audiotape that contains progressive muscle relaxation instructions and relaxing imagery. The tape, made for a previous research project, contains two sets of instructions, a full 45-minute set of instructions

on side 1, and a shorter version of the same instructions on side 2 for individuals who have mastered the instructions on side 1. They will be encouraged to use the tape, and practice the relaxation techniques, at home between meetings. Participants' experiences with the relaxation exercises and the audio-tape will be reviewed during the following meetings. Participants will continue to practice stress reduction techniques during the remaining meetings. This will be done by opening each meeting by practicing the deep breathing technique and a modified version of the progressive muscle relaxation technique which can be completed in approximately fifteen minutes.

The progressive muscle relaxation exercise:

We can reduce the tension in our muscles in many ways, including a process referred to as “tense/release.” We over-tense a muscle group, hold that tension for a few moments, and then fully release it, coordinating this action with our breathing. Doing this throughout all the major muscle groups of our bodies is called Progressive Muscle Relaxation. The procedure outlined below, follows the procedure explained in the audio tape used in class.

Begin by getting into a comfortable position, and be sure you will be free from distractions. Loosen any tight fitting clothes, and begin breathing calmly, as you prepare to enter a deeper state of relaxation.

Bring your attention to your feet. Notice how they feel. Now tense the muscles in your feet as you inhale. Squeeze the muscles tightly and feel the tension. Hold it. Now, release it completely, as you exhale. Notice the difference between the tension and relaxation. Repeat this a second time.

Bring your attention to your legs - to your calves and thighs. Notice how they feel. Now tense

these muscles....

Continue this procedure with the remaining muscle groups of your body:

the buttocks

the abdomen

the back

the arms and hands

the shoulders

the neck

the face.

After you have completed this sequence, take time to remain quiet and calm. Keep breathing with a comfortable and easy rhythm. Notice and enjoy your state of relaxation. Be aware of how much better you feel from when you began.

This exercise and this state of relaxation can be accomplished whenever you need it. Use it to take good care of yourself during the day, or before you go to sleep. Be well.

6. Problem Solving Taking care of Oneself (20 minutes)

The leader facilitates a group problem solving effort to help one or two members focus on strategies to resolve pressing problems they articulated at pre-test or that have emerged as the group progresses as well as identifying ways group members are taking care of themselves

7. Between Meetings (5 minutes)

The leader should ask members to call their telephone buddies and to continue to use the deep breathing and practice the muscle relaxation tape during the week. Written instructions for this exercise are also included in their workbooks on page 41. Also, members should be

encouraged to complete the journal entry included in the participant workbook. Ask members if they are having any difficulty completing the journal entries.

Leader

- a. complete attendance log
- b. label tapes
- c. note any new pressing problems/change goals
- d. call office for "supervision"

Meeting 10

The aim of meeting ten is to continue to practice progressive muscle relaxation techniques that can be used to counteract the negative effects of strain associated with caregiving.

1. Conference Call Hook-up (15 minutes)

The leader will contact the conference call operator, who will place the conference call. The leader should request to be called first so that s/he can initiate small talk with group members as they are linked into the conference call. During this time, the leader can check-in with each member to find out if they have their participant workbooks with them. As group members are linked into the conference call, the leader should have them state their names and take attendance.

2. Brief Overview of the Ninth Meeting (5 minutes)

Overview of ninth meeting, questions, attendance, telephone buddy calls.

3. Check-in About Progress Toward Goals (10 minutes)

A go-round or check-in can be used by the leader to help members briefly describe their progress toward engaging in one pleasurable activity, or one coping strategy they are working toward implementing. The focus should be on progress since the last meeting, and also the positive results members are experiencing.

4. Progressive Muscle Relaxation (15 minutes)

The group facilitator will lead members in a modified version of the taped progressive muscle relaxation exercise.

5. Problem Solving/Taking care of Oneself (25 minutes)

The leader facilitates a group problem solving effort to help one or two members focus on strategies to resolve pressing problems they articulated at pre-test or that have emerged as the

group progresses as well as identifying ways group members are taking care of themselves.

6. Between Meetings (5 minutes)

The leader should ask members to call their partners and to continue to use the deep breathing and practice the muscle relaxation tape during the week. Also, members should be encouraged to complete the journal entry included in the participant workbook. Ask members if they are having any difficulty completing the journal entries.

Leader

- a. complete attendance log
- b. label tapes
- c. note any new pressing problems/change goals
- d. call office for "supervision"

Meeting 11

The aim of meeting eleven is to introduce cognitive restructuring strategies including self-talk, perspective taking, and cognitive self-instruction strategies.

1. Conference Call Hook-up (15 minutes)

The leader will contact the conference call operator, who will place the conference call. The leader should request to be called first so that s/he can initiate small talk with group members as they are linked into the conference call. During this time, the leader can check-in with each member to find out if they have their participant workbooks with them. As group members are linked into the conference call, the leader should have them state their names and take attendance.

2. Brief Overview of the Tenth Meeting (5 minutes)

Overview of tenth meeting, questions, attendance, telephone buddy calls.

3. Check-in About Progress Toward Goals (10 minutes)

A go-round or check-in can be used by the leader to help members briefly describe their progress toward engaging in one pleasurable activity, or one coping strategy they are working toward implementing. The focus should be on progress since the last meeting, and also the positive results members are experiencing.

4. Self-talk (20 minutes)

Building upon exercises presented earlier in the program, participants will be taught by the leader how to use early stress cues as signals to activate more effective appraisals and coping strategies. In particular, participants will be taught how to use the method of "inner dialogue" or coping self-talk to slow down cognitive processes and to plan their coping reactions in a way that is more effective and gratifying for them. Participants will be asked to identify their preferred

coping self-talk and to reflect on its usefulness and function. In addition, participants will be introduced to the concept of coping imagery and asked to identify coping images they prefer.

5. Problem Solving/Taking Care of Oneself (20 minutes)

The leader facilitates a group problem solving effort to help one or two members focus on strategies to resolve pressing problems they articulated at pre-test or that have emerged as the group progresses as well as identifying ways group members are taking care of themselves.

6. Between Meetings (5 minutes)

The leader should ask members to call their partners and to continue to use the deep breathing and practice the muscle relaxation tape during the week . Also, members should be encouraged to complete the journal entry included in the participant workbook. Ask members if they are having any difficulty completing the journal entries.

Leader

- a. complete attendance log
- b. label tapes
- c. note any new pressing problems/change goals
- d. call office for "supervision"

Meeting 12

The aim of meeting twelve is to continue to discuss cognitive restructuring strategies including self-talk, perspective taking, and cognitive self-instruction strategies.

1. Conference Call Hook-up (15 minutes)

The leader will contact the conference call operator, who will place the conference call. The leader should request to be called first so that s/he can initiate small talk with group members as they are linked into the conference call. During this time, the leader can check-in with each member to find out if they have their participant workbooks with them. As group members are linked into the conference call, the leader should have them state their names and take attendance.

2. Brief Overview of the Eleventh Meeting (5 minutes)

Overview of eleventh meeting, questions, attendance, telephone buddy calls.

3. Self-talk, Perspective Taking, and Cognitive Imagery (20 minutes)

The leader can discuss the self-talk, perspective-taking strategies, and cognitive imagery that she finds useful in coping with stress in her own life. This may include deep breathing, removing oneself from a situation for a short period of time, taking a walk, etc. Members should then be encouraged to discuss the coping strategies they use to cope with stress.

4. Using Strategies Selectively (20 minutes)

A group go-round can be used to help each member describe the pleasurable activities, relaxation techniques, coping images, and self-talk phrases that he or she finds most helpful. Members should be encouraged to continue using their newly acquired coping skills once the group has ended.

5. Evaluation and Wrap-up (15 minutes)

The leader should facilitate an informal discussion of what the group has meant to the leaders and the members. The leader should help members to consider issues and needs they are likely to encounter in the future and how to address these issues.

Leader

- a. complete attendance log
- b. label tapes
- c. note any new pressing problems/change goals
- d. call office for "supervision"

References

- Barusch, A. & Spaid, W. (1991). Reducing caregiver burden through short-term training: Evaluation findings from a caregiver support project. Journal of Gerontological Social Work, 17, 7-33.
- Benjamin, S. (1989). Psychological treatment of chronic pain: A selective review. Journal of Psychosomatic Research, 33(2), 121-131.
- Blanchard, E. (1993). Behavioral therapies in the treatment of headache. Headache Quarterly, 4, 53-56.
- Colon, Y. (1996). Telephone support groups: A non-traditional approach to reaching underserved cancer patients. Cancer Practice, 4 (3), 156 – 159.
- D'Zurilla, T. (1990). Problem-solving training for effective stress management and prevention. Journal of Cognitive-Psychotherapy, 4, 327-354.
- Everly, G. (1989). A clinical guide to the treatment of the human stress response. New York: Plenum.
- Galinsky, M., Schopler, J., & Abell, M. (1997). Connecting group members through telephone and computer groups. Health & Social Work, 22 (3), 181 – 188.
- Gallagher-Thompson, D. (1994a). Clinical intervention strategies for distressed caregivers: Rationale and development of psychoeducational approaches. In E. Light, G. Niederehe, & B.D. Lebowitz (Eds.). Stress effects on family caregivers of Alzheimer's patients (261-277). New York: Springer.
- Gallagher-Thompson, D. (1994b). Direct services and interventions for caregivers: A review and critique of extant programs and a look ahead to the future. In M.H. Cantor (Ed.), Family caregiving: Agenda for the future (pp. 102-122). San Francisco, CA: American Society on Aging.
- Gallagher, D., Lovett, S., & Zeiss, A. (1989). Interventions with caregivers of frail elderly persons. In M. Ory & K. Bond (Eds.). Aging and health care: Social science and policy perspectives (Chapter 8, pp. 167-190). New York: Routledge.
- Jacobson, E. (1978). You must relax. New York: McGraw-Hill.
- Kaslyn, M. (1999). Telephone group work: Challenges for practice. Social Work with groups, 22, 63 – 77.
- Kelleher, K. & Cross, T. (1990). Teleconferencing: Linking people together electronically. Norman: University of Oklahoma Press.
- Labrecque, M., Peak, T., & Toseland, R. (1992). Long-term effectiveness of a group program for caregivers of frail elderly veterans. American Journal of Orthopsychiatry, 62, 575-588.
- Lakin, M. (1988). Group therapies with the elderly: Issues and prospects. In B. MacLennan, S. Saul, & M. Weiner (Eds.), Group therapies for the elderly (pp. 43-56). Madison, CT: International Universities Press.
- Lazarus, R., & Folkman, S. (1984). Stress, appraisal, and coping. New York: Springer.
- Meichenbaum, D. (1977). Cognitive behavior modification-An integration approach. New York: Plenum.
- McKenna, K. & Green, A. (2002). Virtual Group Dynamics: Theory, Research, and Practice, 6 (1), 116 – 127.

- Meichenbaum, D. (1985). Stress inoculation training. New York: Plenum.
- Meichenbaum, D., & Cameron, R. (1983). Stress inoculation training: Toward a general paradigm for training coping skills. In D. Meichenbaum & M.E. Jaremko (Eds.), Stress reduction and prevention (pp. 115-154). New York: Plenum.
- Moos, R.H., & Cronkite, R.C., Billings, A.G. & Finney, J.W. (1988) Health & Daily Living Form Manual. Palo Alto CA: Veteran's Administration & Stanford University Medical Centers.
- Rounds, K., Galinsky, M., & Stevens, L.S. (1991). Linking people with AIDS in rural communities: The telephone group. Social Work, 36 (1), 13 – 18.
- Schopler, J., Abell, M., & Galinsky, M. (1998). Technology-based groups: A review and conceptual framework for practice. Social Work, 43 (3), 254 – 267.
- Smokowski, P.R., Galinsky, M., & Harlow, C.K. (2001). Using technologies in group work part II: Computer based groups. Group Work, 13 98 B 115.
- Sorbi, M. & Tellegen, B. (1988). Stress-coping in migraine. Social Science and Medicine, 26, 351-358.
- Stein, L., Rothman, B., & Nakanishi, M. (1993). The telephone group: Accessing group service to the homebound. Social Work with Groups, 16 (1/2), 203 – 215.
- Toseland, R. (1977). A problem solving group workshop for older persons. Social Work, 22, 325-326.
- Toseland, R. (1990a). Group work with older adults. New York: New York University Press.
- Toseland, R. (1990b). Long-term effectiveness of peer-led and professionally led support groups for family caregivers. Social Service Review, 64, 308-327.
- Toseland, R. (1995). Group work with the elderly and family caregivers. New York: Springer.
- Toseland, R., & Rossiter, C. (1989). Group interventions to support family caregivers: A review and analysis. The Gerontologist, 29, 438-448.
- Toseland, R., Rossiter, C., & Labrecque, M. (1989). The effectiveness of two kinds of support groups for caregivers. Social Service Review, 63, 415-432.
- Toseland, R., Smith, G., & McCallion, P. (1995). Supporting the family in elder care. In G.C. Smith, S.S. Tobin, E.A. Robertson-Tchabo, and P.W. Power (Eds.), Enabling aging families: Directions for practice and policy. (pp. 3-24) Newbury Park, CA: Sage.
- Toseland, R., Smith, T. & McCallion, P. (2001). Health education groups for caregivers in an HMO. Journal of Clinical Psychology, 57 (4), 551 – 570.
- Toseland, R., Rossiter, C., Peak, T., & Hill, P. (1990). Therapeutic processes in support groups for caregivers. International Journal of Group Psychotherapy, 40, 297-303.
- Toseland, R., Sherman, E., & Bliven, S. (1981). The comparative effectiveness of two group work approaches for the development of mutual support groups among the elderly. Social Work with Groups, 4(2), 137-153.
- Wasserman, H., & Danforth, H. (1988). The human bond. New York: Springer.
- Wiener, L., 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. Social Work with Groups, 16 (3), 55 – 71.
- Yalom, I. (1985). The theory and practice of group psychotherapy (3rd ed.). New York:

Basic Books.

Zarit, S., Anthony, C & Boutselis, M. (1987). Interventions with caregivers of dementia patients: Comparison of two approaches. Psychology and Aging, 2, 225-232.