A Dissertation

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The Role of the Wellness Management and Recovery (WMR) Program in Promoting Mental Health Recovery

By

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Mental health recovery has gained increasing attention as it relates to the conceptualization and treatment of those individuals experiencing severe mental illness, such as schizophrenia, major depression, and manic-depressive illness. Despite “recovery” serving as a guiding vision for the implementation and practice of mental health service delivery (Anthony, 1993), the concept itself continues to evolve. As part of this evolution, consumers have played an increasing role in the delivery of such services, whether through consumer-operated agencies or through partnerships with traditional, professionally trained mental health providers. The present study sought out to qualitatively assess recovery using a phenomenologically-guided Grounded Theory Analysis (Glaser & Strauss, 1967; Strauss & Corbin, 1990), specifically within the
context of the Wellness Management and Recovery (WMR) program. The WMR program is a 10 session, recovery-focused / consumer-oriented treatment delivered in a group format. WMR is currently being disseminated across the state of Ohio in both traditional mental health centers and consumer-operated agencies. The model that emerged from the qualitative data, based on a sample N=7 consumers of mental health services, consisted of 3 primary themes characterizing the components of recovery: Growth, Group Content & Process, and Overcoming Prejudice & Stigma. Furthermore, the inter-relationships between themes and the sub-categories contained within provided a model of the process of recovery or how it took place for consumers. Of particular importance for many consumers were the aspects of group atmosphere, a sense of belonging, equality, and having fun. Of secondary importance in the present study was the assessment of group change (N=291) from Pre- to Post-Treatment in the areas of mental health recovery, empowerment, quality of life, and symptoms distress. Results are indicative of significant group change across time, with small to medium effect sizes found (Cohen’s $d= .21 - .59$). The present study not only provides further data supporting recovery in general, but details the specific process of recovery within the context of an evolving evidence-based practice (i.e., WMR). Implications for clinical practice as well as a change in mindset or philosophy when it comes to the treatment and conceptualization of those experiencing severe mental illness are discussed.
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Chapter I

Introduction

Historically, the concept of severe mental illness has carried with it a proclivity towards beliefs and perceptions indicative of poor prognosis. The anticipated path of those receiving diagnoses such as schizophrenia, major depression, or manic-depressive illness was stagnant at best and at worst, degenerative. In the past decade, however, the mental health system has witnessed a changing landscape in the perceptions and approaches taken towards those individuals experiencing severe and persistent mental illness. With a growing shift away from traditional views of mental illness as intractable and even degenerative, a concept of recovery from mental illness has emerged. This concept serves as the vision for the implementation and practice of a recovery-oriented mental health system (Anthony, 1993). Consistent with the ideals of a recovery vision are such factors as consumer empowerment, hope, increased decision making in one’s own treatment, as well as greater focus on quality of life. These factors have contributed to consumers taking an active role in advocacy, mental health policy, and even in the provision of mental health services. It is the latter that is particularly relevant to the current study. Empirical data on consumer-provided services, while scant, has shown promising results for the role of consumers in the provision of mental health services (Nelson, Ochocka, Janzen, & Trainor, 2006).
Origins of the Consumer / Survivor Movement

Prior beliefs regarding mental illness, incorporating little to no chance of recovery, resulted in the practice of self-fulfilling institutionalization (Allott, Loganathan, Fulford, 2002), serving to only reinforce a lack of hope. Frese (1998) has stated that the institutionalization of those with severe and persistent mental illness in psychiatric hospitals prior to the Civil War has served as an impetus for the rise of consumerism. In fact, it can be said that the rise of consumerism has its roots in the deinstitutionalization movement of the 1960s and 1970s. Those whose voices were silenced by years of inhumane treatment and stigmatization found themselves able to speak about their experiences.

The concept of recovery has paralleled the so-called consumer / survivor movement. While small in its inception, a minority of those who found themselves able to meet the demands of daily living began to meet with one another and share their stories. A consensus formed among these individuals in that they viewed themselves as part of an oppressed minority group, similar to other traditional groups ostracized by society for issues related to race, religion, or creed (Frese, 1998). The increasing popularity and number of these groups helped lead to a more systematic self-help movement, characterized by negative attitudes towards past mental health practices in general, and the field of psychiatry in particular. In its current form, consumerism has embraced the concept of recovery.

Defining Recovery

One of the most challenging aspects in any discussion of the mental health consumer movement is the ongoing debate regarding the definition of recovery. Due to
the contrast between traditional and consumer perspectives on mental illness and what exactly characterizes improvement or recovery, a lack of consensus in defining recovery remains. Historically, mental health providers, as well as other health care providers in general, have guided their services on a medical or deficit-based model that serves to highlight dysfunction (Davidson, Flanagan, Roe, & Styron, 2006; Schmook, 1996). As a result, success in treatment is said to have been achieved with the remission of symptoms and the return of an individual back to a previous and “normal” state of functioning in their personal, social, and vocational lives (Davidson, O’Connell, Tondora, Lawless, & Evans, 2005). Recovery is therefore an endpoint that has decreased symptomatology as its hallmark (Resnick, Fontana, Lehman, & Rosenheck, 2005). However, it has become apparent in the literature that several problems exist when symptomatology or the number of hospitalizations is used as the primary gauge of improvement in one’s life. Empirical evidence exists documenting the ability of individuals experiencing severe and persistent mental illness to lead productive and enriching lives, despite the ebb and flow of symptoms so often experienced. Davidson et al. use the analogy of an individual suffering from paraplegia not needing “to regain his or her full mobility in order to pursue his or her aspirations and goals” (p. 483). Improvement in such variables as self-efficacy, empowerment, and self-esteem have been shown to be more stable than symptomatology (Bullock, Ensing, Alloy, & Weddle, 2000). Anthony (2004) further cautions that as scientists and practitioners, we have historically approached treatment with a focus on symptoms and pathology, going on to state that this has merely resulted in finding exactly that, highlighting the apparent self-fulfilling nature of the mental health profession for so many years. Despite traditional deficit-based practices, longitudinal
studies have been conducted and have shown evidence in favor of a lack of deterioration in many individuals formally meeting diagnostic criteria for schizophrenia. Moreover, this research has also provided evidence of the potential for improvement, calling into question the long held view of schizophrenia having a degenerative course (Harding, Brooks, Ashikaga, Strauss, & Breier, 1987; Harding, Zubin, & Strauss, 1987).

Contrary to those definitions of recovery as put forth by professionals, a growing emphasis on recovery as a process has emerged (Allott et al., 2002; Frese & Davis, 1997; Ralph, 2000; Schmook, 1996). The process definition of recovery is itself deeply subjective and multifaceted. Anthony (2000) defines recovery as a “deeply personal, unique process of changing one’s attitudes, value, feelings, goals, skills, and / or roles” (p. 15). Given the deeply personal and subjective nature of the concept, some have questioned whether or not recovery defies definition (Davidson et al., 2005). Despite these concerns, a relative consensus exists among those who self identify as consumer / survivors as to the general assumptions and components of a recovery-oriented service delivery system.

Recovery-Oriented Service Delivery

Anthony (1993) has outlined the assumptions of the recovery vision. Predominant among these assumptions is the notion that: 1) The process of recovery can occur without professional involvement. The fundamental principle behind this assertion is that consumers engage in the recovery process, while professionals may provide a facilitating role, 2) Support along the recovery process is critical, 3) Recovery does not adhere to any specific model of illness or theoretical orientation, 4) Recovery does not necessitate the absence of symptoms, 5) Although not of primary importance, the process of recovery
can influence the frequency and duration of symptoms, 6) Recovery is not a linear process, 7) Consequences of experiencing mental illness (unemployment, stigma, reduced quality of life) can be a greater burden to overcome than the mental illness itself, and 8) Recovery from mental illness does not negate the existence or validity of mental illness.

With regard to the specific components thought to facilitate and characterize a recovery framework, Deegan (1988, 1997), a self-identified consumer and clinical psychologist, has spoken at great length about the importance of hope and optimism in the recovery process. Many others in the literature have also endorsed hope as a hallmark of the recovery process (Davidson, Borg, Marin, Topor, Mezzina, & Sells, 2005; Marsh, 2000; Mead & Copeland, 2000). Empowerment, or taking the responsibility and initiative in one’s own recovery, has also received an increasing amount of attention (Corrigan, 2002; Ralph, 2000). Peer support, education, and spirituality have also been identified as central tenets in the recovery process.

Despite knowledge of these factors thought to be integral to recovery, individuals experiencing severe and persistent mental illness have historically not experienced them in their treatment. The barriers so many individuals encounter in this regard have their origins in resistant professionals as well as general problems within the mental health service delivery system. Writing on consumer / survivor’s personal accounts of the recovery process, Marsh (2000) notes that the perceptions held by many within the mental health system promote and reinforce a sense of passivity. Taking on a patient role serves to define and influence behavior, most often in negative ways. Fekete (2004), commenting on her experience as a mental health consumer, has stated how the
traditional mental health service delivery system has reinforced the depersonalization of the doctor / patient relationship. The ubiquitous stigma experienced when labeled with a psychiatric diagnosis can be devastating for many. Deegan (1990) has expressed similar sentiments on the often counter-therapeutic practices of those in a helping role. Instead of its emphasis on controlling symptoms, many consumers wish the mental health system would seek to facilitate improved quality of life. Roe and Lachman (2005) have reported on evidence indicative of psychiatric labeling being negatively associated with quality of life. Professionals assuming an authoritative and omniscient role also add to the continued stigmatization. Common experiences by many consumers characterize psychiatric and psychotherapeutic efforts as counterproductive. With a continued emphasis on dysfunction and medication, at the exclusion of other variables deemed critical by consumers, a true recovery-oriented mental health system will never materialize.

Recognizing the need for transformation and reform of contemporary mental health care, coupled with attention being paid toward those variables deemed critical by consumers, Davidson, Flanagan, Roe, and Styron (2006) have offered an “action perspective” for mental health policy. It has been felt that too often mental health professionals do not appreciate the ability of human beings, predominately those with severe psychiatric disabilities, to be active agents in the world with a profound influence on their environment. As a result, mental health professionals have encountered challenges in treating consumers. The reasons for such challenges are varied and often include professionals focusing too much on “changing” an individual or helping them return to a state of normalcy, rather than asking them what they need and desire.
Davidson et al. note that this action perspective can be facilitated not by attempting to
cure or stabilize, but by helping to remove barriers and provide support and assistance in
the form of enhancing access to opportunities. Advisement from professionals for those
with severe mental illness to forestall making an impact on their environment until they
are asymptomatic is tantamount to delaying the start of their recovery. While such a
model of intrinsic self-determination captures the vision of a new form of mental health
delivery, its dissemination and practice have moved slowly. As a result, evidence of
effectiveness in the form of feedback from consumers is needed in order to validate its
influence.

In attempting to change the current mental health system into one that embraces a
recovery-oriented vision, consumers have had to take an active role. Stemming from the
de-institutionalization of the 1970s, a much greater emphasis on the community in the
promotion of mental health treatment has emerged. This changing landscape of mental
health treatment has not come easily or without resistance. The process of community
integration has certainly been arduous. This has become ever more apparent in the
context of the evolving recovery paradigm. Specifically, individuals with severe and
persistent mental illness have encountered many challenges in trying to find their place in
society. As Bond, Salyers, Rollins, Rapp, and Zipple (2004) have described, true
community integration necessitates major political, societal, and system-level changes.
Community integration is characterized by consumers who have transcended the
“patient” role, with the ability to move beyond the treatment facilities and segregated
housing. Goals include striving towards independence, enjoying meaningful social
relationships, playing a significant role in one’s community, collaborating in the
provision of one’s own healthcare, and feeling a renewed and heightened quality of life. Bond et al. state that, “community integration involves being of the community and not just physically located in the community” (p. 572).

What does a recovery-oriented service delivery system look like? As providers of mental health services, practitioners must be willing to acknowledge that they can learn from the personal accounts and testimonials of those having experienced the effects of conventional mental health practices (Marsh, 2000). One of the most crucial aspects of a recovery-oriented system is personal responsibility. Glover (2005) writes that providers or community agencies can not take responsibility or ownership of an individual’s recovery. Given the highly subjective and idiosyncratic path of recovery for everyone, it is imperative that individuals be in the driver’s seat of their own recovery. This does not imply, however, that professionals have no place in a recovery framework. What it does suggest is that the role historically played by mental health professionals needs to be modified, from one of authoritative expert, to that of collaborator using a recovery-oriented framework to guide clinical practice. Glover (2005) speaks to the challenges inherent in this type of transformation but reminds us that in order to maximize efforts, the knowledge of professionals needs to be used within the framework of that which guides the recovery vision, that being the lived experiences of those with severe and persistent mental illness.

Also paramount in a recovery-oriented system is what Farkas, Gagne, Anthony, and Chamberlin (2005) refer to as “person orientation,” implying that individuals come first and not the disease or diagnosis. This involves a concerted effort on the part of mental health professionals to better recognize and utilize strengths, as opposed to
dysfunction. A related issue suggests that services should foster recovery, and not solely emphasize maintenance or deterioration of symptoms, thus highlighting the importance of hope and optimism (Corrigan, 2002). Along with an emphasis on strengths instead of pathology, a recovery-oriented system needs to help facilitate an individual’s own interests, aside from merely symptom relief. Specifically, this focus includes those factors discussed above, such as improvements in meaningful employment, social relations, peer support, community integration, as well as renewed quality of life.

Speaking to the ability of mental health consumers to take an active role in their recovery efforts, consumer involvement has received an increasing amount of attention. Consumer efforts have been made in the areas of advocacy, policy making, and even in the provision of mental health services. Perhaps no other area of effort has provided more interest in recent years than the latter, the involvement of consumers in the provision of mental health services. Davidson et al. (1999) have identified three forms of consumer involvement or peer support utilizing the contributions of consumers helping fellow consumers. These include naturally occurring mutual support groups, the employment of consumers as providers in clinical settings, and consumer-operated services. Consumer-led and/or consumer-focused service delivery is a burgeoning area within the area of recovery and represents the focus of this proposal. As noted by Goldstrom et al. (2006), results of a 2002 national survey speak to the growth of mental health mutual support groups, self-help organizations, and consumer-operated services. The number of these services currently available was found to exceed the number of traditional mental health services.
Emerging Best Practices

It has become increasingly demanded that clinical and rehabilitative interventions be guided by approaches that are scientifically grounded. As a result, parallel to the rise in interest over the concept of recovery has been a concurrent focus on the adoption of those mental health practices that are deemed by the literature to be “evidence-based.” An evidence-based practice (EBP) is one that has withstood rigorous analysis through the use of empirical methodologies that seek to maximize the ability to determine causation. Historically, research of this nature has utilized quantitative means of measuring an outcome, at the exclusion of other, qualitative measures of success or decline. The exclusion of such qualitative data as both a continued source of theory development for the concept of recovery-oriented service delivery and as a gauge of progress on this front is evident in the literature and highlights the need for continued research.

Some may argue that given the deeply personal and highly unique process that epitomizes mental health recovery (Anthony, 2000), evidence-based practices would not fit into a recovery framework. Frese, Stanley, Kress, and Vogel-Scibilia (2001) have offered a model that encompasses a coexistence between a “paternalistic, externally reasoned treatment approach,” (p. 1464) such as evidence-based practice and the highly subjective, phenomenologically driven recovery approach. The heart of the incongruity, as put forth by those polarized on the issue, namely professionals and consumers or consumer advocates, pertains to the issue of responsibility. Many professionals view themselves in the position of needing to determine what is in the best interest of those they serve, who may at times not appreciate the level of their impairment. However, this view is in sharp contrast to those consumers and consumer advocates who, while still
experiencing the symptoms of mental illness, are in the position to take responsibility for aspects of their treatment planning and thus demand some degree of autonomy for themselves. Therefore, Frese et al. propose a model that endorses a greater emphasis on evidence-based and objective treatment approaches for those in a position of extreme disability while relinquishing responsibility in a graded manner to those who have benefited from treatment and can therefore be afforded greater autonomy.

The Role of Consumers as Paraprofessionals

In an attempt to bridge the gap between the provision of traditional professionally-focused, evidence-based practices and those interventions endorsing a consumer-focused recovery paradigm, consumer-led services or the use of consumer co-facilitators have played an increasingly important role. Both quantitative and qualitative evidence exists to support the benefits of having individuals who experience severe mental illness also playing a role in the provision of mental health services; however, in order to gain credibility and to better understand the ways in which consumer-focused services promote the recovery process, further work remains. A better understanding and appreciation of the effects of consumer-focused services in general in treating those with severe and persistent mental illness, and consumer-provided services in particular, have implications for making dramatic changes in mental health policy. Prince and Segal (2005) have noted that public policy can foster the capacity of self-help agencies to receive the necessary funding to provide supportive, recovery-oriented services to those in need. More recently, in speaking to the convergence of service, policy, and science in promoting consumer-focused mental health care, Carroll, Manderscheid, Daniels, and
Compagni (2006) have reported an increase in public and private interest in consumer-driven care.

Much of the extant literature to date has focused on consumer involvement in mutual self-help and peer support programs. These groups or programs represent vital components of treatment for many individuals experiencing mental health and/or substance use disorders. In fact, Moos (2008) notes that individuals make more trips to self-help groups for either mental health or substance use disorders than to all mental health professionals combined. Furthermore, empirical evidence has increasingly been indicative of “consistent” benefits of engagement in self-groups despite researchers and clinicians’ continued skepticism regarding its effectiveness. Despite the skepticism of some, self-help groups have represented a strong facet of informal care that has been integrated with formal treatment for many years (Kelly, 2003). Of particular significance with self-help or mutual support groups might be the process by which group members develop increases in social support and how this increase translates to improvement in symptomatology and quality of life.

Alcoholics Anonymous (AA), for example, created in 1935 as a type of self-help group for those battling alcoholism, has been found to result in both positive qualitative and quantitative changes in social support. Specifically, a recent review of the literature found that AA involvement has been found to result in higher levels of friendship quality, more friendship resources, and greater friend support. Furthermore, the group friendships made were found to be qualitatively more respectful and trustworthy. These positive changes in one’s socialization are thought to be a powerful and influential mechanism in
the overall effectiveness of AA in fostering a healthier lifestyle characterized by sobriety and wellness (Groh, Jason, & Keys, 2008).

Other self-help or mutual support groups, such as Wellness Recovery Action Plan (WRAP), take on a recovery-oriented perspective as it applies to mental health or psychiatric disability and may not rely as much on the development or expansion of one’s social support as a central tenet. Copeland (2002) defines WRAP as “a structured system for monitoring uncomfortable and distressing symptoms and, through planned responses, reducing, modifying or eliminating those symptoms” (p. 3). It appears as though many self-help or mutual support groups may differ with regard to their emphasis on aspects such as symptomatology, enhancing social support and a bond with one’s peers experiencing shared experiences, as well as the overall degree of structure of the group. Due to the often informal integration of self-help services with more formal and traditional professional treatment, Kelly (2003) has argued that it is difficult to fully appreciate or understand the independent effects of self-help groups or similar services. It is possible, however, that the optimal “treatment” would formally integrate both an emphasis on social support and a sense of belongingness with a structured plan of treatment emphasizing education, goals, and objectives.

Prior to the rise of the consumer movement and consumer involvement in services, empirical literature has addressed the effectiveness of paraprofessionals in the provision of services. Dating back many years, Magoon and Golann (1966) provided evidence in favor of the creditable counseling and psychotherapy services that could be provided by nontraditionally trained women in the mental health field. Furthermore, a somewhat counterintuitive but consistent finding has been the effectiveness of
paraprofessionals in providing services that are equal to or exceed that of formally trained professionals in the provision of case management and mental health services (Durlak, 1979; Hattie, Sharpley, & Rogers, 1984; Truax & Lister, 1970). More recently, Solomon and Draine (1994, 1995a, 1995b, 1995c) have provided evidence documenting equivalent outcomes among consumer case managers and non-consumer case managers, in maintaining the stability of individuals experiencing severe mental illness. Felton et al. (1995), using a quasi-experimental, longitudinal 18-month design, explored the role of consumer peer specialists in providing services to those experiencing severe mental illness in an intensive case management program. Consumers were randomly assigned to three case management groups (case managers plus peer specialists, case managers plus non-consumer assistants, or case managers alone). Consumers in the condition employing a peer specialist were found to have significantly greater improvements in areas pertaining to quality of life and greater reductions of major life problems.

More recently, O’Donnell et al. (1999) investigated the role of consumer-focused services with those experiencing severe mental illness. Consumers referred for case management services were randomly assigned to one of three conditions (usual case management, consumer-focused case management, or consumer-focused case management including a consumer advocate). Consumer-focused case management included case managers who had completed formal training in an empowerment model of clinical practice, while the consumer advocate played a role of encouraging self-advocacy and confidence, acting as a role model during the recovery process, and enhancing consumers’ communication with their case managers. No significant differences were found among groups after 12 months on measures of functioning, disability, quality of
life, service satisfaction, or burden of care. In investigating consumer providers and assertive community treatment (ACT), Clarke et al. (2000) randomly assigned consumers to one of three groups (ACT team staffed by consumers, ACT team staffed by non-consumers, or treatment as usual). Consumers receiving ACT services staffed by fellow consumers experienced fewer hospitalizations than those receiving ACT services by non-consumers. The authors posited that one explanation for this finding is that consumer providers may have had greater motivation to keep their clients out of the hospital due to their own experiences with hospitalization. Furthermore, consumer providers may have also displayed a greater tolerance of psychotic behavior or exacerbation of symptoms, thus not initiating hospitalization as quickly or frequently. The research reviewed has shown evidence of consumer-provided services having either greater or equivalent outcomes to those services provided by non-consumers. In offering equivalent services to fellow consumers, consumer providers also appear adept at integrating mutual support in to their treatment approach (e.g., promoting hope, providing a role model, practical skills; Chinman, Young, Hassell, and Davidson, 2006).

In assessing the relationship between participation in consumer-run services and improvements in the areas such of hopefulness, self-efficacy, social functioning, and coping skills, Yanos, Primavera, and Knight (2001) found further support highlighting the greater effectiveness of consumer-run services over those of traditional mental health services. These results suggest that consumer participation in the provision of services has an empirical, quantitative grounding. Furthermore, it dispels the notion that traditional professional training is a necessary prerequisite for effective helping.
While this empirical evidence is promising, a critical review of the design and methodology of this and other research highlights both its strengths and limitations. The limitations are critical and need to be addressed so that implications regarding the use of consumers in the role of paraprofessional in promoting recovery can be made. While Magoon and Golann’s (1966) work did show evidence of effectiveness for nontraditionally trained women in the provision of psychotherapy services, the ability to generalize these findings to consumers providing mental health services is limited, if not impossible.

Durlak (1979), having reviewed 42 studies in which paraprofessionals were used as treatment providers, noted that in the past the greatest source of empirical support for the effectiveness of paraprofessionals had come from programs focused on the amelioration of specific target problems of middle-class college students and adults, at the neglect of group or individual programs for adults from non-middle class backgrounds. Furthermore, until only recently, paraprofessional literature on such presenting problems as severe and persistent mental illness or such treatment approaches endorsing a recovery orientation was nonexistent. The paraprofessionals utilized in Durlak’s review included psychiatric aides, nurses, college and medical students, and community volunteers. No mental health consumers played the role of paraprofessional in these studies. Furthermore, the pioneering literature in this area at times used methodologies that had paraprofessionals providing different treatment services compared to those provided by professionals. This significant limitation confounded results and made it impossible to assess provider and treatment effects separately, limiting conclusions that could be drawn. More recently, Nelson et al. (2006), in a
longitudinal study of mental health consumer / survivor initiatives addressing some of the
aforementioned limitations, noted that their use of a small non-representative sample in
Ontario was also a limitation in this form of research. An effort to address these
limitations in the literature has begun.

Despite the random assignment used in the aforementioned research investigating
the role of consumer providers on treatment outcomes (Clarke et al., 2000; O’Donnell et
al., 1999; Felton et al., 1995; Solomon and Draine, 1995a, 1995b, 1995c), this research is
still limited with respect to the services utilized. Specifically, in reviewing the literature
on consumer-provided services, Chinman, Young, Hassell, and Davidson (2006) have
suggested that most studies of this nature employed consumers as a member of a case
management team, either individually or as an adjunct to a non-consumer provider. While
case management or ACT services represent a critical role in mental health care for
consumers experiencing severe and persistent mental illness, these services may be
considered by many to be distinct from traditional, psychotherapeutic /
psychoeducational forms of treatment with regard to both the goals and process of the
given modality. While some may argue that the results cited above can be generalized to
consumers providing psychotherapy or psychoeducational services within a group format,
not enough empirical grounding exists to support this assumption.

The paraprofessional literature to date is not only starting to incorporate
consumers as paraprofessionals, as opposed to paraprofessionals with no known history
of psychiatric disabilities, but is also focusing on recovery-oriented treatment or case
management for those with severe and persistent mental illness (Solomon & Draine,
1995a; Yanos et al., 2001). In an attempt to empirically support the role of consumer
providers within a formal treatment context, as opposed to solely case management services, future research efforts need to focus on this limitation and address it accordingly. In consideration that research efforts of this sort are in their nascent stage, further work is warranted to better understand the role that consumer providers or recovery-oriented services can have within the context of a psychotherapeutic/psychoeducational treatment modality.

As quantitative evidence documenting the effectiveness of paraprofessionals in general and consumers in particular in the provision of mental health services has emerged slowly, qualitative data has also begun to provide some richer explanations regarding those aspects of treatment that have facilitated the recovery process. It has been proposed that consumers may be in a particularly powerful position to provide mental health services and peer support to other consumers given their firsthand experience with serious mental illness and its consequences. Wilson, Flanagan, and Rynders (1999) note that, as a consumer seeking mental health services, it may be easier to accept help from another who has had similar experiences. Furthermore, this firsthand knowledge may also lead to perceptions of consumers possessing greater credibility in offering potential solutions to everyday problems. In a qualitative analysis of consumer versus non-consumer practice patterns in the provision of assertive community treatment, Paulson et al. (1999) found differences in what was referred to as the “practice cultures” (p. 259) of the consumer and non-consumer teams. Activity logs were utilized by both groups to assess what activities were being performed by both groups. While both consumer and non-consumer case managers showed similar patterns in what specific activities were
performed for clientele, differences were observed in how both case manager teams provided services.

Paulson et al. (1999) identified four themes that highlighted differences between teams, including a) boundaries between consumers and their case managers, b) case managers’ authority, c) the presence and pace of case managers, and d) the burden of care among case managers. Results suggested that consumer providers were perceived as putting a greater emphasis on the case manager-consumer relationship, whereas the non-consumer providers maintained a far more “professional” focus, centered on the accomplishment of tasks. Furthermore, consumer providers were far less likely to set and enforce provider-client boundaries, whereas the group of non-consumer providers was perceived as enforcing those boundaries, both verbally and through their actions. This resulted in what Paulson et al. referred to as a “we-they” tone. Non-consumer providers were found to show little reluctance in imposing treatment regimens, while consumer providers tended to work cooperatively with the client to improve behavior rather than impose treatment regimens not collaboratively agreed upon. Consumer providers were perceived as “just being there” (p. 263), as opposed to their non-consumer counterparts who were concerned with concrete task completion. Finally, with regard to burden of care, non-consumer providers were observed often expressing their feelings of fatigue or burden that came with their roles of case manager, while consumer providers did not outwardly express this burden.

These results speak to the different cultures or practices of traditional versus consumer-operated agencies or even consumer-focused services provided by professionals. Of particular interest in the present study is the influence that consumer-
focused services employing a recovery-oriented paradigm, either through traditional or consumer-operated agencies, have on mental health recovery. One explanation for consumer-operated agencies being of particular benefit to consumers may lie in how the respective agencies are run. Specifically, as opposed to the paternalistic and task-focused culture that has so long characterized traditional mental health care, consumer-operated agencies and/or recovery-oriented care appear to operate according to equalitarian and democratic principles where the primary motive is consumer care and not profit.

Ochocka, Nelson, Janzen, and Trainor (2006), conducting one of the first controlled studies of consumer-run organizations, compared active and non-active consumers longitudinally over a period of 18 months. Quantitative results were followed with in-depth, semi-structured interviews on 26 participants from the larger sample of 118. The purpose of the interviews was to assess, through narrative, personal changes experienced over the 18-month period of the study. Qualitative data gathered were indicative of differences contingent upon participation in consumer-run organizations. Specifically, those participants who were active in a consumer-run organization expressed that these sites offered safe and welcoming environments that were nonjudgmental. Furthermore, these organizations provided social arenas that gave members an opportunity to socialize, share similar experiences, learn coping skills, and support others. Many consumers reported that the experience helped foster community integration, by way of being able to participate in and contribute to a community organization. Active consumers verbalized maintenance or strengthening of their support system, while non-active consumers did not tend to have the same maintenance or strengthening of support, either through the consumer-operated site or from other
settings. Symptomatology based on active or non-active membership was also apparent, with active consumers reporting decreases in their perceptions of symptomatology while the number of non-active consumers reporting significant mental health problems remained constant across time. Increased independence with regard to work, income, education, and training was also verbalized more by active as opposed to non-active consumers.

In attempting to seek clarity regarding those aspects thought to foster recovery, Corrigan et al. (2002) sought to assess recovery processes responsible for significant improvements for consumers who have taken part in mutual-help programs. The “Blue Book” of the GROW program, an 84-page collection of readings and words of wisdom, was qualitatively assessed using a content analysis attempting to find recurrent themes regarding recovery. Thirteen reliable recovery processes emerged from the analysis: 1) Be reasonable, 2) Decentralize, participate in community, 3) Surrender to the healing power of a wise and loving God, 4) Grow closer to maturity, 5) Activate one’s self to recover and grow, 6) Become hopeful, 7) Settle for disorder, 8) Be ordinary, 9) Help others, 10) Accept one’s personal value, 11) Use GROW, 12) Gain insight, and 13) Accept help. In a second study presented with the aforementioned work by Corrigan et al., those recovery processes that emerged were compared to 22 written testimonials provided by GROW facilitators. This analysis showed “Being reasonable” and “Decentralizing” to be essential processes within the GROW mutual-help program.

Following up on their research assessing recovery processes gathered from qualitative data on the GROW program (Corrigan et al., 2002), Corrigan et al. (2005) performed qualitative interviews with 57 members of the GROW program in order to
explore what active GROW participants perceived to be important recovery processes. Findings from these analyses indicated that those problems that appeared most prominent to participants included relationships, a desire to live more comfortably and intimately with family members as well as others, while some also identified psychiatric symptomatology. To a lesser extent, members of GROW also endorsed concern with regard to achieving life goals, including an emphasis on finding employment and independent living. Central to the definition of recovery among many members of GROW was independence or self-reliance. Differences existed among members, with some identifying recovery as an endpoint whereas others viewed it as a process. However, regardless of this, members of GROW tended to see recovery as being ultimately related to behaving independently, as opposed to a focus of psychiatric symptoms. The elements of GROW found to promote the recovery process were other GROW members and the ability to learn from and help one another. “The caring and sharing community of GROW was repeatedly cited as the single process that facilitates recovery” (Corrigan et al., 2005; p. 733). Cooperation was also perceived as highly important.

The results cited thus far, while all based on experiences taken from participation in a consumer-operated organization or self-help group, do not discount the influence of professionals in a recovery framework. The recovery literature is replete with personal accounts and testimonials of consumers sharing their experiences with mental illness and treatment. These include some accounts applauding the role that professionals have played in their journey of recovery. Borg and Kristiansen (2004) conducted a qualitative analysis based on interviews with 15 individuals experiencing severe mental illness who
identified as service users. In their review of helping relationships from the perspective of service recipients, consumers “valued professionals who conveyed hope, shared power, were available when needed, were open regarding the diversity in what helps, and were willing to stretch the boundaries of what is considered the ‘professional’ role” (p. 493). An expression of empathy and respect were viewed as the most beneficial qualities of a helping professional. This included an equalitarian relationship, as opposed to an authoritative “professional-patient” dichotomy. Also perceived as extraordinarily helpful and sensitive were professionals who were available for both minor and major challenges experienced by consumers in everyday life. Those professionals who exhibited a willingness to use not only their professional time but their personal time as well were perceived as helpful, highlighting the need of consumers to have people “just being there.” An aspect of this investment in one’s client included curiosity about the consumers’ everyday life, as opposed to solely symptomatology. While the reasons why it helped in their recovery often varied, what was found to be of help to many consumers was psychotherapy itself. Many viewed their helping professional as fostering hope and courage when life’s circumstances were chaotic. Lastly, professionals who exhibited an ability to straddle the edge of what is typically deemed “professional behavior” were seen as helpful. For example, a consumer spoke of their treatment professional accepting a gift and thereby fostering a sense of being able to “give back” (Borg & Kristiansen, 2004).

Marsh (2000) identified several implications for professionals based on personal accounts of consumers with severe mental illness. These included: 1) a willingness to hear consumers’ stories, learn and benefit from them, 2) assisting consumers in learning effective coping skills, 3) focusing on more than the illness, utilizing consumer strengths,
providing help without crushing one’s character, 4) focus on outcomes that include quality of life in addition to merely symptomatology, and 5) provide a caring, collaborative, more humane environment of care. Tenney (2000) has expressed that one needs to view recovery as the expectation rather than the exception.

The research to date that has attempted to capture the process of recovery and treatment experiences qualitatively, including both its helpful and hindering aspects, can also be characterized as possessing both strengths and limitations in design and methodology that can guide and refine future research. In qualitatively assessing the differences in practice parameters between consumer and non-consumer mental health service providers, Paulson et al. (1999) failed to provide any discussion of theoretical background that guided the qualitative analysis, calling into question any implications inferred from their qualitative data gathered, as opposed to Ochocka et al. (2006) who clearly endorsed a grounded theory approach, documenting all aspects to analysis. A more recent qualitative research study by Corrigan et al. (2002) assessed recovery processes in the mutual-help group GROW for those with severe mental illness also has its limitations. Conclusions about recovery processes based on the analysis of the ‘Blue Book” are tenuous at best given the unstructured nature of its development. Furthermore, recovery processes generated from a mutual-help group of this nature may not generalize well to the experiences of those receiving their services through a consumer-operated setting with a recovery-driven approach.

Solomon and Draine (2001), speaking to the current state of knowledge on the effectiveness of consumer provided services, note that the extant literature is promising but in need of further refinement, both in terms of the aforementioned research foci as
well as methodological issues. Specifically, they state that the focus of research efforts needs to be centered to a greater extent on the effectiveness of stand-alone services provided by consumers rather than consumer provided services as an adjunct to professionally provided services. Until this is achieved, designs that employ the use of consumers solely as adjuncts or co-facilitators to professionally delivered services will only confound the effect of consumers as principal providers of a given treatment. This has implications for both quantitative and qualitative analysis. Research efforts, in addition to focusing exclusively on evaluating professional versus consumer facilitation of services, need to remain cognizant of the role of consumer-focused services (regardless of traditional or consumer-operated site location) and the impact these services have on mental health recovery.

Statement of the Problem

The aforementioned literature provides evidence in the form of both quantitative and qualitative data regarding consumer-provided care and/or traditional care. However, not much literature to date transcends this dichotomy and has focused on recovery-oriented services, provided by both consumer and traditional, professionally trained facilitators alike. The primary problem addressed in this study is the lack of knowledge regarding how recovery-oriented services as a whole (professional and consumer-led) help promote mental health recovery for those experiencing severe and persistent mental illness. This knowledge is needed in order to identify those factors responsible for the recovery process, irrespective of facilitator type. Furthermore, this knowledge will add credence to the notion that it not as important who delivers a particular service but how that service is delivered, as it pertains to those experiencing severe and persistent
mental illness. The ability to assess not only the general effectiveness (quantitative) of a recovery-oriented service but the mechanisms responsible for such effectiveness (qualitative) would provide valuable data useful in guiding clinical practice. There is a dearth of current programs aimed at providing services for those in this population that adhere to such a recovery-oriented philosophy while not employing strictly consumers vs. professional facilitators.

*The Wellness Management & Recovery (WMR) Model*

Recommendations from the recovery literature were incorporated into the current investigation of the role of the Wellness Management and Recovery program (WMR) in promoting mental health recovery. This study represents an adjunct to an ongoing, multi-site project investigating the general effectiveness of WMR in promoting mental health recovery among individuals experiencing severe and persistent mental illness in the community. Wellness Management and Recovery (WMR) is a structured, curriculum-based psychotherapeutic / psychoeducational treatment program, designed to promote recovery and wellness for individuals experiencing severe and chronic mental illness. The WMR program is currently being implemented across the state of Ohio by the Wellness Management and Recovery Coordinating Center of Excellence (WMR CCOE), supported by the Ohio Department of Mental Health (ODMH). Beginning in 1999, ODMH carried out the CCOE model as part of a Quality Care initiative. CCOE’s currently serve as resources in the promotion, training, and implementation of evidence-based and best clinical practices within the state of Ohio. The WMR program has been disseminated since May of 2006, at which time the WMR Advisory Committee helped initiate ten pilot locations for its initial inception. The number of dissemination sites has since increased...
across the state of Ohio. Current agency locations include Southeast, Inc. in Franklin County, Greater Cincinnati Behavioral Health Services in Hamilton County, Daymont Behavioral Health Services in Montgomery County, Bridges: Mental Health Consumer Empowerment and Neighboring Inc. in Lake County, Gathering Hope House in Lorain County, Bridgeway, Inc., Center of Vocational Alternatives, Choices, The Main Place, Inc., Maumee Valley Guidance Center, and Northcoast Behavioral Healthcare in Lucas County. Members of the WMR CCOE contributing to its implementation include WMR program coordinator Kelly Wesp, M.S., trainer/consultants Debra Wilcox, Ph.D, and Gregg Pieples, and trainer/peer specialist Stephanie Rich, BSSW, LSW. Other contributors in the design and implementation of the WMR program include Mary Kay Smith, M.D. and Wesley Bullock, Ph.D with the University of Toledo.

The philosophy of WMR embraces a holistic approach to recovery and wellness, attempting to help foster happier and healthier lifestyles. The primary goals set forth by the WMR program to achieve this include teaching skills that seek to strengthen and empower individuals to: 1) articulate and make progress towards personal goals, 2) develop a well-informed and collaborative approach to one’s own treatment, and 3) achieve a healthier lifestyle. A unique component of the WMR program lies in its facilitation. Group sessions are team taught and facilitated by both a staff member of the respective mental health agency and a peer specialist who is a consumer of mental health services. Additionally, three of the aforementioned pilot sites (i.e., Bridges: Mental Health Consumer Empowerment, the Recovery Center of Greater Cincinnati Behavioral Health Services, and Gathering Hope House) are consumer-operated sites. Therefore,
WMR programs implemented at these agencies are facilitated by a consumer staff member as well as a consumer co-facilitator.

The WMR curriculum encompasses a structured, ten-session approach offered in a group format that covers topics related to general health and wellness issues as well as co-occurring mental and substance abuse disorders. Specific WMR curriculum components covered in each session include: 1) Mental Health Recovery, 2) An Understanding of Mental Health, 3) The Role of Medication, 4) Learning to Manage Symptoms and Side Effects, 5) Effective Communication, 6) Communicating with Your Providers, 7) Wellness, 8) Coordinating Your Care, 9) Building Social Supports & Involving Others, and 10) Planning for Wellness.

Purpose of the Present Study

The present study had two primary goals. The most fundamental and overarching goal of the study was to capture the process of recovery as revealed by participants in the WMR program and discover how it promotes mental health recovery. Given the prior literature that has documented the role of recovery in the treatment of those experiencing severe and persistent mental illness, it was expected that the present study would provide the critically needed qualitative data that does not easily lend itself to quantification. Given that the concept of recovery from mental illness is still in its nascent stage, an exploratory approach, using in-depth semi-structured qualitative interviews for those having successfully completed WMR, was used so that the mechanisms underlying recovery can gain better recognition and be expanded upon. The secondary goal was to provide further evidence in support of WMR being an effective intervention for those experiencing severe and persistent mental illness.
Research Questions

Given that the primary purpose of the present study was to assess how the WMR program promotes mental health recovery, the following research questions were assessed qualitatively: 1) What are consumers’ experiences regarding the facilitation of WMR? 2) What did participation in the WMR group do for consumers and their recovery? 3) What do consumers view as helpful / hindering about the process of participating in the WMR program? 4) What are consumers’ thoughts, attitudes, or perceptions regarding the impact of WMR? Of secondary interest in the present study was an assessment of the effectiveness of WMR across locations as a whole.

Hypotheses

The qualitative research questions are exploratory in nature and were anticipated to provide clarity not only to recovery in general, but to the role of WMR in promoting recovery in particular. The qualitative data obtained were expected to provide information that would inform and guide further clinical practice using the WMR model with those experiencing severe and persistent mental illness. With regard to the quantitative components of the present study it was hypothesized that individuals, assessed as a group, would show significant improvements across several areas of recovery and empowerment.
Chapter II

Method

Participants

A total of 18 consumers of mental health services experiencing severe and persistent mental illness took part in a semi-structured qualitative interview following completion of the WMR program. For the purposes of qualitative analyses, saturation was reached with N=7 participants (n=3 Male, n=4 Female), saturation being the point where no new themes emerged. Of those participants included in analyses (N=7), 42.9% (n=3) received their mental health services, including WMR, through a consumer-operated agency, while 57.1% (n=4) were attending a traditional community mental health center. Participants were sampled across 4 separate agencies (2 consumer-operated and 2 traditional): Greater Cincinnati Behavioral Health Services in Cincinnati, OH (n=2), Daymont Behavioral Health Services in Dayton, OH (n=2), Gathering Hope House in Lorain, OH (n=2), and Bridges: Mental Health Consumer Empowerment in Painesville, OH (n=1). Given that the purpose of the present study was to obtain a better understanding of the role of the WMR program in promoting recovery, “theoretical sampling,” as described by Glaser and Strauss (1967), as opposed to random sampling, was used in order to intentionally sample participants that responded, quantitatively (as measured by the MHRM; Young & Bullock, 2003), to WMR significantly positive,
significantly negative, or neutral. The mean age was 52 (SD=8.5) with a range of 37-63, while the ethnic makeup of the current sample was 57.1% European-American ($n=4$) and 42.9% African-American ($n=3$). Participants, compensated $50 for their participation in qualitative interviews, were referred by site coordinators or WMR group facilitators of their respective agencies.

For quantitative purposes, a total of 291 consumers completed the WMR program. Consumers were receiving psychiatric, case management, or community support services from either traditional ($n=225$, 77.3%) or consumer-operated ($n=66$, 22.7%) sites across the state of Ohio. The gender distribution of the sample was 59.1% female ($n=172$) and 40.9% male ($n=119$). The average age of the sample was 46.4 (SD=11.5; range 20-74). Additional demographics found that there were 61.5% European-Americans, 22.7% African-Americans, 1.4% Native American / Pacific Islander, 1% Asian, 0.7% Latino/Hispanic-Americans, and 12.7% other ethnicity. Due to an increasing number of individuals completing the WMR program and filling out Post-Treatment questionnaires from various site locations, it was found to be exceedingly difficult to collect all questionnaires for each participant. As a result of managing a data set of this size, there were a number of participants who had missing/incomplete/never filled out questionnaires. Therefore, while $N=291$ represents the total number of participants who have some form of post-test data, the total $N$ for each individual measure reported on (Ohio Outcomes Consumer Form, MHRM, and WMR Client Self-Rating) was found to differ slightly.
Measures

Narrative Evaluation of Intervention Interview. The Narrative Evaluation of Intervention Interview (Hasson-Ohayon, Roe, & Kravetz, 2006; NEII) form was used for the purpose of performing the semi-structured, qualitative interview. The NEII is a 16-item open-ended, qualitative interview protocol that was specifically developed for the use of evaluating psychosocial intervention outcome for individuals with severe and persistent mental illness and developed out of a grounded theory model. Developed with the recommendation that qualitative analysis of psychotherapy should focus on two aspects, process and outcome (Maione & Chenail, 1999), the NEII incorporates these aspects as an attempt to explore how persons experiencing severe and persistent mental illness perceive, understand, experience, and feel about the particular intervention in which they participate. The 16-item measure is dichotomized into either descriptive or evaluative questions. Descriptive questions targeted what occurred during the intervention and what resulted from the process (e.g., “What did the practitioner delivering the intervention do during the intervention?”). The evaluative questions targeted participants’ judgments of the intervention process and the intervention outcome (e.g., “What did the practitioner delivering the intervention do that helped you?”). After completing the initial few interviews, it was apparent that participants were not endorsing any challenging or difficult aspects related to their experiences with WMR. Therefore, the NEII was altered by adding two questions to elicit such experiences: 1) “What was the hardest part of completing WMR?” and 2) “What did you like least about attending WMR?”
Ohio Outcomes Consumer Form. One of the primary means for the assessment of quantitative change over time in the present study was the Ohio Outcomes Consumer Form. The Ohio Outcomes Consumer Form is a 67-item self-report measure designed specifically for use with individuals experiencing severe and persistent mental illness. The measure itself is multidimensional and assesses four broad domains: 1) Clinical Status, a measure reflecting level of distress brought about by the severity of psychiatric symptoms, 2) Quality of Life, a measure of general satisfaction and fulfillment in one’s life, 3) Functional Status, measuring engagement in meaningful activity, and 4) Safety and Health, assessing the degree of freedom in one’s life from physical or psychological harm, as well as one’s general physical health.

The Ohio Outcomes Consumer Form is comprised of 4 primary scales with their corresponding means and standard deviations: 1) Quality of Life ($M = 2.83, SD = .79$), 2) Symptom Distress ($M = 41.16, SD = 15.37$), and the 3) Making Decisions Empowerment scale (Rogers, Chamberlin, Ellison, & Crean, 1997) ($M = 2.63, SD = .36$). Psychometric data, gathered from a psychiatric population, has provided evidence of strong internal consistency for the Quality of Life, Symptom Distress, and Making Decision Empowerment scales, with Cronbach alpha estimates of .86, .96, and .86, respectively. The Quality of Life, Symptom Distress, and Making Decisions Empowerment scales have shown evidence of good construct validity, significantly correlating with one another. The Making Decisions Empowerment scale (Rogers et al.) has shown evidence of convergent validity as well, having been found to correlate significantly with the Mental Health Recovery Measure (Bullock & Young, 2003), another measure of recovery also used in this study.
Mental Health Recovery Measure. The Mental Health Recovery Measure (MHRM), developed by Young and Bullock (2003), is a 30 item self-report measure of mental health recovery. The MHRM is a behaviorally-anchored measure, assessing actual behaviors used in an individual’s recovery process, as opposed to an attitude or intent. It was developed qualitatively from a grounded theory model of recovery based on individual and focus group interviews with individuals experiencing severe and persistent mental illness. The measure is comprised of eight conceptual subscales: 1) Overcoming Stuckness, 2) Self-Empowerment, 3) Learning and Self-Redefinition, 4) Basic Functioning, 5) Overall Well-Being, 6) Spirituality, 7) New Potentials, and 8) Advocacy/Quality of Life. Individuals respond to each MHRM item on a 5-point Likert scale, ranging from Strongly Disagree to Strongly Agree, with a potential range of 1-120 for a MHRM Total score. Psychometric data for the MHRM measure is available (MHRM Total score: $M = 80$, $SD = 20$) and is indicative of strong internal consistency (Cronbach alpha = .91). Initial psychometric data for the MHRM was gathered from a psychiatric population utilizing community mental health supports / resources.

Furthermore, in addition to possessing good construct validity, the MHRM has also been found to demonstrate good convergent validity with another measure of recovery ($r = .70$), the Making Decisions Empowerment scale (Rogers et al., 1997) (Bullock & Young, 2003).

WMR Client Self-Rating Scale. The WMR Client Self-Rating scale is a 20 item self-report measure used to assess consumers’ progress on those content areas targeted by the WMR psycho-educational curriculum. These include progress towards recovery goals, health and wellness habits, as well as skills for effectively managing one’s
medication. Individuals respond to item content on a 5-point Likert scale with a total score created by summing all items. Having only recently been adapted from the 15-item Illness Management and Recovery (IMR) Client Self-Rating scale (Mueser, Gingerich, Salyers, McGuire, Reyes, & Cunningham, 2004), little is known regarding its psychometric properties. However, given its strong similarity to the IMR scale, with only five additional items, estimates from the original scale (IMR) will be applicable for predicting psychometric properties until sufficient WMR data has been collected. Internal consistency estimates of the IMR Client Self-Rating Scale have shown promise (Cronbach alpha = .72) in addition to test-retest analyses (.81). Furthermore, recently presented analyses have shown the IMR scale to correlate significantly at a two week follow-up with the Recovery Assessment Scale (.65), indicative of good convergent validity (Godfrey, Salyers, Mueser, Labriola, 2006).

Procedures

The principal investigator contacted several of the aforementioned WMR site locations seeking participants for the current study. After receiving a referral from either a site coordinator or a WMR group facilitator, an interview date and time was arranged at the participants’ convenience. All interviews were conducted on site at the agency in which the participant had received his or her WMR services. Before interviewing was initiated, participants were given both oral and written information regarding informed consent. While participants had previously signed consent to take part in the WMR program, informed consent for the current study also entitled the principal investigator to have access to quantitative data used for pre-post assessment of treatment response. All participants were informed that they may decline to respond to any interview questions
and may terminate the interview at any time without any negative repercussions. After obtaining informed consent, a participant was interviewed by the principal investigator. Interviews lasted on average between 30 to 60 minutes and were audio-recorded with the permission of each participant. All participants who took part in the qualitative interview component of the present study had previously completed and graduated from the WMR program.

Data Analysis

Due to support from a grant secured from the Ohio Department of Mental Health (ODMH), all interviews were professionally transcribed immediately following the interview process. The method of qualitative data analysis for the present study was phenomenological in nature and guided by Grounded Theory Analysis. Grounded Theory Analysis, originally developed and conceptualized by Glaser and Strauss (1967), is a qualitative analysis methodology. Grounded theory can be defined as, “a qualitative research method that uses a systematic set of procedures to develop an inductively derived grounded theory” (p. 24) about a phenomenon of interest (Strauss & Corbin, 1990). This is contrasted with theory having been generated from deductive logic and a priori assumptions.

Historically, debate has been spurred by those arguing that the distinction between qualitative versus quantitative analyses is tantamount to the generation versus verification of data. However, Glaser and Strauss (1967) argue that the either-or debate is unnecessary and even highlight the benefit of both forms of data being necessary and used as supplements, as mutual verification of one another. Their grounded theory model of analysis applied in the present study allowed for the qualitative data gathered to
contribute to the emerging theory of recovery from severe and persistent mental illness, specifically within the context of WMR, a recovery-oriented model of treatment.

After the initial interviews were completed and transcriptions obtained, each transcript was micro-analyzed in a line-by-line manner, using a process of open-coding, defined by Strauss and Corbin (1990) as, “the process of breaking down, examining, comparing, conceptualizing, and categorizing data” (p. 61). While considered the most detailed type of analysis, it is also the most generative in that each individual meaning unit contained within the transcript, even if redundant within the same protocol, was identified. A meaning unit was conceptualized as any significant idea, event, happening, experience, etc. verbalized by the interviewee. This process of initial analysis and open-coding also allowed for the alteration of the semi-structured interview (NEII), adding the aforementioned questions assessing for hard or difficult aspects experienced in WMR. This form of “selective” (p. 30) analysis, as outlined by Strauss and Corbin (1990), implies that the first few interviews or field notes generated should be transcribed and then analyzed before proceeding to further interviews, thereby allowing the researcher to guide subsequent interviews by incorporating various modifications in order to increase clarity. Conceptual labels were then given to all relevant meaning units related to recovery. A constant comparison process was utilized throughout all stages of analysis, attempting to identify both similarities and contradictions within the same or successive protocols. Meaning units were then constructed into meaningful categories and sub-categories.

Following the open-coding process, a protocol thought to be one of the most representative of all those obtained was subjected to further analysis and reconstructed
after having been broken down in order to “put those data back together in new ways by making connections between a category and its sub-categories” (p. 97). This process of axial-coding helped arrange meaning units into categories and sub-categories that began to take the form of a theory that was grounded in the experiences of an individual having gone through the WMR program experiencing severe and persistent mental illness. Further axial coding by way of a constant comparison process was utilized with successive protocols in order to further refine and conceptualize the evolving theory. This continuous comparative method between the representative protocol and successive protocols continued with the goal of reaching saturation, when no additional data was emerging regarding categories or sub-categories. This absence of further variation or change in the grounded theory that emerged from the data was achieved after seven protocols. In addition to merely identifying the components of the emerging recovery theory, all protocols were repeatedly analyzed further using axial and process coding in order to discover connections, relationships, consequences, and interactional sequences that ultimately told a story of the path of recovery as it relates to the WMR program.

The process of qualitative data analysis in the present study, guided by grounded theory, was not a structured or rigid process, and therefore the different aspects of analysis (e.g., open coding, axial coding, etc.) were used interchangeably. This was achieved through the use of constant comparison with the aid of personal notes and diagrams. In an effort to arrive at an inductively-derived theory regarding the process of recovery as it relates to the WMR program, “selective” analysis was also used as it pertains to the order in which to select protocols. Specifically, in order to avoid the potential bias of only analyzing protocols of participants who responded significantly
positively to WMR (as measured by the MHRM; Young & Bullock, 2003), the seven protocols used to reach saturation included a mixture of participants who responded significantly positive, significantly negative, as well as those who had a neutral response to WMR based on their MHRM Total score from Pre- to Post-Treatment. This method was thought to prevent the present study, its findings, and implications from being open to criticism as a theory representing only those participants who have responded positively to WMR in a quantitative sense. Throughout the process of qualitative analysis, the emerging theoretical model of recovery obtained was reviewed by two committee members in addition to the principal investigator.

Outcome analyses documenting quantitative change over time, using group means, on the dependent measures described above (i.e., MHRM, Ohio Outcomes Consumer Form, and the WMR Client Self-Rating scale) will take the form of dependent t-tests comparing Pre- to Post-Treatment scores. Effect sizes will also be computed for group means. Analysis of individual change scores will be performed for the MHRM in order to identify reliable changes (Jacobson & Truax, 1991).
Chapter III

Results

The primary aim of the present study was to better understand how the recovery process works, as it pertains to the Wellness Management & Recovery (WMR) program. The resulting theory obtained from the data is indicative of three primary themes or categories and a number of sub-categories contained within. First, a primary or overarching theme will be presented, followed by the sub-categories contained within. This will allow for a better understanding of the multiple components discovered that characterized the recovery process in the WMR program. Secondly, in consideration that merely identifying the components of the phenomenon of interest in the present study would not suffice in providing a clear understanding of the actual process of recovery, a more thorough discussion will follow that highlights the interrelations among themes, thereby allowing the reader to gain a clearer and refined understanding of the story that the data are telling, as articulated by the lived experiences of consumers taking part in WMR. In order to allow the results that follow to stay grounded in the data, passages from the interview data will be interjected where appropriate to highlight the verbiage that formed the emerging theory presented.
Qualitative Results

Individuals coming into the WMR program tended to present at varying levels of recovery. However, based on the data obtained there were a number of similarities that characterized their thoughts, feelings, behaviors, and states of mind as they entered the WMR program. Particularly relevant were feelings of fear, isolation, doubt, and inhibition.

(ID 02): It’s hard to convince yourself that it’s (mental illness) not a part of you.
(ID 04): I had it (help) to offer, but I was too afraid to let it come out or too upset or get too nervous…
(ID 08): I wasn’t ready to talk to people, afraid that they would jump on me because I had had some problem with other people not understanding my mental illness and I was getting it full force from different people. I had like stagnated. I felt like I was all alone in a crowded room…
(ID 09): It’s just, coming in scared, I guess was the part that I didn’t like at first…The only thing was is the fear when I first went in there, the fear of what it was gonna be like to be in this group.
(ID 12): …that’s where I was feeling inhibited about. And I always get to that point, and I would stop and think, “Can I make it?” And then I’d feel like I can’t, then I’ll fall back and I’ll start questioning myself again…
(ID 14): I wasn’t participating as much as I really should have, or could have. I wasn’t being open. I had doubt in myself for actually getting any farther in life than I was at that point in time.
(ID 17): I didn’t think nobody would ever come to help me when I needed help. I was still skeptical. I didn’t think it (recovery) was possible.

In responding to the questions posed in the semi-structured interview, the three primary themes of 1) Growth, 2) Group Content & Process, and 3) Overcoming Prejudice & Stigma were identified.

Growth

Table 1 illustrates the theme of GROWTH and its structure, comprised of the five major categories 1) Improvement / Progress, 2) Revelation / Rebirth / New Beginnings,
The theme of growth was composed of several different categories. The first category, Improvement / Progress, highlighted the change process that consumers went through whereby issues related to control, stuckness, and chaos or disorganization were addressed. Improvement / Progress, in a general sense, encompassed many aspects including symptom relief and was illustrated by the following comments.

(ID 02): My paranoia seemed to lessen a little bit, at least when I was taking the course. My anxiety was going down a little bit. I was really in bad shape. I was seeing a psychiatrist three times a week. It was horrible. Now I haven’t seen a psychiatrist in almost six months.
(ID 04): I’m doing a lot of things that I didn’t think I would do. I don’t feel that depressed feeling anymore. I felt even better after I went through it (WMR).

(ID 09): I had there for a while when I first found out I had an illness and first found out that I’m a little different than the others. You look over your shoulder just to see who’s looking at you and wondering what they’re saying. I don’t do that anymore.

Contained within the category of Improvement / Progress were sub-categories related to consumers’ emerging sense of empowerment and control. Coming into WMR with a sense of being powerless and incapable, this appeared to have led many consumers to feel pessimistic and act in a passive manner. The sub-category of Regaining Control / Sense of Control spoke to consumers emerging sense of responsibility and empowerment in dealing with life. No longer were consumers feeling incapable or helpless. On the contrary, they began to feel capable and in control of their mental health.

(ID 04): …it just empowered me…being able to take control of myself. (ID 08): So I was learning to control my mental state of mind. (ID 09): I can cope out in this world just as well as they can. We learned how to be – cope out in the world, how to make sure we take our medicines and learn different things that we normally didn’t know or we knew, but didn’t realize we could do it that way. …it (mental illness) ain’t gonna control me, I’m gonna control it. (ID 12): …the biggest impact that I had was the feeling that I’ve got a book now, I can go over it and re-read it if I wanted to. Especially like when my depression becomes overwhelming, I had something I can go back and re-read and study and think about something to help me out. (ID 14): …being able to handle my anxiety better. It was like they (group and group members) were kinda the gateway, and once I got in; I was able to just take it from there.

The second sub-category, Breaking Free of Stuckness, highlighted an experience verbalized by many consumers in the present study. There appeared to be an experience for many consumers of feeling unable to progress or having a sense of stagnation with no change in site. This feeling of stuckness appeared to change during WMR, with many consumers feeling a sense of progression and a breaking free from inertia.
(ID 08): I saw myself grow further. I had like stagnated.
(ID 12): …they were able to break loose from that. …trying to get myself to break down those barriers and get in there and really see that yes, this can happen. Yes you can do this. My life before I got into the WMR program was stagnant. I was stuck in a rut, something I couldn’t find myself getting out of, and the harder I pushed and pulled, the deeper I sunk into that rut.
(ID 14): I was actually getting somewhere in life, actually, with it. I was starting to see that I was bettering myself. That I wasn’t slipping backwards.

The final sub-category of Improvement / Progress highlighted the process whereby consumers moved from a sense of chaos or disorganization to feeling as though they were back to a state of clarity. This sub-category, Back on Track, suggested that consumers had a sense of direction and purpose that they either never had or had lost at some point in the past.

(ID 08): …when I started taking the course itself, right, things began to fall in place, information like light bulbs. And finally everything went straight. I knew where I was going, how to get past it. I knew how to work with my mental illness, how to work around it.
(ID 12): But the management helped me out more than anything because it taught me how to look at what I’ve got to do and how I need to do it.
(ID 14): I guess I didn’t have that feeling of being lost anymore.
(ID 17): It (WMR) helped me get things in focus.

The second major category within Growth, titled Revelation / Rebirth / New Beginnings, addressed what for many consumers was a process of rejuvenation or rebirth in which they were experiencing a new beginning in life after WMR. After being confined for so long by periods of isolation and inhibition, consumers began a process in which they would expose themselves to the world, including both parts of themselves that they were aware and unaware existed.

(ID 08): They brought me out of a shell. I was – had gone into a shell and you know how you try to break out and you can’t? Well, they broke the – it’s like a bird’s egg trying to break out and I finally broke out with the class itself.
(ID 09): …you learn how to open your own self up. I opened up a part of me that I didn’t even know existed.
(ID 12): …just being able to come outside and not be isolated, and meet some people who are coming through the same thing, coming out of their shell, it helped. …somewhere between 1995 and 1998, I was in a coma…after I came out of the coma, I had to go through a whole history of things I had to learn how to do. I had to learn how to roll over in the bed and little things like lifting your legs…And in a way, WMR was teaching me again how to do that.
(ID 14): …it (WMR) was kind of like starting over.

The third category, Intrapersonal / State of Mind, reflected changes taking place within consumers themselves. While intrapersonal change could be conceptualized as highly unique or idiosyncratic, a number of common themes were present across consumers. One such theme related was a sense of growing from a position of weakness to strength. Becoming increasingly independent was also apparent. Furthermore, intrapersonal growth had a number of facets and encompassed changes within one’s state of mind or outlook as well. Of particular relevance for those taking part in WMR were increased hope, confidence, pride in one’s accomplishments, as well as maintaining a positive versus negative outlook.

(ID 02): I was trying to be more independent. It gives me strength, more strength. It made me a stronger person. I’m very proud of being a part of it. …it was hope
(ID 04): It made me strong. …it made me more confident in myself. That I could – could make things better. I felt good about myself. It just gave me the strength to just go ahead on, take off and do the things that she (facilitator) had been doing that I never did and didn’t think I could do. Now I can, and I’m doing it. I’m proud of me. Because you know you was going to find something…it was something different that you would be able to learn to do for yourself to make you strong. …it gave me more confidence and made me feel good about myself.
(ID 09): And now today we can actually do jobs. We can do things. We can walk around and they don’t treat us like that anymore. I hold my head up just as proud as could be and I don’t care if they know I’ve got a mental illness.
(ID 12): It gave me something that I could look forward to. But right now, I feel I can do it. I can make it.
(ID 14): I think I actually had a better outlook on my illness. I think when I first heard about WMR, it kind of gave me a new window in life. I wasn’t sure if I was just gonna stay in it or just get up and walk out at first. And something told me to just hang in there, that something good was gonna become of that group. So I did. I was starting to learn to not doubt myself, to trust myself more. I was staying more positive. And it didn’t take me long down the road until I actually was able to do that. And I did it on my own, without any help from my doctor or my case manager.

In addition to solely intrapersonal growth, some form of growth on an interpersonal level was also achieved by consumers taking part in WMR. Growth on an interpersonal level most often took the form of differences and areas of improvement in how consumers interacted in their environment, either in group or outside of WMR. One such change in the Interpersonal / Environmental realm was that of consumers beginning to exert an active influence over their environment, as opposed to passive acceptance of their situation in life. Specifically, this included taking the initiative to better themselves in some way, whether that be socially or learning about their illness, not settling for the status quo, or showing assertiveness. This sub-category was titled Active vs. Passive.

(ID 02): In fact, sometimes instead of just doing the next chapter in WMR I’d read ahead two or three chapters at home trying to figure out my illness.
(ID 04): I could get out and do the things that I wanted to do.
(ID 08): They just haven’t approached me or are afraid to approach me, so I started to approach them. I say hi to total strangers. Like I said, I say hi to anybody and everybody. …if they were reading a lot of material, I would have them stop and define just what they read because I didn’t understand it. But I’m one to pound on the table. The one (previous doctor) I had before her I did not like…right after the first visit with her, I told a couple of people, told Dr. ___ that I didn’t like her and I’d prefer to have someone else. So next thing I know, I had ____ , so it works.
(ID 14): …when I had a situation or problem, really actually go to someone and let them know instead of holding back.
(ID 17): And…I try to keep a list of people who help me so when I feel down I can call them, like my group members. I was working, keeping busy so that I wasn’t thinking about it (sources of stress) all the time, you know.
Also consistent with Interpersonal / Environmental growth was a process whereby consumers experienced increasing courage opening themselves up to others. As part of this growth, less social anxiety along with the willingness and increased skill in knowing how to communicate with others were apparent. Consumers had less fear in sharing their experiences with others and tended to find it immensely therapeutic reorienting themselves to the social world. This sub-category of Interpersonal / Environmental was titled Less Social Anxiety / Finding a Voice.

(ID 02): To be able to be in group every week and share what I was feeling and get it off my shoulders. I got to express my ideas and feelings about my illness.
(ID 12): So the big change, I think, is my ability to communicate with people right now. But being able to just sit down, like right now, to talk to you, I couldn’t do this about a year ago.
(ID 09): I learned how to talk to people different than I usually do. I learned from WMR how to say stuff with people with different kinds of illnesses without hurting them. I’ve made quite a few new friends. I became close with a lot of members.
(ID 08): I was not being afraid of talking. Finally not afraid to go out in the big bad world and not be able to say something. …there were those that were so shy. They’re not shy now. I have gotten to the point where I can be myself and laugh, just laugh out loud.

The final category within the major theme of Growth, titled Learning / Knowledge / Education, pertained to two aspects of learning, Concrete and Experiential. First, the sub-category titled Concrete was found to characterize consumers’ search or thriving for information and knowledge. This search for education or knowledge was found to pertain to anything from practical facts regarding medication to a better understanding of self. This is titled Seeking Answers / Knowledge.

(ID 02): …I try to understand what I’m going through.
(ID 04): Took lots of notes…asked questions. I go for the book.
(ID 08): I had questions about my meds. I asked questions.
(ID 12): …the second time I went (to WMR), I went for the educational level on it. I wanted to get more in-depth information about the
management of WMR. I’m joining a WMR course again. Because I want to get a little bit more to what this new concept that they were talking about when they had their meeting…
[ID 14]: (When asked why he wants to continue with another WMR group) Just to see what else I could learn about my illness and how to just better myself.

Also contained within the sub-category Concrete was not only the search for knowledge or education but evidence of consumers having actually achieved some form of education. This sub-category was titled Finding Answers.

(ID 02): …I got answers from them on what they’re experiencing and how they handled different problems. I learned about schizophrenia. I gained knowledge from WMR.
(ID 04): …it was so much I learned. If it was something I needed to know in WMR, it was answered.
(ID 08): I got answers.
(ID 09): It gave me a lot of information I didn’t already know. I learned certain things that I didn’t know, which made me feel good.
(ID 12): …it was informative …because I was learning so much.

The final sub-category, Experiential, referred to a specific type of learning that took place for consumers within WMR. Titled New Perspectives, consumers conveyed how they began to see things in a different light. They began to see themselves differently, have more insight into their lives, and achieve greater perspective. Furthermore, such experiential learning tended to occur more as a result of group interaction or a consumer’s engagement in the WMR process, as opposed to learning that was more a result of the curriculum-based agenda, such as that addressing psychoeducation regarding medications or diagnostic symptomatology.

(ID 02): You learn so much about yourself… It’s like a looking glass, you can look back at yourself and see yourself…what’s going on in your life. …learning that it is just a symptom (delusion) and not my real perception of what’s going on.
(ID 04): It gave you more ideas, more insight on what’s happening to you. It was putting everything in perspective.
(ID 08): I learned quite a bit about myself….when I saw the light of what was on the pages… It opened up for me a new idea…I can be a person now.

(ID 09): That was really helpful for me…knowing how they see things and how people have treated them and how they would like to be treated, which gave me a perspective in life. They made me open my eyes to a lot of different things that I didn’t realize that people have gone through in the years.

(ID 12): Learning about myself in a way, yeah. The WMR program taught me that.

(ID 14): …the group really gave me insight… I think I was looking for a light for myself. A light in the dark, so to speak. And it seemed like, in the program, I kind of – I found it actually.

Group Content & Process

Table 2 illustrates the theme of GROUP CONTENT & PROCESS and its structure, including the three major categories contained within 1) Group Atmosphere,

2) Therapeutic Factors, and 3) Session Activities. See Table 2.
The second overriding theme obtained, titled Group Content & Process, was composed of three categories. These categories were Group Atmosphere, Therapeutic Factors, and Session Activities. All three of these categories were thought to be related to aspects characterizing many therapeutic interventions, that being content or process. In consideration of Group Atmosphere, six sub-categories were identified: Partners in Wellness, Fun / Engaging, Growth Focus, Open Forum, Structure, and Holistic Focus. The sub-category Partners in Wellness appeared to be particularly relevant to consumers.
taking part in WMR. A feeling among group members existed that there was a shared
suffering or bond between everyone taking part in WMR, including facilitators. Related
to this sense of shared suffering was a sense of belonging among group members,
something not often experienced for many consumers prior to WMR when many
verbalized experiences of isolation. For many, a sense of comfort or relaxation was
fostered through this atmosphere of belongingness.

(ID 02): Comfort out of the answers from the other people, the way they
handled things and the way it’s affecting them the same way it’s affecting
me. …they would touch on what you were feeling and that would give you
a sense of comfort.
(ID 08): …there were other people in the group that had the same thing
happen to them.
(ID 09): I’m not the only one that’s getting treated that way. It’s
happening to everyone. It made me feel like I wasn’t alone. …it just made
my day just knowing that I can go there and I could talk to other people
and relate to them just as they relate to me. We all got our illness and we
all can relate because we’re living the experience.
(ID 12): My association with other people who have been through
traumatic changes that isolated them in their lives, I felt like I can be
familiar with them… There was enough people there where I could
identify with somebody or I could hear them say, “Well, hey, don’t worry
about it. I’ve been there.” Mostly, I think what they did was give me the
feeling that I’m not alone in the particular process. They’ve been through
it. …just being able to come outside and not be isolated… I was part of a
group. …it has helped me understand I’m not alone.
(ID 14): The other clients that were in the group with me felt the same
way. And because of our illness, because we were different, but yet the
same. I’m not alone.
(ID 17): …when I came in here and they all had the same problems, I
started feeling more relaxed because I thought they would understand how
I felt. They’re looking forward to seeing me. I don’t feel shut out, you
know. …it just brought us all closer together.

Related to an atmosphere of shared suffering between all group members, equally
as important to many consumers was the partnership that specifically pertained to groups
members and the facilitators delivering WMR. This sub-category, Equality, reflected how
many consumers found the facilitators’ willingness to admit to their own struggles as
helpful, whether these struggles were mental health related or merely divulging one’s stress experienced while driving in congested traffic. The realization of being in a group setting with facilitators who did not endorse or perpetuate a hierarchy or division between therapist and client was found to be comforting and highly therapeutic.

(ID 04): …you can be in some groups and some people are – have this authority. They the big people and you the little people. In WMR we at the same level.

(ID 08): They (facilitators) say, “Hey girlfriend, I’ve been there.” You should hear ___’s (facilitator) story. It was wonderful. I felt so good when he divulged to the whole class. That’s a hard thing to do. …there’s ___ and ___ (facilitators), me and this person and that person and they all have something that they’re trying to work towards.

(ID 09): I feel like we’re all equals and I learned that through the program that we all have problems, we’re all equals. They made us all feel equal. Nobody thought they were better than anybody else. They treated us just as normal as they would treat anybody else. And when I was introduced to WMR I liked it because everybody, nobody’s any better than anybody else. Treating me like I was a human being and I wasn’t my illness.

(ID 12): They (facilitators) were like us. Even if it was, “Oh I had trouble combing my hair that day.

The sub-category titled Fun / Engaging was another aspect that pertained to the overall atmosphere of the WMR program. Specifically, consumers conveyed the importance of WMR having been fun. For many, there was an experience of excitement during group fostered by the willingness of facilitators and group members to maintain humor and fun in the context of therapeutic work. Furthermore, along with the aspect of fun, WMR appeared to be led in an engaging manner, with consumers identifying a lack of stagnation as particularly helpful. New and varied topics week-to-week appeared to keep consumers’ interest and attention, thereby maximizing the potential for learning and growth.
(ID 02): In fact they gave me a birthday cake. It was during my birthday during a WMR meeting. They brought a birthday cake and they celebrated my birthday in the group… They would reach out to new areas instead of lingering in one area all the time. (ID 04): Never boring. I was so overjoyed and excited… (ID 08): Other days I’d be joking around having a good time. (ID 09): It was just fun being, the facilitators made everything fun. The people that I was in class with just made it fun to be there, fun to learn. You learn something new every day. (ID 12): …each page, it enlightened my mind with something new on each thing that I had to do. ..it was interesting. (ID 14): Just, it seemed like every week it was like a different chapter and I liked the way she would bring out the chapter… And it always kept my attention in the group. It wasn’t boring. Like a new adventure every week. (ID 17): Like when we started with the wellness wheel and the icebreakers, throwing a tomato in the room, pretending it was a ball but it was a fake tomato with a smiley face. And I kept it. I took that home with me. And they just made it interesting. Every time you came we ended up laughing and joking but we were serious at the same time, you know, and we got the message. …it was just something new every week.

A third sub-category highlighted how the atmosphere of WMR was conducive to expressing oneself. This sub-category, Open Forum, addressed consumers not feeling afraid to opine or share their own experiences.

(ID 02): I got to express my ideas and feelings about my illness to the people around the group. …they would let me voice my opinion when I had one. ….letting you speak… (ID 04): We could…whatever we have to say, we could be able to talk to that person and let that person know how you feel. …be able to get it off your chest. I was able to ask the questions in the wellness group. (ID 08): …other classes were like closed in and it was just what they (past group leaders) had to say. You weren’t allowed to have an opinion. The staff (in WMR)… allowed us to talk without interfering. (ID 09): Shared my experience of what I went through with my illness… it just makes me feel good when somebody takes the time to listen to what I have to say… (ID 14): …voicing our opinion… (ID 17): …they would go around the room and ask everybody’s opinion. And there wouldn’t be one person over-talking the other person.

A fourth sub-category, Structure & Flexibility, addressed how many consumers appreciated WMR being structured. For those who were feeling lost or off track, the
structure appeared to be an initial step towards regaining control and order in their lives. However, while structure did exist in WMR, based on that conveyed by consumers, it did not exist without an equal amount of flexibility in applying that structure. Whereas it appeared as though structure was highly beneficial for many consumers throughout their recovery and during WMR, for others it was also beneficial to break free from a structured activity or exercise in order to process something meaningful or address an emerging issue.

(ID 02): She seemed to keep things in line. They’d keep the whole ordeal of WMR moving in the right direction… They were able to keep the order and were able to keep the group moving. They kept it structured.

(ID 04): In some groups you get in and they just want to focus on the book, straight down the book. They don’t wanna change. People have other things to say sometimes…just like I said, you don’t have to go by the book all the time to get back to the wellness.

(ID 08): …I needed that structure that WMR gave me and it was a good structure… Structure was good, but then they broke the structure when it needed to be broken.

(ID 17): …everybody wanted to keep playing the game, you know. And she’s like we’ve got work to do, come on, let’s buckle down. And we’d say, “Okay, only if you do another icebreaker.”

The fifth sub-category, Holistic Focus, spoke to the comprehensive nature of WMR. Perhaps a defining feature setting WMR apart from other mental health interventions, including many focused on psychiatric rehabilitation, WMR was found by consumers to address a health on a broader level than merely mental health. As a result, the focus of WMR was not solely on dysfunction or the elimination of symptomatology. Consumers were being exposed to activities and exercises addressing not only mental health, but also issues related to general wellness, including physical health and getting needs met in the community for oneself.

(ID 02): …there was just learning about everything…about life and the way to live with a mental illness.
In the end, it all comes out to being some way that make you feel whole and well.

...if there’s something that you need to try and get an answer to, they try and give you either an address or telephone number. So they dealt with everything from housing to getting you to see a doctor.

He brought a little bit of everything into the group…teaching you how to live life.

It was symptoms, it was therapy, it was what your doctor had to say, it was diagnosis, it was everything. ...our whole basis for the WMR was not totally psychological. It was other things that were going on, it was our well-being, our good health, our nature, our feeding habits, and all those sorts of things like that.

The final sub-category related to the WMR program’s atmosphere was titled Growth Focus. This category spoke to consumers’ views of WMR as an environment or context focused on growth versus task completion. In other words, based on consumers’ perspectives, WMR tended to focus to a greater extent on growth and development, with facilitators taking the time to process material and assure that such material is internalized before moving on. WMR, therefore, was not perceived as being primarily focused on completing a specified chapter or task. Rather, if something needed to be run through multiple times or there were questions to be answered, the goal was to reach understanding versus merely finishing the task for the sake of it.

They would explain it…do it all over again.

It was (in other groups)…read this or they would read it and they didn’t give you a chance to answer a question or say “Hey, wait a minute. I’ve got something else to say.” And they’re already two or three pages past. They let you ask questions you needed to ask.

And when you’re sick, you don’t want to sit there and talk about why you’re sick. You want to know what you can do to get yourself better and I grew from that.

The second major category within Group Content & Process, entitled Therapeutic Factors, contained five sub-categories. These sub-categories included Support / Caring, No Judgment / Respect, Trust / Privacy, Patience, and Relinquishing Control.
Therapeutic Factors could be characterized as aspects consistent with those factors generally thought to be the basis of good psychotherapy encounters, whether individually or in a group context such as WMR. The first sub-category found, Support / Caring, demonstrated the supportive nature of WMR, with consumers’ identifying the importance of receiving help or support during difficult times. Furthermore, for others, just the feeling of being thought of during an absence carried importance. As part of the process of receiving caring and support from others, bonds were also made.

(ID 02): I’d cry sometimes and they’d come over and actually hug me and say, “we know what you’re going through, we’ve gone through it.” They’d hug me and the girls would hug me. They were very supportive. It felt like people cared.

(ID 08): …I maybe should have been in the hospital, but the staff here, they hung on to me during the roughest part. They cared for me as a person.

(ID 12): …now I can say I’ve got two or three people I have written up on my support group.

(ID 14): …my case manager wouldn’t let me down. You know, he would fix it some kind of way, you know, work things out for me.

(ID 17): …my friends have been support to me because when I came in I was feeling lonely. …they were worried about me if I didn’t show up.

The second sub-category, No Judgment / Respect, described consumers’ appreciation for facilitators and group members level of respect. Specifically, it appeared as though many consumers felt treated with respect and had their opinions valued, with no perceptions of judgment from others. Furthermore, as opposed to other groups or classes in the past, certain consumers did not experience a sense of being devalued, as if they were not a person. Others felt respected simply by being listened to.

(ID 04): They (facilitators) don’t make you feel like you little or you smaller than they are. Just like I say, everybody in that group they don’t make you feel like you’re a little person or they over you. She (facilitator) respects my opinion in things that I have to say and I like that.

(ID 08): …this class itself didn’t rate you, you know. Like you weren’t a number, so to speak. You were a person. When I first started the program I
was kind of afraid…afraid of what I’d run into more…being treated like dirt.
(ID 09): People would actually listen, respect your opinion.
(ID 17): She learned our names. She was familiar with us by the third time. My birth name is ____ …I didn’t answer to my birth name. So, like I would tell them I would go by ____. So, I feel like if they hear me say my name is ____ or this about me or that about me and they actually remember that and they say, “Hi, how are you doing ____” …I know they’ve been listening to me.

The third sub-category, Trust / Privacy, reflected the importance some consumers placed on having others maintain privacy and trust with one another. It appeared as though once consumers could believe they were in an environment with others who would honor a sense of privacy and trust, this allowed them to open up more. It was also apparent that having facilitators reiterate a sense of trust and privacy was beneficial.

(ID 08): …that’s when we went to the privacy clause. People get to where they can loosen up and tell you what’s going on and how they feel during the day and what’s happening with them.
(ID 14): …the facilitator always say, “What’s said in here, stays in here.” You know? And that always made me feel good because they’d say that in every group that we have here.
(ID 17): I could trust them. It’s being able to trust them that is a big thing for me.

The fourth sub-category, Patience, highlights how some consumers perceived WMR in general, and facilitators in particular, to be patient. The willingness of facilitators to take time and not rush through materials or exercises was viewed as important.

(ID 04): …they were so patient. They were patient with you and so we never – we didn’t rush for anything; it just went smoothly like it should. 
(ID 08): They (facilitators) would take time. 
(ID 12): And being able to take our time when we sat around. They would give us a chapter that we would talk about.

The final sub-category in Therapeutic Factors, entitled Relinquishing Control, speaks to how two consumers perceived WMR facilitators as allowing consumers to take
control of their own recovery and wellness. While this did not imply that facilitators had no purpose, it merely reflected how facilitators were perceived as fostering growth and change through removing barriers or giving up total control, rather than being in the driver’s seat of another’s recovery.

(ID 08): …the facilitators allowed them to work through their, actually beat the door down, so to speak. You know, to me, that’s what the facilitator needs to do, break down all those barriers.

(ID 14): …after she (facilitator) would take the roster, who was there, you know, that day, she let us pretty much run it ourselves. You know, she’d sit back and let us do most of the talking.

The third major category within Group Content & Process, entitled Session Activities, contained six sub-categories. The first sub-category, Imparting Knowledge / Wisdom, characterized how consumers viewed WMR and its facilitators to be sources of valuable information and knowledge. The knowledge or wisdom imparted could pertain to coping skills, general reading material, or merely advice.

(ID 02): They (facilitators) gave you ideas on how to cope. They were throwing material out at you to improve yourself. They had coping skills to give you to handle your illness.

(ID 04): They taught us so much. They all – they explained things to us.

(ID 08): They (facilitators) read things to us that we didn’t have in our book. They would explain.

(ID 09): Well, they gave us a lot of information that we didn’t know.

(ID 12): Each one (facilitator) I’ve had so far had a little more information than the last one. They were teaching. They would give us a chapter.

(ID 14): She (facilitator) actually gave us a little more wisdom.

(ID 17): And they give helpful advice.

The second sub-category, Reading, highlighted the specific activity of reading various pieces of material throughout the group.

(ID 02): I was reading.

(ID 04): We had this thick book that we went through.

(ID 08): I would read the material.

(ID 12): We read through each chapter. Well, I kept my book with me.
instead of turning it in every week. I kept mine because I would re-read it. And re-read it and I studied on it, and I contemplate how it would help me a little better. I read each chapter prior, before the class, and then I would re-read it with the class.

(ID 14): And the actual literature we read in the group and everything at certain points of time during the group.

The third sub-category, Processing / Discussion, reflected the group activity of opening up and sharing thoughts or feelings with ones’ peer group in WMR. This sharing of feelings often took the form of a reciprocal discussion between consumers.

(ID 04): …different things you had to do and discuss through this (group)
(ID 08): …they’d ask a question, “How do you feel today?”…everybody would go around and give an answer.
(ID 09): …when we started doing the role-playing stuff and we actually got to tell our feelings…
(ID 14): I just opened up and let everybody know how I felt.
(ID 17): Sometimes we would go around the room and ask how I made people feel…

The fourth sub-category, Listening, spoke to the importance some consumers placed on simply listening to other group members comments or life stories that pertained to experiencing chronic mental illness.

(ID 04): I was – I don’t know, just it back and listen and took everything that I could grasp and that helped a lot.
(ID 09): …just listened to what other people had…
(ID 17): Hearing their stories, how long that had been here…

The fifth sub-category, Role-Plays, related to consumers’ having engaged in skill-building role-plays that allowed them to practice exercises such as communication skills or assertiveness training.

(ID 04): And also, we would play these heavy scenes like if you – this is one that I really enjoyed that we did. You put things together like little dramas – sketches. We did little sketches and I liked that.
(ID 08): We did a lot of role-playing.
(ID 09): We went through and did role-plays…it was just really helpful.
The sixth sub-category, Peer-to-Peer Help Process, contained three sub-categories of its own. These included Providing Help, Feedback, and Modeling. Providing Help demonstrated how consumers not only received help themselves throughout WMR but also had the opportunity to help peers as well.

(ID 02): Sometimes I had better coping skills than they had but sometimes they gave me ideas where I could use them to benefit myself. I can talk with them and make them feel better than I can make myself feel better. I tried to help other people if I could.
(ID 04): …this gave me the opportunity to be with other folks to try to help – so much help was given to me at one time so it made me feel like I could be able to give some of that help back. …it made me feel good that I was able to help where she was gone – wasn’t there and everybody looked forward to me for the things that they needed and I was able to help them with that.
(ID 08): Sometimes they (peers) couldn’t find the paper…so I was over there helping this one and helping that one.
(ID 09): I took the time to talk to her (friend) the way that I was taught in the class. And she said, “You know what? If it wasn’t for you, I would end up in the hospital. I’ve helped people by talking to them.
(ID 12): …with the WMR program, we not only asked each other questions, we gave each other answers.
(ID 14): And we kinda helped each other along the way in the group, in the program.

The second sub-category within Peer-to-Peer Help Process, entitled Feedback, described the process by which consumers taking part in WMR, in addition to facilitators, would give feedback. Furthermore, one consumer even described material in a workbook as a form of feedback to herself, while another found feedback from the group helpful in challenging symptoms.

(ID 02): They also had feedback on some of that. Having somebody there to reflect on the same thing. Teachers would reflect on what I’m talking about and tell me, “That was a delusion or paranoia.”
(ID 08): …I would get positive feedback from the book itself, on just paper. …if you don’t get feedback of some kind, it’s not a program because they’re not telling you what you need to know.
(ID 12): …communicating our own feedback.
(ID 14): We would give each other a lot of feedback.
The final sub-category within Peer-to-Peer Help Process was titled Modeling. As the title suggests, this sub-category highlighted another form of helping that took place for a number of consumers within WMR. Of particular importance appeared to be the role of the WMR facilitator in modeling behavior. This included both modeling of opening up and expressing oneself regarding one’s mental health history as well as modeling of specific behaviors for activities, such as a role-play. Furthermore, modeling tended to result in increased activity on the part of others who witnessed such modeling.

(ID 08): I was willing to tell them…going back into my high school years where my mental illness first started. I would tell them about my stay in hospitals…then they would feel free looking at me to tell me what had happened to them.
(ID 09): (Facilitator) would do some and then everybody else would watch while they let one of us do the role-play with them.
(ID 14): And when they (facilitators) were open and letting the rest of the group know their illness, I was able to open up better about my own.

Overcoming Prejudice & Stigma

Table 3 illustrates the theme of OVERCOMING PREJUDICE & STIGMA and its structure, including the six major categories contained within 1) Inhibiting Emotions,

2) Recognition of Self-Worth, 3) Acceptance, 4) Perseverance, and 5) Person vs. Illness,

6) Advocacy. See Table 3.
Table 3
Outline of Core Themes: OVERCOMING PREJUDICE & STIGMA

A) Inhibiting Emotions
B) Recognition of Self-Worth
C) Acceptance
D) Perseverance
E) Person vs. Illness
F) Advocacy

The third and final overriding theme obtained was titled Overcoming Prejudice & Stigma. Within this theme included six sub-categories: Inhibiting Emotions, Recognition of Self-Worth, Acceptance, Perseverance, Person vs. Illness, and Advocacy. The first sub-category, Inhibiting Emotions, highlighted the feelings and experiences of many consumers when initially beginning WMR. Many of these emotions experienced are due in part to past experiences of encountering stigma and prejudice due to mental illness. Specifically, consumers identified feelings of fear, anxiety, and shame regarding their illness. As a result, many consumers experienced feelings of inhibition, apprehension, or pessimism when starting WMR. These experiences pertained to not only the process of WMR in general and whether it would or would not be beneficial, but also to interactions with others.

(ID 04): …I was too afraid to let it come out or too upset or get too nervous or too – I don’t know. My heart would beat really fast and I’d be all nervous.
(ID 09): It’s just, just coming in scared, I guess was the part that I didn’t like at first.
(ID 12): It’s not as well as I would like it to be because I still have those inhibitions, and they still tend to bother me, the anxiety and a lot of other things that go along with it. …that’s where I feel inhibited about. I think I
wasn’t ever going to go any further than where I was, because I was really scared all the time, and I was really apprehensive about being around people…I was just too afraid to make a move.

(ID 14): I did feel shame in it (mental illness). I was still skeptical.

(ID 17): I didn’t think nobody would ever come to help me when I needed help. …for the first couple sessions I wouldn’t open my mouth. …at first I was kinda skeptical…I get cold feet really easy, I was like, “Okay, should I do this or should I just stay home?”

The second sub-category, Recognition of Self-Worth, characterized what represented for many consumers a new or renewed sense of self-worth. Feeling good about oneself and no longer feeling a sense of worthlessness in life was thought to be an integral aspect in one’s fight against prejudice and/or stigma experienced in the past. An evolving sense of self-worth is what was thought to put consumers in the position of having something to fight for, as opposed to passively accepting the prejudicial treatment of others.

(ID 02): …it makes me feel good about myself, like I’m worth something.

(ID 04): I feel good about myself.” …it makes me feel good about myself.

(ID 08): …I may have a mental illness, but don’t make me feel as if I’m not worth being a person. You know, I’m a person, I am not something that you walk on and that’s the way it was before I started the program.

(ID 09): They made us feel like we are a somebody, not a nobody. After it was complete I felt like I was a somebody.

(ID 12): And yes I can feel this way without having to feel problems or inhibitions of somebody wanting something against me or whatever.

The third sub-category, Acceptance, spoke to consumers’ increased willingness to accept themselves as a whole. As part of this acceptance process, some consumers learned through WMR that it was okay to express emotion or experience unhappiness, while others used acceptance as a vehicle through which they were able to carry forward and not let their illness stagnate their growth or serve as a barrier to success and accomplishment.
The program said it’s okay to be a person. It’s okay for me to cry…to be sad.

I tried to keep shame out of it. I tried to take shame out of this. And the WMR program taught me to more actually accept it (mental illness) and take it from there. It’s like to not let my illness get in the way, to be more – to accept, you know, the way I am.

…she (facilitator) would say either, “You’re right,” or, “If you want to feel that way, it’s all right for you to feel that way.

The fourth sub-category, Perseverance, addressed how many consumers experienced the process of recovery as arduous and effortful. A realization of the time commitment and difficulty that was involved came about. Some consumers even highlighted how they had to persevere against not only difficulty but fear and uncertainty as well. Furthermore, for some, this process of perseverance inspired a sense of confidence and determination in striving further.

It’s hard to convince yourself that it’s (mental illness) not a part of you.

I was just – willing to do anything, be anything.

The prejudice was pushing me back…the group showed me how to go forward instead of stopping and just saying, “I can’t do this anymore.” …I made it through. I’m going to break through this wall of prejudice…I kicked it in and I punched it until I finally got through. …if something is worth striving for, it takes work…my mental state, it took work to get my mental state where it should be.

…you just have to make the best of the situations. You know, don’t let the illness get to you.

And it’s not that easy, like I said, to come out of that little shell, that little shell, that you feel safe in. It takes a whole lot to get through that. But, like I said, it was still difficult that very first time. It was hard. It’s not easy, and I know there’s a lot further I have to go to get there, but I feel like I can make it.

The fifth sub-category, Person vs. Illness, represented a critical step in the process whereby consumers worked on battling and overcoming prejudice and stigma. Related to a greater recognition of self-worth, acceptance, and perseverance, consumers began to
learn and define themselves not by their mental state but by their humanity. Essentially, after years of being treated by many of those around them as merely a diagnosis or disease, consumers began to see themselves as a greater whole, as a human being, with mental illness not defining them but being only one of many aspects of the self. Mental illness shifted from being the center of their existence and identity to an aspect on the periphery.

(ID 02): Like it’s (symptoms) a part of the illness, and not part of me. (ID 08): Know me by my personality, by me, not my illness. (ID 09): …we’re not our mental illness. We’re a human illness before we are a – because a lot of people think we’re the illness. We’re not our illness, which made me feel good. (Facilitator) taught me that I am not my illness. I learned that I’m a human being just as well as anybody else and I can be just as normal as they can. Since I took WMR, I learned that I am not my illness. (ID 12): I felt like I was my person. I wasn’t put into a category and labeled. (ID 17): You know, and I didn’t feel like I was defined by my medical records.

The sixth and final sub-category within Overcoming Prejudice & Stigma was titled Advocacy. Advocacy included both efforts at self-advocacy and peer-advocacy. Specifically, consumers remarked on how they advocated in describing their needs and desires, as well as beliefs pertaining to their capacity to live “normal” lives like everyone else who may not be experiencing a mental illness. Furthermore, consumers’ support and encouragement of others represented a form of peer-advocacy.

(ID 04): I already talked four or five people into coming to the next one. (ID 08): I just have to stand up for me. Treat me the same way as somebody that has cancer or another disease. If you (fellow group member) had something to say…I would say, “Go ahead and say it.” We’re here for everybody. (ID 09): You can live just as normal as anybody else. (ID 12): …I think sometimes I do have something to say. (ID 14): I’ve even gone out since I’ve done it the second time, I’ve even
told other clients in here that haven’t taken it yet, “Hey you ought to take that group.”

While not pervasive enough across the majority of protocols examined to warrant a formal theme or category, some unhelpful aspects identified by consumers included aspects such as filling out questionnaires, scheduling conflicts of WMR with other appointments, the two-hour length of each WMR group, as well as difficulty personalizing WMR to a single consumer in the context of a group modality.

After having identified the critical components that make up the recovery process, it was imperative that the relationships among these themes and sub-categories be further expanded upon in order to build a working grounded theory of how the process of recovery actually takes place and unfolds within the context of WMR. As mentioned earlier, individuals coming into the WMR program tended to present at varying levels of recovery. A number of similarities did exist, however, that characterized their thoughts, feelings, and behaviors.

It appears as though the group atmosphere, in addition to solid / general group therapy skills or factors (no judgment, patience, respect, trust, support), played a role in consumers becoming less fearful and more comfortable in the group, thereby making the atmosphere more conducive to learning, growth, and putting oneself “out there” so to speak or having the willingness to engage in the group and its activities (such as exercises that may prove beneficial). The bond or belongingness among not only group members but facilitators as well was especially important. Specifically, consumers simply came (hopefully with time and some struggle / perseverance) to the realization that WMR groups are an environment where they would not encounter the judgment, stigma, and
hierarchy they had received in other environments. Furthermore, it was these experiences in other environments that have reinforced the need to isolate, close off, lose hope, etc.

This feeling of greater comfort was fostered to a great extent by the session activities, engagement in group process, and atmosphere (equality, openness regarding similar struggles) that gave consumers in WMR a sense of belongingness and an understanding that they were not alone in their suffering, that they had a common bond with others. Realization of this belonging / bond tended to give consumers a renewed sense of self-worth, that aided in the process of acceptance, all of which helped to overcome thoughts, perceptions, and feelings associated with pre-WMR conditions and other issues related to or resulting in prejudice and stigma. Part of this process involved coming to change one’s perceptions of self, from being defined by illness to taking on an identity of a whole person. In turn, with a renewed sense of self and greater acceptance, consumers were better able to persevere and work through the arduous but rewarding process of recovery, while also advocating for themselves and others.

The fun / engaging nature of WMR appeared to be a very important factor (endorsed by all 7 of the protocols analyzed), therefore something about WMR being fun (or even silly at times) not only helped create a bond but also helped make the atmosphere lighter and promoted learning and growth. Session activities (icebreakers, role-plays, reading, listening, processing, helping one another, etc.) that helped in creating a bond with group members were also associated with growth and learning later on (concrete and experiential learning, improvement / progress, revelation / rebirth / new beginnings, as well as interpersonal and intrapersonal growth).
New learning and growth tended to also influence one’s battle to overcome prejudice and stigma as well. Furthermore, it did not tend to end with a single form of growth (intrapersonal, interpersonal, improvement, or revelation / rebirth / new beginnings). In fact, at that point it appeared to become reciprocal, with learning and growth having created conditions or states of mind conducive to further learning and growth (example: Intrapersonal growth such as increased courage or empowerment put one in the position of really benefiting from session activities that targeted role-playing and therefore led to that same consumer having experienced growth when it came to dealing with the interpersonal / environmental realm).

The aforementioned qualitative results described a process whereby consumers entered WMR having experienced a host of negative experiences. After entering WMR, consumers began a journey that many would describe as transformational. They began to overcome stigma and prejudice, while having experienced growth that was multifaceted. It was those experiences, verbalized by consumers themselves, that were not subject to quantification. However, the following results highlighting group change over time were thought to be complementary.

Quantitative Results

Dependent t-tests were used to assess overall group changes following completion of the WMR program on the Mental Health Recovery Measure (MHRM), the Ohio Consumers Outcomes Form, and the WMR Client Self-Report. Results indicated that there was a significant increase in Total MHRM score (N=273) from Pre- (M=80.3, SD=20.3) to Post-Treatment (M=88.8, SD=18.4). This same trend was also significant for all eight of the MHRM subscales: Overcoming Stuckness, Self-Empowerment,
Learning and Self Redefinition, Basic Functioning, Overall Well-Being, New Potentials, Advocacy, and Spirituality. The effect sizes for these statistically significant increases were in the small to medium range (Cohen’s $d=.30 - .50$). See Table 4. An exploratory analysis was performed in an attempt to compare consumer to traditional site location on the MHRM Total score. No significant difference was found between consumer and traditional site location, $t(272)=3.78, p=.51$.

Table 4

<table>
<thead>
<tr>
<th>Scale</th>
<th>Pre-WMR Mean (SD)</th>
<th>Post-WMR Mean (SD)</th>
<th>$t(272)$</th>
<th>Effect Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>MHRM Total</td>
<td>80.3 (20.3)</td>
<td>88.8 (18.4)</td>
<td>8.22*</td>
<td>.50</td>
</tr>
<tr>
<td>Overcoming Stuckness</td>
<td>11.6 (3.0)</td>
<td>12.6 (2.7)</td>
<td>5.39*</td>
<td>.33</td>
</tr>
<tr>
<td>Self-Empowerment</td>
<td>10.5 (3.4)</td>
<td>11.7 (3.2)</td>
<td>6.75*</td>
<td>.41</td>
</tr>
<tr>
<td>Learning &amp; Self Redefinition</td>
<td>11.8 (3.0)</td>
<td>12.9 (2.8)</td>
<td>6.88*</td>
<td>.42</td>
</tr>
<tr>
<td>Basic Functioning</td>
<td>10.2 (3.1)</td>
<td>11.1 (3.1)</td>
<td>5.07*</td>
<td>.31</td>
</tr>
<tr>
<td>Overall Well-Being</td>
<td>10.3 (3.8)</td>
<td>11.7 (3.2)</td>
<td>6.85*</td>
<td>.42</td>
</tr>
<tr>
<td>New Potentials</td>
<td>10.8 (3.4)</td>
<td>11.9 (3.1)</td>
<td>5.91*</td>
<td>.36</td>
</tr>
<tr>
<td>Advocacy</td>
<td>9.6 (3.5)</td>
<td>10.6 (3.2)</td>
<td>4.94*</td>
<td>.30</td>
</tr>
<tr>
<td>Spirituality</td>
<td>5.6 (2.3)</td>
<td>6.2 (1.9)</td>
<td>5.21*</td>
<td>.32</td>
</tr>
</tbody>
</table>

*p < .001

In addition to average changes, individual Pre-Post changes were computed for each participant. Statistically reliable ($p<.05$) improvement or deterioration was based on the standard error of measurement for each outcome measure (Jacobson & Truax, 1991).
A reliable change index of +/- 15 points on the MHRM Total score was used to indicate Reliable Improvement or Reliable Deterioration. “Some Improvement” or “Some Deterioration” was assigned if the individual increased/decreased on the measure, but not at a level of reliable change. Results indicated that 31.9% (n=87) showed reliable improvement, 6.6% (n=18) showed reliable deterioration, and 61.5% (n=168) failed to show either reliable improvement or deterioration.

Results were also indicative of significant changes on the Ohio Consumer Outcomes Form (N=248). Specifically, there were significant improvements on the Quality of Life and Empowerment scales, as well as a significant decrease in Symptom Distress. As a group, persons completing the WMR program reported significantly greater levels of mental health recovery on all of these measures at the end of treatment. See Table 5. Lastly, a significant increase from Pre (M=68.9, SD=11.8) to Post-Treatment (M=74.7, SD=11.9) was also found on the WMR Client Self-Rating scale (N=280), t(279)=9.83, p=.000, with a medium effect size (Cohen’s d=.59).

Table 5
Mean Pre and Post scores on the Ohio Consumer Outcomes Form (Quality of Life, Empowerment, and Symptom Distress)

<table>
<thead>
<tr>
<th>Scale</th>
<th>Pre-WMR Mean (SD)</th>
<th>Post-WMR Mean (SD)</th>
<th>t(247)</th>
<th>Effect Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of Life</td>
<td>3.26 (.71)</td>
<td>3.45 (.69)</td>
<td>5.62*</td>
<td>.35</td>
</tr>
<tr>
<td>Empowerment</td>
<td>79.5 (9.0)</td>
<td>82.1 (9.5)</td>
<td>4.89*</td>
<td>.34</td>
</tr>
<tr>
<td>Symptom Distress</td>
<td>34.6 (12.7)</td>
<td>31.2 (11.4)</td>
<td>5.27*</td>
<td>.34</td>
</tr>
</tbody>
</table>

*p < .001
Chapter IV
Discussion

Severe and persistent mental illness represents a critical issue on political, societal, and healthcare-related levels. While once thought by many, both within and outside the field, to represent a condition of deterioration at worst and stagnation at best, the concept of recovery has emerged. While the dissemination of a recovery-oriented framework along with the transformation of traditional deficit-based models of mental health care has developed slowly in recent years, its impact on many of those experiencing severe psychiatric disability has been monumental. So much so that much of the current literature addressing the mental health needs of those experiencing such illnesses as schizophrenia, major depression, and bipolar illness includes discussions revolving around recovery-oriented care.

As part of the dissemination of a recovery-oriented vision, it is crucial to refine and deepen our understanding of what recovery is and more importantly, how it is achieved. Given that recovery is already known to be a highly personal and unique process (Anthony, 2000), it is certainly possible that recovery defies definition. However, in an attempt to further educate ourselves as well as make efforts to inform clinical practice, it is worthwhile to explore the recovery process within the context of a specific treatment program, such as WMR.
The present study explored the recovery process as it pertained to participation in the WMR program. Qualitative results obtained were consistent in many respects to previous research exploring recovery. This consistency was primarily found in the components that emerged and characterized recovery. For example, consumers qualitatively interviewed in the present study endorsed the benefits and major life changes associated with WMR. This happened despite some consumers being found, quantitatively, to have responded negatively or with a neutral response to WMR with regard to symptomatology. Therefore, this finding adds credibility to Davidson et al.’s (2005) assertion of there being a problem with decreased symptomatology being the primary gauge of improvement.

Consumers’ responses were also consistent with Anthony’s (1993) assumptions of what characterizes a recovery-oriented vision. Specifically, the results were indicative of recovery-related changes taking place at both consumer and traditional sites, suggesting that professional involvement is not essential. Furthermore, support from others was found to be highly important and integral in the process, as well as excerpts from consumers highlighting how they often struggled as much, if not more, with fear, isolation, doubt, lack of employment, and low social support than they did with symptomatology. This is a critical point and has implications for future clinical practice.

Consumers found hope and a positive outlook to be especially helpful in their recovery. This representation of intrapersonal growth or state of mind is consistent with much of the extant literature (Davidson et al., 2005; Deegan, 1988, 1997; Marsh, 2000; Mead & Copeland, 2000). Similar to the components of empowerment and responsibility discussed by Corrigan (2002) and Ralph (2000), consumers in the present study identified
regaining control, a sense of initiative with new opportunities, and taking responsibility for themselves and their well-being. Taking greater responsibility for oneself in WMR is unique to the recovery vision and differs from traditional models that emphasize therapist or facilitator direction. Glover’s (2005) contention that providers can’t take responsibility for another’s recovery is consistent with the experience some had in WMR whereby they perceived WMR facilitators as supporters who removed barriers but did not attempt to direct the route of one’s recovery. Specifically, facilitators were perceived by some to be relinquishing control.

A critical process of overcoming prejudice and stigma took place for many consumers going through WMR. Based on the qualitative results obtained it appears as though much of the transcendence over past prejudices, particularly emanating from mental health care professionals endorsing a deficit-model, was fostered by WMR facilitators’ endorsement of an equalitarian atmosphere, where no hierarchy existed between facilitator and group member. Furthermore, for many going through WMR there was an increasing sense of self as a whole person rather than being defined by an illness. This is consistent with Roe and Lachman’s (2005) discussion of the often harmful and counterproductive effects that take place when labeling someone. Therefore, individuals in WMR experienced a “person orientation,” as discussed by Farkas et al. (2005), as opposed to having their illness or disease take precedence over their sense of humanity or individuality.

Also in line with previous research were the qualitative findings that echoed Paulson et al.’s (1999) discussion of practice cultures. The results obtained, across both consumer-operated and traditional site location, were indicative of facilitators who
stretched the boundaries of the facilitator-group member relationship, recognized no hierarchy or boundary, emphasized understanding and growth as opposed to simply task completion, and collaborated with group members.

While Ochocka et al. (2006) cited research suggesting that consumer-run organizations were safe and welcoming environments, qualitative evidence obtained in the present study indicated that consumers, whether at consumer or traditional site location, found WMR to be a safe and receptive environment, therefore helping foster recovery. Therefore, the ability of the aforementioned findings to appear across site location again suggests that perhaps what is of vital importance is not whether a facilitator is a consumer of mental health services or a professional mental health provider, but how a given provider or agency chooses to facilitate the recovery process, or the philosophy they use to guide their clinical practice. Further support for this claim comes from the work of Borg and Kristiansen (2004), highlighting how consumers valued professionals who conveyed hope, showed respect and fostered an equalitarian atmosphere, shared power, were available to just “be there,” using one’s own time to help versus solely professional time, and even stretched the boundaries of the professional role. All of the acts cited by Borg and Kristiansen (2004) were expressed by consumers as being part of WMR.

While the aforementioned components of recovery cited throughout the literature were similar in many respects to those components identified by consumers having taken part in WMR, perhaps the unique aspects of the present study pertain to the theory that emerged detailing the inter-relationships between concepts. While certainly not linear, the path of recovery for those within WMR appeared to be highly unique but did center
around similar mechanisms of change and growth. Specifically, for many individuals it appears as though the relationships among important concepts identified were reciprocal, with a change in one area or a particular aspect of the group context being related to further change in another area and vice versa. With that being said, what appeared to contribute to the success of many within WMR were components specifically related to group atmosphere. Factors such as trust, support, respect, as well as making treatment fun and engaging certainly fostered greater engagement in tasks and greater potential for growth and learning. Furthermore, also conceptualized in the present model as a vital basis for WMR’s success was the feeling of belonging that group members experienced. This feeling of belonging among peers appeared to be fostered by group members’ increasing sense or realization of shared suffering that they had with one another. Of further importance is not that group members merely felt this sense of a common bond between themselves and fellow group members but that a bond was found to exist between group members and facilitators. The idea of everyone involved, from group members to facilitators, being partners in wellness appeared to have a powerful impact on many consumers. Specifically, some consumers speaking to the fact that facilitators, some without a history of mental illness, admitting to faults or succumbing to everyday stressors speaks to the developing idea that what might be of most importance is not who delivers a particular recovery-oriented service (those with or without a mental illness), but how that service is provided.

While the quantitative, exploratory analyses assessing group change in the present study were only of secondary importance, the results do provide positive and promising evidence in support of WMR being an effective intervention and experience for those
experiencing severe and persistent mental illness. In addition to solely symptom-focused measures of change, it is apparent based on the results of the present study that the experience and transformation that occurs as a result of WMR leads to significant improvement (quantitatively) as a group in many areas, including quality of life.

This convergence of qualitative and quantitative data lends further support to the notion that recovery-based services, or how a given service is delivered, is of greater importance than the debate over who is most apt to deliver such as service. The fact that no significant difference was found between consumer and traditional site location, either quantitatively or qualitatively, supports this assertion.

**Implications**

The present study and its results have a number of specific implications for not only clinical practice but also for a change in mindset or philosophy when it comes to how to conceptualize treatment for those experiencing severe and persistent mental illness. Of utmost importance should be the continuing shift away from symptomatology as the primary and, at times, sole gauge of improvement for this population. Clinical interventions geared towards promoting recovery should put less emphasis on decreasing symptoms and more energy and attention on addressing those experiences that an individual with severe mental illness finds him or herself battling with as a result of either symptoms or past treatments that had the effect of disempowering individuals in a number of ways. These experiences result in or exacerbate a diminished quality of life, hopelessness, passivity, stigma, and a lack of rewarding interpersonal relationships, etc. An appreciation for the fact that many individuals dealing with chronic mental illness will have symptoms that may wax and wane indefinitely can redirect clinical efforts to
those aspects of experience mentioned above that can be improved despite the presence or absence of symptoms.

A second implication from the present study pertains to the notion of how interventions or group treatments are run. It is apparent from the aforementioned results that the theoretical model of recovery that emerged from the data was not contingent upon site location. Individuals from both consumer and traditional site locations expressed many similar reactions and sentiments characterizing their feelings and the changes that took place for them in WMR. Therefore, it may then be inferred that the key to successfully promoting mental health recovery does not lie in whether or not you are a mental health consumer or a traditional, “professionally” trained provider, but how you approach those you are serving. Specifically, this includes making the experience engaging, promoting an atmosphere of partnership in wellness (by becoming transparent with the group in a sense, admitting to personal struggles as a way to promote a bond and eliminating a provider-patient hierarchy), and fostering a sense of belonging. These are the elements within the present model, along with education, that promoted recovery.

Finally, speaking to the educational component of WMR, perhaps the greatest task within the whole scheme of promoting recovery is the successful integration of education with the supportive therapeutic elements listed above. When done right, this could potentially be a critical piece to the puzzle of successfully promoting mental health recovery. This way of thinking, of course, differs from other interventions that might make the decision of which to employ as an either-or issue, when in fact it is critical to integrate the two.
Limitations and Future Research

The current study was an open clinical trial that did not include a control group comparison. Most, if not all, WMR participants were receiving ongoing case management and psychiatric services in addition to participating in the WMR program. Furthermore, while results suggest overall group improvement for those taking part in WMR, exploratory analyses comparing traditional and consumer-operated site location were not indicative of any significant differences, however, there was quite a discrepancy in sample sizes between the number of individuals having completed WMR through traditional and consumer-operated site locations which likely affected this result.

However, the fact that WMR within traditional sites was facilitated by a professional and consumer, this exploratory analysis would not have addressed the concerns of Solomon and Draine (2001), citing the need for comparison of stand alone services, as opposed to consumers working alongside traditionally-trained professionals. Until such stand alone services (solely professional versus solely consumer) can be performed and measured, the effects of paired service providers will continue to confound results. Long-term follow-up data are currently being collected to determine whether the gains achieved are stable over time. Closer attention to the minority of participants who showed deterioration on the recovery outcome measures is warranted to help determine what variables were related to their self-reported decline.
Chapter V

References


Chapter VI
Appendix

Sample Transcript of a Qualitative Interview

*Interviewer:* All right. Tell me what change if any took place during participation in WMR?

*Interviewee:* Actually the change was I saw myself grow further. I had like stagnated. I felt like I was all alone in a crowded room and when I started taking the course itself, right, things began to fall in place information like light bulbs. I gained a lot. I had questions about my meds about how to deal with doctors and medical people and so on.

And in general, yeah, I learned how to talk to my doctor, how to talk to my caseworker, what was up with me as a person, how far it hadn’t gone, how much I knew I could, with new information how I could grow more than I had. So I learned quite a bit about myself as an inward person to be able to bring all those hidden things out in the open.

*Interviewer:* Hidden things. Can you tell me a little more about what that means?

*Interviewee:* Me, in my brain, I am a bipolar manic-depressive schizophrenic affective and I look at the world different than most people. I was like the only one in the room and I felt like closed off.

*Interviewer:* Like isolation?

*Interviewee:* Isolated, yes. I felt very, very isolated. I wasn’t ready to talk to people, afraid that they would jump on me because I had had some problem with other people not understanding my mental illness and I was getting it full force from different people. And the course taught me how to deal with them, how to say, “Hey, I may have a mental illness, but don’t make me feel as if I’m not worth being a
person. I’m not like a broken person. I’m me. My name is ___. I have a life. I am a person. I’m worth something.”

Interviewer: A person, not an illness?

Interviewee: That’s right, a person, not an illness. Know me by my personality, by me, not my mental illness. Don’t be judging me and that’s what I was getting, a lot of judgment.

Interviewer: Prior to WMR.

Interviewee: Prior to WMR. I was getting a lot of prejudice that I wasn’t capable of doing anything from keeping my own checkbook to eating. I had to be handed everything. I’m on assisted living at ___ where I reside. They have an assisted living program where they dispense medicine and all these things. They do housekeeping and all things and I had gone beyond that to where I was doing all the things that I needed to do for me, you know, as a person.

And the group showed me how to go about doing that, how to actually work my through the maze of different people and how to handle them and actually how to handle myself working through, it’s called recovery and that’s where I was at. Finally you decide I was working through, I found answers that really, really, as you say, gave me a starting point and now I could grow. And I just started to grow. I saw myself growing.

Interviewer: Uh huh.

Interviewee: And I was not being afraid of talking. I wasn’t - feared someone was gonna yell at me for saying what I said.

Interviewer: So is it safe to say that during WMR you pushed yourself to move out of your comfort zone?

Interviewee: Exactly, yeah. I was able to move forward instead of going backwards.

Interviewer: I see.

Interviewee: The prejudice was pushing me back and the group itself showed me how to go forward instead of stopping and just saying, “I can’t do this anymore. Put me away. Put me in a hospital. Put me where I’ll ‘be safe’ you know.” And the program showed me that I can be safe. I can be safe outside the doors.
I just have to stand up for me, so that’s part of - actually, that’s a part of what I had learned, to stand up for me. I was like a rug that people wiped their feet on and this brought me out of that. So now I’ve been out of the hospital, oh, I’d say about six months and for me, that’s good.

Interviewer: Tell me, how has your definition of recovery changed since taking part in WMR?

Interviewee: Recovery has changed.

Interviewer: If it has in terms of -

Interviewee: Okay. The program says it’s okay to be a person. It’s okay for me to cry. It’s okay for me to be sad. It’s okay for me to be in the hospital if I need to be in the hospital. It’s okay for me to be a person, not a figment of somebody’s imagination, treating me with disrespect. I’m a person of worth, take my meds, I see my doctor, I see my caseworker, do all the things I need to do.

Treat me the same as somebody that has cancer or has another disease, like I have a pacemaker, things like that. You know, I’m a person. I am not something that you walk on and that’s the way it was before I started the program. But now I’m worth - I’m not dirt.

Interviewer: Uh huh. So in terms of your definition of recovery, was there a difference that took place in terms of what you thought recovery was before you started and then after you started?

Interviewee: Yeah. When I first started the program I was kind of afraid, let’s put it that way, afraid of what I’d run into more, you know, being treated like dirt, so to speak. I figured that’s what would happen, but it didn’t. By the end of the course I knew I was a person, I knew I had an illness, right. I had my definitions and stuff, but there were other people in the group who had the same thing happen to them.

So I’m not alone. I wasn’t, I realized that point when it was just about over. I’m not alone. There are others out there who may not say anything or do anything to show that they have a mental illness, but it’s there. And at one point they said that three-fourths of people in the United States have some form of mental illness and to me that was a Godsend, you know. That included me with other people. I’m not trash. I’m not dirt for people to walk on.

Interviewer: More a sense of belonging?
Interviewee: Uh huh.

Interviewer: Okay.

Interviewee: I felt like, “Yay, I’m a person.” You know, I haven’t lost being a person. I did there for a while. Actually, I maybe should have been in the hospital, but the staff here, they hung on to me during the roughest part, right. And yeah, I made it through. And when I saw the light of what was in the pages, you know, and I finally started applying them to me, right.

I found that I’m not alone in the room. There are other people standing there. They just haven’t approached me or are afraid to approach me, so I started to approach them. I say hi to total strangers.

Interviewer: What did the practitioners delivering WMR do during WMR?

Interviewee: Well, if I get the gist of what practitioner mean, we -

Interviewer: The facilitators.

Interviewee: Okay.

Interviewer: Yeah.

Interviewee: They did little games and little skits. There was one where we stood against the thing and had another rope and we slowly, but surely walked to each other until you got to your comfort zone and you could go this away and say, “Stop.” And I got to where it was like yay and when I finished, it was like there.

Interviewer: So you saw some improvement?

Interviewee: I saw improvement, yeah.

Interviewer: What else did they do during sessions?

Interviewee: Okay. We had the - they read things to us that we didn’t have in our book, which made it nice because you could hear it as well as see it, those things that we had in a book, right.

Interviewer: So they supplemented the material that was in the book with -

Interviewee: Uh huh, uh huh. And that made it good because it added to what was in front of you, right? One thing I would have liked to have seen though is having the things that they have for us where we
could actually read what they were saying, that’s one of the only things that I kind of disliked. I liked the entire thing, but that there because a lot of people do better by seeing and hearing than they do just reading.

Interviewer: Sure.

Interviewee: Me, I like to hear. It’s easier for me to hear than to read sometimes. It’s like you read for me today. Sometimes, you know, it’s easier for me to hear it.

Interviewer: So they provided information, they did skits. Now, when you say skits, did that include things like role plays?

Interviewer: So they provided information, they did skits. Now, when you say skits, did that include things like role plays?

Interviewee: Yes, we did a lot of role playing.

Interviewer: We did a thing with yarn which made like a spider web and you reach out a handful and it showed that you’re not alone. You’re connected to somebody no matter where it’s at.

Interviewer: Anything else that they did that you can - that jumps out at you?

Interviewee: Yeah. They had little drawings in our book, you know, with signs and so on. That, I liked, I really did. A lot of the people took and colored them in which made it nice, you know. They had something to hold on to that they had made. We made little bitty figures out of clay and that was real nice. I tried to make an ashtray, but it didn’t look like an ashtray when I was done, you know. There were things that we did and in -

Interviewer: So what was the purpose of making things like that?

Interviewee: Okay. The purpose was to show diversity in the people that were doing it. Different people at different times in their growth, right, their mental, spiritual, etcetera, etcetera growth, right. That showed where they were at. Some just put a round ball saying, “I’m going nowhere. I’m stuck, you know. I’m stuck. Unstick me. Help me unstick myself.”

So it was like yeah, and it showed where everybody had something that matched somebody else. It showed that you weren’t alone. That I stress too because, you know, being alone is not good. I found out the hard way. Being alone is just the pits and going through it, you know, it’s like a depression you can’t get out of.
It gets worse and worse and worse and things like that were happening to me, were getting worse and worse and worse and worse. And finally everything went straight. I knew where I was going, how to get past it. I knew how to work with my mental illness, how to work around it. And today I’m doing pretty good.

**Interviewer:** Good. What did you actually do during WMR week to week, during sessions?

**Interviewee:** Okay. We had turns where we could read, so I would read the material. I asked questions. I got answers. I’d say, “Oh, wait a minute. Back up here. Say this again and tell me.” And we had things on the board that he would write, ___ would write, and we would write on the board the things like they’d ask a question like, “How do you feel today?” And everybody would go around and give a answer and stuff, you know.

And going around and talking to everybody, one would up another and, “Hey, I had that happen. How’d you feel?” You know, so on and so forth. And for me, it was a learning tool for me anyway, knowing how to apply the different rules to myself, not being outrageously happy or mania depressive, you know. So I was learning to control more my mental state of mind. It was healthy.

**Interviewer:** Anything else that you did during WMR that you remember?

**Interviewee:** Oh, yeah. Besides the reading and all that, I received questions that got answers to and other people that were around me, sometimes they couldn’t find the paper, the place where we were at, so I was over there helping this one and helping that one find the paper and things like that.

**Interviewer:** So you were able to help your peers in the group.

**Interviewee:** Yeah. Uh huh. And some people who were like, they hadn’t been there for a while and didn’t know what was going on, I kind of explained where we had gotten to, you know. And I would show the - if I’d done it in writing on my paper, I’d show them the paper, you know. And when we went around the room a lot of times we just went around and we’d say like one word. How do you feel today or how did you feel yesterday? And one of my all time answers was, “I feel like I’m dead, but I’m alive.”

You know, I would say, “Hey, this has been a bad week. Anybody else had my problems, you know?” And we’d give information
too, right. They’d ask a question and I’d say, “Hey, it’s like this.” And I would give them answers. So I did the talking for a lot of people, but they saw if I said something they wouldn’t feel afraid to say what they needed to say. I was like in the center, so they -

*Interviewer:* So you felt comfortable opening up about your feelings and what was inside.

*Interviewee:* Yeah. I felt comfortable telling them about my mental illness. They asked some questions about my pacemaker, blah, blah, blah. And then insulin dependent diabetic. They asked me medical questions, which I did not mind answering. A lot of people, you know, like some had just started using insulin. “How’d you do this, you know?”

And medical questions as well as the physical and mental problem questions. And I was willing to tell them, you know, going back into my high school years where my mental illness first started, right. And I would tell them about my stay in CPI and Community Health Partners, Memorial, so on and so forth, right. And they would look at me and say, “You really went through that?” And then they would feel afraid looking at me to tell me what that happened to them, you know.

*Interviewer:* Oh, okay.

*Interviewee:* It was a center thing. They found someone who wasn’t afraid to talk, but when I first began the class, oh, boy, you couldn’t get me to say anything.

*Interviewer:* It took some time, huh?

*Interviewee:* Yeah. I wasn’t really leery. I was more or less afraid of what people would say, right, cause on the outside I got treated pretty badly.

*Interviewer:* Like judging and - okay.

*Interviewee:* Yes, yeah, being judged, yeah.

*Interviewer:* Okay.

*Interviewee:* Yeah.

*Interviewer:* How does WMR differ from other treatments you’ve attended in the past?
Interviewee: Oh, okay. How is it different? Okay. Material, for one, was presented in a better manner.

Interviewer: How so?

Interviewee: The wording, how one sentence played off another, what the different medicines meant, what the different terms, meeting to your doctors meant.

Interviewer: Yeah.

Interviewee: It opened up for me a new idea. A new idea for me is like I can be a person now.

Interviewer: So this was something pretty foreign to you and other treatments, this idea that you’re not just an illness, you’re a person.

Interviewee: Yeah. Yeah. They made it like you have to be this way. You can’t be that way. And I’m saying, “Wait a minute. You’re not me.” And I learned talking with different people and doing the exercises and telling them about my meds and how my meds had helped or didn’t help, you know.

Interviewer: Did you feel other groups or other treatments in the past wouldn’t allow you to really open up and -

Interviewee: They - it was typically read this or they would read it and they didn’t give you a chance to answer a question or say, “Hey, wait a minute. I’ve got something else to say.” And they’re already two or three pages past and I’m saying, “Hey, they didn’t give a chance to ask, you know.” At this program, they let you ask the questions you needed to ask and you got answers. And that to me is one of the best ways to learn, to get answers.

Interviewer: So did it feel like - what I’m hearing is as though it felt like there was mutual respect in the group.

Interviewee: Yeah, there was.

Interviewer: But there wasn’t a hierarchy?

Interviewee: That’s exactly it. Everybody was on the same page. Everybody was on the same level.

Interviewer: Nobody was better than anybody.
Interviewee: That’s right. They didn’t disrespect you by saying, “Hey, you’re not important enough for us to hear. If you had something to say, all right, I would say, “Go ahead and say it. We’re here for everybody. It’s not just this one or that one.” And a lot of times they said what was on their mind and they weren’t afraid.

If Yvonne said go ahead and say it, they would. If ___ or ___ would say, “Go ahead and say it,” they would. But yeah, some of the other classes were like closed in and it was like just what they had to say. That’s the way it was. There was no difference. You weren’t allowed to have an opinion. You weren’t allowed to have an opinion, so.

Interviewer: In what ways is WMR similar to other treatments you’ve had in the past?

Interviewee: Okay. Some of the material, doctors, and medicines were the same, similar. Attitude now, some people had a real good attitude and some people didn’t. And that was -

Interviewer: In terms of like the treatment leaders?

Interviewee: Uh huh, and the class itself, every -

Interviewer: Oh, okay.

Interviewee: Yeah. No one was better than anybody else. The staff, you know, that were there allowed us to talk without interfering. They would let the people who needed to say something then say something and they wouldn’t brush them off into another page. They would bring it out and find out how they really felt, you know. If it’d been a bad week for them and they would just kind of tell people what had happened and nobody was listening. They would bring it back to where they could talk, you know, and say what happened to them, how they felt and what was going on with them.

Interviewer: So was that something that was similar to other treatments?

Interviewee: Uh huh, it was similar, but this class itself didn’t rate you, you know. Like you weren’t a number, so to speak. You were a person.

Interviewer: Okay.

Interviewee: That right there.
Interviewer: Okay. Any other similarities though between this group and other groups or treatments?

Interviewee: Yeah, the very people themselves. The other classes had the same format as we had and the information played off one for another, so to speak. One group had this going on. Hey, this one was doing the same thing, only at a different way or different time, you know. So they were together and yet they were - they had their own notebook, whatever, and their own material. And the materials themselves were similar.

Interviewer: I see. It sounds like it was perhaps more so in WMR, the presentation of the material that made it different.

Interviewee: Yeah. It made it easier, that’s my good word, easier. You understood what you were reading. You - and if you had a question here in the WMR class, you could ask without feeling like you were taking up their time, you know, the classes’ time.

Interviewer: Okay.

Interviewee: They allowed you to do this. You wanted an answer, you were allowed to get that answer.

Interviewer: So really that understanding as opposed to finishing the task.

Interviewee: Uh huh.

Interviewer: Okay. Okay. Describe for me what WMR contributed to you or in other words, what was the impact after WMR was complete?

Interviewee: The impact was finally knowing I could be a person, finally believing in me, not afraid to go out in the big bad world and not be able to say something. Now I could say, “Hey, wait a minute, I’m an adult. I’m not two. Treat me as an adult, not my mental illness.” I made more friends, I did, serious time after being here. I made more friends. Like I said, I say hi to anybody and everybody.

Interviewer: So even after the group you’re able to be out there and socialize more.

Interviewee: Uh huh. They brought me out of a shell. I was - had gone into a shell and you know how you try to break out and you can’t? Well, they broke the - it’s like a bird’s egg trying to break out and I finally broke out with the class itself.
**Interviewer:** Maybe you’ve already described this to some extent. How did they help - what did they actually do or the way in which they acted, the group facilitators or the other members of the group, how did they actually help pull you out of that shell? What was the process in which that happened?

**Interviewee:** Okay. It started with me suddenly realizing I’m not trash. I’m adult. I’m not a kid. I’m an adult. Suddenly it showed me that I wasn’t always wrong cause at that point when I started cause I was always wrong. I was never right about anything, no matter what it was.

**Interviewer:** And how did you start feeling that? What - was it people respecting your opinion and wanting you to talk or -

**Interviewee:** Yeah. They drew me out. They said, “Okay, ___. You’re always talking.” You know, cause I always talk a lot. And I was beginning to get that. What’s going on? And ___ would say, “What’s going on? You’re quiet.” And I’m never quiet. ___ will tell you. I am never quiet, ever since the course, all right.

And they’d take time and they’d explain. I’d explain to them what was going on and then they would ask anybody else in the room if they’d had such an experience, right. And then they would say, “Well, wait a minute. I’ve had something similar.” And they would tell me about what had happened to him.

So we were actually drawing each other out. You know, ___ was bringing the focus on the group itself to be able to help cause he said that’s what part of the group was, help for those who needed help, those who really - we had those who really didn’t think they had a mental illness. If they didn’t have a mental illness, why were they in our class?

**Interviewer:** Sure.

**Interviewee:** And things like that. And we drew one another out, right, and they got to where they could draw me out and I said what I needed to say. Other days I’d be joking around having a good time and some of the other clients would say, “You had a good day.” You know, things like that. And then they’d ask me what I had done that day. And some of them that were down, I mean really down, were laughing and spent a lot of joy, you know.

And that’s when I decided that I was not junk. I’m a person. I’m going to break through this wall of prejudice, you know, and I
kicked it in and I punched until I finally got through. That’s where the class - that’s actually where the class became my starting point because I broke through.

*Interviewer:* Okay. What parts of WMR were helpful?

*Interviewee:* The parts on the medicine and how to talk to your doctor and how to be a - actually be a person other than what you feel you are, you can grow more. Some of the information was confusing to me, but.

*Interviewer:* Like what? Can you - anything stick out?

*Interviewee:* Okay. Yeah. They had a questionnaire type thing, right, that we had to fill out. And the questionnaire, some of the questions I didn’t understand. They asked about if you have enough money and things like that. And I’m saying, “Wait a minute.” And so I go on through the thing and you know how you fill in the thing or check or whatever you do?

I found some there that could have been changed, I think, to make it more personal. And that would have like, you know, to me would have been better because when I felt it the first time and then the second time, I saw myself where I grew and I wasn’t afraid. That’s why I said that I grew. I could tell through the little, you know, question box.

*Interviewer:* Sure.

*Interviewee:* Yeah.

*Interviewer:* Okay. What about the parts of WMR that were desirable? What made it so you looked forward to it every week?

*Interviewee:* Okay, the material itself. A lot of the material was really, really good. I mean I was excited because it made me know that I understand this. I’m not a complete dunce, you know. I get my questions answered. They had, how would you say, multi questions.

*Interviewer:* When you said you got your questions answered, did you feel as though you got genuine feedback?

*Interviewee:* Yeah. I knew that I knew now, that could read the paper and say, “Hey, that’s me. That’s me.” And I would get positive feedback back from the book itself, on just paper. I’d be reading and all of a sudden I’d read and I’d hear and I’d say, “Hey, wait. ____ , wait.
This is where I’m at, ___.” And they were willing to stop and ask everybody else if they saw themselves in the pages, you know, things like that.

**Interviewer:** What about questions that you might have had or maybe that you saw other group members having where they asked the group or asked the facilitator specific questions like do you think this was a good idea or bad idea or do you think I acted appropriately?

**Interviewee:** We had a lot of that.

**Interviewer:** Do you think - was it helpful for you and other group members to get real no nonsense feedback?

**Interviewee:** Yes. That is a really good point. In a program, the way I look at it, if you don’t get feedback of some kind, it’s not a program cause they’re not telling you what you need to know.

**Interviewer:** Even if it might be hard to take?

**Interviewee:** Hey, if it’s hard to take, it’s true. I’ve been raised through my, you know, relatives, my parents and stuff, that if something is worth striving for, it takes work. And to me, my mental state, right, it took work to get my mental state where it should be. If I got it from here, fine. If I got it from outside, fine. And sometimes they came together, you know, through our facilitators and clients.

Everybody had something that they could add. You never went away like, “What did I just do? I spent 40 minutes doing nothing.” No, that didn’t happen. You had your questions. You had your answers to the questions you had and you could write them down. They even went to - that’s why I said they needed bigger binders and more information.

___ was going and taking maybe one paper and making 20 copies and giving everybody in the room a copy. So we were getting the material anyway, but to eliminate ___ or ___ having to do that, it would have been easier for them just to put it - include it as part of the packet in your notebook, you know.

**Interviewer:** Tell me what you like the least about WMR groups.

**Interviewee:** The least? Well, sometimes they gave you the little stick people, things like that, trying to understand what it meant to me, what I saw. Those were kind of - they say a picture’s worth 1,000 words, right. Sometimes those 1,000 words could be pointed to that
picture and that would have been all right. Yeah. That, to me, was really the thing that I really didn’t understand, why they - and they put little bitty things and put a little saying, but they didn’t put what it actually meant. That was the thing that I least liked. They didn’t tell me what the - they had the little sayings, but a lot of times it didn’t ring true.

Interviewer: Okay.

Interviewee: Yeah. That was the least that I disliked.

Interviewer: Okay. Anything else about it that you -

Interviewee: No, no, no.

Interviewer: What was the hardest part about attending WMR groups?

Interviewee: The hardest part to me was remembering what day my group was cause I had so many. I was taking Bridges, Wrap. Well, it was when we’re talking about. And then there was another one that I was taking. Yeah, it was the creative writing class. I was taking all four of them at once, you know, so my days, all right.

Interviewer: Sure.

Interviewee: So I was active and all the materials kind of overlapped and I knew where and I felt good because I’d already maybe had one and things like that. Yeah.

Interviewer: What about when you were actually in the group? You got there, it sounds like you had a lot to keep track of, but once you actually got to the group.

Interviewee: The focus was brought back to what we were studying. Maybe we were on chapter three or chapter four or whatever and it was all brought back to this chapter.

Interviewer: Okay.

Interviewee: And they had this thing where they put the thing here and there was a light there and it shined on the wall. We had that. We did a lot of that, which was nice, and they gave us copies of all those. So it was nice. And they explained a lot what the pictures meant, you know, from their teacher’s manuals. They explained, but I’d have liked to have had them here where I could see it and listen as they’re reading it.
Interviewer: I see.

Interviewee: I’m one of those how would you say? I have to see as well as hear something.

Interviewer: Sure.

Interviewee: Yeah.

Interviewer: What did you do during participation in WMR that helped you?

Interviewee: Okay. I spoke about the things that had happened to me in my early years and so on. I’ve explained how my mental illness progressed. It’s like sugar. It progresses if you don’t control it and mine was because I was on the wrong medicines there for a long time and they found out that I was literally on lithium. And they finally got me on ___.

Okay. Got me to the right doctor, which was Dr. ___ who is now the heard of the ward and the right caseworkers, right. My caseworker, ___ is really spectacular. She’s a good egg. I like her a lot. The one I had before her I did not like and we - I, right after the first visit with her, I told a couple of people, told Dr. ___ that I didn’t like her and I’d prefer to have someone else. So next thing I know, I had ___, so it works.

You know, and here if there’s something that you need to try and get an answer to, they try and give you either an address or telephone number. You know, you need some information or something, they did all that. They told you numbers for ___, caseworkers, things like that. So they dealt with everything from housing to getting you to see a doctor, so.

Interviewer: Okay.

Interviewee: Yeah.

Interviewer: What did the facilitators deliver in WMR? What did they do that was helpful to you?

Interviewee: Okay. ___ and ___, if there was a question that I had, they wouldn’t hesitate to stop and answer the question and there would be others had about the same questions, so they helped by stopping. And if they were reading a lot of material, I would have them stop and define just what they read because I didn’t understand it. “Hey, tell me, what did you read? You’re reading
all these papers and all these words. Come back here and talk to us down here. I’m not way up there with you. I’m down here sitting in a chair, right.”

And there were others who had the same problems, so to me it would have been better if I’d have had, like I said, had what they had written down in their teacher’s manual or what they showed on the wall so that I could actually see and hear the information I’m getting.

*Interviewer:* Okay. Kind of keep that material.

*Interviewee:* Uh huh.

*Interviewer:* Okay.

*Interviewee:* Yeah.

*Interviewer:* Okay. Did WMR help you in a way that was different from other treatments you’ve attended in the past?

*Interviewee:* Yeah, it did. It made me feel like I am real, not a statue, that I feel like everybody else does, you know. I can have a bad day as well as I can have one good day. Hey, some days are spectacular for me, believe it. There are those days I am so down, just leave me be and they wouldn’t know. And they cared for me as a person. I give that to all the staff people here, but specifically to ___ and ___ and ___. They say, “Hey, girlfriend. I’ve been there.”

And see, the facilitators are clients too, so they know where we’re coming from. They know how we feel when something is being said. You can tell when the frown on somebody’s face or, you know, gritting of teeth or raising their eyes, no, and shaking their head, you know.

*Interviewer:* So did it seem like the relationship between yourself and the facilitators was, I don’t know, maybe more intimate, closer than other treatments?

*Interviewee:* Yes, yes. That’s one thing that I agree with. Everybody, this is about the way we had our tables, right, and everybody had an opinion. Nobody was treated like they were not worth having an opinion. If they had an opinion, they felt free to say that opinion or stop, “___, please tell me. I want an answer.” And it goes for everybody as well as for me.
But I’m one that I’d pound on the table. “Hey, wait.” They kind of drew me out and you didn’t feel like you were interrupting class. You felt like you should be here and yet you are a part of the class. You’re a part of the whole. Without you, there isn’t any whole. You know what I mean? A lot of people don’t understand that when I say that.

In other words, there’s __ and __, me and you and this person and that person and that person and they all have something that they’re trying to work towards, trying to work through. And the facilitators allowed them to work through their, actually beat the door down, so to speak. You know, to me, that’s what the facilitator needs to do, break down all those barriers. And don’t tell me we don’t build up barriers around ourselves because we do. I have seen so many besides me.

**Interviewer:** I agree.

**Interviewee:** Like yeah, like through the wall. And it was so good because there are those that were so shy. They’re not shy now. They come put their arm around me, say, “Thank you.” And see, I shouldn’t say that. That’s tooting my own horn, but I’m a talker and I work in the clothing closet and I do other things, like on the phones and stuff.

And I have gotten to the point where I can be myself and laugh, just like laugh out loud. Before, I was afraid to even be, you know, have any kind of emotion, I guess you’d say, afraid to say what I needed to say. I was taught to be, to speak up for myself. And a lot have learned from that as well as me, so you can’t say just me when the entire group did that.

**Interviewer:** Sure.

**Interviewee:** Broke through those hard walls, those hard spots. “___, I can’t get past this.” ____ will say ______, I guess, what you’d call a ______. Oh, you should hear ___’s story. It was wonderful. I felt so good when he, you know, divulged to the whole class, you know. That’s a hard thing to do.

**Interviewer:** So the idea of the people leading the group having had their own history of difficulty made a difference?

**Interviewee:** Uh huh. It gave them a compassion for the people around us as well as those outside our door around the - outside the door, outside itself.
Interviewer: And do you think it would have made a difference for you if the people leading the groups were “professionals” who hadn’t had any history?

Interviewee: Exactly.

Interviewer: Would that have made -

Interviewee: That had no history of what we were through, they couldn’t have taught the class. They wouldn’t have understood it. Understanding a mental illness, I know people who even their families don’t understand it. You have to know how to deal with a person with mental illness. You have to have been around them to understand them. We’re not stone like a lot of people think, all right.

We’re the bad person who yells and screams on the bus or we cry or we get angry. We’re not allowed to get angry. “Oh, your mental illness is just acting up. Have you taken your medicine today? What’s wrong with you? Get out of it. What’s wrong with you?” You know, things like that and -

Interviewer: Whereas “normal” people are allowed to have bad days.

Interviewee: That’s right. That’s right. That’s right. If they came in here during one of our classes they’d be looking around. I’m serious. Yeah. They don’t understand mental illness and that’s why now I can say, “Hey.” I got them in my church even last Sunday. I stood up and they gave us a, you know, they had one of those, right, and we talked.

And I told them, “I have a mental illness,” and I gave them my description. I’m a bipolar manic schizophrenic affective. Say that five times, that’s hard. And I stood up and I said that. And after it was over there were people coming up to me and were telling me that they loved me so much because I said what I thought and it had been a long time since I was able to even stand up in church and talk.

And she kind of, different ones came up and hugged me and says, “I’ve got a son who just committed suicide. I’ve got a daughter,” you know, things like this. “He’s a bipolar. We can’t handle her,” and so on, looking for me some information. And I always come here and scream at ___ or ___ or one of them. When I need information, I need it now.
Interviewer: I’m curious in what way WMR was helpful to you that’s similar to other treatments in the past.

Interviewee: Okay. The Bridges class, right. I took it. I really enjoyed Bridges. Some of the things that were taught in this class like about the different like schizophrenia, bipolar, and so on was in more in view in the Bridges class than it was here. And I think maybe if they would have covered it more in this class they would have gotten more out of a class like Bridges or Wrap, you know.

Interviewer: So just material and information itself.

Interviewee: Uh huh, uh huh. And the doctors, they had doctors’ numbers and things like that. I think they should have been included in both books, one playing off another. If you can’t reach one, you can do another and they can always go back and forth and check materials or get a number from another book or something. But I think those numbers should be in both books.

Interviewer: Any other similarities between WMR and other treatments?

Interviewee: Yeah.

Interviewer: That was helpful to you.

Interviewee: Yeah, allowing me to talk. Once I broke through the wall, allowing me to tell them how I feel, not being ashamed of having a mental illness because before I broke through I was so ashamed. It was like a come down to me. People would say stuff and I’d just start crying and go off in the corner.

Interviewer: So even before WMR you felt comfortable opening up and -

Interviewee: Uh huh. Well, it went through when I was in the class itself. I didn’t feel comfortable being with other people. I really did not. I, like I said, alone in a crowded room and when I finally took that, you know, and then the Wrap, I started seeing things, but a lot of confusion. That’s a big word, confusion. That takes a lot for me. And when I finally got into the WMR class, right, it broke through the wall. So now I know that it doesn’t have a mental illness, I’m a person first, then a mental illness.

Interviewer: Okay. It might seem like an obvious question now. Did you benefit from WMR?
Interviewee: You’re right, it is an obvious question. Yes, I did. I benefited quite a bit from it. If I hadn’t have taken it, I think I would have either been in the hospital right now or had a nervous breakdown, one of the two. The way I was going I needed that structure that WMR gave me and it was a good structure.

That’s another thing too. Some of the other programs don’t have a structure. What I mean by structure is like this is the day, what’s today’s topic, how many questions, you know, do we have a little thing that we have to fill out after each of the things, after each chapter, things like that. Structure was good, but then they broke the structure when it needed to be broken, when -

Interviewer: Okay. So they didn’t stick to it 100% of the time.

Interviewee: No, no.

Interviewer: Okay.

Interviewee: And I’m glad about that because there were a lot of people besides me that needed to be able to talk without being, how would you feel? Okay, give you an example. Best of my knowledge, being in here and going out there and saying in here what you’ve said by somebody else who wasn’t even in the class, now things like that. And that had happened and that’s when we went to the privacy clause. What’s said here stays here, you know.

Everybody’s not at the same knowledge level, I would say, all right. But that right there was one thing that I thought needed to be addressed more so by all facilitators, that what’s said here stays here. That’s only fair. People get to where they can loosen up and tell you what’s going on and how they feel during the day and what’s happening with them. Yeah, trust.

Interviewer: Uh huh. You might have already answered this to some degree as well. Would you like to continue participating in a similar treatment?

Interviewee: Oh, yes.

Interviewer: Yeah.

Interviewee: Oh, yes.

Interviewer: Why?
Interviewee: Oh, yes, yes. Because I found out that the material and the facilitators helped me. I broke through that wall. I don’t want to go back. I want to go further in my growth, not standing here and stagnant. I want to take a step at a time. That’s how far I want to go. So for another class, oh, yes, oh, yes.

Interviewer: Would you recommend to others to participate in WMR?

Interviewee: I’ve already done that.

Interviewer: Okay. And again, why?

Interviewee: Because it was such a good program and I thought the material was in all when you come right down to it, presented well. I still say I would have liked to had the, what the facilitators were reading in front of me so I could see what they were reading and read along with them. That’s, you know, right there. And yes, I would recommend it to anybody and everybody and I have already done that.

Quite a few people ask me how I felt about the program and I says, “I’ll tell you what. If you want to grow, that’s the program to go to.” I tell them about Bridges and Wrap. And then there’s one, Climbing Into the Driver’s Seat, that I haven’t taken yet, but I haven’t filled out my paper.

One other thing we were talking about was the welder’s toolbox. I haven’t done my welder’s toolbox yet. We were given a plastic when we graduated about that big with a blue lid and little things in it, you know, for each part of the program we had, which was really nice. And we had a cake and we had, we got diplomas, yes.

Interviewer: Nice.

Interviewee: Yeah. So, yes, I would, you know, to anybody who wanted to ask me what programs I had attended, I would just read them off and I’d say you - but and I always tell them, “Start with WMR and then go to Wrap and then it’s Bridges.” It’s like one. And then you know what I’d also like to see? All the programs grouped together like college courses.

Now, I know that’s weird, but like if you take this one and then you can take this one and, you know, vary it through different months, right. And that way they could have a facilitator for each class, two for each class. ____ has one. I think she does Wrap, but
I’m not sure. Don’t mind me. Yeah, I would definitely recommend it, yes.

*Interviewer:* Any remaining last comments that you’d-

*Interviewee:* Yeah. I have one comment that I want to make. If you’re looking to grow, the WMR class to me is the class you should take first because that connects with everything else like Wrap and Bridges and even the Driving Into the Front Seat or whatever it’s called, okay. Yeah, those go hand in hand. I think if you’re gonna take one, take the second one, take the third one, you know.

And we should be given some kind of incentive like maybe a free meal or something for taking the class and they do that anyway. We get a free meal if you take the class. But I’m talking like pizza or something like that, you know, to celebrate that you’ve finished and so on. And we always have cake and so on. So, but I think that they should be like a college course, you know, so many points, something else happens.

*Interviewer:* Oh, okay. I see.

*Interviewee:* So, yeah.

*Interviewer:* Okay. Thank you.

*Interviewee:* Yeah. Thank you.