A Thesis

Entitled

The Role of the Wellness Management and Recovery (WMR) Program
in Promoting Social Support

By

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Submitted as partial fulfillment of the requirements for
The Master of Arts degree in Psychology

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To many consumers, recovery is much more than just a return to a normal state of functioning or symptom remission: it is a journey (Deegan, 1995). Social support has been found to play an important role in this recovery journey (Frese & Davis, 1997) for individuals with serious mental illness (SMI). However, individuals with SMI have been found to have social networks that are one-half the size of those of the general population (Corrigan & Phelan, 2004; Wilson, Flanagan, & Rynders, 1999).

Many individuals with SMI have a dual diagnosis for co-occurring substance use disorders (MacDonald et al., 2004), and the recovery process is not unique to the field of mental health (e.g., other health arenas such as cancer and substance abuse also address recovery processes). Today, in the age of the consumer-survivor movement, where the client is an active and informed participant in their treatment and recovery (Gonzalez, 1976; Wilson et al., 1999), there is much debate about the definition of recovery.

This study represents an integration of the current recovery and social support literature with an evaluation of the Wellness Management and Recovery (WMR) program. The WMR program is an ongoing, multi-site project which is designed to promote mental health recovery among individuals experiencing severe and persistent mental illness in the community. The current research was an adjunct to WMR and examined how this recovery program affects the quality and quantity of the social support of the participants. The present study was designed to evaluate whether a recovery-oriented program helped individuals with SMI to gain not only in number of social supports (quantitatively), but also whether these supports were perceived to be meeting their needs (qualitatively). Results found that participants successfully completing the WMR program showed a significant increase in both quantity and quality of their social support networks. Exploratory analyses of follow-up data, as well as an open-ended question regarding the most important persons in the lives of participants (Intimates versus Friends), are also discussed.

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Chapter One

Introduction

Social Support

Social support is a complex construct that involves not only the number of people with whom an individual interacts, but also how that individual perceives the quality of the interactions with others (Corrigan & Phelan, 2004). Meta-analyses have found a significant relationship between psychological well-being and social support (Wilson, Flanagan, & Rynders, 1999). Social support has been found to be a key aspect in the recovery process (Frese & Davis, 1997) for persons with serious mental illness (SMI). Social support also plays an important role in coping and adjustment in non-clinical populations, as well as for individuals with SMI (Rogers, Anthony, & Lyass, 2004). In general, individuals who do not have a strong social support system are at greater risk for developing psychological disorders, as well as requiring a longer recovery period from such disorders (Pevalin & Goldberg, 2003).

Social support can be defined by both objective and subjective factors (Corrigan & Phelan, 2004). Objective factors of social support are the number / quantity of people with whom the individual with SMI interacts—his or her support network (including friends, family, coworkers, etc.). Subjective factors of social support are the person's perception of the quality of these interactions with their support network; such factors are often measured on a Likert-type scale using “satisfaction” verbiage as anchors (Corrigan

& Phelan). The recovery process is positively associated with both objective and subjective factors of social support (Corrigan & Phelan).

For the general population, social support has been associated with numerous mental and physical health outcomes, such as depression, anxiety, overall functioning, improved life satisfaction, greater coping skills with daily stressors, and recovery from chronic illnesses (Rogers et al., 2004). Symptoms of SMI have been found to decrease as life satisfaction increases; because greater social support has been associated with increased life satisfaction, it follows that improved social relationships (for some individuals) helps to improve mental health (Markowitz, 2001). Certain aspects of social support, such as its buffering / protective effects from stressful events, appear to be the active components in helping to improve individuals' coping mechanisms, reduce stress, and improve life satisfaction (Rogers et al.).

Perception of support may be key to stress reduction because it allows the individual to alter their problem-solving behaviors and coping strategies and it allows them to change how they appraise the stressful situation (Cohen, Underwood, & Gottlieb, 2000). By feeling as though they are a part of a social group, individuals may have a greater sense of stability and self-worth, have more positive moods, thus improving their overall level of well-being (Cohen et al.). Another possible alternative to how social support actively benefits individuals is the buffering hypothesis (Cohen & Wills, 1985). According to this hypothesis, social support protects the individual both physically and emotionally from stressful life events (Cohen & Wills; Wilson et al., 1999).

Thus far, the literature regarding social support for individuals with SMI, has found that having social support is associated with the following: fewer psychiatric

hospitalizations, greater stability in psychiatric residents, and greater access to outpatient substance abuse and health services for homeless individuals (Rogers et al., 2004). Perception of social support has also been found to be related to depression (Rogers et al.). Individuals who reported greater levels of satisfaction with their social support networks report less depressive symptomatology (Corrigan & Phelan, 2004). Individuals with SMI who report having larger and / or more satisfactory social support networks also indicate better quality of life (Corrigan & Phelan). In a study by Corrigan and Phelan, 176 individuals with SMI and a significant functional disability (resulting from the SMI) completed quantitative measures (including the Social Network Scale and the Recovery Assessment Scale), as well as the Brief Psychiatric Rating Scale (a semi-structured interview). Results showed that individuals with larger social networks and greater levels of satisfaction with their networks reported higher levels of certain aspects of recovery, such as hope and being more goal- and success-oriented (Corrigan & Phelan).

The literature has shown that social support is an important factor in the recovery process for depression, among other disorders (Pevalin & Goldberg, 2003). A study by Pevalin and Goldberg indicated that low social support is associated with increased likelihood for onset of SMI and decreased chance of recovery from SMI. In this study, social support was measured by five items designed to assess instrumental social support (e.g., having someone to help in a crisis, having someone who will listen, having someone to count on to offer comfort). Responses to these five items had three categories: no one, one person, or more than one person. The scale was dichotomized into low versus high social support, with low social support representing the lowest quartile of the scale. Social support becomes problematic for individuals with SMI when higher levels of

support are desired than are available. This study consisted of more than 5,000 British households (data from 10,000 individual interviews), collected over eight yearly intervals, and was measured by a 12-item General Health Questionnaire as an indicator of minor psychiatric morbidity (Pevalin and Goldberg).

It has been suggested that severity of an individual's mental illness may be affected by their interpersonal well-being (Markowitz, 2001), and lack of social support is related to greater psychological distress (Wilson et al., 1999). Lower levels of interpersonal well-being may be the result of social isolation due to the adverse and, at times, consuming nature of SMI.

The symptomatology of SMI can make social interactions a difficult experience, and can make social relationships even more difficult to maintain (Markowitz, 2001). Individuals with SMI have been found to have social networks that are one-half the size of those of the general population (Corrigan & Phelan, 2004; Wilson et al., 1999). In addition to symptomatology, other reasons for the difficulty in maintaining adequate social networks include: loss of former employment / social status, isolating themselves, repeated hospitalizations, uncharacteristic / uncontrollable behaviors, and a "toxic" family environment that is critical and emotionally labile (Wilson et al.). The resulting withdrawal and rejection from others often leads to fewer relationships, or places more strain on those relationships that have been maintained (Markowitz).

As expected, one of the primary concerns of many individuals with SMI involves friendships: making and maintaining friends, as well as overcoming loneliness (Markowitz, 2001). Five areas of support that friends were able to provide have been identified as: companionship, emotional, financial, informational, and services (e.g.,

helping around the house) (Wilson et al., 1999). The companionship aspect was most effective in improving psychological well-being and decreasing an individual's loneliness. In addition, social support that is a reciprocal interaction increases psychological well-being, while having friendships is related to increased happiness in general (Wilson et al.).

The idea of reciprocal interactions with peers is an important aspect in relationship development because it helps individuals to develop a sense of autonomy and competency, which results in greater self-esteem. Reciprocity also makes the social support network stronger and more effective, decreasing the probability that the system will break down (Wilson et al., 1999). Although improved social relationships have been found to increase life satisfaction, thereby suggesting that social relationships may help to improve mental health, the reverse may also be true: more severe symptomatology leads to poor interpersonal relationships / social interactions (Markowitz, 2001). Individuals with SMI tend to utilize their social network less when they are stressed, and symptom severity is exacerbated when individuals with SMI have inadequate social support (Wilson et al.).

The Role of Social Support in Other Health Arenas

The recovery process is not unique to the field of mental health. For individuals with long-term health problems (e.g., cancer or substance abuse) or for those involved in recovery-oriented programs, (e.g., 12-step programs for recovering substance users), social support is a key component to helping the individuals on their journeys to recovery. For individuals with SMI, substance abuse is common, much higher than that of the general population (Clark, 2001; MacDonald et al., 2004), and many individuals with SMI have a dual diagnosis for co-occurring substance use disorders (MacDonald et al.).

For individuals with SMI, substance use is often their vehicle for social contact; therefore, dually diagnosed individuals find it very difficult to lose their primary source of social support when they abstain from substance use and the associated peer network (MacDonald et al.).

Contrary to those dually diagnosed individuals who use substances as a social medium, there are those dually diagnosed individuals, as with SMI alone, for which social support serves a protective function by helping them to abstain or minimize their substance use, in addition to the more general protective factors (MacDonald et al., 2004). However, because individuals with dual diagnoses are often at greater risk for homelessness, isolation, and unemployment, they are often at an increased risk for lower levels of social support, resulting in lower resistance to substance use (MacDonald et al.). Providing social support to recovering substance-abusing peers is the key component to 12-step programs (Laudet, Cleland, Magura, Vogel, & Knight, 2004). Twelve-step groups, such as Alcoholics and Narcotics Anonymous, have become the most well-known and widely utilized source of recovery support in the United States. Because substance abuse and psychiatric disorders are prone to relapse, recovery often requires ongoing support (Laudet et al.), especially for dually diagnosed individuals. In addition to relapse, individuals (especially dually diagnosed individuals) must also learn to cope with stigma from society; therefore, the need for support is crucial (Laudet et al.).

Positive relationships have been found for individuals with dual diagnoses between their social supports and the following: reduced substance use, greater sense of personal well-being, and improved mental health (Groh, Jason, Davis, Olson, Ferrari, 2007; MacDonald et al., 2004). The type of social support is key for such positive

outcomes (e.g., the support must be for the individual's abstinence) (MacDonald et al.). Although social support is crucial for recovery from SMI and substance abuse, friendships may begin to fall apart (especially in the early stages of recovery) as the person stops using substances but has not developed a new network of substance-free supports (Laudet et al., 2004). However, as individuals are exposed to abstinent 12-step peers, they can begin to develop the skills necessary to form friendships with substance-free persons (Laudet et al.). There are contradictory findings in the literature about the utilization of 12-step recovery groups by dually diagnosed individuals.

A study by Laudet et al. (2004) examined 99 participants (from baseline to one-year follow-up) involved in a 12-step program of recovery (Double Trouble in Recovery—DTR) that specifically addressed recovery from psychiatric illness and substance use. Results showed that longer participation in DTR during the first year of the study was associated with less substance use during the second year, and this effect was partially explained by a high level of social support (Laudet et al.). Social support was measured using a 14-item scale developed for the DTR study; however, participants were assessed at baseline and one-year follow-up (only substance use was measured during the second year of the study). The authors stated that 99 participants were recontacted at two-year follow-up and 141 participants were recontacted at one-year follow-up (Laudet et al.). The authors reported that the 99 individuals constitute the sample for the study because they obtained complete baseline and follow-up data (Laudet et al.), but assessing social support at two-year follow-up could have benefited this study by: examining the relationship to see if social support was truly a mediator between DTR attendance and substance use, examining whether the effect on individuals' social support

networks (by participating in DTR) was temporary, and determining if social networks that were formed remained stable when substance use relapsed. It was only partially mediated by social support because the authors stated that the association between substance use and DTR participation was also mediated by spirituality (Laudet et al.). Dually diagnosed individuals with greater levels of participation in dual-focus recovery groups (e.g., DTR) and with higher levels of social support report lower levels of substance use (Laudet et al.).

Social support is also a key component to recovery from long-term, serious physical illness (e.g., cancer). A diagnosis of cancer carries with it great emotional, social, and physical distress (Walker, Zona, & Fisher, 2006). Such support enhances the prospect of physical recovery and emotional adjustment for individuals who are already ill (Taylor, Falke, Shoptaw, & Licktmann, 1986). Social support is psychologically beneficial for cancer patients, as a positive relationship between physical / psychological adjustment to cancer and emotional support has been found (Taylor et al.). At times, the cancer patient's social support network can be threatened by the cancer experience (causing feelings of fear / aversion in the supports, but their belief that they must put on a cheerful and optimistic façade for the patient). Although cancer patients often have long-term needs for social support, there is often a substantial reduction in their support network, even within the first year of diagnosis (Arora, Finney Rutten, Gustafson, Moser, & Hawkins, 2007). This reduction can result from a variety of reasons, such as support provider burnout or support provider's perception of decreased need by the patient (although the patient's support needs do not decrease over time, rather they evolve and change in their content and focus) (Arora et al.).

Through victimization by family and friends, physical avoidance by significant others, obvious avoidance of communication about the disease, discrepancies in the supports' behaviors, etc., the patient can feel rejected and abandoned by loved ones (Taylor et al., 1986). Cancer patients report emotional support (from loved ones and professionals) as being most helpful; breast cancer patients (as they move further away from their diagnoses) reported family and friends assisting them with their emotional support (Arora et al., 2007). Emotional support includes empathy, love, caring, and reassurance (Arora et al.). Patients indicate that informational support from professionals is also warranted (Taylor et al.); breast cancer patients reported that family members also assist with informational support closer to diagnosis (Arora et al.). Informational support includes assistance with seeking / understanding medical information, tangible aid, assistance with problem solving tasks / medical decision-making (Arora et al.).

Cancer patients benefit from social support from fellow or former patients because of the empathy, validation, self-disclosure / willingness to discuss the illness by their peers (Helgeson & Cohen, 1996; Pistrang, Solomons, & Barker, 1999). Peer support interventions are said to enhance functional and emotional adjustment to cancer, and the idea behind peer support is that "similar others" have experiential, first-hand knowledge that they can bring to the group. They can share their unique (yet not-so-unique) perspectives to support others in their journey to recovery (Pistrang et al.). Results from a study by Taylor et al. (1986) of 667 individuals who completed a questionnaire survey of cancer patients who either had participated in a cancer support group or had not participated in a cancer support group indicated that unavailable / inadequate social support is only modestly related to joining a (cancer) support group, as most respondents

of the questionnaire indicated having helpful support from family, friends, and medical caregivers (Taylor et al.). Although cancer patients often benefit from peer support groups, it is not an inadequate social support that leads them to their involvement in such groups. This is quite contradictory to the findings in the literature for the social support networks for individuals with SMI or dual diagnoses, who desire (and benefit from) social support but often struggle to receive the necessary numbers of supports and level of satisfaction with these supports.

Like individuals with SMI or dual diagnoses who have to deal with the stigmatization by society, individuals diagnosed with lung cancer often have high levels of distress, not only because of the poor prognosis and the sense of responsibility for causing their cancer, but also because of the stigma which stems from lung cancer's association to smoking (Walker et al., 2006). With physical illness, as well as SMI, two types of social support are often utilized by the support network: Directive and Nondirective support. Directive support involves the support person taking responsibility for tasks and telling the patient what to feel, choose, and do. Nondirective support involves cooperating and assisting the patient but allowing them to have responsibility for their behavior and choices. Nondirective support is associated with better health and mental health outcomes than directive support (Walker et al.)

In a study by Walker et al. (2006), 119 patients were assessed at baseline and for up to three years to examine coping style and social support as predictors of depressive symptomatology among individuals newly diagnosed with lung cancer. The Beck Depression Inventory was the primary outcome measure used for the study, and the Social Support Inventory, which distinguishes between Directive and Nondirective

support, was also used. Results indicated that 29% of patients met criteria for clinical depression. In addition, depressive symptomatology was also related to less adaptive coping methods and Directive instrumental social support (Walker et al.). Those patients who sought social support to help them deal with their illness, who did not have family members giving them Directive support, and who did not disengage from/deny their illness had the fewest depressive symptoms. Nondirective support was associated with more adaptive coping, although Directive support may be helpful in more severe or acute cases (Walker et al.).

The History of Recovery and the Consumer-Survivor Movement

Traditionally, health care and mental health care have followed a prescriptive model in which the client presents with a problem and the health care provider decides what route is best to take to help reduce or eliminate the symptoms (Gonzalez, 1976). However, as consumers gained knowledge about the mental health system, along with societal advances and increased expectations, these individuals became more vocal about their needs (Gonzalez). Beginning in the 1950s, escalating in the 1960s, and becoming solidified in the 1970s, these consumers (who were originally groups organized of lay persons) have organized into consumer-oriented organizations that exist on all governmental and societal levels (Gonzalez). These organizations insist that each consumer has a voice in the delivery and decision-making processes of their mental health services.

Such consumer-oriented organizations pursue a model of care in which the client is an active and informed participant in their treatment and recovery (Gonzalez, 1976; Wilson et al., 1999). The pioneers and followers of this movement support the principle

that no person shall be hospitalized involuntarily, as well as agreeing upon the government's right to subject dangerous (even though mentally unstable) individuals to the criminal justice system (Frese & Davis, 1997).

The consumer-survivor movement began in the United States immediately following the Civil War (Frese & Davis, 1997). The modern American movement, also known as the psychiatric patients' liberation, began in the 1970s when numerous individuals with SMI all over the United States realized that formerly institutionalized psychiatric patients had been treated inhumanely (often receiving demeaning, involuntary treatment) and had been denied their basic human rights (Frese & Davis). Along with such dehumanizing treatment, these pioneers of the consumer-survivor movement began to see that the language that was used concerning their illness and them as individuals was insulting and derogatory. Like many other marginalized groups, individuals with SMI were facing social stigma and discrimination, and they decided to band together to make changes in health care, policy, and their rights and roles as empowered consumers (Frese & Davis). Empowerment is an important concept in the consumer-survivor movement, as well as in recovery research. To the mental health consumer, (personal) empowerment embodies self-determination and control over their lives, in addition to their treatment, and has become the fundamental goal of many consumers (McLean, 1995).

Until recent years, most individuals with SMI were thought to have a permanent condition, and a life full of medication and little hope for regaining any semblance of the lives they once knew (Ellis & King, 2003; Frese & Davis, 1997). It was commonplace that individuals with SMI would be permanently dependent on others, have lowered

expectations for what the remaining years of their life would hold, and take no risks that might cause them any upset (Ellis & King; Frese & Davis). However, after the period of psychiatric deinstitutionalization, the ideas of recovery began to grow (Anthony, 1993). The consumer-survivor movement served to give hope to those diagnosed with a SMI, and as a result the recovery vision from the consumer-survivor perspective is most concerned with the process of recovery (e.g., life's meaning and personal comfort), rather than outcomes (e.g., symptom remission) (Corrigan & Phelan, 2004).

The idea of a recovery vision for mental health consumers has resulted from both the consumer-survivor movement's gains in patient rights, as well as the mental health profession's gains in knowledge about the prognosis of SMI (Ellis & King, 2003). With schizophrenia in particular, the consumer-survivor movement has been striving to change the perception that it always has a long-term, deteriorating course (Andresen, Oades, & Caputi, 2003). The recent concept of recovery has been embraced by consumer-survivors, and the consumer-oriented groups have paved a path to recovery through self-help, support from others, demanding that individuals with SMI maintain the same rights of those in the general population, and promoting that consumers have a voice in their mental health care.

Recovery

Today there is much debate in the literature, among professionals, and among consumer-survivors about the definition of recovery. According to the literature, there are several meanings of the recovery concept which developed from the consumer movement (Andresen et al., 2003). These definitions presumably fall along a continuum: the medical model definition, the rehabilitative model definition, and the empowerment model

definition. According to the medical model, mental illness is viewed as a disease and recovery occurs when an individual is “cured”—when he or she returns to their former health state prior to the onset of their mental illness (Andresen et al.). In this definition, also called clinical recovery, syndromal recovery, or remission, the main focus is the absence of symptoms and the overcoming of disabilities (Corrigan & Phelan, 2004; Ellis & King, 2003). This particular definition of recovery is not used by the consumer or recovery movements, but is used commonly when referring to medications, level of functioning, symptomatology, and hospitalization.

The second definition along this recovery continuum is the rehabilitative model, which states that mental illness is incurable, but the individual is often able to return to some resemblance of their former mental health state (Andresen et al., 2003). This model (also known as the functional model of recovery) states that, although the illness or disability may still be present, an individual changes his/her feelings, skills, goals, roles, and attitudes to continue to function in society (Anthony, 1993; Ellis & King, 2003). According to this model, recovery is an ongoing process, even as symptoms persist, but individuals have hope that their goals in life can be reached (Corrigan & Phelan, 2004).

The final definition along this continuum is the empowerment model. According to this concept of recovery, there are no biological bases for which a person’s mental illness develops; rather, mental illness is caused by extreme emotional distress, and it is a combination of empowerment, understanding, and hope that will lead a person to recovery (Andresen et al., 2003). This vision supposes that everyone is able to fully recover, and with proper self-care and social support, an individual with SMI will be able to be a part of society and feel whole once again (Ellis & King, 2003). In the midst of

these models, an additional definition has been found to be most in line with consumer-survivors: psychological recovery (Andresen et al.).

Psychological recovery has been defined as “the establishment of a fulfilling, meaningful life and a positive sense of identity founded on hopefulness and self-determination” (Andresen et al., 2003, p. 588). Psychological recovery differs from the aforementioned, and has been found to be most compatible with consumer beliefs, because it makes no statement about the cause of mental illness, the necessity of medication, does not define recovery by roles valued by society, or define whether the illness is still present during recovery—it actually allows for the presence of symptoms and ongoing management of the illness in the midst of recovery (Andresen et al.).

The recovery process is said to involve symptom control, dealing with discrimination and stigma by society, regaining a positive sense of self, and attempting to lead a satisfying and productive life (Markowitz, 2001). Individuals are often not only in recovery from their SMI, but also from societal stigma attached to having a mental illness, from the negative effects of unemployment and loss of dreams prior to diagnosis, from shattered opportunities for self-determination, and from the iatrogenic effects that can result from treatment settings (Anthony, 1993). To many consumers, recovery is much more than just a return to a normal state of functioning / symptom remission, a destination, or a cure: it is a journey (Deegan, 1995). It has been described as a deeply personal process, a way of living a hopeful and satisfying life while contributing to society despite one’s limitations (Anthony). Recovery has been said to involve developing new purpose and meaning in the individual’s life as they develop beyond their SMI (Anthony).

One key aspect in the recovery process is social support: having individuals in the lives of those consumers with SMI who can offer them hope, understanding, and who promote self-determination and self-actualization (Frese & Davis, 1997). In addition to the role of people who stand by the individual recovering from SMI, other key factors that contribute to recovery include: medication compliance (especially with bipolar disorder and schizophrenia), knowledge and acceptance of one's illness (including personal responsibility for emotional well-being), spirituality (as a source of hope or life purpose), collaborative treatment planning, role of self-will and self-monitoring of symptoms, and strengths-based interventions (reinforcing the importance of maintaining high expectations and feelings of empowerment) (Ellis & King, 2003). Many of these factors that have been found in the literature to be conducive to recovery are also part of the Wellness Management and Recovery program curriculum and have been identified by consumers (e.g., from qualitative data) as key in their recovery process. In particular, the present study examined the impact that a recovery program had on social support / relationships for individuals with SMI.

The Wellness Management and Recovery (WMR) Program (and Related Studies)

This research represents an integration of the current recovery and social support literature with the Wellness Management and Recovery (WMR) program. The WMR program is an ongoing, multi-site project which is designed to promote mental health recovery among individuals experiencing severe and persistent mental illness in the community. The current research was an adjunct to the program and examined how this recovery program affects the quality and quantity of the social support of the participants. Although the more broad objective of this was to complement the ongoing WMR

program, the specific focus of this research was to assess how the WMR program affected the social support of the groups' participants, thereby promoting mental health recovery (Bullock, Sage, Hupp, O'Rourke, & Smith, 2007; O'Rourke, 2007; Wellness Management and Recovery Website, 2007).

WMR is a psychotherapeutic / psychoeducational treatment program that is structured and curriculum-based. Currently, it is being implemented at sites across the state of Ohio by the Wellness Management and Recovery Coordinating Center of Excellence (WMR CCOE), which is supported by the Ohio Department of Mental Health (ODMH). The CCOE model was carried out by the ODMH beginning in 1999 as part of an ODMH Quality Care initiative. The purpose of the CCOE is to serve as a resource in the promotion, training, and implementation of evidence-based and best clinical practices within the state of Ohio (Bullock et al., 2007; O'Rourke, 2007; Wellness Management and Recovery Website, 2007).

In May of 2006, the WMR program began its dissemination to ten pilot sites across the state of Ohio. Current agency locations include: The Recovery Center of Greater Cincinnati Behavioral Health Services, The Main Place in Licking / Knox County, The Nord Center in Lorain County, Center of Vocational Alternative in Franklin County, Maumee Valley Guidance Center in Defiance County, Bridgeway, Inc. in Cuyahoga County, 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, and Gathering Hope House in Lorain County. In addition are two residential sites, Redmond House and Carpenter House, which are a part of Southeast, Inc.

Contributing members of the WMR CCOE include: WMR program coordinator Kelly Wesp, trainer/consultants Debra Wilcox and Gregg Pieples, and trainer/peer specialists Stephanie Rich and Zan Pesta. Additional contributors to the design and implementation of the WMR program include Mary Kay Smith, M.D. and Wesley Bullock, Ph.D., both from the University of Toledo (Bullock et al., 2007; O'Rourke, 2007; Wellness Management and Recovery Website, 2007).

The theory behind WMR is one of recovery and wellness. By embracing a holistic approach, participants can begin to foster happier and healthier lifestyles. The primary goals of the WMR program are to empower and strengthen the participants by teaching them the necessary skills to achieve the following: 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. Facilitation of the sessions is perhaps the most unique aspect of the WMR program. The group sessions are taught and facilitated by a team comprised of both a staff member of the respective mental health agency *and* a peer specialist, who is also a mental health consumer. Five of the aforementioned locations (Bridges: Mental Health Consumer Empowerment, The Recovery Center of Greater Cincinnati Behavioral Health Services, The Main Place, Bridgeway, Inc., and Gathering Hope House) are also run entirely by consumers; they are consumer-operated sites. Thus, the WMR programs implemented at these five agencies are facilitated by both a consumer staff member and a consumer co-facilitator (Bullock et al., 2007; O'Rourke, 2007; Wellness Management and Recovery Website, 2007).

The WMR curriculum includes a manualized, ten-session approach offered in a group format. A wide range of topics related to general health and wellness issues, as

well as co-occurring mental and substance abuse disorders, are covered during the ten sessions. The specific WMR curriculum is as follows: 1) Mental Health Recovery, 2) Wellness, 3) An Understanding of Mental Health, 4) The Role of Medication in Recovery and Wellness, 5) Learning to Manage Symptoms and Side Effects, 6) Effective Communication, 7) Communicating with Your Providers, 8) Coordinating Your Care, 9) Developing Relationships and Building Social Supports, and 10) Planning for Wellness (Bullock et al., 2007; O'Rourke, 2007; Wellness Management and Recovery Website, 2007).

Research has found that one facilitating factor to recovery for individuals with SMI is the opportunity for interaction with peers (Yanos, Primavera, & Knight, 2001). These interactions have been found to positively impact individuals on several psychological factors: empowerment, self-efficacy, hopefulness, and adaptive coping strategies (Yanos et al.). According to pre- and post-qualitative data from consumers in the program, a key aspect to the success of the WMR program is the group interaction and discussion (Bullock et al., 2007).

Although only session nine (Developing Relationships and Building Social Supports) specifically addresses social support, individuals within the group are encouraged to interact with peers who are also diagnosed with SMI. Such peer interaction (e.g., sharing stories, obtaining information from other consumers, discussing issues most relevant to them, etc.) occurs throughout the group process, and is facilitated by both the professional co-facilitator and the consumer co-facilitator. Although the group process involved in WMR is similar to the process in both support or therapy groups, the WMR program strives to facilitate its psychoeducation component through skill-building,

increasing communication skills, role-play, and modeling. Although group interaction is encouraged from the very first session, at session six (Effective Communication) an association can begin to be drawn between the WMR program and social support. The WMR program provides a secure, protected, and comfortable environment for individuals to practice and exercise the social and communication skills they have gained through WMR's psychoeducation and by modeling other group members and facilitators. Feedback during skill-building exercises, as well as during role-play, helps participants to practice and fine-tune the skills they have learned, in order to put them to use in the community.

The FRIENDS psychosocial rehabilitation program for individuals recovering from a psychiatric disability is similar to the WMR program, but with an emphasis on social support. In this program, like WMR, there is a collaboration between professionals and consumers that promotes self-help values, supports social skills development and healthy social interactions, and endorses recovery (Wilson et al., 1999). The goal of this program is to increase the participants' capacities to maintain durable social networks. The authors state that traditional psychosocial treatment programs focus on managing symptoms and developing social skills but do not focus on helping individuals to develop lasting relationships; on the other hand, more informal social groups aid in the development of friendships but lack formal structure in teaching social skills. Self-help groups offer a forum for friendships and personal growth but lack the valuable collaboration with a professional. The FRIENDS program bridges the gap in the aforementioned models (Wilson et al.).

Results of the FRIENDS program at 12-month follow-up indicate that 76% of the participants maintained an increased size of their social support network. However, the authors did not define how they measured the size of the participants' social support networks, which is a critical piece of information for a study published to endorse a peer support group model. In addition, the program results indicated that 68% of participants showed an increase in social and leadership skills and 30% showed a decreased use of psychiatric hospitalization at 12-month follow-up (Wilson et al., 1999). The WMR program is a recovery model that offers collaboration with a mental health professional, offers a forum for friendship and personal growth, and teaches communication, self-help, and social skills; the purpose of this research study was to determine whether participation in WMR promoted social support in individuals with SMI.

Statement of the Problem

Based on the current literature, and the mental health system's stance on treatment and recovery, future research endeavors that attempt to better understand the impact of recovery programs on an individual's social relationships are vital. Because social support is a crucial aspect in the recovery process, it is necessary to obtain empirical data that supports the efforts of recovery programs to enhance individuals' recovery processes. Social support and relationships often act as a catalyst for improvement in this recovery process, and more research must be conducted to support recovery programs in such efforts.

Purpose of the Present Study

The current study's primary goal was to quantitatively and qualitatively measure how a recovery program (the WMR program) affects an individual's interpersonal

relationships and social support network, both in number and level of satisfaction. The literature has shown the importance of social support to an individual's treatment and recovery from SMI, but for the WMR program this specific variable has not been examined in depth. The WMR program extensively measures an individual's level of recovery from SMI; however, Bullock et al. (2007) did not include any measure of social support in their research protocol, although authors (such as Corrigan & Phelan, 2004; Frese & Davis, 1997; Pevalin & Goldberg, 2003; Wilson et al., 1999) repeatedly describe the important role that social support plays in the recovery process of an individual with SMI. Inclusion of a social support measure as part of the assessment that occurs prior to, and following completion of, the WMR program has provided a better understanding of the role the WMR program plays in affecting an individual's social support. It is important to determine whether this holistic recovery program helps to improve the perceived quality and quantity of social support for participants. In addition, the nature of the relationships / social support network (e.g., Mother, Father, Friend, (Mental) Health Professional, etc.) has been examined at both pre- and post-participation to determine whether completion of the WMR program facilitated a change in the composition of the individuals' social support networks.

Research Questions

Given that the primary purpose of the current study was to assess how the WMR program affects a WMR's participant's level of social support and perceived satisfaction with this support, the following questions were of interest: 1) Does an individual's number of social support persons increase from pre-WMR to post-WMR? 2) Does an

individual's perceived level of satisfaction with this support increase from pre-WMR to post-WMR?

Hypotheses

Research shows that individuals with SMI not only have fewer social supports, but also that these supports are less satisfactory (Corrigan & Phelan, 2004). The present study was designed to examine whether a recovery-oriented program helped individuals with SMI to gain not only in number of social supports (quantitatively), but also whether these supports were perceived to be meeting their needs (qualitatively). Through the WMR program, consumers are given the skills to communicate and cope more effectively in their day-to-day lives, and the present study is designed to discover whether, by aiding these consumers in their journey to recovery, the WMR program also helps them to rebuild confidence to start new relationships and to improve existing relationships through more effective communication (as well as by aiding them in their recovery and giving them hope and increasing their level of self-esteem). The following hypotheses will be investigated: 1) Participants successfully completing the WMR program will show a significant increase in the number of persons in their social support network, as measured by the WMR Social Support Questionnaire. 2) Participants successfully completing the WMR program will show a significant increase in level of satisfaction with their social support network, as measured by the WMR Social Support Questionnaire.

Additional Research Questions

In addition to the aforementioned questions, the present study will also examine the following: 1) What is the relationship between the WMR Social Support

Questionnaire and the recovery measures, both pre- and post-participation in the WMR program? 2) According to the participants' responses to the open-ended question on the WMR Social Support Questionnaire, who are the specific individuals that the participants consider as part of their social support networks? Does this change from pre-to-post participation in WMR? If so, how does the composition of their social support networks change?

Chapter Two

Method

Participants

The current research is an adjunct to an ongoing, open clinical trial that is evaluating recovery outcomes of the WMR program. The participants are mental health consumers who are recruited from their respective mental health agencies. Currently, there are 12 mental health and consumer-operated agencies involved in the WMR program, representing 15 sites across the state of Ohio. The primary referral sources are staff members, case managers, therapists, and psychiatrists working in the aforementioned agencies. Participants must be at least 18 years of age and, although experiencing severe and persistent mental illness, will be legally competent and able to sign consent for themselves.

From a sample of 208 participants at pre-test, 194 participants completed the quantitative portion of the WMR SSQ and 175 participants completed the qualitative portion of the measure. From a sample of 92 participants at post-test, 91 participants completed the quantitative portion of the WMR SSQ and 78 participants completed the qualitative portion of the measure. Finally, from a sample of 54 participants at follow-up, 53 participants completed the quantitative portion of the WMR SSQ and 48 participants completed the qualitative portion of the measure. The sample was quite diverse. The majority of participants were from community mental health centers (74%), while 26% were referred from consumer-operated sites. A little more than half of participants were

female (58% female, 42% male). The vast majority of participants who chose to answer the question regarding their race identified themselves as European American (68%), followed by participants identifying themselves as African American (26%). The number of participants who identified themselves as Asian (1%), Hispanic / Latino (1%), or Native American / Pacific Islander (4%) was relatively small in this sample.

In addition, participants who chose to answer the question regarding last school grade completed reported that the highest grade they have completed ranged from first grade through post-graduate studies, with “high school diploma / GED” reported most frequently (37%), followed by “some college” (18%). Approximately half of participants who chose to answer the marital status question indicated that they have “never married” (53%), followed by approximately one-fourth who endorsed “divorced” (27%). In regard to their current living situation, approximately 58% of participants who answered this question live in their own home, followed by 14% who live in a relative’s home or supervised group living. Of those participants who chose to answer the question of employment status, approximately 45% reported being disabled and 30% reported being currently unemployed. Finally, of those who chose to respond to the question of being in treatment because they want to be, 87% reported that were in treatment because they chose to be.

Measures

WMR Social Support Questionnaire. The WMR Social Support Questionnaire (WMR SSQ) (See Appendix A) is a 7-item, self-report measure used to assess mental health consumers’ number of social supports and perceived level of satisfaction with these supports. The first six items quantitatively assess the number and level of

satisfaction of six domains of social support; the last item requires an open-ended response, asking participants to list the three most important people in their lives (by name and relationship). Participants respond to each item first by checking a box (numbered from “None” through “10+,” by increments of one), indicating how many people in their lives fulfill that particular social support domain. Next, participants respond to each of the six domain items on a 5-point Likert scale (1 to 5), ranging from *very dissatisfied* to *very satisfied*, indicating how satisfied they are with this level of support. If participants checked the box labeled “None,” they are asked to indicate how they feel about not having anyone to support them in that particular domain.

Across the six domains of social support, participants can indicate up to 10 individuals that fulfill each particular domain. Thus, the theoretical range of Total quantitative score on the WMR SSQ is 0 to 60. The theoretical range of Total scores on the qualitative (satisfaction) scale is six (indicating that participants were *very dissatisfied* on all six items) to 30 (indicating that participants were *very satisfied* on all six items). The two scales (number of persons in the social support network and level of satisfaction with these supports) can be used / analyzed individually. Both Total scores (for quantitative social support and qualitative social support) and Average scores (for quantitative social support and qualitative social support) will be examined. Average scores will be calculated in order to gain better psychological meaning of the scores. Because the WMR SSQ is a new measure, it was unclear as to how it would perform. Therefore, both Total and Average scores will be calculated and discussed. There is one additional question on the WMR SSQ that is an open-ended, free-response question to

assess the nature of the relationships of those individuals who play the most significant roles in the lives of the participants (“the three most important people in your life”).

The WMR SSQ was developed specifically for the WMR project and is adapted from two currently existing social support scales: the People in Your Life (PIYL) Scale (Marziali, 1987) and the three-item Social Support Questionnaire (SSQ3) (Sarason, Sarason, Shearin, & Pierce, 1987). An earlier version of the WMR SSQ was given to the WMR trainer/consultants, who provided feedback to improve the wording and language of individual items.

The SSQ3 is a three-item, self-report measure derived from the 27-item Social Support Questionnaire (SSQ), also by Sarason et al. (1987). The three items used were items 19, 22, and 24 of the full scale SSQ (Sarason et al.). Each of the three items was scored for number or perceived availability of social supports and overall level of satisfaction with these available supports. The SSQ3 is similar to the 27-item SSQ in both its social competence and relationships to personality scales. Although its test-retest reliability is acceptable (Sarason et al.), its internal reliability (coefficient alpha for SSQ3 Number = .75; coefficient alpha for SSQ3 Satisfaction = .79) is lower than that of the full scale SSQ, and all the desirable psychometric properties may not be provided by this measure (Sarason et al.).

The PIYL Scale is a 23-item, self-report measure (Marziali, 1987). Each item is divided into two sections: the first 13 items consist of questions concerning availability of casual relationships and friends; the second set of items (10 items) consists of assessing intimate bonds / close attachment figures. Each item addresses two things: first the number of persons available as a support, and secondly the level of satisfaction with

varying aspects of these relationships. Participants respond to each satisfaction item on a 4-point satisfaction scale, ranging from *very dissatisfied* to *very satisfied* (Marziali). The PIYL Scale consists of four support subscales: 1) Friends Available (FAV), 2) Friends Satisfaction (FSAT), 3) Intimate Available (INAV), and 4) Intimate Satisfaction (INSAT). For each of the four subscales, alpha coefficients were indicative of good internal consistency (Cronbach's $\alpha = .88, .93, .93, \text{ and } .94$, respectively) (Marziali). This scale was derived from the Interview Schedule for Social Interaction (ISSI) by Henderson, Byrne, Duncan-Jones, Scott, and Adcock (1980). The formatting of the WMR SSQ was based on Marziali's PIYL Scale. The first six questions on the WMR SSQ were derived from the PIYL Scale (Marziali) and the SSQ3 (Sarason et al., 1987). All six questions were generated based on the two existing scales; however, all questions were adapted (e.g., wording changes) with the help of WMR consultant-trainers. The content of all three questions of the SSQ3 (Sarason et al.) was used on the WMR SSQ. The other three items on the WMR SSQ were selected because they were the best items from the PIYL Scale (Marziali) to address additional domains of social support that had not already been addressed by the SSQ3 (Sarason et al.).

WMR Client Self-Rating Scale. The WMR Client Self-Rating scale (See Appendix B) is a 20-item, self-report measure used to assess mental health consumers' progress on those content areas targeted by the WMR psychoeducational curriculum. These target areas include: progress towards recovery goals, health and wellness habits, and skills for effectively managing one's medication. Participants respond to each item on a 5-point Likert scale, and a total score is obtained by summing all items. In a sample of 214 individuals, the alpha coefficient was indicative of good internal reliability (Cronbach

alpha = .81) (Bullock et al., 2007; O'Rourke, 2007; Wellness Management and Recovery Website, 2007).

Mental Health Recovery Measure. The Mental Health Recovery Measure (MHRM) (See Appendix C) was developed by Young and Bullock (2003) and is a 30-item, self-report measure of mental health recovery. It assesses actual behaviors, rather than intent or attitude, used in an individual's recovery process. The MHRM is based on individual and focus group interviews with individuals experiencing severe and persistent mental illness, and was developed qualitatively from a grounded theory model of recovery. The measure is comprised of eight 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. Participants respond to each item on a 5-point Likert scale, ranging from *Strongly Disagree* to *Strongly Agree*. The potential Total score ranges from 1-120. Psychometric data is indicative of strong internal consistency (Cronbach's alpha = .91). Normative data is available (MHRM Total score: $M = 80$, $SD = 20$). Initial psychometric data for the MHRM was obtained from a psychiatric population utilizing community mental health supports / resources. The MHRM has been found to demonstrate good construct validity, as well as good convergent validity with another measure of recovery ($r = .70$)—the Making Decisions Empowerment scale (Bullock et al., 2007; Bullock & Young, 2003; O'Rourke, 2007; Rogers, Chamberlin, Ellison, & Crean, 1997; Wellness Management and Recovery Website, 2007).

WMR Pre- and Post-Program Feedback Forms. The WMR Feedback Form (See Appendices D and E, respectively) is a 10-item, self-report measure which allows for the

assessment of participants' general views and opinions on the program, including one's expectations, the utility of curriculum material, benefit of the group process, and the effectiveness of WMR facilitators. Questions 1-7 of the measure are answered on a 5-point scale, while the remaining three questions are open-ended qualitative questions. The open-ended questions are used to assess those aspects of the WMR program that each consumer liked the most and the least, as well as the role WMR has played in each consumer's recovery process (Bullock et al., 2007; O'Rourke, 2007; Wellness Management and Recovery Website, 2007).

The Ohio Outcomes, Adult Consumer Form. The Ohio Outcomes, Adult Consumer Form (See Appendix F) is a 67-item, self-report measure designed specifically for use with individuals experiencing severe and persistent mental illness. It is one of the primary tools used to assess the quantitative change over time in the WMR program. The measure is multidimensional and assesses four broad domains: 1) Clinical Status, to measure level of distress brought about by the severity of psychiatric symptoms, 2) Quality of Life, to measure general satisfaction and fulfillment in one's life, 3) Functional Status, to measure engagement in meaningful activity, and 4) Safety and Health, to measure the degree of freedom in one's life from physical or psychological harm, in addition to one's general physical health (Bullock et al., 2007; O'Rourke, 2007; Wellness Management and Recovery Website, 2007). The Adult Consumer Form gathers the individual's perceptions of the following: recovery and empowerment, level of distress due to symptomatology, concerns regarding medications, quality of life, and the effects of health on functioning (The Ohio Department of Mental Health, 2007).

The Ohio Outcomes, Adult Consumer Form consists of 4 primary scales: 1) Quality of Life ($M = 2.83$, $SD = .79$), 2) Safety and Health ($M = 3.52$, $SD = .57$), 3) Symptom Distress ($M = 41.16$, $SD = 15.37$), and the 4) Making Decisions Empowerment scale ($M = 2.63$, $SD = .36$) (Rogers et al., 1997). Psychometric data was gathered from a psychiatric population and has provided evidence of strong internal consistency for the Quality of Life, Symptom Distress, and Making Decision Empowerment scales (Cronbach's alpha = .86, .96, and .86, respectively). The Quality of Life, Symptom Distress, and Making Decisions Empowerment scales significantly correlate with one another, indicating good construct validity. The Making Decisions Empowerment scale (Rogers et al.) has been found to correlate significantly with the Mental Health Recovery Measure (Bullock & Young, 2003)—another measure of recovery—indicating that there is convergent validity as well (Bullock et al., 2007; O'Rourke, 2007; Wellness Management and Recovery Website, 2007). Additional information regarding the development and psychometric properties of the Ohio Outcomes, Adult Consumer Form can be accessed from the ODMH Outcomes website (The Ohio Department of Mental Health, 2007).

Procedure

The current research study is a quasi-experimental, longitudinal design. Data was collected prior to beginning participation in the WMR program (pre-treatment), immediately after completing the program (post-treatment), and at 3-to-6-month follow-up. Although this design did not involve randomization to groups or include a wait-list control group, the study evaluated the proposed role of WMR in increasing the number of individuals in the participants' social support networks and their levels of satisfaction

with this support. After participants were recruited and had consented to participate in the program (see Appendix G for Informed Consent Form), they completed their pre-treatment assessment, and subsequently engaged in a weekly WMR group (for a total of ten weeks).

WMR group sessions are two-hours in length, with a ten-minute break after the first hour. Depending on the composition of the group's members and each group's individual needs, the length of breaks and time in session is flexible, as long as participants spend a minimum of 20 hours in the group. Groups include, on average, eight to ten mental health consumers. Each of the sites followed the same format, curriculum, and procedures for the facilitation of the WMR program sessions (see Appendix H for WMR Curriculum). After participants completed the tenth and final session, participants completed the same outcome measures as they did at pre-treatment. This measurement served as their post-treatment assessment. After 3-to-6 months, participants were contacted by their respective agencies and asked to complete the measures for a third and final time.

Chapter Three

Results

Descriptive Statistics for the WMR SSQ

The WMR Social Support Questionnaire (WMR SSQ) was created based on two existing social support questionnaires, the People in Your Life (PIYL) Scale (Marziali, 1987) and the three-item Social Support Questionnaire (SSQ3) (Sarason et al., 1987). For the WMR SSQ data collected at pre-test (N = 194) on the dependent variable of quantity of social support, a mean of 25.08 (obtained range 1-60) was found with a standard deviation of 14.14. (See Table 1 below for descriptive statistics on both quantitative and qualitative data.) The internal reliability of the quantitative SSQ scale was found to be good, (Cronbach's alpha = .86, N = 194). (See Table 2.) For pre data collected on the dependent variable of quality of social support, in a sample of 175 participants, a mean of 20.52 (obtained range 6-30) was found with a standard deviation of 6.46. Evidence of strong internal consistency was also found on the qualitative SSQ scale (Cronbach's alpha = .90, N = 175). (See Table 3.) The obtained range for average quantity (possible range 0-10) and quality (possible range 1-5) of social support for the sample can be found in Table 4.

Table 1

Descriptive Statistics for Pre, Post, and Follow-Up Total Quantitative and Qualitative Data for the Wellness Management and Recovery Social Support Questionnaire (WMR SSQ)

<i>Total Quantitative and Qualitative</i>	<i>N</i>	<i>Obtained Minimum</i>	<i>Obtained Maximum</i>	<i>M</i>	<i>SD</i>
Total for Pre Quant SSQ	194	1	60	25.08	14.14
Total for Post Quant SSQ	91	0	60	30.43	14.95
Total for FollowUp Quant SSQ	53	9	60	29.85	14.67
Total for Pre Qual SSQ	175	6	30	20.52	6.46
Total for Post Qual SSQ	78	6	30	23.33	6.33
Total for FollowUp Qual SSQ	48	9	30	22.83	6.22

Table 2

Reliability Statistics for Pre Quantitative Data for the WMR SSQ (N = 194)

<i>Item Number</i>	<i>Corrected Item-Total Correlation</i>	<i>Cronbach's Alpha if Item Deleted</i>
PreSSQ21a	.50	.86
PreSSQ22a	.67	.83
PreSSQ23a	.71	.82
PreSSQ24a	.78	.81
PreSSQ25a	.73	.82
PreSSQ26a	.53	.86

Cronbach's alpha for quantitative data = .86

Table 3

Reliability Statistics for Pre Qualitative Data for the WMR SSQ (N = 175)

<i>Item Number</i>	<i>Corrected Item-Total Correlation</i>	<i>Cronbach's Alpha if Item Deleted</i>
PreSSQ21b	.65	.89
PreSSQ22b	.73	.88
PreSSQ23b	.75	.88
PreSSQ24b	.74	.88
PreSSQ25b	.79	.87
PreSSQ26b	.71	.88

Cronbach's alpha for qualitative = .90

Table 4

Descriptive Statistics for Pre, Post, and Follow-Up Average Quantitative and Qualitative Data for the WMR SSQ

<i>Average Quantitative and Qualitative</i>	<i>N</i>	<i>Obtained Minimum</i>	<i>Obtained Maximum</i>	<i>M</i>	<i>SD</i>
Avg for Pre Quant SSQ	194	.17	10.00	4.18	2.36
Avg for Post Quant SSQ	91	.00	10.00	5.07	2.49
Avg for FollowUp Quant SSQ	53	1.50	10.00	4.97	2.44
Avg for Pre Qual SSQ	175	1.00	5.00	3.42	1.08
Avg for Post Qual SSQ	78	1.00	5.00	3.89	1.06
Avg for FollowUp Qual SSQ	48	1.50	5.00	3.81	1.04

WMR SSQ Results Following WMR Participation

Because there were many more individuals who completed both the pre and post (N = 71) WMR SSQ compared to the sample who completed the post and follow-up (N = 12) and pre and follow-up (N = 17) WMR SSQ, a series of dependent (pairwise) *t*-tests were used to evaluate changes on the WMR SSQ following participation. A dependent *t*-test was used to compare pre to post Total quantitative score (questions regarding “how many people...”). The results were significant, $t(70) = 3.08, p < .01$, such that the mean of the post Total quantitative score was significantly larger ($M = 30.72, SD = 14.95$) than the mean of the pre Total quantitative score ($M = 25.85, SD = 12.86$). With regard to the much smaller sample (N = 12) who completed the post and follow-up WMR SSQ, a dependent *t*-test was not significant, $t(11) = 2.02, p > .05$. Finally, with regard to the much smaller sample (N = 17) who completed the pre and follow-up WMR SSQ, a dependent *t*-test was not significant, $t(16) = .11, p > .05$. Using the pooled standard deviation ($S_{\text{pooled}} = 13.90$), a small to medium effect size was found for pre to post Total quantitative score ($ES = .35$). Using the pooled standard deviation ($S_{\text{pooled}} = 15.61$), a medium effect size was found for post to follow-up Total quantitative score ($ES = .48$).

Finally, using the pooled standard deviation ($S_{\text{pooled}} = 12.60$), no effect size was found for pre to follow-up Total quantitative score ($ES = .03$). (See Table 5.)

Table 5

Pre, Post, and Follow-Up Quantitative Data (“how many people...”)¹

<i>Total Quantitative</i>	<i><u>M (SD)</u></i>	<i><u>M (SD)</u></i>	<i><u>t</u></i>	<i><u>df</u></i>	<i><u>p</u></i>	<i><u>Effect</u></i> <i><u>Size</u></i>
Total for Pre Quant SSQ - Total for Post Quant SSQ	25.85 (12.86)	30.72 (14.95)	3.08	70	.003	.35
Total for Post Quant SSQ - Total for FollowUp Quant SSQ	25.92 (14.71)	33.42 (16.51)	2.02	11	.068	.48
Total for Pre Quant SSQ - Total for FollowUp Quant SSQ	27.76 (11.05)	28.12 (14.16)	.11	16	.915	.03

¹Sample sizes for each pairwise comparison are as follows:

Pre-Post Quantitative: N = 71

Post-FollowUp Quantitative: N = 12

Pre-FollowUp Quantitative: N = 17

A dependent *t*-test was also used to compare pre to post Total qualitative score (questions regarding “indicate how satisfied you are...”). The result was significant, $t(56) = 3.10$, $p < .01$, such that the mean of the post Total qualitative score was significantly larger ($M = 23.26$, $SD = 6.76$) than the mean of the pre Total qualitative score ($M = 20.25$, $SD = 6.76$). Again, with regard to the much smaller sample ($N = 9$) who completed the post and follow-up WMR SSQ, a dependent *t*-test was not significant, $t(8) = .97$, $p > .05$. Finally, with regard to the much smaller sample ($N = 12$) who completed the pre and follow-up WMR SSQ, a dependent *t*-test was not significant, $t(11) = .00$, $p > .05$. Using

the pooled standard deviation ($S_{\text{pooled}} = 6.76$), a medium effect size was found for pre to post Total qualitative score ($ES = .45$). Using the pooled standard deviation ($S_{\text{pooled}} = 7.76$), a small effect size was found for post to follow-up Total qualitative score ($ES = .26$). Finally, an effect size equal to zero was found for pre to follow-up Total quantitative score ($ES = .00$) because no change was found comparing the means from pre-test to post-test. (See Table 6.)

Table 6

Pre, Post, and Follow-Up Qualitative Data (“indicate how satisfied you are...”)²

<i>Total Qualitative</i>	<i><u>M (SD)</u></i>	<i><u>M (SD)</u></i>	<i><u>t</u></i>	<i><u>df</u></i>	<i><u>p</u></i>	<i><u>Effect Size</u></i>
Total for Pre Qual SSQ - Total for Post Qual SSQ	20.25 (6.76)	23.26 (6.76)	3.10	56	.003	.45
Total for Post Qual SSQ - Total for FollowUp Qual SSQ	20.11 (7.08)	22.11 (7.85)	.97	8	.359	.26
Total for Pre Qual SSQ - Total for FollowUp Qual SSQ	20.25 (6.27)	20.25 (7.14)	.00	11	1.00	.00

²Sample sizes for each pairwise comparison are:

Pre-Post Qualitative: N = 57

Post-FollowUp Qualitative: N = 9

Pre-FollowUp Qualitative: N = 12

As noted earlier, in addition to Total scores for the WMR SSQ, Average scores were calculated, and a series of *t*-tests were used to determine whether the average changes were significant following WMR participation. As with the analyses for Total WMR SSQ scores, a series of dependent *t*-tests were run to analyze the changes from pre,

post, and follow-up using the Average scores for the quantitative and qualitative portions of the WMR SSQ. As with the Total quantitative scores, significant change was found from pre- to post-test, $t(70) = 3.08, p < .01$, such that the mean of the post Average quantitative score was significantly larger ($M = 5.12, SD = 2.49$) than the mean of the pre Average quantitative score ($M = 4.31, SD = 2.14$). However, due to the much smaller sample sizes at post-test and follow-up, results were not significant. (See Table 7.) These results make it clearer that, on average, participants report that they gained approximately one social support person from pre-test to post-test. As with earlier analyses of the Total quantitative score, effect sizes for Average quantitative scores range from small to medium. (See Table 7.)

Table 7

Pre, Post, and Follow-Up Average Quantitative Data

<i>Average Quantitative</i>	<i><u>M (SD)</u></i>	<i><u>M (SD)</u></i>	<i><u>t</u></i>	<i><u>df</u></i>	<i><u>p</u></i>	<i><u>Effect Size</u></i>
Avg for Pre Quant SSQ - Avg for Post Quant SSQ	4.31 (2.14)	5.12 (2.49)	3.08	70	.003	.35
Avg for Post Quant SSQ - Avg for FollowUp Quant SSQ	4.32 (2.45)	5.57 (2.75)	2.02	11	.068	.48
Avg for Pre Quant SSQ - Avg for FollowUp Quant SSQ	4.63 (1.84)	4.69 (2.36)	.11	16	.915	.03

Average scores were also calculated on the qualitative data, and a series of t -tests were used to determine whether the average changes were significant following WMR participation. A series of dependent t -tests were run to analyze the changes from pre, post, and follow-up using the Average scores for the portions of the WMR SSQ. As with the Total qualitative scores, significant change was found from pre- to post-test, $t(56) = 3.10$,

$p < .01$, such that the mean of the post Average qualitative score was significantly larger ($M = 3.88$, $SD = 1.13$) than the mean of the pre Average qualitative score ($M = 3.37$, $SD = 1.13$). However, due to the much smaller sample sizes at post-test and follow-up, results were not significant. (See Table 8.) These results make it clearer that, on average, participants report that they gained in their level of satisfaction with their social supports, moving from “equally satisfied / dissatisfied” closer to “somewhat satisfied” from pre-test to post-test. As with earlier analyses of the Total qualitative score, effect sizes for Average qualitative scores range from small to medium. (See Table 8.)

Table 8

Pre, Post, and Follow-Up Average Qualitative Data

<i>Average Qualitative</i>	<i><u>M (SD)</u></i>	<i><u>M (SD)</u></i>	<i><u>t</u></i>	<i><u>df</u></i>	<i><u>p</u></i>	<i><u>Effect Size</u></i>
Avg for Pre Qual SSQ - Avg for Post Qual SSQ	3.37 (1.13)	3.88 (1.13)	3.10	56	.003	.45
Avg for Post Qual SSQ - Avg for FollowUp Qual SSQ	3.35 (1.18)	3.69 (1.31)	.97	8	.359	.26
Avg for Pre Qual SSQ - Avg for FollowUp Qual SSQ	3.38 (1.04)	3.38 (1.19)	.00	11	1.00	.00

Correlations Between the WMR SSQ and the MHRM

Pearson correlations were conducted between the WMR SSQ and the Mental Health Recovery Measure for pre-test data. The MHRM Total Score was correlated with both the SSQ Total quantitative score and the SSQ Total qualitative score. The purpose of such analysis was to describe the relationship between mental health recovery and social support prior to participating in the WMR treatment program. At pre-test, the mean for SSQ Total quantitative score was 25.08 with a standard deviation of 14.14. The mean

for Total MHRM score was 78.85 with a standard deviation of 21.38. The relationship between MHRM Total score and SSQ Total quantitative score was significant ($r = .456$, $p < .01$, $N = 174$). Thus, the two measures share 20.8% of the variance. Using correlation as a measure of effect size, this indicates a medium to large effect size (Cohen, 1988). At pre-test, the mean for SSQ Total qualitative score was 20.52 with a standard deviation of 6.46. The mean for Total MHRM score was 78.85 with a standard deviation of 21.38. The relationship between MHRM Total score and SSQ Total qualitative score was significant ($r = .562$, $p < .01$, $N = 156$). Thus, the two measures share 31.6% of the variance. Using correlation as a measure of effect size, this indicates a medium to large effect size (Cohen).

Open-Ended Question Regarding Individuals Viewed as a Social Support

Because the quantity (the number of individuals who act in supportive roles) and quality (how satisfied WMR participants are with this level / quantity of support) of social supports were being examined, an open-ended, free-response question (“Please list the first name(s) of up to three people who are the *most important people in your life...*”) was added as a part of the WMR SSQ to assess the nature of the relationships of those individuals who play the most significant roles in the lives of the participants. This question asked participants to list the name and nature of the relationship of “the three most important people in [their lives].” The name was simply used to personalize the question and to get the participants to truly think about their social support network and those who play the most important role. It must be noted that only the first three responses were coded; if a participant listed more than three responses, only the first

three listed were used. In addition, if a respondent gave only names and indicated no relationship, the data was not used because a relationship could not be inferred.

Based on the data provided by participants of the “nature of relationship” responses, 23 total different responses (e.g., Mother, Cousin, Friend, Significant Other, Health Professional which included Mental Health Professional, etc.) were obtained. (See Table 9 for Pre Frequency data, Table 10 for Post Frequency data, and Table 11 for Follow-Up Frequency data.) Of these 23 different responses, frequencies were also examined based on two broad categories: Intimates and Friends (See Table 12 for Pre Frequency data, Table 13 for Post Frequency data, and Table 14 for Follow-Up Frequency data). The categorical labels of “Intimates” and “Friends” were suggested by the PIYL Scale (Marziali, 1987); however, which of the 23 responses belong in each of the two categories was determined by this researcher. For example, Mother, Brother, Cousin, Self, and Significant Other were determined to be Intimates, whereas Friend / Peer, Neighbor, Health Professional, and Spiritual Support Entity (e.g., Priest) were determined to be Friends.

At pre-test, 188 participants completed the open-ended question (out of 194 who completed the quantitative portion of the WMR SSQ and 175 who completed the qualitative portion at pre-test). At post-test, 81 participants completed the open-ended question (out of 91 who completed the quantitative portion and 78 who completed the qualitative portion at post-test). Finally, at follow-up, 51 participants completed this open-ended question (out of 53 who completed the quantitative portion and 48 who completed the qualitative portion at follow-up). Of those completing this question, there

were 522 total responses at pre-test, 227 total responses at post-test, and 143 total responses at follow-up.

When examining the frequencies of the 23 total different responses at pre-test, participants indicated that Friends / Peers are considered to be “the most important people in their lives” (22%), followed by Mother (12.5%), Sister (11%), Health Professional (10%), and Father and Significant Other (each at 7.5%). However, at post-test, participants indicated that the most frequently occurring “most important person in their lives” is their Sister (15%), followed closely by Friends / Peers (14%), Mother (12%), Brother and Health Professional (each at 10%), and Significant Other (9%). Finally at follow-up, participants indicated that the most frequently occurring “most important person in their lives” is again their Friend / Peer (16.5%), followed by Health Professional (15%), Mother (14%), Sister (12.5%), and Significant Other (9%). (See Tables 9 – 11).

Although the sample sizes for pre-test (N = 188), post-test (N = 81), and follow-up (N = 51) and corresponding number of responses (N = 522 at pre, N = 227 at post, N = 143 at follow-up) were different, it was found that the number of Intimates reported was always proportionately higher than the number of Friends reported (nearly twice as high). At both pre-test and follow-up, Intimates were reported 64% of the time (335 pre Intimate responses out of 522 total pre responses; 92 follow-up Intimate responses out of 143 total follow-up responses), while Friends were reported 36% of the time (187 pre Friend responses out of 522 total pre responses; 51 follow-up Friend responses out of 143 total follow-up responses). At post-test, Intimates were reported 71% of the time (162

post Intimate responses out of 227 total post responses), while Friends were reported 29% of the time (65 post Friend responses out of 227 total post responses).

When examined in terms of Intimates versus Friends, of the Friend category at pre-participation, Friend / Peer was reported 61% of the time as the most frequently occurring “most important person in their life” and Health Professional was reported 27% of the time. Of the Intimate category at pre-participation, Mother was reported 19.5% of the time as the most frequently occurring “most important person in their life,” followed by Sister (17%), Father and Significant Other (each at 12%), Daughter and Son (each at 10%), and Brother (9.5%). Of the Friend category at post-participation, Friend / Peer was reported 49% of the time as the most frequently occurring “most important person in their life” and Health Professional was reported 35% of the time. Of the Intimate category at post-participation, Sister was reported 21% of the time as the most frequently occurring “most important person in their life,” followed by Mother (17%), Brother (13.5%), Significant Other (13%), Father (9%), Son (8.5%), and Daughter (8%). Finally, of the Friend category at follow-up, Friend / Peer was reported 47% of the time as the most frequently occurring “most important person in their life” and Health Professional was reported 43% of the time. Of the Intimate category at follow-up, Mother was reported 22% of the time as the “most important person in their life,” followed by Sister (19.5%), Significant Other (14%), Father and Brother and Daughter (each at 10%), and Son (7.5%). (See Tables 12 – 14.)

At pre-participation, post-participation, and follow-up, a clear gender difference in type of support was found. Because Mother and Sister were among the most frequently occurring responses to the open-ended question (“the most important people in your life”),

it was evident that females are more often members of social support networks of individuals with SMI, at least among this group of participants. However, it is important to remember that there is a slight gender difference in the sample (58% female, 42% male), and this gender difference may have affected the gender difference in type of support found (e.g., women could seek out more women as supports, such as their mothers and sisters).

Table 9.

Frequency Table of Pre-Test Responses to the Open-Ended Question (“please list...”) of the WMR SSQ (N = 188 participants; N = 522 responses)

Nature of Relationship	Frequency (out of 522)	Approx. Percentage
Mother	65	12.5
Father	40	7.5
Sister	56	11.0
Brother	31	6.0
Grandmother	4	.5
Grandfather	2	0.5
Aunt	6	1.0
Uncle	0	0.0
Daughter	34	6.5
Son	34	6.5
Niece	6	1.0
Nephew	3	0.5
Granddaughter	8	1.5
Grandson	1	0.0
Cousin	6	1.0
Significant Other (Spouse, Girlfriend, Boyfriend, Fiancé)	39	7.5
Self	0	0.0
Friend (Peer)	114	22.0
Neighbor	7	1.5
Co-worker (Boss)	3	0.5
Health Professional (Doctor, Nurse, Mental Health Professional)	50	10.0
Spiritual Support Entity (God, Priest, Church Group Leader)	11	2.0
Other	2	0.5

Table 10.

Frequency Table of Post-Test Responses to the Open-Ended Question (“please list...”) of the WMR SSQ (*N* = 81 participants; *N* = 227 responses)

Nature of Relationship	Frequency (out of 227)	Approx. Percentage
Mother	27	12.0
Father	14	6.0
Sister	34	15.0
Brother	22	10.0
Grandmother	2	1.0
Grandfather	0	0.0
Aunt	6	2.5
Uncle	2	1.0
Daughter	13	5.5
Son	14	6.0
Niece	2	1.0
Nephew	0	0.0
Granddaughter	0	0.0
Grandson	1	0.5
Cousin	4	2.0
Significant Other (Spouse, Girlfriend, Boyfriend, Fiancé)	21	9.0
Self	0	0.0
Friend (Peer)	32	14.0
Neighbor	0	0.0
Co-worker (Boss)	1	0.5
Health Professional (Doctor, Nurse, Mental Health Professional)	23	10.0
Spiritual Support Entity (God, Priest, Church Group Leader)	9	4.0
Other	0	0.0

Table 11.

*Frequency Table of Follow-Up Responses to the Open-Ended Question (“please list...”)
of the WMR SSQ (N = 51 participants; N = 143 responses)*

Nature of Relationship	Frequency (out of 143)	Approx. Percentage
Mother	20	14.0
Father	9	6.0
Sister	18	12.5
Brother	9	6.0
Grandmother	1	1.0
Grandfather	0	0.0
Aunt	1	1.0
Uncle	0	0.0
Daughter	9	6.0
Son	7	5.0
Niece	2	1.5
Nephew	0	0.0
Granddaughter	1	1.0
Grandson	0	0.0
Cousin	0	0.0
Significant Other (Spouse, Girlfriend, Boyfriend, Fiancé)	13	9.0
Self	2	1.5
Friend (Peer)	24	16.5
Neighbor	1	1.0
Co-worker (Boss)	2	1.5
Health Professional (Doctor, Nurse, Mental Health Professional)	22	15.0
Spiritual Support Entity (God, Priest, Church Group Leader)	0	0.0
Other	2	1.5

Table 12.

Intimates versus Friends: Frequency Table of Pre-Test Responses to the Open-Ended Question (“please list...”) of the WMR SSQ

Nature of Relationship	Frequency	Approx. Percentage
<i>INTIMATES</i>	(out of 335)	(% of Intimates)
Mother	65	19.5
Father	40	12.0
Sister	56	17.0
Brother	31	9.5
Grandmother	4	1.0
Grandfather	2	0.5
Aunt	6	1.5
Uncle	0	0.0
Daughter	34	10.0
Son	34	10.0
Niece	6	1.5
Nephew	3	1.0
Granddaughter	8	2.5
Grandson	1	0.5
Cousin	6	1.5
Significant Other (Spouse, Girlfriend, Boyfriend, Fiancé)	39	12.0
Self	0	0.0
<i>FRIENDS</i>	(out of 187)	(% of Friends)
Friend (Peer)	114	61.0
Neighbor	7	3.5
Co-worker (Boss)	3	1.5
Health Professional (Doctor, Nurse, Mental Health Professional)	50	27.0
Spiritual Support Entity (God, Priest, Church Group Leader)	11	6.0
Other	2	1.0

Table 13.

Intimates versus Friends: Frequency Table of Post-Test Responses to the Open-Ended Question (“please list...”) of the WMR SSQ

Nature of Relationship	Frequency	Approx. Percentage
<i>INTIMATES</i>	(out of 162)	(% of Intimates)
Mother	27	17.0
Father	14	9.0
Sister	34	21.0
Brother	22	13.5
Grandmother	2	1.0
Grandfather	0	0.0
Aunt	6	4.0
Uncle	2	1.0
Daughter	13	8.0
Son	14	8.5
Niece	2	1.0
Nephew	0	0.0
Granddaughter	0	0.0
Grandson	1	0.5
Cousin	4	2.5
Significant Other (Spouse, Girlfriend, Boyfriend, Fiancé)	21	13.0
Self	0	0.0
<i>FRIENDS</i>	(out of 65)	(% of Friends)
Friend (Peer)	32	49.0
Neighbor	0	0.0
Co-worker (Boss)	1	1.5
Health Professional (Doctor, Nurse, Mental Health Professional)	23	35.5
Spiritual Support Entity (God, Priest, Church Group Leader)	9	14.0
Other	0	0.0

Table 14.

Intimates versus Friends: Frequency Table of Follow-Up Responses to the Open-Ended Question (“please list...”) of the WMR SSQ

Nature of Relationship	Frequency	Approx. Percentage
	(out of 92)	(% of Intimates)
<i>INTIMATES</i>		
Mother	20	22.0
Father	9	10.0
Sister	18	19.5
Brother	9	10.0
Grandmother	1	1.0
Grandfather	0	0.0
Aunt	1	1.0
Uncle	0	0.0
Daughter	9	10.0
Son	7	7.5
Niece	2	2.0
Nephew	0	0.0
Granddaughter	1	1.0
Grandson	0	0.0
Cousin	0	0.0
Significant Other (Spouse, Girlfriend, Boyfriend, Fiancé)	13	14.0
Self	2	2.0
	(out of 51)	(% of Friends)
<i>FRIENDS</i>		
Friend (Peer)	24	47.0
Neighbor	1	2.0
Co-worker (Boss)	2	4.0
Health Professional (Doctor, Nurse, Mental Health Professional)	22	43.0
Spiritual Support Entity (God, Priest, Church Group Leader)	0	0.0
Other	2	4.0

Chapter Four

Discussion

Discussion of Findings

Social support has been found to be a key aspect in the recovery process (Frese & Davis, 1997) for persons with SMI. Having individuals in the lives of those consumers with SMI who can offer them hope and understanding, and who promote self-determination and self-actualization is a vital part of recovery (Frese & Davis). However, the research has shown that individuals with SMI not only have fewer social supports, but also that these supports are less satisfactory (Corrigan & Phelan, 2004). The purpose of the present study was to examine whether a recovery-oriented program (WMR) helped individuals with SMI to gain not only in number of social supports (quantitatively), but also whether these supports were perceived to be meeting their needs (qualitatively). Authors (such as Corrigan & Phelan; Frese & Davis; Pevalin & Goldberg, 2003; Wilson et al., 1999) repeatedly describe the important role that social support plays in the recovery and treatment process of an individual with SMI; however, the WMR program did not include any measure of social support in their research protocol (Bullock et al., 2007), although the program extensively measures an individual's level of recovery from SMI.

The current study found that participants who successfully completed the program (post-WMR) showed a significant increase in the number of persons in their social support network, as well as a significant increase in their level of satisfaction with these

support individuals, as measured by the WMR SSQ. Such results are encouraging, and in the right direction, but this result must be interpreted with some caution because the quantity and quality of social support is unknown for those individuals who have not completed the post-WMR data (but who may have in fact completed the WMR program). Thus, the current sample is biased towards those participants who both finished the WMR program and completed the post-WMR data measures.

Average scores were also calculated on both the quantitative and qualitative SSQ items to offer clearer psychological meaning to the Total score gains seen in the post-WMR data. It was found that participants, on average, added approximately one social support person to their support network following participation in the WMR group. The mean quantitative score, which is the number of individuals acting in various supportive roles, significantly increased from pre- to post-WMR participation by nearly one. Because average scores were used, the psychological inference might be made that from pre- to post-participation in the WMR program, participants (on average) made approximately one social support that was added to their social support network. Qualitatively, individuals were becoming more discernibly satisfied (a significant change from pre- to post-participation) with their social support network. Pre-participation, participants were, on average, “equally satisfied / dissatisfied” with their level of support (mean score = 3.37). However, post-participation, individuals were closer to “somewhat satisfied” with their level of support (mean score = 3.88). (According to the Likert scale, 3 represents “equally satisfied / dissatisfied” and 4 represents “somewhat satisfied.”)

According to the participants’ responses to the open-ended question on the WMR SSQ, Friend, Mother, Sister, and (Mental) Health Professional were the top four reported

“most important people” in the lives of these participants at pre-test, post-test, and follow-up. It was not surprising that Intimates overall (rather than Friends) were reported more frequently as “the most important people” because often family members and significant others are the primary supports for individuals with SMI (Arora et al., 2007; Markowitz, 2001). However, it was interesting that the subcategory Friends / Peers were reported as “the most important people” at both pre-test and follow-up, but not at post-test, given that it was anticipated that participants would have engaged with other group members / participants and formed friendships, thus leading to an expected increase of friends on this open-ended question at post-test (in which measures are given *immediately* following WMR participation). It may appear that these results are contradictory; however, the results are actually just being viewed from two different perspectives (e.g., Intimate versus Friend as compared to the overall 23 categories). Moreover, it is important to remember that the current results reported (those percentages and frequencies discussed) are not an identical sample from pre to post to follow-up due to the problem with participants’ rates of attrition (e.g., incomplete paired data).

It is possible that participants have begun to repair relationships with their family members and loved ones through WMR participation (which may be a part of their recovery process), thus leading to their increased frequencies for Sister (and Mother). It is encouraging that Health Professional, which encompasses Mental Health Professionals (e.g., psychiatrists, psychologists, case workers, social workers, etc.), was found as one of the most frequently occurring “most important people in the lives” of these WMR participants across all pre, post, and follow-up data. In future analyses, a chi square test might be appropriate when cells / categories have been combined (e.g., female versus

male social supports). Currently, a chi square test was not appropriate because this analysis was exploratory in nature, and collapsing the cells would result in the loss of valuable data. Until more data has been collected or more meaningful collapsed categories can be created, a chi square test is not currently feasible.

The present study also examined the relationship between the WMR SSQ and one of the WMR program's recovery measures (the Mental Health Recovery Measure, MHRM). It was found that there is a strong positive relationship between recovery and qualitative social support and a medium to strong positive relationship between recovery and quantitative social support. Thus, as a participant's level of recovery increased, so did their perceived quality and quantity of social support. Likewise, as a participant's level of recovery decreased, so did their perceived quality and quantity of social support. In future analyses of recovery and social support, those participants' scores who deteriorated on the recovery measures (e.g., the MHRM) from pre-test to post-test will be closely examined on the WMR SSQ. In addition, it may be useful in the future to more closely examine the group of participants who reliably deteriorated on the MHRM, the group who reliably improved on the MHRM, and then their mean level of change (e.g., their average level of satisfaction) on the WMR SSQ from pre-test to post-test will be compared. Ideally, those individuals in the deterioration group would not have gained as much, or may have even lost, on the WMR SSQ, compared to those individuals in the improved group, who have gained on the WMR SSQ.

To many consumers, recovery is much more than just a return to a normal state of functioning / symptom remission: it is a journey (Deegan, 1995). It has been described as a deeply personal process, a way of living a hopeful and satisfying life while contributing

to society despite one's limitations (Anthony, 1993). Recovery has been said to involve developing new purpose and meaning in the individual's life as they develop beyond their SMI (Anthony). The inclusion of the WMR SSQ as part of the assessment that occurs prior to, and following completion of, participation in the WMR program has provided a better understanding of the role the WMR program plays in affecting an individual's social support, and an individual's journey to recovery and wellness. Overall, it has played an important role in determining that this holistic recovery program helps to improve the perceived quality and quantity of social support for these participants.

Limitations

Although there were significant findings, four limitations should be noted. First, although follow-up data were reported, it is important to remember that these data were exploratory in nature and are suggestive only of what results might look like as sample size increases. Because of missing data (both due to participants missing responses and missing entire pre-post-follow-up pairs), there was only a sample of 10 who had complete pre-post-follow-up data. Therefore, a one-way repeated measures analysis of variance was not possible for these data at this time, and dependent t-tests were conducted instead. Because of this extremely small follow-up sample size, any meaningful analyses that included follow-up data were precluded.

A second limitation of the study results from the method of data collection itself. Because data was collected at each individual site across the state of Ohio and returned to the University of Toledo research team, it was very difficult to obtain attendance records for each of the groups. Without attendance records, participants may have attended the first session and the last session (to complete both pre-test measures and post-test

measures, for example) and no sessions in between. Although this is an extreme example, the researcher has no way of knowing which participants in the sample have in fact participated in at least eight sessions (which is the preferred minimum number of classes to obtain the maximum benefit from the WMR program and provide the most reliable outcome change data).

A third limitation to the current study is the difficulty in determining whether the participants are thinking of the same support persons or different support persons for each question on the WMR SSQ. Although the open-ended question asked them to list “the three most important people in their life,” it is unclear on the measure whether the person is consistently thinking of the same supports throughout the quantitative and qualitative questions, or whether there is a variety of individuals involved in their lives that they consider to be supports. If they are not thinking about the same individuals for each question, although this is unlikely, then this would be handicapping their Total quantitative score.

The PIYL Scale (Marziali, 1987) handled this potential problem at the outset by asking participants to list the top five most important people in their life (and the nature of each relationship) at the beginning of the Intimate scale, and then asking them to consider only those individuals when answering the questions that followed. These individuals were used for the Intimate items / scale only. For each Intimate item, participants would select from their top five original list those that best fit the question, and then would indicate their level of satisfaction. On the Friendship scale, for each question the participants were asked to indicate the number of friends (1-10) and level of satisfaction with this number (similar to the formatting on the WMR SSQ). Because the

formatting of the WMR SSQ was structured like that of the Friendship scale of the PIYL Scale (and not like the Intimate scale of the PIYL Scale), it was decided to ask one open-ended question at the end of the measure.

Finally, the fourth limitation of the current research study was the inability to absolutely determine where to attribute the change in quantitative and qualitative social support from pre- to post-participation. Although it is likely that some change took place during the course of the WMR program which elicited the significant differences from pre- to post-test, it is impossible to say that such changes were due solely to participation in the WMR program. Because of the nature of SMI, there is flux in the recovery process, moods, relationships, etc. As stated previously, this is an open clinical trial with no control group; therefore, it is impossible to say, with certainty, that any change observed from pre- to post-test was due to participation in the WMR program rather than variables that have not been controlled for.

In addition, it is unknown as to how many participants were involved in other groups or therapy during the course of the WMR program. Because this question of other therapeutic or group involvement was not a part of the measures or demographics, it cannot be determined if a group of individuals involved in such interventions may be significantly increasing the overall scores. Such therapeutic involvements, although not discouraged, could also have played a role in the increases found in social support by aiding these individuals in their recovery process.

Implications

Regardless of the limitations, the current research does have implications for the clinical / applied setting and for future research. The literature has supported the notion

that social support is a vital part of the recovery process. The current study has provided empirical data as to whether a recovery program (specifically the WMR program) promoted social support / relationships in individuals with SMI. Because the number of supports as well as the perceived level of satisfaction with these supports were found to significantly increase from pre- to post-participation, and because the WMR MHRM was found to have medium to strong correlations with both the quantitative and qualitative portions of the measure, it was found that increases in recovery were associated with increases in social support after participation in this recovery program (WMR).

Further research endeavors that attempt to better understand the impact of recovery programs on an individual's social relationships are vital. It is necessary to obtain more empirical data in this area of research because it is known that social support is a key component in the recovery process, and now it is important that recovery programs are supported in their efforts to enhance not only individuals' recovery processes but also their social support networks.

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Appendix A

WMR Social Support Questionnaire

WMR Social Support Questionnaire

The next set of questions is about the people in your life. We want to find out about your social support network and how satisfied you are with your level of social support.

21. How many people do you talk to regularly who share your interests (for example, interests in sports, music, political activity, hobbies, etc.)?

Check one of the boxes:

☐ None
 ☐ 1
 ☐ 2
 ☐ 3
 ☐ 4
 ☐ 5
 ☐ 6
 ☐ 7
 ☐ 8
 ☐ 9
 ☐ 10+

Indicate how satisfied you are with this level of support by circling one item below. (If you checked the box labeled “None,” indicate how you feel about not having anyone.)

1	2	3	4	5
very dissatisfied	somewhat dissatisfied	equally satisfied / dissatisfied	somewhat satisfied	very satisfied

22. How many people can you turn to when you are in trouble and need help?

Check one of the boxes:

☐ None
 ☐ 1
 ☐ 2
 ☐ 3
 ☐ 4
 ☐ 5
 ☐ 6
 ☐ 7
 ☐ 8
 ☐ 9
 ☐ 10+

Indicate how satisfied you are with this level of support by circling one item below. (If you checked the box labeled “None,” indicate how you feel about not having anyone.)

1	2	3	4	5
very dissatisfied	somewhat dissatisfied	equally satisfied / dissatisfied	somewhat satisfied	very satisfied

23. If something unpleasant or irritating happens and you get upset or angry about it, how many people can you tell just how you feel?

Check one of the boxes:

☐ None
 ☐ 1
 ☐ 2
 ☐ 3
 ☐ 4
 ☐ 5
 ☐ 6
 ☐ 7
 ☐ 8
 ☐ 9
 ☐ 10+

Indicate how satisfied you are with this level of support by circling one item below. (If you checked the box labeled “None,” indicate how you feel about not having anyone.)

1	2	3	4	5
very dissatisfied	somewhat dissatisfied	equally satisfied / dissatisfied	somewhat satisfied	very satisfied

24. How many people do you trust to give you honest feedback?

Check one of the boxes:

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
None 1 2 3 4 5 6 7 8 9 10+

Indicate how satisfied you are with this level of support by circling one item below. (If you checked the box labeled “None,” indicate how you feel about not having anyone.)

1	2	3	4	5
very dissatisfied	somewhat dissatisfied	equally satisfied / dissatisfied	somewhat satisfied	very satisfied

25. How many people totally accept you for who you are (on both your “good days” and “bad days”)?

Check one of the boxes:

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
None 1 2 3 4 5 6 7 8 9 10+

Indicate how satisfied you are with this level of support by circling one item below. (If you checked the box labeled “None,” indicate how you feel about not having anyone.)

1	2	3	4	5
very dissatisfied	somewhat dissatisfied	equally satisfied / dissatisfied	somewhat satisfied	very satisfied

26. How many people do you feel truly love you deeply?

Check one of the boxes:

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
None 1 2 3 4 5 6 7 8 9 10+

Indicate how satisfied you are with this level of support by circling one item below. (If you checked the box labeled “None,” indicate how you feel about not having anyone.)

1	2	3	4	5
very dissatisfied	somewhat dissatisfied	equally satisfied / dissatisfied	somewhat satisfied	very satisfied

27. Please list the first name(s) of up to three people who are the *most important people in your life*. Beside each name, list the nature of your relationship with each person (e.g., spouse, significant other, child, friend, peer, parent, step-parent, sibling, (mental) health professional, neighbor, grandparent, etc.).

First Name of Person

Nature of Relationship

Appendix B

WMR Client Self-Rating Scale

Wellness Management and Recovery Scale: Client Self-Rating*

Agency Name: _____ Date: _____
 Pre-Assessment _____ Post-Assessment _____ Follow-up Assessment _____
 Your First Name: _____ Last Four Digits of SNN: _____

Please take a few minutes to fill out this survey. We are interested in the way things are for you, so there is no right or wrong answer. If you are not sure about a question, just answer it as best as you can.

Just circle the number of the answer that fits you best.

1. Progress towards personal goals: In the past 3 months, I have come up with...

1	2	3	4	5
No personal goals.	A personal goal, but have <u>not done anything</u> to finish my goal.	A personal goal and made it a <u>little way</u> toward finishing it.	A personal goal and have gotten <u>pretty far</u> in finishing my goal.	A personal goal and have <u>finished it</u> .

2. Knowledge: How much do you feel like you know about symptoms, treatment, coping strategies (coping methods), and medication?

1	2	3	4	5
Not very much.	A little.	Some	Quite a bit.	A great deal

3. Involvement of family and friends in my mental health treatment: How much are family members, friends, boyfriend/girlfriend, and other people who are important to you (outside your mental health agency) involved in your mental health treatment?

1	2	3	4	5
Not at all	Only when there is a serious problem	Sometimes, like when things are starting to go badly	Much of the time	A lot of the time <u>and</u> they really help me with my mental health

4. Contact with people outside of my family: In a normal week, how many times do you talk to someone outside of your family (like a friend, co-worker, classmate, roommate, etc.)

1	2	3	4	5
0 times/ week	1-2 times/ week	3-4 times/ week	6-7 times/ week	8 or more times/ week

5. Time in Structured Roles: How much time do you spend working, volunteering, being a student, being a parent, taking care of someone else or someone else's house or apartment? That is, how much time do you spend in doing activities for or with another person that are expected of you? (This would not include self-care or personal home maintenance.)

1	2	3	4	5
2 hours or less/ week	3-5 hours/ week	6 to 15 hours/ week	16-30 hours/ week	More than 30 hours/ week

6. Symptom distress: How much do your symptoms bother you?

1	2	3	4	5
My symptoms <i>really</i> bother me <i>a lot</i> .	My symptoms bother me <i>quite a bit</i> .	My symptoms bother me <i>somewhat</i> .	My symptoms bother me <i>very little</i> .	My symptoms don't bother me <i>at all</i> .

7. Impairment of functioning: How much do your symptoms get in the way of you doing things that you would like to or need to do?

1	2	3	4	5
My symptoms <i>really</i> get in my way <i>a lot</i> .	My symptoms get in my way <i>quite a bit</i> .	My symptoms get in my way <i>somewhat</i> .	My symptoms get in my way <i>very little</i> .	My symptoms don't get in my way <i>at all</i> .

8. Relapse Prevention Planning: Which of the following would best describe what you know and what you have done in order not to have a relapse?

1	2	3	4	5
I don't know how to prevent relapses.	I know a little, but I haven't made a relapse prevention plan.	I know 1 or 2 things I can do, but I don't have a written plan	I have several things that I can do, but I don't have a written plan	I have a written plan that I have shared with others.

9. Relapse of Symptoms: When is the last time you had a relapse of symptoms (that is, when your symptoms have gotten much worse)?

1	2	3	4	5
Within the last month	In the past 2 to 3 months	In the past 4 to 6 months	In the past 7 to 12 months	I haven't had a relapse in the past year

10. Psychiatric Hospitalizations: When is the last time you have been hospitalized for mental health or substance abuse reasons?

1	2	3	4	5
Within the last month	In the past 2 to 3 months	In the past 4 to 6 months	In the past 7 to 12 months	I haven't been hospitalized in the past year

11. Coping: How well do you feel like you are coping with your mental or emotional illness from day to day?

1	2	3	4	5
Not well at all	Not very well	Alright	Well	Very well

12. Involvement with self-help activities: How involved are you in consumer run services, peer support groups, Alcoholics Anonymous, drop-in centers, WRAP (Wellness Recovery Action Plan), or other similar self-help programs?

1	2	3	4	5
I don't know about any self-help activities.	I know about some self-help activities, but I'm not interested	I'm interested in self-help activities, but I have not participated in the past year	I participate in self-help activities occasionally.	I participate in self-help activities regularly.

13. Using Medication Effectively: (Don't answer this question if your doctor has not prescribed medication for you). How often do you take your medication as prescribed?

1	2	3	4	5
Never	Occasionally	About half the time.	Most of the time.	Every day.

14. Functioning affected by alcohol use. Drinking can interfere with functioning when it contributes to conflict in relationships, or to money, housing and legal concerns, to difficulty showing up at appointments or paying attention during them, or to increased symptoms. Over the past 3 months, how much did drinking get in the way of your functioning?

1	2	3	4	5
Alcohol use really gets in my way a lot	Alcohol use gets in my way quite a bit	Alcohol use gets in my way somewhat	Alcohol use gets in my way very little	Alcohol use is not a factor in my functioning

15. Functioning affected by drug use: Using street drugs, and misusing prescription or over-the-counter medication can interfere with functioning when it contributes to conflict in relationships, or to money, housing and legal concerns, to difficulty showing up at appointments or paying attention during them, or to increased symptoms. Over the past 3 months, how much did drug use get in the way of your functioning?

1	2	3	4	5
Drug use really gets in my way a lot	Drug use gets in my way quite a bit	Drug use gets in my way somewhat	Drug use gets in my way very little	Drug use is not a factor in my functioning

* Items 1 – 15 adopted from the Illness Management & Recovery Scales with permission

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16. Tobacco use: In the last 3 months which of the following best describes your attitude or behavior regarding smoking or tobacco use?

1	2	3	4	5
I have not thought about quitting my tobacco use.	I have thought about quitting my tobacco use	I have decided to quit using tobacco.	I have tried to quit using tobacco.	I quit using tobacco, or never used tobacco.

17. Healthy life-style choices: How often do you take active steps to try to improve your health (like eating better or getting more exercise)?

1	2	3	4	5
Never	Occasionally	1 – 2 days each week	3 – 5 days each week	Every day

18. Working with mental health medical professionals (psychiatrists, nurses). In the last 3 months, when you have had questions or concerns about the medications you are taking, do medical professionals listen well to your concerns? Do you feel like you are a significant partner with your doctor when it comes to managing your medication?

1	2	3	4	5
Not at all	A little bit	Sometimes	Quite a bit	Nearly all the time

19. Use of wellness plan: Are you using a “wellness plan” as a tool to support your continuing recovery and wellness?

1	2	3	4	5
Not at all	A little bit	Sometimes	Quite a bit.	Very often

20. Recovery philosophy integrated into your life: Recovery includes many processes (like hope, choice, empowerment, self-esteem, balance, and spirituality). To what extent do you feel that recovery processes are a central part of your life and how you see the world?

1	2	3	4	5
Not at all	A little bit	Sometimes	Quite a bit	Nearly all the time

Appendix C

Mental Health Recovery Measure

Mental Health Recovery Measure (MHRM)[©]
(Young & Bullock, 2003)

Your First Name: _____ **Last Four Numbers of Your SSN:** _____

The goal of this questionnaire is to find out how you view your own current recovery process. The mental health recovery process is complex and is different for each individual. There are no right or wrong answers. Please read each statement carefully, with regard to your own current recovery process, and indicate how much you agree or disagree with each item by filling in the appropriate circle.

SD = Strongly Disagree D = Disagree NS = Not Sure A = Agree SA = Strongly Agree

	SD	D	NS	A	SA
1. I work hard towards my mental health recovery.	☐	☐	☐	☐	☐
2. Even though there are hard days, things are improving for me.	☐	☐	☐	☐	☐
3. I ask for help when I am not feeling well.	☐	☐	☐	☐	☐
<hr/>					
4. I take risks to move forward with my recovery.	☐	☐	☐	☐	☐
5. I believe in myself.	☐	☐	☐	☐	☐
6. I have control over my mental health problems.	☐	☐	☐	☐	☐
<hr/>					
7. I am in control of my life.	☐	☐	☐	☐	☐
8. I socialize and make friends.	☐	☐	☐	☐	☐
9. Every day is a new opportunity for learning.	☐	☐	☐	☐	☐
<hr/>					
10. I still grow and change in positive ways despite my mental health problems.	☐	☐	☐	☐	☐
11. Even though I may still have problems, I value myself as a person of worth.	☐	☐	☐	☐	☐
12. I understand myself and have a good sense of who I am.	☐	☐	☐	☐	☐
<hr/>					
13. I eat nutritious meals everyday.	☐	☐	☐	☐	☐
14. I go out and participate in enjoyable activities every week.	☐	☐	☐	☐	☐
15. I make the effort to get to know other people.	☐	☐	☐	☐	☐

Please continue on next page.

SD = Strongly Disagree D = Disagree NS = Not Sure A = Agree SA = Strongly Agree

	SD	D	NS	A	SA
16. I am comfortable with my use of prescribed medications.	O	O	O	O	O
17. I feel good about myself.	O	O	O	O	O
18. The way I think about things helps me to achieve my goals.	O	O	O	O	O
<hr/>					
19. My life is pretty normal.	O	O	O	O	O
20. I feel at peace with myself.	O	O	O	O	O
21. I maintain a positive attitude for weeks at a time.	O	O	O	O	O
<hr/>					
22. My quality of life will get better in the future.	O	O	O	O	O
23. Every day that I get up, I do something productive.	O	O	O	O	O
24. I am making progress towards my goals.	O	O	O	O	O
<hr/>					
25. When I am feeling low, my religious faith or spirituality helps me feel better.	O	O	O	O	O
26. My religious faith or spirituality supports my recovery.	O	O	O	O	O
27. I advocate for the rights of myself and others with mental health problems.	O	O	O	O	O
<hr/>					
28. I engage I work or other activities that enrich myself and the world around me.	O	O	O	O	O
29. I cope effectively with stigma associated with having a mental health problem.	O	O	O	O	O
30. I have enough money to spend on extra things or activities that enrich my life.	O	O	O	O	O

Thank you for completing this measure.

The MHRM[®] was developed with the help of mental health consumers by researchers at the University of Toledo, Department of Psychology. This research was supported through a grant from the Ohio Department of Mental Health, Office of Program Evaluation and Research. For further information, please contact Wesley A. Bullock, Ph.D. at (419) 530-2721 or email: wesley.bullock@utoledo.edu.

Appendix D

WMR Pre-Program Feedback Form

Wellness Management and Recovery (WMR) Pre-Program Feedback Form

First Name: _____

Last 4 Numbers of SSN: _____

Date: _____

Now that you have completed the Pre-Program WMR Orientation Session, please take a few minutes to fill out this survey. We are interested in your feedback about the WMR Pre-Program Orientation, so there are no right or wrong answers. If you are not sure about a question, just answer it as best as you can.

Just circle the number of the answer that best expresses your opinion.

1. Based on the Pre-Program Orientation, is the WMR program what you expected?

1	2	3	4	5
No the WMR program is not at all what I expected.	The WMR program is sort of what I expected.	The WMR program is mostly what I expected.	The WMR program is just about all that I expected.	The WMR program is <u>exactly</u> how I expected it to be.

2. Is the curriculum material and the topics covered by WMR sessions what you need? Do you think that the WMR program is what you need to further your recovery?

1	2	3	4	5
Not at all.	A little.	Some	Quite a bit.	Yes, very much

3. Are the group attendance requirements or the length of sessions too time demanding?

1	2	3	4	5
All of the time too demanding	Most of the time too demanding	Sometimes too demanding	A little too demanding	Not at all demanding

4. Are the WMR handout materials user friendly?

1	2	3	4	5
Not at all.	A little.	Some	Quite a bit.	Yes, very much

5. Is the WMR homework too demanding?

1	2	3	4	5
All of the time too demanding	Most of the time too demanding	Sometimes too demanding	A little too demanding	Not at all demanding

6. Were the WMR group leaders effective?

1	2	3	4	5
Not at all effective.	A little.	Some	Quite a bit.	Yes, very effective

7. Was having other members in the WMR group helpful?

1	2	3	4	5
Not at all helpful.	A little.	Some	Quite a bit.	Yes, very helpful

8. What part or aspect of the WMR program do you like best? _____

9. What part of aspect of the WMR program do you not like? _____

10. How will participating in the WMR program help you in your recovery? _____

Appendix E

WMR Post-Program Feedback Form

Wellness Management and Recovery (WMR) Post-Program Feedback Form

First Name: _____ Last 4 Numbers of SSN: _____

Date: _____

Now that you have completed the WMR Program, please take a few minutes to fill out this survey. We are interested in your feedback about the WMR program, so there are no right or wrong answers. If you are not sure about a question, just answer it as best as you can.

Just circle the number of the answer that best expresses your opinion.

1. Was the WMR program what you expected?

1	2	3	4	5
No the WMR program was not at all what I expected.	The WMR program was sort of what I expected.	The WMR program was mostly what I expected.	The WMR program was just about all that I expected.	The WMR program was <u>exactly</u> how I expected it to be.

2. Was the curriculum material and the topics covered by WMR session what you needed? Was it what you needed to further your recovery?

1	2	3	4	5
Not at all.	A little.	Some	Quite a bit.	Yes, very much

3. Were the group attendance requirements or the length of sessions too time demanding?

1	2	3	4	5
All of the time too demanding	Most of the time too demanding	Sometimes too demanding	A little too demanding	Not at all demanding

4. Where the WMR handout materials user friendly?

1	2	3	4	5
Not at all.	A little.	Some	Quite a bit.	Yes, very much

5. Was the WMR homework too demanding?

1	2	3	4	5
All of the time too demanding	Most of the time too demanding	Sometimes too demanding	A little too demanding	Not at all demanding

6. Were the WMR group leaders effective?

1	2	3	4	5
Not at all effective.	A little.	Some	Quite a bit.	Yes, very effective

7. Was having other members in the WMR group helpful?

1	2	3	4	5
Not at all helpful.	A little.	Some	Quite a bit.	Yes, very helpful

8. What part or aspect of the WMR program did you like best? _____

9. What part of aspect of the WMR program did you not like? _____

10. How has participating in the WMR program helped you in your recovery? _____

Appendix F

Ohio Outcomes, Adult Consumer Form

Ohio Mental Health Consumer Outcomes System Adult Consumer Form A

A

Today's Date ____ / ____ / ____

Name _____

Date of Birth ____ / ____ / ____

Gender (check one): Male ☐ Female ☐

Agency Use Only

Client's Medical Record Number

We are very interested in how you are doing, and how our services may or may not be helping you. Please answer all of the questions below, then give the questionnaire to your case manager or another staff person at the mental health agency.

Part 1

Below are some questions about how satisfied you are with various aspects of your life in *the past 6 months*.

For each question, checkmark ☒ the answer that best describes how you feel.

How do you feel about:

1. The amount of friendship in your life?

- ☐ Terrible
- ☐ Mostly dissatisfied
- ☐ Equally satisfied/dissatisfied
- ☐ Mostly satisfied
- ☐ Very pleased

2. The amount of money you get?

- ☐ Terrible
- ☐ Mostly dissatisfied
- ☐ Equally satisfied/dissatisfied
- ☐ Mostly satisfied
- ☐ Very pleased

3. How comfortable and well-off you are financially?

- ☐ Terrible
- ☐ Mostly dissatisfied
- ☐ Equally satisfied/dissatisfied
- ☐ Mostly satisfied
- ☐ Very pleased

4. How much money you have to spend for fun?

- ☐ Terrible
- ☐ Mostly dissatisfied
- ☐ Equally satisfied/dissatisfied
- ☐ Mostly satisfied
- ☐ Very pleased

5. The amount of meaningful activity in your life (such as work, school, volunteer activity, leisure activity)?

- ☐ Terrible
- ☐ Mostly dissatisfied
- ☐ Equally satisfied/dissatisfied
- ☐ Mostly satisfied
- ☐ Very pleased

6. The amount of freedom you have?

- ☐ Terrible
- ☐ Mostly dissatisfied
- ☐ Equally satisfied/dissatisfied
- ☐ Mostly satisfied
- ☐ Very pleased

7. The way you and your family act toward each other?

- ☐ Terrible
- ☐ Mostly dissatisfied
- ☐ Equally satisfied/dissatisfied
- ☐ Mostly satisfied
- ☐ Very pleased
- ☐ Does not apply

Please turn to the next page →

8. Your personal safety?

- ☐ Terrible
- ☐ Mostly dissatisfied
- ☐ Equally satisfied/dissatisfied
- ☐ Mostly satisfied
- ☐ Very pleased

9. The neighborhood in which you live?

- ☐ Terrible
- ☐ Mostly dissatisfied
- ☐ Equally satisfied/dissatisfied
- ☐ Mostly satisfied
- ☐ Very pleased

10. Your housing/living arrangements?

- ☐ Terrible
- ☐ Mostly dissatisfied
- ☐ Equally satisfied/dissatisfied
- ☐ Mostly satisfied
- ☐ Very pleased

11. Your health in general?

- ☐ Terrible
- ☐ Mostly dissatisfied
- ☐ Equally satisfied/dissatisfied
- ☐ Mostly satisfied
- ☐ Very pleased

12. How often do you have the opportunity to spend time with people you really like?

- ☐ Never
- ☐ Seldom/rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

Part 2

The next few items ask you about your health and medications *within the past 6 months*.

13. How often does your physical condition interfere with your day-to-day functioning?

- ☐ Never
- ☐ Seldom/rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

14. Concerns about my medications (such as side effects, dosage, type of medication) are addressed:

- ☐ Never
- ☐ Seldom/rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always
- ☐ Not applicable/no medications

The next two items deal with how you have been treated by other people.

15. I have been treated with dignity and respect at this agency.

- ☐ Never
- ☐ Seldom/rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

16. How often do you feel threatened by people's reactions to your mental health problems?

- ☐ Never
- ☐ Seldom/rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

Part 3

The following questions ask you about how much you were distressed or bothered by some things *during the last seven days*. Please mark the answer that best describes how you feel.

During the past 7 days, about how much were you distressed or bothered by:

17. Nervousness or shakiness inside

- ☐ Not at all
- ☐ A little bit
- ☐ Some
- ☐ Quite a bit
- ☐ Extremely

Please turn to the next page →

18. Being suddenly scared for no reason

- ☐ Not at all
- ☐ A little bit
- ☐ Some
- ☐ Quite a bit
- ☐ Extremely

19. Feeling fearful

- ☐ Not at all
- ☐ A little bit
- ☐ Some
- ☐ Quite a bit
- ☐ Extremely

20. Feeling tense or keyed up

- ☐ Not at all
- ☐ A little bit
- ☐ Some
- ☐ Quite a bit
- ☐ Extremely

21. Spells of terror or panic

- ☐ Not at all
- ☐ A little bit
- ☐ Some
- ☐ Quite a bit
- ☐ Extremely

22. Feeling so restless you couldn't sit still

- ☐ Not at all
- ☐ A little bit
- ☐ Some
- ☐ Quite a bit
- ☐ Extremely

23. Heavy feelings in arms or legs

- ☐ Not at all
- ☐ A little bit
- ☐ Some
- ☐ Quite a bit
- ☐ Extremely

24. Feeling afraid to go out of your home alone

- ☐ Not at all
- ☐ A little bit
- ☐ Some
- ☐ Quite a bit
- ☐ Extremely

25. Feeling of worthlessness

- ☐ Not at all
- ☐ A little bit
- ☐ Some
- ☐ Quite a bit
- ☐ Extremely

26. Feeling lonely even when you are with people

- ☐ Not at all
- ☐ A little bit
- ☐ Some
- ☐ Quite a bit
- ☐ Extremely

27. Feeling weak in parts of your body

- ☐ Not at all
- ☐ A little bit
- ☐ Some
- ☐ Quite a bit
- ☐ Extremely

28. Feeling blue

- ☐ Not at all
- ☐ A little bit
- ☐ Some
- ☐ Quite a bit
- ☐ Extremely

29. Feeling lonely

- ☐ Not at all
- ☐ A little bit
- ☐ Some
- ☐ Quite a bit
- ☐ Extremely

30. Feeling no interest in things

- ☐ Not at all
- ☐ A little bit
- ☐ Some
- ☐ Quite a bit
- ☐ Extremely

31. Feeling afraid in open spaces or on the streets

- ☐ Not at all
- ☐ A little bit
- ☐ Some
- ☐ Quite a bit
- ☐ Extremely

Please turn to the next page ➔

32. How often can you tell when mental or emotional problems are about to occur?

- ☐ Never
- ☐ Seldom/rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

33. When you can tell, how often can you take care of the problems before they become worse?

- ☐ Never
- ☐ Seldom/rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

Part 4

Below are several statements relating to one's view about life and having to make decisions. Please check the response that is closest to how you feel about the statement. Check the word or words that best describes how you feel now.

34. I can pretty much determine what will happen in my life.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

35. People are limited only by what they think is possible.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

36. People have more power if they join together as a group.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

37. Getting angry about something never helps.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

38. I have a positive attitude toward myself.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

39. I am usually confident about the decisions I make.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

40. People have no right to get angry just because they don't like something.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

41. Most of the misfortunes in my life were due to bad luck.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

42. I see myself as a capable person.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

43. Making waves never gets you anywhere.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

Please turn to the next page →

44. People working together can have an effect on their community.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

45. I am often able to overcome barriers.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

46. I am generally optimistic about the future.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

47. When I make plans, I am almost certain to make them work.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

48. Getting angry about something is often the first step toward changing it.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

49. Usually I feel alone.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

50. Experts are in the best position to decide what people should do or learn.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

51. I am able to do things as well as most other people.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

52. I generally accomplish what I set out to do.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

53. People should try to live their lives the way they want to.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

54. You can't fight city hall (authority).

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

55. I feel powerless most of the time.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

56. When I am unsure about something, I usually go along with the rest of the group.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

57. I feel I am a person of worth, at least on an equal basis with others.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

Please turn to the next page →

58. People have a right to make their own decisions, even if they are bad ones.

- ☐ Strongly agree
☐ Agree
☐ Disagree
☐ Strongly Disagree

59. I feel I have a number of good qualities.

- ☐ Strongly agree
☐ Agree
☐ Disagree
☐ Strongly Disagree

60. Very often a problem can be solved by taking action.

- ☐ Strongly agree
☐ Agree
☐ Disagree
☐ Strongly Disagree

61. Working with others in my community can help to change things for the better.

- ☐ Strongly agree
☐ Agree
☐ Disagree
☐ Strongly Disagree

Part 5

Please tell us some things about yourself.

62. What was the last school grade you completed?

☐ Less than 1 st grade	☐ 10 th grade
☐ 1 st grade	☐ 11 th grade
☐ 2 nd grade	☐ High school diploma/GED
☐ 3 rd grade	☐ Trade/Tech school
☐ 4 th grade	☐ Some college
☐ 5 th grade	☐ 2 yr college/Associate degree
☐ 6 th grade	☐ 4 yr college/Undergraduate degree
☐ 7 th grade	☐ Graduate school courses
☐ 8 th grade	☐ Graduate degree
☐ 9 th grade	☐ Post-graduate studies
	☐ Further special studies

63. Race (check all that apply):

☐ White	☐ Hispanic/Latino
☐ Native American/Pacific Islander	☐ Asian
☐ Black/African American	☐ Other _____

64. What is your marital status?

- ☐ Never married
☐ Married
☐ Separated
☐ Divorced
☐ Widowed
☐ Living together

65. What is your current living situation?

- ☐ Your own house/apartment
☐ Friend's home
☐ Relative's home
☐ Supervised group living
☐ Supervised apartment
☐ Boarding home
☐ Crisis residential
☐ Child foster care
☐ Adult foster care
☐ Intermediate care facility
☐ Skilled nursing facility
☐ Respite care
☐ MR intermediate care facility
☐ Licensed MR facility
☐ State MR institution
☐ State MH institution
☐ Hospital
☐ Correctional facility
☐ Homeless
☐ Rest home
☐ Other _____

66. What is your employment status?

- ☐ Employed full time
☐ Employed part time
☐ Sheltered employment
☐ Unemployed
☐ Student
☐ Homemaker
☐ Retired
☐ Disabled
☐ Inmate of institution

67. Are you in treatment because you want to be?

- ☐ Yes
☐ No

Please stop here. Thanks!

Appendix G

Informed Consent Form

Informed Consent for Adult Research Participation

Title of Project: Wellness Management and Recovery (WMR) Program

Project Director: Wesley A. Bullock, Ph.D.
Department of Psychology (M.S.#948), University of Toledo

Project Assistants: Michael O'Rourke, M.A., Julie Sage, M.A., Danelle Hupp

Description of Project:

The University of Toledo, in collaboration with the Ohio Coordinating Center of Excellence for Wellness Management and Recovery (WMR), is inviting individuals to participate in a clinical service and research project designed to evaluate the effectiveness and outcomes of the Wellness Management and Recovery program (WMR).

The WMR program is based on clinical best practices promoted by the Ohio Department of Mental Health. WMR is a psycho-educational program designed to provide people with knowledge and skills to better cope with their mental health problems, to develop and pursue goals, and to gain more control over their lives. The WMR curriculum teaches strategies designed to help individuals work collaboratively with mental health professionals, reduce their susceptibility to illness, and cope effectively with their symptoms. Recovery occurs when people discover, or rediscover, their strengths and abilities for pursuing personal goals and develop a sense of identity that allows them to grow beyond their mental health problems.

The WMR program curriculum will be provided in a group format, with approximately eight persons in each WMR group. The WMR curriculum is 10 sessions long. Each session is two hours, with a 10 minute break in the middle. Volunteer participants will play an important role in helping to evaluate the effectiveness of the WMR program. Information and feedback will be requested from mental health consumers and WMR service providers, to evaluate how well the program is working.

As a WMR program and research participant, you will be asked to complete a group of self-report opinion questionnaires at three times: (1) before starting in the WMR program, (2) immediately after the WMR program is completed (after 10 sessions), and (3) six months after completion of the WMR program. The group of outcome questionnaires includes: 1) the Ohio Consumer Outcomes Scales designed by the Ohio Department of Mental Health (67 items), 2) the Mental Health Recovery Measure (30 items), 3) The WMR Client Self-Report Scales, and 4) The WMR Client Feedback form. This packet of self-report questionnaires takes about an hour to complete and asks your opinion about your mental health symptoms, your quality of life, and your mental health recovery process. These outcome measures will also be used by your WMR treatment provider to help tailor the WMR program to best meet your unique needs and recovery goals.

Summary of Important Points:

- **Voluntary Participation:** Your participation in the Wellness Management and Recovery (WMR) program is *voluntary*. Participation in the WMR program is not necessary for you to receive your usual mental health services through your community agency. A decision to not participate, or a decision to withdraw from this project, will *not* affect your current or future relationship with your mental health provider agency, or the University of Toledo.
- **Confidentiality:** All data collected for the purpose of evaluating the effectiveness of the WMR program will be kept *strictly confidential*. Names of participants will not be used on research records – only identification numbers. Only group data or group themes, not individual responses, will be reported in any publications coming from the outcome evaluation of this project.
- **Protected Health Information:** Some of the information to be collected for the purpose of the project evaluation is protected health information (such as your clinical service utilization information).

By signing this consent, you are allowing the University of Toledo, Department of Psychology to collect this information from you for the purpose of the program evaluation only.

- **Risks:** Participation in the WMR program offers you a chance to change, grow, and take responsibility for your life; change can be difficult and you run the risk of facing emotional issues that may be raised in the course of your participation.
- **Benefits:** By volunteering for this program, you will have the opportunity to participate in a treatment program that is based on best clinical practices in mental health. The primary goal of this program is to help individuals develop personal strategies for coping with mental illness, and identify and pursue goals that are important to them. Participating in the outcome evaluation may contribute to our understanding of the recovery process for persons with mental health problems.
- **You May Withdraw From The Project At Any Time:** You do not need to answer any question that you do not want to, and you may revoke your consent to participate in the program or its evaluation. You will continue to receive your regular standard care from your mental health provider whether or not you participate in this program. If you revoke your consent to participate, your data will not be used in any project analysis, so long as no irreversible use of the data has been made (such as the publication of summary results that include your data).
- **Questions:** You will receive a copy of this consent to keep. The individual reviewing this consent form with you will be happy to answer any questions you may have about the research project at any time. You may also contact the University researcher by mail, phone, or email (listed on the letterhead and at the end of this form). If you have a questions about your rights as a research participant you may also contact Jeffrey Busch, Ph.D. at the University of Toledo Office of Research at 419-530-2416.

Consent: This is to certify that I have read the above information describing this project, and have had the project explained to me verbally. I understand the nature of the project and the nature of my participation. I give consent to participate in the project for the purpose of evaluating the WMR program outcomes.

Client Signature: _____ Date: _____

Please Print Client Name: _____

Person Obtaining Informed Consent: _____ Date: _____

Please notify Wesley A. Bullock, Ph.D. at the University of Toledo if you have any questions of if you wish to revoke your consent:

Department of Psychology (MS#948)
University of Toledo
2801 W. Bancroft St.
Toledo, OH 43606-3390

Phone: 419-530-2719

email: wesley.bullock@utoledo.edu

Appendix H
WMR Curriculum

WMR Curriculum

Session 1: Mental Health Recovery

Session 2: Wellness

Session 3: An Understanding of Mental Health

Session 4: The Role of Medication in Recovery and Wellness

Session 5: Learning to Manage Symptoms and Side Effects

Session 6: Effective Communication

Session 7: Communication with Your Providers

Session 8: Coordinating Your Care

Session 9: Developing Relationships and Building Social Supports

Session 10: Planning for Wellness