A qualitative analysis of participant feedback from the wellness management and recovery (WMR) program

Danelle R. Hupp

The University of Toledo

Follow this and additional works at: http://utdr.utoledo.edu/theses-dissertations

Recommended Citation
Hupp, Danelle R., "A qualitative analysis of participant feedback from the wellness management and recovery (WMR) program" (2011). Theses and Dissertations. 589.
http://utdr.utoledo.edu/theses-dissertations/589

This Dissertation is brought to you for free and open access by The University of Toledo Digital Repository. It has been accepted for inclusion in Theses and Dissertations by an authorized administrator of The University of Toledo Digital Repository. For more information, please see the repository's About page.
A Dissertation
entitled

A Qualitative Analysis of Participant Feedback from the Wellness Management and Recovery (WMR) Program

by
Danelle R. Hupp, M.A.

Submitted to the Graduate Faculty as partial fulfillment of the requirements for the Doctor of Philosophy Degree in Psychology

____________________________
Wesley A. Bullock, Ph.D., Committee Chair

____________________________
Jeanne H. Brockmyer, Ph.D., Committee Member

____________________________
Sallyann Treadaway, Ph.D., Committee Member

____________________________
Yueh-Ting Lee, Ph.D., Committee Member

____________________________
Janet Hoy, Ph.D., Committee Member

____________________________
Patricia Komuniecki, Ph.D., Dean College of Graduate Studies

The University of Toledo
August 2011
For most individuals a diagnosis of serious mental illness (SMI) is a catastrophic event (Marsh & Johnson, 1997). However, a wellness-centric or recovery perspective views an individual with SMI as living beyond their diagnosis (Deegan, 1995). 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, Oades, & Caputi, 2003, p. 588). The Wellness Management and Recovery (WMR) program is an example of a psychotherapeutic/psychoeducational program that is designed to promote communication, social support, wellness, and self-empowerment. The goal of the WMR program is to support mental health recovery and promote better overall health. A central tenet of the WMR model is that the individuals with SMI benefit
from having opportunities for both intra-personal growth and inter-personal relationship building (Bullock et al., 2009).

The WMR program places an emphasis on empowerment and “finding the voice” of each consumer participant. The primary goal of the current study was to determine what participants of the WMR program liked most and least about the program, as well as what components of WMR participants believed were most influential in their individual journeys to recovery. Using qualitative data analysis of three open-ended questions regarding participants’ experience in the program, the following phases of data analysis were conducted: 1) initial thematic categories for three open-ended questions were inductively developed during a pilot study using a subsample of 75 responses; 2) the coding system developed for the pilot study was utilized by this author to code all data (current N = 500+ who have completed the WMR program, and who have provided responses to the qualitative questions for the current study); 3) a team of three researchers (this author and two intern-level graduate students unaffiliated with the WMR program and blind to the research questions) developed a revised coding system; 4) all current data was coded independently by the three raters (inter-rater reliability was high); and 5) the author analyzed data using NVivo (qualitative data analysis software).

Current findings suggest high levels of overall satisfaction with the WMR program and the strongly expressed belief by the majority of participants that the WMR program was beneficial to their individual recovery journeys. Results suggest that key aspects of the WMR program’s success in aiding individuals in their individual recover journeys included: group dynamics; social support; the program content (e.g., materials) and educational components; its focus on wellness; communication skill-building; and
individual activation (e.g., feelings of empowerment, gains in self-insight, becoming an active participant in their recovery). Participants indicated that certain elements of time, social interaction, and content were components that they liked least about WMR. Results of the current study supported those of a previous study conducted using in-depth interviews to look at recovery outcomes following participation in WMR, and other qualitative studies of recovery. Results also offered insight into limitations and areas for growth within the program, which will aid in future training of facilitators as well as offer information as to how to expand or modify the WMR program.
Acknowledgments

I would like to thank my advisor, Dr. Wesley Bullock, for his support and assistance in this entire process. I would also like to acknowledge my committee members, Dr. Jeanne Brockmyer, Dr. Sallyann Treadaway, Dr. Janet Hoy, and Dr. Yueh-Ting Lee for their support and understanding throughout the project. A special thank you to Dr. Cody Bullock and Dr. Troy Ertelt, without whom my dissertation would not have been complete -- neither would my internship experience. I would like to send many thanks to my wonderful friends for their caring and understanding during these many trying years. And, of course, Chin-upp -- we did this! Finally, I would like to send my greatest thanks to my mom and dad who have always been there for me. They have believed in me, even when I was unsure of myself. They have pushed me to work hard, do my best, and “just be myself.” I thank them for their love, guidance, and many forms of support. Without them I would not be where I am today.
# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstract</td>
<td>iii</td>
</tr>
<tr>
<td>Acknowledgements</td>
<td>vi</td>
</tr>
<tr>
<td>Table of Contents</td>
<td>vii</td>
</tr>
<tr>
<td>List of Tables</td>
<td>x</td>
</tr>
<tr>
<td>I. Introduction</td>
<td>1</td>
</tr>
<tr>
<td>II. Literature Review</td>
<td>4</td>
</tr>
<tr>
<td>The History of Recovery and the Consumer-Survivor Movement</td>
<td>4</td>
</tr>
<tr>
<td>Recovery</td>
<td>6</td>
</tr>
<tr>
<td>Role of Social Support and Communication in the Recovery Process</td>
<td>9</td>
</tr>
<tr>
<td>The Wellness Management and Recovery (WMR) Program</td>
<td>10</td>
</tr>
<tr>
<td>Qualitative Research</td>
<td>13</td>
</tr>
<tr>
<td>Phenomenology as a Research Method</td>
<td>14</td>
</tr>
<tr>
<td>Grounded Theory Analysis</td>
<td>16</td>
</tr>
<tr>
<td>Grounded Theory Analysis/Qualitative Analysis and Recovery</td>
<td>16</td>
</tr>
<tr>
<td>NVivo (Qualitative Analysis Software)</td>
<td>21</td>
</tr>
<tr>
<td>Statement of the Problem</td>
<td>22</td>
</tr>
<tr>
<td>Purpose of the Present Study</td>
<td>23</td>
</tr>
<tr>
<td>Research Questions</td>
<td>23</td>
</tr>
<tr>
<td>Primary Research Questions</td>
<td>24</td>
</tr>
<tr>
<td>Additional Research Questions</td>
<td>24</td>
</tr>
<tr>
<td>Section</td>
<td>Title</td>
</tr>
<tr>
<td>---------</td>
<td>-------</td>
</tr>
<tr>
<td>III.</td>
<td>Method</td>
</tr>
<tr>
<td></td>
<td>Participants</td>
</tr>
<tr>
<td></td>
<td>Measures</td>
</tr>
<tr>
<td></td>
<td>WMR Post-Program Feedback Form</td>
</tr>
<tr>
<td></td>
<td>Mental Health Recovery Measure (MHRM)</td>
</tr>
<tr>
<td></td>
<td>WMR Social Support Questionnaire (WMR SSQ)</td>
</tr>
<tr>
<td></td>
<td>WMR Client Self-Rating Scale</td>
</tr>
<tr>
<td></td>
<td>WMR Procedure</td>
</tr>
<tr>
<td></td>
<td>Qualitative Analysis Procedures</td>
</tr>
<tr>
<td>IV.</td>
<td>Results</td>
</tr>
<tr>
<td></td>
<td>Results of Qualitative Analysis using Pilot Study’s Coding System</td>
</tr>
<tr>
<td></td>
<td>Results of Qualitative Analysis using Pilot Study’s Coding System: Question #8</td>
</tr>
<tr>
<td></td>
<td>Results of Qualitative Analysis using Pilot Study’s Coding System: Question #9</td>
</tr>
<tr>
<td></td>
<td>Results of Qualitative Analysis using Pilot Study’s Coding System: Question #10</td>
</tr>
<tr>
<td></td>
<td>Results of Qualitative Analysis using Revised Coding System</td>
</tr>
<tr>
<td></td>
<td>Results of Qualitative Analysis using Revised Coding System: Question #8</td>
</tr>
<tr>
<td></td>
<td>Results of Qualitative Analysis using Revised Coding System: Question #9</td>
</tr>
<tr>
<td></td>
<td>Results of Qualitative Analysis using Revised Coding System: Question #10</td>
</tr>
<tr>
<td></td>
<td>Results of NVivo</td>
</tr>
<tr>
<td></td>
<td>Results of Current Study Compared to Results of Quantitative Measures</td>
</tr>
<tr>
<td></td>
<td>Mental Health Recovery Measure</td>
</tr>
<tr>
<td></td>
<td>Post-Program Feedback Form</td>
</tr>
<tr>
<td></td>
<td>Social Support Questionnaire</td>
</tr>
</tbody>
</table>
V. Discussion

Discussion of Findings

Discussion of Revised Thematic Categories

Discussion of NVivo Results

Discussion of Quantitative Measures Compared with Current Study

Mental Health Recovery Measure

Post-Program Feedback Form (quantitative questions)

Social Support Questionnaire

Proposed Model for WMR

Discussion of Previous Qualitative Studies of Recovery Compared with Results of Current Study

Limitations

Implications

VI. References

VII. Appendix A: Post-Program Feedback Form

VIII. Appendix B: Mental Health Recovery Measure (MHRM)

IX. Appendix C: WMR Social Support Questionnaire (WMR SSQ)

X. Appendix D: WMR Client Self-Rating Scale

XI. Appendix E: Informed Consent Form

XII. Appendix F: WMR Curriculum

XIII. Appendix G: Participant responses to Question #8

XIV. Appendix H: Participant responses to Question #9

XV. Appendix I: Participant responses to Question #10
List of Tables

Table 1: Question #8: Original Thematic Categories, Sample Responses, and Frequency of Responses 38
Table 2: Question #9: Original Thematic Categories, Sample Responses, and Frequency of Responses 42
Table 3: Question #10: Original Thematic Categories, Sample Responses, and Frequency of Responses 47
Table 4: Inter-rater Reliability Results 50
Table 5: Question #8: Revised Thematic Categories, Sample Responses, and Frequency of Responses 51
Table 6: Question #9: Revised Thematic Categories, Sample Responses, and Frequency of Responses 53
Table 7: Question #10: Revised Thematic Categories, Sample Responses, and Frequency of Responses 55
Table 8: Mean Pre and Post Scores for Participants on the MHRM 58
Traditionally, health care and mental health care have followed a prescriptive model. In this model, a client presents with a problem and the provider decides what route is best to take to help reduce or eliminate the symptoms (Gonzalez, 1976). However, as society has advanced and consumers have gained knowledge about the mental health system, individuals diagnosed with a serious mental illness have become more vocal about their needs (Gonzalez).

For most individuals a diagnosis of serious mental illness is a catastrophic event, as it has an immense effect on all involved (Marsh & Johnson, 1997). However, a wellness-centric or recovery perspective views an individual with SMI as living beyond their diagnosis (Deegan, 1995). To many consumers, recovery is much more than just a return to a normal state of functioning or symptom remission: it is a personal journey of redefining oneself beyond one’s illness (Deegan). 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, Oades, & Caputi, 2003, p. 588). 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).

The Wellness Management and Recovery (WMR) program is an example of a psychotherapeutic / psychoeducational program that is designed to promote communication, social support, wellness, and self-empowerment (Wellness Management...
and Recovery Website, 2007). Consisting of ten weekly small group therapy sessions, WMR is designed to promote mental health recovery among individuals experiencing SMI in the community. The goal of the WMR program is to support mental health recovery and promote better overall health by teaching skills that empower individuals with SMI to: (1) identify and achieve personal recovery and wellness goals, (2) develop informed, collaborative approaches with mental health providers to effectively select and manage their treatment and recovery, and (3) achieve an overall healthier lifestyle. A central tenet of the WMR model is that the individuals with SMI benefit from having opportunities for both intra-personal growth and inter-personal relationship building (Wellness Management and Recovery Website).

The WMR program places an emphasis on empowerment and “finding the voice” of each consumer participant. Given this emphasis, it is vital that this recovery program recognize the voice and opinions of all participants. The primary goal of the current study is to determine what participants of a recovery-focused treatment program (the WMR program) liked most and least about the program, as well as what aspect of WMR participants believed was most influential in their individual journeys to recovery. In addition, this study will compare its findings with that of a pilot study, a previous study conducted using in-depth interviews to look at recovery outcomes following participation in WMR, and other qualitative studies on mental health recovery. First, a review of the literature will be conducted, including: the history of the consumer-survivor movement, defining recovery, the WMR program, and qualitative research methodologies. Second, a review of the study’s methodology will be conducted. Thirdly, analyses and results will
be discussed. Finally, a discussion of the results and limitations of the study will be conducted.
Chapter II

Literature Review

*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). 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).

*The Role of Social Support and Communication in the Recovery Process*
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). 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., 2009).

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.

The WMR program places an emphasis on communication because of its known effects on mental health recovery. Sessions six (“Effective Communication”) and seven (“Communication”) are dedicated to developing and enhancing communication skills with family members, social supports, and providers. Throughout the program,
individuals within the group are encouraged to interact and communicate with peers who are also diagnosed with SMI. The WMR program intends to provide a secure, protected, and comfortable environment for individuals to practice and exercise the social and communication skills they have gained through WMR’s psychoeducation component and by modeling other group members and facilitators. Feedback during skill-building exercises, as well as during role-play, helps participants to practice and modify the communication skills they have learned, in order to put them to use in the community (e.g., when talking with their healthcare providers).

In addition to the role of social support in recovery 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.

The Wellness Management and Recovery (WMR) Program

This research represents an integration of the current recovery literature with the Wellness Management and Recovery (WMR) program. WMR is a psychoeducational, group therapy program designed to promote mental health recovery among individuals experiencing severe and persistent mental illness. The WMR research project is an
ongoing multi-site, open clinical trial that is evaluating the outcomes of the WMR program as it is being implemented in community and hospital settings (Bullock et al., 2009; 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 22 mental health and consumer-operated agencies 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., 2009; 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 Vici Hill. 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., 2009; O’Rourke, 2007; Wellness Management and Recovery Website, 2007).

The treatment philosophy 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 helping them to gain 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., 2009; 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., 2009; O’Rourke, 2007; Wellness Management and Recovery Website, 2007).

Qualitative Research

Use of qualitative methodologies is growing within the mental health field as a means to understand individuals’ recovery from serious mental illness. Such methodology has taken many forms and led to important discoveries, such as using personal accounts of psychiatric survivors to develop in-depth, first person understandings of the recovery process (Mancini, 2007). The goal of qualitative research is to understand and represent experiences of individuals as they encounter and live through various life situations (Elliott, Fischer, & Rennie, 1999). It is designed to interpret and describe participants’ experiences in a context-specific setting (Ponterotto, 2005). Using qualitative research designs, researchers attempt to develop an understanding of the phenomena being studied, based primarily in the perspective of the participants. Although it is impossible to set one’s biases and perspectives aside completely, the goal of qualitative researchers is to monitor their biases and values, engage in self-reflective strategies to acknowledge their biases, and use these actions to help them gain and understanding of participants’ experiences. The central purpose of
qualitative research is to enrich understanding, rather than confirm previous conclusions (Elliott et al.). In general, findings are presented in everyday language, incorporating participants’ own words to describe the phenomenon or experience of interest (Ponterotto).

The scientific questions that qualitative research hopes to answer are different from those of quantitative research (Elliott et al.). Qualitative research allows researchers to understand participants’ perspectives and views, define phenomena in terms of observed variations and experienced meanings, and develop a theory based on field work (Elliott et al.). In quantitative research, numbers contribute to the “power” of this type of investigation; in qualitative research, the actual words of participants are essential because this allows readers to see that findings of the researcher are grounded in the lived experiences of participants (Morrow, 2005).

**Phenomenology as a Research Method**

Rooted in the philosophical traditions of Edmund Husserl, phenomenology seeks to describe basic lived experience and is the study of essences (Van Manen, 1990; Phillips-Pula, Strunk, & Pickler, 2011). Husserl believed that researchers could move beyond normal bounds and identify conscious and unconscious beliefs and biases by achieving a transcendental state. Husserl believed that the acceptance of participants’ descriptions of their experience exactly as related by the participants can assist researchers’ efforts to grasp the essence of the experience (Moustakas, 1994; Phillips et al.). Husserl focused on meanings and identifying the essence (or central theme) of an experience as a way of furthering knowledge (Phillips et al.).
Research using phenomenology seeks to uncover meanings in everyday existence (Van Manen, 1990). Phenomenology is a description of lived experience and describes meaning of how such lived experience is expressed. Through text or symbols, interpretations are made of life experiences. This text is descriptive because it gives such experience a name and allows for expression of this experience. As a research method, phenomenology attempts to “ward off any tendency toward constructing a predetermined set of fixed procedures, techniques, and concepts that would rule-govern the research project” (Van Manen, p. 29).

Specifically, hermeneutic phenomenology examines the structure and interpretation of texts and focuses on language and communication (Moustakas, 1994). Regardless of the approach, the first research step is to develop a question concerning the phenomenon of interest. The second step involves identifying a sample of appropriate and willing study participants. Data is then generated based on observations of (or interviews with) participants or through their written descriptions of the phenomenon. Finally, data is analyzed using a process of coding and categorizing (Phillips et al., 2011). Hermeneutic phenomenological research is an interplay of six research activities: “1) turning to a phenomenon which interests us and commits us to the world; 2) investigating experience as we live it rather than as we conceptualize it; 3) reflecting on the essential themes which characterize the phenomenon; 4) describing the phenomenon through the art of writing; 5) manipulating a strong and oriented pedagogical relation to the phenomenon; and 6) balancing the research context by considering parts and whole” (Van Manen, 1990, pp. 30-31). The hermeneutic phenomenological research process was
the basis for this study’s initial development of lower- and higher-order categories and their labels.

Grounded Theory Analysis

Grounded Theory Analysis is a method of qualitative analysis. It was originally developed and conceptualized by Glaser and Strauss (1967). Grounded theory can be defined as “a qualitative research method that uses a systematic set of procedures to develop an inductively derived grounded theory” (Strauss & Corbin, 1998, p. 24) about a phenomenon of interest. This is contrasted with theory having been generated from deductive logic and a priori assumptions. Historically, there has been a debate arguing that the distinction between qualitative versus quantitative analyses is equivalent to the generating versus verifying of data. However, Glaser and Strauss argue that the either-or debate is unnecessary, and the authors highlighted the benefit of both forms of data being necessary and used for mutual verification of one another. The process of Grounded Theory Analysis involves separating in-depth interviews into individual meaning units, forming categories of meaning units using a constant comparative method. Higher-order categories are then formed by identifying categories with unifying conceptual themes. This model is used to ensure that results are grounded in consumer generated data and not based on preconceived ideas and biases of the researcher (Young & Ensing, 1999).

Grounded Theory Analysis/Qualitative Analysis and Recovery

A qualitative research study by Young and Ensing (1999) explored recovery from the perspective of individuals diagnosed with mental illness, using Grounded Theory Analysis. In this study, a semi-structured interview guide consisting of eight questions explored the construct of recovery from the consumers’ perspective. Frequency data
based on prevalence rates of each conceptual theme across protocols was tallied to determine the general importance of each component. Categories represented in at least eight of the nine protocols were classified as general themes; categories contained in five to seven of the protocols were classified as typical themes; categories contained in three to six of the protocols were classified as variant themes; and categories in less than three of the protocols were removed from analyses due to limited generalizability and utility (Young & Ensing).

Results of the Young and Ensing (1999) study found some general aspects of recovery that are typical in the process, though each individual’s recovery process follows its own unique path (Anthony, 1993). Five higher-order categories emerged, indicating that recovery is a process of: overcoming “stuckness,” discovering and fostering self-empowerment, learning and self-redefinition, returning to basic functioning, and improving quality of life. In the initial phase of recovery, overcoming “stuckness” appears to occur, which includes a change process of acknowledging and accepting illness, developing the desire and motivation to change, and finding and utilizing a source of hope and inspiration (Young & Ensing).

During the middle phase of the recovery process, regaining what was lost and moving forward, individuals begin to discover and foster self-empowerment, gain new perspectives about self and illness, and attempt to recapture and maintain a basic level of functioning (Young & Ensing, 1999). A second aspect of the middle phase of recovery appears to include the process of learning new perspectives about self, illness, and the world. A third aspect of the middle phase of recovery includes an attempt to return to basic functioning, a return to adaptive ways of living, and reintegration with society.
During the later phase of recovery, improving the quality of life emerges as a theme; this includes attempts to attain an overall sense of well-being and striving to reach new potentials of higher functioning beyond basic self-care and functioning (Young & Ensing).

A recent qualitative study by Corring and Cook (2007) examined quality of life from the perspective of individuals diagnosed with a serious mental illness. This study included 18 in-depth interviews and 35 interviews with participants in focus groups in a variety of settings (e.g., hospitals, community agencies, participants’ homes). Many similarities with the Young and Ensing (1999) study were evident. Two general themes arose in this study: presence of stigma and pervasive fear of positive symptoms of psychosis. Four additional domains were identified: 1) Experience of illness (e.g., living day to day with a mental illness, loss of life roles/dreams, limited financial resources, importance of living one day at a time, gaining an understanding of their illness, identifying coping strategies and feeling a sense of control over their illness, medications); 2) Relationships (e.g., with family, friends, peers with mental illness, significant others, and mental health providers); 3) Occupation (e.g., becoming active socially, employment); and 4) Sense of self (e.g., building a more positive self-image, feeling valued, spirituality) (Corring & Cook).

Corrigan et al. (2002) and Corrigan et al. (2005) examined recovery processes that account for positive outcomes for a mutual-help program, GROW. GROW is an educational/mental health organization run by its members and follows a highly structured group method. For over 40 years GROW has offered a community of sharing and caring, understanding and respect to its members. It is a 12-step mutual-help program
(based on the premise of Alcoholics Anonymous) for individuals diagnosed with serious mental illness. Participants in such programming report high levels of satisfaction with the program, as well as improved self-concept, feelings of empowerment, improved well-being, reduced psychiatric symptoms, and larger social support networks. Catalysts of positive changes in recovery of individuals in such consumer-operated programs include social support from peers, reduced self-stigma, improvements in interpersonal skills, and social comparisons in a supportive setting. Participants in the GROW program specifically identify self-reliance, industriousness, gaining a sense of personal value, and self-esteem as vital aspects of recovery, though the most prominent element that participants identified as facilitating recovery was peer support (Corrigan et al., 2002; Corrigan et al., 2005).

A qualitative analysis using Grounded Theory Analysis identified factors that influenced the recovery journeys of 15 psychiatric survivors who were also mental health service providers (Mancini, 2007). These peer role models acted as recovery consultants, similar to consumer co-facilitators in the WMR program. Participants in this study identified a more competent and efficacious sense of self as key to their recovery. Also identified as vital aspects in their recoveries were participation in meaningful activities, peer support/egalitarian relationships, self-help peer role models/support from mental health professionals (who are also consumers), and choice about treatment. Participants readily identified the transition from an illness-centric self-identity to a wellness-centric self-identity (which included feeling competent, efficacious, and improved sense of well-being) as being at the heart of recovery (Mancini). This idea of illness- versus wellness-centric sense of self is also the central component and philosophy of the WMR program.
In an extensive qualitative study by Pickett, Phillips, and Kraus (2011), the Recovery International (RI) Method was evaluated. RI is a cognitive-behavioral, peer-to-peer self-help program designed to help its participants change thoughts and behaviors, which in turn changes attitudes and beliefs. RI is used as an adjunct to professional health care and is provided by trained peer facilitators (similar to the consumer co-facilitators of the WMR program). This peer-to-peer component is one of its unique features, as with the WMR program, because its facilitators are consumers (rather than professionals) who have successfully used RI to cope with emotional problems and stressors. Also similar to the WMR program is that meetings are 1.5 to 2 hours in length. Group size varies between 4 and 20 adults; groups are held weekly and are open to anyone interested in attending. Three-quarters of the participants in this study were female, and the vast majority were Caucasian. Age ranged from 25 to 73, with a mean age of 50 years. On average, participants in this study attended 15 years of school, two-thirds earned $20,000 or less per year, a third were employed full- or part-time, the vast majority lived in their own home or apartment, and a third were married, (Pickett et al.).

RI participant satisfaction was assessed in three ways: the Client Satisfaction Questionnaire, rating group leaders’ skills, and reporting in their own words what they liked and disliked about the program (Pickett et al., 2011). Participants indicated moderate to high levels of overall satisfaction with RI, and they felt that the group leaders were skilled and did a good job. Overall, participants indicated that they were very satisfied with RI, felt the information and tools met their needs, and the group leaders were qualified. Participants indicated that RI’s structure and tools were helpful, and that RI promotes a positive and open environment (Pickett et al.).
Particularly helpful to participants was when group facilitators faced similar challenges, and peer support was indicated as key to the program’s success (Pickett et al., 2011). The vast majority of participants indicated that RI was helpful and gave them important skills to help them better manage their daily lives. Over time participants reported experiencing fewer and less severe psychiatric symptoms, increased confidence in personal recovery, increased hopefulness, enhanced self-esteem and coping ability, and more social support. Three key findings were identified: participants felt that they received the help they wanted to better manage mental health symptoms, peer support is powerful, and participation in RI enhances mental health recovery (Pickett et al.).

**NVivo (Qualitative Analysis Software)**

NVivo is software that supports qualitative analysis by providing researchers with a set of tools to assist in undertaking an analysis of qualitative data (Bazeley, 2007). The use of the NVivo software is not to replace coding completed by the researcher; rather, NVivo is intended to increase the efficiency and effectiveness of what can be taken and learned from the data. NVivo has the capacity to record, sort, match, and link data, which in turn can assist the researcher in answering research questions and offer validity to a researcher’s coding. NVivo can support a researcher’s analysis of qualitative data by: 1) managing the data (organizing and keeping track of records); 2) managing ideas (organizing and providing rapid access to conceptual and theoretical knowledge that was generated by the researcher in the course of the study); 3) querying data (asking simple or complex questions of the data and having the program retrieve all relevant information from its database); 4) graphically modeling (showing ideas, concepts, or cases being built from the data and the relationships between them, and displaying the conclusions.
visually); and 5) reporting from the data (using contents of the qualitative database, such as information in the original data, resulting ideas, and processes by which outcomes were reached) (Bazeley).

NVivo can enhance the rigor in the analysis process by, for example, ensuring a more complete set of data for interpretation than often occurs when working manually (Bazeley, 2007). Such software helps to ensure that the researcher is working more methodically, thoroughly, and attentively. It is important, however, to remember that human factors and the mind of the researcher remain involved in the process, and NVivo cannot compensate for a researcher’s poor workmanship (Bazeley). For the current study, data was analyzed using NVivo after coding was completed by this author and a team of evaluators. NVivo was utilized to enhance findings, offer validity to the researcher’s findings, and for this author to develop new skills for future research endeavors.

Statement of the Problem

Based on previous findings about general outcomes of the WMR program, research endeavors that attempt to better understand the specific aspects of this multidimensional recovery program that impact participants’ mental health recovery in positive ways will be useful in improving those components of the program that participants themselves have found most important. Such data will help researchers remedy components of the program that participants have found less helpful, as well as providing the potential to improve the program through suggestions of the participants themselves. Previous studies of the WMR program have shown that participating in the program leads to improved mental health recovery outcomes and an increase in quality and quantity of social supports (Bullock et al., 2009; O’Rourke, 2007; Hupp, Bullock,
Brockmyer, & Treadaway, 2008). However, prior to the current study, data regarding participants’ feedback about components of the program they liked least, liked most, and that they found were most helpful to their recovery have not been systematically and fully analyzed. It is necessary to analyze this empirical qualitative outcome data to further support the efforts of the WMR program to enhance individuals’ recovery processes.

Purpose of the Present Study

The primary goal of the current study was to qualitatively measure how a recovery program (the WMR program) helps or hinders participants’ individual journeys through recovery. Although in-depth interviews were not obtained, the vast number of participants’ open-ended responses to three central questions made it possible to obtain and analyze an extensive range of participant experiences with the program and achieve saturation of the thematic categories that were generated. These categories were then condensed to minimize overlap between categories, and data was recoded. Thus, findings are generalizable, in part, due to the large number of participant responses.

Research Questions

Given that the primary purpose of the current study was to assess how the WMR program affects a participant’s individual journey to recovery, the following inductive questions were of interest: 1) From the participants’ perspectives, is the WMR program beneficial in their individual journeys through recovery? 2) What aspects of the WMR program do participants identify as most beneficial to their recovery? 3) What aspects of the WMR program do participants like most? 4) What aspects of the WMR program do participants like least?
Primary Research Questions

Previous studies have identified common themes of recovery amongst individuals diagnosed with a serious mental illness. The WMR program was developed to aid such individuals in their recovery journey. The current study was designed to reveal components of this recovery program that participants themselves identified as most helpful in their recovery. The current study also sought to identify consistent themes found throughout the literature regarding aspects of recovery, as well as themes identified from a previous qualitative research study within the WMR program. The following research questions were investigated: 1) In what ways will participants completing the WMR program indicate that the WMR program has been beneficial to (or has hindered) their recovery journeys, as measured by open-ended questions on the Post-Program Feedback Form? 2) Will identified themes be consistent with findings of a pilot study, a previous qualitative analysis of participant feedback utilizing in-depth interviews, and current literature identifying common themes of recovery?

Additional Research Questions

In addition to the aforementioned research questions, the present study examined the following: 1) Are results of the current study consistent with results of the quantitative outcome measures being used to evaluate recovery processes of WMR program participants (e.g., Mental Health Recovery Measure (MHRM), Social Support Questionnaire (SSQ), Client Self-Rating Form)? 2) Will three individual evaluators (this author and two intern-level graduate students unaffiliated with the WMR program) using the revised coding system have acceptable inter-rater reliability? 3) Do participants whose mental health recovery deteriorated from pre- to post-program, as indicated by
negative difference scores on the MHRM, also indicate in their qualitative responses that they did not find the WMR program helpful in their recovery? 4) Similarly, do participants who indicated in their qualitative responses that the WMR program was not helpful to their recovery and/or that they did not like the program also have difference scores on the MHRM that indicate deterioration at post-program?
Chapter III
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 were mental health consumers (current N = 500+ who have completed the WMR program, and who have provided responses to the qualitative questions for the current study) who were recruited from their respective mental health agencies. Currently, there are 22 mental health and consumer-operated agencies involved in the WMR program, representing sites across the state of Ohio. For the current study, qualitative outcome data was available from 18 of those sites. The primary referral sources were staff members, case managers, therapists, and psychiatrists working in the aforementioned agencies. Participants were at least 18 years of age and, although experiencing severe and persistent mental illness, were legally competent and able to sign consent for themselves (or had a legal guardian review and sign a consent form along with the participant’s consent). (See Appendix E for Informed Consent form.)

The majority of WMR participants were from community mental health centers (75%), rather than consumer-operated sites. Over half of participants (58%) were female. 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%). Few participants self-identified as Asian (1%),
Hispanic/Latino (1%), or Native American/Pacific Islander (4%). 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 postgraduate 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 those who endorsed “divorced” (27%). In regard to their current living situation, over half of participants (58%) who answered this question live in their own home, followed by individuals residing in a relative’s home or supervised group living (14%). Of those participants who chose to answer the question of employment status, approximately half reported being disabled (45%), and a third reported being currently unemployed (30%). The vast majority of participants indicated that they were in treatment because they chose to be (87%).

**Measures**

*WMR Post-Program Feedback Form.* Consumers taking part in WMR were given a 10-item, WMR Post-Program Feedback form (See Appendix A) to complete, allowing 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, assessing those aspects of the WMR program that each consumer liked (Question #8: “What part or aspect of the WMR program did you like best?”) and disliked (Question #9: “What part or aspect of the WMR program did you like least?”), as well as the role
WMR has played in each consumer’s recovery process (Question #10: “How has participating in the WMR program helped you in your recovery?”).

*Mental Health Recovery Measure.* The Mental Health Recovery Measure (MHRM) (See Appendix B) 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., 2009; Bullock & Young, 2003; O’Rourke, 2007; Rogers, Chamberlin, Ellison, & Crean, 1997; Wellness Management and Recovery Website, 2007).
**WMR Social Support Questionnaire.** The WMR Social Support Questionnaire (WMR SSQ) (See Appendix C) 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).

**WMR Client Self-Rating Scale.** The WMR Client Self-Rating scale (See Appendix D) 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., 2009; O’Rourke, 2007; Wellness Management and Recovery Website, 2007).

**WMR Procedure**

Throughout the 10-12 week program, WMR participants take part in group sessions that 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 F for WMR Curriculum). Participants are asked to complete outcome measures (e.g., Post-Program Feedback Form, Mental Health Recovery Measure, WMR Social Support Questionnaire, and Client Self-Rating Form) at pre-program and after they have completed the tenth and final session. The WMR Post-Program Feedback form is completed only after they have completed the final session. The WMR program design does not involve randomization to groups or a wait-list control group.

**Qualitative Analyses Procedures**

For the purposes of the present study, and the nature of the qualitative data collected, the premise of Grounded Theory Analysis was utilized. However, rather than analyzing and in-depth interviews with a small set of program participants, three open-ended qualitative questions were directly responded to by all participants at post-program. This thematic analysis draws on the tenants of grounded theory; however, the nature of the data precluded theoretical sampling. A constant comparative method was used to develop coding schemes, though not ongoing samplings. This study utilized content analysis for word counts and frequencies. Verbatim transcriptions of all responses (See Appendices G-I for participant responses) were utilized. Though data was refined (e.g., spelling was corrected), the context and content of the responses were not modified. These 1,578 total participant transcribed responses were reviewed for meaning units, categories, and themes. Thus, the analysis and conclusions continue to be grounded in data generated directly by the consumer, rather than ideas and biases of the researcher. The central difference between a traditional Grounded Theory Analysis and the current methodology used involves the vast number of responses that were reviewed, rather than
several interviews with fewer participants providing in-depth responses with the opportunity to clarify or expand on responses. Data was separated into individual meaning units, and categories of meaning units/higher-order categories emerged using a constant comparative method.

In qualitative research, it is vital that the researcher make biases and assumptions known to both self and others (Morrow, 2005). This process has become known as bracketing (i.e., becoming aware of personal biases, assumptions, and predispositions then setting them aside so that they do not influence the research). It is important to note that several years prior to the current study, a thematic coding system was inductively developed using a subsample of 75 responses to the three open-ended questions; these responses were reviewed and coded by a team of researchers (e.g., the author, her advisor, and two other graduate students). This coding system was used by the author to code the larger sample. Although the researcher had prior data that lead to assumptions regarding the current study, this data was only used as a guideline and for comparative purposes, not a steadfast rule regarding current findings. The researcher was not bound by themes that emerged in the pilot data; rather these themes were used as a guideline and new themes were sought out with the vast increase in number of participants since the pilot study was conducted. The first phase of the present study involved coding of all current data using the original coding system (from the pilot study); this phase was completed by the author.

In this next phase of data analysis, thematic categories based on the framework provided by the pilot study were further refined and condensed by this author and two intern-level graduate students who are unaffiliated with the WMR program and naïve to
the research questions being evaluated. The two additional graduate student evaluators have previous training and experience in qualitative analysis. Each evaluator had a basic understanding of the WMR program. The three evaluators together developed the updated coding system (e.g., the categories/thematic structure) by discussing differences in individual coding and ways to modify existing categories/themes (e.g., by condensing/collapsing categories). This revised coding system was discussed with the author’s advisor prior to each of the three evaluators’ independent coding of participant responses using the revised system. Each evaluator was given all participant responses to each question, though they were blind to the question itself. They were instructed to code data using the updated coding system that the three evaluators developed.

Because the original coding system was cumbersome and there was a great deal of variability of thematic categories (at times, with few responses in each category), the revised coding system was developed. This revised coding system was developed to determine if the existing framework could be improved, as well as to determine if the revised framework (developed using additional, blind evaluators) led to the emergence of new themes or captured the themes within the data in a more parsimonious, yet still complete, manner. Thus, the author re-analyzed the full data set to aid in the development of a revised category structure (e.g., to simplify and condense the cumbersome coding system developed for the pilot study and used in the initial analysis phase of the current study), as well as to ensure reliable results (e.g., by including additional evaluators blind to the research questions). Inter-rater reliability was calculated for the revised category structure, and kappa was found to be high (> .7) for all three questions and between the three raters (See Table 4 in Results).
In the final phase of data analysis, the author analyzed the full data set using NVivo (qualitative data analysis software) to compare and contrast the current findings. More specifically, queries of word frequency were completed to further explore responses and coding completed by the researchers. Themes were found by association between words.
Chapter IV
Results

Results

Results of Qualitative Analysis Using the Pilot Study Coding System. An organizing framework, partially based on Grounded Theory Analysis by Strauss and Corbin (1998), was developed. Responses were categorized by this author, her advisor, and two clinical psychology graduate students for a pilot study based on approximately 75 participants who had responded to the open-ended questions; currently there are 513 participants who have completed the WMR program, and who have provided responses to the qualitative questions for the current study. General, typical, and variant themes, along with superordinate categories, were developed independently by each researcher and subsequently discussed as a group to generate a consensus framework. This emergent consensus framework was subsequently used as the basis of comparison for current coding of data, which was completed by this author and two new graduate-level coders. Categories were refined at this time (e.g., collapsing several previous categories due to similarity between categories).

Frequency data based on the prevalence of each theme across participant responses was tallied for each category and sub-category (Pickett, Phillips, & Kraus, 2011). Themes were classified as general, typical, or variant based on the frequency of responses within each question (Young & Ensing, 1999). Per Young and Ensing, some themes were dropped at this level of analysis due to their low frequency, and thus their
limited generalizability. The category structure, sample responses, and frequency of responses for each of the three questions are presented in Tables 1-3 below (in subsequent sections). In text and tables, themes are identified using the following conventions to distinguish each level of the framework:

I. **Higher-Order (Superordinate) Category**

A. GENERAL THEME

1. typical theme

   a. variant theme

Results of Qualitative Analysis Using the Pilot Study Coding System: Question #8. Results suggested overall satisfaction with the WMR program. Question #8 asked participants “What part or aspect of the WMR program did you like best?” Three higher-order (superordinate) categories emerged that encompassed the nature of the 632 total responses: **Group Process** (group dynamics and individual activation), **Content** (topics and materials), and **Learning** (bridges process and content). In addition, a fourth higher-order category, labeled “**Gestalt**” (e.g., “I liked all of WMR” or “Everything”) emerged. (See Table 1.) Within each of the first three categories, general themes emerged. Within the **Group Process** category, the following general theme was indicated: GROUP DYNAMICS (e.g., comparing themselves with others, learning boundaries, feeling no pressure within the group). This general theme contained the following typical themes: **discussion and interaction** (e.g., listening to others, socializing, participation, sharing experiences and ideas, talking about problems) and **social support** (e.g., making friends, camaraderie, bonding with others, feeling not alone, feeling accepted and cared about).
The GROUP DYNAMICS category also contained the following variant themes: role-playing and facilitator/leader (e.g., general praise for facilitators). Team approach, taking on a teacher/mentor role, group peer (e.g., general praise for peers in the group), and consumer co-facilitator (e.g., general praise for the consumer co-facilitator) were dropped from the analysis due to their limited generalizability. Within the Group Process category, the following variant themes were also indicated: a) individual activation (e.g., doing the “work” of recovery, becoming an active participant in their treatment and recovery, engaging in group activities); b) insight into self (e.g., self-realization, self-awareness, gaining an understanding of self, taking control, caring for self, gaining confidence, openness in the group setting); c) receiving feedback from peers; and d) feeling respected (e.g., feeling not judged, feeling comfortable talking and sharing, confidentiality within the group). Self-advocacy, sense of accomplishment, and passive learning from listening attentively to peers were themes that were dropped from analysis due to their lack of generalizability.

Within the Content category (e.g., materials, topics covered) the following general theme emerged: TYPES OF MATERIAL (e.g., handouts, activities, pamphlets, WMR workbook, the way in which material was conveyed). Typical themes included: a) relevance of content (e.g., personalized examples, goodness of fit for needs of participants, proving information, topics covered) and b) comprehensiveness of material. Variant themes included: a) homework; b) user-friendly materials/well-structured; and c) the break-down of information.

Within the Learning category, which bridges the content of WMR with the group dynamics to aid in learning and retention of information, included the following general
themes: a) LEARNING ABOUT MENTAL ILLNESS (including stigma, self-help, symptoms, medication, side effects, triggers); b) LEARNING ABOUT RECOVERY (and relapse prevention); c) MAINTAINING WELLNESS (e.g., wellness plans, Wellness Wheel activity, maintaining balance in daily life); and d) COMMUNICATION SKILL-BUILDING. The following typical themes emerged: a) goal-setting and b) coping skills (e.g., problem-solving, controlling impulses, crisis intervention strategies). Nutrition emerged as a variant theme, while spirituality and motivation were dropped from the analysis due to lack of generalizability.

Overall, although there were a large variety of responses, the typical theme of discussion and interaction occurred in nearly 20% of participant responses. Social Support, another typical theme emerging from the Group Process category, emerged in 11% of participant responses. Nine percent of participants indicated that they liked WMR in its entirety (e.g., reported that they liked WMR in general but did not specify specific components). The type of materials used and how the content was conveyed emerged in 6% of participant responses, general praise for group facilitators emerged in 5.5% of participant responses, and learning about various aspects of mental illness emerged in 5% of participant responses. It appeared that the group process and group dynamics that developed over the 12 week program were found to most commonly occur in participant responses. (See Table 1.)
Table 1

Question #8 (“What aspect of the WMR program did you like best?”): Original thematic categories, sample responses for each category, and frequency of responses.

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>DESCRIPTION/PARTICIPANT RESPONSES</th>
<th>FREQUENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>Group Process</strong></td>
<td>(Group process)</td>
<td></td>
</tr>
<tr>
<td>A. <strong>GROUP DYNAMICS</strong></td>
<td>Compare self with others; learn boundaries; casual setting; not feeling pressured</td>
<td>13</td>
</tr>
<tr>
<td>1. <strong>Discussion and interaction</strong></td>
<td>Listen to others’ stories and experiences; socializing; participation; sharing experiences and ideas; talking about problems; talking with others</td>
<td>119</td>
</tr>
<tr>
<td>2. <strong>Social support</strong></td>
<td>Make friends; camaraderie; sharing the same diagnosis; bonding; ice breakers; knowing there are others “like me;” feeling not alone in mental illness; advice; guidance; caring about self; feeling accepted</td>
<td>69</td>
</tr>
<tr>
<td>3. <strong>Facilitator/leader</strong></td>
<td>Praise; helpful; knowledgeable</td>
<td>35</td>
</tr>
<tr>
<td>a. Consumer co-facilitator</td>
<td>Praise; helpful</td>
<td>8</td>
</tr>
<tr>
<td>4. <strong>Role plays</strong></td>
<td>Role play activities</td>
<td>22</td>
</tr>
<tr>
<td>5. <strong>Group peer</strong></td>
<td>Praise; offered personal examples</td>
<td>8</td>
</tr>
<tr>
<td>6. <strong>Take on teacher/mentor role</strong></td>
<td>Improve listening skills, take on mentor or teacher role</td>
<td>3</td>
</tr>
<tr>
<td>1. <strong>Team approach</strong></td>
<td>Collaboration; goal-oriented; doing the work together</td>
<td>2</td>
</tr>
<tr>
<td>B. <strong>Individual activation component</strong></td>
<td>Doing the “work” of recovery; active participant in recovery and treatment; doing the exercises/activities</td>
<td>9</td>
</tr>
<tr>
<td>1. <strong>Self-insight/self-awareness</strong></td>
<td>Taking control; openness; caring for self; building confidence; self-realization; self-understanding</td>
<td>15</td>
</tr>
<tr>
<td>2. <strong>Receiving feedback</strong></td>
<td></td>
<td>11</td>
</tr>
<tr>
<td>3. <strong>Feeling respected</strong></td>
<td>Not judged; comfortable talking and sharing; confidentiality</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>4. Self-advocacy</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>5. Graduation/sense of accomplishment</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>6. Passive learning through others’ experience</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td><strong>II. Content</strong></td>
<td>(Topics/material)</td>
<td></td>
</tr>
<tr>
<td><strong>A. TYPE OF MATERIAL</strong></td>
<td>Exercises/activities; paperwork; cartoons/pamphlets/music; handouts/workbook; the way the material is conveyed (visual and auditory)</td>
<td>39</td>
</tr>
<tr>
<td><strong>B. Comprehensive</strong></td>
<td>Materials; education; topics covered; overview</td>
<td>16</td>
</tr>
<tr>
<td><strong>C. Relevance</strong></td>
<td>Personalized examples, goodness of fit for needs of participants; provide information; topics; identified specific sessions</td>
<td>15</td>
</tr>
<tr>
<td><strong>D. Homework</strong></td>
<td></td>
<td>6</td>
</tr>
<tr>
<td><strong>A. Break down information</strong></td>
<td>Review</td>
<td>5</td>
</tr>
<tr>
<td><strong>B. User-friendly</strong></td>
<td>Good structure</td>
<td>3</td>
</tr>
<tr>
<td><strong>III. Learning</strong></td>
<td>(Bridges process and content)</td>
<td>12</td>
</tr>
<tr>
<td><strong>A. LEARNING ABOUT MENTAL ILLNESS</strong></td>
<td>Stigma; self-help; symptoms; triggers</td>
<td>30</td>
</tr>
<tr>
<td><strong>B. RECOVERY</strong></td>
<td>Including relapse prevention</td>
<td>23</td>
</tr>
<tr>
<td><strong>C. MAINTAINING WELLNESS</strong></td>
<td>Wellness wheel; balance in life</td>
<td>20</td>
</tr>
<tr>
<td><strong>D. COMMUNICATION AND RELATIONSHIP SKILLS</strong></td>
<td></td>
<td>17</td>
</tr>
<tr>
<td><strong>E. Medication/side effects</strong></td>
<td></td>
<td>14</td>
</tr>
<tr>
<td><strong>F. Goal-setting</strong></td>
<td></td>
<td>13</td>
</tr>
<tr>
<td><strong>G. Coping skills</strong></td>
<td>Problem-solving; control impulses; crisis intervention strategies</td>
<td>11</td>
</tr>
<tr>
<td><strong>H. Other-nutrition</strong></td>
<td></td>
<td>5</td>
</tr>
</tbody>
</table>
Results of Qualitative Analysis Using the Pilot Study Coding System: Question #9.

When participants were asked “What part or aspect of the WMR program did you not like?” 326 participants responded to this question. Again, there was a great degree of variability in participant responses. The following superordinate categories emerged from the data: a) **Content/Material** (e.g., desiring more hands-on activities, desiring more depth of material); b) **Time**; c) **Interaction with Others** (e.g., anxiety from group dynamics, group format itself, participation strongly encouraged, ice breakers); and d) “None”/“Liked all of WMR” (See Table2.) Within the superordinate category of **Content/Material**, the following general themes emerged: a) **CONTENT NEEDS SIMPLIFIED** (e.g., course moved too fast, difficult to read or follow, content was unclear or overwhelming); b) **HOMEWORK**; and c) **COMPLETING MEASURES** at pre- and post-program.

The following typical themes emerged from this category: a) **material was redundant**; b) **incomplete booklets/not everything was covered in the booklet**; c) **role-playing activities**; and d) **specific topics covered**. A variant theme that the content was not challenging enough emerged, and several themes were eliminated because of their lack of generalizability (e.g., overheads were too simple or difficult to see, “the
lecture”, too much reading, “the class work”, and not enough information related to the later stages of recovery).

Within the superordinate category of Time category, the TWO-HOUR GROUP FORMAT and feeling there was NOT ENOUGH TIME ALLOTTED (e.g., ended abruptly, unsure of future steps, desired longer sessions, desired longer program, desire for follow-up sessions) emerged as general themes. Themes of the program being too slow-paced and the day/time selected were dropped from analysis because of their lack of generalizability.

Within the superordinate category of Interaction with Others category, a general theme regarding NOT HAVING ENOUGH PARTICIPANTS/DESIRE FOR PARTICIPANTS TO BE MORE ACTIVE AND ENGAGED emerged. Group etiquette (e.g., lack of turn-taking, one individual monopolizing the group) emerged as a typical theme. Feedback from peers, hygiene of peers, and not knowing other participants at the beginning of group were themes that were dropped from analysis due to their lack of generalizability.

Forty-eight percent of respondents indicated that they liked all of WMR and had no aspect which they liked least. The following themes were dropped from analysis because of lack of generalizability: transportation issues, desire for more experts to speak to the group, not all mental health issues were addressed, group leaders were not knowledgeable or helpful, feeling that the group was too personal and uncomfortable to share experiences, feeling judged by others, and not caring or being invested in the group.

Overall, the data suggested that the majority of participants enjoyed WMR overall and did not have any suggestions or recommendations (48% of participant responses).
Many participants indicated that they would have liked more time in the group/more group sessions (8% of participant responses) and that the two-hour group format was too long (5% of participant responses). Other participants indicated that the group dynamics/interactions with others (4% of participant responses), the content/material needed simplified (7.5% of participant responses), and the amount of homework (4.5% of participant responses) were the least desirable aspects of the WMR program. (See Table 2.)

Table 2

*Question 9 ("What aspect of the WMR program did you like least?"): Original thematic categories, sample responses for each category, and frequency of responses.*

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>DESCRIPTION/PARTICIPANT RESPONSES</th>
<th>FREQUENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>Content/Material</strong></td>
<td>Would like more hands-on activities; would like more in-depth materials; learning; would like more information for each topic</td>
<td>4</td>
</tr>
<tr>
<td>A. NEEDS SIMPLIFIED</td>
<td>Moved too fast through materials; difficult to read and follow; overwhelming; unclear</td>
<td>15</td>
</tr>
<tr>
<td>B. HOMEWORK</td>
<td></td>
<td>15</td>
</tr>
<tr>
<td>C. MEASURES/PAPERWORK</td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>D. Redundant</td>
<td></td>
<td>9</td>
</tr>
<tr>
<td>E. Difficult to follow</td>
<td>For visually impaired participants; difficult to follow book; handouts unclear</td>
<td>9</td>
</tr>
<tr>
<td>F. Role plays</td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>G. Specific topics</td>
<td>Difficult to set goals</td>
<td>6</td>
</tr>
<tr>
<td>H. Incomplete binders</td>
<td>Not everything in binder was covered</td>
<td>5</td>
</tr>
<tr>
<td>I. Illustrations</td>
<td>Too simple; would like more visuals</td>
<td>5</td>
</tr>
<tr>
<td>J. Not challenging</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>K. Overheads</td>
<td>Too simple; difficult to see</td>
<td>2</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>------------------------------</td>
<td>---</td>
</tr>
<tr>
<td>L. Lecture</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>M. Too much reading</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>N. Class work</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>O. Not enough information for late recovery</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>P. Review</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td><strong>II. Time</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. NOT ENOUGH TIME</td>
<td>Abrupt ending to WMR; unsure what to do/where to go next; each session was too short; would like more weeks for the group; need follow-up sessions; got off topic and wasted group time; too much material to cover in short time and with large number of participants</td>
<td>25</td>
</tr>
<tr>
<td>B. TWO HOUR GROUP FORMAT</td>
<td>Too long</td>
<td>17</td>
</tr>
<tr>
<td>C. Day of week/time of day</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>D. Slow-paced</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td><strong>III. Interaction with Others</strong></td>
<td>Anxiety-provoking; group format; participation strongly encouraged; ice breakers; nervous when speaking</td>
<td>13</td>
</tr>
<tr>
<td>A. NOT ENOUGH PARTICIPANTS IN GROUP</td>
<td>Not enough participation</td>
<td>10</td>
</tr>
<tr>
<td>B. Poor group etiquette</td>
<td>Lack of turn-taking; one person monopolizing group</td>
<td>7</td>
</tr>
<tr>
<td>C. Feedback from peers</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>D. Not knowing anyone in group</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>E. Hygiene of peers</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td><strong>IV. Gestalt</strong></td>
<td>Did not like any aspect least; liked all of WMR</td>
<td>157</td>
</tr>
<tr>
<td>V. Too personal</td>
<td>Having to tell stories about self to strangers</td>
<td>4</td>
</tr>
<tr>
<td>VI. Feeling judged/arguments</td>
<td></td>
<td>3</td>
</tr>
</tbody>
</table>
between group peers

<table>
<thead>
<tr>
<th>VII. Group leaders not helpful</th>
<th>Group leaders not confident or knowledgeable</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>VIII. The party</td>
<td>Should not have had junk food; had no snacks</td>
<td>3</td>
</tr>
<tr>
<td>IX. Was not invested in group</td>
<td>Bored; did not care about group or WMR</td>
<td>2</td>
</tr>
<tr>
<td>X. Transportation</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>XI. Would like more experts to speak</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>XII. Did not address some mental health issues</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>XIII. Physical setting</td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>

**Results of Qualitative Analysis Using the Pilot Study Coding System: Question #10**. Participants were also asked “How has participating in the WMR program helped you in your recovery?” There was a great deal of variability in the 620 total responses; however, several superordinate categories emerged: a) **Information can be applied/education** (e.g., gaining knowledge, obtaining resources, information was useful, the learning process, referencing materials later); b) **Clarified recovery goals**; c) **Changes in self**; d) **Interaction with others**; and e) **Gains in insight and perspective**. (See Table 3.) Thirteen percent of participants indicated that WMR was helpful overall (e.g., “instrumental in my recovery,” “integral part of my life journey,” “helpful in many ways”). A few of the participants (e.g., 2% of respondents) indicated that WMR was not helpful or they were unsure as to how it helped them.

Within the superordinate category of **Information can be applied/education** superordinate category, the following three general themes emerged: a) **GAINING COPING SKILLS** (e.g., patience, how to cope with mental illness, new tools for self-help, avoiding relapse and hospitalizations – occurring in 7.5% of participant responses); b) **UNDERSTANDING MENTAL ILLNESS** (e.g., learning about medication and
symptoms, understanding triggers – occurring in 6.5% of participant responses); and c) LEARNING COMMUNICATION SKILLS (e.g., assertiveness, talking with doctors and family members, learning to express self, asking questions – occurring in 5% of participant responses). A typical theme that emerged within this category is learning about recovery, how to manage recovery, and feeling whole again. Variant themes included: a) wellness (e.g., wellness plan, Wellness Wheel activity); b) WMR was a reiteration of previously learned information; c) practical examples that were relevant to participants (e.g., usage in daily life, putting situations in perspective); and d) structure in daily life/structure and organization of program. Crisis management strategies, homework, and WMR as a holistic program were themes dropped from analysis because of their lack of generalizability.

The superordinate category Clarification of recovery goals contained no themes or sub-categories. This category included responses related to how WMR has affected participants’ recovery journeys in a positive way and allowing participants to create and achieve clear goals for their recovery.

Within the superordinate category of Changes of self, the following general themes emerged: a) SELF-INSIGHT (e.g., getting to know self, becoming a better person/self, understanding and learning about self, discovering self, getting “in touch with me,” personal growth, self-reflection, increased self-awareness) and b) SENSE OF CONTROL/EMPOWERMENT/CONFIDENCE and appreciation of self (e.g., gains in self-respect, feeling better about self, increases in self-esteem, self-advocacy, responsibility for own recovery, being more effective, being more active in treatment, internal locus of control, feeling stronger, thinking for self and making choices,
confidence to talk and engage with others). Typical themes of **positive attitude** (e.g., positive thinking, positive attitude about life) and **applying self** (e.g., staying focused, being held accountable, being forced to think) emerged from participant responses. **Sense of autonomy and desire to help others** (e.g., feelings of responsibility, useful, and purpose) and **self-discourse/openness** in the group emerged as variant themes.

Within the superordinate category of **Interaction with others**, **Social Support/Socialing** (e.g., developing interpersonal relationships, improving relationships with family and friends, making new friends, not feeling alone, sharing and knowing there are differences feels empowering, feeling part of a family, learning social skills, having people who care, identifying with others, knowing others have similar issues/struggles) emerged as a general theme. **Discussion** (e.g., how to work in a group, talking about problems) and **passive learning** (e.g., understanding others’ experiences, listening more attentively to others) emerged as typical themes. **Receiving feedback from others** emerged as a variant theme.

Within the superordinate category of **Gaining insight and perspective**, **Maintaining a healthy lifestyle** (e.g., eating healthy, exercising, medication management, staying clean and sober, finding balance in life, maintaining wellness, understanding the importance of self-care, increasing enjoyable activities) emerged as a general theme. **Increasing feelings of hope** and feeling enlightened, as well as the **desire to recover** (e.g., motivation to go on, using skills learned in group to recover, motivation overall) emerged as typical themes. Recognizing healthy others in life to aid in recovery and feeling less ashamed of mental illness were themes dropped from analysis because of lack of generalizability.
Overall, 13% of participants indicated that the WMR program overall was helpful. Twelve percent of participants indicated that social support and improving personal relationships helped them the most in their recovery journey, while 8.5% of participants indicated gains in insight and awareness were integral in their recovery. Eight percent of participants who responded to this question indicated that gaining a sense of control, empowerment, confidence, and self-appreciation was the key element from the WMR program that aided their recovery. Increased coping skills and understanding aspects of mental illness (occurring in 7.5% and 6.5% of participant responses, respectively) were the most beneficial gains from the WMR program, while applicable information and knowledge, communication skills, and clarification of recovery goals were integral for many participants (occurring in 6%, 5.5%, and 4.5% of participant responses, respectively). (See Table 3.)

Table 3

*Question 10 (“What aspect of the WMR program helped you the most in your recovery?”): Original thematic categories, sample responses for each category, and frequency of responses.*

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>DESCRIPTION/PARTICIPANT RESPONSES</th>
<th>FREQUENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Applicable information/education/learning</td>
<td>Offered new ideas, good resources; provided useful information; knowledge; use materials given to reference later</td>
<td>38</td>
</tr>
<tr>
<td>A. COPING SKILLS</td>
<td>Patience; dealing with mental illness; new tools for self-help; handle symptoms; prevent hospitalizations; avoid relapse</td>
<td>45</td>
</tr>
<tr>
<td>B. UNDERSTANDING MENTAL ILLNESS</td>
<td>Learn about medications, triggers, and symptoms; decrease symptoms</td>
<td>39</td>
</tr>
<tr>
<td>C. COMMUNICATION SKILLS</td>
<td>Assertiveness; talking with doctors and family; learning to express self; asking questions when you do not understand</td>
<td>33</td>
</tr>
<tr>
<td>D. Learn about recovery</td>
<td>Manage recovery; feel whole</td>
<td>15</td>
</tr>
<tr>
<td>-------------------------</td>
<td>-----------------------------</td>
<td>----</td>
</tr>
<tr>
<td>E. Structured steps</td>
<td>Organized; structure in daily life; get out of house</td>
<td>7</td>
</tr>
<tr>
<td>F. Wellness</td>
<td>Wellness plan; wellness wheel; handouts; achieve wellness; refreshed mind</td>
<td>7</td>
</tr>
<tr>
<td>G. Reiterate previous knowledge</td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>H. Relevance</td>
<td>Put things in perspective; use everything learned in daily life; provided practical examples</td>
<td>6</td>
</tr>
<tr>
<td>I. Crisis management</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>J. Holistic program</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>K. Homework</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>II. Clarified recovery goals</td>
<td>Affected recovery journey in positive way; see things in better way</td>
<td>27</td>
</tr>
<tr>
<td>III. Self</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. SELF-INSIGHT</td>
<td>Know self; become better self/person; learn about self/understand self; target problems; learn strengths and weaknesses; discover self; getting in touch with self; personal growth; being a leader; self-reflection; paying better attention to how I feel in order to understand self better; increase awareness; identify areas of needed work</td>
<td>53</td>
</tr>
<tr>
<td>B. SENSE OF CONTROL AND EMPOWERMENT/GAINS IN SELF-APPRECIATION AND SELF-RESPECT</td>
<td>Gaining confidence; feeling better about self; self-advocacy; responsible for own recovery; be more effective; be more active in treatment; getting a job; internal locus of control; talking to others more; increased self-esteem; recognizing there are choices; thinking for self; giving strength on many levels</td>
<td>43</td>
</tr>
<tr>
<td>C. Apply self</td>
<td>Stay focused; be held accountable; makes you think</td>
<td>12</td>
</tr>
<tr>
<td>D. Positive thinking</td>
<td>Positive attitude; more positive about life and self</td>
<td>12</td>
</tr>
<tr>
<td>E. Self-disclosure/openness</td>
<td>Talking to others without being judged</td>
<td>7</td>
</tr>
<tr>
<td>IV. Interaction with others</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>A. SOCIAL SUPPORT/SOCIALIZING</td>
<td>Improve relationships with family and friends; making friends; did not feel alone; sharing and realizing differences can be empowering; being a part of a family; learning social skills; having friends who care; identifying with others; recognizing that others have similar issues</td>
<td>75</td>
</tr>
<tr>
<td>B. Discussion</td>
<td>How to work in a group; talking through problems; talk with others</td>
<td>17</td>
</tr>
<tr>
<td>C. Passive learning</td>
<td>Understanding others’ experiences; learning to listen to others</td>
<td>11</td>
</tr>
<tr>
<td>D. Receiving feedback</td>
<td></td>
<td>5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>V. Insight/gain perspective</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A. MAINTAIN HEALTHY LIFESTYLE</td>
<td>Eat healthy; exercise; medication management; stay sober; find balance in life; maintain wellness; importance of self-care; increase enjoyable activities</td>
</tr>
<tr>
<td>B. Hope/enlightenment</td>
<td></td>
</tr>
<tr>
<td>C. Desire to recover</td>
<td>Got motivation to go on; use skills learned to recover; motivation</td>
</tr>
<tr>
<td>D. Recognize healthy others in life to aid in recovery</td>
<td></td>
</tr>
<tr>
<td>E. Not ashamed of mental illness</td>
<td></td>
</tr>
</tbody>
</table>

| VI. Helpful | Helpful in many ways; instrumental in my recovery; integral part of my life journey | 80 |
| VII. Not helpful |   | 9 |
| VIII. Unsure |   | 4 |
| IX. Improve quality of life |   | 2 |
| X. Other | Would like longer groups and more homework | 1 |

*Results of Qualitative Analysis Using Revised Coding System.*
The following results are based on the revised coding system that was developed as previously described. Revised category structure, sample responses, and frequency of responses for each of the three questions are presented in Tables 5-7 below (in subsequent sections). Using the revised thematic categories, these three new raters coded all responses. Cohen’s kappa was computed to check the reliability of responses to each question by each individual evaluator. The resulting kappa (kappa > .7 for all three questions and all three raters; see Table 4 below) indicates that all raters provided similar responses when coding responses to each of the three questions, as kappa was high (Leech, Barrett, & Morgan, 2005).

Table 4

Inter-rater Reliability Results (for three raters and across three questions)

<table>
<thead>
<tr>
<th></th>
<th>Rater 1 (author) x Rater 2</th>
<th>Rater 1 (author) x Rater 3</th>
<th>Rater 2 (author) x Rater 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Question 8</td>
<td>Kappa = .80</td>
<td>Kappa = .72</td>
<td>Kappa = .70</td>
</tr>
<tr>
<td>Question 9</td>
<td>Kappa = .92</td>
<td>Kappa = .88</td>
<td>Kappa = .87</td>
</tr>
<tr>
<td>Question 10</td>
<td>Kappa = .78</td>
<td>Kappa = .80</td>
<td>Kappa = .77</td>
</tr>
</tbody>
</table>

Results of Qualitative Analysis Using Revised Coding System: Question #8.

Results of data analysis using the restructured categories suggest overall satisfaction with the WMR program. Question #8 asked participants “What part or aspect of the WMR program did you like best?” Thirty-four percent of the 513 total average responses of the three evaluators indicated that participants identified group dynamics as the aspect of WMR they liked best. Content of WMR was indicated by 17.5% of responses as the
aspect they liked best, and 12% of responses indicated they liked the program in its entirety. Twelve percent of responses indicated that the education aspect of WMR was what participants liked best, and 7% of responses indicated that the recovery piece was important to participants. The group facilitators and communication skill-building were identified in 6.5% of participants’ responses; the individual activation component was identified in 4% of participants’ responses; and only .5% of responses indicated that participants did not find the WMR program helpful.

Results of data analyzed using the restructured thematic categories are similar to the results using the original coding system developed for the pilot study. For Question #8, group dynamics (e.g., social support and discussion/interaction) were reported by participants as the aspect they liked best about the WMR program using both the original and revised coding systems. Liking all aspects of the program as well as types of material/content of the program were reported as well liked by participants. Facilitators and communication play an important role in participants’ reported benefits of the program. (See Table 5.)

Table 5

*Question #8 ("What aspect of the WMR program did you like best?"): Revised thematic categories, sample responses for each category, and average frequency of responses of the three raters.*

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>DESCRIPTION/PARTICIPANT RESPONSES</th>
<th>FREQUENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group Dynamics</td>
<td>Social support; discussion; interaction with others; team focus; peers in group; feedback from others; mutual respect</td>
<td>175</td>
</tr>
<tr>
<td>Content</td>
<td>Types of materials; comprehensive; personal relevance; identified specific sessions as helpful</td>
<td>86</td>
</tr>
<tr>
<td>Like it all/helpful</td>
<td>Everything was helpful; liked the whole program</td>
<td>64</td>
</tr>
<tr>
<td>--------------------------------------------------------</td>
<td>-------------------------------------------------</td>
<td>-----</td>
</tr>
<tr>
<td>Education/skills/knowledge</td>
<td>Homework; learning; coping skills; learning about medication, side effects, mental illness, stigma, symptoms, triggers</td>
<td>62</td>
</tr>
<tr>
<td>Recovery</td>
<td>Wellness; wellness wheel; goals; relapse prevention; crisis management</td>
<td>36</td>
</tr>
<tr>
<td>Communication</td>
<td>Role plays; assertiveness; talking with doctor and family members</td>
<td>33</td>
</tr>
<tr>
<td>Facilitators/leaders</td>
<td>Praise for facilitators; facilitators were helpful; consumer co-facilitator; professional co-facilitator</td>
<td>33</td>
</tr>
<tr>
<td>Individual Activation</td>
<td>The “work” of recovery; active participant in treatment and recovery; self-advocacy; self-insight; self-awareness; self-understanding; control/empowerment; openness; confidence/self-esteem/self-respect; take on mentor role/help others; motivation; sense of autonomy; apply self; positive thinking</td>
<td>21</td>
</tr>
<tr>
<td>Not helpful</td>
<td>Program was not helpful</td>
<td>3</td>
</tr>
</tbody>
</table>

*Results of Qualitative Analysis Using Revised Coding System: Question #9.*

Question #9 asked participants “What part or aspect of the WMR program did you like least?” Forty-nine percent of the 382 total average responses of the three raters indicated that participants were unable to identify any aspect of the program they did not like, often stating that they liked the entire program and found it helpful. Twenty-five percent of participant responses indicated that they did not find some aspect of the content helpful. Over 14% of participants identified the group interaction as the aspect of the program they liked least, where as over 11% of participants identified some aspect of time as not helpful or conducive to their recovery journeys in the program.
For question #9, the vast majority of participants reported that they liked the program in its entirety and were unable to identify an aspect they did not like, in both the original and revised coding systems. However, with the restructured thematic categories with multiple evaluators, content and group interaction were identified as aspects participants liked least, whereas using the original coding system, time was identified as an aspect participants liked less than both content and interaction. It is important to note, however, that this discrepancy appears to be due to the reorganization of the categories, rather than an error in coding. In the restructured coding system, several categories from the original coding system were condensed to form the overarching content and group interaction categories. When this was taken into account, both the restructured and original coding categories fell into the same order of frequency of responses. (See Table 6.)

Table 6

Question #9 (“What aspect of the WMR program did you like least?”): Revised thematic categories, sample responses for each category, and average frequency of responses of the three raters.

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>DESCRIPTION/PARTICIPANT RESPONSES</th>
<th>FREQUENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>None/like it all</td>
<td>Everything was helpful; liked the whole program</td>
<td>187</td>
</tr>
<tr>
<td>Interaction</td>
<td>Group format; participation; ice breakers; nervous/anxious in group setting; feedback from peers; poor group etiquette; not enough participants; lack of participation; poor group leaders; too personal; felt judged; party/no snacks</td>
<td>96</td>
</tr>
<tr>
<td>Content/material</td>
<td>Needs simplified; want more information; hard to follow; role plays; redundant; did not address all issues; illustrations; measures/paperwork/homework</td>
<td>55</td>
</tr>
</tbody>
</table>
Results of Qualitative Analysis Using Revised Coding System: Question #10.

Question #10 asked participants “What aspect of the WMR program did you find helped you the most in your recovery?” Twenty-five percent of the 469 total average responses of the three raters indicated that participants identified both the education aspect and individual activation component as most helpful in their recovery. Seventeen percent of participants indicated that the program in its entirety aided them in their recovery, and 14% of participant responses indicated that the interaction with others was vital to their recovery. Eleven percent of participant responses indicated that the recovery and wellness piece aided them in their recovery; 6% of participant responses indicated that communication skill building was most helpful; and only 2% of participant responses indicated that nothing about the WMR program helped them in their individual recovery journeys.

For question #10, coding based on both the original and restructured thematic categories indicated that the education offered and individual activation component were the aspects of the WMR program most influential in their individual recovery journeys. Participants also indicated that the program was helpful overall, as well as the group interaction/group dynamics were particularly salient in their recovery. Recovery/wellness were identified slightly more frequently using the revised coding system with multiple raters; however, both recovery and communication were identified as important components of the program to individuals’ recovery journeys. (See Table 7.)
Table 7

*Question #10 ("What aspect of the WMR program helped you the most in your recovery?"): Revised thematic categories, sample responses for each category, and frequency of responses.*

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>DESCRIPTION/PARTICIPANT RESPONSES</th>
<th>FREQUENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interaction</td>
<td>Personal relationships; feedback; passive learning through others’ experience; social support; socializing; discussion; identify with others</td>
<td>118</td>
</tr>
<tr>
<td>Recovery</td>
<td>Wellness; wellness wheel; goals; relapse prevention; crisis management; hope; desire to recover; healthy lifestyle; enlightenment; balance</td>
<td>116</td>
</tr>
<tr>
<td>Like it all/helpful</td>
<td>Everything was helpful; liked the whole program</td>
<td>81</td>
</tr>
<tr>
<td>Individual Activation</td>
<td>The “work” of recovery; active participant in treatment and recovery; self-advocacy; self-insight; self-awareness; self-understanding; control/empowerment; openness; confidence/self-esteem/self-respect; take on mentor role/help others; motivation; sense of autonomy; apply self; positive thinking</td>
<td>65</td>
</tr>
<tr>
<td>Education/skills/knowledge</td>
<td>Homework; learning; applicable; useful resources; coping skills; learning about medication, side effects, mental illness, stigma, symptoms, triggers</td>
<td>50</td>
</tr>
<tr>
<td>Communication</td>
<td>Role plays; assertiveness; talking with doctor and family members</td>
<td>27</td>
</tr>
<tr>
<td>Not helpful</td>
<td>Program was not helpful</td>
<td>12</td>
</tr>
</tbody>
</table>
**NVivo Results.**

In the final phase of data analysis, the author analyzed data using NVivo (qualitative data analysis software) as described earlier. Results for Question #8 indicated the following frequency of responses from highest to lowest frequency: group dynamics, liked the whole program, education, recovery, communication, content, individual activation, and facilitators. In both coding by the three-person research team as well as with NVivo, participants indicating that the group process/group dynamics was the aspect of WMR they liked best was far higher than other responses. It appears that the content category was underrepresented in word frequency using the NVivo software. Because NVivo is unable to discern the context in which words were utilized by participants, a limitation of the software is that some categories or themes are underrepresented.

Results for Question #9 indicated the following frequency of responses from highest to lowest frequency: liked the whole program, time, interaction, and content. Consistent with coding by the three-person research team, NVivo identified that the vast majority of participants indicated that they did not dislike any aspect of the program. Using NVivo software, the categories time, interaction, and content were represented with nearly the same frequency, whereas the three evaluators indicated that interaction with peers had a significantly higher frequency than both time and content. Again, this discrepancy is likely due to NVivo’s inability to code using context of response. Finally, results for Question #10 indicated the following frequency of responses from highest to lowest frequency: interaction, individual activation, and liked the whole program resulted in the same high frequency; recovery, education, communication, and WMR was not helpful followed. Consistent with coding by the three raters, few participants indicated
that the program was not helpful, followed by communication and education. Consistent with coding by the three raters, interaction was represented by the greatest frequency of participant responses. There was a discrepancy between liking the entire program, individual activation, and recovery between the NVivo software and the three raters, again potentially due to NVivo’s limitation of using context of the responses.

Results of Current Study Compared to Results of Quantitative Measures

Mental Health Recovery Measure (MHRM). Paired (dependent) $t$-tests were used to assess overall group changes (N=504) on the MHRM following completion of the WMR program. Results indicated that there was a significant increase in Total MHMR scores from pre-treatment ($M=77.32$) to post-treatment ($M=86.40$), $t(503)=11.68, p<.01$. As a group, participants completing the WMR program reported significantly greater levels of mental health recovery on the MHRM at the end of treatment. The effect size for this statistically significant increase was in the medium range (Cohen’s $d=.45$). (See Table 8.)

In addition to average changes, individual pre-post changes were computed for each participant. Statistically reliable improvement or deterioration ($p<.05$) was based on the standard error of measurement for each outcome measure (Jacobson & Truax, 1991). “Moderate” improvement or deterioration was assigned if the individual change reached a “clinically meaningful” level of change ($p<.20$). Based on normative data, the reliable level of change represents a .75 SD change, while the “moderate” level of change represents a .5 SD change on the MHRM. The individual change data illustrate the wide inter-individual differences in the amount, and direction, of change from pre- to post-treatment. While 205 persons (44%) of the participants were found to have moderate or statistically reliable improvement, 26 persons (10%) of the participants had moderate to
reliable deterioration, while 216 persons (46%) showed no significant individual change from pre to post MHRM score.

Table 8

Mean Pre and Post Scores for Participants on the Mental Health Recovery Measure (MHRM; N=504)

<table>
<thead>
<tr>
<th>Scale</th>
<th>Pre-WMR Mean (SD)</th>
<th>Post-WMR Mean (SD)</th>
<th>t (df)</th>
<th>p&lt;</th>
<th>Effect Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>MHRM Total</td>
<td>77.32 (21.6)</td>
<td>86.40 (19.4)</td>
<td>11.68 (503)</td>
<td>.01</td>
<td>.45</td>
</tr>
</tbody>
</table>

The majority of participants indicating that their mental health recovery decreased at post-program (based on outcomes of the MHRM; N = 46) indicated on the qualitative outcomes on the Post-Program Feedback Form that they liked the education, social, communication components of the program, made gains in self-insight/awareness of areas to be improved, increased areas of motivation, and that they liked the program in its entirety. Some participants with meaningfully decreased difference scores on the MHRM from pre- to post-program (who also completed the qualitative responses) indicated on Question #9 (what they did not like about the program) that they liked the entire program; others indicated that they did not like the homework, measures, had difficulty following and understanding, and role plays. Conversely, when more closely examining the MHRM gain scores for individuals who indicated on the qualitative questions that they did not like the WMR program, several of these participants made significant gains on the MHRM, several indicated significant loss on the MHRM, and several indicated no significant change in mental health recovery from pre- to post-program.
Post-Program Feedback Form (quantitative questions). Approximately 500 participants responded to the seven, Likert-scale quantitative questions on the Post-Program Feedback form. Results indicated overall satisfaction with the WMR program and specific components of the program. When participants were asked if WMR was what they expected, participants (on average) reported that it was just about all they expected. When participants were asked if the curriculum material and topics covered were what they needed to further their recovery journeys, on average participants reported that the materials were quite helpful and what they needed for recovery. When asked if the group attendance requirements or length of sessions were too time demanding, participants (on average) indicated that this component was just a little too demanding. Participants, on average, indicated that the handout materials were quite user friendly, and they indicated that the homework was just a little too demanding. Participants, on average, indicated that the group facilitators were quite effective, as well as indicating that having other members in the group was quite helpful.

Social Support Questionnaire (SSQ). A previous study found that participants of the WMR program reported an increased number of participants in their social support networks as well as increased levels of satisfaction with their social support networks (Hupp, Bullock, Brockmyer, & Treadaway, 2008). Such findings are consistent with the current study, which indicated that the group experience (e.g., peer support, socializing, discussion, interaction) is the component of WMR participants liked most and identified as one of the most helpful aspects of WMR to their individual recovery journeys.
Chapter V

Discussion

Discussion of Findings

Recovery has become the guiding vision for the treatment of those experiencing severe and persistent mental illness (Anthony, 1993). As part of the transformation process away from treatment models that seek to merely manage symptoms, the role that consumers of mental health services play in the process of their recovery is no longer one characterized by consumers acting as passive recipients of their care. The WMR program has consistently sought to improve the lives of its participants through gains in empowerment, knowledge, use of skills learned, self-advocacy, and support. Previous research outcomes have found that participants in the WMR program make significant gains across various (quantitative) outcome measures (Bullock et al., 2009).

The current study sought to capture the voice of participants by allowing them the freedom to respond to several open-ended questions about their personal experiences, both positive and negative, in the WMR program. This data, although collected over a number of years, had yet to be unearthed. Gaining insight into the minds of the participants has offered the researchers validation that WMR is doing what it had originally intended to do. Results of this study converged, in large part, with outcomes found on the quantitative measures. Overall, this study found that participants liked the following aspects of the WMR program best: the discussion and interaction, aspects of social support, and WMR in its entirety. The type of materials used and how the content was conveyed, general praise for group facilitators, and knowledge/learning about various aspects of mental illness also occurred frequently in participant responses. A high
frequency of participants also reported that they enjoyed and benefitted from WMR as a whole.

These findings are consistent with previous outcomes that social support, knowledge, and becoming involved in their own recovery/self-help activities are common aspects of the programs that participants indicate are beneficial (Bullock et al., 2009). The type of materials and how content was conveyed, as well as praise for group co-facilitators are additional areas that had previously not been documented in the data as aspects of the program participants like. The group process/group dynamics, including the importance of discussion, interaction, and feeling supported, plays a considerable role in the success of WMR. Although this is an area frequently discussed and believed to be a driving force behind the success of the program, it has previously been without the support of outcome measures.

This study also indicated that participants appear to like the following aspects of WMR the least: participants would have liked more time per session/more weeks in the program, the 2-hour format was too long, the content/material needs to be simplified, the amount of homework/paperwork was too great, and the group dynamics/interactions with others could be anxiety-provoking or disruptive at times. It should be noted that the majority of participants enjoyed WMR overall and did not have any suggestions or recommendations to improve the program. Again, many of these opinions had been voiced by participants over time to their co-facilitators; however, it was not until this study that outcome data was collected on this area.

Additionally, participants reported that the following aspects of the WMR program have helped them the most in their individual recovery journeys: WMR in its
entirety was helpful; social support and improving personal relationships; gains in insight and awareness; gaining a sense of control, empowerment, confidence, and self-appreciation; increased coping skills; understanding aspects of mental illness; receiving applicable information and knowledge; communication skill-building; and clarification of recovery goals. As previous outcome data has shown, social support/personal relationships, empowerment, coping skills, knowledge about mental illness, and clarification of recovery goals are vital in what makes WMR beneficial to its participants. However, this study has demonstrated that participants are also making gains in insight and awareness, gains in self-worth, and gains in communication skills and assertiveness, all of which have been failed to be captured by quantitative measures.

Discussion of Revised Thematic Categories. Results using the restructured thematic categories were consistent overall with the original coding system used by this author and in the original pilot study. Participants reported that the group dynamics, content, education, recovery/wellness, facilitators, communication, and the program in its entirety were what they liked the most about the program. A majority of participants indicated that they liked the entire program and could not identify aspects they did not like. Various aspects of the content of WMR and the group dynamics, as well as the temporal aspect of WMR, were indicated as areas liked least and potential areas for improvement. Finally, participants indicated that WMR was vital in their individual recovery journeys. Specific components of the program include education, individual activation aspect, group dynamics, recovery/wellness, and communication. Few participants indicated that the program was not beneficial to them or their recovery.
Discussion of NVivo Results. The aforementioned results when compared to NVivo software results are mixed. Though group dynamics/interaction was rated with the highest frequency for both the aspect participants liked best and the aspect that was most helpful to their recovery – and most participants reported they liked all/disliked none of the WMR program – other categories identified by the three evaluators appeared to be underrepresented when using the NVivo software due to the software’s potential limitation of not identifying the context in which words were identified into categories.

Discussion of Quantitative Measures Compared with the Current Study

Mental Health Recovery Measure. Results of the Mental Health Recovery Measure (MHRM), a consumer-derived recovery measure, indicated that there was a significant increase in Total MHRM score from pre- to post-program. This same trend was significant for all eight of the MHRM subscales: overcoming “stuckness,” basic functioning, self-empowerment, learning/self-redefinition, overall well-being, new potentials, spirituality, and self-advocacy/quality of life (Bullock et al., 2009). Overall quantitative results on this measure indicated that less than 10% of participants deteriorated from pre- to post-program; less than 50% of participants indicated no significant change from pre- to post-WMR; and over 40% of participants indicated either reliable change (p<.05; gain of 15 points) or moderate/meaningful change (p<.20; gain of 10 points). Results also indicated that these gains are maintained over time (e.g., at six-month follow-up) (Bullock et al.).

When examining qualitative responses on the Post-Program Feedback Form for those participants whose gain scores decreased from pre- to post-program on the MHRM, it is unclear why there were decreases on this quantitative outcome measure. As stated previously, the majority of participants indicating that their mental health recovery
decreased at post-program indicated on the qualitative outcomes that they actually liked the program overall or indicated specific components of the program that they felt most helped them in their recovery journeys. Some participants with decreased difference scores (e.g., reporting decreased mental health recovery) from pre- to post-program indicated that they liked the entire program when asked for specific components of the program they did not like. Other participants, however, did identify components of the program they liked the least. When more closely examining the MHRM gain scores for individuals who indicated on the qualitative questions that they did not like the WMR program, several of these participants made significant gains on the MHRM, several indicated significant loss on the MHRM, and several indicated no significant change in mental health recovery from pre- to post-program.

Such discrepancies between mental health recovery (as indicated quantitatively on the MHRM) and satisfaction with WMR (as indicated on the qualitative portion of the Post-Program Feedback Form) are unclear and call for further investigation in future studies. It is possible, however, that such inconsistencies between the qualitative and quantitative outcomes suggest that the quantitative data alone may not accurately reflect the participants’ actual “experience” of WMR. A potential limitation of the quantitative data (e.g., what appears to be a psychometric “loss” on the MHRM may not be an accurate reflection of participants’ actual experiences, how well they liked the program, and if they believed the program helped in their recovery) may be better accounted for by the richer qualitative responses to open-ended questions. It is the belief of this researcher that qualitative outcomes may offer richer, more in-depth data of the participants’ actual experiences in the program. This, in turn, will allow researchers to continue revising and
modifying the program and its various components (e.g., eliminating or restructuring components frequently identified as unhelpful, placing more emphasis on aspects identified as most beneficial).

Post-Program Feedback Form (quantitative questions). Approximately 500 participants responded to quantitative questions on the Post-Program Feedback Form. Results indicated overall satisfaction with the WMR program and specific components of the program, which is consistent with results of the current study. Participants suggested that, overall, WMR was what they expected it to be and that the curriculum/topics were what they needed for their recovery journeys. On average, participants indicated that the length of sessions and homework were just slightly too demanding, while the materials were user-friendly, the leaders were effective, and having other members in the group was helpful. Although time, interaction, and content were identified by some participants as the components of WMR they liked least (in the qualitative responses), participants overall reported liking the WMR program in its entirety. As such, many participants who indicated that there was a component of WMR they liked the least still reported gains in mental health recovery as measured by the MHRM. This suggests that distaste for a certain component of the program does not necessarily hinder mental health recovery or satisfaction with the program overall. This also suggests that quantitative measures alone may not thoroughly depict or convey the richer, deeper experiences of the participants.

Social Support Questionnaire. A previous study (Hupp, Bullock, Brockmyer, & Treadaway, 2008) found that participants of the WMR program reported an increased number of participants in their social support networks as well as increased levels of satisfaction with their social support networks. Results of the current study indicated that
participants frequently identified the group experience (e.g., peer support, socializing, discussion, interaction) as the component of WMR participants liked most. Participants in the current study also identified social support/group experience as one of the most helpful aspects of WMR to their individual recovery journeys. Social support has been found to be a key aspect in the recovery process (Frese & Davis, 1997) for persons with SMI. Authors (such as Corrigan & Phelan, 2004; Frese & Davis; Pevalin & Goldberg, 2003; Wilson, Flanagan, & Rynders, 1999) repeatedly describe the important role that social support plays in the recovery and treatment process of an individual with SMI. Results of the current study are consistent with previous findings that suggest social support plays an integral role in the recovery process, as well as contributes to the success (and participant enjoyment) of recovery programs (e.g., the WMR program).

**Proposed Model for WMR.**

Results of the current study’s most helpful/most liked aspects of WMR are depicted in Figure 1 below. This proposed model for WMR organizes participants’ responses of how WMR has been a (potential) catalyst for change. Consistent with the Pickett, Philips, and Kraus (2011) study of the Recovery International (RI) Method, peer support (including group facilitators) and group experience, along with communication, led to gains in confidence and feelings of empowerment [the individual activation component of WMR] that promote change, belief that personal goals can be reached, and hope for wellness [the recovery component of WMR]. This conceptual model is loosely based on the “flow of change in Family-to-Family” model by Lucksted, Stewart, and Forbes (2008), allowing the author to map results of the current study onto a model based on a group intervention with similarities to the WMR program. Family-to-Family is a
structured, peer-led, 12-week group. The Lucksted et al. study attempted to understand the processes that take place during participation in Family-to-Family which might lead to benefits gained from the program, with the intent of developing a conceptual model of how the program causes its effects using qualitative data analysis. Participants in the WMR program frequently identified gains in knowledge and the content of the program as key aspects that helped in their recovery journeys; therefore, this aspect has been included as an early part of the change process, integral to participants’ feelings of empowerment and control, as well as insight and understanding into self.

Figure 1

*Proposed model for WMR*

This proposed model suggests that interaction with others/peers (including group facilitators, as well as the supportive group experience) in conjunction with education and
gaining skills in assertive communication leads to gains in confidence/sense of empowerment as well as self-insight. These gains made in the program allow participants to be able to do the “work” of recovery (e.g., individual activation). Being an active participant in one’s recovery and communicating with family and (mental) health professionals helps participants promote and maintain wellness/recovery.

Discussion of Previous Qualitative Studies of Recovery Compared with Results of the Current Study

A previous qualitative study of the WMR program using in-depth, semi-structured interviews and Grounded Theory Analysis (O’Rourke, 2007) identified three primary themes: growth, group process and content, and overcoming stigma and prejudice. The theme of growth was composed of several different sub-categories related to regaining control, overcoming “stuckness,” assertiveness, finding a voice, learning/knowledge/education, interpersonal learning, self-discovery, increased hope, and increased confidence. The theme of group content and process was composed of several different sub-categories related to the group atmosphere which included feelings of belonging and equality amongst peers, feeling supported and not judged, and session activities (e.g., discussion, role-plays, helping others). The theme of overcoming prejudice and stigma was composed of several different sub-categories related to accepting self, recognizing self-worth, person versus illness, and advocacy (O’Rourke).

Although category names and organization of categories differ from those of the present study, participants providing in-depth interviews voiced many similar themes as those identified in the current study. Participants in the O’Rourke (2007) study identified aspects related to group dynamics/interaction, facilitators, communication skill-building, education/content, recovery, and individual activation. Both the current study and the
previous qualitative analysis (O’Rourke) explored the recovery process as it pertained to participation in the WMR program. Results of both qualitative studies were consistent with existing literature regarding the recovery process for individuals diagnosed with a serious mental illness.

Results of a qualitative study of the satisfaction with the Recovery International (RI) method (Pickett et al., 2011) were strikingly similar to that of the present study. Participants of the RI program indicated they liked the following aspects most: 1) structure and methods [education and content categories in present study]; 2) the group [group dynamics in present study]; 3) peer support [interaction and group dynamics in present study]; 4) group leader [facilitator category in present study]; and 5) materials [content category in present study]. Participants of the RI program indicated that they liked the following aspects least: 1) meeting format [time category in present study]; 2) other group members [interaction category in present study]; 3) materials [content category in present study]; 4) meeting logistics [time category in present study]; and 5) group leaders [facilitators, included in interaction category in present study]. As with WMR, some participants indicated that RI was not helpful and not for them (Pickett et al.).

In the Pickett et al. (2011) study, when asked how RI was helpful to them, participants indicated the following: 1) materials [content category in current study]; 2) peer support [interaction and group dynamics in present study]; 3) learning new skills [education and individual activation categories in present study]; 4) improvements in emotional well-being [decreased symptoms was included under education/skills category, though was not as readily identified by WMR participants]; and 5) having a changed outlook [individual activation category in present study]. Most participants, when asked
how RI was not helpful, indicated that everything was helpful, as was the case with WMR participants. Other RI participants indicated that the following aspects were least helpful to them: 1) meeting format [some aspects of the content category in the present study]; 2) materials [content category in present study]; 3) meeting logistics [time category in present study]; and 4) other group members [group dynamics and interaction categories in present study]. Few participants indicated that RI was not helpful or not for them, as was the case with the current study (Pickett et al.).

As is evident, this extensive examination of RI (Pickett et al., 2011) had similar findings to the present study regarding participant likes and dislikes, overall levels of satisfaction, and aspects of a program they found least and most helpful to their recovery. Over time participants in RI reported experiencing fewer and less severe psychiatric symptoms, increased confidence in personal recovery, increased hopefulness, enhanced self-esteem and coping ability, and more social support. Three key findings were identified in the Pickett et al. study. Participants felt that they received the help they wanted to better manage mental health symptoms (e.g., gained skills and tools, opportunities to learn and practice methods in the program, application to daily lives). Participants reported that peer support is powerful (e.g., group facilitators were positive role models, giving and receiving feedback within the group helped build confidence that they can make changes and achieve goals, felt less lonely and isolated, met others “just like me”). Finally, participants reported that participation in RI enhances mental health recovery (e.g., gains in knowledge/skills to move beyond illness-centric view of self; significant increases in recovery-goal orientation scores [similar to gains on the MHRM and other WMR measures]; and improved confidence in the belief and ability to achieve
life goals, which participants attributed to the program and tools offered, practicing skills with peers, and having peer group leaders as examples/role models) (Pickett et al.). Again, such findings are similar to the present study, as well as previous quantitative and qualitative analyses of the WMR program.

Young and Ensing (1999) developed a recovery model from the perspective of individuals diagnosed with a serious mental illness using Grounded Theory Analysis. As noted earlier, this model identified five general aspects of recovery that are typical in the recovery process. They are as follows: 1. Overcoming “stuckness;” 2. Discovering and fostering self-empowerment; 3. Learning and self-redefinition; 4. Returning to basic functioning; and 5. Improving quality of life. Much of WMR’s outcome data (e.g., quantitative measures such as the Mental Health Recovery Measure and Client Self-Rating Scale) can be readily transferred into this recovery model. The current study found that participants, when given the opportunity to respond freely to open-ended questions regarding the program and its effects on their recovery, identified many of the same categories and themes as identified by Young and Ensing.

A qualitative analysis of the GROW program sought to identify aspects of this mutual-help/consumer-operated program that facilitated participants’ recovery journeys (Corrigan et al., 2002; Corrigan et al., 2005). Similar to the goal of this study (e.g., to identify aspects of the WMR program that participants identify as facilitating recovery), the qualitative analysis of the GROW program found some similarities in their results. In the GROW study, recovery was often equated with self-reliance, industriousness/independence, and gains in self-esteem (Corrigan et al., 2002; Corrigan et al., 2005). The current study identified an individual activation (e.g., doing the work of
recovery, active participant in recovery, empowerment, gains in self-esteem) component and recovery/wellness as vital in the WMR program’s success. These concepts appear to map onto what the GROW study has identified as self-reliance, industriousness, and self-esteem. Support of others was identified in GROW and WMR as facilitators of participants’ recovery journeys, as was program philosophy (e.g., recovery and wellness rather than illness in WMR), literature (e.g., content in WMR), hope and power (e.g., aspects of recovery and individual activation), and gains in coping skills (Corrigan et al., 2002; Corrigan et al., 2005).

According to a study by Mancini (2007), subjective factors identified as central to recovery included hope (by observing the successes and recovery journeys of peer role models with similar diagnoses), choice among treatments, social support, spirituality, engagement in meaningful activities, advocacy, self-help, and self-determination. Quantitative methodologies have identified empowerment (e.g., perceived control, self-esteem, and agency), hope/optimism, knowledge, and life satisfaction as being associated with recovery (Mancini). Similarities between quantitative data analysis for the WMR program and the current study have been found (e.g., importance of recovery role models/consumer co-facilitators; social support; engagement in life activities, hope, empowerment, and choice/individual activation and recovery).

Limitations

One 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 and unlikely 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). In addition, the WMR program is an ongoing, open clinical trial with a longitudinal design. There is no random assignment to groups, nor is there a comparison to other active treatment programs (Bullock et al., 2009).

According to Morrow (2005), the absence of a high-quality relationship with participants (e.g., in-depth individual interviews) could lead some to doubt the findings. Morrow also reported that using a single data source rather than multiple sources (e.g., observation, interviews, field notes, documents) has its limitations. Although multiple sources of information about this group of participants (e.g., observation, interviews) were not utilized to help triangulate results (Corrigan et al., 2002), the focus on comparison with quantitative outcome data and a previous qualitative study which used Grounded Theory Analysis offered support to the current study’s findings. The nature of the current analysis could pose question to some, as it did not adhere to stringent guidelines of qualitative data analysis, as Grounded Theory might propose. However, the extant number of participant responses did afford the researcher the ability to achieve saturation/redundancy in responses, as well as allow for generalizability of results because of the diversity in participant demographics, agency type, level of ability, etc.

NVivo software was utilized to provide the researcher with unbiased, systematic results of the data. However, this program also had its limitations. Because NVivo is
unable to identify themes within the data, word frequency queries were completed. Themes were identified by the researcher, and the frequency of occurrence of themes was identified using word count queries. However, it was often difficult to determine the context in which words were identified as falling into the various researcher-identified themes. There is potential for error when using this software because words may not have been used in the same context as intended by identified themes/coding categories. Because of its incapability to identify meaning units, context, and nuances, NVivo’s inclusion of words (and thus the frequency of their occurrence) into categories may have been flawed.

An additional limitation is that participants were encouraged to complete the open-ended responses; however, this was not a requirement for participation or completion of the program. Therefore, those participants who elected to respond to the open-ended questions were a self-selected group (e.g., possibly more motivated/engaged in the group, further along in their recovery).

Another potential limitation to collecting qualitative data is the possibility of participants who are illiterate or unable to write. Although group facilitators were available during the measures portion of the program, participants who were unable to complete the open-ended questions by themselves may have been reluctant to ask for help or may have censored their responses because they had to be shared with a group facilitator (due to demand characteristics or socially desirable responding). Some participant responses were difficult to read (e.g., illegible handwriting) or difficult to understand (possibly due to years of education/illiteracy, intelligence, active symptoms of
mental illness, or English as a second language), which may have led to some errors when responses were coded.

Implications and Future Directions

Regardless of the limitations, the current research does have implications for the clinical/applied setting (including the WMR program) and for future research. Results of qualitative studies, such as the current research, provide item-material for use when developing quantitative questionnaires by using the participants’ own language (Elliott, Fischer, & Rennie, 1999). Results of the current study have confirmed, in the voice of participants, results of quantitative analysis of the program, a previous qualitative analysis of the program, and other qualitative studies on recovery. Results of the current study have also confirmed that the vast majority of participants enjoy the program and find it beneficial in their individual recovery journeys. Limitations of the program identified by participants can be used in future trainings of group facilitators to ensure fidelity to the program and that participants receive the maximum benefit from the program.

Further research endeavors that attempt to better understand the impact of recovery programs on an individual’s recovery journey are vital in order to continue to keep the recovery movement moving forward. Such research is necessary to improve our understanding of the impact of mental illness and what professionals, family members, and the individuals experiencing mental health issues can do to promote and maintain recovery.

Because the majority of participants in the WMR program were Caucasian, continuing outreach efforts to racial and ethnic minority communities may help the WMR
program enhance areas that could potentially be lacking or left undiscovered. Reaching out to younger participants (the current mean age of participants is approximately 45 years) would benefit the program by offering support and intervention to a younger generation who are earlier in their illness. Younger participants who have fewer years of illness/treatment may have family members who are better able/more inclined to attend meetings. Family inclusion is an area of the program that has proven difficult but is desired so additional research regarding family members and their interactions with participants may be conducted.

Updating materials, using more professional illustrations, and simplifying some of the content may enhance certain aspects of the program for participants. Two-hour sessions and only 10 weeks of the program were often cited as aspects of WMR participants liked least. A committee to re-evaluate such time constraints would be beneficial to possibly increase the overall satisfaction with the program. Offering follow-up or refresher sessions (for those participants not interested in taking the program in its entirety again), offering additional WMR Alumni sessions, or offering additional WMR sessions that address specific issues (e.g., trauma) may help participants seeking additional support. Offering WMR facilitators additional training in group facilitation skills – such as keeping participants on topic, conducting the groups so that all participants are encouraged to contribute (and one participant does not monopolize the conversation), and maintaining appropriate pace in the group based on participant ability/participant preference – is recommended to ensure that participants are receiving the maximum benefit from the program.
Future research within the WMR program may take a closer look at community mental health centers compared to consumer-operated sites (and compared to inpatient settings) to identify differences in participant satisfaction with the program. As Corrigan et al. (2002) and Corrigan et al. (2005) indicated, social support from peers, social comparisons in a supportive setting, lessened self-stigma, and improved interpersonal skills have been identified as catalysts for change in consumer-operated settings. Also identified as promoting change in consumer-operated programs were gains in insight and self-understanding, accepting personal value and worth, and helping others (Corrigan et al., 2002; Corrigan et al., 2005). Corrigan et al. (2002) and Corrigan et al. (2005) also reported that consumer-operated programs provide a community of caring and sharing in which participants receive understanding and recognition from peers through interactions with equals. Personal empowerment is an essential component, and satisfaction with such programming as well as improved self-concept, increased overall well-being, and decrease psychiatric symptoms are frequently identified (Corrigan et al., 2002; Corrigan et al., 2005).

A closer analysis within the WMR program of these different kinds of sites may help trainers and facilitators identify strengths within each setting that may be generalized to other settings, or that may be enhanced within that setting. As the current study (and previous quantitative studies) demonstrated, social support, peer interaction, and the group co-facilitators are integral for program and participant success. A closer analysis of consumer-run sites may offer insight into what these facilitators are doing differently, if participants feel more comfortable within such agencies, and what the program can
capitalize on to make these a strength for all settings (if any differences are identified between type of site).

According to Mancini (2007), aiding in the development of self-efficacy (e.g., belief in one’s competence and agency) can offer mental health providers (or programs such as WMR) insight into how the recovery process can be facilitated. As the current study (and previous quantitative studies) have identified, the individual activation component (e.g., empowerment, advocacy, competency, self-esteem, doing the work of recovery) is central to the success of the WMR program and for its participants. Such results are consistent with Mancini’s (2007) findings regarding self-efficacy’s role in recovery. Mancini suggested that mental health professionals can facilitate feelings of self-efficacy and contexts of recovery by engaging clients in meaningful activities, encouraging advocacy and helping others, being supportive professionals (e.g., warm, respectful, caring), offering access to self-help and peer support/recovery role models, and encouraging assertive communication with treatment providers/offering education regarding choice among various treatment approaches (Mancini). Further research into the specific role that self-efficacy plays within the WMR program may continue to provide WMR trainers and facilitators with ideas to facilitate participants’ recovery journeys through the WMR program.
Chapter VI

References


qualitative research. Chicago: Aldine.


Appendix A

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?

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

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

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all.</td>
<td>A little.</td>
<td>Some</td>
<td>Quite a bit.</td>
<td>Yes, very much</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>All of the time too demanding</td>
<td>Most of the time too demanding</td>
<td>Sometimes too demanding</td>
<td>A little too demanding</td>
<td>Not at all demanding</td>
<td></td>
</tr>
</tbody>
</table>

4. Where the WMR handout materials user friendly?

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all.</td>
<td>A little.</td>
<td>Some</td>
<td>Quite a bit.</td>
<td>Yes, very much</td>
<td></td>
</tr>
</tbody>
</table>

5. Was the WMR homework too demanding?
6. **Were the WMR group leaders effective?**

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not at all effective.</td>
<td>A little.</td>
<td>Some</td>
<td>Quite a bit.</td>
<td>Yes, very effective</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not at all helpful.</td>
<td>A little.</td>
<td>Some</td>
<td>Quite a bit.</td>
<td>Yes, very helpful</td>
</tr>
</tbody>
</table>

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

9. What part or aspect of the WMR program did you not like? ____________________________  
_________________________________________________________________________________  
_________________________________________________________________________________  
_________________________________________________________________________________

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

87
Appendix B

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.

<table>
<thead>
<tr>
<th></th>
<th>SD = Strongly Disagree</th>
<th>D = Disagree</th>
<th>NS = Not Sure</th>
<th>A = Agree</th>
<th>SA = Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I work hard towards my mental health recovery.</td>
<td>O O O O O</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Even though there are hard days, things are improving for me.</td>
<td>O O O O O</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>I ask for help when I am not feeling well.</td>
<td>O O O O O</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>I take risks to move forward with my recovery.</td>
<td>O O O O O</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>I believe in myself.</td>
<td>O O O O O</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>I have control over my mental health problems.</td>
<td>O O O O O</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>I am in control of my life.</td>
<td>O O O O O</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>I socialize and make friends.</td>
<td>O O O O O</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Every day is a new opportunity for learning.</td>
<td>O O O O O</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>I still grow and change in positive ways despite my mental health problems.</td>
<td>O O O O O</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Even though I may still have problems, I value myself as a person of worth.</td>
<td>O O O O O</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>I understand myself and have a good sense of who I am.</td>
<td>O O O O O</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>I eat nutritious meals everyday.</td>
<td>O O O O O</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>I go out and participate in enjoyable activities every week.</td>
<td>O O O O O</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>I make the effort to get to know other people.</td>
<td>O O O O O</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>SD</strong> = Strongly Disagree</td>
<td><strong>D</strong> = Disagree</td>
<td><strong>NS</strong> = Not Sure</td>
<td><strong>A</strong> = Agree</td>
<td><strong>SA</strong> = Strongly Agree</td>
<td></td>
</tr>
<tr>
<td>16.</td>
<td>I am comfortable with my use of prescribed medications.</td>
<td></td>
<td></td>
<td></td>
<td>O O O O O O</td>
</tr>
<tr>
<td>17.</td>
<td>I feel good about myself.</td>
<td></td>
<td></td>
<td></td>
<td>O O O O O O</td>
</tr>
<tr>
<td>18.</td>
<td>The way I think about things helps me to achieve my goals.</td>
<td></td>
<td></td>
<td></td>
<td>O O O O O O</td>
</tr>
<tr>
<td>19.</td>
<td>My life is pretty normal.</td>
<td></td>
<td></td>
<td></td>
<td>O O O O O O</td>
</tr>
<tr>
<td>20.</td>
<td>I feel at peace with myself.</td>
<td></td>
<td></td>
<td></td>
<td>O O O O O O</td>
</tr>
<tr>
<td>21.</td>
<td>I maintain a positive attitude for weeks at a time.</td>
<td></td>
<td></td>
<td></td>
<td>O O O O O O</td>
</tr>
<tr>
<td>22.</td>
<td>My quality of life will get better in the future.</td>
<td></td>
<td></td>
<td></td>
<td>O O O O O O</td>
</tr>
<tr>
<td>23.</td>
<td>Every day that I get up, I do something productive.</td>
<td></td>
<td></td>
<td></td>
<td>O O O O O O</td>
</tr>
<tr>
<td>24.</td>
<td>I am making progress towards my goals.</td>
<td></td>
<td></td>
<td></td>
<td>O O O O O O</td>
</tr>
<tr>
<td>25.</td>
<td>When I am feeling low, my religious faith or spirituality helps me feel better.</td>
<td></td>
<td></td>
<td></td>
<td>O O O O O O</td>
</tr>
<tr>
<td>26.</td>
<td>My religious faith or spirituality supports my recovery.</td>
<td></td>
<td></td>
<td></td>
<td>O O O O O O</td>
</tr>
<tr>
<td>27.</td>
<td>I advocate for the rights of myself and others with mental health problems.</td>
<td></td>
<td></td>
<td></td>
<td>O O O O O O</td>
</tr>
<tr>
<td>28.</td>
<td>I engage in work or other activities that enrich myself and the world around me.</td>
<td></td>
<td></td>
<td></td>
<td>O O O O O O</td>
</tr>
<tr>
<td>29.</td>
<td>I cope effectively with stigma associated with having a mental health problem.</td>
<td></td>
<td></td>
<td></td>
<td>O O O O O O</td>
</tr>
<tr>
<td>30.</td>
<td>I have enough money to spend on extra things or activities that enrich my life.</td>
<td></td>
<td></td>
<td></td>
<td>O O O O O O</td>
</tr>
</tbody>
</table>

*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 C

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.)

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>very dissatisfied</td>
<td>somewhat dissatisfied</td>
<td>equally satisfied / dissatisfied</td>
<td>somewhat satisfied</td>
<td>very satisfied</td>
<td></td>
</tr>
</tbody>
</table>

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.)

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>very dissatisfied</td>
<td>somewhat dissatisfied</td>
<td>equally satisfied / dissatisfied</td>
<td>somewhat satisfied</td>
<td>very satisfied</td>
<td></td>
</tr>
</tbody>
</table>

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.)

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>very dissatisfied</td>
<td>somewhat dissatisfied</td>
<td>equally satisfied / dissatisfied</td>
<td>somewhat satisfied</td>
<td>very satisfied</td>
<td></td>
</tr>
</tbody>
</table>
24. How many people do you trust to give you honest feedback?
Check one of the boxes:

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10+</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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.)

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>very dissatisfied</td>
<td>somewhat dissatisfied / dissatisfied</td>
<td>equally satisfied</td>
<td>somewhat satisfied</td>
<td>very satisfied</td>
</tr>
</tbody>
</table>

25. How many people totally accept you for who you are (on both your “good days” and “bad days”)?
Check one of the boxes:

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10+</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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.)

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>very dissatisfied</td>
<td>somewhat dissatisfied / dissatisfied</td>
<td>equally satisfied</td>
<td>somewhat satisfied</td>
<td>very satisfied</td>
</tr>
</tbody>
</table>

26. How many people do you feel truly love you deeply?
Check one of the boxes:

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10+</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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.)

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>very dissatisfied</td>
<td>somewhat dissatisfied / dissatisfied</td>
<td>equally satisfied</td>
<td>somewhat satisfied</td>
<td>very satisfied</td>
</tr>
</tbody>
</table>

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.).

<table>
<thead>
<tr>
<th>First Name of Person</th>
<th>Nature of Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

93
Appendix D

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…

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

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

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not very much.</td>
<td>A little.</td>
<td>Some</td>
<td>Quite a bit.</td>
<td>A great deal</td>
<td></td>
</tr>
</tbody>
</table>

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?

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

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.)

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 times/week</td>
<td>1-2 times/week</td>
<td>3-4 times/week</td>
<td>6-7 times/week</td>
<td>8 or more times/week</td>
<td></td>
</tr>
</tbody>
</table>
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.)

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 hours or less/ week</td>
<td>3-5 hours/ week</td>
<td>6 to 15 hours/ week</td>
<td>16-30 hours/ week</td>
<td>More than 30 hours/ week</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>My symptoms really bother me a lot.</td>
<td>My symptoms bother me quite a bit.</td>
<td>My symptoms bother me somewhat.</td>
<td>My symptoms bother me very little.</td>
<td>My symptoms don’t bother me at all.</td>
</tr>
</tbody>
</table>

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?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>My symptoms really get in my way a lot.</td>
<td>My symptoms get in my way quite a bit.</td>
<td>My symptoms get in my way somewhat.</td>
<td>My symptoms get in my way very little.</td>
<td>My symptoms don’t get in my way at all.</td>
</tr>
</tbody>
</table>

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?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>I don’t know how to prevent relapses.</td>
<td>I know a little, but I haven’t made a relapse prevention plan.</td>
<td>I know 1 or 2 things I can do, but I don’t have a written plan</td>
<td>I have several things that I can do, but I don’t have a written plan</td>
<td>I have a written plan that I have shared with others.</td>
</tr>
</tbody>
</table>
9. **Relapse of Symptoms**: When is the last time you had a relapse of symptoms (that is, when your symptoms have gotten much worse)?

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Within the last month</td>
<td>In the past 2 to 3 months</td>
<td>In the past 4 to 6 months</td>
<td>In the past 7 to 12 months</td>
<td>I haven’t had a relapse in the past year</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Within the last month</td>
<td>In the past 2 to 3 months</td>
<td>In the past 4 to 6 months</td>
<td>In the past 7 to 12 months</td>
<td>I haven’t been hospitalized in the past year</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not well at all</td>
<td>Not very well</td>
<td>Alright</td>
<td>Well</td>
<td>Very well</td>
</tr>
</tbody>
</table>

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?

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>I don’t know about any self-help activities.</td>
<td>I know about some self-help activities, but I’m not interested</td>
<td>I’m interested in self-help activities, but I have not participated in the past year</td>
<td>I participate in self-help activities occasionally.</td>
<td>I participate in self-help activities regularly.</td>
</tr>
</tbody>
</table>

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?

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Never</td>
<td>Occasionally</td>
<td>About half the time.</td>
<td>Most of the time.</td>
<td>Every day.</td>
</tr>
</tbody>
</table>
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?

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol use really gets in my way a lot</td>
<td>Alcohol use gets in my way quite a bit</td>
<td>Alcohol use gets in my way somewhat</td>
<td>Alcohol use gets in my way very little</td>
<td>Alcohol use is not a factor in my functioning</td>
<td></td>
</tr>
</tbody>
</table>

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?

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug use really gets in my way a lot</td>
<td>Drug use gets in my way quite a bit</td>
<td>Drug use gets in my way somewhat</td>
<td>Drug use gets in my way very little</td>
<td>Drug use is not a factor in my functioning</td>
<td></td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have not thought about quitting my tobacco use.</td>
<td>I have thought about quitting my tobacco use</td>
<td>I have decided to quit using tobacco.</td>
<td>I have tried to quit using tobacco.</td>
<td>I quit using tobacco, or never used tobacco.</td>
<td></td>
</tr>
</tbody>
</table>
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)?

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>Occasionally</td>
<td>1 – 2 days each week</td>
<td>3 – 5 days each week</td>
<td>Every day</td>
<td></td>
</tr>
</tbody>
</table>

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?

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>A little bit</td>
<td>Sometimes</td>
<td>Quite a bit</td>
<td>Nearly all the time</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>A little bit</td>
<td>Sometimes</td>
<td>Quite a bit</td>
<td>Very often</td>
<td></td>
</tr>
</tbody>
</table>

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?

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>A little bit</td>
<td>Sometimes</td>
<td>Quite a bit</td>
<td>Nearly all the time</td>
<td></td>
</tr>
</tbody>
</table>
Appendix E

Informed Consent Form (for WMR participation)
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 of 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 reversible 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 any 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 or 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 F

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
Appendix G

Participant Responses to Question #8
8. What part or aspect of the WMR program did you like best?

009—Medical information, breakdown of mental illness diseases
010—[blank]
018(#2)—Having the group situation-group work or group setting
20 (#2)- the party
024(#2)—The interaction between the clients and staff. Staff listened to what we had question about the material and the material was user friendly.
024(#3)—The give and take in conversation among the group. The presentation of the material and the drawings etc.
034 – The discussions
038—It’s well-roundedness of all the subjects.
039—The way group leaders presented WMR was outstanding and helpful
040—[blank]
041 – The discussions which were generated form the topics
042 – The material covered aspects of recovery in a user-friendly manner.
043 – Group interaction.
044 – The part that I liked the best was about the difference between assertive, passive and aggressive speech behavior.
045 – The goal setting.
046 - The interaction among the consumers who could give direct examples pertaining to the topic at hand.
047 - Getting feedback from others.
049 – The camaraderie of all the group members and leaders – everyone respected everyone else and their opinion – no one was put down or judged.
050 - Homework
051 - The homework helped me to start making goals and get my medical info together. I liked doing the homework and telling about doing it the next week.
052 – The interacting among the group
055 – Information about my illness
057—listening to the other group members on feed back
058—peer advisor are very helpful
061—realizing symptoms, relapse, triggers and working with the wellness team.
062—about taking medications and after effects
063—recovery
064—All of it.
065—getting together in group
066—Everything in the program was good.
066(#2) None
067—Meet people and friend get help.
068—learn about how to cope with people
069—When you have a problem you can get help in the group about anything.
069(#2)—Getting to know lots of people.
071—I feeling better about myself when I take my medicines.
072—Learning about my recovery
The determination of all the group leaders to help.

Wellness wheels

The different parts of our life that showed where we were and now how we have become

the cartoons

How I recently or was going through some of the same situations at the time. It really helped me work through it, and how to also

I liked it all.

[blank]

How it explain the different symptoms of schizophrenia

It helped me to better understand my illness also to recognize the good care and service that I’m receiving at the doctor’s, the Recovery Center and good advice from all.

Where we all came together and we could talk to each other

The talking between people in the group.

To take in the group and get responses back.

Homework

Learning about the pros and cons of treatment including medication plus important roles played by exercise and nutrition

Learning how I can see myself and others

The discussion and feedback

Illness-spirituality

The part I liked best was the open discussions.

The group discussions

The chance to do some socializing skills

[blank]

The everyday awareness wheel

Talk about goals asking questions being with people

The involvement to talk out some of your own issues.

The learning about the issues, about the program.

The group leaders. They tell everything like it should. And they made it easy.

the discussion

Working in a group

Learning different things about mental illness I did not know. And listening to other consumers talk about how they handle their problems and get back to normal.

The stress guides and recovery notes. Also the depression guidelines.

The family and stuff.

Discussion of feelings, goals

the Wellness wheel

I really like all of it best. There’s not just one I like best.

all of it

about my recovery and how to handle it

Learning all about recovery that I never heard before

Having someone concerned about my well-being

Doing the role plays and like all the chapters in the book

coming here easing to see Gathering Hope House is very interesting

studying guide a bit
— the group facilitators, the booklet, and all the information
— all of them
— everyone of them
— Learning more about myself
— learning that you’re not the only one with problems and can get help just like everyone else. I like the role plays. It shows me a better understanding about life and how to handle it.
— talking, play roles
— what I got out of it
— participating in recovery and coping and learning and reading and being helpful in support
— when others share their experiences
— The discussion about our problems.
— Interaction and discussion with others in the group
— Interaction with the other group members
— This is my 4th WMR group, and I actually learned something I didn’t know.
— Discussion your problems.
— Everything was good.
— I like the focus of the group—the mental health of its members.
— The support of the group/group atmosphere and also awareness about meds and side effects
— Communicating with your providers—role play
— The discussions
— Trigger, dealing with what is going on in my life and having the willingness to talk to sponsor or any support people in recovery
— Counselors and peers.
— Patience yet still maintaining efficiency
— How everyone cares for each other and the support we give each other.
— Group discussion and group support.
— The interaction with other people, learning about recovery
— Meeting other people, learning about their problems
— Being able to teach others about recovery.
— The openness of each person and the facilitators are so good
— Taking the information that we’re given and applying it to each of our own goals and sharing with each other how things are — good and bad.
— Learning to understand mental illness and being able to speak up for myself.
— The sharing and discussion
— The program
— Telling my symptoms
— talk about our mental illness
— just being in the group I’m diagnosed schizophrenia
— The pamphlets
— come across with helpful knowledge to assist me
— getting to better understand the new me being sober and having a mental health problem.
— That it addressed an important topic
That being open with discussion in group.
interaction and group therapy
To cope better. Learning. Board (chalk) work. To be assertive when needed.
I liked it all
When everybody gave their opinions and got along with one another.
Went we talked about the doctor and feedback
All the topic
Group work.
that I was not alone in some of the things I go through.
Role plays/Dr. patient role play
coping with my social life
All of it.
all of it
making goals and role-playing
Not sure
caring people
Bingo, Listen to music
the peer interaction with one another learning about each other who has the same and different illness
I think having the person trained in counseling and someone who has mental illness. This made it easier for the participants to open up in the group
I liked the role plays tat were done and I liked the quizzes that were given.
I liked all the role playing. I like a discussion
the drawings
group take home, homework study program
I liked sharing feelings about our recovery
The discussions of what steps help in recovery.
Talking about how to deal with mental illness from a recovery perspective
being part of a group, it’s like a team.
the group leaders.
Staff
Communication sections
I like how the curriculum teaches you to be your own person and gives you the right steps to stand up for yourself.
Group discussions
It helped me with my problems
suggestions given to me
The final session
knowing others are also in recovery and get information from staff and group members
Meds. Learn
All of it. About the medicine
Takeing control of your life and learning goals
Talking sessions
learning about wellness and recovery
266—learning to socialize outside my home making different decisions in my life and finding new direction
267—The fact that each person were called on to speak.
268—When we had papers to work on in class—ie: (24 hr. and etc.) The wheels I would have preferred more handouts to work on in group.
269—classes
271—I loved the overheads and sheets with the cartoons especially the big doctor and the little person!
272—the whole program
275—ALL
276—The material covered
279—It kept me coming to this aspect of life some times. The program help me to keep me from going back to the hospital
280—graduation
281—the group
285—enjoy all the program. So feel and like everything. Was Great indeed.
286—I like the participation.
287—I liked that we had good discussions skillfully managed by the facilitators.
291—All of it I found out a lot about my mental illness and tools I can use to help me get better and what to do in case of an emergency
293—a) other members present  b) learning to [continue] advocating for myself.
295—The interaction, to be a part of
297—Being able to talk about our try feelings
299—Recovery
300—Freedom to express your opinion
302—All of it!
303—Helping me feel much more comfortable socializing with others, such as role playing.
304—Gifts. Talking
305—Be with people.
306—Writing in thee Book
307(#2)-I like everything about it.
309—teach you to talking to people.
310—The wellness wheel / having balance
312—the ice breakers
313—When the class broke up into smaller groups of 3 or so and answered the handout questions. I liked the intimacy and hearing others speak up.
314—to be more assertive when I talk to someone who has put me down
315—Descriptions of assertive responses (“when you..., I feel...”) The constant reiteration and different examples of how it untangles you. Goals
316—The bonding of the group. How we came to know each other and accept each other unconditionally.
317—the illustrations
318—all of it
The support and the help from all the people there, The love and affection we had for each other.

The time and consideration the facilitators provided

The group Leaders

Sharing experiences & recovery concepts with others who have similar issues

role plays, brainstorming, break time, sessions, when everyone participated

The handout I liked the best.

Homework

I thought every part of WMR was helpful, I liked it all.

The knowledge that I to have a role in my recovery, and that my participation is needed and wanted

The sharing of experiences

Introduction of a wellness plan

When we were feeling concern

All of it

Making friends

Meeting new people, sharing same diagnosis.

I like it very much

Keeping phones numbers of relevant people

The descriptions of the various mental illnesses

(# 2) support systems, /medication/ doctor/ side effects etc

Role-playing

All

I liked how everyone participated

all of it, role play was sometimes hard

varied ways to experience material – text, overheads, experientially, etc.

The ability to compare yourself with others

Discussion of boundaries

The first meeting we had

all of them

the teacher and snacks

the T.V. show and the role modeling act

Discussions of interpersonal communication.

Power of attorney. Dual power of attorney. Advance directive

They help me have in sight on were [where] my recovery was needed most

The part about communication and how to address others

Finding out more about my mental illness and having someone there to help.

homework and group

Where we’re open with each other about our testimonies about things we’ve been through

learning

Doing the exercises I agree it’s most important!!

I like them all

“All of them”

Communication,
393—learning how talk to doctor and other people, respect for other people
393(#2)—The learning how to talk to people
394—I loved all of it.
399—All of it was good
400—Group interaction.
402(2)—it was a real good class
409—Everything break time, morning meetings activities the planning of events the atmosphere. That’s right. Everything
410—Handouts
422—Knowing that there are people, that are other people like me.
425—The social support provided by the members was effective
429—The Wheel
430—“they helped me with my Recovery I liked talking about my problems”
431—communicating
442—communication skills and symptoms and triggers.
443—The facilitators knew about mental illness from some rather wide personal experiences. both consumer facilitators and the professional
444—The Circles Naming.
445—The goals setting.
448—all
449—All of it
450—Learning how to deal with family and depression.
456#2—the meditation session
456 (#3) Medication management session, talking about stigma
461—all WMR
462 Advice and guidance
463—social interaction
464—Very Helpful (All)
466—All of it.
483—that it gave an overview of the mental health system process/schizophrenia (the elements of it). That it made think about things in a different manner
484—Paperwork
485—getting ideas from group to improve my self awareness.
486—I enjoyed the role playing. It was very educational.
489—I liked this program very much, I learned many friendly people and group leaders that helped me a lot with thoughts and feelings.
490—all aspects
491—I feel Katie--Michelle were very knowledgeable and very “in tune” with us. They were a good source of information.
493—about relationships
494—Medication
495—session ten
496—Goals
497-The sharing amongst al of us; peer facilitator, facilitator and other participants.
500—the week to week lessons was very helpful
501—Learning how to talk to your doctor, case manager counselor
All of it

— group discussion

good – lots of learn about lessons

— I like to learn – important

Learning the information that could assist in problem solving.

Discussion between group members

—I liked learning new things about mental health and recovery every week!

— review

— hours

I think the WMRI groups are A necessity for my well being

— a thorough perspective of recovery!

Overcoming the stigma of MI [mental illness]

—I liked the whole thing

How to get along with your doctor

— Advocating for yourself

—I learned that lots of things I thought were wrong with me were side effects.

I liked discussing as a group the topics and getting feedback. Communication topic
nutrition and relationships

we did things with a focus on something. There was always direction.

The lessons

— Advocating for yourself

— The topics that were covered.

— Socialization

— When writing on the board - can see not just hearing it.

— talking with people that you have things in common

— openness of group; and confidence that no one will talk about was said. Very cheerful & friendly. Linda & Kathy (Ice Breakers)

— I liked the explanations and the handout materials best.

— The casual atmosphere. There was no pressure to be successful in achieving the goals of the group.

— talking

— Being able to talk through the different topics with other group members + team leaders helped me solidify the concepts.

—I liked the socialization and I hope to keep in contact with most of them.

— I had to talk more

— Talking about what might happen if you don’t take medication

— Types of mental illness

— Socialization and meds info

— discussions & role plays.

— It about take care about you

— Their learning using obstacles and finding out new concepts developing your mind better. For example ring learning two laws that hold together by strings.

— party handouts, field trips jobs network
I got to make new friends one of the leaders of the group is a registered nurse. She is my cousin; too. The other moderator was a girl I met in another group. The workbook was informative and the discussions were helpful all of it was very well. Talking about symptoms and how they effect me helped me go day to day in a different way. The feedback from the group leader was very helpful. The Group Leaders Being with my friends and talking about my problem was very helpful. The fellows毕业
Learning within a group. “Ice-breaker”
Friendship goals-Learning goals-Social Activities-being around people.
going over the material in the notebook.
the goal setting part
Learning About Coping skills, to develop a better self
Nice presentation, group leaders
The way it was attended
All of this
(#2) all of it
Being able to feel comfortable about saying how I feel and also other group members feelings and thoughts expresses were very helpful to me!
balance wheel
Talking with other group members and supporting each other.
meeting with peers
liked all aspects the staff & clients had an opportunity to interact with one another, opportunity to meet new people, new info on how to manage mental illness
learning about communication.
The aspect of the WMR I liked best is the lessons were taught in sessions *10 session) for each week
I liked the hand-note and the discussion and the projection of goals every week that we did.
Learning about self help
every one
Instruction and friendship
the peer facilitator
When we did the role playing
Very informative; really enjoyed group leaders and other members in group.
Talking about different topics
group interactions
Listening people to contact in emergencies.
(#2) the party
The role playing – client involvement. Opening up in group coming out of my shyness. Being able to feel comfortable talking in a group setting.
I think the aspect I like the best was the way it is presented with book material the easy to read and comprehend. I liked the information on dealing with mental illness stigma and communication. Input from other group members. Listening to others opinions.

When Trish or the other group speaker gave us hand-outs, or spoken information.

#2-- reading learning spelling

#3-- reading, the Facilitators

Everything.

Hearing what other people have to say.

All of it.

The way the group was facilitated. People in the group - very comprehensive discussion.

The interaction where we are asked questions and pulled into the lectures.

The group involvement and relationships developed.

Mary Ellen Copeland W.R.A.P.

All was very informative and useful.

Support each other, learning experience, motivation.

I have social anxiety so showing up and being around people was best.

The leaders Pam & Belinda and the other members.

Learning about the illness.

The group interaction.

Getting to talk about stuff with other people.

Ice breakers and visual—what’s written on the boards and class participation.

Talking to doctor with my input. Being a teacher and a student.

Seeing people, talking to them, eye contact.

The worksheet.

The wellness wheel and how it changed throughout the course.

I liked the fact that I could use charts and diagrams to help myself form a plan.

Individual participation was required; smooth and cool leader’s personality; guest speakers.

Sharing with others during discussion and keeping privacy commitment of “what we say here, stays here.”

Knowledgeable presentations—all the camaraderie.

The feedback from the other people in the group.

Active participation.

Work sheets filling them out help a lot.

Making new friends.

Knowing that I’m not the only one with mental disorders.

Disguising how different people deal with problems in different ways.

Having to do the pie graph to see goals I need to work on.

Icebreakers introductions, and exercises, that was different in group than I thought.

Role playing.

It help me learn to speak to doctors for my meds.

Like it all.
Socialization. Looking at the options open for recovery and knowing that options are available.
I pretty much enjoyed the whole thing.
Teaching me to help me control my impulsiveness.
Learning about my many symptoms and that I am not alone in my illness.
Learning the different information about relapses and mental health things.
Being able to speak freely in confidentiality.
People got me to talk.
The part of WMR program that was most affective to me was learning to set boundaries and respect other people’s boundaries. I also learned how to work with my doctor to get the best medicines for me.
I appreciate the basic structure of the curriculum which allows for open, topic-related discussions.
Caring for yourself.
Relapse prevention.
The medical sheets, how to participate in my own treatment.
It was a laid back atmosphere where I felt free to me.
The subjects/topics. Being able to participate and ask questions.
Information explained thru group leaders as well as information from other members.
The food that a participant brought. The round table type of discussion. Good participation.
Open discussion-relating our experiences.-comparing notes.
Interaction with others.
When it ended.
The lessons on I messages.
Going over the handouts. The information was very useful.
All of the good learning materials. Sharing out thoughts about mental illnesses.
Pier sharing, good group leaders, fun ice breakers and over all very good people.
When we talked about the medications.
Don’t know.
The education and the people.
Learning and being accepted with having mental issues.
Group interaction and handouts.
Being able to talk to others openly about everything.
I liked the fact that we all (in the group) were able to express our concerns and our stages of recovery.
Interaction with others.
I wasn’t alone. I could bounce off ideas and frustrations – others we all could relate.
It did reinforce things I knew and provided some new information.
Wellness wheel; clarity and usefulness of handouts; group discussions.
Seeing everyone feel better about themselves at the end. And to know we’re are not alone! We all can help each other.
All of it.
Learning about how to handle relapse better (like cutting)
Participation in group discussions about treatment and inter-acting with other people
being able to make new friends
help me with problems program group
playing games, going outside.
party
I enjoyed materials on side effects and symptoms very much so.
Being with people that have problems like me.
sessions 6 through 10.
group discussions.
the people and open discussions
The material was very helpful.
All
Material, resources and the speakers
none
good
talking about my problems
Wheel
just getting out of the house since mom died
Socialization with other people in the group
The staff were good listeners and explained the steps we take
the wellness wheel
types of mental illness
The group leaders are interesting and explain the materials and are professional.
learning that there are avenues of help and people, who will listen.
the wellness wheel and positive thinking
instructors
All the ideas of self help and things you can do for yourself
Total participation everyone involved made everyone want to improve on themselves
The socialization and interaction
“Learn more about things to do and education on what she wants to do”
None
I don’t know.
Taking control of our own wellness and learning how to communicate.
Learning about my recovery and managing my symptoms.
openness and ability to learn
The counselors we had was very nice touch. We had a trained clinician 4 “street smart” counselor. the two together made it great
Meeting others with mental health issues.
the notebook.
Listening to others input; It helped to hear how they dealt with things and it was extremely helpful being with people who understand!
I learned a lot about my support groups, my treatment team. I thought the material was very helpful. The importance of taking medication.
It was all good and I learn a lot.
Reading the material, the subjects in the handouts.
Everyone and everything
making new friends
Were people talked about things they experienced negative of there life and asked for advice
sharing our goals and commons interests through individual games i.e. the pic, the other fun separated exercises
the positive aspect of relating yourself to mental health outlooks
Everything
All of it.
That everyone could be honest in the group. Then they have helpful feedback.
I liked all of it.
Social activity
Pick on the leaders
The group was relaxing and comfortable. I felt okay after the first day.
being around other people
I liked what was explained about negative and positives
Discussions on different topics we need to know in everyday life.
felt comfortable with other people similar to myself.
Appendix H

Participant Responses to Question #9
9. What part or aspect of the WMR program did you not like?

018 (#2)—“could not smoke cigarettes”
020(#2)—all of it
024(#2)—I really didn’t find anything that I didn’t like.
024(#3)—I disliked some of the wording.
038—I feel it could be a little more simplified, so it is easier to remember and use daily.
039—the feedback from the clients
041 - The review at the beginning of each session.
042 – The illustrations were fairly silly.
043 – Homework. Not being from here getting information was very difficult.
044 – None.
045 – Nothing.
046 - The overhead projection material was superfluous most of the time since it was already in the booklet. Also the art work was seriously lacking.
047 - A lot of lecture.
049 – Some of the material was a little redundant for me – it wasn’t as challenging as I would have liked though I know it had to be this way.
050 - Nothing
051 - I liked all of it.
052 - The overheads were already in the binder and it was distracting and took away from the flow of the class.
057—none
061—none
062—the homework
063—I like all the WMR
064—none
065—none
066(#2)—I like it all
067—I like every thing about
069—I like everything about the program.
069(#2)—I enjoy the WMR program very much!
080—I cant really think of anything.
081—didn’t have a part I did not like
083—Doing the homework
087—I liked all the handouts, cartoons, and the group leaders
089—everything
091—in some of the chapters it repeated itself.
092—There wasn’t any aspect that I did not like.
093—none
095—The homework.
095(#2)—All that reading.
096—None
097(#2)—Sometimes slow and repetitive.
100—Doing the homework
101—The homework
101(#2)—The homework (sorry)
104—none
105—Learning to stay well
106—to much reading.
107—Not to understand the drawings that we learn about.
107 (#2)- Nothings.
108—There wasn’t a part that I didn’t like
110—None
111—None!
112—I liked all of it.
113—it was very good too be.
114—It’s all good.
114(#2)-- Not sure
115—none
116—two hours
120—talking about my triggers and help with it.
123—Just a wee bit too long of class time to stay focused 2 hrs. maybe could be just a little shorter
124—Everything was fine
126—Nothing
127—meet new people
127(#3)- enjoying the group
130—nothing
131—nothing
131(#2)—none
133—nothing
135—class work
136—I did like it.
140—I can’t think of any part I did not enjoy
142—it didn’t seem like we had enough time.
142 (#4) Nothing except one on one activities
145—Everything was good.
145(#2)—There wasn’t any part.
146—I liked mostly everything.
147—two hour groups
150—I liked it all
151—None
153—Hard to follow material for someone who is visually impaired.
153(#2)—Nothing
156—This program seems geared toward people who are just beginning their recovery path, but I would like to see some tools/material about taking recovery to the next level (beyond stabilization).
157—There was no aspect I didn’t like
158—Starting out not knowing anybody
160—Not enough time to go over all the information and still have time for discussion
160(#2)—I think the time frame should be longer. Two hours is not long enough.
164—Something to do-
165(#2)—nothing, the working
168—not being able to keep up as my group did have fun from the beginning
169—orientation
169(#4)—it didn’t build my awareness.
170—the time
171—All was ok or better
174—None
175—the length
176—none
179—Liked it all. Everyone very friendly.
180—Went it was a different word you can’t understand. I knew nothing at about it
185—none.
187—No parts. I enjoyed all of it.
189—coping with medication and recovery
208—Missing papers in WMR book
209—nothing
212—none
214—Too many chapters covering communication with providers.
218—None
221—nothing
222—Not having enough time to cover everything
224—I did not like the talks of the aggression behavior.
226—I liked it all.
227—homework
228—I feel that it was not intense enough, I feel we needed to spend more time on each chapter
230—homework
233—The homework.
234—homework
236—I like it all.
238—Role-playing in certain sections
241—I liked it all
244—I didn’t find anything that I didn’t like
247—nothing
252—running late, not staying on point
254—Clean the house everyday.
255—Nothing.
257—I like everything about WMR.
260—I liked it all.
261—too many hours
264—homework
266—when others don’t respect the person speaking in the class
267—Some people with mental illness are less than hygiene safe and in a closed space it was unpleasant.
There was a lot of information given by group leaders that I prefer a copy of because of disturbances and them reading too fast. It was good info, but my brain could not contain all info. Or write it down fast enough. Also- too many weeks without class. Loose continuity
As happens often, that a few consumers talk and talk and take time away from others.
I LIKED THE WHOLE PROGRAM
Some of the work sheets.
Not enough people come to the program.
It was on Thursday!
Nothing
Never dislike any of the program.
The possibility of relapses
Sometimes one person monopolized the group.
There was nothing that I did not like. everything was good.
mid-morning time slot.
None
None of it liked all of it.
Role playing
None
Nothing
None
the screening page because I did not understand it
I like it I aspect got what I needed.
none
The paperwork at the beginning and end.
Not long enough to be able to go into some aspects deeper.
Asking me for detailed wellness plans was too hard.
How it ended. It felt like we reached a peak and then it just ended and I felt a bit lost
Almost everything
It was all effective
Nothing at all I liked every aspect of it.
The “handouts” were not always the same or not at all in our handbooks – we didn’t have all the information
All of it.
I did not feel that the group leaders were knowledgeable enough
Being read to
Nothing
nothing.
Role playing. I get embarrassed and shy
Some of it was self explanatory
Not enough time; the handouts were not always clear in their meaning
when you didn’t care.
None
Nothing
Nervousness when speaking.
I like it all
two hour sessions
(#2)- the length of the meetings
None
I loved it all
Enjoyed all
There wasn’t anything that I didn’t like.
role play
none
More attention to physical setting please. More recognition and consideration of group members’ other resources please.
None
like them all
paperwork
(#3)-nothing
the time
Nothing in particular
(Non) Everything was exactly wellness management or recovery.
None
Telling other people I don’t know my life and business.
very helpful
enjoyed it all
Everything
None
None at all
No
I liked it all
role playing; but I need to do this.
nothing it was very helpful
Arguing; joking; teasing; screaming
Not many other people were in the class
ended too soon. Would like to see a Wellness Group, once a month.
cant think of anything in particular
“not being able to write my answers down, I’m blind”
liked all parts
I seemed to like everything that I experienced in this group
Question I didn’t understand.
Role Playing
nothing I liked it all
A facilitator died a couple weeks ago
None
Just going to group was boring to me.
None
All was helpful
It was personal—I had hard time writing the journal in parts and trying to memorize the classifications of symptoms and side effects and write something meaningful. It seems the related symptoms and side effects were not in an order (of classification of problem)

Needed longer breaks

too much goal setting, when I have no idea what goals to set

The homework was a little too demanding, I found myself stressed out over it

When the truth comes out it really hurts, like when people judge you and tell secrets behind your back or yell at you and boss you.

To be honest, I can’t think of any part I didn’t like.

writing about myself

I truly loved every aspect.

starting all over

I liked them all

There was nothing negative

To be honest I can’t think of anything because I liked it all

There wasn’t any.

I like all of it

None

Should have been expanded to a 2.5 hour format with additional rest periods and more props for visualization.

I didn’t like the fact that I felt like I was having problems with mental health issues while I was in the group; but at least the feedback I got was helpful!

conversation study

formation

I have to stay well for my health

None

None

there was nothing that I didn’t like

I guess none of it. I don’t remember disliking something. They forgot our snacks sometimes.

not enough time spent on some of the topics – need more weeks for the class

Nothing at ALL

Liked everything

Some of the words were hard

Nothing

Not enough time to cover ALL chapters.

to difficult for myself to read the material

calling me in the group and did not understand what you talking about

Had to go too fast on the paperwork.

liked it all.

I didn’t like having to do ice-breakers.

Nothing. Every part was good.

My group members were too quiet! I wish Karen would have talked more, she has great insight!

meeting other people and talking as a group.
571(#2)-- Too much paperwork and too many repetitious questions!
574- Don’t like homework
575- Liked all parts
576- none
578- Nothing
582- the telephone advice mail
582(#2)-- constant fighting day to day in job functioning type skills and putting out garbage cigarette butt etc..
583-- I had transportation problems sometimes! I couldn’t always get there! One time my ride did not even show up! Sometimes I had previously scheduled appointments and could not make it.
584-- I got a better understanding of my role [role] in the recovery process and in the treatment team
586- one on one talk I didn’t know how to word things.
587--coming at first it was a little uncomfortable but the more I came the easier it was
589-- The reading and talking. Or I’ll say lecturing.
594—Too Long
596—paperwork
597—education-learning
604-There was no part I did not like. Maybe then maybe too long.
607-there was none.
612-Not enough peer participation
613-that we get sidetracked with the pharmacies. talk.
614-None
616(2)-When the instructors read material that was not in OUR book. It sort a of was confusing – WAY TOO FAST!
619-- Nothing really a lot of info I had heard before. Probably the worst is filling out surveys.
621-being on time
624-all aspects where beneficial, each aspect related to the other; videos, lectures, written assignments etc.
625-It was somewhat difficult for me to really talk about myself without being worried about what I was saying.
626-Had difficulty with goal setting from and little time to fill out form adequately
627-I liked everything especially the track every week.
628-I felt that the handouts could have been more detailed
632-recaling
638-too short o time
639-- I liked it all
640-- Nothing. I liked it all
641-- There really wasn’t an aspect I didn’t like. I hope another program comes along.
643-- The WMR book was confusing.
644-- It didn’t address the problem of “harassing voices.”
646-- I liked it all.
646 (#2)-- I liked it all.
None. I like all parts of WMR program. Everything was very educational and can be used as a reference in the future.

Karen Biggs the group leader was extremely helpful and really got everyone to share important thoughts and feelings. Notebooks were great!

The stick figure illustrations. I think all of the illustrations need to be re-assessed

Low attendance leaders not very sure of themselves

It was Always very helpful

#2-none

#3- none at all

the WMR give me what I needed

overall I like it very much

I liked it all

Too much paperwork.

All the paperwork.

The paperwork

10 am start. Also I thought 2 classes/week 1-1.5 hours in length (can’t read this part) best.

The paperwork

Missing the last few weeks of WMR

Homework-I’m always busy (but homework helps, out of class)

Carrying heavy books

Liked everything about it

The sessions were a bit too long and somewhat difficult to follow.

I would like to see more time for experts to speak regarding subjects like medications etc. Thank you for having the pharmacist visit.

sometimes overwhelmed with amount of presented material

liked everything

sometimes it was to long

I like all parts

I was fine with all of it

none!

There is now part I did not like.

ice breakers

Amount of time it is.

The sessions were most often too short. It felt like a rush to finish all of the information.

There was not anything to dislike.

pages need to be numbered

(#2)- The length of the sessions.

Maybe letting people read more.

some of it is different not that I didn’t like it

I thought when role playing we should have done as a group rather then pair in two’s

The lack of opportunities for more peers to become involved. This issue has been noted by the C.C.O.E. and is actively being addressed.

it was all ok
Not enough time to go over all the material.
Keeping the 3 ring binder organized.
(#2) this paperwork
(#2) seemed to be too rushed.
too time consuming
the same lessons repeated
People that talked too long during group
sitting for 2 whole hours
don’t know
I wish it was a longer program
(#2) Felt rushed –by myself- so I couldn’t comprehend I missed to many classes
Not enough members
I really didn’t have a problem with any part of the program.
too much paper work to go over – page flipping/searching for the right page.
The project at the end has one worried because I have no idea of what to do.
too much material to cover bigger class size 9-12
There was nothing about this program that I did not like!
(#2) There was nothing I did not like about WMR!
nothing
I can’t take the class immediately after this class
nothing at all
set on the floor people being late 15-20 minutes late
The cake and soda and food. Trying to make people fat on junk food.
the party
I would have liked a bit more information on each topic.
when I asked the leader to help me because I didn’t understand things, she would respond and say, “its in the book read it.”
none.
the reading of the same stuff over and over about mental health issues and nothing new no new perspective
Everything was great!
none
(#2)none
—nothing
Nothing
All was good and helpful
none
dealing with section addressing my family
homework worksheets
The WMR program was fine.
none
—Being afraid to talk to people in the group because of my voice
—role playing
—Working on goals and circles of physical, mental, spiritual, social, emotional, and nutritional.
868-nothing
869- The constant talking, while others are talking
870-“no issues”
877-None.
888-The handbook was partially incomplete for some chapters/sessions. Sometimes, disruptive groups members would dominate the discussion.
889-None I actually enjoyed the program.
899- nothing
890-It didn’t last long enough or was in-depth enough for me! I would have liked more hands on and in depth/definitive training/info
901-Transportation
902-I liked all very much.
904-a lot of what was in the note book was not covered. Some students were disruptive- mainly rambling on.
905- I liked all of it!
906-Speaking in front of other people at first.
913- Having to stay home when I was sick.
916-Nothing
940-ball
941-passing that damn ball around
942-some people weren’t honest of themselves and not very talkative
943-the ball was o.k.
944- the part related to how you would get along with others
945-The ball
946-Sometimes there wasn’t time for everyone to talk about their issues.
947- Nothing at all
948-time to do things
949-I like all
950-none
952-the ball
953-I didn’t quite understand the program.
954-no cookies
956-waiting in the waiting room
Appendix I

Participant Responses to Question #10
10. How has participating in the WMR program helped you in your recovery?

009—Talking about issues and medical diseases.
018 (#2)—“It focused more on the non smoking policy”
20(#2)—very much so
024(#2)—It gave me answers to many questions I had about my own recovery and how to move on with my life despite my mental illness. My mental illness is not all of me.
024(#3)—It changed my life because I thought I was totally lost and it showed me I was still a person.
034 - It clarified some of my goals for recovery.
038—It mostly reiterated groups I’ve had for 20 years, now.
039—realizing that we all have problems 2 deal with
041 - It helped me to see that I appreciate my own company.
042 – It reinforced what I’ve learned in other groups that I’ve taken in the program.
044 – WMR has been helping me concerning good techniques to use in speech behaviors with family, friends, doctors, acquaintances concerning conflicts or difficulties and has also taught me coping methods and strategies to use to avoid relapse.
045 – Getting me to look at things I had not thought of before
046 - I’ve gotten to know some of the participants better and thus better socializing.
047 - Learning about my recovery through material that was presented.
049 – I learned to open up with others more and to recognize who were the people in my life health enough to aid me in my recovery.
050 - Having a 24 hour wheel…..The thing you like to do the most.
051 - I have been motivated to set goals and achieve them. I do this every week. Coming to this helped me to have more people to talk to about my life, my health, and my problems.
052 - The goals were a big help toward putting things in action.
057—how to deal with my mental illness
058—relieves stress by talking about issues
061—To speak up when something is wrong
062—Its helped me to know myself better.
063—learn new things
064—very much
065—Learning me to cope with life
066(#2)—Very much
067—Meet people. learn things
069—It helps me to speak up for myself.
069(#2)—I am a more outgoing person.
071—I learn from other by being myself.
072—Learning about myself
080—It gave me usefulness and responsibility.
081—Taught me to look at myself as a whole
083—It has helped me to become more aware of myself
087—I have a plan now and it put me in a better frame of mind when we had discussions I felt included that I could be a good help as well. The fun we had made me want to be well and recover as a whole.
— in all kinds of positive ways!! And in my personal relationships
— Helped me a great deal. Everything about the Group was helpful.
— It gave me more information about my sickness
— yes it has helped me to be more aware of my improvement in recovery by getting up each morning, coming here experiencing and learning new information.
— It made me see that I am not alone at all. Thank you WMR for that
— Yes
— A lot
— Eating healthy, exercise, medication management
— It has helped me to know how much better how I can recover.
— It has helped me see how I can help myself and others.
— some it helped with some things
— To better myself and get educated.
— WMR has helped me to learn about my mental illness a little bit more
— It has helped by making me more aware of my mental health recovery
— It has toned some skills for me to use in my recovery
— So very much, it helped me to take a good look at myself and my condition.
— Not to worry about what I cannot change
— became more aware of coping skills.
— yes I learn more about my illness more than ever.
— The whole thing. Thank you
— to get me to do the things I should be.
— very much
— Feedback from others. Learning more about yourself.
— I will use it for further recovery.
— it help me very much and I hat too do more if I can.
— Helps me to understand my illness better; not to be ashamed of my illness, and to ask my doctor about my medication side effects.
— A whole lot
— the info and support I have received can be applied to my life (recovery)
— Helped me understand what I needed to help with recovery
— Getting all the information about it
— to remember the material while functioning in activities thru the day to put to use the things that we learned because it really makes a differences, improves life, and makes it better
— having support makes me hopeful.
— My recovery
— people
— learning a lot getting through
— Learn about a plan for crisis
— I learned a lot of different stuff
— everything
— show me that I can change it’s just up to me to want to
— By talking things out.
— Learning and finding time to socialize and having fun with people no matter how they are in health
138—a little still have congested thing tank sometimes
140—what each member of my team is supposed to do, what their job is—now I KNOW I’m the one in control of my recovery!
142—It gave me another aspect to look at, as far as relapse goes.
142(#2)—I have learned that I am a better person and I know what I need for future wellness
142(#3)—It has helped me tremendously with trust of others
142 (#4) It has been a great experience all 4 times.
145—I will be able to learn about myself.
145(#2)—I got to know a little about myself.
146—I feel more at ease with myself.
147—By addressing both my mental health and other issues vs. both of them separately.
149—Help balance my life, positive thoughts, stay sober by apply myself to it.
150—it will help me in realizing I am not alone in this.
151—I have to focus on my trigger and what I need to do to follow through
153—Inspiration and somewhat of a level of empowerment. It has also been fluttering.
153(#2)—confidence, openness, reinforcement
154—I have learned a lot about mental illness and lots of good suggestions from all of the group members. I have made a lot of friends and good support.
156—Remind me that I have choices that therefore I am in control (even when it seems like other things are not controlled, I can still control myself).
157—I’m not sure
157(#2)—Understanding relapse
158—Reminds with all info, coping skills and crisis mgmt plan
160—it gives me day to day structure to help me in certain areas.
160(#2)—It’s made me deal with outside situations better. Made me stronger. I’ve made more friends that are recovering just like I am.
161—Very much. By making me feel better as a person. Being more positive when talking. 162—Be more assertive about my needs
164-Help me cope-
165(#2)—Better the understanding health
168—yes!!
169—hope that get better
169 (#4)- It makes me feel good about myself.
170—by knowing how to better take care of myself, with their use of techniques.
171—Increased awareness
174—That reminds me that we all have the same problems and relate to others.
175—to reach out and interact with other people
176—I learn more by participating. A lot of the issues were good for me.
179—Helps me to get out and communicate with others.
180—the whole thing really
185—yes.
186—I learned to open up and I met different people
187—Helped me to get out around other people. Would not have testified at grad. the group participation
189—yes
208—Social and learn with other deaf people
209—helped a lot
212—It helped me learn and I can relate to some of the handouts
214—Not much
217(#2)—I learned from my peers
218—yes, it helped.
221—yes I will be willing to participate a second time
222—I think I got a deeper appreciation for what others go through. Seeing the changes in other people. I too need to make some changes in the way I do things
224—I have learned how to approach people and case management. In a more passive manner.
226—Have goals to achieve. Wellness wheel was helpful.
227—advice about talking
228—The program gave me different options on my way to recovery and resources that could come in handy if I had a relapse.
230—it has helped me understand my mental illness
231—The WMR program helped in my recovery by providing practical examples of things helpful in recovery.
233—very much
234—I try to be more positive of myself.
236—I get out more and talk to people a little more.
237—Understanding all aspects of the program
238—Better communication with Southeast Staff
241—it help me in my recovery because it gave us confidence to believe and steps to follow to do anything you would like.
244—it was fun
247—it helped me with the problems I was having.
247(#2)—how to deal with people and problems
248—I got along better on the job.
252—I can go back to my workbook as a reference. Talk more to mod squad and counselors.
254—yes.
255—Educated more
257—Will we move to a house, that we wanted
260—it helped me to get along with others.
261—By keeping my nerves settled
264—yet to be determined
266—I’m in control of my emotions and try to maintain that level of balance that keeps me stable.
267—More out spoken, I feel like I can take on the problems I need to handle and resolve.
268—it has shown me how to cope and how to make medical plans – also supports.
Exception: other ideas such as Dialectic Behavior coping skills. Since no one has a class, but everyone says how helpful it would be, could some training in D.B.T. be included?
269—still working
A beautifully holistic program as we interpreted things with our illness. I wrote things down and am still working on adapting goals to myself.

Reminding me of other things I’ve learned an putting things together as a whole

IN MANY WAYS

Helps me think my way through the class

It will keep me out of the hospital for good. I don’t have to expect to have a nervous breakdown in go back to a hospital

some

Better myself Believe that there is another way of life

Need to read and listen to other more often. So it has open my eyes and ears too.

The reminder and recovery of WMR

It has help me to see myself as a human being and to know I am important. And not to get down on my self. to take my medicine to live life on life terms not use drugs or alchole not to get depressed and to know life is good

(a) self-advocating (b) learning triggers and how to watch for them (c) advance directives and emergency/crisis management plan

I show me how I could manage my own Recovery with the input of other

It makes me feel better about my self.

I told exactly about me to talk about things did me some good.

It identified areas of needed work

Alot.

Helping me with socializing and making more friends.

I listened instead getting wound up

tell me about my medications

it got me motivated

Yes it did help.

gave me enlightenment

let me know what I can do to reach goals. I now have goals. I didn’t before.

It helped me stay focused and accountable by coming every week.

Feel I have a say so in what goes on from here, not just mental health but overall life wise.

To talk to my doctor better. In conversations with others. How important it is to take my medications. To take better care of myself personally.

meeting people – mentally ill people can be very nice and act very normal. Sharing and differences can be empowering.

I’m more assertive with my mental health care providers.

not at all

New friends, better about myself, not being alone

It has helped me communicate effectively, It has helped me understand issues with my mental illness, and it has helped me discover myself.

It has helped me in my mental health, physical and social skills.

The WMR program was very helpful in every way.

Helped to show me that my 13 years spent in recovery circles & the knowledge that I have gained can be useful in helping others.

It made me more aware of my strengths and weaknesses. It helped me with assertiveness training.
All of it helped.

Homework helped me understand, and cope good.

I have started asking questions when unsure, and have asserted myself on several occasions as to what my needs and wants are.

It helped me to realize better ways to handle my illness and my recovery.

The wellness plan helped me to realize more about my mental illness and with my coping skills.

Talking out the problems helped me realize more about my mental illness and with my coping skills.

Seeing others that have similar health problems helped me a like

more organized

pay attention to phone number

It’s given me insight about my brain injury

the voice went away

learned some new tools.

The recovery on the blackboard helped most.

It has helped me come up with different solutions for my recovery.

better management ideas

more focused

some

It’s helped increase the internality of my locus of control.

It helped getting me a job in the community.

Ok

Basic fundamental

It helped me be more effective.

it taught me stuff I needed to help me learn

Helped me refocus of things I learned in the past.

To gain more knowledge about

WMR help me to target my problem and gave me what I needed to improve

It help me to cope with everyday activities or should I say life in a positive way.

It helped me to better deal with my mental illness and to try to control my life.

like WMR program very much

Eyes and ears more open to hear and see what’s happening.

I talk more

Do what doctor advises

yes very much

All of them

Learn how talk doctor, case mgr., respect for other people

yes learn new stuff in class

Gave great skills, very educating very supporting

It has given me a lot of useful information

interacting and listening to others.

I took it twice.

Talking to me about not get upset.
—Trying to get balance in my life and getting out of the house.
—Understand more about me, and to understand more.
—It will reinforce the goals coping mechanisms recommended by the book
—It keep me well
—“helps me to use the skills I learned to recover”
—it provided me with needed information
—Just the sharing of the experienced materials by long-known L.M. members.
—finding mind in control prepared to learn how to take up classes and going for the goal and keep going without stopping.
—Gives my mind better focus
—everything
—Taught me a lot about my recovery and how to deal
—#2-helped me get over the death of my mom
—#3) Coping w/ death of mother
—it helped me mentally
—not much recovery or change has progressed through me as a person. Just me has to change and grow up and be mature as person and take things not so stressful and not respond to things and not overreact to things that make me stressed out and more mentally ill and/or disorder.
—It helped me on my mental issues
—Taught a lot of thing that I hadn’t thought about
—It has helped me with my doctors and friends
—it made me see something as simple as not always feeling able to boast. at certain times it made me cognizant of the other things that were happening to me at that time, not just feeling foggy, and blacking out but muscle problems and other symptoms.
—Nice exercise Everyone participated, good reading material
—not much
—I’ve learn how to ask question when I see my doctors; also how to handle others when they act negative towards me.
—I am glad to be I’ve changed my life from drugs and drinking. I want my life and medicine has changed me very much.
—It will help in helping me maintain my wellness and help family members that need some wellness in their lives.
—I feel the WMR Program got me “in touch” with me.
—yes, very much helpful with much information
—it made me look at myself. To see what I was doing wrong. Like judging others
—I make better goals to have a healthier life.
—very helpful
—Learning more about myself, my meds, my life and friends and family
—Yes. I am more confident that I’m at the place I’ve hoped to be. WMR has confirmed for me things about myself that at the beginning I was hoping was true, but I was not sure.
—it made me realize that I’m not the only one with a prob.
—Help me to be a better. I learned a lot in the group.
—it has help me to learn more about myself
I was able to obtain information that assisted me with several aspects of my recovery process. Wonderful and Amazing – Wow!

good

we like to improve to learn

I learned a lot of information.
instrumental

It helped me realize that other people have issues and that everyone (including myself) gave a lot of good feedback and I have grown and have learned a lot in this group!
refresher course

compliance with institutionalized organizations

I am still in recovery

It gave me a chance the think of past and present actions and see how to live at a higher standard, plus be more responsible for recovery.

Health and wellness and what to do to maintain homeostasis

the whole group helped me

learn how to talk out

It helps me cope better. Get along with things.

I was able to talk with my doctor and work out a plan to lose weight also I went from seeing my psychiatrist every 3 months to every four months. I also am sewing again and enjoying it. Listening better in communication and being assertive with my boyfriend

it has made me think about things some more kind of like mediation opens ones mind.

To learn about My Mental Recovery

By talking about things.

Just better.
talking to people

It helped me learn how to deal with the good & bad aspects of life. I now know how to deal with certain situations.

Helped me realize that we have choices

Just being in group not just one on one for a change

a lot betting coping skills

some background (symptoms & where to go for help)

It’s given be valuable information about talking to providers and considering stressors & side effects. It’s also given me valuable forms to keep records and to consider being well-balanced in all areas of life.

I was exposed to more knowledge of how to deal with the voices.

help a lot

The material brought focus to what I need to do for myself.

I learned a lot and would love to take the class again!

I relaxed. I had to talk more

Knowing I have friends who care.

more insight into nature of mental illness

I have made a few friends from the class
More Self-esteem
- everyday
- several
- getting to know the work crew from inside out. Meeting new members of the team.

I learned a lot of tips to help me in my recovery in future years (did not graduate because of these reasons!!)
The group was too short
it helped me in not being so isolated from others.
It has helped me with my own issues leaning a little more about myself and a little more about myself. It’s helped me identify and recognize what part I played in it and what I should be aware of and the questions I should be asking.

--- Coping Skills
everything
education-learning
Great
the mental exercise and capturing memories again

It helps you understand yourself better and other people. And helps you understand things in general better.

It gave me social contact with others
gives me more insight into my psychological make-up
Helps w/ talking to people and Not be so Aggressive
Yes
It’s taught me more about Mental Illness
learning everything
(#2)- exercise, medication
Learning how better to safely express myself to others and goal setting and setting boundaries.

-Making me more aware of that I need to take care of all of me not just nutrition, not JUST medicines. Good overall balance
It gave me a routine for awhile something to get up for; do, or look forward to.
learn to get along with family members & staying well
the program was why helpful; a lot of positive information and how to manage my mental issues & improve my quality of life; did cover a lot of material in a short period wish we could have done more homework in class so we could have more information & motivate one another not that motivated at home
It helped me understand myself and my relationship with my mental illness so that I can live now happily and productively.
I can use notebook from the sessions as a reference. Session materials can help me stay focused on my recovery. Use the list of resources to guide me. (from resource sheet hand-out.)
I have learned how to act with my doctor and social situations + also learned about emotions anonymous. Other groups that are available and about medication mgmt. + learned a lot about recovery mgmt.
It has given me thoughts to ponder about how I look at myself
--- I love it
638--Made me more aware of my problems.
639-- People listen to me & understand
640-- I learned better ways to cope with my problems. How to be assertive without being aggressive.
641-- It has helped me with coping skills and in learning much more information that I knew in the past. I enjoyed the socialization.
643-- Kind of.
644-- I still feel alone in battling voices. I don’t think anyone believe me about the voices.
646-- Its given me hope – that I can set goals & achieve
646(#2)-- expand my horizons
647-- I have reference material to look at for future help.
648-- grow
654-Now I know the is more about my Illness and more people the I can’t imagine.
655-I feel more positive about my life and handling my symptoms now.
656-Gave me another approach to dealing with personal issues.
657-Give me something to think about
660-Quite a lot.
662#2-How reading and spelling Help me Learning a lot
662(#3)- things thing good things to think about.
669-By using the tools that was in the class. Note: I didn’t get or others felt that they didn’t express feelings on there background or Anything
673-knowing all the tools I have so I will able to ge better. But it’s up to me to get 100% well if I can.
676-Every thing in group helped.
683-Self-reflexion – meeting with [unable to read]… group – an talking to those which on [unable to read]… about things that helped their recovery
685-I get to know people which really makes me happy.
686-Socialization and helpful hints
687-Gaining more knowledge in my mental illness.
688-I can use everything I learned in my WMR class in my everyday life.
689-Pushing me toward my goals and motivated me during rough time
691-(can’t read this at all)
693-It helped me to get out of the house and have a supportive place to go and also used the computers here.
695-To know about the illness that you have
696-By using information in my life
697-I will use the information later.
698-Achieving goals
699-Taught goals that I set for myself not just told what to do.
700-Help me learn better, think for myself
701-Meets good friends
702-I will be using the WMR steps in my recovery.
703-It has opened my eyes and taught me that there is a way to be proactive; that it is possible for us to improve our mental health. I really thought my only hope was doctor
and counselor and now I know there are so many more tools that I can act with.

Resources!

704-By sharing personal situations, I am so grateful for all who shared and allowed me not to feel so alone.

705-has shown me how to handle myself and my brother (who is bi-polar) and to give me so much additional information on mental illness; i.e., that’s there is a “possible” recovery.

706-Enlightenment encouragement, devotion-family style setting

709-Gave me more support in my recovery.

711-improved social interaction

715-it help me to grown and also to be leader also

716-working with the Nord staff, case managers, doctors, etc

720 #2- Wow it really made me & help me threw

730-The familiarity of it helped with problems that I had in the past.

733-to help release what I need to work on

734-Helped with dealing with depression and my physical and mental handicaps meds other.

736-set more goals, be more active and sociable

737-It help me learn about how really important med not skipping. Learning to talk to any kind of doctors.

737-May me learn better about myself.

738-It has made me think about what it means to achieve wellness. I’m not sure I am there yet.

739-It made me see things in a better way.

740-Refreshed my mind

744-Its helped me realize my problems are shared by most of my peers.

744 (#2)-it has shown me that I’m not as ill as I thought I was.

746-It has helped my self-esteem and I’ve learned a lot more about things

748-To be positive & maintain what I learned here.

749-Some

750-I have learned communication skills as well as learning to work in a group. How to respect myself as well as others How to cope with my illness as well as how to communicate with my recovery team.

751-I am already trained as a facilitator and currently very active with our Lake County Alumni Club. The WMR program came into my life at a time when I was searching for what to do next. This program has become an integral part of my life journey-an opportunity to mesh my professional background in education (teaching) and my personal mental health issues. I attribute so much of my positive growth to the W.M.R. program!!

752-to pay better attention to how I feel to understand better

753-Planning Relapse Prevention (etc)

754-I made my own medication sheet.

756-Made me aware

758-It gave me strength on many levels. It also has helped me to not be afraid. I’m not the only one.

759-Gave me knowledge to empower me to improve my quality of life.
sets good foundations and methods.
760(#2)- Helps put things in perspective.
761-I understand myself a little better
gives me more tools to help myself
762(#2)- It has given me more tools to deal with life.
765- it didn’t
766- quite well
768- It had taught me new skills.
Gave me more hope and will power
I’ve learned a lot about myself and over-all great information
To have patience, to take meds to prevent relapse
don’t know
It’s educated in me in many areas of mental health. I was given tools to help fight depression. I was very happy with all the people.
It taught me in so many areas about resources to help myself.
-somewhat
It helped me most by talking things over w/ Debbie
It has helped me realize more that I’m not the alone one.
Gave me a chance to work on areas I need to and helped me recognize and set goals.
As in #8 it kept me from crashing as bad and gave me some hope and strategy, understanding and empowerment.
It helped to some degree my recent mental health but other factors have me more concerned.
structure- for example, the Wellness Recovery Action Plan
It’s helped me have a much more positive attitude towards my recovery.
Very much, it’s given me a positive mental attitude. Its Great!
learning more about recovery (like how to handle hallucinations)
everyone
helped in so many ways I can not say I loved the group
ask questions; helps me sleeping
Keep my mind open, doing something.
Happy times in the in the classroom
I appreciated the information used developing effective communication styles, this will help me in more effective communication styles.
to know that people have’s the problems to.
confidence.
Knowing that there are programs in place to turn to for help is good to know.
keep me mindful that I am going to get out of this sort of cycle so I don’t need to be like this or these people any more. Been here too long already!
It reminded me of things for wellness-thinking positive exercise-eating well-meeting new people
I was able to get out of the house and socialize with people my age
knowing how to advocate for myself.
—none
(#2)-- yes
—yes
841- Learning more about others and myself!
842- smile more
843-It helped to identify factors for my recovery choices
844- everybody gave support and self-esteem
845-information. was very helpful. (ie, How to set goals) I could identify with what other
group members talked about
846-medication needs and importance
847-The materials are helpful because you can set goals for recovery.
848—Help me to look at myself in a different perspective more positive
849—Pinning goals to the mirror so that I think of them every day
850—bit more socialization
851—I felt that with new med combinations and classes, I focused on my recovery
868-become a better person and deal more effectively with my mental illness
869-I can take pointers from here and set a [can’t read] that I can go on from
870—“good”
877-None.
882-A lot.
888-It has helped me develop what skills were always there, while giving me new
approaches towards problems that I’ve had in the past.
889-It showed me things about recovery that I did not know.
890-I felt truly as if I was able to be a part of something that was going to help others 😊
That is service work!
899- give me reason the go on
901-some
902- It has helped to show me that I’m not alone in my struggles.
904-hasn’t helped, but eventually will.
905-It gave me suggestions and ideas that I wouldn’t have thought of. It is very important
to be with people who understand, care and do not judge! I would still like to meet with
someone who can help me deal with extreme negative effects caused by STIGMA! Susan
B. 419-382-5800.
906-Helped me to learn to be more social, become more active in my treatment. Become
more physical taught me to advocate for myself.
913- A lot it made me think about thing.
914-Insight in how to communicate with my doctor and treatment team, discuss relapse,
when to look for warning signs.
916-Being a part of a family
940-I’m not alone
941-lets me express myself w/o being judged
942- noticing the person I can be and be help of others to help control are emotions and
behavior and continue group!
943-It was very effective in sharing our lifestyles and gaining new friendships
944-It has deeply affected my road to better mental and emotional health
945-Alot
946- I’ve been able to make friends who have similar issues
947- It helped a lot it helped me be a positive person
948-It may help with depression
949- It is fun.
950-to realize symptoms
951-I feel like it has helped me get out of the house and with people.
952-very much
953-About explaining about medication usage
954-to deal with things better
956-not really sure