The Healthy Relationships Pilot Program: A Cognitive-Behavioural Therapy Group to Enhance Interpersonal Relationships in a Group of Adults with Mental Health Disorders

by

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The procedures in this workshop are meant to be used by agency staff, as part of the broader services they provide, or under supervision of agency staff.
DEDICATION

I wish to dedicate this thesis to my family, because without your love and support, none of this would be possible.
ABSTRACT

Relationship building and maintaining relationships can often pose difficulties for individuals with chronic mental health diagnoses. Isolation, stigma, and deficits in communication often contribute to the lack of relationship and intimacy skills that adults with mental health disorders face. The present pilot program focused on improving interpersonal skills using the tools that the peer support group model provides for individuals with severe mental health disorders. A cognitive behavioural group intervention was implemented to enhance relationship and intimacy skills with four adults with chronic mental health diagnoses. There were five, 90 minute sessions and met once a week at a local mental health agency. The goal for the group was to enhance healthy relationships by utilizing cognitive behavioural strategies to teach communication, conflict resolution, stress management, coping strategies, and social skills training via the peer support model. While the main focus of the group was building and maintaining healthy relationships, every session had a theme that focused on these five core skills areas.

Pre- and post- test questionnaires were given to participants in order to evaluate effectiveness. Overall, feedback revealed that the group was effective in demonstrating gains in knowledge about relationships and that most group members reported that they had positive reactions to the group experience. Limitations of the current study included the brief period of implementation and small group size. Recommendations are that future groups should include more individuals and therefore, increased opportunities for social interaction, and an increased number of sessions over a longer period of time. In addition, improved measures of group effectiveness could be developed over time in order to continue to provide guidance to peer support groups that aim for improved community integration of those with chronic mental illness.
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Chapter 1: Introduction

Overview

The use of peer support is becoming a more widely used component in post-institutional mental health care services. It provides social support, empowerment, and independence to consumers of mental health services and employs self-directed care that otherwise would not be offered in an institutionalized setting (Schutt & Rogers, 2009). The importance of social support and belonging is especially important as relationship building and maintaining can often pose to be quite a struggle for individuals with mental health diagnoses. Isolation, stigma, and deficits in communication skills attribute to the lack of relationship and intimacy skills that adults with mental health disorders often face (Basco, Prager, Pita, Tamir, & Stephens, 1992). The peer support model can be therapeutic because the individual has the opportunity to interact and share stories with people who face similar challenges and experiences. The peers can offer tools and perspectives to others as well as from others and build a social support network outside of immediate family and gain a sense of belonging and community (Soloman, 2004).

There has been a closer focus on post-institutional care for adults with more intense and serious disorders such as schizophrenia and disorders with psychotic features. It has been shown that outpatient care is effective and helpful for adults diagnosed with schizophrenia or other serious mental health disorders (Salokangas & Saarinen, 1998). The clients served by mental health outreach programs, such as the agency involved in the current study, are usually adults over the age of 18, who are diagnosed with serious and persistent mental illness or personality disorders, with severe functional impairments, who have avoided or not responded well to traditional outpatient mental health care and psychiatric rehabilitation services. Persons served by the Assertive Community Treatment teams (ACT) often have co-existing problems such as homelessness, substance abuse problems, or involvement with the judicial system. Referrals to ACT teams are accepted from community agencies, hospitals, medical or mental health professionals and self-referrals. The mental health consumer peer support agency that was also involved in the study provides peer support throughout the community for individuals 16 years and older who live with or have lived with mental health challenges. The collaboration of these two agencies to offer a peer counselling program is especially valuable as clients have the opportunity to come together under a common goal of wanting to improve interpersonal relationships and share stories and strategies to overcome barriers and challenges that they regularly face. Group counselling interventions can enhance self-esteem and promote healthy relationships. Peer support as provided within a group can help to reduce mental health problems and provide opportunities to change perceptions about self, others and the outside world (Shen & Armstrong, 2008). These tools that can be acquired through group peer support can be utilized to educate, empower, and equip individuals to improve their relationships with others as well as to enhance intimacy skills which can make a positive impact on their lives.

As there is limited research with the use of a peer group counselling intervention and education related to relationship skills in adults with mental health disorders, it is
important to investigate and further findings to expand research in this area of mental health services

**Hypothesis**

It is proposed that a cognitive behavioural intervention involving peer support, stress management strategies and self-monitoring techniques will be effective in enhancing relationship and intimacy skills in a group of adults with mental health diagnoses. There was a common goal among the participants of wanting to improve and enhance healthy interpersonal relationships. During the course of discussions with group members in the pre-group assessment meetings, the following five core skills were identified as group goals that were focused on in the intervention:

- Communication
- Conflict resolution
- Stress management
- Coping strategies
- Social skills training

It was hypothesized that after learning and developing these 5 core skills areas in the group, that the members will experience improved and more meaningful interpersonal relationships. It is believed that some of the undesired behaviours that members were experiencing in their personal relationships were maintained by negative reinforcement through avoidance of seemingly aversive social interactions or for other behaviours, positive reinforcement through the acquisition of desired outcomes for those with aggressive conflict management styles. The goal for the group was to enhance healthy relationships and intimacy skills by utilizing cognitive behavioural therapy to teach communication, conflict resolution, stress management, coping strategies, and social skills training via the peer support model. A relationship that has better and more effective communication, less conflict, healthy alternative coping strategies and effective training on appropriate social skills has been expressed as ideal for these individuals. A general hypothesis statement for the group members is as follows: If a peer support group counselling intervention is implemented that focuses on the enhancement of the areas of communication, conflict resolution, stress management, coping strategies and social skills training exists for these individuals, then the interpersonal relationships of these individuals will be improved.

This thesis will include: a review of the relevant literature; the methodology of the current study; the results and an overall discussion and conclusion.
Chapter II: Literature Review

The current literature looks at adults with mental health diagnoses and the social skills deficits and challenges that occur with this population. Additional information is explored on the importance and recent significance that peer support offers due to positive social interactions and social support building. Further research on Assertive Community Treatment teams (ACT) will also be explored and its effect on recovery as the participants of the intervention study includes persons from this population. The influence that positive and healthy interpersonal relationships have on adults with mental health disorders is also discussed as well as how social skill training affects mental health, peer support, CBT, and the influence of the Assertive Community Treatment teams on mental health.

The Effect of Healthy Interpersonal Relationships on Mental Health

The benefits of interpersonal relationships are important to all individuals as establishing and maintaining interpersonal relationships is a pivotal developmental activity. Forming an emotional connection provides an important social identity, contributes to a positive self-conception, and is a source of social integration. Individuals seek companionship, emotional security, love, and physical intimacy from interpersonal relationships and the importance of a powerful emotional connection can be investigated further in order to examine the benefits that it can offer to people diagnosed with severe mental illnesses (Simon and Barrett, 2010). According to Basco et al. (1992), problems in romantic and interpersonal relationships of mentally ill persons is common due to a lack of coping abilities, communication, problem solving, and intimacy skills. Establishing and maintaining intimate and satisfying relationships has been shown to counter the effects of psychological stressors that individuals with mental health issues experience (Lowenthal & Haven, 1968; Roy, 1978).

The benefits of intimate relationships are vast but romantic relationships, particularly high quality romantic relationships, present benefits such as social support, companionship, love, and sexual involvement (Rhoades et al., 2011). Due to social skills deficits and barriers to communication which is associated with severe mental illness, it can be very difficult for people diagnosed with severe mental illness to establish let alone maintain healthy romantic relationships. Studies by McCann (2003) indicate that there is a lack of research investigating intimate relationships of individuals with diagnosed mental disorders and a need to integrate the improvement of relationship and intimacy skills in present cognitive behavioural interventions. This researcher also concluded that there should be a conscious effort towards encouraging communication about intimacy, providing education, and encouraging the exploration of these individuals’ feelings and thoughts surrounding healthy relationships on the part of mental health care providers. In a study by Simon and Barrett (2010) evidence gathered suggested that supportive intimate relationships are associated with higher levels of well being, while strained relationships are related to decreased psychological functioning. Also, this research reported findings that establishing and maintaining healthy relationships was important to emotional and psychological well being and that there seemed to be no gender
differences found in the relationship quality and mental health status when males’ and females’ distinct expressions of distress were considered (Simon & Barrett, 2010). This study suggested that further development in this area is needed for both women and men and that the link between positive and healthy interpersonal relationships is vital to mental health recovery and needs to be implemented into treatments for this population group.

**Social Skills and Mental Health Disorders**

Social skills are vital for the ability to interact, adapt, and properly function within one’s own environment. The capacity to effectively interact and establish relationships with others is a crucial factor to a healthy and full life. Attaining proper social skills is also vital to transitioning into independent living in the community. Without those important skills, the basic need for human interaction and relationships can be neglected and result in significant barriers in functioning (Deniz, 2009).

Recent literature has shown that individuals who are diagnosed with mental health disorders have difficulty and significant barriers with social interaction, social skills, and therefore have significant difficulties with interpersonal and intimate relationships (Galderisi et al., 2010). Serious mental illnesses such as schizophrenia are characterized by hallucinations, delusions, and other psychotic symptoms. Schizophrenia is associated with a lack of employment, increased risk for homelessness, as well as marital discord. Symptoms of schizophrenia are also linked to impairment in academic performance, daily living activities, parenting and social relationships. These symptoms may be due to cognitive impairments, stigmatization and deficits in coping and communication skills (Gregory, 2010).

Research on relationships suggests that communication and problem solving skills are extremely important in coping and maintaining successful relationships (Basco et al., 1992). Galderisi et al. (2010) stated that cognitive impairment and deficits in social skills have been largely documented and acknowledged in individuals with serious mental illness and are increasingly recognized as barriers to recovery. According to Segrin et al. (2007), deficits in social skills is a major factor in predicting risk of mental health disorders, and depression and poor social skills seemed to prevent an individual from receiving positive social reinforcement from others. The results of this study suggested a relationship between social skills acquisition and a sense of well being for individuals, as well as lower levels of perceived stress.

According to Segrin, Hanzal, Donnerstein, Taylor, & Domschke (2007), social skills were predicted to be associated with the following two indicators of psychological well-being: reduced symptoms of depression and life-satisfaction. Social skills were also found to be associated with a reduction in the experience of stress. Segrin et al. (2007) also demonstrated that people with adequate social skills seemed to have higher self-esteem, greater satisfaction with social interactions and increased perceived social support as compared to those with inadequate social skills. Results showed that individuals with strong social skills experience less stress in their daily life, likely due to well developed methods of coping with problems. It is proposed, therefore, that if proper social skills are related with reduced stress and greater overall wellbeing, then social
skills deficits are associated with psychological problems such as depression and an overall a less satisfying quality of life.

According to Tucker (2009), group therapy is effective in developing social skills as it promotes more positive outcomes from interactions with others. Interactions with peers can counter feelings of isolation and stigmatization as peer support can be an outlet for people to identify with others and find solutions to their problems without excessive guidance from the counsellor (Avinger & Jones, 2007). The peer support model and cognitive behavioural interventions offered through a group counselling program can aid in equipping individuals with severe mental illness with the tools to improve social and interpersonal relationships and overall quality of life.

Peer Support and the Influence on Mental Health

The use of peer support and consumer run centres have become an important component of post-institutional mental health care services. Consumer empowerment and peer support allows for independent decision making and self-directed action and care compared to the paternalistic and dependent nature of hospitalization (Schutt & Rogers, 2009). Peer group counselling is also becoming a more widely accepted and practised therapy for adults with mental illnesses. Peer support offers social and emotional support for those who have similar mental health conditions and share a common desire to evoke personal change in their lives (Soloman, 2004).

Group counselling interventions can enhance self esteem and promote healthy relationships. Peer support as provided within a group can help to reduce mental health problems and provide opportunities to change perceptions about self, others and the outside world (Shen & Armstrong, 2008). These tools that can be acquired through group peer support can be utilized to educate, empower, and equip individuals to improve their relationships with others as well as to enhance intimacy skills which can have a positive impact on their lives. The need for peer support groups for adults with psychosis has been shown to be an increasingly demanded practise and is important. Peer support groups are helpful as it has positive effects on relapse, psychological symptoms, social network and quality of life compared to the negative effects on one’s social life that occurs during hospitalization (Castelein, et al, 2008). Peer support is a powerful tool in recovery as it provides a venue for those with shared experience to exchange information, stories and tools as well as gain role models and social support. These programs also provide a sense of belonging and community which combats the isolation and stigma that these individuals often face while receiving mental health services (Schutt & Rogers, 2009).

Peer support is important for a variety of reasons but specifically it is powerful because “as with all aspects of human behaviour in the social environment, support of one’s peers is crucial for healthy living, successful vocation/recreation, and a full life” (Hodges, 2006). Mental health service consumers are offered a myriad of services once diagnosed but peer support is becoming increasingly established and demanded among these services as it employs autonomy, independence, and consumer input into services that is sometimes not offered in hospitals or other mental health agencies. Other benefits of peer support for the individual is feeling welcomed, contributing to a larger process outside of themselves, and building trust with others where otherwise stigma might be a factor. The
peer support model allows the clients to step out of traditional helpless “patient” roles that institutionalized clients often face into one of independence and worthiness.

Sharing views and stories with others of similar experiences allows clients to find mutual validation of injustices they may have faced and motivate them to take control of their own care and lives (Adame, & Leitner, 2008). Results of a study by Castelein (2008) reveal that peer support groups are effective in improving the social networks of individuals with psychosis as it encourages mutuality and self esteem. A study by Bouchard, Montreuil, & Gros (2010), investigated the effects of peer support on inpatients in an adult mental health setting and results revealed that participants perceived peer support to be a thoughtful process that involves observing, reflecting, taking action, and evaluating outcomes. What participants found most beneficial was “Supportive actions including helping with activities of daily living, sharing material goods, providing information and advice, sharing a social life, and offering emotional support.” This investigation concluded that peer support results in various positive outcomes for providers and recipients of peer support, such as improved mental health outcomes and an improved quality of life. The combination of peer support and the facilitation of a cognitive behavioural intervention will help to bridge the gap of information and research for these individuals and possibly improve the overall quality of their lives by equipping them with tools and information to better their own lives.

**Cognitive Behavioural Therapy (CBT) and Mental Health**

Cognitive Behavioural Therapy (CBT) is considered to be the most empirically validated psychological treatment for depression and a range of other mental disorders (Hides, Samet & Lubman, 2010). CBT is a time-limited, evidence-based psychotherapy that is as effective as medication as an intervention for anxiety disorders and other more severe mental health disorders. Cognitive behavioural therapy has also been shown to be efficacious for the treatment of social phobias and CBT is considered the psychological intervention of first choice for the disorder (Piet, Hougaard, Hecksher and Rosenberg, 2010). Compared to traditional mental health approaches, CBT offers fewer side effects and is more cost effective. CBT has improved outcomes in schizophrenia and bipolar disorder due to its client centered nature and unlike medication, CBT requires less constant administration to maintain effectiveness. Advantages of CBT over pharmacotherapy includes fewer dropouts and relapses, and higher satisfaction according to mental health consumers (Myhr & Payne, 2006).

Cognitive behavioural therapy is based on the assumption that irrational thoughts, low levels of positive activities, deficits in related skills and poor cognitive coping strategies all contribute to depression. Therefore, the goal of CBT is to modify thoughts, behaviours, skills and associated feelings in order to improve psychiatric symptoms (Pinquart, Duberstein, & Lyness, 2007). An investigation conducted by Mhyr and Payne (2010), evaluated and analyzed several studies about CBT and demonstrated that investment in CBT represented more value for money spent by the Canadian government than any other intervention for mental illness alone. As an intervention for depression or anxiety, CBT is cheaper than medication and therefore CBT can be supplemented with usual therapies for mental health treatment and adds little cost to current health care systems. Population studies surrounding depression and anxiety treatment find that
interventions including CBT cost less and increase societal benefit, compared to current care. Greater accessibility of CBT could produce significant cost savings to the Canadian government and contribute to better mental health outcomes.

In a meta-analysis by Pinquart, Duberstein and Lyness (2007), 57 controlled studies were examined to determine the effects of psychotherapy and other behavioural interventions on depressive symptoms in clinically depressed adults. The results of the study revealed that psychotherapeutic interventions such as CBT were effective in reducing depressive and psychiatric symptoms in adults. CBT also has application for persons with post-traumatic stress disorder and co-occurring severe mental illness. In a study by Meuser et al. (2008) a cognitive behavioural therapy program for post-traumatic stress disorder (PTSD) was developed to address its implications for persons with severe mental illness. CBT was compared with standard treatment in a randomized controlled trial with 108 clients with PTSD symptoms and either major mood disorder, schizophrenia, or schizoaffective disorder of whom 25% also had borderline personality disorder. Results showed that CBT clients improved significantly more than did clients in standard treatments. The effects of CBT on PTSD were strongest in clients with severe PTSD. Homework completion in CBT predicted greater reductions in psychiatric symptoms. The findings suggested that clients with severe mental illness and PTSD can benefit from CBT despite severe symptoms such as suicidal thinking, psychosis, and susceptibility to recurrent hospitalizations. In the present thesis study, CBT strategies such as psycho-education, self-monitoring, role play, Progressive Muscle Relaxation Training (PMRT) and thought records were utilized in order to improve the coping and stress management strategies in the interpersonal relationships of the participants involved in the study.

The Assertive Community Treatment team (ACT) and Its Role in Recovery

Individuals with severe mental health disorders face multiple challenges living in the community. Individuals with mental illness often lack adequate life skills which results in a multitude of challenges in all areas of life. Compounding these challenges, persons with mental health disorders have the added barrier of stigma associated with their illnesses. Stigma can result in social isolation. As a result of these complex challenges, individuals with severe mental illness living in the community are at risk of symptom aggravation, re-hospitalization, and/or incarceration. Helping individuals with severe mental illness maximizes their chances for successful reintegration into the community, but requires an intensive, versatile intervention. Assertive Community Treatment is one such intervention. (Scheyett et al., 2010).

Assertive Community Treatment or ACT is an intensive and highly integrated approach for community mental health service delivery. ACT programs serve people whose symptoms of mental illness result in severe functional difficulties that interfere with their ability to achieve personally meaningful recovery goals in several major areas of life such as employment, social skills, daily living skills, living independently, and many other skills. The ACT model works as a means to aid in the transition from hospitalization to community integration continuity of care. The ACT model focuses on reducing the utilization of expensive mental health services such as emergency rooms and hospitals and like peer support, the goal of the ACT model is consumer empowerment and recovery (Salyers, Hicks & McGuire, 2009).
According to a study by Furlong, Leddy, Ferguson, and Heart (2009) which compared to traditional approaches to care, “ACT results in lower use of inpatient services, more independent living, better control of psychiatric symptoms, better quality of life, higher rates of remitted substance abuse, higher rates of competitive employment, and greater consumer and family member satisfaction.” Stein and Test (1980) stated that the main features of ACT include small case loads, individualized care, crisis support, in vivo care, a whole team approach, regular meetings, medication monitoring and a no discharge policy. This leaves a gap in service delivery for peer support which should be an integral component of mental health recovery. According to Salyers et al. (2009) consumers found peer support helpful to recovery and beneficial in addition to the support provided by the ACT team. The addition of peer specialists to the ACT team showed the greatest improvement in consumer satisfaction and rate of recovery as compared to the traditional ACT team models. Therefore, the integration of peer support with cognitive behavioural therapy would benefit clients with severe mental illness and would result in decreased symptoms of mental illness and provide a comprehensive and successful integration in the community.

Summary
In summary, the empirical literature suggests that the effect of social interaction and healthy interpersonal relationships is vital to all individuals not only because it provides an important social identity, but that it also contributes to a positive self-conception, and is a source of social integration. It has also been demonstrated in recent studies that individuals who are diagnosed with mental health disorders often experience significant barriers with regard to social interaction, social skills, and have resulting difficulties in interpersonal and intimate relationships (Galderisi et al., 2010). Therefore, an intervention that integrates social integration and focuses on the enhancement of interpersonal relationships is beneficial for people with mental illnesses and can play an important role in recovery. According to Tucker (2009) group therapy is effective in developing social skills as it promotes positive outcomes from interactions with others. Also, interactions with peers can counter feelings of isolation and feelings of being different, as it provides an outlet for people to identify with others and find solutions to their problems without excessive guidance from the counsellor (Avinger & Jones, 2007). The peer support model and cognitive behavioural interventions offered in a group counselling program can aid in equipping individuals with severe mental illness with the tools to improve social and interpersonal relationships. With the unique clientele that the Assertive Community Treatment Team (ACT) serves, an equally innovative and distinctive intervention should be employed as people with serious mental illness encounter severe functional difficulties, which can interfere with their ability to achieve personally meaningful recovery goals. The intervention investigated in the current study integrated peer support with cognitive behavioural therapy for clients of an ACT team and added to the research surrounding peer support and interpersonal relationships for adults with mental health disorders.
Chapter III: Method

Participants
This study evaluated the effectiveness of a peer support group in building and maintaining healthy interpersonal relationships. The peer counselling group program was designed for adults with the diagnosis of at least one mental health disorder who were also receiving services from a mental health agency. The group was comprised of five adults over the age of 18, all who had been diagnosed with a severe mental illness and were clients of the ACT Team or another mental health agency in an adjoining community.

An information flyer about the group was sent out to surrounding mental health agencies in the community. Clients with current and severe psychotic symptoms and impairments were excluded from the study and those who met the common need of wanting to improve the relationships in their support network were included in the study. Along with the participants, there was one peer co facilitator and student who attended to observe. The agency supervisor also co-facilitated the group every week. The group was comprised of two women and three men between the ages of 24-45. Four of the members who attended the meetings were ACT clients and one member was from a local mental health clinic. The peer worker was a volunteer of the consumer peer support agency where the sessions were held and contributed to the sessions by sharing experiences, writing on the board during discussions, and participating in group activities but did complete any questionnaires, self monitoring or consent forms. The individual participant characteristics and needs will be discussed below as well as individual goals for the group.

Participant 1

Client characteristics/needs: Participant 1 was a female in her 20’s and was a client of the ACT team. She was diagnosed with schizophrenia and was living independently at the time of the study. She had had a history of paranoid delusions, paranoid thoughts and a slight intellectual disability but her psychotic symptoms were stable enough that inclusion in the group was appropriate. Upon review of her file at the agency, she expressed that one of the areas that she wanted to improve in her life was her interpersonal relationships as demonstrated on her OCAN (Ontario Common Assessment of Needs). She was interested in participating in the group because she wanted to learn how to initiate conversations with new people and “learn to make new friends”. Her main goal was therefore established as improving her social support network and enhancing her social skills.

Participant 2

Client characteristics/needs: Participant 2 was a middle-aged married woman who has been a client ACTT for a short time previous to joining the study. She was diagnosed with Major Depressive Disorder and displayed no psychotic features. She had been referred to ACT due to her hospitalizations for depression and insomnia and had been
treated with medication and was stable for the study. Her major issues had been surrounding sleep disturbances and conflict with family members. She was approached to participate in the study because she was expressing her concerns with her relationship with her family to staff members. The purpose of the study and the potential benefits were explained to her and she decided to join the study to learn stress coping strategies and conflict management skills. She also wanted to improve relationships with family members and work on “creating boundaries” between herself and her family. Her main goal therefore was to improve relationships and learn conflict management skills.

**Participant 3**

**Client characteristics/needs:** Participant 3 was a male in his 20’s and was living with his parents at the time of the study. He was diagnosed with schizophrenia but was not experiencing any severe symptoms of psychosis when he agreed to join the study. He was interested in participating in the study because he wanted to make new friends and learn conflict management strategies to use with his family as he was experiencing conflict in the home with his siblings. He also wanted to improve his social communication skills through role play with other group members.

**Participant 4**

**Client characteristics/needs:** Participant 4 was a male in his late 20s. He was living with his parents at the time and had participated in peer support groups in the past. Participant 4 was diagnosed with a personality disorder and some symptoms of obsessive compulsive disorder. He had been a client with ACT for several years and was active in the community and working toward recovery. He received a flyer from an ACT staff and was very interested in participating in the group as he had interest in CBT. Participant 4 identified that he was interested in improving his social skills and learning “how to have deeper conversations”. He also was interested in hearing what other people with mental health diagnoses had to say about their experiences and to learn from one another. He identified his overall goals as improving his social skills and learning conflict management skills.

**Design**

The main goal of the group was to enhance healthy interpersonal relationships and intimacy skills in adults diagnosed with mental health disorders. Coping strategies, cognitive behavioural therapy, peer support and behavioural treatments were introduced in order to improve communication and stress management skills and so that individuals could improve functioning in their personal relationships with family, friends, and significant others. The group was closed to new members joining once it had started to meet in order to enhance and boost open sharing and privacy between members. Peer support and CBT strategies were practised throughout in order to support independence and widen the social support networks of the members of the group. The group was also designed to serve as a means to improve self-esteem and provide a prevention strategy to approach key undesirable behaviours in relationships. The group met once a week for 5
sessions as one session had to be cancelled due to scheduling issues. The sessions took place at a local consumer peer support agency, which was a central location for all members. The members met in the conference room which had ample space to accommodate members, facilitators and enough space for activities. The group sessions were 90 minutes in length allowing time for psycho-education lectures, group activities, and group discussions but some sessions were extended if group discussions or activities ran longer than the assigned time. The sessions generally involved an overview of a topic related to healthy relationships or coping strategies followed by sharing of thoughts, an activity, group discussion and wrap up. Materials required for the session include handouts, materials for activities, and a workspace in a consistent location central for all participants to attend on a weekly basis. The emphasis of the intervention included a strong focus on group discussions and the sharing of experiences. The study was also approved by the St. Lawrence College Research Ethics Board.

**Procedure**

Prior to the commencement of the group and periodically throughout the sessions, members from both agencies were consulted for input about the sessions. The volunteer and recovery coordinator from one of the organizations who was asked about a new and relevant subject for a peer support group, suggested an intimacy and relationship group as previous group facilitators and clients have mentioned a need for it and it was thought to be a pertinent addition the existing groups that they currently offered to the community. During the design of the sessions, the agency supervisor as well as the peer specialist on the ACT team suggested that the handouts and lectures remain light on text and focus on peer support in order to accommodate members that may have issues with comprehension or communication. This input was incorporated into the format and execution of the sessions. The idea of a healthy relationships group seemed to be well received by the group participants. The content and theme of the program appeared relevant to the clients as improving relationships are important not only to recovery but a better quality of life.

The umbrella topic of the group was healthy relationships but every session had a theme and separate topics each time. A pre- and post- test questionnaire was given to participants to screen for need, participation, common goals, and to omit those who appeared to have severe symptoms of psychosis, or those that did not meet the common goal of trying to improve or establish healthy interpersonal relationships. Content for the sessions was taken from academic journals, online resources, and books about the peer support model and group facilitation. The areas of concentration for the group were healthy relationships, stress management, communication, conflict management and peer support. Interventions selected for the group were self-monitoring, peer support, progressive muscle relaxation, role-play, and identifying and challenging cognitive distortions about interpersonal relationships.

There were five sessions presented to the participants as well as a pre-screening interview that was conducted with each individual before the group commenced. The first group session began with a small introduction by the co-leaders and group members. The members were asked to share personal experiences of what brought them to group and what they hoped to gain from the experience. The members were told what to expect from treatment and a psycho-educational presentation on healthy relationships, and
intimacy followed. An overview of the delivery schedule and activities for the group sessions was included this first session. There was also a discussion of why participants chose to come to the group and what they could do to improve their relationships.

This first session concluded with an overview of self-monitoring and the importance and benefits of this approach. The goal was to have the clients complete a self-monitoring sheet outside of sessions, throughout the week. The members were advised to identify some individual and group weekly objectives and overall group goals.

The second session began with a check-in that required members to reflect on the previous session and follow up on self-monitoring. The theme of this session was communication and included a psycho-educational lecture with a focus on communication management styles, barriers to communication and strategies for improving communication. An overview of active listening and nonverbal communication tactics was included in order to accommodate members who lack adequate communication skills. There was also a discussion of healthy relationships and common challenges, and a friendship and communication role play that included practising active listening and positive communication in pairs. The session concluded with a wrap-up discussion of skills taught and utilizing communication skills outside of the group, as well as an overview of the upcoming session.

The third session began with a review of self-monitoring and asking group members to share their past week’s experiences and to report on their overall individual goals. The theme of the third session was conflict management and included group cohesion and self-esteem building activity to build trust and unity between members. There was also a group discussion about conflict and identifying and challenging cognitive distortions about self and others during conflict. The group discussion included strategies for conflict resolution and coping strategies for conflict in relationships. There was also a video shown about conflict resolution followed by group brainstorming and a conflict resolution role play. The session concluded with an overview of the next session and a reflection on the session.

The fourth session commenced with a check in of the preceding week’s session and a sharing of the past week’s experiences. This session covered material related to stress management. A group discussion was conducted that asked members to reflect on how stress affected their daily life while they were encouraged to identify their cognitions and emotions when they are experiencing stress. A discussion of what strategies peers use to cope with stress was also included. The discussion was followed by a psycho-educational lecture on stress and the different types of stress. A progressive muscle relaxation exercise was also practised as a group and then peers were asked to reflect on how they felt. The session concluded with a review of grounding techniques and deep breathing strategies as well as peer problem solving for members who were experiencing stress and sleeping difficulties.

The fifth and final session was about co-dependence and began with brainstorming the differences between enmeshment and disengagement. There was also a lecture and
discussion about expanding and improving social support networks, encouraging independence and communication with partners. Medication side effects and coping strategies were also discussed and an overview of some alternative treatments was provided. A group discussion was also included that covered topics such as relapse prevention, family supports, crisis and emergency planning, closure, and final wrap-up of the entire program. The post-group questionnaires and evaluations were then distributed to the members as was followed by an informal feedback session and review of the program and as well as plans for the future.

Every session of the program had a corresponding participant handout so the participant could follow along with the co-facilitator’s presentation. The participant handout contained the slide handouts and instructions for group activities as well as questions to lead the group discussion. There were also blank self-monitoring sheets distributed each week to be used to record weekly objectives according to the individual goals of the participants. This will be discussed further in the measures section.

Confidentiality/Informed Consent

Participants were required to sign a consent form from St. Lawrence College (Appendix A) and to sign a confidentiality form from the agency where the sessions were held (Appendix B). At the intake meeting before the group commenced the consent form was distributed and explained fully by the co-facilitator and signed by the participant if they decided to take part in the study. At that point it was explained to the participants that participation was voluntary and sessions would remain confidential. There was also verbal and written confirmation that withdrawal from the program was permitted at any time. The understanding of their informed consent and confidentiality measures were confirmed after verbal clarification and questions or concerns were addressed prior to obtaining a signature. Participants were assured that they could continue to attend the group even if they withdrew from the study, and if they chose to withdraw and did not consent to having their data retained for the study, it would be destroyed in a confidential manner. All documents such as consent forms and questionnaires were kept in a locked filing cabinet in a private secured location at the agency and only co-facilitators had access to them. Information on computer was password protected and will be stored for 7 years following the study. Participants were not identified by name in any reports resulting from this project and clients also used a participant code on the questionnaires to ensure confidentiality.

Measures

There were two questionnaires used during this study. The “Healthy Relationships Questionnaire” was an original questionnaire that was developed by the researcher. This questionnaire was a 19-item scale that included questions relating to relationship and conflict management, stress and coping strategies as well as providing a means of rating the overall satisfaction of their current relationships. The questionnaire scoring included a Likert scale that ranged from “1” being “strongly agree” to “5” being “strongly disagree”. The questionnaire included positive statements and reversed statements to ensure validity.
and has a total possible score of 38. There were three subscales in the questionnaire. Questions 1, 2, 3, 4, 8, 10, 11 and 12 represented stress management and conflict resolution subscale. Questions 5, 6, 7, 8, 9, 13, 14, 15, 16, and 18 represented the social support subscale and questions 17 and 19 represented reconnecting with a loved one subscale.

This questionnaire was administered before the group began, and then again after the group finished, to measure effectiveness of the group and assess whether the clients perceived an improvement in their relationships and coping skills. Refer to Appendix C for the full questionnaire with instructions and scoring key. The “Healthy Relationships Questionnaire” was administered to all participants as it applied to those who were single or in a relationship. However, the “Intimacy Questionnaire” was only given to those who were in intimate relationships at the time the group began.

The “Intimacy Questionnaire” is a 12-item scale includes statements related to intimacy, anxiety as well as feelings and cognitions about partners and relationships (Appendix D). The ratings options ranged from “0” (“definitely not me”) to “4” (“definitely me”) with three overall areas assessed. A score higher than “10” on any of the three areas mentioned on the scale indicated a deficit in intimacy skills.

There was also a final evaluation that was distributed to the members during the last session. In the final evaluation, clients were asked to rate their satisfaction across different areas on a five point Likert scale ranging from 1 (strongly agree) to 5 (strongly disagree). The members were also asked to respond to what they liked most about the group and what they would improve for the future facilitation of the group (Appendix E). The final evaluation data was collected by way of pre- and post-test questionnaires scores and corresponding subscale scores. The scores of the pre-screen questionnaires were presented in graphs to measure effectiveness of the group.

In addition to the questionnaire, there was also to be an ongoing assessment element in the form of self-monitoring designed to obtain individual results. For each individual member, an overall goal as well as weekly objectives was established according to personal need and circumstance. For members who were lacking social skills and were experiencing isolation, objectives were usually aligned with those objectives. For those who wanted to improve relationships and conflict resolution skills, goals and objectives were customized to improve those skills. Group members were provided with a self-monitoring sheet (Appendix F) and a weekly goal was collaboratively set up so that the objectives were not too challenging or overwhelming to achieve in the time allotted. Unfortunately, due to reasons that will be examined during the discussion section, the self-monitoring was not successful for most group members.

Chapter IV: Results

The main hypothesis of the program was that participation in the relationship group would strengthen social support, conflict resolution and stress management skills due to a focus on peer support. The pre-to post-questionnaire subscales of the “Healthy
Relationships Questionnaire” (stress management, social support and reconnecting with a loved one) were analyzed in order to evaluate the effectiveness of the group intervention. Intimacy Questionnaires were given to only those clients involved in intimate relationships in order to measure impact the group may have had on their partner relationship. Therefore, the pre- and post-“Healthy Relationship Questionnaire” scores were the main means for evaluating the results of the program. Raw data is presented in Appendix G and a graph representing pre- and post- questionnaire scores can be found in Appendix H.

**Individual Participant Questionnaire Results**

Participant 1 was administered the “Healthy Relationships Questionnaire” during the pre group assessment interview. She was not given the “Intimacy Questionnaire” as she was not in an intimate relationship at the time that the study began. She scored 29 out of 38 on the scale during baseline. She scored a 12 on the stress management subscale, a 17 on the social support subscale and 0 on a reconnecting with a loved one subscale. Participant 1’s score on the final “Healthy Relationship Questionnaire” was 35 out of 38 which was an increase of 6 points overall. According to the subscales, during intervention, participant 1 scored 16 on the stress management subscale, 17 on the social support subscale and 2 on the reconnecting with a loved one subscale.

Participant 2 completed both the “Healthy Relationships Questionnaire” and the “Intimacy Questionnaire” because she was in an intimate relationship at the time of the study. She took both measures during the pre-group assessment interview. She scored 11 on the “Healthy Relationships Questionnaire” and 20 on the “Intimacy Questionnaire” during baseline. According to the subscales of the “Healthy Relationships Questionnaire” she scored 4 on the stress management subscale, a 5 on the social support subscale and 2 on the reconnecting with a loved one subscale. Her treatment score on the “Healthy Relationships Questionnaire” was 8 which was a decrease of 3 points overall. Her final score on the “Intimacy Questionnaire” was 15 which suggested an improvement in intimacy skills. According to the subscales from the “Healthy Relationships Questionnaire”, participant 2’s scores were 4 on the stress management subscale, 2 on the social support subscale and 2 on the reconnecting with a loved one subscale on the post intervention “Intimacy Questionnaire”.

Participant 3 completed the “Healthy Relationships Questionnaire” only as he was not in an intimate relationship at the time of the study. He completed it during the pre-group assessment interview where he also established his goals for the group. Participant 3’s baseline score on the “Healthy Relationship Questionnaire” was 18. The stress management subscale was 8; the social support subscale was 10, and his reconnecting with loved one’s subscale was 0. During the final session, the questionnaire was administered again and participant scored 17 which was a decrease of 1 point. The subscales for the post treatment scores then went to 6 for stress management, 9 for social support and 2 for reconnecting with a loved one.
Participant 4 only completed the “Healthy Relationships Questionnaire” as he was not in an intimate relationship at the time of the study. He completed it during the pre-group assessment interview. Participant 4’s baseline score on the “Healthy Relationship Questionnaire” was 5. The stress management subscale was 0; the social support subscale was 3, and his reconnecting with loved one’s subscale was 2. During the final session, the questionnaire was administered again and participant scored 8 which was an increase in 3 points. The subscales for the post-treatment scores then went to 1 for stress management, 3 for social support and 4 for reconnecting with a loved one.

Participant 5 decided not to attend the group before the last session and therefore her data was omitted from the study.

**Results from the Participant Evaluation Survey**

During the final session, clients were asked to rate their satisfaction of the group on a five-point Likert scale ranging from 1 (strongly agree) to 5 (strongly disagree). The clients generally responded very positively and emphasized that they found peer support useful and utilized the skills they acquired in their everyday lives. Both members responded to the statements “I would attend this group again” and “I would recommend this group to others” with “strongly agree” and gave comments that they liked the group and the material was easy to comprehend. When asked to reflect on what they enjoyed about the program, participants responded that they enjoyed “coming together to share and work through issues and problems” and “meeting different people in the group to practice social skills.” When asked that they would like to improve in the program, participants responded by stating that they would enjoy more role playing with other group members to increase their chances of establishing relationships within the group. Overall, there were positive statements from the members and agency staff from both organizations as well as agency staff in the community. All participants expressed that they would attend this group again and recommend it to others.

**Chapter V: Discussion**

**Discussion of Individual Participant Results**

The discussion of the results of the individuals will be organized by participant and include overall goals for the client and ongoing assessments as well as an exploration of their participation in the group.

**Participant 1**

Participant 1 attended all five sessions and actively participated in group discussion and peer support of the other members. Due to a lack of understanding and cognitive impairments that are attributed to her intellectual disability, she was not able to complete all of the self-monitoring and had continuing difficulty in recording her weekly goals and rating scales. Of the sheets that she did complete and shared with facilitators, goals such as initiating conversation with a new person and practising conversations with another group member was achieved.
**Ongoing assessments:** Prior to the commencement of the group and during the first session, self monitoring was explained to participant 1 as well as explaining the importance of recording goals. Her overall goal was to learn how to make new friends and her weekly goals consisted of goals such as practicing conversations and active listening skills during sessions, initiating conversations with new people and using active listening to have meaningful conversations with friends and family based on skills learned during sessions.

**Participant 2**

Participant 2 attended three out of the five sessions. Her main goal for the group was to improve relationships and learn conflict management skills.

**Ongoing Assessments:** Participant 2 was not comfortable with sharing her goals or self-monitoring progress with the facilitators and the other group members and therefore, her self-monitoring data was not included in the study. She did mention that her goals were to improve her relationship with her husband, better her sleep and relaxation strategies and enhance her conflict resolution skills but she did not wish to share the results with the researcher or ACT staff.

**Participant 3**

Participant 3 participated in the study because he wanted to make new friends and learn conflict management strategies. He also wanted to improve his social communication skills. Participant 3 was not very active in group discussions but did attend 4 out of the 5 sessions before refusing to attend at the last session due an increase of psychotic symptoms and a subsequent hospitalization.

**Ongoing assessments:** Participant 3 did not participate in the self-monitoring procedures. When probed as to his reasons, he responded that did not have any goals that he wanted to record and was content with just listening during the sessions instead of participating in self-monitoring.

**Participant 4**

Participant 4 attended all 5 sessions and actively participated in group discussions and peer support activities.

**Ongoing assessments:** Participant 4 was not able to record or complete any self-monitoring in between session possibly due to a lack of understanding. He expressed that he felt he was reaching all his goals within the sessions and did not feel the need to record outside of group sessions.
Thesis Summary

The current project aimed to enhance healthy interpersonal relationships and intimacy skills in adults who are diagnosed with mental health disorders. These interpersonal and intimacy skills were chosen as the target behaviours based on consultation with various community staff members and an extensive literature review. Community service members suggested this type of group as clients expressed difficulties with maintaining meaningful relationships and coping with miscommunication and conflict. Coping strategies, cognitive behavioural therapy, peer support and behavioural treatments were introduced in order to improve communication and stress management skills and so that individuals could improve functioning in their personal relationships with family, friends, and significant others. Peer support was included throughout in order to support independence and widen the social support networks of the members of the group. Self-esteem was also to be a goal for the group but not directly measured. As outlined in the literature review, researchers have indicated that there is a need for psychoeducation in the area of intimacy and interpersonal relationship skills for adults with mental health (McCann, 2003). This study also encouraged that there should be a conscious effort towards encouraging communication about intimacy, providing education, and encouraging exploration of individuals’ feelings and thoughts surrounding healthy relationships on the part of mental health care providers. The gaps identified within current mental health services were the psychoeducation, peer support, and coping strategies for adults with these severe mental health disorders and were approached in the present study. The information flyer as well as a sample of the first session handout is represented in Appendix I and J respectively.

In the group intervention investigated here, a combination of peer support and the introduction of specific cognitive behavioural interventions was implemented to help equip the participants with tools to better their relationships with others and thereby improve their quality of life. This workshop format that employs CBT strategies and the peer support model bridges the empirical gap that past interventions have presented. The workshop’s material and design was determined using input and resources from several sources. There was a compilation of items from online resources, past manuals, information from the Canadian Mental Health Association peer support groups and online peer reviewed journal articles of past Cognitive Behavioural Therapy group counselling interventions. The present study was reviewed and approved for research by the St. Lawrence College Research Ethics Board prior to implementation and was given no revisions or elaborations for intervention.

Due to the fact that this was a pilot program, several revisions from the original implementation plans were included as well as adaptations for the individual needs of the participants. The participant handouts were followed as closely as possible but within sessions there were some variations and differed somewhat from initial applications and proposals prior to intervention. Changes also occurred according to the input from agency staff and the participants themselves.
**Strengths**

A major strength of the current study was that the material presented was based on strong empirical information and this was integrated into the sessions. There was an extensive review of several journal articles, online resources from both mental health associations and peer support sites, as well as books on various approaches to design interventions for this target population.

Although there were empirically supported practices integrated into the design of the workshop, due to the pilot nature of the program there was a lot of flexibility to allow for individual needs of the participants. For example, initially the program schedule was to include a significant amount of time per session on psychoeducational lectures and more written activities but as time went on and requests for more group discussion and role play was expressed, the material was altered to serve those needs. The participants expressed that they appreciated having their input taken into consideration and actually implemented into the sessions as opposed to lectures and topics that they did not find as useful.

Another strength of this thesis is that because it was a pilot there was a lot of potential for improvement through revision and further implementation of the group in different settings. The agency where the sessions were held opted to keep the group and planned to run it in the future due to the positive response of the various agencies involved and the participant feedback. The group members most enjoyed the peer support element of being able to share experiences and take comfort in knowing that other people felt similarly about various topics.

A further strength of the study that has been mentioned in previous sections, is that the peer support model and group facilitation of this nature is vital to community integration from hospitalization and transition housing to independent living arrangements in the community. The skills that are acquired through the group equips the individual with tools which can be used to interact and build meaningful relationships which aids in coping skills and overall recovery. The link between positive and healthy interpersonal relationships is vital to mental health recovery and needs to be implemented into treatments for this population group. This thesis is unique because it aids in the transition to community integration and the intervention provides social support, empowerment, and independence to consumers of mental health services and employs self-directed care that otherwise would not be offered in an institutionalized settings such as hospitals and in-patient facilities.

Also due to the voluntary participation and high participant input in program design, the participant felt highly valued and it was strongly tailored to their needs, which was shown to be effective. Also, for many of the participants it was the first time they had attended a group of its kind and chose to continue to attend groups and volunteer in peer support groups which shows a level of generalization and will help combat the stigma and isolation that they often face.
Overall, feedback from the participants revealed that the group was highly effective and had impacted them in a positive manner. The clients responded very positively and emphasized that they found peer support useful and learned and utilized the skills they acquired in their everyday lives. Three out of the five members responded to the statements “I would attend this group again” and “I would recommend this group to others” with “strongly agree” and gave comments that they liked the group and the material was easy to comprehend. When asked to reflect on what they enjoyed about the program, participants responded that they enjoyed “coming together to share and work through issues and problems” and “meeting different people in the group to practice social skills.” When asked that they would like to improve in the program, participants responded by stating that they would enjoy more role playing with other group members to increase their chances of establishing relationships and practising conversational skills. Therefore, a great strength of the program is that participants and staff rated the intervention so favourably and as a result it could be concluded that more intervention programs of this nature are warranted.

Limitations

Due to the fact that the “Healthy Relationship Program” was a brief pilot that was developed to meet the specific needs of this unique population, the main limitation of the study is further development is required for future success. Another limitation of the program was that due to limited time constraints and a late approval by the ethics board, there were only five sessions scheduled for the group and therefore, material needed to be condensed and shortened to accommodate all that needed to be covered. Also, due to limited time, participants were only beginning to open up to one another by the end of the program, and did not have time to become completely comfortable before the program ended and therefore in the future, having more sessions over an extended period of time could allow for participants to have more time to build group cohesion and to begin to feel comfortable in opening up with one another as well as sharing experiences and challenges.

A further limitation of the study was due to low motivation of the clients who are diagnosed with severe mental health disorders, self-monitoring and other activities were often not completed. Many of the clients found themselves unable to complete the self-monitoring sheets due to cognitive difficulties, low motivation, memory problems and lack of understanding of how to complete the chart. Due to these issues, self-monitoring on individual goals was not required for all clients after the first session. Instead, clients took turns within the session to discuss their overall goals and how they could reach these through weekly objectives. In the future, simplifying the self-monitoring and having clients complete the sheets in session may be valuable so that the group members can benefit from self-monitoring techniques.

Another limitation of the study is that the “Healthy Relationship Questionnaire” was developed by the researcher to fit the needs of the clients, and thus was not a sophisticated measure and therefore, has not been empirically tested. Furthermore, the Intimacy questionnaire was omitted from the study as there was only one participant in an
intimate relationship so only the one questionnaire was included. This may have impacted the reliability and validity of the study as there was only one questionnaire included that was developed by the researcher.

The final limitation of the study was that it was difficult to encourage participation from the agencies and community service members. A flyer went out to most major mental health agencies in the area in order to enlist participants for the group. There was hesitation and reservations on the part of agency staff about their clients participating in a pilot program. There were some staff members that were concerned about the clients’ data being misused in an unethical manner and therefore a lot of clarification was required. Also due to time constraints, it was not possible to coordinate transportation in order to optimize participation of other ACT clients in the study. If the group was to be facilitated in the future, these limitations should be addressed in order to ensure the effectiveness of the program and these things will be discussed more extensively in the recommendations for further research section.

**Multilevel Challenges to Service Implementation**

**Client Level:** The goals of a group counselling intervention and more specifically a peer support group with a focus on healthy relationships is to enhance social skills, provide the individual with coping skills and offer the individual support on a reciprocal basis. However, with this population, many challenges may arise with agency implementation. For example, as mentioned earlier, problems with low motivation and lack of enthusiasm may pose as barriers to clients receiving service. Due to symptoms of their disorder, medication side effects or general stressors associated with mental illness, low motivation is common within this population and as a result, clients may find it challenging to actively participate in the group process and to complete homework assignments such as journaling and self-monitoring. This may also result in low attendance and high dropout rates from group sessions. As a result, in order to approach this challenge, the facilitator must employ a plan to allow the individual to move at their own pace as well as permit this individual to complete tasks in session as well as remaining patient and sympathetic towards their needs. Emphasizing the benefits and importance of attendance and completing group activities is also essential for the group and individual’s success and therefore this should remain present in the mind and practises of the facilitator at all times. It is important to identify these barriers before implementation and develop strategies to overcome them in order to ensure success of the individual. Therefore, throughout the intervention, in the current study, constant adaptation and modification were adopted to fit the unique needs of the participants.

**Program Level:** Although challenges at the client level are common when conducting group counselling interventions, barriers at the program level may also occur when it comes to implementation. For example, in order for this type of group intervention to be successful, there needs to be active participation and cooperation from agency staff to promote the group to the clients and encourage participation and potential benefits that may be obtained from attending the group. Time constraints as well as varying schedules pose as an issue to coordinate with agency staff in order to reach the maximum amount of
clients possible within the agency. In addition to this barrier, challenges may also exist to enlist participation from clients because they may have issues with transportation, talking with new people or even issues with attending sessions with each other due to the sensitive nature of conversation that may arise. In order to approach these barriers, the facilitator must allow enough time beforehand to coordinate schedules as well transportation and program issues in order to overcome these challenges as smoothly as possible.

**Organizational Level:** On the organization level, challenges may exist with agency and other community service members when it comes to coordinating this intervention as challenges may arise with pooling resources and offering time for facilitation, transportation, advertising, etc. Gathering the essential resources such as the space for group sessions as well as refreshments, materials for the group and most importantly staff participation is difficult to obtain especially when coordinating with more than one agency where schedules and resources are unknown. There also poses challenges to implementation when community service staff members are hesitant about their clients participating in a pilot program and are concerned about their data being misused in an unethical manner. As a result, the facilitator must properly allow for ample time for advertising, coordinating and foreseeing logistical issues, as well as encouraging staff to talk to clients about participating in the group by giving adequate information and emphasizing the overall benefits for the clients.

**Societal Level:** Working with this population and implementing a group counselling intervention may have some implications and barriers on a societal level. There is definitely stigma attached to mental illness and as a result, clients may be discouraged from participating in a peer support group and in some cases may refuse to cooperate and interact with one another. Even after completing treatment and acquiring these skills, they may still face stigma in society due to their behaviours and cognitive differences. Also, due to the short time frame of the intervention, skills may not be generalized outside of sessions and clients may find it difficult to utilize and practice these skills in their lives following treatment. Clients may also not be able to use the skills in their own relationships and in society and therefore may feel discouraged to attend groups of its kind in the future. In order to overcome these barriers, reiterating that there is support and others facing similar challenges as well as follow up sessions to promote generalization of skills should be integrated in order to facilitate the transition from treatment into everyday life. Another challenge that occurs at the societal level is funding from government disability support programs such as Ontario Disability Support Programs and Canadian Pension Plans where a great many number of issues arose over funding transportation to and from the location where the sessions were held. Improved recognition and development of these policies would need to be investigated so that these individuals can even access these valuable resources to supplement their recovery plan outside of just medication management and psychiatric care.
Contributions to the Behavioural Psychology Field

The behavioural psychology field and more specifically cognitive behavioural therapy approaches aim to solve problems concerning dysfunctional thoughts and resulting emotions, and behaviours using a goal-oriented, systematic procedure in the present. When working with individuals with mental health disorders, it is important to provide the individual with opportunities for social interaction and support for community integration after hospitalization. The current group was able to integrate the empirically proven benefits of CBT with the peer support element to fill the gaps in research and providing a study that has had a unique approach to mental health care.

In the past research on adults with severe mental health disorders such as schizophrenia and bipolar disorder, have focused on psychotic symptoms and medication management. There has not been an emphasis thus far on the interpersonal relationships of these individuals and the importance of social skills training and peer support. This study also contributes to the field of behavioural psychology as there is not much research on the effect of peer support on interpersonal and romantic relationships in individuals with mental illness. The five core areas covered in the intervention (communication, conflict resolution, stress management, coping strategies and social skills training) allowed the individuals to focus on the skills that they found of personal importance and to use them effectively to improve their interpersonal relationships. This study adds to this growing body of literature, by successfully combining and adapting several group treatment approaches for use with adults with chronic mental health diagnoses.

Recommendations for Further Development

It is recommended that future groups in this agency should include more individuals and therefore, increased opportunities for social interaction, and that groups should have an increased number of sessions and meet over a longer period of time. In addition, more sophisticated measures of group effectiveness should be developed and with continued development of group materials other similar peer support groups could be established to further improve community integration of those with chronic mental illness. As discussed earlier there were issues with coordinating and facilitating this pilot across different agencies in the community, which should be addressed in future development of groups. Also part of the multilevel challenges to service implementation, apparent at all levels in the intervention, was how constant adaptation and modification was necessary to fit the unique needs of the participants and to overcome these stigma and barriers. For example, the facilitator should allow enough time before the group begins to coordinate client schedules, arrange transportation for clients, and to address program implementation issues.
References


Appendices
Appendix A: St. Lawrence College Consent Form
Consent Form

**TITLE:**  
*The Healthy Relationships Program: A Peer Group Counselling Program to Enhance Healthy Interpersonal Relationships and Intimacy Skills in a Group of Adults with Mental Health Issues.*

**STUDENT:**  
ANEESHA SIDHU

**COLLEGE SUPERVISOR:**  
DEBORAH SMITH, PhD.

(613) 544-5400 EXT.1442

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**Invitation**

I am a student in my 4th year in the Behavioural Psychology at St. Lawrence College and I am currently on placement at Summit Housing and Outreach programs on the Assertive Community Treatment Team (ACTT). As a part of this placement, I am completing a special project called an applied thesis and I am asking for your assistance to complete this project. The information in this form is intended to help you understand my project so that you can decide whether or not you want to participate. Please read the information below carefully and ask all the questions you might have before deciding whether or not to participate.

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**WHAT IS THE PURPOSE OF THE STUDY?**

My program is on the healthy relationships group that will take place at Summit Housing and Outreach Programs in collaboration with T.E.A.C.H. Support and Housing Halton. I will be co-facilitating a group about establishing and maintaining healthy interpersonal relationships for adults with mental health issues. The main purpose and goal of the group is to improve and build healthy interpersonal relationships as well as provide useful coping strategies within the field of cognitive behavioural therapy. I have created a questionnaire to see if the group is useful to you and helps you to cope better in your personal relationships. We believe this group is useful for yourself and for those in your support system and we want to know what is most helpful for you so this group can be successful now and in the future. Your thoughts and opinions are extremely valuable so I greatly appreciate your help in completing all the written questionnaires and self monitoring sheets that will be assigned once the group has started and goals are established.
WHAT WILL YOU NEED TO DO IF YOU TAKE PART?

If you agree to participate in this group, we will meet once a week for 90 minutes in the conference room at the T.E.A.C.H. office which is located in Milton. If there are any changes in location, you will be notified in the previous session and arrangements may be made if you need assistance to get there. In addition to the regular assigned group sessions, there will be a 30 minute individual intake meeting that will take place before the group begins. The initial meeting will involve participants filling out questionnaires, discussing goals, going over consent forms and describing the activities that will take place in the sessions while also allowing time for you to ask questions or clarify any concerns. Activities such as psycho-education lectures, ice breakers, group building activities, peer support, behavioural treatments, and group discussions will take place during the sessions and a handout and tentative schedule will be given out at the beginning of every meeting. Self monitoring sheets will be assigned outside of the sessions to be completed independently, such as goals, objectives, and behaviours to improve personal relationships. These will be established and developed according to personal goals and can be modified as the group progresses and goals change. Activities, lectures, therapies, and group discussions will be scheduled in advance but feel free to bring up any areas of interest or concerns you may have or would like assistance with as we are here to help you. Once the group has ended, you will be asked to fill out the same initial questionnaire and evaluation form to see if this group has affected you or helped you to improve or enhance your relationships. The questionnaires take about 10 minutes to complete and the self monitoring sheets take about 5 to 10 minutes to fill out depending on the situation and if it is ongoing. Please keep in mind that you are not obligated to participate or fill out any questionnaires or forms as it is on a completely voluntary basis. If you choose to do so, however, it will be greatly appreciated and feedback on any area of the group is welcomed so it can be improved upon in the future.

WHAT ARE THE POTENTIAL BENEFITS TO ME OF TAKING PART?

The potential benefits of participating in this group will be learning tools and strategies to building and maintaining healthy relationships between peers, family, friends, and others in your life as well as coping mechanisms to reduce stress and aid in recovery. The results are not guaranteed but the skills learned will be a building block in understanding and improving communication as well as problem solving skills within your many relationships. You may learn more about yourself, it may improve the quality of relationships you have in your support system and knowing that you are helping to measure the success of this pilot program. You are a valuable part of this process and your intake and feedback can be used to improve the program in the future.

WHAT ARE THE POSSIBLE DISADVANTAGES AND RISKS OF TAKING PART?
The risks of participating in this group are minimal and mostly emotional in nature. Some topics and subject matter that will be brought up may cause sadness or may make you feel uncomfortable due to the sensitive nature of the discussions or questions, but the tools to overcome any emotional hardship will also be provided as there is support from myself, or any other co facilitator.

**WHAT HAPPENS IF SOMETHING GOES WRONG?**

Every precaution will be taken to ensure your physical and emotional safety and well being but in the unlikely case that something were to go wrong, you may talk to me, your counsellor, another co facilitator, your own counsellor or someone else you trust. You may also contact my college supervisor, Deborah Smith, at (613) 544-6600 ext. 1442 or DSmith@sl.on.ca at any time if there are questions or concerns that I cannot resolve and please keep in mind that you can withdraw at any time if there irreconcilable issues that arise.

**WILL MY TAKING PART IN THIS PROJECT BE KEPT PRIVATE?**

All efforts to ensure confidentiality will be taken unless required by law. All documents will be kept in a locked filing cabinet and in a private secured location that only I will have access to. Information on computer will be password protected and be stored for 7 years following the study. You will not be identified by name in any reports, publications, or presentations resulting from this project. The only circumstance that would require confidentiality to be broken is if during the course of the sessions, information about the intention to harm one’s-self or others is revealed. In this case, authorities and appropriate persons will have to be notified.

**DO YOU HAVE TO TAKE PART?**

As mentioned earlier, participation in this project is completely voluntary and you are free to withdraw at any time without it effecting your participation in the group. If you do decide to take part, you will be asked to sign this consent form. If during the course of the group, you decide to withdraw and do not give consent to retain any data collected, your data will not be used in the project and destroyed in a confidential manner. Also, if you do decide to participate you are asked to attend meetings as regularly as possible as you are a valuable member of the group and topics build on each other. It is also important to attend as many of the session as possible as we have limited time together and the self monitoring data that you volunteer to complete is important in measuring the success of the program.
CONTACT FOR FURTHER INFORMATION.

This project has been approved by the Research Ethics Board at St. Lawrence College. The project will be developed under the supervision of Deborah Smith Ph.D., my supervisor from St. Lawrence College. I really appreciate your cooperation. If you have any additional questions or concerns, feel free to ask me, Aneesha Sidhu at asidhu09@student.sl.on.ca, or you can contact my College Supervisor, Deborah Smith Ph.D. at (613) 544-6600 ext.1442 or DSmith@Sl.on.ca. You may also contact the Research Ethics Board at appliedresearch@sl.on.ca.

CONSENT

If you agree to participate in the project, please complete the following form and return it to me as soon as possible. A copy of this signed document will be given to you for your own records. An additional copy of your consent will be retained at the agency and in a secure location with the Behavioural Psychology program at St. Lawrence College.

CONSENT

By signing this form, I agree that:

- The study has been explained to me.
- All my questions were answered.
- Possible harm and discomforts and possible benefits (if any) of this study have been explained to me.
- I understand that I have the right not to participate and the right to stop at any time.
- I am free now, and in the future, to ask any questions about the study.
- I have been told that my personal information will be kept confidential.
- I understand that no information that would identify me will be released or printed without asking me first.
- I understand that I will receive a signed copy of this consent form.

I hereby consent to participate.

Participant Printed Name: ____________________________

Signature: _______________________________ Date: _________

SLC Student Signature: ___________________________ Date: _________

Printed Name: ____________________________
Appendix B: T.E.A.C.H. Confidentiality Form
T.E.A.C.H.
Teach, Empower, Advocate for Community Health

Confidentiality Form

I, ________________________________, understand that any information gained from my participating in T.E.A.C.H. activities, regarding another person is to be confidential.

(Confidential Information Examples: revealing to another person or in public, another participant's names, comments, behaviours, place of employment, etc.)

I understand that breaching confidentiality may result in my being discharged from the workshop/group.

I understand that information that I share during a T.E.A.C.H. activity that suggests I may be considering harming myself or another person cannot be held in confidence and will be shared with appropriate third-parties (Example: physician, police, hospital).

Signed on __________________________

Month    Day    Year
Appendix C: Healthy Relationships Questionnaire
**Title of Project:** The Healthy Relationships Program: A Peer Group Counselling Program to Enhance Healthy Interpersonal Relationships and Intimacy Skills in a Group of Adults with Mental Health Issues.

**Name of student researcher:**

**Student email and phone number:**

**Name of course and professor:** Applied Thesis I, Marie-Line Jobin, Professor and Coordinator (yrs. 2-4) in the Behavioural Psychology Program

**Name of faculty supervisor:** Deborah Smith, Ph.D. (613) 544-5400, ext. 1442

**Purpose of project:** The group focus is about establishing and maintaining healthy interpersonal relationships for adults with mental health diagnoses. The main purpose and goal of the group is to improve and build healthy interpersonal relationships as well as to provide useful coping strategies with a cognitive behavioural therapy emphasis. The purpose of the study is to assess the effect of peer group counseling on skills and perspectives of interpersonal relationships in a group of adults with mental health issues.

**Description of procedures:** The umbrella topic of the group will be healthy relationships and coping strategies but every session will have a separate theme and have different activities. The sessions will consist of follow-up discussions from the previous session, psychoeducation lectures with handouts for the participants to follow along, a discussion of the session topic and a chance to answer questions. A group activity and sharing will follow and the group will finish with an overview of goals for the following session. Self-monitoring sheets will be distributed at the end of each session for the upcoming week and are to be completed and brought back for the next meeting.

**Benefits of participation:** The potential benefits of participating in this group will be learning tools and strategies to building and maintaining healthy relationships with peers, family, friends, and partners. It will be a building block in understanding and improving communication as well as problem solving skills.

**Confidentiality:** All efforts to ensure confidentiality will be taken unless required by law. All documents will be kept in a locked filing cabinet and in a private secured location to which only I will have access. Information on computer will be password protected and be stored for 7 years following the study. Participants will not be identified by name in any reports, publications, or presentations resulting from this project. Participation in this project is completely voluntary and members are free to withdraw at any time without it effecting participation in the group. If clients decide to take part, you will be asked to complete this questionnaire. If during the course of the group, you decide to withdraw and do not give consent to retain any data collected, your data will not be used in the project and will be destroyed in a confidential manner.

**Please note that if the questionnaire is completed, it will be assumed that consent has been given.**

Please allow 5 to 10 minutes to complete the questionnaire and return it to a facilitator only once you have completed it. If you have any questions, please ask a facilitator and they will be happy to assist you.
To ensure confidentiality, do not put your name on the questionnaire, only your participant code, which will be assigned to you before you fill out the form.

**Thank you so much for participating and feel free to express any concerns or questions to a group leader**

Participant Code: _______________________

Date: ________________________

The questionnaire takes about 5 to 10 minutes to complete. Please keep in mind that you are not obligated to participate or fill out any questionnaires or forms as it is on a completely voluntary basis. If you choose to do so, however, it will be greatly appreciated and feedback on any area of the group is welcome so it can be improved upon in the future.

Below are some general statements about the current status of your relationships and your stress management skills. Please indicate the degree to which you agree or disagree by circling the appropriate number below the statement. This is just to assess how you are feeling and how the group can benefit you. There are no correct or incorrect responses and this questionnaire will remain confidential. To ensure confidentiality, do not put your name on the questionnaire but instead put your participant code that will be assigned to you before group begins.
Circle "1" if you strongly agree with the statement;
Circle "2" if you agree with the statement;
Circle "3" if you neither agree nor disagree with the statement or are unsure;
Circle "4" if you disagree with the statement;
Circle "5" if you strongly disagree with the statement.

1. I can generally resolve conflicts with people I love in a calm and respectful manner.
   
   Circle 1 2 3 4 5

2. I often feel stressed out with balancing close relationships and my daily life.
   
   Circle 1 2 3 4 5

3. I have no problems managing relationships with family, friends, and partners in my life.
   
   Circle 1 2 3 4 5

4. I can cope well with stress and challenges in my life.
   
   Circle 1 2 3 4 5

5. I have a support system I can rely on.
   
   Circle 1 2 3 4 5
6. I have someone in my life I know will be there for me no matter what.

   1  2  3  4  5

7. I am emotionally supportive to others in my life.

   1  2  3  4  5

8. I often feel very depressed, overwhelmed, or angry when there is a disagreement with loved ones.

   1  2  3  4  5

9. I believe the people in my life value me as a person and treat me with respect.

   1  2  3  4  5

10. If I am upset, I can generally calm myself down rather quickly.

    1  2  3  4  5

11. I can get explosive and abusive during a major disagreement.

    1  2  3  4  5

12. I isolate myself when I am upset.

    1  2  3  4  5

13. I need a lot of reassurance from people in my life to know that I am loved.

    1  2  3  4  5

14. I feel a strong sense of closeness with one or more people in my life.

    1  2  3  4  5

15. I often feel alone.

    1  2  3  4  5

16. I let people take advantage of me.

    1  2  3  4  5

17. I have lost touch with someone important to me that I would like to reconnect with.

    1  2  3  4  5
18. I know who I can turn to if I need help or someone to talk to.

1 2 3 4 5

19. I want to improve one or more relationships in my life.

1 2 3 4 5

Score: _____/38

Scoring Key

For questions: 1,3,4,5,6,7,9,10,14,17,18,19

Strongly agree (1)-2 points
Agree (2)-1 point
Neither agree nor disagree (3)-0 points
Disagree (4)-0 points
Strongly disagree (5)-0 points

For questions: 2, 8, 11, and 12,13,15,16

Strongly agree (1) -0 points
Agree (2) -0 points
Neither agree nor disagree (3) -0 points
Disagree (4)-1 point
Strongly disagree (5) - 2 points

Simply add the points to get the total score out of 38
Appendix D: The Intimacy Questionnaire
# Intimacy Questionnaire

Assign a number that best describes how you feel concerning each of the following statements. Base your answers on what has been true for you for the greater part of your life. What comes most quickly to your mind is usually the best answer.

0=definitely not me, 1=mildly disagree, 2=neutral, 3=mildly agree, 4= definitely me

<table>
<thead>
<tr>
<th>Statement</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. You are concerned that if you truly reveal yourself to another person, s/he will leave.</td>
<td></td>
</tr>
<tr>
<td>2. You fear that if someone really knew you that s/he wouldn’t like you.</td>
<td></td>
</tr>
<tr>
<td>3. You have an uneasy feeling that people will smother you if you get too close.</td>
<td></td>
</tr>
<tr>
<td>4. A parent physically or emotionally abandoned you in your childhood.</td>
<td></td>
</tr>
<tr>
<td>5. You were teased or shamed for your feelings or needs when you were younger.</td>
<td></td>
</tr>
<tr>
<td>6. You feel that one of your parents or significant caretakers was overly involved in your life.</td>
<td></td>
</tr>
<tr>
<td>7. You would feel a sense of panic if you had a conflict with your partner and s/he pulled away.</td>
<td></td>
</tr>
<tr>
<td>8. You would want to hide if your partner did a background check on you that was really on the mark.</td>
<td></td>
</tr>
<tr>
<td>9. You find yourself needing more space in relationships once another person tells you that s/he really cares about you.</td>
<td></td>
</tr>
<tr>
<td>10. You get angry when the person you’ve been involved with for six months says that s/he’s taking a vacation with friends that doesn't include you.</td>
<td></td>
</tr>
<tr>
<td>11. You are comfortable showing your checkbook to your partner.</td>
<td></td>
</tr>
<tr>
<td>12. You feel smothered when in the first few weeks of a relationship your partner wants you to call every day.</td>
<td></td>
</tr>
</tbody>
</table>
Scoring

1. Fear of Abandonment (add your scores for questions 1, 4, 7, and 10)
   Total

2. Fear of Exposure (add your scores for questions 2, 5, 8 and 11)
   Total

3. Fear of Engulfment (add your scores for questions 3, 6, 9, and 12)

If you score higher than 10 on any of the three areas, this is a strong indication that this could be creating a block that prevents you from becoming more fully intimate with others.
Appendix E: Final Evaluation
The Healthy Relationships Program

Final Evaluation

Date: ____________________

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The group was helpful.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. The facilitator presented the material in a way I could understand.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. The skills I learned were helpful.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. I was able to use these skills to improve certain relationships in my life.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. I found peer support useful.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. I learned ways to strengthen and widen my support network.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. I learned and utilized skills to reduce anxiety.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. I learned and utilized skills to improve communication.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. I would attend this group again.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. I would recommend this group to others.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

What I liked about the program was:

What I would like to see improved about the program is:
Appendix F: Self Monitoring Sheet
**Example of a self monitoring sheet/record**

<table>
<thead>
<tr>
<th>Overall goal</th>
<th>Weekly goal (objective)</th>
<th>Thoughts (What words or images went through my mind? What meaning did I give the situation?)</th>
<th>Feelings (What emotions did I feel? Rate 1 - 10, 1 worst)</th>
<th>Outcome (What did you do? Did you reach your weekly goal?)</th>
<th>Rate of satisfaction of outcome (1-10, 1 worst)</th>
<th>Goal for next week</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: “I want to improve my relationships with my friends”</td>
<td>“I will spend an hour with a friend” “My friend will not want to spend time with me” “My friend does not like me anymore”</td>
<td>Nervous, excited, indifferent, etc.</td>
<td>I cancelled on my friend because I was nervous.</td>
<td>Disappointed in myself, sad, angry, relieved etc.</td>
<td>Arrange a meeting with my friend for next week.</td>
<td></td>
</tr>
</tbody>
</table>
Appendix G: Raw Data from the “Healthy Relationships Questionnaire”
<table>
<thead>
<tr>
<th>Participant</th>
<th>Total Healthy Relationship Score</th>
<th>Stress Management Subscale</th>
<th>Social Support Subscale</th>
<th>Reconnecting with a Loved One Subscale</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre</td>
<td>Post</td>
<td>Pre</td>
<td>Post</td>
</tr>
<tr>
<td>1</td>
<td>29</td>
<td>35</td>
<td>12</td>
<td>16</td>
</tr>
<tr>
<td>2</td>
<td>11</td>
<td>8</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>18</td>
<td>17</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>4</td>
<td>5</td>
<td>8</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>
Appendix H: Graph Representing pre- and post- Questionnaire Scores
Appendix I: Information Flyer
Are you having difficulty managing relationships with family, friends and partners?

Are you feeling stressed out and alone?

Do you need help working through conflict in your relationships?

Summit Housing and Outreach Programs are pleased to team up with T.E.A.C.H Support and Housing Halton to offer a healthy relationships support group for our clients.

The goal of the group is to provide you with helpful strategies to cope with relationship troubles and equip you with the tools to enhance your relationships while offering peer support from people in your community who face similar challenges.

The group will run starting October 27th to December 1st 2011, every Thursday from 1 to 3 p.m., and if you choose to participate, we will contact you closer to the date to confirm times and provide more details.

Participation is free and greatly appreciated!

Refreshments will be provided!

Sessions will take place at the Milton T.E.A.C.H. office located at 348 Bronte St. South, Unit 12, Milton, ON L9T 5B6

Registration is required

For more information or to register, please contact Summit ACTT at actt@summit-housing.ca; (905) 847-3206 or Debbie at
Appendix J: Sample of First Session Handout
“The Healthy Relationships Program”

Session One

Thursday, October 27, 2011

Agenda

✓ Facilitator introductions
✓ Purpose and explanation of group program
✓ Contact information
✓ Group member introductions
✓ Ice breaker activity
✓ Consent form and questionnaires
✓ Confidentiality
✓ Break
✓ Group expectations/group goals
✓ Self monitoring/individual goals
✓ Introduction to healthy relationships and group discussion
✓ Peer support
✓ Wrap-up and goals for next session
Introduction and purpose of program

My name is Aneesha Sidhu and I am a student in my 4th year in the Behavioural Psychology at St. Lawrence College. I am currently on placement at Summit Housing and Outreach programs on the Assertive Community Treatment Team (ACTT). As a part of this placement, I am completing a special project called an applied thesis and I am asking for your assistance to complete this project. My program is on the healthy relationships group that will take place at Summit Housing and Outreach Programs in collaboration with T.E.A.C.H. Support and Housing Halton. I will be co-facilitating a group about establishing and maintaining healthy interpersonal relationships for adults with mental health diagnoses. The main purpose and goal of the group is to improve and build healthy interpersonal relationships as well as provide useful coping strategies within the field of cognitive behavioural therapy. We believe this group is useful for yourself and for those in your support system and we want to know what is most helpful for you so this group can be successful now and in the future. Your thoughts and opinions are extremely valuable so I greatly appreciate your help in completing all the written questionnaires and self monitoring sheets that will be assigned once the group has started and goals are established. We will meet once a week for 90 minutes in the conference room at the T.E.A.C.H. office. Participation in this project is completely voluntary and you are free to withdraw at any time without it effecting your participation in the group. If during the course of the group, you decide to withdraw and do not give consent to retain any data collected, your data will not be used in the project and destroyed in a confidential manner. You are asked to attend meetings as regularly as possible as you are a valuable member of the group and topics build on each other. It is also important to attend as many of the session as possible as we have limited time together and the self monitoring data that you volunteer to complete is important in measuring the success of the program.

Is there anything else you would like to know about me or the program?
Contact information

- Your active participation in this group is extremely valuable and appreciated by both the facilitators and the members.
- Because we have limited time together and participation is important for peer support, we encourage that you try your best to attend all the sessions every week, on time.
- If you are unable to attend a session, however, we ask that you try to contact T.E.A.C.H. or Summit at the numbers and contact information listed below.
- Thank you again for participating and please do not hesitate to communicate if you have any questions or concerns.

- T.E.A.C.H.: (905) 693-8771 Ext. 2 or Debbie Jones at djones@shhalton.org
- Summit ACTT: (905) 847-3206 or actt@summit-housing.ca
- Aneesha: asidhu09@student.sl.on.ca
Ice Breaker Activities

Circle of Friends Game
This is a great greeting and departure for a large group who will be attending a seminar for more than one day together and the chances of meeting everyone in the room is almost impossible. Form two large circles (or simply form two lines side by side), one inside the other and have the people in the inside circle face the people in the outside circle. Ask the circles to take one step in the opposite directions, allowing them to meet each new person as the circle continues to move very slowly. If lines are formed, they simply keep the line moving very slowly, as they introduce themselves.

Remember me?
The two teams sit on either side of the bed sheet. Two leaders pull the bed sheet up, hiding both teams from each other’s view. Then both teams select a player silently for the round, and both players move and sit facing the bed sheet in the middle. When the leaders can see that both players are ready, they drop the sheet so they can see each other.

The first player to yell the other person’s name wins a point for their team.
The Human Web:

This ice breaker focuses on how people in the group inter-relate and depend on each other.

The facilitator begins with a ball of yarn. Keeping one end, pass the ball to one of the participants, and the person to introduce him- or her-self and what has brought them to group. Once this person has made their introduction, ask him or her to pass the ball of yarn on to another person in the group. The person handing over the ball must describe how he/she relates (or expects to relate) to the other person. The process continues until everyone is introduced.

Look around you. This is a new circle of friends and trust. They will be here to support and help you through this journey and you are an important part of this network. We're all connected and we are here to learn from and help one another.
**Group Expectations**

As a member of the “Healthy Relationships” group, we all have an important role in helping and learning from each other.

**Goals:**

What goals do you propose for the group? What do you wish to learn and gain from this experience?

**Group expectations:**

Respect for one another

Confidentiality

A non-judgmental atmosphere

The right to "pass" during sharing or group discussion

The right to speak/share

...Anything else to add?

**Self-Monitoring/Individual Goals**

Within the field of cognitive behavioral therapy, self monitoring is the exercises by which an individual records behaviors or thoughts in a journal or on a tape. The purpose is to increase an individual’s awareness of distorted, negative thoughts and dysfunctional self-talk, thereby allowing him or her to make the appropriate modifications to these behaviors. The individual has the power to monitor their own behaviours and thoughts and modify them according to their own goals.

What are your individual goals for this group?

What would you like to achieve overall?

What small steps can you take to reach that goal?
**Example of a self monitoring sheet/record**

<table>
<thead>
<tr>
<th>Overall goal</th>
<th>Weekly goal (objective)</th>
<th>Thoughts (What words or images went through my mind? What meaning did I give the situation?)</th>
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<th>Outcome (What did you do? Did you reach your weekly goal?)</th>
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<tr>
<td>Example: “I want to improve my relationships with my friends”</td>
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<td>Disappointed in myself, sad, angry, relieved etc.</td>
<td>Arrange a meeting with my friend for next week.</td>
</tr>
</tbody>
</table>
Introduction to Healthy Relationships

Group Discussion:

What would you define as a healthy relationship?

What attributes, features, or properties make up a healthy relationship or partner?

What would you like to improve in your relationships?

Are satisfied with the state of the relationships you have with family, friends, partners, or peers? Why or why not?

Some qualities of healthy relationships:

Trust.

Honesty.

Support.

Fairness/equality.

Separate identities.

Good communication.

What do these mean to you?

What else could we add to this list?

Some qualities of unhealthy relationships:

Fear

Physically Abuse

Unable to express oneself
Relief when a particular person leaves the room

Afraid of being alone because you lack an adequate support system

Verbally abusive

Ongoing unresolved hurt feelings

...Any qualities you would like to add to this list?

**Healthy relationships and why they are important**

- Relationship building and maintaining relationships is especially difficult among those who are diagnosed with mental health disorders. Relationship and intimacy problems are common among depressed clients due to deficits in coping and communication skills. Research on relationships suggests that communication and problem solving skills are extremely important in coping and maintaining successful relationships (Basco et. al, 1992).

- Establishing and maintaining intimacy and satisfying relationships has been shown to counter the effects of psychological stressors that individuals with mental health issues experience (Lowenthal & Haven, 1968; Roy, 1978).

- A great difficulty that adults who are diagnosed with mental disorders face, is a lack of social support and self isolation. As a result, it is a challenge to establish and maintain healthy relationships for them. Interpersonal relationships, such as marriage and other forms of social support is important to the positive mental health of individuals and deserves further focus on the topic in order to improve on mental health symptoms (Spotts et al., 2005).

**Group discussion**

What are your opinions on relationships?

What do they mean to you?

Why do you think it's important to have relationships and a support system you can count on?
Introduction to peer support

Group discussion

What does peer support mean to you?

What are your experiences with peer support?

Why do you think it’s important to recovery?

- Peer support is important for a variety of reasons but specifically it is powerful because “as with all aspects of human behavior in the social environment, support of one’s peers is crucial for healthy living, successful vocation/recreation, and a full life” (Hodges, 2006).

- Peer support offers social and emotional support for those who have similar mental health conditions and share a common desire to evoke personal change in their lives (Soloman, 2004).
What does peer support offer?

- Social support
- Mutuality
- Friendship
- Sense of belonging
- Combats stigma
- Empowerment
- Helping others
- ...what other advantages are there?

- Peer support is a powerful tool in recovery as it provides a venue for those with shared experience to exchange information, stories and tools as well as gain role models and social support (Schutt & Rogers, 2009).

- Mental health service consumers are offered a myriad of services once diagnosed but peer support is becoming increasingly established and demanded among these services as it employs autonomy, independence, and consumer input into services that is sometimes not offered in hospitals or other mental health agencies. Other benefits of peer support for the individual is feeling welcomed, contributing to a larger process outside of themselves, and building trust with others where otherwise stigma might be a factor.

Wrap-Up and goals for next time

- Questions?
- Anything to share?
- Please think about an overall goal and objectives for next time!