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For the degree of   Master of Science

Is approved by the final examining committee:

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EVALUATING THE EFFECTS OF NAMI'S CONSUMER PRESENTATION PROGRAM ENTITLED

IN OUR OWN VOICE

A Thesis

Submitted to the Faculty

of

Purdue University

by

Madeline Brennan

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PREFACE

This thesis contains two studies. Study 1, entitled Evaluating the Effects of NAMI's Consumer Presentation Program Entitled *In Our Own Voice*, forms the main body of the thesis. Appendices of the main thesis (i.e., Study 1), are labeled A, B, C, etc. Study 2, entitled Evaluating Recovery Expectations in Consumer Audience Members of a Consumer-Delivered Recovery Program Entitled *In Our Own Voice,* is included in Appendix E. Appendices of Study 2 are labeled as follows: E1, E2, E3, etc.

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ABSTRACT

Brennan, Madeline. M.S., Purdue University, May 2012. Evaluating the Effects of NAMI's Consumer Presentation Program Entitled *In Our Own Voice.* Major Professor: John H. McGrew.

Research suggests that misperceptions about the mentally ill and about their ability to recover and live productive lives are still commonly held by the public. Psychoeducation programs and direct contact can help both correct misperceptions and offer encouraging messages about recovery in those with and without mental illness. Consumer presentation programs, such as NAMI's *In Our Own Voice* (IOOV), were designed in part for these purposes. This study examined archival IOOV audience evaluations (n = 599) from 2009 to better understand how audiences respond to IOOV in natural settings. Qualitative and quantitative analyses were conducted to examine: 1) viewers' responses to the program, 2) differences between consumer and nonconsumer responses, and 3) whether the program satisfies program goals for audience members. Results indicate that the majority of viewers respond positively, in a variety of ways and to a variety of program elements not previously identified. Additionally, the program's effects appear to generalize across consumers and nonconsumers equally well, with the exception that nonconsumers more frequently reported finding the program educational and consumers more frequently reported personally relating to presenters. Finally, results suggest that IOOV is indeed meeting its two stated program goals for audience members: educating the public and offering a hope-inspiring message of recovery. In conclusion, IOOV, as it is performed in the field, appears to be a valuable addition to educational and inspiring recovery-oriented programming available to the public.

INTRODUCTION

The concept of recovery as a plausible outcome for those with severe mental illness is slowly working its way into the public eye (Corrigan & Watson, 2004). Until fairly recently, the accepted "wisdom" in the medical community, and consequently the public at large, was that recovery from severe mental illness was not possible (Liberman et al., 2002). Consumers (i.e., those seeking mental health services) subsequently internalized this hopeless view which suggested to them and others that a life with meaningful activity (i.e., educational, occupational, and personal achievement) was out of reach (Frese & Davis, 1997). Fortunately, during the past few decades, a growing body of empirical evidence has accumulated to dispel this myth and a much more complex, less dire, and more hopeful picture of recovery from severe mental illness has emerged (Liberman et al., 2002; Lehman et al., 2004; Drake et al., 2005). This view is gradually being absorbed into the cultural landscape, in part, due to deliberate efforts to educate the public about mental illness and the possibility of recovery made by organizations such as the National Alliance on Mental Illness (NAMI, 2011a). This study will examine the impact on the public of one of NAMI's educational outreach programs known as *In Our Own Voice: Living with Mental Illness.*

What is Recovery from Mental Illness?

One of the difficulties inherent in the identification of programs which promote the concept of recovery from mental illness is defining the term. Until fairly recently, researchers have tended to define it using measurable outcomes (e.g., symptom reduction, reduced rates of hospitalization) (Bellack, 2006; Davidson et al., 2005; Young & Ensing, 1999). Consumer advocates, on the other hand, have tended to describe it using more difficult-to-measure terms imbued with meaning (Bellack, 2006). According to this latter group, recovery is defined as process- rather than outcome-oriented (Deegan, 1988; Frese & Davis, 1997), involving hope as a crucial element (Anthony, Cohen, & Farkas, 1990; Corrigan, et al., 2004; Davidson et al., 2005; Deegan, 1988; Fisher & Chamberlin, 2005; Mead & Copeland, 2000), and including a focus on

the resumption of responsibility and control for one's life (Chamberlin, 1978). This vision of recovery as the development of a meaningful life within a community while managing symptoms was eventually integrated into research studies examining outcomes (Lieberman et al., 2008; Liberman et al., 2002), and is the vision adopted by the New Freedom Commission on Mental Health (US PHS Office of the Surgeon General, 2003).

<u>Public Perceptions of Mental Illness: Effects on Recovery</u>

There has been recent progress in the public's knowledge about the treatment, causes, and outcomes for those with mental illness (Jorm et al., 2006); however, stigma resulting from commonly held misconceptions remains a problem across cultures (Stier & Hinshawn, 2007). Stigma is often the result of misperceptions about mental illnesses and how symptoms might pose a threat to the public (Hinshaw & Cicchetti, 2000; Guimon, Fisher, & Sartorius, 1999). Stigmatizing attitudes can lead to very real negative outcomes including lost employment and/or housing opportunities, and even social exclusion (Thornton & Wahl, 1996). In order to address this, various intervention efforts involving better educating the public and increasing direct contact with consumers have developed to dispel misperceptions (Jorm et al., 2006).

<u>Benefits of Education and Direct Contact on the Public</u>

Individuals without mental illness are likely to benefit from educational efforts aimed at offering accurate information about mental illness to correct misperceptions and reduce stigma (Corrigan et al., 2001; Penn et al., 1994). As an example of the kinds of misperceptions that are common, one study found that 17% of those who identified having had previous contact with someone with mental illness provided an incorrect example (e.g., Down Syndrome; Penn et al., 1994). This lack of knowledge is associated with stigmatizing attitudes. For example, several studies suggest that persons who are more knowledgeable are less likely to endorse stigmatizing attitudes about mental illness (Brockington et al., 1993; Link and Cullen, 1986; Link et al., 1987; Roman & Floyd, 1981). Direct education efforts can help. In one series of studies, graduate students demonstrated better attitudes about individuals with psychiatric disabilities (e.g., decreased stigma) after participating in short (e.g., 2 hour) seminars about mental illness (Keane, 1990, 1991; Morrison, 1980; Morrison et al., 1980; Morrison & Teta, 1980). Other researchers have examined the effects of brief education interventions on decreasing

stigmatizing attitudes in nonstudent populations and also found positive results (Penn et al., 1994, 1999; Thornton & Wahl, 1996). One study found that familiarizing the public with the current life context of successfully recovered patients led to a decrease in negative conceptions (Thornton & Wahl, 1996).

Direct contact between individuals with and without mental illness has also been an effective means of educating the public, particularly with regard to reducing negative misperceptions (Corrigan et al, 2001). Intergroup contact theory provides a useful theoretical framework for explaining this effect. Intergroup contact theory suggests that negative biases held by ingroup members about outgroup members can be reduced through direct contact between the two groups (Pettigrew, 1998). Findings of studies examining the effects of intergroup contact between those with and without mental illness support the idea that direct contact reduces negative biases towards those with mental illness (Corrigan & O'Shaughnessy, 2007; Desforges et al., 1991). Additionally, studies have demonstrated an inverse association between direct contact with an individual with mental illness and endorsement of stigmatizing attitudes held by individuals without mental illness (Link & Cullen, 1986; Penn et al., 1994; Holmes et al., 1999). Another study found that the most salient factor predicting fewer stigmatizing attitudes was previous contact with consumers (Thornton & Wahl, 1996). Thus, research suggests that public misconceptions regarding mental illness could, theoretically and practically, be altered through direct contact with consumers of mental health services.

<u>Benefits of Education and Direct Contact on Recovering Consumers</u>

Education and/or exposure (i.e., direct contact) with recovering consumers has also been shown to increase recovery expectations and decrease internalized stigma in consumers themselves (Andreson et al., 2003; Kylmä et al., 2006; Lucksted et al., 2011). For example, one education intervention pilot study attempted to reduce internalized stigma through a 6-week psychoeducation program. The program had positive effects: decreased self-stigma, increased self-acceptance, increased self-esteem, and improved overall psychological health (Macinnes & Lewis, 2008). However, exposure to successful peers in recovery themselves is the more frequently advocated strategy for offering a hope-inspiring, recovery-oriented message to consumers (Davidson, Chinman, Sells, & Rowe, 2006; Deegan, 2005; Drake, Merrens, & Lynde, 2005; Fisher & Chamberlin, 2005; Kirkpatrick, Landeen, & Byrne, 1995; McCann, 2002). Such

experiences have the advantage of demonstrating that recovery is a valid possibility, thereby increasing hope for personal recovery (Jacobson & Greenley, 2001). Theoretically, this idea finds support in upward comparison theory which states that individuals will sometimes compare to similar better-off others in order to feel better themselves (Buunk et al., 1990; Collins et al., 1996). Qualitative research on recovering individuals with mental illness suggests that consumer participants may engage in and benefit from upward comparisons. In a recent review of the literature on hope and schizophrenia, "receiving direct knowledge of successful peers" was identified as an effective strategy for inspiring hope in those with schizophrenia (Kylmä et al., 2006, p. 659). Similarly, in a review of recovery stories by Andresen and colleagues (2003), consumers described gaining hope through exposure to a significant other, peer or role model.

<div align="center">NAMI's In Our Own Voice (IOOV)</div>

The National Alliance on Mental Illness--a grassroots nonprofit organization at the National, state, and local levels--offers a variety of psychoeducation programs developed to educate the public about mental illness and recovery (NAMI, 2011a). *In Our Own Voice: Living with Mental Illness* is one among a variety of peer-led programs designed to deliver an educational, hope-inspiring message about recovery from mental illness to the public through direct contact with those who have been there (NAMI, 2011b). This free educational outreach program was developed in part to meet the needs of consumer-run initiatives that educate the public about the possibility of mental illness recovery. Three of the program's goals address this directly: to meet the need for consumer-run initiatives, to offer genuine work opportunities, and to encourage self-confidence and self-esteem in presenters. Two other goals are geared towards audience members: to set a standard for quality education about mental illness from those who have been there, and to focus on recovery and the message of hope. IOOV has been in existence since 1997, and has been viewed by over 270,000 people in 44 states. Surprisingly, despite having been in existence for nearly 15 years, the program has never been formally evaluated for its ability to successfully achieve these goals for audience members.

<p style="text-align:center"><u>What does IOOV look like?</u></p>

IOOV is a 90-minute multi-media presentation led by two trained consumers who present their personal stories of recovery to audiences of students, family members, providers, consumers, police officers, and the general public in community settings across the country (NAMI, 2011b). Topics discussed include Dark Days; Acceptance; Treatment; Coping Strategies; and Successes, Hopes and Dreams. During Dark Days, the speakers explore their feelings and experiences during the darkest moments of living with mental illness. During Acceptance, speakers explain how they achieved acceptance of their illness and the role it played in their recovery process. During Treatment, presenters demonstrate how treatment is unique to the individual, and explain what treatment plans are effective for them. During Coping Strategies, presenters share personal coping skills and how these enhanced their ability to manage the illness. Finally, during Successes/Hopes/Dreams, speakers share their current activities/successes and plans for their futures in order to demonstrate that a key component of recovery is setting goals while pursuing personal dreams. Audience participation is encouraged throughout the program.

<p style="text-align:center"><u>Empirical support for IOOV</u></p>

Four studies have examined IOOV, focusing specifically on its ability to reduce stigma in students in controlled university settings, and have demonstrated positive results (Corrigan et al., 2010; Pitman, Noh, & Coleman, 2010; Rusch, 2008; Wood & Wahl, 2006). In the first study of 114 undergraduate students randomly assigned to receive IOOV, subjects in the experimental group showed increased knowledge of mental illness and improved attitudes toward those with mental illness relative to those in the control group (who received a presentation on careers in psychology) (Wood & Wahl, 2006). A replication of this study with masters level social work students reported similar findings (Pittman, Noh, & Coleman, 2010). Another study examined whether the program decreased stigma for mental illness generally or only for the disorder specifically represented by the two presenters (i.e., bipolar disorder) (Rusch, 2008). Compared to those in the psychoeducation control group, undergraduate students randomly assigned to the IOOV group showed the greatest decrease in stigma for the presented disorder (bipolar disorder), but also showed a significant decrease in stigma toward mental illnesses in general, providing some evidence for both specificity and generalization effects. The most recent study

(Corrigan et al., 2010) showed that a shortened version of the program was as effective as the original version in decreasing stigma in college students.

Although these studies provide useful information about IOOV, the results are limited by an exclusive use of student samples, examination of a limited set of outcomes (e.g., stigma, specific knowledge), and implementation of IOOV in controlled settings (efficacy) rather than in the field (effectiveness). To our knowledge, only 1 unpublished study (a conference presentation) has examined results of the program when implemented in the field for general audiences. In this unpublished report, the authors reviewed multiple choice items from over 2200 archival NAMI evaluations to explore self-reported program effectiveness (Wood, 2003). Their findings suggest that almost three quarters of the audience members indicated that the program provided "great information," and 70% reported that it had "excellent depth and scope."

Currently, then, there is limited knowledge of the range and content of viewers' responses to the program as it is conducted in the field and of whether these responses reflect NAMI's stated program goals. Moreover, although theoretically direct contact with a consumer should produce positive effects on audience members with and without mental illness through different mechanisms (e.g., instilling hope through identification vs. changing misperceptions), studies have not examined potential differences in program impact on consumers vs. nonconsumers. To address these gaps in the literature, the current study will examine archival program data to attempt to answer the following questions: (1) what are audience members' general responses to the program as it occurs in natural settings? (2) are there differences between consumer and nonconsumer responses? (3) does the program satisfy NAMI's two program goals for audience members by (a) providing quality education about mental illness from those who have been there and (b) focusing on recovery and the message of hope (NAMI, 2011b)? To this end, both quantitative and qualitative analyses were used to examine closed-ended and open-ended items from 2009 archival NAMI program evaluations**.**

METHOD

Procedure

The first author collaborated with NAMI National to identify NAMI affiliates from across the country that offered IOOV and were willing to participate. One state office (NAMI IN) and one affiliate (NAMI Austin, TX) provided their 2009 IOOV archival audience evaluations (n = 599), which presenters are required to distribute at the end of every presentation for general feedback about the program. In addition to the original form, five variant forms had been used at these sites. Three of the six forms—labeled Form A (original) (Appendix A), Form B (Appendix B), and Form C (Appendix C)—were selected for analysis based on (1) item overlap with the original evaluation form and (2) administration at sites with sufficient representation by both consumer and nonconsumer audience members.

Measures

The original NAMI IOOV evaluation (Form A) was developed by NAMI National to obtain immediate audience feedback on the program. However, since the program's inception, several variant forms have developed in local affiliates. As noted above, this study analyzed data relevant to the research questions from the original form, plus two variant forms (Forms B and C). Since the original form is the standard used to evaluate the program, and since it was administered to the bulk of the study sample, all items selected for analysis (with one exception—see explanation below) are from Form A. Fifteen items—14 from the original and 1 from the variant forms—were selected for analysis (see Table 1). Items were selected based on their ability to answer the research questions (e.g., "I see recovery as a real possibility"). Of these 15 items, 12 are closed-ended items and 3 are open-ended items.

Form A (original)

The original NAMI IOOV Audience Evaluation is a 27-item self-report questionnaire. The 14 items selected for analysis included two checklist-style items, five dichotomous forced-choice

items, three Likert-type rating items, two fill in the blank items, and two open ended items. The two checklist-style items included audience role (consumer, family member, social worker, health provider, educator, student, law enforcement, service administrator, or other) and nominations for their "favorite section" (made by checking any of the 5 section titles listed, e.g., Dark Days). The five dichotomous items included the following: three questions which asked whether, "as a result of viewing the presentation, viewers agreed or disagreed with the statements (1) "I see recovery as a real possibility," (2) "A mental illness is a physical illness, like diabetes," and (3) "I would feel comfortable working with someone who has a mental illness," and two yes/no items assessing (1) whether viewers were aware of NAMI prior to the presentation (2) whether they had previously seen an IOOV presentation. The two fill-in-the-blank items prompted for "Ethnicity" and "Religion." The three 5-point Likert-type items (1 = disagree, 5 = agree) asked viewers to rate (1) program usefulness, (2) comfort level asking questions of presenters, and (3) program as "interesting and easy to follow." A subsequent open-response item prompted viewers for an explanation of favorite topic with the stem, "because…" A second open response stem read "Other Comments."

Thirteen items were not selected for analysis. Two included fill-in items asking for the date of the program and the name of the facility. Three checklist-style statements (check if item applies) assessing participants past views of recovery, mental illness, and consumers (e.g., "In the past, I haven't felt encouraged regarding recovery from mental illness") were excluded because of ambiguity in interpretation of the items. For instance, in interpreting the example item given, it is unclear whether individuals might check the item because they felt recovery was not possible for them or because they felt that others had not been encouraging about recovery, regardless of their own personal views about it. Also, the broad time frame implied by the term "past" makes interpretation as it applies to research questions about the program's direct effects difficult. Additionally, six checklist style items assessing interest in opportunities for continued contact/work with NAMI, and two fill-in items asking for personal and venue contact information, were not included in analyses.

Form B

Form B had a total of 38 items, 12 of which were identical to those selected for analysis on Form A. Form B also included one open-response item not found on Form A that was

deemed valuable for addressing the first research question assessing range of viewer responses to the program. This item stem read, "If I could change one thing about the presentation it would be…" Form B did not include the 2 items assessing favorite program topic (closed-ended) and reason for choosing favorite topic (open-ended).

Form C

Of the 25 items found on Form C, five were utilized: 2 closed-ended and 3-open ended items. Four of these items were identical to those on Form A (two checklist-type items—audience role and prior awareness of NAMI—and two open-response item). However, one open response item, though identical to that found on Form A (i.e., "because…."), was in response to "most helpful" as opposed to "favorite" program topic. One open-response item not found on Form A was identical to the item found on Form B prompting for suggestions for program improvement.

Although Form C had a low number of closed-ended items found on Form A (i.e., two), it was included because (1) it had all three open-response items which provided substantial data for qualitative analyses, and (2) it was administered to a high proportion of consumers, informing the second research question.

Data Preparation

Each evaluation form was assigned a participant number. Items selected for analysis were coded and entered as variables into the database for Statistical Package for the Social Sciences (SPSS) version 17 (see Table 1). Because participants could endorse multiple options when identifying their "Audience Role," persons who endorsed "consumer" were considered "consumers" for subsequent analyses, regardless of whether they endorsed other audience roles.

Qualitative Coding

Written responses to open-ended items were transcribed verbatim and entered into an SPSS database for the development of a codebook. Because the study was attempting to capture the breadth of responses to the program without attention to a priori biases suggested by item stems, initial coding was done on comments apart from their item stems, a practice

common to a Grounded Theory approach to qualitative research (Charmaz, 2006). A consensus-based iterative approach was utilized for coding. First, three coders reviewed all comments together to identify emergent theme categories. Coding decisions (i.e., combining two codes, creating additional codes) occurred throughout this process as needed. Once a final codebook was established, coders worked independently to score comments for the presence or absence of each code (e.g., 1 = code present; 0 = code absent). Agreement was checked for 15% of comment sets. An acceptable level of agreement was set at kappa > .70 (Denzin & Lincoln, 2000). Agreement was very good across codes (kappa > .83) (see Table 3).

The final codebook (see Appendix D) included 16 codes subdivided into two code domains: Affective/Attitudinal (8 codes) and Program Elements (8 codes). The two domains were created to account for the fact that comments seemed to reflect both an attitudinal/affective response (e.g., feeling encouraged or found interesting…) and a content-oriented response (e.g.,…*about* hearing a positive message of recovery or *about* treatment practices). A single comment usually (but not always) received at least one code from each domain, and could receive multiple codes from both domains.

Domain One (Affective/Attitudinal) included the following codes: Feeling Encouraged, Found Interesting, Found Educational, Appreciating, Personally Relating, Critiquing, Generalizing/Stating a Belief, and Uncodable. Additionally, to better understand audience members' suggestions for improvement, the Critiquing code was further divided into eight subcodes: Program length, Program Structure, Program Availability, Educational Content, Presenter Stories, Presenter Skills, Technical Issues, and Uncodable. Interrater agreement (i.e., kappas) for critiquing subcodes ranged from .66 - .98. Domain Two, Program Elements, included the following codes: Illness Experiences, Recovery is Possible, Recovery is Individual, Recovery is Conditional, Practical Information, Program Format, Presenter Qualities, and Uncodable. Uncodable categories were assigned when comments, or portions of comments, were indecipherable or could not readily be coded into a given category.

Following the above, a second level of coding was performed to address specific research questions using rules of traditional content analysis (Denzin & Lincoln, 2000). First, to address question #1 (i.e., What are audience members' general responses to the program?), all comments were coded for attitudinal valence (i.e., 1 = positive, 2 = neutral, 3 = negative). The range for interrater agreement across the three coders for these codes was acceptable (.77 -

.99). Additionally, to assess question #3 (i.e., Does the program satisfy NAMI's audience goals relating to 1) education and 2) a message of hope/recovery?), frequency counts of codes judged to pertain directly to these goals are reported. Thus, comments coded as "Found Educational" were coded as meeting Goal 1 and comments coded as "Feeling Encouraged," "Recovery is Possible," "Recovery is Individual," or "Recovery is Conditional" were coded as meeting Goal 2.

Analyses

Because various quantitative and qualitative analyses were used to answer research questions, a full description of the analytic methods for each question are offered in table format (see Table 2).

Quantitative Analyses

To address the first research question (i.e., viewers' responses to the program), descriptive statistics (means, SDs) of closed-ended items and frequency counts of codes developed from comments made in response to open-ended items are reported. Additionally, t-tests comparing mean vs. neutral (i.e., middle) scores of closed-ended item responses are reported.

To address the second research question (i.e., differences between consumer and nonconsumer responses), frequency counts for closed-ended items, Chi-Square tests for dichotomous items, and t-tests for continuous items, are reported. Chi-Square analyses were also run comparing codes for consumer vs. non-consumer comments for all open-ended items.

To answer the third research question (i.e., did the program address select program goals?), frequency counts of relevant closed-ended items, and of open-ended comments coded for specific goals, are reported.

RESULTS

Sample Characteristics

Demographic data were available from 599 NAMI audience evaluations: Form A: *n* = 338 (54%), Form B: *n* = 201 (34%), and Form C: *n* = 60 (10%). Of these, almost two-thirds (*n* = 370; 62%) were from NAMI Indiana and the remainder were from NAMI Austin, TX (*n* = 229; 38%). In terms of audience makeup, over half of the subjects (*n* = 315; 53%) were students, and the remainder were consumers (*n* = 106; 18%), family members (*n* = 82; 14%), providers (*n* = 68; 11%), law enforcement officers (*n* = 42; 7%), educators (*n* = 22; 4%), and others (*n* = 44; 7%). Only Forms A and B assessed race/ethnicity. Of those who answered these items (*n* = 445), the majority were Caucasian (*n* = 353; 79%), with modest representation by Latinos/as (*n* = 47; 11%) and African Americans (*n* = 30; 7%). Over three fourths of the sample responding to the item on religion reported that they were Christian (*n* = 468; 78%) and the remainder (22%) were a mix of other religions, or were agnostic or atheist. A little more than half reported no previous exposure to NAMI (*n* = 314; 52%). The majority had no previous exposure to IOOV (Forms A and B, n = 539) (*n* = 467; 89%).

Question 1: How do viewers respond to the program?

Overall Response to IOOV

Evidence from 2 closed-ended items and 1 open-ended item revealed strongly positive responses to the program. Analysis of closed-ended items revealed that 94% (*n* = 317) agreed that the program was "interesting and easy to follow" (Form A) (M = 4.88; SD = .468), 95% (*n* = 513) agreed that the program information was "useful," (Form A & B) (M = 4.75; SD = .663) and 90% (*n* = 457) agreed that viewers were comfortable asking questions or going into deeper discussion with presenters (Form A & B) (M = 4.52; SD = .951). One sample t-tests comparing the means of these items with the neutral response (i.e., 3 = "unsure") were conducted to see if the mean was significantly different from the middle score. All three showed significant

differences: program as "useful"(Forms A & B only) (t (531) = 60.970; $p < .001$), viewer comfort asking questions (Forms A & B only) (t (531) = 35.910; p < .001), and program as "interesting and easy to follow" (Form A only) (t (334) = 37.688; $p < .001$). Further evidence for a positive response to the program was found in comments written in response to the "Other Comments" open-response item. This item was selected for quantitative analysis because it was the only item that was identical across all three forms that did not prime the respondent in any particular direction. Similar to the close-ended questions, the majority of those who commented (86%; n = 112/131) gave positive responses (e.g.,"awesome!"), with 9% (n = 12) offering neutral comments (e.g.,"nothing"), and 5% (n = 7) giving negative comments (e.g., "The female speaker has no idea about anything we deal with.").

Favorite Program Topic

Form A (n = 338) asked viewers to check their "favorite" part of the program from a list of the 5 program topics. Viewers often selected more than one, and 10% (n = 35) endorsed all five. Program topic preferences were as follows (n = 338): Successes/Hopes/Dreams (n = 175; 52%), Dark Days (n = 114; 34%), Coping (n = 102; 30%), Acceptance (n = 78; 23%), and Treatment (n = 57; 17%).

Affective/Attitudinal and Program Elements

To determine general responses to the program, all responses to the three open-ended items were initially analyzed together without regard to stem. Results are reported separately by two coding domains: *how* viewers were responding (Domain 1: Affective/Attitudinal Effects) and to *what* they were responding (Domain 2: Program Elements).

Affective/Attitudinal

Eight different types of responses (Domain 1) were given in comments made in response to any of the open-ended stems (n = 437). By far, the greatest number of comments made by viewers reflected "Feeling Appreciative" (n = 193; 44%). One audience member wrote, "I really enjoyed the presentation. I thought the speakers were wonderful and they really helped you understand what they went through." Many also noted that they found the program educational (code: "Found Educational") (n = 153; 35%). For instance, one commented, "I

understand now that medication accompanied with psychotherapy can help those that have those illnesses." Another, who felt both educated and inspired, wrote, "V. [sic] informative and inspiring. I feel much more educated and am excited to learn more about how I can help or play a role in the NAMI org." Others reported "Feeling Encouraged" (*n* = 102; 23%). For example, one consumer wrote, "It gave me the courage to do anything I can do to get better!" Some responded with a more cerebral interest (code: "Found Interesting") (*n* = 45; 10%). One noted, "The medication aspect is very interesting to me." Many also responded by "Personally Relating" (*n* = 66; 15%): "I am actually going through the process of being diagnosed with general anxiety disorder and it helped a ton!" Other viewers (*n* = 62; 14%) simply stated a personal belief (i.e., "Stating a Belief") such as one who wrote, "They [program topics] are all equally important in the journey of recovery."

Program Elements

Viewers' comments also reflected program content to which they were responding (Domain 2). A sizeable number responded to the entire "Program Format", or to a specific program section (e.g., Dark Days) (*n* = 130; 30%). One wrote, "The whole process comes together with each piece—very interesting!" A viewer who had endorsed "Dark Days" as the favorite section explained "This, I believe, is the most powerful section." Other viewers wrote comments about the "Presenters' Qualities" (*n* = 81; 19%). One wrote, "It is interesting to see how confident the speakers were" and another "Both [speaker name] and [speaker name] were excellent speakers…" Many viewers also remarked about "Practical Information" reported in the program (*n* = 76; 17%) (e.g., coping skills, mental illness education, work and/or family applications, and treatment information). For example, one provider noted, "Gives practical ideas to clubhouse members for dealing with their mental illness." Another viewer noted, "Treatment encompasses many things—biological, cognitive, and social therapies. I like to learn what works."

Several commented on presenters' "Illness Experiences" (*n* = 116; 27%). One viewer noted, "For those who don't understand what the dark days really are like, sometimes we think they are just normal depressions." Some viewers also noted the individual nature of mental illness recovery (i.e., "Recovery is Individual") (*n* = 17; 4%): "It helped to see how something very small to one person can really start another person down the road to recovery." Several also

commented on the conditional nature of recovery (i.e., "<u>Recovery is Conditional</u>") (n = 26; 6%),
"It is important to accept [the illness] to begin the process to recovery." Many viewers
responded to the general recovery message (i.e., "<u>Recovery is Possible</u>") (n = 153; 35%). One
wrote, "Thanks! It was great to see how it is possible to recover from mental illness!"

Critiquing the Program

Several viewers (n = 71; 27%) offered critiques (i.e., Domain 1: <u>"Critiquing"</u>) of the
program; however, most (n = 61; 86%) of these were in direct response to an item stem
prompting for suggestions (i.e., "If I could change one thing about the program it would be…")
found only on Forms B and C (n = 261).

Suggestions offered covered a range of areas. Many viewers suggested altering some
aspect of the program format; most commonly, by increasing program length (17%; n = 12/71)
which simultaneously suggested a positive response to the program (e.g., "A little longer—I am
hungry to learn more"). Others suggested altering other aspects of program format (25%; n =
18) such as increasing or decreasing audience size, increasing diversity among the speakers
("Have a male and female do presentation together"), allowing more time for discussion ("more
open discussion"), and hearing about presenters' lives before illness onset ("I would like to have
heard more about Diana's life before postnatal depression"). Several reflected on the narratives
presenters offered (13%; n = 9). One viewer suggested "the presenters going deeper into their
'bad days' because these are what I have to deal with everyday [sic]. " Although most of these
were appreciative, a few were quite negative. For example, one police officer wrote, "The
female speaker has no idea about anything we deal with." Other viewers critiqued speakers'
presentation skills (14%; n = 10) with comments such as "more energy," "a little more
organized," "louder," and "stop getting interrupted in the classroom." Some viewers also had
suggestions regarding the educational content (11%; n = 8) (e.g.,"Handout for us to refer to
about what phases you would cover") and technical aspects of the program (7%; n = 5) (e.g.,
"newer, more informative video").

Question 2: Do consumers and nonconsumers respond to the program differently?

A comparison was made between consumer and nonconsumer responses to the closed-ended items assessing post-program attitudes and topic preferences (see Table 4). No significant differences were found.

Additionally, comparisons between the two groups were made in responses to the open-ended items. First, a Chi-Square test was conducted to compare the frequency of writing comments for both groups for each item since not all items appeared across all three forms. Next, Chi-Square tests were conducted to examine differences in the use of the 16 codes for each item.

For the open-response item asking for explanation of "Favorite" program topic (Form A only) (n = 338), not unexpectedly, consumers (69%; n = 37/54) were significantly less likely to write any comment than were nonconsumers (82%; n = 233/284) (χ^2 = 4.845; p = .028). However, the large proportion of students in the nonconsumer sample (84%; n = 239) complicated the interpretation of consumer vs. nonconsumer differences. When students were removed from the analysis, there was no difference between the two groups on comment frequency: (χ^2 = .670; p = .413). Subsequent analyses of codes used to explain favorite program topic were done both with and without student subjects. Table 5 displays an overview of the results.

As might be expected, consumers (30%; n = 16/54) were significantly more likely than non-consumers (8%; n = 22/284) to favor a topic because of personally relating to it (χ^2 = 21.77; p < .001). On the other hand, nonconsumers were significantly more likely than consumers to express favoring a topic because of feeling more encouraged (25% vs. 13%) (χ^2 = 3.899; p = .049), more educated (29% vs. 15%) (χ^2 = 4.394; p = .036), and of hearing messages of recovery/success (38% vs. 24%) (χ^2 = 4.401; p = .036). However, when analyses were rerun excluding students, only one significant difference remained: nonstudent nonconsumers (38%; n = 17/45) were still significantly more likely to report preferring a topic because of finding it educational than did consumers (15%; n = 7/46) (χ^2 = 4.330; p = .037) (see Table 6).

Form C (n = 60) had a similar question but asked for "most helpful" rather than "favorite" program topic; therefore, comments in response to this stem were analyzed separately for the quantitative analysis. However, the overall Chi-Square analysis of frequency of

responses made by consumers vs. nonconsumers could not be conducted because of an assumption violation (i.e., cell frequency < 5).

For responses to the item "Other Comments" which occurred on all three forms (*n* = 131), no difference was found when comparing consumer (17%, *n* = 18/105) and nonconsumer (23%, *n* = 113/493) response rates (χ^2 = 1.689; *p* = .194). Additionally, no significant differences were found for code use between the two groups, even when controlling for students (see Table 7).

Finally, there were no significant differences found between consumers (41%, *n* = 21/51) and nonconsumers (39%, *n* = 81/210) in overall response rates to the item found on Forms B and C (n = 261) that prompted for suggestions for program improvement (χ^2 = .101; *p* = .751), nor were there differences in their use of codes on any Chi-Square analyses that were viable (see Table 8).

Question 3: Were NAMI's program goals met?

As noted earlier, closed-ended items were selected that were judged to provide indirect evidence of Goal 1 (i.e., educating the public) and Goal 2 (i.e., recovery is possible). For these items, viewers were instructed to check statements with which they agreed, "as a result of seeing the IOOV presentation." With respect to the first goal of providing education about mental illness, few of the items were particularly informative. However, the majority of subjects agreed that mental illness is a physical illness "like diabetes," 67.9% (*n* = 366) (Forms A & B, *n* = 539). Similarly, as reported earlier, 84% (*n* = 453) strongly agreed that the information in the program was "useful," considered here to be suggestive of the program's educational quality. With respect to the second goal, 80% (*n* = 432) agreed that recovery was possible, again, "as a result of seeing the IOOV presentation."

Corroborating evidence from qualitative analysis shed additional light on the program's ability to attain goals. Recall that comments coded as "Found Educational" were coded as meeting Goal 1 and comments coded as "Feeling Encouraged," "Recovery is Possible," "Recovery is Individual," or "Recovery is Conditional" were coded as meeting Goal 2. Of those who commented in any way on any of the three forms (*n* = 437), 35% (*n* = 153) *spontaneously* wrote comments reflecting that they felt the program was educational (Goal 1) even though no item stem prompted for this. For instance, one viewer noted, "Presentation was awesome, great

learning experience" and another, "I felt I learned from [presenters] exposing me to their life circumstances (successes and challenges)." Another 45% (n = 195) spontaneously reported feeling that the program encouraged them or that they heard a recovery-oriented message (Goal 2). For example, one viewer commented, "It is nice to see how well some people recover from their mental illness." A consumer wrote, "By knowing that the 2 people teaching the class both have a mental illness and are managing their illness, gave me hope that I could manage my illness and lead a healthy life as well."

DISCUSSION

The results of this pilot study indicate that, similar to findings of prior research with students in controlled settings, IOOV appears to be quite successful in the field. Audiences found the program "interesting and easy to follow" (94%) as well as "useful" (95%), and generally wrote positive comments (86%) about their experience of IOOV. Qualitative findings broadened this picture, revealing a wide range of positive responses, from appreciating to feeling encouraged, from personally relating to feeling educated, from experiencing academic interest to finding inspiration; and all in response to a variety of the program's features. These findings demonstrating the program's overall success are important because prior findings were largely limited to university settings and samples, and therefore were less representative of the range of sites and populations the program typically serves. Additionally, prior studies focused on a limited range of response outcomes (e.g., stigma and education about mental illness). In contrast, the current study showed that viewers experienced the program in its entirety very positively.

In addition to offering a better understanding of the overall response of audiences in the field, this study was the first to examine how viewers responded to different program topics. Consumer and nonconsumer viewers alike most preferred hearing the Successes/Hopes/Dreams section and least preferred hearing the Treatment section, suggesting that audiences are perhaps most responsive to hope-engendering stories about mental illness. The plethora of negative images about mental illness found in the media (Thornton & Wahl, 1996) might explain the responsiveness of both consumers and nonconsumers in this sample to stories of success and hope. Why treatment was the least preferred is open to speculation. This section may be less likely to "pull" for personalized narratives from presenters than other sections, giving them less emotional appeal. Future research might examine what variables (e.g., presenter factors, content factors) would help explain these differences in preferences.

An additional contribution of the study was its examination of recommendations by viewers for program improvement. It is noteworthy that several comments identified quality

assurance issues (e.g., program format, presenter skills), suggesting the potential value of developing tools to ensure quality assurance (e.g., consistent use of program fidelity scale, refresher trainings).

A second key question was the generalizability of IOOV across participant groups, specifically contrasting consumers and nonconsumers; and further subdividing nonconsumers into students and nonstudents. Prior studies have not examined differential effects of the program. Although n's were small for a few analyses, making some Chi-Squares not viable (see Tables 5 - 8), for the most part, sample sizes were sufficient. Overall, the results revealed very few differences in how groups viewed or responded to the program. For example, there were no between-group differences in the closed-ended items, suggesting that the program is meeting the needs of its various audience members equitably (e.g., both groups felt the program was interesting and useful, and agreed that recovery is possible). Consumers and nonconsumers also tended to have similar preferences for specific program topics. For example, both groups most preferred the section entitled "Successes/Hopes/Dreams." The only differences that did emerge involved reasons groups gave for topic preferences. For instance, consumers tended to favor a topic (e.g., Dark Days) because of personally relating to it while nonconsumers—the majority of whom were students—favored topics because they found them encouraging, educational, and related to a message of recovery. However, when students were excluded from this analysis, only one difference remained: nonconsumers still reported favoring a topic because of finding it educational significantly more than consumers did. This finding may reflect a ceiling effect for consumers whereby greater previous exposure to recovery-oriented programs in or out of treatment settings, and of their own experiences living with mental illness, resulted in their being more educated about program topics. In other words, consumers may enter the program somewhat more informed through direct experiences than do nonconsumers. Additionally, the nonconsumer group, when students were included, showed significantly greater use of the codes "Feeling encouraged" and "Recovery is possible" in discussing favorite program topic, effects that disappeared when students were removed from this analysis. This suggests that students in particular may be less aware of the possibilities of recovery from mental illness, perhaps by virtue of their age/experience level. Too, the student populations used in previous studies were psychology and/or social work students whose reported feelings of encouragement may have reflected a particular interest in the topic and/or in pursuing related

fields. Future research might examine whether these differences are found in other samples; and if so, what variables might underlie differential effects of the program.

The study was also the first of its kind to begin to examine whether the program satisfied the two NAMI program goals for audience members. Importantly, there was suggestive evidence from both qualitative and quantitative analyses that the program is indeed satisfying the program goals of educating the public about mental illness and offering a hopeful message about recovery. As noted earlier, such messages are crucial for the public, as well as for consumers in recovery, to correct damaging misconceptions about the nature of the illnesses and about the prospects of recovery (Corrigan et al., 2004b; Corrigan et al., 2001; Holmes et al., 1999). However, the assessment of program goals was limited by the use of indirect measures derived from qualitative analyses and did not systematically assess for changes over time. Future research is needed to assess the program's goals for audience members more directly.

<div align="center">Limitations</div>

There were several limitations to the study. Although the program is offered in over 200 affiliates from 44 states across the country as cited earlier, only evaluations from one state office (NAMI IN) and one affiliate (NAMI Austin, TX) were represented, and these exhibited a fairly homogenous demographic sample. Also, the NAMI evaluations themselves were not designed with research in mind; several items were poorly worded and were therefore not particularly informative. For example, it is unclear whether the item, "In the past, I haven't felt encouraged regarding recovery from mental illness," refers to just prior to viewing IOOV (as intended), or anytime in the viewer's past. This makes interpretations as they relate to research questions somewhat problematic. Additionally, because variants of the original form contained altered, deleted or additional items, integrating all the available data in a way that effectively addressed research questions was an unwieldy task; and evidence was often indirect at best (i.e., taking viewers agreement that the program was "useful" as an indication that it was educational). The development and implementation of a standardized NAMI IOOV audience evaluation form, designed to evaluate specific program goals and adequately capture the program's wide-ranging effects, might serve to more effectively accomplish this task. Many analyses addressing research questions were drawn from open-ended items, limiting points of view to those who offered written comments. Moreover, audience members may have

been influenced by demand characteristics, feeling compelled to respond positively, especially since evaluations are usually administered by the IOOV presenters themselves. However, the large number of suggestions for program improvement, as well as some direct criticism, suggests that feedback was not entirely the result of social desirability influences. Interpretational difficulties also arise with some quantitative analyses of open-ended responses. Due to insufficient frequencies, several Chi-Square analyses comparing consumer and nonconsumer responses could not be conducted suggesting that existing differences may have gone unnoticed. Additionally, percentages for overall code use pose interpretational challenges in light of the fact that codes were developed without attention to item stem, and certain item stems on certain forms may have pulled for some codes more than others (e.g., "Favorite Program Topic" on Form A only). Therefore, caution must be exercised in drawing conclusions from the reported percentages. Finally, though an attempt was made to develop codes without a priori coding categories, a degree of coding bias may have arisen as one of the three coders (the principal investigator) had a priori knowledge of program goals through previous affiliation with NAMI.

The study's major strengths were its ecological validity and large sample size which enhanced power. Moreover, the fact that viewers' feedback was given in natural settings with no interference from researchers lent external validity to the design.

Conclusions

The results of this pilot study support the conclusion that IOOV is a recovery-oriented presentation that is both educational and hope-inspiring. Future research is needed to more effectively capture the program's wide-ranging and potentially differential effects on viewers. However, taken together with results from prior studies, there is increasing evidence that *In Our Own Voice* fills a much-needed gap in recovery-oriented, educational programming accessible to the public and available for the potential benefit of all.

TABLES

Table 1

Variables Selected for Analysis from 2009 IOOV Archival Evaluations.

		Form A (*n* = 338)	Form B (*n* = 201)	Form C (*n* = 60)	FORMAT/FORM (A, B, C)	SPSS VARIABLES
1	AUDIENCE ROLE	X	X	X	9-Item Checklist	dummy coded: 1 = yes; 0 =no
2	ETHNICITY	X	X		Fill In (A); 7-Item Checklist (B)	Each option assigned number: 1 - 7
3	RELIGION	X	X		Fill In (A); 8-Item Checklist (B)	Each option assigned number: 1 - 8
4	PREVIOUS NAMI AWARENESS	X	X	X	Yes/No Option	dummy coded: 1 = yes; 0 =no
5	PREVIOUS IOOV EXPOSURE	X	X		Yes/No Option	dummy coded: 1 = yes; 0 =no
6	"As a result of the presentation…" SEE RECOVERY AS POSSIBLE	X	X		Check Option	dummy coded: 1 = yes; 0 =no
7	"As a result of the presentation…" SEE MI AS A PHYSICAL ILLNESS	X	X		Check Option	dummy coded: 1 = yes; 0 =no
8	"As a result of the presentation…"COMFORTABLE WORKING WITH PERSON W/MENTAL ILLNESS	X	X		Check Option	dummy coded: 1 = yes; 0 =no
9	I FOUND THE INFORMATION THE PRESENTERS SHARED TO BE USEFUL	X	X		5-Item Likert	strongly disagree = 1; strongly agree = 5
10	I FELT COMFORTABLE ASKING QUESTIONS OR GOING INTO DEEPER DISCUSSION	X	X		5-Item Likert	strongly disagree = 1; strongly agree = 5
11	THE PRESENTETRS TOLD THEIR STORIES IN A WAY THAT WAS INTERESTING AND EASY TO FOLLOW	X			5-Item Likert	strongly disagree = 1; strongly agree = 5
12	FAVORITE (FORM A) TOPIC OF PRESENTATION (e.g., Dark Days vs. Acceptance)	X			5-Item Checklist	dummy coded: 1 = yes; 0 =no
13	PROMPT FOR ITEM 12 (above): "BECAUSE…"	X		X**	Open Response	Transcribed verbatim
14	PROMPT:" If I could change one thing about this program it would be…"		X	X	Open Response	Transcribed verbatim
15	PROMPT: "OTHER COMMENTS"	X	X	X	Open Response	Transcribed verbatim

MI = severe mental illness; IOOV = *In Our Own Voice*; NAMI = National Alliance on Mental Illness; SPSS = Statistical Package for the Social Sciences **
Item stem for this is "Most Helpful" instead of "Favorite" program topic

Table 2

Quantitative and Qualitative Analyses for Research Questions

Research Question	Quantitative Analysis	Qualitative Analysis
1) What are audience members' general responses to the program as it occurs in natural settings?	• Means, SDs of closed ended items • Frequency counts of codes from open-ended response items • T-tests comparing mean scores and "neutral" (e.g.,3 on 5-pt Likert scale) scores of closed-ended items	Coding for • Coding for themes across all comments irrespective of item stem • comment valence (i.e., positive, negative, neutral)
2) Is there a difference between consumer and nonconsumer responses?	• frequency counts of closed-ended items • t-tests of continuous closed-ended items • Chi square analyses of dichotomous closed ended items, and of code use for all open-ended responses.	
3) Does the program satisfy NAMI's two audience goals by • Goal 1: providing quality education about mental illness from those who have been there • Goal 2: focusing on recovery and the message of hope	Frequency counts for • related closed-ended items • comments coded for Goal 1 or Goal 2 (see qualitative coding analysis for this item)	Codings for • Goal 1: all comments coded as "Found Educational" • Goal 2: Comments coded as any of the following: "Feeling Encouraged," "Recovery is Possible," "Recovery is Individual," "Recovery is Conditional."

Table 3

Codes and Examplars for Qualitative Analysis of Audience Comments

Code	Examplar	N	kappa
Feeling Encouraged	By knowing that the two people teaching the class both have a mental illness and are managing their illnesses, gave me hope that I could manage my illness and lead a healthy life as well.	105	.969
Found Interesting/Entertaining	The medication aspect is most interesting to me.	44	.931
Found Educational	I understand now that medication accompanied with psychotherapy can help those that have those illnesses.	148	.929
Appreciating	Thank you for very illuminating presentations, told in memorable ways.	191	.907
Personally Relating	It was nice to hear people share their stories with us who also have mental illnesses.	66	.942
Critiquing	Both presenters are wonderful but both have bipolar-- maybe two different illnesses.	71	.90
Generalizing/Stating a Belief	This, I believe, is the most powerful section. Here, you can help other people identify with the stories. If someone is struggling, and they identify with a story, they may seek help.	56	.863
Uncodable (Domain 1)	examples given	22	.850
Illness Experience	Very rarely do you hear the point of view of someone with a disability. Interesting.	102	.906
Recovery is Possible	It helped me to see that there is success at the end of the tunnel.	138	.978
Recovery is Individual	It helped me to see how something very small to one person can really start another down the road to recovery.	17	.941
Recovery is Conditional	Until you accept, you cannot move forward.+	26	.952
Practical Information	"At times in my work as a nurse, I am very uncomfortable working with the adult psych patients because I am not sure how to best help because I don't fully understand the sickness or disease process. I love learning and understanding. Helping me help them!	73	.833
Program Format	The whole process comes together with each piece— very interesting!	182	1.0
Presenter Qualities	The presenters were truthful, honest, open, and forthcoming.	80	1.0
Uncodable (Domain 2)	I was there to learn.	44	.847

Table 4

Comparisons on Closed-Ended Items Between Consumer and Nonconsumer Viewers (Forms A and B)

Closed-ended Items (n = 539)	Consumers (n = 80)		Nonconsumers (n = 459)		t-test	Chi-Square
	n	%	n	%		
*Interesting and easy to follow (n=338)	52	96	283	99	t(333) = -.301; p = .764	--
Comfortable asking questions of presenters	70	88	449	98	t(517) = -1.442; p = .150	--
Program information useful	76	95	456	99	t(530) = -1.387; p = .166	--
Post-presentation: view recovery as possible	66	83	366	80	--	χ^2= .805; p = .370
Post-presentation: view SMI as a physical illness	57	71	309	67	--	χ^2= 1.183; p = .277
Post-presentation: view of comfort working w/ individuals with mental illness	60	75	375	82	--	χ^2= .677; p = .410
*Favorite Topic (n=338)	(n = 54)		(n = 284)			
Dark Days	16	30	98	35	--	χ^2= .411; p = .522
Acceptance	16	30	62	22	--	χ^2= 1.702; p = .192
Treatment	10	19	47	17	--	χ^2= .157; p = .692

Table 5

Explanations of Favorite Program Topics (Form A only): Comparisons between Consumer and Nonconsumer Responders.

Code Category	Consumers (n =54)		Nonconsumers (*n* = 284)		Chi-Square
DOMAIN 1: Affective/Attitudinal	n	%	n	%	
Feeling Encouraged	7	13	72	25	χ^2= 3.899; p = .049*
Found Interesting/Entertaining	2	4	36	13	χ^2= 3.660; p = .056
Found Educational	8	15	81	29	χ^2= 4.394; p = .036*
Appreciating	10	19	66	12	χ^2= .580; p = .446
Personally Relating	16	30	22	8	χ^2= 21.774; p = .000**
Critiquing	<5	--	<5	--	--
Generalizing/Stating a Belief	7	13	32	11	χ^2= .128; p = .721
Uncodable	<5	--	<5	--	--
DOMAIN 2: Program Elements					
Illness Experiences	13	24	71	25	χ^2= .021; p = .885
Recovery is Possible	13	24	108	38	χ^2= 4.401; p = .036*
Recovery is Individual	<5	--	9	3	--
Recovery is Conditional	<5	--	19	7	--
Practical Information	<5	7	42	15	--
Program Format	6	11	34	12	χ^2= .032; p = .858
Presenter Qualities	<5	--	14	5	--
Uncodable	<5	--	<5	--	--

 *p < .01; **p < .001

 --Chi-Square not calculated due to low frequency count (i.e., < 5 per cell)

Table 6

Explanations of Favorite Program Topics (Form A only): Comparisons between Consumer and

Nonconsumer Responders when student subjects are removed.

Code Category	Consumers (n =46)		Nonstudent nonconsumers (*n* = 45)		Chi-Square
Domain 1	n	%	n	%	
Feeling Encouraged	5	11	7	16	χ²= .436; p = .509
Found Interesting/Entertaining	<5	--	5	11	--
Found Educational	7	15	17	38	χ²= 4.330 ; p = .037*
Appreciating	8	17	10	22	χ²= .335; p = .563
Personally Relating	16	35	<5	--	--
Critiquing	<5	--	<5	--	--
Generalizing/Stating a Belief	7	15	<5	--	--
Uncodable	<5	--	<5	--	--
Domain 2					
Illness Experiences	11	24	13	29	χ²= .290; p = .590
Recovery is Possible	12	26	5	11	χ²= 3.358; p = .067
Recovery is Individual	<5	--	<5	--	--
Recovery is Conditional	<5	--	<5	--	--
Practical Information	<5	--	11	24	--
Program Format	6	13	7	16	--
Presenter Qualities	5	11	<5	--	--
Uncodable	<5	--	<5	--	--

p < .01*; p < .001**

--Chi-Square not calculated due to low frequency count (i.e., < 5 per cell)

Table 7

"Other Comments": Comparisons between Consumer and Nonconsumer Responders

Code Category	Consumers (n =18)		nonconsumers (*n* = 113)		Chi-Square
Domain 1	n	%	n	%	
Feeling Encouraged	<5	--	12	11	--
Found Interesting/Entertaining	<5	--	<5	--	--
Found Educational	5	28	35	31	χ² = .075; p = .785
Appreciating	14	78	80	71	χ² = .373; p = .541
Personally Relating	13	72	<5	--	--
Critiquing	<5	--	8	7	--
Generalizing/Stating a Belief	<5	--	15	13	--
Uncodable	<5	--	<5	--	--
Domain 2					
Illness Experiences	<5	--	20	18	--
Recovery is Possible	<5	--	13	12	--
Recovery is Individual	<5	--	<5	--	--
Recovery is Conditional	<5	--	<5	--	--
Practical Information	<5	--	14	12	--
Program Format	9	50	59	52	χ² = .030; p = .861
Presenter Qualities	8	44	46	41	χ² =.003; p = .954
Uncodable	<5	--	5	4	--

--Chi-Square not permissible due to low frequency count (i.e., < 5 per cell)

Table 8

Suggestions for Program Improvement (Form B & C only): Comparisons between Consumer and Nonconsumer Responders.

Code Category	Consumers (n =21)		Nonconsumers (*n* = 81)		Chi-Square
DOMAIN 1: Affective/Attitudinal	n	%	n	%	
Feeling Encouraged	<5	--	<5	--	--
Found Interesting/Entertaining	<5	--	<5	--	--
Found Educational	<5	--	7	9	--
Appreciating	<5	--	33	41	--
Personally Relating	<5	--	<5	--	--
Critiquing	13	65	50	62	X^2 = .000; *p* = .988
Generalizing/Stating a Belief	<5	--	<5	--	--
Uncodable	<5	--	<5	--	--
DOMAIN 2: Program Elements					
Illness Experiences	<5	--	<5	--	--
Recovery is Possible	<5	--	<5	--	--
Recovery is Individual	<5	--	<5	--	--
Recovery is Conditional	<5	--	<5	--	--
Practical Information	<5	--	<5	--	--
Program Format	<5	--	18	22	--
Presenter Qualities	<5	--	11	14	--
Uncodable	<5	--	<5	--	--

*p < .01; **p < .001

--Chi-Square not calculated due to low frequency count (i.e., < 5 per cell)

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APPENDICES

Appendix A

NAMI In Our Own Voice
National Alliance on Mental Illness

AUDIENCE EVALUATION

**Please fill out both sides of this form.

Date: 02/24/2009   Name of Facility: PORTER COUNTY SHERIFF'S DEPARTMENT.

I am a: (check all that apply)

__Consumer ✓Family Member __Social Worker __Health Provider __Educator
__Student ✓Law Enforcement __Service Administrator __Other_____

Prior to this presentation, were you aware of NAMI? ___ YES ✓ NO

Have you seen an IOOV presentation before? ___ YES ✓ NO

As a result of seeing the IOOV presentation, please place a check in <u>all lines that apply</u> for the statements below. If a statement does not apply, don't mark that line.

✓ I see recovery as a real possibility
✓ In the past, I haven't felt encouraged regarding recovery from mental illness
✓ A mental illness is a physical illness, like diabetes
✓ In the past, I haven't felt that mental illness is a physical illness
✓ I would feel comfortable working with someone who has a mental illness
✓ In the past, I wouldn't have been very comfortable with the idea of working with someone who has a mental illness

Please write your number rating next to each statement below regarding the IOOV presentation and presenters:

1	2	3	4	5
Disagree	Somewhat Disagree	Unsure	Somewhat Agree	Agree

4 I found the information the presenters shared to be useful

5 I felt comfortable asking questions or going into deeper discussion with the presenters

4 The presenters told their stories in a way that was interesting and easy to follow

My favorite section of the presentation was:

__ Dark Days   __Acceptance __Treatment __Coping ✓ Successes, Hopes, Dreams

Because:_____
_____
_____

(OVER)

Other Comments:

_____ (
_____
_____

*In order for us to find out more about the diverse communities we are reaching with the IOOV presentations, we would like to collect some demographic information. If you are comfortable, we would greatly appreciate your responses to the following. These questions are completely optional:

Ethnicity: WHITE _____
Religion: CHRISTIAN . _____

As a result of listening to this presentation, I would like NAMI to contact me about:
__Becoming a NAMI member.
__Becoming an IOOV Presenter (must be a person living with mental illness)
__Receiving NAMI and/or related mental health events and news items via Email.
__Volunteering with my state/ local NAMI.
__Participating in the Annual NAMI Walk for the Mind of America.
__Contributing financially to my state/ local NAMI.

If you would like us to contact you, please provide the following information:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____ (
Email: _____ Phone: _____

Organization you know that might benefit from this presentation:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Contact Name: _____ Phone: _____
Email: _____

Appendix B

AMS.

⊚ nami In Our Own Voice

National Alliance on Mental Illness

AUDIENCE EVALUATION

Please fill out both sides of form. If you are comfortable, please feel free to share your ethnicity and religious beliefs, as this helps us to get an idea of the diverse range of audiences we are reaching in these presentations.

Date: 3/27/09

I am a: (check all that apply)

✗Consumer _Family Member _Social Worker _Health Provider _Educator
_Student _Law Enforcement _Service Administrator _Other_____

My ethnicity is: (OPTIONAL)

__African American __Caucasian __Latino(a) __Native American __Asian __Pacific Islander __Other: _____

My religious beliefs follow: (OPTIONAL)

__Jewish __Christian __Buddhist __Muslim __Agnostic __Atheist __Not practicing __Other:_____

Have you seen an IOOV presentation before?   ___ YES   ✗NO

This presentation was given in: (please place a check in front of your selection)

✗Mental Health Treatment Setting _Civic Group __Business/Office _Community Meeting Place _General Hospital
_Club House/ Peer Run Organization _Consumer/Day Program _Court/Legal Office _F2F Class _Group Home
_Faith Organization _Political Organization _School (K-12) _Library _School, Medical _School, Social Work
_College/ University _Law Enforcement Setting _Inmate Facility _Private Residence _Other _____

Please rate the extent of your agreement or disagreement with the statements below regarding the IOOV presentation and presenters:

1	2	3	4	5
Disagree	Somewhat Disagree	Unsure	Somewhat Agree	Agree

5 I found the information the presenters shared to be useful

5 What I learned in this presentation was relevant to my work/ focus area

3 The presenters went into the appropriate amount of depth on each topic—If not, please clarify:
        *Too much? ____   *Not enough? ____
        *Was there a specific topic that comes to mind? _____

5 I felt comfortable asking questions or going into deeper discussion with the presenters

5 The presenters told their stories in a way that was interesting

3 The presenters told their stories in a way that was clear/ easy to follow

__I think that the presenters have accomplished significant achievements in their lives

(OVER)

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As a result of seeing the IOOV presentation, please check all boxes that apply for the statements below, moving from left to right (present to past). If a statement does not apply, don't mark that box.

PRESENT FEELINGS	PAST FEELINGS
__I see recovery as a real possibility	__In the past, I haven't felt encouraged regarding recovery from mental illness
__A mental illness is a physical illness, like diabetes	__In the past, I haven't felt that mental illness is a physical illness
__I am more fearful of people with mental illness than those without mental illness	__In the past, I have been more fearful of people with mental illness than those without
__I feel comfortable discussing the topic of mental illness	__In the past, I haven't been comfortable discussing the topic of mental illness
__I feel that I have little in common with people who have mental illnesses	__In the past, I have usually felt that I have little in common with people who have mental illnesses
__I would feel comfortable renting a room to someone who is in recovery from their mental illness	__In the past, I wouldn't have felt very comfortable with renting a room to someone who is in recovery from their mental illness
__I would feel comfortable working with someone who has a mental illness	__In the past, I wouldn't have been very comfortable with the idea of working with someone who has a mental illness

If I could change one thing about the presentation it would be:

_NO_

Other Comments:

Organization you know that might benefit from this presentation:

Name:
Address:
Contact Name: Phone:
Email:

Prior to this presentation, were you aware of NAMI? ___ YES   X NO

As a result of listening to this presentation, I would like NAMI to contact me about:
1. Becoming a NAMI member.
2. Becoming an IOOV Presenter (must be a person living with mental illness)
3. Receiving NAMI and/or related mental health events and news items via Email. Email address:_____
4. Volunteering with my state/ local NAMI.
4. Participating in the Annual NAMI Walk for the Mind of America.
5. Contributing financially to my state/ local NAMI.

Please provide the following information so we may stay in touch with you:

Name: ANONYMOUS
Address:
Email: Phone:

Appendix C

NAMI
National Alliance on Mental Illness
In Our Own Voice

Audience Evaluation Form

Please fill out both sides of form   Date: _____

I am a:

_Consumer _Family Member _Social Worker _Physician/nurse _Educator
✓Student _Law Enforcement _Service Administrator _Other _____

Please rate this presentation by choosing one answer on **each** line:

✓Great information _Some good information _Very little useful information _No useful information
✓Very encouraging _Somewhat encouraging _Neutral reaction _Discouraging _Very discouraging
✓Very relevant to my work _Somewhat relevant to my work _Not relevant to my work
✓Excellent depth & scope _Okay depth & scope _Overwhelming _Not what I was looking for

This presentation was given in:

✓Mental Health Treatment Setting   _Civic/Community Group   _Faith Organization
_Political Meeting   _School   _Inmate Facility   _Other _____

How do you view recovery now that you've seen In Our Own Voice: Living with Mental Illness?
Check all that apply:

_I have always believed recovery is possible
✓I see recovery as a real option for the first time
✓I see myself/people with mental illness in a new light
✓I am encouraged not to give up hope for recovery even in the face of obstacles
_I wish I felt encouraged, but I don't
✓I realize the recovery process is unique to each person

The portion of the presentation I found most helpful was:

_Dark Days ✓Acceptance _Treatment ✓Coping ✓Success, Hopes, and Dreams

It was helpful because: _made you to think of things_
the best out ourselves things three

If I could change one thing about the presentation it would be: _____

--- OVER --

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Organization you know that might benefit from this presentation:

Name: _____
Street Address: _____
City: _____ ZIP _____ Phone: _____
Contact Name: _____

If you are a person with a mental illness and would be interested in being a presenter of In Our Own Voice: Living with Mental Illness, please provide your contact information below:

Name: _____
Street Address: _____
City _____ ZIP _____ Phone: _____
Email Address: _____

Other Comments:

_____
_____
_____
_____
_____
_____

Prior to this presentation, were you aware of NAMI? ___ YES ___ NO

As a result of listening to this presentation, I would like NAMI to contact me about:
1. Becoming a NAMI member.
2. Receiving NAMI and/or related mental health events and news items via Email. Email address:_____
3. Volunteering with NAMI.
4. Participating in the Annual NAMI Walk for the Mind of America.
5. Contributing Financially to NAMI.

Please provide the following information so we may stay in touch with you:

Name: _____
Street Address: _____
City: _____ ZIP: _____ Phone: _____
Email Address: _____

Appendix D

Study 1 Codebook
DOMAIN 1: RESPONSE

Remember: *you need to have at least one code for each of the 2 domains, even if it is uncodable.*

1) **Feeling Encouraged:** by definition, to feel "hope, courage, or confidence; heartened". This is if they specifically mentioned being encouraged, feeling inspired, or hopeful, or motivated (or if they believe others felt this way, or would feel this way from the presentation). (e.g., "it gave me hope," "It gives hope to those with mental illness." Also, may include "it's good/nice/great to see/hear if context suggests they feel "heartened." If they are evaluating, and just say that they "like" something, it would be coded under "appreciating".

2) **Found Interesting/entertaining:** i.e., reference to finding something interesting w/o much affect. This may be limited to exposure, e.g., "It was interesting to hear about different treatments."

3) **Found Educational:** refers to person or others gaining information or learning something new, e.g., "It gave me a new perspective on mental illness"), new insight, new understanding, etc., *or* that the information was educational for others, e.g., "it showed/proves that it's possible to recover from mental illness." *Might* include "It was helpful to see/hear…" *if context suggests they learned something; if unclear though, uncodable.*

4) **Appreciating:** This refers to expressions of gratitude (e.g., "thank you"), respect, value, appreciation, or supportive statements and general compliments (e.g., great job!). Also, would be appropriate if they mention liking the positive aspects of program, or if they start a sentence with things like, "it was great/good to see/hear…," "it's nice to see/hear…," "I liked…" since these are evaluative statements (unless context suggests they feel encouraged/heartened). This can also be if they make a statement that is their own opinion, "e.g., I feel this is the most important…" (different than "Stating a General Belief" b/c this is personal, not global).

5) **Personally Relating:** mentions specifically that they can relate this experience to themselves (personally or professionally), a family member, a provider, clients, someone they know, *or generally as a human being.* (e.g., "everybody struggles with difficult days.") Relating in terms of past or present personal or professional experiences.

6) **Critiquing:** This includes making suggestions or giving critical feedback. May be (but is not necessarily) in response to "If I could change one thing about the program…" If they write, "nothing" in response to this prompt, code as "appreciating."

7) **Generalizing/Stating a Belief:** This is when an individual is making a general statement that has a global feel to it (e.g., "No one watches the news for happy stories" or "This is the most important part of the program.") as if they are stating a fact.

8) **Uncodable:** put if cannot easily put into other code from this domain, or if would need to infer (or really "stretch" to put in another code).

Study 1 Codebook
DOMAIN 2: MESSAGE/CONTENT

1) **Illness Experience:** This refers to what the presenters or people with SMI share about their experiences in living with mental illness. Specifically, includes their own symptoms, experiences, struggles, and challenges. Also, includes references to presenters' personal story(ies), e.g., "It was good to hear real stories of people with SMI" or "They talked about the difficulties they had with accepting their illnesses." *Mention of successes would be coded as "Recovery is possible."* Mention of their full story, from dark days through successes would be coded as both "Illness Experiences" and "Recovery is possible."

2) **Recovery is Possible:** this refers to ideas connected with recovery (e.g., successes) and the idea that presenters, or others with SMI, *can or did* come through their illness, are actively accepting and coping with their illness, and have hopes and dreams; understanding that recovery, or successes related to recovery, is/are possible: i.e., people get better, people overcome obstacles and achieve success in overcoming SMI, or have positive outcomes despite obstacles; also includes mention of seeing a "light at the end of the tunnel."

3) **Recovery is Individual:** understanding that recovery is different for different people; what works for one person may or may not work for another. Includes comments referring to idea that different things work for different people.

4) **Recovery is Conditional:** when there is a suggestion of a condition (e.g., treatment) for recovery, i.e., "if…, then…." Statements about recovery, e.g., "If one accepts his illness, he can get better", or mentions necessary/important conditions for recovery, or that "recovery is possible following treatment" or "following acceptance"

5) **Practical Information:** Practical knowledge/information for audience or others (not presenters) on a number of topics including illness information ("it was interesting to hear about bipolar disorder"), treatment information ("I learned about different types of treatments available"), coping skills information ("I will use some of these coping skills."). Information can be applied to themselves or others, personally or professionally. Includes references to learning that there are a *variety* of strategies available. Includes comments from those not yet in the field (i.e., students) who feel they've learned something they can apply later.

6) **Program Format:** This refers to the program itself as a whole, or to elements of the program (e.g., Q and A periods), length of program, aspects of the program that should be added, are missing, or that the audience members feel are important.

7) **Qualities of Presenters:** This refers to when audience members are referring to *characteristics or traits of presenters as evidenced during the presentation* (e.g., compliments "honest, courageous" or criticism, "naïve") or if they comment on the overall work of the presenters (e.g., "Great job!" or "He did a great job presenting the information." Or "You didn't make enough eye contact.")

8) **Uncodable:** put if cannot easily put into other code from this domain, or if would need to infer to put in another code

Appendix E

Evaluating Recovery Expectations in Consumer Audience Members of a Consumer-Delivered
Recovery Program Entitled *In Our Own Voice*.

Madeline Brennan

Indiana University Purdue University Indianapolis

ABSTRACT

Hope is frequently deemed a crucial element of recovery by both consumers and researchers in the field. Consumer advocates submit that peer role models, integrated into mental health services, provide a unique and potentially effective means by which to inspire hope in recovering consumers. Research in the fields of attitude change, persuasion, social identity, and social comparison, suggest that the use of role models to engender hope has theoretical and empirical support as well as intuitive appeal. This study examined the ability of a consumer-delivered educational outreach program—NAMI's *In Our Own Voice*—to inspire hope for recovery in consumer viewers. Questions asked were 1) do consumers feel more hopeful about their own recovery prospects after viewing the program? 2) Do levels of perceived similarity and psychological closeness predict an increase in hope for recovery? Results suggested that the program does indeed increase consumers' recovery expectations: however, the role of perceived similarity and/or psychological closeness in predicting that change was not supported.

INTRODUCTION

Recovery from severe mental illness (SMI) can be a difficult challenge for sufferers. For many, meaningful recovery seems a dimly hoped-for prospect, even as the current empirical evidence demonstrates the genuine feasibility of it. Given this state of affairs, there is strong consensus for the need to provide services which instill a sense of hope to those in recovery (Anthony, Cohen, & Farkas, 1990; Corrigan, Salzer, Ralph, Sangster, & Keck, 2004; Davidson, O'Connell, Tondora, Lawless, & Evans, 2005; Deegan, 1988; Fisher & Chamberlin, 2005; Hatfield & Lefley, 1993; Jacobson & Curtis, 2000; Jacobson & Greenley, 2001; Mead & Copeland, 2000; Smith, 2000; Young & Ensing, 1999). One helpful hope-inspiring strategy is exposure to successful peer role models (Davidson, et al., 2006; Deegan, 2005; Drake, et al., 2005; Fisher & Chamberlin, 2005; Kirkpatrick, et al., 1995; McCann, 2002).

Hope

Defining and measuring an abstract concept such as hope is challenging at best in scientific research. In one prominent model, hope is comprised of 3 distinct elements: goals, envisioning pathways to the goals, and belief in one's ability to pursue the goals (Snyder et al., 1991). Hope is defined in this model as involving 2 factors: (1) agency (belief in one's capacity to initiate and sustain actions) and (2) pathways (belief in one's capacity to generate routes). Other researchers view hope as multi-dimensional (Herth, 1991; Miller & Powers, 1988). A review of studies of hope in those with schizophrenia showed that most authors defined it simply as positive expectations of the future (Kylmä, Juvakka, Nikkonen, Korhonen, & Isohanni, 2006).

Peer Role Models and Hope

Evidence of the value of integrating peers into recovery-oriented programs is beginning to accumulate (Cook et al., 2009; Davidson, et al., 2006; Felton, Stastny, Shern, & Blanch, 1995; Jacobson & Greenley, 2001; Lucksted, McNulty, Brayboy, & Forbes, 2009; Paulson et al., 1999). Positive outcomes include improved psychosocial functioning, increased security and self-

esteem, and enhanced knowledge of early warning signs and coping skills. Additionally, several researchers have suggested that exposure to recovering role models can increase hope in those with mental illness (Davidson, et al., 2006; Deegan, 2005; Drake, et al., 2005; Fisher & Chamberlin, 2005). In a recent review of the literature on hope and schizophrenia, "receiving direct knowledge of successful peers" was cited as inspiring hope in consumers with schizophrenia (Kylmä, et al., 2006, p. 659), the great value of which is stressed by consumer-provider recovery leaders (Deegan, 1988; Frese & Davis, 1997).

Though intuitively appealing, it is important to ask whether or not there is a theoretical support for the notion that consumer role-models can positively influence consumers in recovery.

Theories of Attitudinal Change and Source Factors

Message sources have long been identified as sources of influence in persuasive contexts (Hovland, Janis, & Kelley, 1953; Hovland, Lumsdaine, & Sheffield, 1949)More recent single process models suggest that a single processing system with varying levels of complexity is more likely, and that source factors (e.g., source credibility) can lead to lasting attitudinal change (Albarracin, 2006).

In support of the potential salient influence of a message source, social identity theorists suggest that individuals will have a positive bias towards information presented by in-group member sources, a phenomenon known as in-group favoritism (Jackson, Sullivan, Harnish, & Hodge, 1996; Sherman, Klein, Laskey, & Wyer, 1998). This bias is theorized to serve a self-enhancement role since part of our identities is derived from the groups with which we identify (Turner, Brown, & Tajfel, 1979; Turner, Hogg, Oakes, Reicher, & Wetherell, 1987). Studies by Mackie and colleagues (1992; 1990) confirm that systematic processing of persuasive messages can occur when a message source is an ingroup member. On the other hand, this effect is not necessarily universal. For individuals of stigmatized groups, effects of ingroup favoritism may be lessened by internalized stigma based on cultural perceptions (Dasgupta, 2004).

Social comparison theory may further our understanding of the potential impact in-group message sources can play in attitudinal change. The earliest theory of social comparison suggested that individuals will make comparisons to similar others who are better (upward comparisons) or worse off (downward comparisons) than themselves for the purposes of self-

evaluation (Festinger, 1954). Wills (1987) argued that threatened individuals typically perform downward comparisons for self-enhancement purposes, and there is evidence to support this (Gibbons & Gerrard, 1991; Taylor, Wood, & Lichtman, 1983; Wood & VanderZee, 1997). However, research among cancer patients suggests upward comparisons can also lead to positive effects (Taylor and Lobel, 1989). Presumably, better-functioning peers offer hope and inspiration through their examples, and subsequent research has supported this (Buunk, Collins, Taylor, VanYperen, & Dakof, 1990; Collins, 1996; Lockwood & Kunda, 1997; Major, Testa, & Blysma, 1991; Mussweiler & Strack, 2000). An explanation for the unpredictable nature of social comparisons is that evaluating yourself against someone who is better off than you tells you (a) that you are not as well off as others (which might make you feel worse) and (b) that it is possible for you to improve (which might make you feel better) (Buunk, et al., 1990).

Adding to our understanding of the effects of social comparisons is Upward Assimilation Theory which suggests that assimilation (i.e., attitudinal agreement) results from a comparer feeling *mostly similar* to a comparison target; contrast results from a comparer feeling *mostly different* from the comparison target (Collins, 2000; Mussweiler, 2001; Suls, Martin, & Wheeler, 2002). In the first formal model of upward assimilation theory, Collins suggests that people are more likely to seek similarities first rather than differences in situations of social comparison; and it is their subsequent perceptions of similarity with the comparison target that potentially lead to assimilation (Collins, 1996, 2000). In a related manner, Buunk and colleagues (Buunk, Schaufeli, & Ybema, 1994) found that in in-group situations specifically, where similarity is clearly salient, the comparison target's position is apt to reflect one's own potential position. In the Selective Accessibility (SA) model, Mussweiler and Strack (2000) suggest that what determines whether assimilation or contrast will occur in social comparisons is what information is most easily accessible in the mind of the comparer: similarities or differences. Psychological closeness has been identified as both a moderator (Pelham & Wachsmuth, 1995) (i.e., by strengthening the relationship) and a mediator of accessibility (Brown et al. 1992).

In Our Own Voice

Consumer-delivered programs, such as *In Our Own Voice* (IOOV), were designed to offer hope of recovery to audiences by allowing them to hear presenters' personal stories of recovery (NAMI, 2010). Developed by the National Alliance on Mental Illness (NAMI), this free 90-minute

multi-media educational outreach program is presented by two trained consumers to audience groups in a variety of settings across. Topics discussed include Dark Days; Acceptance; Treatment; Coping Strategies; and Successes, Hopes and Dreams. Presenters discuss the five topics with corresponding portions of an accompanying DVD showing 9 recovering consumers representing a range of demographics. Audience participation is encouraged throughout.

Four studies have examined IOOV's ability to reduce stigma in controlled university settings and have demonstrated positive results (Corrigan, et al., 2010; Pittman, et al., 2010; Rusch, 2008; Wood & Wahl, 2006; Wood, 2004).

This study will seek to understand the processes that underlie the program success and will address whether or not consumers program viewers will assimilate with presenters' recovery-oriented viewpoints, and whether perceived similarity and psychological closeness, as suggested by research in assimilation theory, will help explain this outcome. Research hypotheses are as follows:

•   HYPOTHESIS 1: There will be an overall increase in recovery expectations in consumers after viewing the program;

•   HYPOTHESIS 2: Increased perceived level of similarity between consumer subjects and IOOV presenters will predict an increase in recovery expectations for upward comparers;

•   HYPOTHESIS 3: Psychological closeness will moderate the relationship between perceived similarity and recovery expectations such that upward comparers who report a higher level of psychological closeness will show a stronger relationship between perceived similarity and positive recovery expectations.

•   HYPOTHESIS 4: The relationship between perceived similarity and increased recovery expectations will be mediated by degree of perceived psychological closeness in upward comparers.

For the current study, assimilation resulting from upward comparison was defined using Festinger's description "a tendency to change one's own position so as to move closer to the group" (Festinger, 1954, p. 126). Thus an increase in consumer audience members' expectations of recovery will be deemed evidence of assimilation.

METHOD

Participants

In collaboration with NAMI National, NAMI affiliates across the country that offered IOOV to consumer audiences were invited to participate in data collection via an email from the NAMI National IOOV Director. Interested affiliate staff/volunteers contacted the researcher. Exclusion criteria included presentations scheduled to patient groups at inpatient psychiatric facilities (to simplify the IRB approval process). In addition, participating NAMI research assistants could not collect data at their own presentations. The research assistants received telephone training on the research protocol, participated in ongoing consultation as needed, and were given a $25.00 stipend per data collection. Data was collected at previously scheduled IOOV presentations at approved venues with high consumer participation (e.g., day programs, consumer support groups).

Measures

Data was collected at the participant and program levels. At the participant level, data was collected from subjects using the following instruments: (1) a 16-item Recovery Expectations (REX) Scale, (2) a 2-item Similarity Scale (author-generated), (3) a 2-item Psychological Closeness Scale (revised from Inclusion of Other in Self Scale (IOS)), (4) a 6-item Snyder State-level Hope Scale, (5) a 6-item Self-Stigma Scale (revised from Public Regard items of the Multidimensional Inventory of Black Identity (MIBI) Scale), and (6) 11 author-generated miscellaneous questions including demographic items and those related to research hypotheses. At the program level, an IOOV 12-item fidelity scale (see Appendix X) was completed at the end of each presentation by the research assistant. This scale was developed by the researcher in cooperation with NAMI National to assess adherence to the IOOV program elements.

Recovery Expectations (REX) Scale

The Recovery Expectations scale was developed to capture hope change specific to recovery that might result from viewing an IOOV program. The REX was adapted from the Consumer Optimism Scale, which was designed to assess providers' optimism regarding their consumer clients in various stages of recovery.

The 16-item Consumer Optimism Scale (see Appendix F) (Salyers, Tsai, & Stultz, 2007) was an extension and adaptation of Grusky's original 7-item scale (Grusky, Tierney, & Spanish, 1990). Provider subjects are instructed to think about consumers they are currently working with and to respond to statements related to their potential recovery on a five-point Likert-type scale. Six of Grusky's seven items were included and 10 items relating to medication use, drug and alcohol use, housing, and competitive employment were added to broaden domains associated with recovery (Tsai et al., 2011). Initial examination of the reliability of the 16-item scale found excellent internal consistency (α = 0.91) and test– retest reliability over a 2-week period (r = .92) (Salyers, et al., 2007). For the current study, the scale was revised to be administered to consumers, and renamed the Recovery Expectations (REX) Scale (see Appendix G). Revisions to the scale included: (1) the instructions and items were revised to be administered to consumers instead of providers, (2) item anchors were changed so that only 4 of the 16 items required reverse-scoring, and (3) items were revised to increase clarity for consumer subjects. All items were revised to begin with "I," and instructions rewritten to direct participants to think of each statement as it pertained to their own recovery expectations. The anchor descriptions were revised to reflect degree of concordance with the item rather than number of consumer clients for which the statement was true (i.e., "Almost All" was changed to "Strongly Disagree"; "None" was changed to "Strongly Agree"). Additionally, four items were rewritten based on piloting feedback with consumers to enhance comprehensibility: "Will be able to work in a competitive job in the community," was changed to "I will be able to work in a job of my choosing in the community;" "Will be able to cope successfully with persistent symptoms," was changed to "I will be able to cope successfully with my symptoms;" "Will find work that enables me to be economically self-sufficient," was changed to "I will find work that will help me be financially independent;" and "Will be able to have satisfying intimate relationships," was changed to "I will be able to have satisfying romantic relationships."

Snyder Hope Scale

The Hope Scale (Snyder et al., 1996) was included to assess criterion validity of the REX with an established scale. Items are rated along an 8-point Likert format with anchors ranging from "definitely false" to "definitely true." Internal consistency for the scale is good; alphas for various administrations range from .82 - .95 with a mean of .93 (Snyder et al., 1996). The scale also shows evidence for criterion and construct validity. It is strongly correlated with the dispositional hope scale (r = .78) and correlates as expected with measures of self-esteem (r = .68) and state positive affect (r = .65) and, negatively with state negative affect (r = -.47).

Similarity Scale

The Similarity Scale is a 2-item author-developed measure to determine the degree of overall perceived similarity between subjects and (a) a consumer presenter and (b) the consumer subjects felt most influenced by from the IOOV DVD. Because the initial scoring, which required raters to mark an X anywhere on a line with end point anchors of extremely different and extremely similar, produced data indicating that respondents were misunderstanding the instructions, the scoring was changed to a 5-point Likert format (1=extremely different; 5=extremely similar) (see Appendix E1). Internal consistency reliability for the scale when using the Likert format was good, with a Cronbach's alpha of .89.

Psychological Closeness Scale

This 2-item scale is a modification of the single-item Inclusion of Other in Self (IOS) Scale developed by Aron and colleagues (1991). Directions ask subjects to select one of seven diagrams of overlapping circles that they feel best represents the degree of closeness they perceive within various dyadic relationships (e.g., between self and mother). An alternate-form reliability check of the scale, comparing two forms of the scale that used either circles or diamonds pictorially, revealed an alpha of .93. Additionally, 2-week test-retest reliability was good (r = .83). However, as was true with the Similarity Scale developed for the study, a review of the data collected 2/3rd's of the way through the study revealed that subjects were confused about how to properly endorse items. Therefore, the scale was adapted and revised so that its format would be consistent with all other study measures (see Appendix A). Anchors were reduced from seven to five, and verbal anchors were added underneath pictorial anchors,

ranging from "not at all close" to "very close." Internal consistency reliability of the revised scale was acceptable (α = .851).

Self-Stigma Scale

The items from the Public Regard subscale (6) of the Multidimensional Inventory of Black Identity (MIBI) were used to assess self-stigma in individuals with mental illness. Items were reworded to be relevant to those with mental illness (see Appendix E2). For example, the item "Overall, Blacks are considered good by others" was reworded to read, "I consider people with mental illness to be good people." Each item has a 5-point Likert scale format with anchors ranging from "strongly disagree" to "strongly agree." Two items are reverse-scored. Internal consistency (i.e., alpha) for the Public Regard subscale items was .66 (Sellers et al., 1998).

Miscellaneous Items

Twelve items designed to provide the following additional information: change in belief about ability to recover (3 items), social comparison of current level of recovery (1 item), program satisfaction (2 items), prior exposure to IOOV program (1 item), and demographics (5 items). The three items assessing change in recovery assessed (1) change in belief about possibility of recovery for all consumers, (2) change in belief about possibility of recovery for participant, and (3) change in belief about current personal level of recovery. The five demographic items used a checklist format to assess audience role (i.e., consumer, provider, family member, etc.), age range, gender, ethnicity, and previous exposure to the IOOV program.

NAMI IOOV Fidelity Scale

This 12-item scale was completed by the research assistant following the presentation to determine whether fidelity to the IOOV presentation format was maintained. The items were rated using a 4-point Likert Scale format (1 = didn't meet; 4 = met completely). Example items were "Had two presenters give presentation," and "Presenters showed video portions appropriately (e.g., Dark Days before Dark Days discussion; Acceptance before Acceptance discussion, etc.)."

<div align="center">Procedure</div>

NAMI National IOOV Coordinator Cynthia Evans sent an email out to NAMI affiliates inviting them to participate in the study. Interested NAMI staff and volunteers then contacted the researcher and participated in telephone training with the researcher. Data was collected between May and August 2011. Research assistants were given a stipend of $25.00 (plus postage) for their participation in data collection funded by a research grant from the IUPUI Graduate Student Organization (GSO).

The research assistants followed a script (see Appendix E4) and introduced the study, invited audience members to participate, passed out study packets to interested participants, and reviewed an oral consent form included in packets. Packets were labeled either Group 1 or Group 2 and were distributed alternately to audience members for a quasi-randomized design. Subjects were asked to remove the Pre-Program Questionnaires from their packets. Group 1 subjects completed the following: REX scale (16 items), Snyder State-level Hope Scale (6 items), and demographic items (5 items). Group 2 subjects completed demographic items (5 items) and the Self-Stigma Scale. At the end of the presentation, participants were asked to remove the Post-Program questionnaires from their packets. Group 1 subjects completed the following items: REX Scale (16 items), Psychological Closeness Scale (2 items), the Similarity Scale (3 items), Snyder Hope Scale (6 items), Self-Stigma Scale (6 items), and miscellaneous items (7). Group 2 subjects completed the following: the REX, the Snyder Hope Scale, the Psychological Closeness Scale (2 items), the Similarity Scale (3 items), and miscellaneous items (7). Following completion of the measures, subjects replaced the measures back in the packets which were collected and mailed to the principal investigator along with the completed NAMI IOOV fidelity scale.

<div align="center">Data Entry and Preliminary Analyses</div>

Data were entered into SPSS. Data were cleaned and examined for outliers and out-of-range values; however, none were found. Data were also examined for normality, homoscedasticity, and multicollinearity violations before running statistical analyses. Levels of skewness and kurtosis were acceptable for all scales used (i.e., skewness < 2.0; kurtosis < 4.0). Mean substitutions for missing items were done on all measures for subsequent analyses.

To establish convergent validity for the REX, a bivariate correlation was calculated for the REX and Hope scales. The correlation was strong (r = .75) suggesting that these scales were likely measuring similar constructs.

Internal consistency (i.e., Chronbach's alpha) was calculated for all scales, including author-generated (Similarity Scale) and author-revised (REX, Psychological Closeness, and Self-Stigma) scales, and was within acceptable ranges (.848 > α > .761). Additionally, inter-item correlations for the 2-item Similarity Scale (author-generated) and the Psychological Closeness Scale (2 items revised from original 1-item scale) were found to be at acceptable levels (r = .726; r = .718 respectively). Because Similarity and Psychological Closeness are related constructs, a correlation was calculated to assess possible collinearity. The correlation (r = .324) suggested that these measured related but distinct constructs.

Levene's test was conducted on scales prior to all t-tests to ensure homogeneity of variances. All results were nonsignificant suggesting assumptions of variance homogeneity were not violated.

Because ability to detect change had not been previously established for the Recovery Expectations Scale (REX), priming effects were tested by comparing post-test scores for REX between groups 1 and 2. No significant difference between Groups 1 and 2 were found: $t(111)$ = .516; p = .607.

Fidelity was measured to assess degree of appropriate program implementation. Subjects viewing programs with unacceptably low fidelity (i.e., < 75%) were excluded (n = 15). Subsequent analyses were limited to data for viewers of high fidelity programs (n = 103).

Because the Stigma Scale administered to the first group of subjects was flawed, analyses involving this scale were subjected to a smaller sample (n = 45) who received a corrected version of the scale. However since this scale was not used to address study hypotheses directly, this error did not significantly compromise the study's integrity. Since multicollinearity between predictors can be a problem in running regressions, this was addressed by examining the VIF and Tolerance values. Values for all regressions were within accepted limits.

RESULTS

<u>Sample Description</u>

A total of 102 consumers who viewed high fidelity programs participated in the study. About half of the participants that endorsed ethnicity (*n* = 94) were Caucasian (48%), with the next largest group being African American (29%), and the remainder, Latino (7%), Native American (6%), Asian (4%) and other (7%). The largest age cohort (48%) were between the ages of 41 – 55, followed by the 26 – 40 range (20%), the 56 – 65 range (16%) , the 19 – 25 range (8.5%), and the over 65 range (7%). Gender (*n* = 85) was approximately equally split (F = 41; M = 44). Only 8% (*n* = 8/97) reported previously viewing the program. Of those endorsing the item on social comparison level (*n* = 78), 36% endorsed making an upward comparison, 23% reported making a downward comparison, and 41% reported making an equal comparison.

<u>Overall consumer perspectives on program</u>

Regarding viewers' evaluation of the presentation overall (*n* = 84), 94% agreed or strongly agreed that the program was "excellent" and 93% agreed or strongly agreed that they "very much enjoyed" the presentation (*n* = 86). More significantly, 86% reported agreeing or strongly agreeing that the presentation increased their hope of recovery for those with mental illness in general (*n* = 86), and 94% agreed or strongly agreed that the presentation increased their hope for their own personal recovery from mental illness (*n* = 85). Additionally, 74% stated that the program changed their view or feeling about their recovery from mental illness in some way (*n* = 81).

<u>Does *In Our Own Voice* increase consumers' hope for recovery?</u>

Hypothesis 1 stated that subjects Recovery Expectations (REX) scores would increase following the presentation. To test Hypothesis 1, Time 1 and Time 2 REX scores were compared for Group1 using a paired samples t-test. Results revealed a significant difference (one-tailed) in recovery expectations for Group 1 subjects after viewing the program ($t(47)$ = -2.304; p = .013).

A related question was whether hope, as assessed by the Snyder State Hope Scale, increased as a result of viewing the program; however, no significant difference was found: $t(46) = -.163$; $p = .871$.

Does perceived similarity predict an increase in recovery expectations?

Hypothesis 2 stated that perceived similarity between presenter and audience members would predict an increase in recovery expectations for viewing consumers. The analyses were limited to those making an upward comparison ($n = 28$). The correlation between Time 2 REX score and Similarity Score was moderate but nonsignificant: $r = .326$, $p = .069$. Next, a hierarchical regression analysis was performed whereby Time 1 REX was entered in Step 1, and mean Similarity Score in Step 2, to predict Time 2 REX for upward comparers who completed the required measures ($n = 12$). Results were nonsignificant. Time 1 REX accounted for approximately 70% of the variance in Time 2 REX scores ($Adj\ R^2 = .692$; $F(10,1) = 25.769$; $p < .001$). Similarity explained little additional variance (R^2 change = .014) and was not a significant predictor of Time 2 REX ($\beta = .120$; $p = .510$).

Does psychological closeness moderate the relationship between perceived similarity and recovery expectations?

Hypothesis 3 proposed that a relationship between perceived similarity and increase in recovery expectations would be moderated by psychological closeness; thus, individuals endorsing greater psychological closeness with presenters would show a stronger relationship between perceived similarity and increased recovery expectations. A hierarchical regression (n = 11) was run for upward comparers whereby Time 1 REX was entered in Step 1, centered mean perceived similarity and mean psychological closeness were entered in Step 2, and their centered interaction term was entered in Step 3, to predict Time 2 REX. Once again, Time 1 REX explained the majority of the variance (60.4%) to a statistically significant degree ($F(1,9) = 16.246$; $p = .003$). Perceived similarity and psychological closeness together only explained an additional 5.4% of the variance and this was not statistically significant ($\Delta F(2,7) = .619$; $p = .566$). The interaction term also was not significant ($\Delta F(1,6) = .345$; $p = .578$) and in a negative direction ($\beta = -.226$) suggesting that psychological closeness is not a significant moderator in the

hypothesized direction of the relationship between perceived similarity and change in REX scores for this sample.

Does psychological closeness mediate the relationship between perceived similarity and recovery expectations?

Hypothesis 4 suggested that psychological closeness will act as a mediator between perceived similarity and change in recovery expectations for upward comparing subjects. This was tested using the model suggested by Fairchild & McKinnon (2009) which is especially useful for small samples.

In order to get the necessary pathway statistics for calculating a confidence interval in Prodclin (i.e., unstandardized coefficients and standard errors), two linear regressions were run. First, mean Similarity Score was entered as a predictor for mean Psychological Closeness B = .034; p = .914), after controlling for Time 1 REX. Second, T1 REX score was entered in Step 1, followed by Similarity Score and Psychological Closeness scores entered in Step 2, to predict T2 REX score. Step 2 only added 5.4% (ΔR^2 = .054; p = .566) to the explained variance, and was not significant. Using Prodclin, the confidence interval for the possible mediation effect was calculated by entering the raw regression coefficient and SE from the first regression (B_a = .034; SE = .310), and the raw regression coefficient and SE for the second regression (controlling for REX time 1) (B_b = .086; SE = .173), the correlation between the relationship of path a to path b (assumed to be 0), and the alpha level (α = .05) into the program. The result showed a nonsignificant effect: CI (95%) = -0.12416, 0.13849.

Post-hoc Analyses

In order to see if Time 2 REX scores differed significantly among social comparison groups, a one-way ANOVA was run. No significant difference among comparison groups was found (F(2,72) = .577; p = .564).

In addition to these hypothesized questions, a supplemental question was whether stigma would be reduced by the program since previous studies indicated that stigma had been reduced post-program in student populations in controlled settings. A quasi-pre/post design based on the recurrent institutional cycle design was used whereby the pre-test for Group 1 (n =

23) was compared to the post-test for Group 2 (*n* = 22). A one-tailed t-test showed nonsignificant results: *t*(43) = .505; *p* = .616.

Since Miscellaneous item #2 directly assessed increased hope for personal recovery resulting from viewing the presentation, a linear regression for upward comparers (*n* = 28) was run whereby Similarity Scale was entered as a predictor for this item. The results showed a moderate relationship between perceived similarity and self-reported increase in hope for personal recovery (*B* = .237) but was nonsignificant (*p* = .260) accounting for 6.3% of the variance. Another regression was run whereby perceived similarity and psychological closeness entered simultaneously to predict for item 2 (post-program hope for recovery) for upward comparers only. This accounted for 12.6% of the variance in item 2, although results were again nonsignificant (*B* = .191; *p* = .352).

DISCUSSION

Only one other study has examined consumer outcomes for this program (Brennan, 2011, unpublished thesis). That study examined archival data to assess audience responses to the program, as well as its ability to satisfy program goals of educating the public and delivering a hopeful message about recovery. This study is the first of its kind to directly assess the program's ability to increase hope for recovery, specifically for consumer viewers in field settings. Overall, there was converging evidence from comparisons of pre and post-program recovery expectations scores, as well as post-program ratings of changes in hope and recovery, that the program is effective in increasing recovery expectations for consumer viewers. Factors hypothesized to moderate and mediate the change in recovery (i.e., perceived similarity and psychological closeness) were not supported, however. Whether this is due to a genuine lack of relationship, a low sample size, or poor operationalization of relevant constructs is unclear. Future studies with larger samples and carefully operationalized constructs of interest might continue to investigate this question.

This study was also the first of its kind to examine the effects of the program within a theoretical framework which integrated various fields of social psychology (e.g., attitudes and persuasion research, social identity research, etc.). Despite the fact that results did not support the model, two interesting findings emerged: (1) only about 1/3 of subjects characterized themselves as performing upward comparisons with peer presenters, and (2) level of social comparison did not seem to impact outcome significantly, assuming the operationalizations of relevant constructs were valid. The first finding suggests that it cannot be assumed that consumers viewing the program feel that the peer presenters are in a better state of recovery than they are (i.e., they are not necessarily being viewed as "role models.") The second suggests that level of social comparison does not appear to impact the program's effects on viewers. It seems that regardless of level of social comparison, or perceived similarity between subject and presenter(s), consumer viewers generally feel more positively about the possibilities of their own recovery after viewing the program.

Limitations

Several limitations to the study are likely to impact generalizability of results. Confounding variables such as individual characteristics of both presenters and viewers compromised internal validity, and therefore, generalizability to different samples of presenters. However, since the sample was drawn from subjects and presenters from 7 different states across the country, some of these factors may have been effectively washed out, and certainly, lend the study strong ecological validity. Also, since the design was quasi-experimental, a causal effect could not be determined. However, as this was a pilot study seeking to determine if the program showed any effect on recovery expectations in consumer viewers, internal validity was not a priority.

Several other factors relating to the study subjects limited interpretation of results. Demand characteristics and expectancy effects are always a hazard for studies relying on self-report measures. In attempting to control for this, participants were asked several times to report feedback as honestly as possible. The small sample size, particularly for upward comparers (i.e., n = 28), severely limited the investigator's ability to carry out sufficiently powered analyses, particularly regarding testing the theoretical model.

All but one measure used (i.e., Snyder Hope Scale) were either revisions of psychometrically validated scales (or subscales) or author-generated (Similarity Scale), and therefore their ability to adequately capture the constructs in question is open to question. However, measures were chosen with two factors in mind—brevity and face-validity—with the purposes of reducing subject burden and assessing constructs not previously assessed in those with severe mental illness. Interestingly, the one measure that was psychometrically validated (i.e., Snyder Hope Scale) did not capture change in state-level hope.

Finally, the fact that the researcher as well as research assistants collecting data had or have a past or present affiliation with NAMI raises questions about researcher bias as well as demand characteristics during the data collection process. Attempts to address this were made by excluding the IOOV presenters themselves from collecting the audience data (as they ordinarily would for IOOV audience evaluations), or even being present while the post-program data was collected.

Despite these limitations, this study was the first of its kind to demonstrate that IOOV does raise recovery hopes for consumer viewers, filling a much-needed void in publicly

accessible programs that directly address this need. In this sense, though the conclusions must be held tentatively at best, this pilot provides support for the program's valuable contribution as an effective recovery-focused intervention too.

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Appendix E1

Psychological Closeness and Similarity Questionnaire

1) Think of the NAMI presenter you felt most influenced by today. Circle the option that shows how close you feel to that presenter.

a) Not at all close   b) slightly close   c) somewhat close   d) moderately close   e) very close

2) Think of the speaker you felt most influenced by **in the video/DVD today.** Circle the option that shows how close you feel to that speaker.

a) Not at all close   b) slightly close   c) somewhat close   d) moderately close   e) very close

3) Overall, do you see yourself as being more similar to or different from the NAMI presenter you felt most influenced by today (see question 1)?

a) Extremely different   b) mostly different   c) neutral   d) mostly similar   e) extremely similar

4) Overall, do you see yourself as being more similar to or different from the speaker **in the video/DVD** that you felt most influenced by today (see question 2)?

b) Extremely different   b) mostly different   c) neutral   d) mostly similar   e) extremely similar

5) If you marked above that you feel more similar to then different from the presenter *or* speaker in the DVD, please explain the way(s) that you feel similar to them:

_____

_____

_____

_____

_____

Appendix E2

Perceptions of Those with Mental Illness

Directions: Circle the response that best represents your <u>honest</u> view of each statement.

1) Overall, I consider persons with mental illness to be good people.

1	2	3	4	5
strongly disagree	disagree	neutral	agree	strongly agree

2) I respect those with mental illness.

1	2	3	4	5
strongly disagree	disagree	neutral	agree	strongly agree

3) I believe that, on average, people with mental illness are <u>less</u> effective compared to people without mental illness.

1	2	3	4	5
strongly disagree	disagree	neutral	agree	strongly agree

4) I view persons with mental illness in a positive manner.

1	2	3	4	5
strongly disagree	disagree	neutral	agree	strongly agree

5) I view persons with mental illness as an asset (a strength) to society.

1	2	3	4	5
strongly disagree	disagree	neutral	agree	strongly agree

6) I do not respect people with mental illness.

1	2	3	4	5
strongly disagree	disagree	neutral	agree	strongly agree

Appendix E3

Miscellaneous and Demographic Items
NOTE: Recovery is defined below as having a fulfilling life despite having a mental illness.

1) After having seen this presentation, I am more hopeful than ever that recovery from mental illness is possible *for people with mental illness.*

_____
1	2	3	4	5	N/A
strongly disagree	disagree	don't know	agree	strongly agree	

2) After having seen this presentation, I am more hopeful than ever that recovery from mental illness is possible *for me.*

_____
1	2	3	4	5	N/A
strongly disagree	disagree	don't know	agree	strongly agree	

3) I very much enjoyed today's presentation.

_____
1	2	3	4	5	N/A
strongly disagree	disagree	don't know	agree	strongly agree	

4) I would give the presenters a rating of "Excellent" for their presentation today.

_____
1	2	3	4	5	N/A
strongly disagree	disagree	don't know	agree	strongly agree	

5) This presentation changed my feeling or view (check one) about my recovery from mental illness:
Yes ☐   No ☐   Please explain your answer:
_____
_____

6) Overall, compared to the presenters or consumers in the *In Our Own Voice* video, I am (check one):

☐ not quite at their level of recovery
☐ at the same level of recovery
☐ somewhat further along in my recovery

I am a:
❒ Consumer (person w/mental illness) ❒ Family Member ❒ Health Provider
❒ Educator   Other _____

ETHNICITY   **AGE**

❏ Black/African-American ❏ Native American/Indian   ❏ Under 18 ❏ 19-25
❏ Asian/Pacific Islander   ❏ White/Caucasian   ❏ 26-40   ❏ 41- 55
❏ Middle Eastern ❏ Hispanic/Latino   ❏ 56-65   ❏ 65+
Other _____

GENDER
❏Male ❏Female

HAVE YOU EVER SEEN AN *IN OUR OWN VOICE* PRESENTATION BEFORE? ❏ Yes ❏ No

Appendix E4

INSTRUCTIONS FOR RA'S DOING RESEARCH ON IOOV

MATERIALS:
- **STUDY INSTRUCTIONS (THIS PAGE)**
- **PACKETS (FOR GROUP1 AND GROUP 2 SUBJECTS)**
- **PENCILS/PENS**

BEFORE THE PRESENTATION:

TALK WITH IOOV PRESENTERS: You'll need to explain to your presenters beforehand what you will be doing and why. *Be sure to reassure them that this is not an evaluation of them as presenters, but of the program!* **However, it would be best for them not to see the questionnaires because they might unconsciously try to adapt their presentations to how they believe they'll be assessed.** You'll also tell them that they'll be asked to leave the room for the post-program questionnaire period so that their presence doesn't influence the audience's responses.

SCRIPT:

RA: Hello. My name is _____. I am working with a researcher at IUPUI (a branch of Indiana and Purdue Universities) on a study about audience members' responses to the *In Our Own Voice* Program. This study is specifically interested in the views of audience members who have a mental illness. The results of this research will help us develop better programs. If you are interested in participating, you'll be asked to fill out some questionnaires before and after the presentation. Your participation is completely voluntary and you may withdraw at any time if you are no longer comfortable. *At no time will you be asked for your name or any other identifying information, so your information will be completely anonymous.*

Because of the study design, you will not all have the same questionnaires so don't be confused if your neighbor has a different color or different questions to fill out than you do. This is due to the research design.

If you are a consumer and would like to participate, please raise your hand and I will give you a packet; however, do not open the packets until I ask you to. If you are not interested in the study, that is no problem—just feel free to enjoy the presentation.

Distribute Packets and pencils.

RA: Please open your packet and remove *only* **the white paper.** This is called a consent form and explains the study fully. It also includes contact information should you have any questions after you leave today. Please take a moment now and read through the consent form **[to the RA: give time for them to review or you can summarize the main points of the form for them].** If you wish to participate, *you do not need to sign it;* when you fill out the forms, this will be taken as your consent. If you do not wish to participate, simply do not fill out any of the questionnaires. You may keep this form with you should you wish to contact the researchers *after* today's presentation. Are there any questions?

RA: Now, please remove the set of questions entitled **"TO BE FILLED OUT** *BEFORE* **IOOV"** from your packet. Depending on your packet, these may be different colors (SALMON OR GREEN). Read through the items for all pages and let me know if you have questions. We'll begin the *In Our Own Voice* presentation after you are done. **Please be as honest as possible—this will be most helpful to us!** When you're finished, simply put the question set back in your packet.

NOTE TO RA: *Once everyone seems finished, ask if there are any questions. <u>If not, ask them to return the questionnaires into their packets.</u> This is extremely important as there is no identifying information on the surveys and no way to match pre and post-data except by putting them back into the original packets.*

Thank you. We'll do the other questions after the presentation. Please now give your attention to our IOOV presenters _____ and

_____ .

AFTER THE PRESENTION (and after any discussion/questions they have with the presenters), NAMI RA WILL BE SURE PRESENTERS HAVE LEFT THE ROOM

RA: Now, please take out the set of questionnaires entitled **"TO BE FILLED OUT** *AFTER* **IOOV"** and fill them out. Again, you may have different color sets because of the study design (PINK OR YELLOW). **Please remember to answer the questions as honestly as possible.** If you have any questions, feel free to ask at any time. When you finish, please replace the questionnaires inside the packets.

NAMI RA will collect packets after they have finished—ALL MEASURES MUST BE REPLACED BACK INTO PACKETS BEFORE YOU COLLECT THEM.

RA: Again, thank you so much for your valuable time and feedback!

_____

NOTE TO RA's: In order to reduce subject burden, <u>*DO NOT GIVE THE STANDARD NAMI IOOV AUDIENCE EVALUATION FORM* </u>for those presentations to be included in this study. This decision has been approved by the NAMI National IOOV Director Cynthia Evans.

Finally, NAMI RA's will complete the <u>NAMI FIDELITY SCALE</u> after the presentation and mail this with all the packets to the researcher. You will be reimbursed for postage—please mail a copy of the postage receipt to the researcher.

THANK YOU VERY MUCH! ☺