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Speech-Language Pathologists Serving Clients With Mental Illness: A Collaborative Treatment Approach

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Psychiatric disorders are defined and classified in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1994). Although the diagnosis of a mental illness is predominantly the domain of the psychiatrist, the assessment, treatment strategies, and intervention involve many other professionals.

Traditionally and in general, speech-language pathologists have not provided speech/language services for individuals with mental illness, and no articles have been found to be published on this topic in the *Journal of Speech, Language, and Hearing Research* from 1995 to date. However, communication difficulties have been identified by other researchers as the primary symptoms exhibited by clients with mental illness (Hamera, Peterson, Young, & Schaumloffel, 1992; Murphy & Moller, 1993; Sullivan, Marder, Liberman, Donahoe, & Mintz, 1990). In October 1996, at a training workshop for nursing students, an internationally renowned psychiatric nurse, Dr. Mary Moller, stated, "Individuals with mental illness have a communication disorder. They also have a 'diseased' brain which affects their communication abilities" (Moller, 1996). For example, persons with schizophrenia have been described as (a) being unable to interpret and respond to incoming messages (information-processing difficulties), (b) exhibiting difficulty connecting thoughts in logical sequences by either jumping from one topic to another (loose associations) or talking about unrelated topics (derailment), (c) not having much to say or being unable to maintain a conversation (poverty of speech/speech content), (d) producing incoherent and illogical use of words (neologisms), (e) producing verbal and nonverbal incongruency (alogia), (f) using peculiar word formations and language structure, (g) displaying limited/nonexistent facial expressions and gestures (blunted affect), (h) displaying a lack of interest in socializing, and (i) exhibiting difficulty making decisions and solving problems (Docherty, 1995; Novak, 1997; Torrey, 1995).

Cognitive impairments also affect the ability of individuals with mental illness to process information appropriately.

ABSTRACT: This paper represents the first of several planned investigations regarding the clinical management of clients with mental illness. One major assumption underlying this project is that clients with mental illness can benefit from speech-language therapy, particularly when the clinician is knowledgeable of the nature and progression of mental illness as it relates to communication sciences and disorders. Unfortunately, research studies on the speech and language problems with this population are under-represented in the literature. Examples of service provision by speech-language pathologists for clients with psychiatric disorders will be provided, and preliminary data related to these management approaches will be presented and discussed.

KEY WORDS: mental illness, schizophrenia, collaboration, psychosocial rehabilitation

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Visual and auditory distractability are common, as are memory difficulties for recent events (short-term memory problems). In general, social perception and the ability to recognize signals during social interactions have been impaired. Studies by Landre, Taylor, and Kerns (1992) and Anand, Wales, Jackson, and Capolov (1994) have identified difficulties in the areas of form (syntax, phonology), content (semantics), and use (pragmatics) in clients with mental illness. In a study conducted by Emerson and Enderby (1996), results showed that the most common problems were in the areas of comprehension and naming, with 25% of 138 clients exhibiting difficulties in spontaneous speech. Considering the nature of these symptoms, the speech-language pathologist should be included as a team member providing services for this population.

A TRANSDISCIPLINARY COLLABORATION PSYCHOSOCIAL APPROACH

A transdisciplinary collaboration psychosocial rehabilitation project that involved providing therapeutic services to clients with mental illness began in 1993 at San Jose State University (Connolly, 1995). Psychosocial rehabilitative services have been found to have positive outcomes in terms of employment, skills development, quality-of-life satisfaction, and increased amount of time spent in the community (Dion & Anthony, 1987). Anthony, Cohen, and Farkas (1982) identified several components necessary to have an effective psychosocial rehabilitative program for clients with mental illness. These components, implemented in our collaborative program, were a team approach, functional assessment, client involvement in the assessment and intervention decision-making process, individualized planning specific to the needs and desires of the client, direct teaching of skills, real-life follow-up, referrals to other disciplines when needed, recordation of observable outcomes, and client involvement in future planning. Each component will be presented in the following sections as it applied to our program.

A Team Approach

Team members involved in the project included faculty and students from the disciplines of nursing, speech-language pathology, therapeutic recreation, occupational therapy, social work, and individual case managers; when necessary, other disciplines such as pharmacology, audiology, ophthalmology, and psychiatry were included. Transdisciplinary collaboration involved the development of client-directed and client-centered goals and objectives from various disciplines after obtaining the assessment results of these individuals.

Functional Assessment

Each discipline identified specific assessment tools that addressed the functional skills of their clients. Speech-language pathology used client observations during rehabilitation classes, informal interactions in common areas (i.e., snack bar, pool table, kitchen, patio, television room), interviews with the staff, the Pragmatic Protocol (Prutting & Kirchner, 1987), and the Social Communication Rating Scale (Gajewski & Mayo, 1989) to address the communication and language difficulties experienced by these clients. Observations were made during informal interactions to identify areas of the clients' communication strengths and weaknesses.

The Pragmatic Protocol was used to describe those areas across 30 pragmatic parameters affecting communicative competence. It was used on 43 clients ranging from 34–56 years of age. The clients' diagnoses included schizophrenia (affective, paranoid, and acute), bipolar disorder, multiple personality disorder, major depression, and posttraumatic stress disorder. All assessments were made at a combined residential and day program for clients with psychiatric disorders. The results of the Pragmatic Protocol are presented in Figure 1.

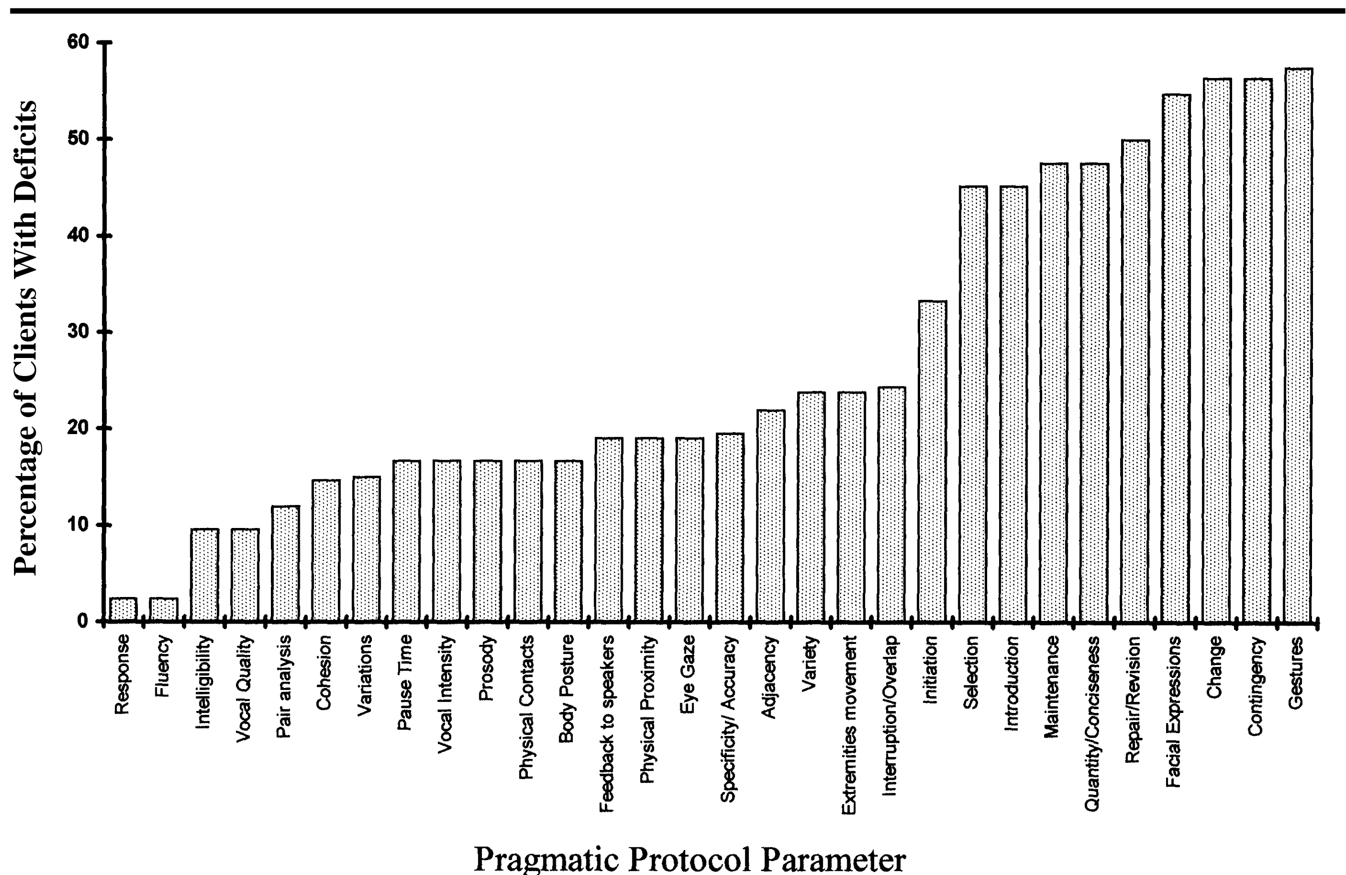
Between 30% to 50% of the clients exhibited deficits in the areas of initiation, topic selection, introduction, topic maintenance, turn length, and repair of a communication breakdown. More than 50% of the clients exhibited deficits in the areas of facial expressions, change of topic, contingency of responses, and gestures. This suggests that deficits in the verbal and nonverbal pragmatic skills exist for clients with mental illness.

Comparisons also were made between residential and day program participants (see Figure 2) and between clients with affective versus paranoid schizophrenia (see Figure 3). A greater percentage of residential clients had difficulty with communication skills as rated on the Pragmatic Protocol as compared with the day program participants. A greater percentage of clients with paranoid schizophrenia (n = 12) had difficulty with communication skills as rated on the Pragmatic Protocol as compared with clients with schizo-affective disorders (n = 10). Clients with other psychiatric diagnoses were not compared due to a small sample size ($n \leq 5$).

The Social Communication Skills Rating Scale (Gajewski & Mayo, 1989) is a behavioral self-rating scale of 63 social communication skills that is completed individually by each client. The client is required to rank each skill from 1 *(never use skill correctly)* to 5 *(always use skill correctly).* The rating scale is related directly to a social skills strategies curriculum that includes the 63 skills identified on the scale. This scale was used during an interview format in which each client was asked to rate his or her competency level for each skill. Each skill was explained and specific examples were provided. For example, the skill "starting and ending a conversation" described feeling comfortable starting conversations, beginning conversations with a greeting and name, and ending conversations smoothly and saying "goodbye."

The results of the rating scale were discussed individually and then each client prioritized five skills to be worked on during individual therapy sessions. The rating scale also was completed by a familiar administrative staff member at the clients' residential treatment facility. The ratings were subsequently compared for each resident. Interestingly, the perceptions of the clients and the perceptions of the staff regarding the clients' ratings differed

Figure 1. Results of the Pragmatic Protocol.



greatly. Accuracy in self-perception of abilities and skills also has been an area that has been identified as problematic for clients with mental illness (Torrey, 1995).

Client Involvement and Collaborative Individualized Planning

Once each discipline obtained the results of its functional assessments and identified the problematic areas for each of its clients, collaborative yet individualized goals and objectives were identified and targeted for each person. Addressing the communicative needs of the clients had to be balanced with addressing their non-communicative health needs.

The communicative needs identified were memory, cognition, speech, grammar, narrative discourse, conversational skills, social skills, hearing, and literacy. The health needs identified were weight loss, exercise, grooming, safe sex, nutrition, stress management, and symptom management. Each client identified specific needs; based on these needs, a primary discipline was selected. For each client, a primary discipline was identified along with supportive disciplines if necessary. The primary discipline was responsible for coordinating the areas for intervention. The supportive disciplines used the primary concern identified by the client and established their goals around the same concern.

For example, one client identified weight loss (a non-communicative issue) as a primary concern even though he also had difficulties expressing himself verbally and organizing his thoughts. He also did not participate in any activities. As a result, nursing was identified as the primary discipline and speech-language pathology and therapeutic recreation were considered as supportive disciplines. Nursing was responsible for assessing the client's nutritional status, eating behaviors, and overall environmental conditions. Nursing also provided intervention in teaching appropriate food selections, establishing an exercise program, and weighing the individual on a weekly basis. Because of the individual's language difficulties, members of the speech pathology team organized an eating schedule, categorized appropriate and inappropriate food choices, followed up with comprehension of information and terminology presented by nursing, and worked on sequencing and organizational skills involved with food preparation activities. Additionally, members of the therapeutic recreation program helped the client identify leisure activities that supported positive weight management, discussed food-related activities, and helped the client establish a daily routine of activities. At the end of the semester, the client had lost five pounds, was attending group therapy sessions, and was actively participating with verbal contributions during these group sessions.

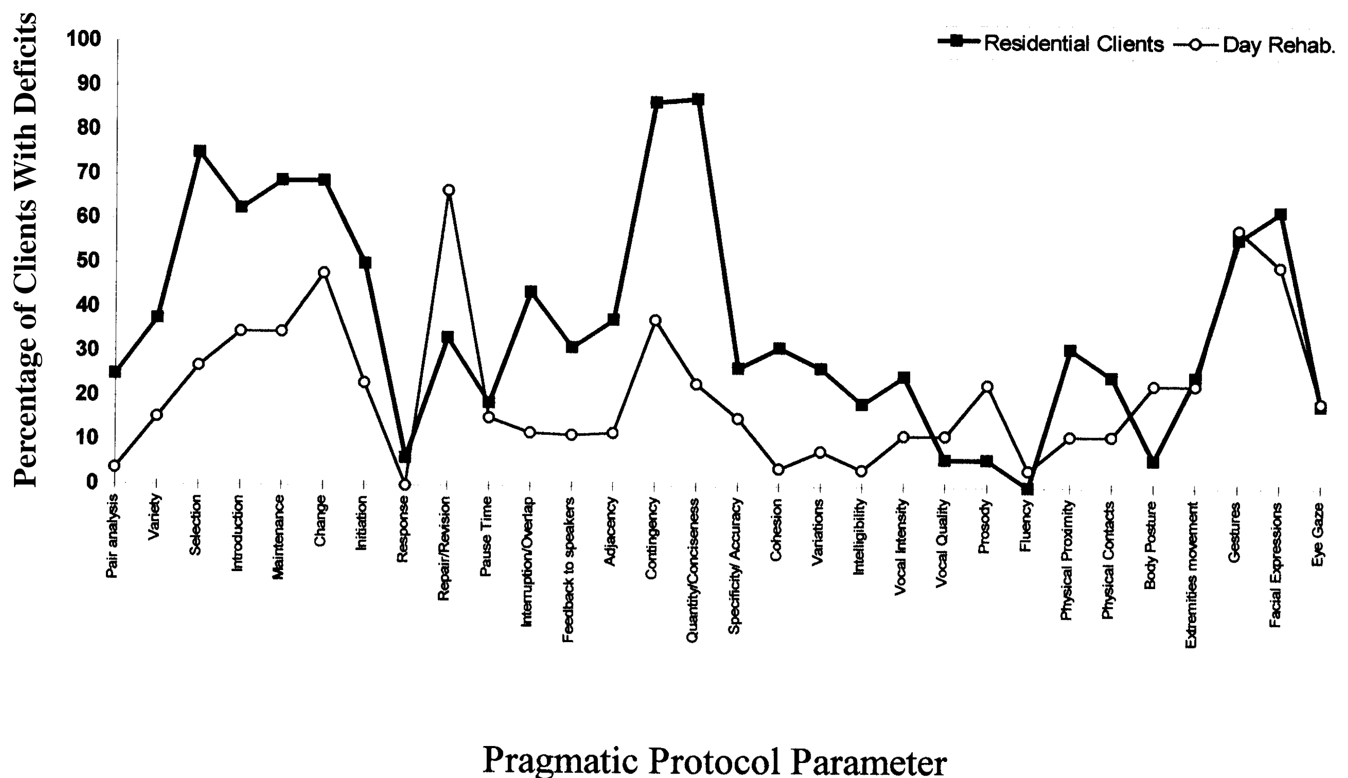


Figure 2. Results of the Pragmatic Protocol for residential versus day rehabilitation clients.

Direct Teaching of Skills

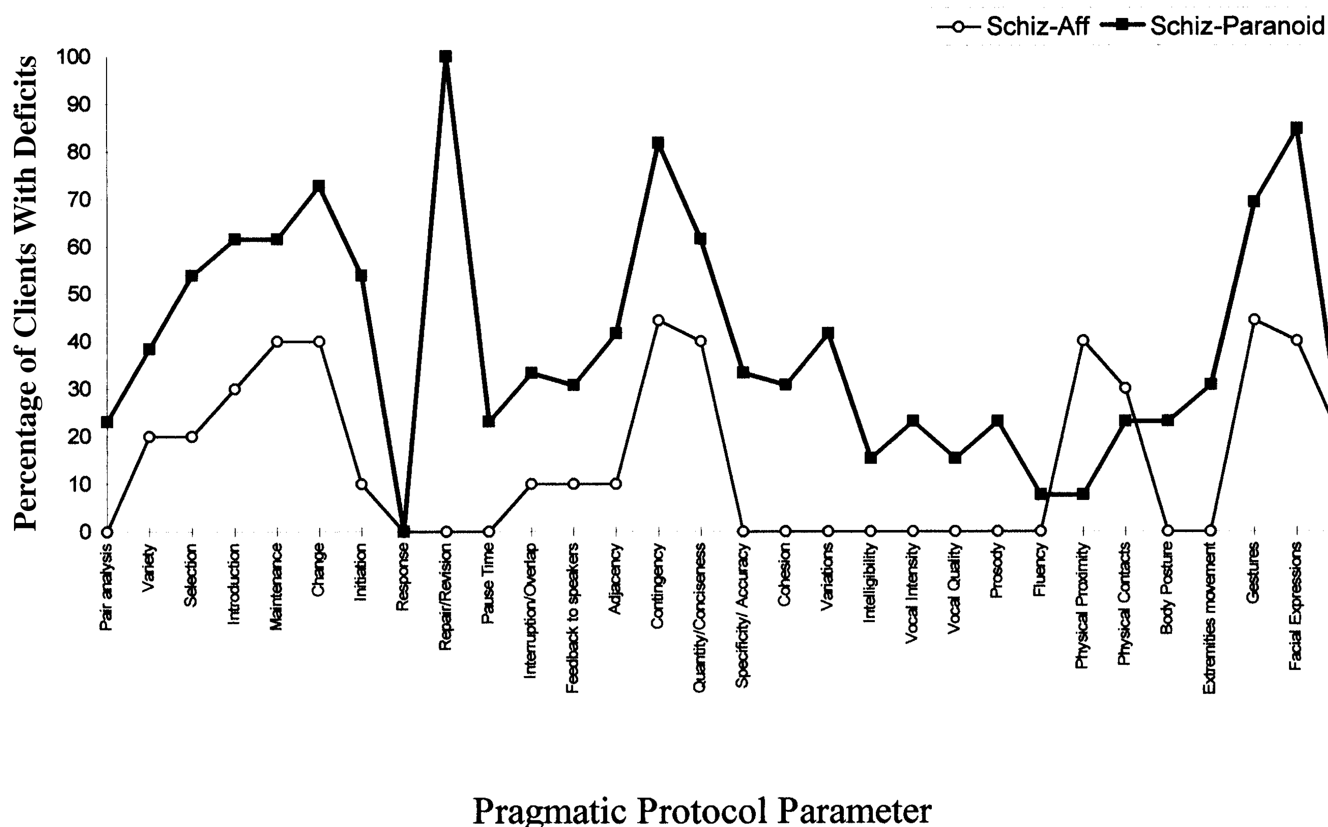
Members of each discipline also provided direct therapy for each client. Individual and group therapy sessions were offered by speech-language pathologists. Individual therapy focused on specific language issues or pragmatic skills selected by the client as related to the collaborative goals and objectives identified. For example, a log sheet with appointments, locations, and date proved helpful to a client who had memory difficulties. Writing things down, visualization, reviewing information on the log sheet, using the context for visual signs, asking for help, and getting information from other sources helped her improve her quality of life. The client was taught to record which strategy was used in various situations, and which strategy was most effective (see Appendix A). At the end of the semester, the client reported having less stress and being able to rely on her memory strategies to help her in difficult and confusing situations.

Group therapy initially began with six treatment modules adapted from Schwartz and McKinley (1984). The modules included listening/attending, humor, social language, specific functional communication, nonverbal communication, and cognitive-linguistic skills. See Table 1 for the rationale and specific content for each module. Thirteen clients completed a satisfaction evaluation form at the end of the six treatment modules. All six modules averaged at least 3 on a scale of 1 *(not helpful)* to 5 *(very helpful).* They are shown in Table 2.

Carryover of the skills previously taught occurred across disciplines during group therapy sessions. During one semester, a journal writing class held by therapeutic recreation individuals followed immediately after the communication module that was run by speech-language pathology members. For example, one day, the communication module focused on personal space. The journal writing class that immediately followed it emphasized writing about personal space experiences the clients had during/outside of the class. The clients also were encouraged to write about their feelings associated with different distances. As a result, the clients were able to write about something they had just experienced, and the writing assignment reinforced and carried over the communication session in a relevant and meaningful manner.

In another instance, the staff was concerned that the clients would have feelings of abandonment and difficulty coping because one of the psychologists was going to leave the facility. A party to acknowledge the psychologist's departure from the facility was planned to address this issue. The planning of the party involved the use of categorization and organizational skills that were part of the cognitive module. The art therapist collaborated by helping the clients make decorations for this event. Each client was able to express his or her gratitude to the psychologist in

Figure 3. Results of the Pragmatic Protocol for clients with affective schizophrenia versus paranoid schizophrenia.



order to facilitate closure and celebrate the departure of this person in a positive and enjoyable manner.

Over the past few years, the *SSS: Social Skills Strategies* (Gajewski & Mayo, 1989) has been adapted and modified for use with the adult clients with mental illness during the group therapy sessions. The Social Communication Skills Rating Scale also is found in these books, and each client is asked to select 10 skills each semester that he or she would like to work on. The six skills that receive the highest number of votes are the group modules that are selected to present to the clients in the group sessions. Lesson plans that have been developed for each skill are presented with activities relevant to the communication needs of the clients. See Appendix B for an example of a group therapy module.

Real-Life Follow-up

Each discipline was responsible for monitoring the maintenance, transfer, or generalization of the skills taught and goals addressed. Staff members also were made aware of the goals and objectives for each of the clients. By the end of the semester, one of the residents who previously had always stayed in her room during most of the day was attending each group therapy session and contributing at least two comments at each communication group session. On the last day of the group session, this individual wrote a thank you note to the facilitator of the group without any prompting.

Another client who had difficulty holding a job due to poor memory and organizational skills was offered a paid cleaning position at the university clinic. An assistive schedule board was devised with a visual representation for each task, including the necessary items required to complete each task. By the end of the second semester, this client used only a written checklist she marked off after completing the cleaning task in each room.

Referrals to Other Disciplines

Clients were referred to other professionals as necessary. Caution was taken not to overinvolve the clients with too many professionals; however, if it appeared that occupational therapy would be beneficial for a client, such a referral was made. Clients who were non-compliant in taking their medications were not seen for direct therapy services in the collaboration project. Clients who were having side effects as a result of their medications were referred to their case worker or psychiatrist for reevaluation and follow-up. During speech therapy, one of the clients

Table 1. Group therapy modules, rationale, and content.

Module	Rationale	Examples of specific content
Figurative/Humor	Appropriate use of humor is dictated by pragmatics.	Pragmatics of telling jokes Types of jokes (categorizing) Presupposition
Nonverbal	Up to 93% of communication can be nonverbal.	Definition Body language/personal space Eye gaze
Cognitive-Linguistic	Improvement in cognitive skills should promote independence.	Problem solving Analyzing (break task into steps) Scheduling/planning Categorizing
Functional	Specific language skills increase communication functions.	Pragmatics of asking questions Interviewing Negotiation Handling complaints
Listening/Attending	One must attend, hear, and process what has been said to respond.	Introduction Listening strategies Barrier tasks Story reconstruction
Social/Conversation	Social language skill facilitates everyday interactions.	Introducing yourself or others Remembering names Starting and finishing conversation Changing topics

Table 2. Client ratings of modules.

Client	*Humor*	*Nonverbal*	*Cognitive*	*Functional*	*Listening*	*Conversation*
1	2	1	2	5	5	5
2	2	3	5	5	5	3
3	-	3	-	-	3	3
4	4	-	-	-	-	4
5	-	5	-	-	-	5
6	2	5	1	1	-	5
7	4	3	4	3	-	5
8	-	5	5	-	5	5
9	5	-	-	5	-	5
10	2	5	5	5	3	3
11	5	5	5	5	5	5
12	5	3	-	3	-	4
Average	3.44	3.80	3.86	4.00	4.33	4.33

Note. 1 = not helpful; 2 = a little helpful; 3 = somewhat helpful; 4 = quite helpful; 5 = very helpful; - = not rated. (Not all clients attended all classes.)

exhibited extreme staring behavior that was making the therapist uncomfortable. It was recommended that he have his hearing checked. The results of the hearing test indicated that this client had a moderate bilateral sensorineural hearing loss. He was fitted immediately with hearing aides and given aural rehabilitation. This client was a 38-year-old male and it had been assumed that he was having difficulty understanding English because English was not his native language and therefore his hearing loss had gone undetected until this time.

Recordation of Observable Outcomes

During each semester, the clients' behavior was observed (i.e., participation in group therapy sessions, increased interaction with other clients and staff), interviews were conducted with the staff on the progress they had observed, and interviews were conducted with the client for feedback and personal reflection. One client said that he was able to take a class at the university and use the social skills training module information to start talking to other students.

Client Involvement in Future Planning

At the end of the semester, individual progress was reviewed with each client and the clients were involved in selecting goals for the following semester as well as prioritizing the list of social skills for the group sessions to be presented in the future. Each client also was free to choose to continue attending individual or group therapy sessions. All goals and objectives remained client-centered and client-directed. Some clients also were given contracts that clearly stated their commitments for the following semester.

SPECIAL CONSIDERATIONS WHEN WORKING WITH CLIENTS WITH MENTAL ILLNESS

At times, clients were not able to participate because of the degree of their psychiatric symptoms (such as hallucinations and delusions) and noncompliance with taking their prescribed medications. As such, expectations needed to remain flexible. For example, one patient was not able to participate due to delusions about someone stealing her shoes. Depending on the degree and escalation of inappropriate behavior, communication goals needed to be deferred in lieu of intervention from other medical staff in psychiatry or psychology. In addition to their psychiatric symptoms, clients presented with other factors that impacted their ability to participate at times. These factors included negative side effects such as drowsiness from taking their medications, external distractions, social stressors (i.e., divorce and/or separation from children while in the residential program), financial problems, legal problems, and compounding disorders such as developmental delays or other physical ailments.

A CASE STUDY

A 62-year-old female with a diagnosis of chronic undifferentiated schizophrenia, bronchitis, and hypertension was living in a board and care facility. She was taking psychotropic medications as well as antihypertensive and asthma medications. Nurses reported that sometimes it was difficult to understand the client because she refused to wear her dentures and she had an enlarged tongue from the medications she was taking. Nurses referred this client for a speech and language evaluation. It was reported by her case manager that she had withdrawn from all social interactions and from participating in group activities at her board and care facility. The Pragmatic Protocol and Social Skills Rating Scale revealed that this individual felt lonely and found it difficult to tell others about her feelings. She provided short and incomplete responses without any verbal expansions to questions asked of her. She also exhibited difficulty with topic maintenance. In addition, she stated that she had problems with her physical health, smoking, handling money matters, getting enough exercise, and having enough energy to do many things. She also had difficulty getting herself organized and keeping appointments.

Speech-language pathology and nursing provided some sessions together for the client as well as group sessions in health and communication focusing on the client's speech and language as well as her health issues. The board and care staff also were involved in working with the client for generalization and carryover of the skills being taught. After 1 year of this transdisciplinary rehabilitation with emphasis on psychosocial intervention strategies, the client was participating in role plays during group sessions, expressing her feelings verbally, and exhibiting improved speech intelligibility. The board and care administrator reported that this resident improved her social interaction skills and increased her participation in various home activities. Her behavior changed dramatically, as she no longer stayed in her room all day. The administrator also stated that this client's symptoms improved from severe to mild, and she began keeping her appointments. Her communication skills increased as she began experiencing positive social interactions. She even was able to joke with the other residents at the board and care facility. Overall, this client increased her social interactions and participation in group activities, as well as improved her speech intelligibility.

CONCLUSION

This project focused on providing high-quality services for clients with serious mental illness in the community while preparing future speech-language pathologists to work with and provide collaborative services for these clients. The project has played an important role in decreasing rehospitalization and emergency services for clients with mental illness. Twenty-five individuals achieved tenure in the community (no rehospitalizations) at a cost of $383,000, as compared with approximately $651,000 spent for the same individuals 1 year before collaborative services were offered (Connolly, 1995). Needs of the clients were addressed, offering more than shelter and symptom relief, but also an opportunity to experience recovery (Connolly & Novak, 2000). This project revealed high levels of client satisfaction and improved quality of life.

FUTURE CONSIDERATIONS

These preliminary findings clearly demonstrate that clients with mental illness can benefit from the services offered by speech-language pathologists and that these services need to be systematically programmatic in order to be beneficial. Unfortunately, however, only a few training programs may offer formal courses or clinical training experience with patients with mental illness. In essence, speech-language pathologists who have these clients on their caseload may find themselves ill-prepared to work with these clients due to the lack of appropriate assessment tools and studies addressing treatment efficacy.

These clients' communication needs may be left untreated by speech-language pathologists, although other disciplines such as psychology and occupational therapy seemingly have realized the need to address communication. We hope that the information presented in this paper has fostered an interest in clinicians who would like to work with these individuals as well as encouraged further research so that treatment approaches can be further developed.

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APPENDIX A. EXAMPLE OF A MEMORY/ORIENTATION STRATEGY LOG USED BY A CLIENT

	Strategies						*A memory problem*		*How did it help? (1–5)*
Purpose	*Writing*	*Visualization*	*Review*	*Using the context*	*Asking for help*	*Other*	*Prevented*	*Helped handle*	
To remember an appointment	Wrote in to news						X		4
To figure out the date						Got up to listen to news	X		4
To figure out the place				Looked for signs				X	4
To figure out the place					Asked someone			X	3

APPENDIX B. GROUP THERAPY MODULE: STARTING A FRIENDSHIP[1]

Intended Therapy Plan

Objectives

1. The clients will be introduced to the topic of starting a friendship in order to reduce isolative behavior and increase social relationships.
2. The clients will be able to identify appropriate friendships to minimize relapses due to stressful friendships.
3. The clients will learn what qualities (personality characteristics) makes them a true friend and what qualities they want in a friend in beginning a friendship.

Materials

1. Posterboard, markers, *SSS: Social Skills Strategies* (Book B, pp. 39–40)
2. *SSS: Social Skills Strategies* (Book B, pp. 43, 45 adapted)
3. *SSS: Social Skills Strategies* (Book B, p. 42) "What Can I Offer," sheet of friendship, and a body outline

Procedure

1a. The clinician will ask clients to:
Define: friendship, friend
1b. The clinician will ask clients the following questions:
- Why is it important to start friendships?
- How do you start a friendship?
- Why is it difficult to begin a friendship?

1c. The clinician will hand out *SSS: Social Skills Strategies* (Book B, pp. 39–40) "Friendship Tips" and will go over each tip.

2a. The clinician will go over pages 43 and 45 (altered) from the *SSS: Social Skills Strategies* (Book B).
2b. The clinician will have the clients write their responses on the pages provided to them.
2c. The clinician will review and write some of the responses on the posterboard.

3a. The clinician will go over *SSS: Social Skills Strategies* (Book B) p. 42, "What I Can Offer."
3b. The clinician will ask clients to share what qualities they have to offer in a friendship.

Results

A. Introduction: The clinician introduced the topic of starting a friendship.

1. The clinician asked the clients for a definition of friendship and friend.
2. The clinician wrote down the clients' responses on a posterboard (see Section D1-2) and provided feedback on the responses.
3. The clinician asked clients the following questions:
   a. Why is it important to start friendships?
   b. How would you start a friendship?
   c. Why is it difficult to begin a friendship?
4. The clinician wrote down the clients' responses to the above three questions on a posterboard (see Section D3-5) and provided feedback on the responses.
5. The clinician handed out *SSS: Social Skills Strategies* (Book B, pp. 39–40) "Friendship Tips" and reviewed each tip with the clients.

[1] Adapted from *SSS: Social Skills Strategies* (Book B, pp. 38–46).

B. The clients demonstrated their knowledge of the topic.
1. The clinician handed out page 43 "Friend vs Dneirf" (adapted), and page 45 (adapted) from the *SSS: Social Skills Strategies* (Book B).
2. The clients wrote their responses on the pages provided.
3. Some of the clients' responses were recorded on the posterboard.
4. Other clients offered their suggestions to different situations given and a discussion followed.
5. The clinician went over page 42, "What Can I Offer?"
6. The clinician asked clients to share with the group what qualities they have to offer in a friendship (see Section D6).
7. The clinician handed out a sheet of FRIENDSHIP spelled vertically. The clients wrote the qualities they would want in a friendship using the letters of the word.
8. The clinician asked the clients to share some of their responses regarding the qualities they would want in a friendship (see Section D7).
9. The clients were asked what is the difference between a true and not true friend (see Section D8).
10. The clients responded to the question of: "What friendship tips do you have to give?" (see Section D9).
11. The clients also provided input on whether they thought they were good at starting new friendships (see Section D10).

C. Wrap Up

1. The clinician reviewed the objectives of the module.
2. The clinician summarized the topic of starting a friendship and the importance of beginning a friendship, and discussed any other issues the clients had related to their own experiences and examples.
3. A game of Wheel of Fortune was played to review some of the main ideas related to friendship building.

D. Client Responses

1. What is a friendship?

state of having a friend
partner
someone to talk to
getting to know someone

2. What is a friend?

brother or sister
buddy
companion
karmic association with someone
acquaintance
fun
someone you can trust

3. Why is it important to start a friendship?

to have fun
prevent loneliness
companionship
acceptance
prevent boredom
to have someone to talk to on the phone or write a letter to
borrow stuff
team work/working together

4. How would you start a friendship?

introduce yourself
find common ground/interests
(carryover from a previous module)
small talk
body language – smile, eye contact, personal space

5. Why is it difficult to begin a friendship?

scared
low self-esteem
different expectations
difficult to trust someone
not knowing if rejection will happen
intimacy
unfamiliarity
shyness

6. What qualities or hobbies do you have to offer a friend?

Qualities	**Hobbies**
hard-working	play guitar
honest	sports
sincere	dancing
good cook	food
time to spend	tv (game shows, MTV)
communicator/good listener	music
nice	gamble
kind	walking
happy	poetry
loyal	swimming
humor	phone
	art
	shopping
	science
	world events
	gardening

7. Clients were asked to create words about their ideal friend that spell out "Friendship."

F faithful, funny, friendly, fun, fantastic
R respect, reasonable, real
I intimacy, independent, important, ideas to do things
E exchange of ideas, enduring, extroverted, entertaining, ethnic
N never dull, nice, neat, near
D dynamic, dependable, dear, dreamy
S sincerity, sharing, special
H honesty, happy, humor
I in common interests, intelligent, interesting
P personable, popular, pleasant, personal, possible

8. Clients were asked: When is a person a true friend and when are they not?

True Friend	**Not a Friend**
Sticks up for you	Telling you to do something you don't want to
Doing things together	Using you for money
Spending time together	Telling your secrets to others

9. What friendship tips do you have to give?

Meet people at work
Be kind
Show appropriate body language
Common interests
Make friends with family or relatives

Be aware
Give a good greeting
Make sure your friend is honest
If relationship is not a two-way street, DROP IT

10. Are you good at starting new friendships? Tell why or why not.

Yes, but I need to be in a safe place.
Yes, because I am friendly.
Yes, because I am honest.

Sometimes, but I do not talk much.
Yes, because I do not come on too strong.
No, because I do not know how to start a conversation.