Graduate Journal of Counseling Psychology

Volume 1
Issue 2 *Spring 2009*

Article 8

3-1-2009

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Abstract: Stress is exceedingly prevalent and affects individuals in a variety of ways; therefore developing skills to combat stress is imperative. Homeless women report greater stress levels than homeless men and may significantly benefit from a stress management group. After completing a literature review, it was discovered that little information on stress management groups for homeless women exists. However, by using the current literature on stress management groups in general, a group can be developed. Completing a psychoeducational group focusing on the most common stressors homeless women experience, and creating a positive community feeling, may help reduce levels of stress.

The purpose of this paper is to examine stressors and stress management, particularly in groups, for homeless women. Many of the stressors homeless women often encounter have been identified and discussed in literature; however, there is a disconnect with what this means in aiding these individuals to overcome these stressors, especially in regards to creating a stress management group. This topic is an important one given that the two most rapidly growing subgroups within the homeless population include women and women with children (Zugazaga, 2004). There are also studies that show homeless women who are single may perceive events as more stressful than either homeless men or homeless women with children (Roll, Toro, & Ortola, 1999; Zugazaga, 2004). The way in which an individual perceives an event will determine if the individual finds the event stressful or not. Knowing this information, it becomes evident that a closer examination of stress and stress management for homeless women is a topic requiring further discussion. Therefore, this paper will look at the types of stress, followed by a brief description of stress management, a discussion about the stress experienced by homeless women in particular, and then end with a review and critique of the existing literature.

OVERVIEW OF STRESS

Even though stress is a part of people's everyday lives, defining stress can prove to be a challenging task. For the purpose of this article, stress will be defined as "the inability to cope with a perceived (real or imagined) threat to one's mental, physical, emotional, and spiritual well-being, which results in a series of physiological responses and adaptations" (Seaward, 2004, p. 5). The key part of this definition is the word perceived. An event

one person finds stressful may not be perceived as stressful to another. With such a great variance in what defines stress, and the way in which each person will experience stress, it is beneficial to examine this phenomenon more closely.

There are three different kinds of stress: eustress, neustress, and distress (Seaward, 2004). Eustress is the positive, motivating, and inspiring stress a person may experience. For example, meeting your hero may involve eustress. Another type of stress is neustress, which is not considered good or bad stress. An example is learning about a tornado in a state across the country from a particular individual; it is neither bad nor good, it just is. Finally, distress is usually considered bad stress. There are two types of distress: acute and chronic. Acute distress is quite intense once it is perceived and then quickly disappears, while chronic distress may not seem so intense at first but lasts for long periods of time.

Another way to examine stress is through a complex mixture of six variables: stressors, distorted stressful appraisals, physiological arousal, medical and emotional distress, reduced psychological functioning, and coping deficiencies (Smith, 2002). First, stressors (stress events or situations) are life events where change and readjustment contribute to stress. Distorted stressful appraisals are the second variable. When these appraisals are irrational and maladaptive, it is most likely to be stressful. Appraisals may interfere with utilizing good coping skills because irrational and maladaptive appraisals often contradict facts or reason. The next variable, physiological arousal, involves the great deal of energy it takes to deal with some of the stressful life events people go through. Some symptoms that may be a sign of physiological arousal related to stress include fast and irregular heartbeat, hurried and uneven breathing, tight and tense muscles, dry mouth, backache, and loss of appetite. The fourth variable is medical and emotional distress. Chronic stress arousal is not healthy and can add to dysfunction and problems in the body. This can increase vulnerability to a wide range of illnesses (e.g. allergies, cancer, diabetes, hypertension, sleep disorders, etc.). In addition, negative emotions such as depression and anxiety often indicate psychological distress. The sixth variable, reduced psychological functioning, may occur when people are markedly stressed. They may not be able to do their best at work and in relating to others.

Coping deficiencies involve problem-focused and emotion-focused coping strategies. Problem-focused coping involves trying to change a stressful situation. Emotion-focused coping entails trying to reduce the discomfort involved in a stressful event without trying to change the situation itself. Research on coping has been expanded from this distinction and can be sorted into four categories: actively trying to

change a stressful condition, altering how we realistically appraise or think about the situation, releasing our pent-up emotions or relaxing, and distorting or denying that a problem exists or withdrawing from a problem (Smith, 2002).

Just as the term stress has various definitions, stress management has created an assortment of definitions and techniques (Smith, 2002). The definition for this article is from Smith (2002) stating stress management is, "a set of skills that enable one to anticipate, prevent, manage, and recover from the wear and tear brought on by perceived threats and coping deficiencies" (p. 5). Along with this definition, there are four pillars of stress management that are applicable in most stressful situations: relaxing, planning how to solve the problem, thinking realistically and productively, and reviewing and rehearing.

HOMELESS WOMEN AND STRESS

As two of the most rapidly growing subgroups of the homeless population include single women and women with children, it is important to examine stress in homeless women (Zugazaga, 2004). Homeless women are often more likely to have poor physical health, experience victimization, and have drug use and dependency troubles (Nyamathi, Stein, & Bayley, 2000). Stressors, such as housing instability, poverty, and work problems or unemployment, are often the experience for homeless women (Milburn & D'Ercole, 1991; Munoz, Vazquez, Bermejo, & Vazquez, 1999; Zugazaga, 2004). Living in poverty can almost assure that one will live a life with chronic struggles because it is necessary to spend income on necessities and have little or no flexibility in spending any money coming in (Milburn & D'Ercole, 1991). Zugazaga (2004) found the top three most frequently occurring stressors for homeless single men, single women, and women with children were a major financial crisis, followed by breaking off a steady relationship, and finally the death of a close friend or relative.

When comparing homeless women with children, single women, and single men, the women, with and without children, reported having higher depression and anxiety levels than single men (Roll, Toro, & Ortola, 1999). This is important because the women did not differ significantly from the men with regards to diagnosis or hospitalization for mental illnesses, thus women may perceive their current situation as more stressful than men. In a more recent study, it was found that single women had the highest rates of being hospitalized in a psychiatric facility and experienced considerably more stressful life events than either the single men or women with children; yet, there still was not a significant

difference between the three groups when examining the diagnosis of a serious mental illness (Zugazaga, 2004). This may again point to single women perceiving these life events as more stressful.

With homeless people who are single it has been estimated that 22% are considered mentally ill, as compared to only 8% for homeless people who have children (National Coalition for the Homeless, 2008). Women with children still often note feelings of powerlessness and loss, distress, fear, and anxiety (Tischler, Rademeyer, & Vostanis, 2007). Disorders such as depression and anxiety are rather prevalent for homeless women in general, and while social support is a key aspect of coping in stressful situations, women often feel separated from sources of support (Tischler, Rademeyer, & Vostanis, 2007). Diagnoses from the American Psychological Association Diagnostic and Statistical Manual of Mental Disorders Fourth Edition Text Revision (DSM-IV-TR, 2000) that may be more relevant to this population when experiencing stress include depression, anxiety, adjustment disorder, acute stress disorder, and post-traumatic stress disorder. The latter two may be due to trauma and victimization that homeless women often experience (Nyamathi, Stein, & Bayley, 2000). Adjusting to homelessness may lead to depression, anxiety, and adjustment disorders. While these are certainly not the only diagnoses within the homeless population, these may be more prevalent due to the stressors this population experiences in life. Although, the DSM-IV-TR (2000) does not have a diagnosis specifically for stress, the stress may manifest itself into some of the aforementioned diagnoses.

It has been well established, as noted above, that homeless women experience a great deal of stress in their lives. Perceiving events to be so stressful, along with a lack of good coping skills, creates a need for stress management for homeless women. Promoting healthy support networks through a group, providing training and skills to afford and maintain housing, integrating into a positive community setting, and developing higher self esteem are some of the areas pointed out in the existing literature to work on in order to help homeless women (Milburn & D'Ercole, 1991; Nyamathi, Stein, & Bayley, 2000; Tischler, Rademeyer, & Vostanis, 2007). Homeless women need to develop stress management skills to help them cope with being homeless at the current time and to take with them when they leave shelters. Perhaps this will aid in their integration back into society more quickly, smoothly, and less stressfully.

REVIEW AND ANALYSIS OF LITERATURE

It is important to note the author was not able to locate any articles examining stress management in group therapy designed specifically for

homeless women. An integrated stress management group for women in general was found which may be applicable to homeless women. This model teaches various relaxation techniques, offers information on nutrition, exercise, and sleep, and encourages the implementation of stress-reducing behavior changes (Ulman, 2000). Cognitive and behavioral interventions are both included in order for clients to become aware of their thoughts and behaviors that affect stress symptoms and help women become more active in their overall health care. Ulman (2000) notes learning new behaviors can feel strange, therefore having a group in which to feel valued, accepted, and validated is important.

In order to understand this integrative group model, Ulman (2000) discusses the composition of the group. It is an eight week group that meets for an hour and a half weekly. Each session has three components: teaching and practicing relaxation techniques, individualized exploration and discussion of the cognitive and behavioral changes needed in order to reduce stress symptoms, and an open-ended discussion of general life situations including the role current relationships play in either helping or hindering the woman to achieve her goals. During relaxation, the women learn how to attain a sense of calmness and stillness and how to differentiate between this calm state and their stressful state. The second component of exploration and discussion is to help the women recognize any resistance and compel the women to think about what has been effective and ineffective in the past when responding to life stressors. The final component is geared towards exploring affect and the development of respect and support.

Ulman (2000) further breaks down the sessions for this group. The beginning sessions (one through three) include major tasks such as getting to know one another, learning relaxation skills, and developing individual goals. The middle sessions (four through six) are considered the working sessions in which group members come together and support each other, while giving evidence of how they took the group with them during the past week. These sessions may involve more unstructured discussion to develop insight into their struggles with making behavior changes. The end sessions (seven and eight) are for saying good-bye and giving examples of how they will take advice and information from other group members with them.

Although this integrated stress management group for women seems well thought out and developed with specific concerns women may have in mind, Ulman (2000) does not have any research data to measure the efficacy of the group model. After conducting fifteen groups using this model, it was observed that most of the women addressed and mastered internal difficulties and felt an increased sense of well-being. There was no

follow-up completed in any of the groups to measure any long-term effects. Conducting a study to measure the success scientifically, rather than solely observing it without a research design in mind, would provide evidence for adopting this model.

The article most closely related to stress management groups for homeless women involved stress management training for women on public assistance, although, it is quite dated (Tableman, Marciniak, Johnson, & Rodgers, 1982). The study involved the Stress Management Training Project (SMTP) in Michigan, which was designed to reduce poor mental health and dysfunctional behavior in women on public assistance. Over two-years, the study examined 65 women in the experimental group (receiving seven to ten training sessions), and 51 in the control group (receiving no sessions). Those in the experimental group were to attend ten weekly sessions lasting from two and a half to three hours. The first three sessions aimed to improve self-esteem and identify aspects of personal relationships that induce stress. This involved labeling feelings, exploring the impact of negative feedback, and practicing to accept and give positive feedback. Sessions four through eight discussed an acceptance of responsibility for their behavior and techniques to use in order to take control. This was completed through clarifying needs and goals, practicing problem-solving skills, and assessing key relationships in their lives. The last two sessions were to aid in understanding stress and stress management strategies. The women reviewed signs of stress and responses to stress, while also practicing positive self-talk and redefining the situation.

This study demonstrated that SMTP may have a positive influence on women's lives, because significant differences between group means was found (Tableman et al., 1982). An increase in self-confidence and decrease in anxiety and depression suggest SMTP may change behaviors that are associated with the low self-esteem many of these women face. Because the findings of this study support a group intervention for these women, it is imperative to further explore and recreate this program to determine the benefits it can provide women. Learning more about what techniques or teachings were most beneficial for these women is important in order to help women in the future.

Another area in literature has reviewed coping, or how a person responds to situations, and stress management (e.g. Majella de Jong & Emmelkamp, 2000; Rayburn et al., 2005). Avoidant coping (e.g. hoping for a miracle, making the self feel better through eating, smoking, or drinking) was found to be related to physical and mental dysfunction (Majella de Jong & Emmelkamp, 2000; Rayburn et al., 2005). Furthermore, experiencing a trauma may contribute to an avoidant coping style, which

may then increase the risk for experiencing depressive symptoms in women residing in shelters (Rayburn, et al., 2005). Another explanation offered by Rayburn et al. for this finding states some behaviors that are inherent in avoidant coping are in essence aspects of depression. On the other hand, active coping (e.g. talking to a professional, becoming informed about the problem) has been shown to be negatively related to dysfunction (Majella de Jong & Emmelkamp, 2000; Rayburn et al., 2005). In one study that examined more long-lasting effects, participants were recruited through their employment site. They completed an eight week long group of stress management training and then had six months time pass. Improvements were maintained with an increase in problem-focused (active) coping and decrease in psychosomatic complaints (Majella de Jong & Emmelkamp, 2000).

One final area within research that will be reviewed involves stress management in women with breast cancer. In a ten week cognitive-behavioral stress management (CBSM) group, women were exposed to didactic material, experiential exercises, and homework assignments (Antoni et al., 2001). The focus was to learn to cope better with the daily stressors associated with cancer and how to optimize the use of social resources. The group used both problem-focused coping strategies, such as active coping and planning, and emotion focused coping strategies, such as relaxation training and emotional support. The control condition received a one day seminar, although the information covered was not explained. For the experimental group, CBSM affected two measures of well-being: an increase in the reports of experiencing a benefit from having breast cancer and an increase in the levels of general optimism about the future. In a similar study for CBSM with women having breast cancer, evidence was again found to support group based stress management intervention as being effective (Antoni et al., 2006).

Given that no studies were found specifically examining stress management group therapy for homeless women, a review of an article explaining how to structure and design a psychoeducational group may be helpful. Through this article we may learn how to better pull the existing literature together in order to develop a psychoeducational stress management group for homeless women. Furr (2000) notes there are two phases, each with three steps, in developing a psychoeducational group. The first phase is conceptual and involves creating a statement of purpose, establishing goals, and setting objectives. The second phase is operational and includes selecting content, designing experiential activities, and evaluating the group. It is important that goals be focused, a theoretical orientation guides the objectives and content that is selected, and that

activities are well-designed and well-processed. Following these steps gives us a starting place when creating a psychoeducational group.

In analyzing the studies for this literature review, these steps for developing a psychoeducational group were not often noted. Some studies did include a theoretical orientation (Antoni et al., 2001; Antoni et al., 2006; Ulman, 2000). Only one study explained the theoretical approach of CBSM, which suggests that techniques to minimize physical tension and anxiety ridden thoughts can promote fewer negative experiences and more positive experiences (Antoni et al., 2006). As previously described, there were studies which noted general topics or areas to work on for sessions, but no study broke down the group session by session with very detailed descriptions of activities, process goals, and didactic material to be covered in session. Using this model in order to develop a study on stress management groups for homeless women may help create a better, more well-designed, and easily replicated group that can then be applied in practice.

The studies being reviewed would also benefit from further examining multicultural issues within stress management groups for homeless women. While knowing how many people are homeless on average each day is rather difficult, it is estimated that the homeless population is about 42% African American, 39% White, 13% Hispanic, 4% Native American, and 2% Asian (National Coalition for the Homeless, 2008). This is important to know because our research should try to match these percentages when developing studies and gaining participants. With the exception of one study reviewed, studies did not match this ethnic diversity and included mostly Caucasian participants. It may be difficult to generalize the findings of some studies, because multicultural concerns are not made known. For example, two studies did not describe the race or ethnicity of the participants (Majella de Jong & Emmelkamp, 2000; Tableman et al., 1982). However, one study examining trauma, depression, and coping in impoverished women included 61.70% Black/African American, 23.22% Hispanic, and 9.91% White participants (Rayburn et al., 2005). Having such a diverse sample in more studies may help generalize the results from other groups of women to impoverished women.

In addition to knowing the race or ethnicity of participants, it may be helpful to obtain information about items such as education level and relationship status. Noting participant's highest level of education completed may be beneficial. It may be found that depending on the amount of education people have, help-seeking behaviors, problem solving skills, optimism, or other variables may look different or have a range of effects on stress. There was diversity in the education level in the same study examining trauma, depression, and coping listed above, with

36.02% completing high school and 38.39% more than high school (Rayburn et al., 2005). Furthermore, recording participant's relationship status may provide valuable information. Many articles discuss the importance of social support, yet some studies did not report participant's relationship status (Nyamathi, Stein, & Bayley, 2000; Tischler, Rademeyer, & Vostanis, 2007). Again, if participants are married or in a relationship they may look at stressful situations in a different way, possibly with more optimism or comfort in knowing someone is there who can help them get through the tough times.

CONCLUSION

It is obvious that there is still a tremendous amount to be done with future research. The multicultural issues just discussed are only a few. First, while it appears that stress management groups for women are successful in reducing a variety of symptoms we are not sure how long this success lasts. Second, there were no studies found that examine stress management groups for homeless women in particular. While we can take pieces of information from other populations that have been studied, we cannot be certain if there are any significant differences in how homeless women react to stress management groups.

All of this information can be applied in creating a stress management group for homeless women to the best of our ability at this time. It is important to use the advice Furr (2000) gives in how to develop a psychoeducational group in order to insure we have a sound background and reasoning for implementing what we are doing in group. Cognitive-behavioral techniques seem to have been the most common methods used and have been shown to be effective in the studies reviewed. Therefore, using a cognitive-behavioral approach to develop the group activities and assignments may be important. For example, relaxation training seems to be an important component to use in stress management, as most studies utilized this and found it effective (Antoni et al., 2001; Antoni et al., 2006; Majella de Jong & Emmelkamp, 2000; Tableman et al., 1982; Ulman, 2000).

There are many different techniques and skills that can be taught in a stress management group; therefore it is essential to remember the stressors many homeless women have experienced or are experiencing and let it dictate the skills and techniques to cover. As discussed, relaxation techniques help calm the mind and become aware of the difference between our relaxed and stressed states. These techniques have been shown effective and should likely be included in a stress management group for homeless women. Problem solving skills and positive self-talk are also areas that have been found beneficial and may be applicable to

homeless women (Antoni et al., 2001; Antoni et al., 2006; Majella de Jong & Emmelkamp, 2000; Tableman et al., 1982). Teaching and reviewing a variety of techniques within a stress management group offers more choices for women and may increase the likelihood that each woman finds something that is helpful in her situation.

Homeless women are experiencing a great amount of stress, as compared to homeless men, and often lack the coping skills that may be most beneficial for them. Developing a positive community experience through group where the women can acquire support from others may offer the social support necessary to help reduce stressful feelings. Even though no studies were found that specifically looked at stress management groups for homeless women, we can use the information from the existing literature to develop this group to the best of our abilities. Until research is completed for this particular population, we may not know for sure that what we create will be successful. This gives us good reason to be sure we are scientifically evaluating our groups in order to examine what we may need to change in order to best help homeless women manage and reduce their stress.

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