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ONE SIZE FITS ALL?
A COMPARATIVE STUDY OF A MIND-BODY STRESS REDUCTION GROUP PROGRAMME TO BUILD RESILIENCY

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A research portfolio submitted in fulfilment of the requirements for the degree of Master of Counselling
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Abstract

This mixed methods study investigated the effectiveness of a five week mind-body stress management group. This programme was delivered to two population groups: tertiary students and people with addictions. The focus was on the impact of stress on health and wellbeing. The interventions were informed by the research indicating that increased coping and resilience strengthens the ability to choose stress reduction activities that do not exacerbate self-harm. By promoting alternative methods overall health can be improved. The programme was delivered to 10 tertiary students and 12 people using community addiction services. The mixed methods approach was as follows: two self-report questionnaires administered prior to commencement and after group completion, measuring depression, anxiety, stress and coping skills. Focus group interviews elicited participants’ historical narratives of stress and coping, plus any perceived influences that the group had on participants’ coping. Results for each group were analysed separately and then compared across the two groups. Findings indicated that although historical and current stressors may have different origins, distress is assisted by engaging in mind-body techniques in a group programme. Together with lessening stress, levels of depression and anxiety were also effectively lowered for the majority of participants. There were marked improvements in coping levels, evidenced in particular by a substantial reduction in suicidal ideation and aggression. Results indicated that in fact the same programme did elicit positive results for two diverse population groups with greatly differing stress triggers. Therefore, stress and anxiety, regardless of the underlying cause, may be well managed within a group setting.
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INTRODUCTION

Personal Reflections: The Rollercoaster

For the past 16 years I have worked as a counsellor in a variety of private, public and non-governmental organisations. I have worked in small rural communities and in the city of Auckland with clients of different ages, nationalities, socioeconomic and ethnic backgrounds, and have learnt from them about their diverse cultures and beliefs. Currently I work as a counsellor in the Student Health and Counselling service of a major University.

I am a 49 year old second generation New Zealand woman, whose heritage rests in Croatia, the former Yugoslavia. Three of my four grandparents immigrated to New Zealand from Yugoslavia, hopeful and searching for a better lifestyle. When I consider the stress involved with immigration, my heart speeds up with feelings of anxiety. Each of these grandparents spent up to three months aboard ship travelling toward a new country of which they were totally ignorant. Upon their arrival, they could communicate with few because they could not speak English. They worked hard and long hours in the gumfields, digging for and scraping kauri gum for sale. One of my grandmothers was a mail order bride, marrying a man with whom she was unacquainted until three days after arrival in Auckland. None of my grandparents ever returned to visit others members of their families, nor set eyes on their parents ever again. I enjoyed their tales, and particularly admire their resilience and coping skills unconsciously instigated to manage and survive this life stage transition. My interpretation of the stories told is that family, connection, community and acceptance of the situation were strategies used to manage stress. Their lack of choice assisted their abilities to accept the situations in which they were placed.

Two generations later, my own stressors originate from a different sphere. I understand the pressure of study, having only entered the “path to study” by beginning as an adult student 16 years ago, then aged 33. Though not as dramatic as immigration, this life-altering phase represented a time of great joy, pressure and immense stress. It was a
rollercoaster ride, linking and overlapping highs, lows, sharp turns, fear, trepidation and excitement. I juggled the demands, challenges and loves of bringing up my three children (the youngest at that stage aged two), while working, parenting and studying simultaneously. For the majority of this time a major stressor was that my place of learning was a three hour drive from my home town.

Despite being supported by friends, I often felt distressed, alone, and quite overwhelmed by the continual tugging of work, career and family life. These enjoyable pressures that pulled me in different directions were completely a result of my choices, but there never seemed to be enough hours in the day. I often felt ill equipped to manage my resultant challenges and distress, and wondered how to best balance my lopsided lifestyle. My parents’ cultural beliefs did not support my newly planned way of life and my husband’s promises of back up help were shallow. This lack of familial assistance added further heaviness to my foray. In hindsight, I recognise relationship, spiritual, emotional, physical and cognitive problems that manifested during this time of my life. I also acknowledge the beneficial coping strategies I used that helped me build resilience over this period, and assisted me in achieving my study goals and managing my multiple roles. However, I believe that if I had known then what I have since learnt about stress management, my overall experience would have been different and more positive overall.

Stress is necessary to motivate myself. It is the driving force towards taking an action, and it is needed in my striving towards and achieving potential goals. I wake every morning to an alarm clock – an external stressor that encourages me to get up and get to work on time. The traffic on the way to work is a stress, and work itself is another stress. Stress is a part of everyday life. Realistically we cannot eliminate stress from our lives, but we can learn how to use coping mechanisms and change our thoughts and views of stressful events. We can also learn to recognise what relaxation feels like, so we are more readily able to incorporate it into our daily lives as a way of building resistance to stress. Building resilience to stress assists self esteem, general health and wellbeing. Having a sense of coping assists our relationships with our self and others and happiness.

My role in this study has included researcher, group facilitator, and additionally I recognise the role I have played of an “empathetic peer” who struggles with stress on an ongoing basis. My background as a student assists me in recognising some stressors
tertiary students may struggle and contend with. I have a family background of addiction and my previous work as an addictions counsellor spanning 10 years assists me in empathising with clients with substance abuse problems.

My interest in stress was initiated by a six session stress management group programme at an alcohol and other drug (AOD) treatment service I recently co-facilitated named “Managing Stress Successfully.” The dominant issues of this client group were alcohol and drug misuse. These substances were often used to manage stress symptomology. People who abuse alcohol and drugs may initially use their substance to manage stress or for other reasons. This may lead to behaviours where they are seemingly unable to cope without their substance of choice, and over time become addicted to its presence. If substances are used as a form of coping, this has the effect of hindering the utilisation of or the potential to learn other different healthier strategies.

The drug of choice takes predominance over all else, causing a raft of social, personal and interpersonal problems, as indicated by the diagnostic criteria for substance dependence and substance abuse in the DSM-IV (1998). Namely, for substance dependence, one criterion translates as “a great deal of time is spent in activities necessary to obtain the substance, use the substance or recover from its effects” (p. 108). Three of the four diagnostic criteria for substance abuse highlight the overwhelming power and control the drug of choice has over its user: “failure to fulfil major role obligations at work, school or home,” “recurrent substance-related legal problems” and “continued use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance” (p. 112). These criteria emphasise that addiction issues rarely occur alone, and relationship and obligatory problems often present along with the substance abuse or dependence.

When lessening or removing substances in a bid to improve individual wellbeing, stress and an inability to manage resulting distress were often causes of lapse or relapse into previous use. However, after attending the six week psychoeducational group programme, group members’ evaluation forms highlighted positive feedback and improved coping strategies for managing their stress. Some group participants chose to repeat the group programme to better concretise their skill base, and one man repeated it four times.
I believe changes in group participants occur in multiple ways. The group context in which the psychoeducational programme is delivered teaches and promotes new ways of being and doing, but there is the additional element of connection and having interrelationships with others. The intimacy of relating with others is a powerful group dynamic. The therapeutic relationships that are instigated and built between facilitator and group participants, as well as among group participants, play an important part in the success of the group. The nature and quality of the interactions in these relationships explain why some groups appear to be more successful than others. My feminist background and grounding promotes a group culture that is nurturing and respectful of all people. I hold beliefs that we are all equal, and therefore do not promote myself as “the expert” preferring a collaborative approach. I believe existentially that “there is no ultimate truth.” This philosophy promotes conversation and transparency, and a building of trust within a group.

I have most recently delivered the same Managing Stress Successfully group programme to students at a tertiary institution in Auckland. They have identified their stressors as: the pressure of deadlines; examination stress and test anxiety; monetary and relationship difficulties; unhelpful thought patterns; and getting the right balancing of social commitments, study, exercise and other important events in their schedules. From my counselling experience I see stress presented in a myriad of forms including anxiety. Students’ reports of stress include feeling overwhelmed, tired, tense, confused, stretched, and concerned about their behaviours of ruminating thoughts, procrastination, disorganisation, isolation, and sleep and eating mismanagement. Often students are physically unwell or have present relationship concerns, and I wonder what part stress plays in their lives and in relation to their problems.

Within the counselling team at the Auckland tertiary service where I currently work, we often discuss anxiety as a common issue for presentation. The DSM-IV (1998) criteria denote this as “excessive anxiety and worry that is difficult to control, occurring more days than not for at least six months” (p. 213). One criterion states “the anxiety and worry are associated with three or more of the following six symptoms of restlessness, being easily fatigued, difficulty concentrating or mind going blank, irritability, muscle tension or sleep disturbance” (p. 213).
Positive comments received from past group participants referred to the power of the group itself, the strategies taught and the comfort gained from the hassle-free atmosphere. Students who have attended the stress management programme to date have voiced that they particularly enjoyed spending time “chilling out.” This was achieved by providing them with a relaxed environment, supported by mindfulness practice at the beginning and end of each meeting. By centring themselves and focussing mindfully they were better able to settle down and incorporate the tools into their lives. They shared their affirmations and recognised that they were not alone in their feelings of stress and anxiety, and reported that they felt empowered by incorporating new ways of coping and building resilience to stress. Group camaraderie assisted this to happen. One female tertiary student wrote on her feedback form that it was “great to have permission to stop the treadmill to take the time to care for myself, without feeling guilty and learning that in fact it was essential for my wellbeing.” This realisation showed an acceptance of her stress levels, plus the recognition of the need to use self care as a coping tool.

In addition to the group participants, I noticed the help and support I gained for myself in managing my own distress, through the regular reminders about ways of coping while facilitating this group programme. Leading the course has felt like an important part of my own self care and growth. Every time I deliver this programme I am reminded of the strategies I need to continually utilise and prioritise to increase resilience and build a stronger sense of my own identity. Mindfulness, thought stopping, deep breathing, healthy eating, exercise and relaxation are strategies I utilise on a daily basis.

Though there are differences as well as similarities among the stressors experienced by tertiary students, myself, and clients with addictions, my work as a counsellor leads me to believe that we are predominantly more alike than different. I therefore became curious about testing my theory that this stress management group programme delivered to both population groups (tertiary students and clients with AOD issues) in this study would be effective for all attending. I was hopeful that the resulting data would show increased coping and resilience for both populations, and I was also expectant there would be other positive interactive and relational effects from attending the five week group.
Key elements of facilitating group work: Reflecting on experience in practice

Integral to the delivery of the stress management programme at the centre of this research project is the nature of group work. Drawing on my professional experience as a facilitator of groups, as well as relevant literature, I considered the advantages as well as the complexities and challenges of delivering group programmes in planning this project. As the facilitator as well as the researcher, it seemed important to identify my own perspectives about group facilitation.

My foundational training is firmly grounded in the person centred approach of Carl Rogers (1951) and I hold his basic assumption that people can generally resolve their own difficulties without direct intervention from others. I agree that individuals have the capacity to self heal if given the right environment, assisting them in developing an internal locus of evaluation (Rogers, 1951). The assumptions and ideas behind client centred practice are more of a philosophy of living that I continually attempt to immerse into my private life as well as my working career. This helps in having integrity as a counsellor. In group work, the person centred approach is particularly useful because of its emphasis on listening and understanding participants from their internal frame of reference, promoting respect and openness (Corey, 2010).

A different way of promoting empathy is to observe the delivery of a group as a participant. One recommended pre-requisite to facilitation is to initially participate fully as a group member (Corey, Callanan & Russell, 2004), in order to experience being on the receiving end. This experience is useful in identifying strengths, weaknesses and gaps in the programme, as well as recognising the more intimate and personal responses noticed from a participant’s point of view.

The most qualified and skilled group facilitator is wise to treat every group as a learning experience, being humble enough to recognise their own limitations and hold an open appreciation toward learning. Being open to learning and change, and recognising expertise within each group participant takes the emphasis away from the facilitator needing to be the “expert.” The attitude and stance of the facilitator is therefore pivotal in group success.
When facilitating groups, I nurture and draw on the client centred qualities identified by Carl Rogers (1951) unconditional positive regard, empathy, respect and genuineness to provide a foundation and culture that upholds these attributes within the group. This group environment assists the process in creating a form of protection or a safe haven, allowing individuals to practice strategies or behaviours with others spontaneously, with minimal fear of negative consequences. This atmosphere thereby promotes behavioural change in a context that offers opportunities for interactive work not available in one to one therapy.

In my experience, the majority of stress management group participants often initially present as tired, quiet and anxious individuals. They may be fearful because of their own or what they imagine to be others’ expectations and what may be asked of them. Feminist counselling theory encourages facilitators to be nurturing and respectful, alongside promoting independence and assertiveness (Chaplin, 1995). The group facilitator role models these qualities in order to build rapport among and within the group participants. The concepts of being nurturing and respectful while fostering members in becoming independent and assertive are seemingly contradictory elements which in turn assist and promote change from distress to coping, yet they are consistent with Rogerian principles.

In order to feel comfortable in acting openly, individual and group safety is paramount. Clear group guidelines developed collaboratively through an exercise at the beginning of the group process are essential in building group cohesion, and further support a culture of safety (Rogers, 1993). Drawing up group guidelines together helps place the responsibility and authority of them clearly with the participants, rather than any agency or facilitator dictating the rules, thereby strengthening their level of commitment. It is beneficial to revoice the guidelines each session because this can often cushion or block potential disruptions to the group process. Guidelines are a positive point of reference if problems occur within the group, and assist in supporting the role of the facilitator, as well as helping group members to take responsibility for their own contribution to maintaining effective group dynamics. Encouragement to locate power in each participant is a premise of applying the person-centred approach in groups (Corey, 2010).
When drawing up the list of group guidelines at week one, a common suggestion is “having the ability to pass” in regard to speaking. I openly discuss this with participants, stating that it is fine to pass, but that group attendance provides an opportunity for growth and a possibility to take a risk in relation to trying something different. From my prior experience facilitating stress management groups I remember one group participant who attended all six sessions and never spoke one word because of shyness. When asked to contribute, he visibly looked at his feet and shook his head. I was amazed that although he struggled socially, he returned to the group every week. When he was respectfully asked to add to the conversations, there was little pressure for him to do so. His feedback form rated the course and coping skills as being useful and helpful.

Each session is structured around a key topic which provides a group focus that assists in breaking down barriers to communication. In turn, confidence increases while social anxiety and stress levels lessen. There is positive vicarious learning that occurs in groups (Jacobs, Masson & Harvill, 2006), and the group setting provides a common experience for group participants. This occurs by promoting universality and increasing familiarity, which in turn promotes interaction and relationships among group members. Yalom (2005) named eleven “curative factors” that he considered essential in a productive and successful group. These include universality which is the recognition that others have similar concerns; providing the instilling of hope about one’s life; modelling positive behaviours from other members while giving to other members altruistically; and group cohesion and closeness among members. This is consistent with MacNair-Semands and Lese’s (2000) study of 15 support groups in tertiary counselling centres. They concluded that student similarities in regard to other group participants assisted in building hopefulness and an ability over time to better manage problems.

To maximise the potential of groups to support change and growth, facilitators’ skills and a positive attitude are crucial (Jacobs et al., 2006). An area of caution in group facilitation is that consideration must be given to balancing the needs of individuals with the group needs. If one participant disrupts the group, for example, by continually arriving late to group, the facilitator needs to decide whether to remain with the group, or take the individual aside to discuss options. Other potentially disruptive dynamics include participants monopolising groups; challenges or confrontations between group
participants; the development of subgroups that can sabotage group process by changing group direction or subject; or simply a few participants talking among themselves. The facilitator holds an important role in managing and supporting all group participants, and this can involve handling awkward situations and delicate interactions at times. Challenging potential inter-relationship and intra-relationship dynamics involves a process that can be better supported by the presence of a co-facilitator. Co-facilitation is valuable in providing another avenue for support and is useful for debriefing and discussion afterwards (Corey et al., 2004).

The relationship dynamics within any group are multi-dimensional. The potential to build resilience is inherent in each person, and this can be activated and assisted in its growth by making and strengthening relationships that foster resilience (Waller, 2001). Seeing this within an ecosystemic view, one of the aims of the group process is to foster resilience, not only via the facilitator of the group, but of equal importance, through other group members. Discussion of stressors that are external problems, such as living arrangements or managing money for example, can incorporate suggestions, recommendations or available resources that can be shared by other group participants with similar experiences. Role play, feedback, coaching, modelling and discussion of homework assist in building resilience and are additional modes of learning (Waller, 2001). Role modelling by group participants is different from the role modelling provided by the facilitator.

The facilitator role models an empathic environment both cognitively and affectively by demonstrating openness, respect, sensitivity and awareness (Corey, 2010). This sets the stage for the enactment of these qualities in the interactions of the group members. Positive therapeutic change therefore occurs when members imitate positive behaviour they experience being modelled by other members and the facilitator, in an environment in which other curative factors (Yalom, 1995) are also experienced.

**The intricacies of running a group programme**

As well as relational qualities of the facilitator and participants, the sophistication of the basic provision and facilitation of a group programme requires ongoing vigilance. This includes having enough time to prepare fully, choosing appropriate and useful material,
and presenting the programme in a way that stimulates learning and interest. This entails a lot of preparation time, which is complicated by not knowing the numbers of attendees from week to week until each session begins.

Participants are sometimes sick and may forget to phone in their apologies, or may simply change their minds about wanting to attend for all sorts of valid reasons. Group numbers may fluctuate in turn. Participants sometimes arrive once the group has begun, disrupting the group process. They may also be affected by different life responsibilities and needs. This can add to the difficult task of finding a meeting time most suitable for all participants and facilitators. Often trial and error is necessary to find the optimal time of day, and which particular day of the week will enable the greatest number of participants to attend. The process of negotiating these practicalities can be time-consuming and disheartening.

There is a nagging concern with solitary facilitation about what would happen if the facilitator was sick on the day of group. Equally there is the same concern when sharing the facilitation, as to whether one facilitator has the knowledge to conduct the session by themselves, or find a back-up facilitator available to co-facilitate.

Psychoeducational groups are structured according to key topics, and they should be facilitated in such a way as to encourage feedback and sharing among participants, and raise members’ self-awareness, which in turn helps bring about personal change for each individual (Corey, 2010). It is the facilitator’s responsibility to balance the presentation of the information in an interesting way from a multi-modal stance, while holding group dynamics and overall group focus at the same time. The information chosen as the focus for discussion in each session and how the information is delivered are therefore equally important. Gladding (2003) advises that if a facilitator is not an expert in the field of the group programme’s focus area or topic, he or she must be responsible in bringing in an expert to present the information. The facilitator of the group holds the prime role in ensuring information is concrete, appropriate to the group members, and clearly presented in a stimulating and thought provoking way.

Jacobs et al. (2006) saw the future of group work as represented by an integration of counselling theories, delivered in an active, interpersonal, multisensory model of learning, and encompassing the involvement of group participants. I agree with this
standpoint, recognising the need to make group work interactive and fun, and facilitation an “active, creative and multi-sensory” process (p. 13).

Group or individual therapy

From a client’s perspective, there are many points that require consideration when offering the choice of individual therapy, group therapy or a mixture of both. Group counselling is not a viable option for everyone, and could be detrimental for some cultures or specific individuals, particularly minority groups, due to the psychological risk posited by group dynamics (Corey, 2010). Where participation is optional, an individual may benefit from a mix of one to one therapy, while attending a group programme simultaneously (MacNair-Semands, 2002). However, the choice of individual therapy could be limited if financial constraints or long waiting lists influence processes within the workplace.

Individual sessions can be used to discuss in more detail the information, skills or processes of a psychoeducational group, or to work on personal issues that arise from the group sessions, thereby complementing the group work. From my previous experience, I recollect many occasions when individual counselling has supported the development of action skills and negated stumbling blocks to innovative and introductory strategies initiated during group time. This back up, individualised support also delivers an opportunity for personal concerns to be expressed or disclosures made that may not be considered appropriate within the larger group. A therapist can therefore work with a client to look more precisely at delicate, private and emotional issues of concern and meet an individual’s unique needs. Working one to one with an individual can build trust and rapport more readily than within a group of people, and therefore important personal stressors or concerns may be spoken of and assisted more directly.

There are some individuals not suitable for group therapy. Although previous and concurrent individual therapy can play a large part in some participants joining and remaining in groups, according to MacNair-Semands (2002), conversely, she found that “angry hostility and social inhibition were predictors of low group attendance” (p. 219). If individuals affected by these traits were to attend group therapy their problems may not be voiced due to personal constraints or group composition. Other participants could
potentially be harmed by being interrupted or judged, or group pressure could force a participant to disclose before he or she was ready. Some individuals feel too socially anxious or for other systemic reasons do not want to attend a group, preferring one to one therapy. Individuals who suffer stress often present as anxious and this can hinder them from feeling able to attend a group. Secondly, it may stop them from making connections with others in the group, which can result in disrupted group attendance and consequential further isolation. Less confident group members may feel reluctant to discuss disturbing cognitions, resulting in these not being explored nor evaluated.

Individual therapy however can leave a client feeling in the spotlight and in effect, blamed or guilty for having stress, whereas in a stress management group setting, experiencing stress is normalised and recognised as being a common experience. From my counselling experience I believe that some people prefer learning by listening to others, and may be better supported within a group where they do not necessarily need to contribute. Relevant here are Yalom’s (1995) curative factors of group cohesiveness, interpersonal learning and universality. These non-specific therapeutic factors hold significant importance in promoting change and improving wellbeing, in addition to the more formal factors provided by the facilitator of a psychoeducational experience, the quality of the facilitation itself, and the leader’s ability to manage therapeutic forces (Jacobs et al., 2006).

**Minority group considerations**

Gender and social factors influence coping responses to stress (Brougham et al., 2009). In my experience of running stress management group programmes, there have been a noticeably greater number of female attendees than male. As a generalisation from my counselling experience over the past 16 years, I believe women appear to talk more readily with others about feeling overwhelmed and distressed, whereas the socially acceptable masculine norms of invincibility, strength and power may discourage some men from coming forward for support. This difference can be particularly relevant with regards to acknowledging distress. This is in line with coping theory that suggests that women prefer or select emotion focussed rather than problem focussed ways of coping (Brougham, Zail, Mendoza & Miller, 2009).
For a man to acknowledge he is not coping may present a challenge to his masculinity. The implications of this as a woman facilitator could involve colluding with other female group participants, and giving predominance to emotion focussed strategies, as well as potentially under-estimating how threatening participation and self-disclosure may seem for male members of a group. It is important to recognise and give respect to individual differences, which helps in breaking down barriers of isolation among group participants. Corey et al. (2004) highlight the importance of adopting a genuine respect for difference among group participants, while having the ability to adapt techniques to fit individual needs. Together, these build a foundational bridge to affirm diversity and create an atmosphere of inclusion.

During facilitation of group work I have noticed through observation of body language and verbal comments a hierarchy at times. In tertiary groups this equates to reactions among undergraduates towards members who identify as postgraduate or doctoral students. In groups in which participants present with AOD issues, the hierarchy may be between genders or working class and unemployed. This also occurs with certain cultural minority groups who may feel marginalised or perceived as alternative.

Past family dynamics are sometimes played out within a group environment (Yalom, 1995) and a person who has played the “quiet” role in their family in the past may be less able to put their ideas forward in a group, but can voice them more readily with one person alone. Body language reactions I have noticed include intimidation, shown by passive behaviours in response to the leader or others. Alternative observed reactions are a sense of pride and satisfaction at being in the same group as others supposedly further up the ladder. Comparisons with others can lessen shame, by seeing that one is not alone. I believe it is important to facilitate these matters in a manner that is beneficial and useful in promoting coping and resilience for all group participants.

The power dynamics can be altered constructively to lessen any power imbalance by using a person centred approach (Rogers, 1993), which is promoted as positively assisting individuals of diverse cultures together to bring about and develop a place of mutual understanding. “The relationship” is foremost in promoting growth, assisted by holding belief in the group process and in the group’s own ability to develop their potential. The relationship is asserted by the facilitator’s attitudes of genuineness,
acceptance and empathy which help build up a trusting approach within the group and among its participants. Empathy helps the recipient feel valued and accepted for who they are, while fostering self-exploration. A genuine acceptance of each participant’s story brings about a mutual trust and greater social equality, endorsing a climate of safety. This accepting and open atmosphere helps each group participant feel included and build connections with other members, breaking down difference.

From my experience of facilitating groups, the interpersonal and intrapersonal benefits for participants include feelings of mutual support and group cohesion from interacting with other group members through socialising, open discussions, role modelling and imitating behaviours. This real-life approximation can be more valuable than individual counselling because of its replication of real-life situations (Jacobs et al., 2006). Such experiences are best facilitated by a group leader who promotes safety and respect within a person centred framework as the paramount foundation for the group.

The following chapter will move from my personal reflections to a more formal literature review. Definitions of stress concepts will be given, followed by an outline of models of stress and coping. Potential areas that can cause stress for tertiary students and people with addictions are identified and detailed, and the consideration of whether individual or group therapy is better suited to their needs. The chapter concludes with an outline of stress management group programmes commonly promoted to raise coping and resilience levels.
This chapter begins with a discussion about the concepts and definitions of stress, followed by an overview of the models of stress. The third section focuses on the multiple ways that stress can affect health. Psychoeducation is identified as being useful in building coping and resilience, and is discussed in regard to stress and addiction problems, including individual and group approaches. The literature review ends with a discussion about stress management programmes and their relevance for both the tertiary student population and individuals with AOD issues.

Definitions used to describe stress concepts

When searching the stress and coping literature, the terms “stress,” “distress” and “anxiety” are often discussed as though they are interchangeable. Similarly, “examination stress” “test anxiety” and “academic stress” are presented as exchangeable concepts. In this section I will clarify the ways in which I will use relevant terms.

The idea of stress has changed over the course of time. The word “stress” originated from the Latin “stringere” meaning “to draw tight” and was often viewed negatively (Keil, 2004). Oswalt and Riddock (2007) defined stress as an inability to cope with a perceived threat. In the context of education, academic stress would be a perceived threat arising during study and learning. “Examination stress” occurs prior to or during examinations, and differs from “test anxiety” which refers to students’ reactions to test or assessment contexts.

Stress can be beneficial or debilitating, and Selye (1975) separated stress into two categories: “eustress” which enhances function (for example beginning a new positive relationship), and “distress” which is persistent stress that is not resolved through coping and adaptation, and may lead to unhelpful behaviours or ill health. Putwain (2007) identified stress as both a cause and an effect, and considering this ambiguity he asked whether “stress” refers to a motivating factor, a “stimulus which causes stress” (p. 212), or the subjective experience of individuals. Hobfoll, Schwarzer and Chon (1998) considered stress as “too inclusive a term” (p. 182) which could create an assumption that
all stressful stimuli were in some way equal. They recommended acknowledging the validity of different ways of conceptualising stress.

Within a research context, it can confuse the results if stress is referred to as a “cause” and also as an “effect,” unless the term is specifically defined. The way in which particular terms are defined will affect the validity of the research results, and consistent understandings need to be determined by the researcher. This is a particular risk in quantitative research, where participants’ meanings cannot be discussed as is possible in qualitative interviews.

Putwain (2007) defined “stress” as the subjective experience of an individual and “stressor” as any taxing environmental event. He defined the “stress response” as a description of biological reactions to stressors, including physical, cognitive and behavioural changes.

Anxiety can be seen as an outcome or effect of a particular stimulus. Putwain (2007) warned that “anxiety” is only one of many possible stress outcomes, and noted that a focus on anxiety in previous research may have limited the recognition of other possible stress responses, including depression, anger, self esteem and self-efficacy. Anxiety was interpreted as “the subjective experience of fear and apprehension accompanied by a state of physiological arousal where heart rate increases, palms become sweaty…” (Putwain, 2007, p. 211).

There are different methods of measuring stress and anxiety. The DSM-IV (1998) has provided guidelines and descriptions that assist in making diagnoses, while cautioning that they omit relevant aspects of competency, disability and individual responsibility. According to the DSM-IV, an individual suffering from anxiety will present with at least three of the six symptoms of “restlessness, being easily fatigued, mind blanks or difficulty with concentration, irritability, muscle tension and sleep disturbance” (p. 213). An alternative quantitative way of measuring anxiety levels is by the use of a questionnaire. The DASS21 (a depression, anxiety, stress scale consisting of 21 questions) is a self-report instrument used to measure levels of stress, anxiety and depression. The stress scale in the DASS21 is similar to the DSM-IV diagnosis of generalised anxiety disorder, and is characterised by symptoms of difficulty relaxing, irritability and nervous tension (Lovibond & Lovibond, 1995).
Both diagnostic methods outlined above pay little attention to individuals’ emotions. Jungbluth, MacFarlane, McCarthy, Veach and LeRoy (2011) acknowledged the role played by feelings in their definitions of stress and anxiety. They identified stress as a cognitive process accompanied by the inability to cope. Anxiety, they saw as being connected with biological responses including arousal of the autonomic nervous system, with additional subjective feelings including tension and worry.

“Resilience” and “coping” relate to the management of the stressors. According to Waller (2001), “resilience, simply stated, is positive adaptation in response to adversity” (p. 292), and “resilience is not static” (p. 293). This means that a person may manage one stressful situation and be vulnerable to a different stressor. Resilience is not a personality type as initially conceptualised, and resilient individuals can still be vulnerable (Waller, 2001). The term “coping” is a response to stress and is a post-stress outcome. Lazarus and Folkman (1984) recognised “coping” as a process initiated in response to a specific stressor. Keil (2004) extended on this definition, noting that “coping” relates to a collection of abstract ideas from a wide spectrum of affective to behavioural responses, and could be viewed as a reduction of stress.

In this study, the terms “stress” and “distress” will be used interchangeably to indicate the sum total of stressors and the stress responses. Drawing on the definitions of Folkman (2008), Hobfoll et al. (1998), Putwain (2007) and Waller (2001), for the purposes of clarifying the meaning of terms used in this project, the definitions are as follows:

**Identified terms used in this project**

*Stressor* – any event recognised as being taxing and activating the stress response

*Stress response* – the biopsyo-physiological response (physical, cognitive and behavioural changes) to a stressor or culmination of life events

*Stress or distress* – Great individual variability from the cognitive evaluation and psychological appraisal of the situation determines the level of distress recognised. This is manifested in: emotional symptoms of fear, anxiety and tension; physical symptoms of aches and pain and ill health; and/or cognitive problems of worsening mental health
Anxiety – a subjective experience involving fear, tension and apprehension, together with physiological arousal

Academic stress – stress conceived during the study and learning process

Examination stress – stress conceived prior to or during the sitting of exams

Test anxiety – students’ reactions to the test or assessment context, with the focus on the stress outcome

Resilience – a predisposition to reacting in a certain way to stressors

Coping – a post stress outcome involving problem-focused, emotion-focused or meaning-focused coping, resulting in a reduction in stress (Folkman, 2008).

Understanding the dynamics of stress

Over time, the stress process has been variously considered as an external, internal, environmental or cognitive happening, or a combination of these. The first significant model was developed by the endocrinologist Selye (1955) whose stress theory was based on a stimulus response model. This model and other early models of stress had a narrower focus than contemporary counterparts, and included the engineering model, the key resource model and the stimulus response and resource based models. These each tended to focus on only one part of the stress process (Hobfoll et al., 1998).

Hans Selye (1955) was a medical student and pioneer in the field of stress. He noticed that when individuals needed to adapt to a change in their environment, they commonly experienced a cluster of symptoms, including reduction in appetite, ambition and muscular strength. Selye (as cited in Hyde & Allen, 1996) initially labelled the concept of stress the “syndrome of just being sick.” His observations of this orchestrated mechanism set off by the physiological bodily system evolved into what Selye (1955) named the General Adaptation Syndrome, and consists of three stages: alarm, resistance and exhaustion. In the initial stage of alarm, adrenaline is produced which begins the fight-flight response. The second stage of resistance involves the body adapting to the stressors. However, this cannot be kept up indefinitely, and the body’s resources can become depleted. When this occurs, the body reaches the stage of exhaustion, and autonomic nervous system symptoms may reappear, including raised heart rate. Over a long period of time the body’s immune system can become exhausted.
and long term damage may ensue, resulting in decompensation. A variety of forms of ill health may eventuate, including ulcers, generalised anxiety disorder and cardiovascular disease. Selye (1978) concentrated on the non-specific biological nature of the stress response. He gave minimal acknowledgement to the source of stress, viewing the stressor as not necessarily important.

The simple stimulus response approach disregards the perceptual and cognitive processes associated with individual differences, and overlooks the psychosocial and organisational contexts. Attention is focused on the objective factors of environmental circumstances that consequentially cause distress through their intensity and repetitiveness (Hobfoll et al., 1998). Similarly, the engineering model of stress ignores individual differences, instead considering stress as a force or weight put on an individual. The engineering model considers stress in terms of the load or level of demand put on the individual (Cox, 1978). In later years, the prevalence of cognitive methods in psychology assisted in moving the stimulus response and engineering models aside.

In the 1960s the homeostatic models of stress focussed on change and the production of either positive or negative effects on the individual. There is an assumption that the positive or negative change will result in challenge and effect a change in the individual (Hobfoll et al., 1998). These models recognise the importance of “unpacking events” by breaking down the set of events into their individual parts, or components of change, and identifying that some parts may be constructive while others may not be (Dohrenwend, Raphael, Schwartz, Stueve & Skodell, 1993). Examples of such events may be marriage, separation or beginning a new job or field of study.

The resource based theories of stress emphasise an individual’s resources, rather than focussing on the stressor itself. Two assumptions involve recognising that resources are perceptions, rather than manifestations of individuals’ realities, and secondly, that personal resources construct each person’s socio-economic reality. These theories are qualitatively different from other models because they recognise the factors and resources that promote health and wellbeing. They rely more on the objective and cultural considerations of the environment, rather than the individual’s perceived construct (Hobfoll, 2001; Hobfoll et al., 1998).
How an individual views him or herself is an essential element in the resource models of stress. Bandura (1997) noted that perceived self efficacy is a mirroring of actual self efficacy and recommended that by raising self efficacy we can reduce fear. He found that individuals with high self efficacy engaged in more challenging tasks while low self efficacy had associations with depression, helplessness and anxiety, and could impede the motivation to act. Other key resource model concepts include optimism versus pessimism and the building up and strengthening of hardiness, which is made up of the three components: control, commitment and challenge, instead of focussing on “threat.” By setting goals, beginning to take action and stimulating motivation, individuals would grow in personal efficacy and be more optimistic.

Comparatively, Lazarus and Folkman (1984) well established theory of stress has assumed a prime role over time due to its comprehensive, holistic approach and nature. While Selye assumed that individuals had little control over environmental demands, Lazarus and Folkman took this a step further, defining “psychological stress” as a relationship between a stressor and a person. The focus is on the person’s perception of the situation, the ideographic appraisal of threat and resources that determine their distress, rather than an objective assessment. When the relationship between the stressor and the person is appraised and is seen as exceeding the personal resources of the individual, it endangers the individual’s wellbeing. This commonly produces psychological or physical distress. This implies that stress is not the product of an imbalance between objective demands and response capability, but of an individual’s perception of these features. Additionally, the result of the inability to cope must be perceived as important to the person involved, in order to endanger the person’s welfare and health.

Considering the environmental component of stress alongside individual factors that contribute, assists in explaining why times of adjustment, transition or change are often viewed as stressful. This is an essential consideration with the two populations being discussed in this project, as both groups may be in a process of transition or life change due to their present student lifestyle or AOD use or AOD goal. How they perceive and appraise their situation strongly influences how well they cope and manage this stage. It is the cognitive interpretation or the appraisal of the event, together with its perceived
significance, which determine the level of distress to the individual. This is the theoretical foundation of the appraisal-based stress model, developed by Lazarus and Folkman (1984).

This model is a well established comprehensive theory that has stood the passage of time. The assessment of the stressful event is seen as being paramount, reflected in the ways in which some people become stressed by situations in which others are not affected. The primary appraisal relates to the initial judgement as to whether the stressor has the potential to produce harm or loss. If this is low, a stress response does not occur. However, if a sense of harm or loss is identified, the secondary appraisal occurs and a judgement is made whether the individual has sufficient capacity to cope with the stressor. If there is a perception of adequate capability, the stress response is minimal. If the individual does not have the necessary resources to counteract the stress, the stress response is exacerbated. Those more capable of coping effectively have more “coping manageability.” Each individual’s own personal resources are seen as influencing their coping capabilities, and those with more resources have a greater capacity to cope.

**Coping**

In Lazarus and Folkman’s model of stress and coping, the latter was considered a resource, and assumed “resources” were seen as facets of the person’s individual self or social environment that influenced and paved the way for managing. Coping is a process that uses cognitive and behavioural means to manage stressors that are proving to be taxing or surpassing their personal resources (Lazarus & Folkman, 1984).

Coping theory, as discussed by Hyde and Allen (1996) maintains that one’s coping style is made up of two parts. Firstly, the personality traits or characteristics which include self esteem and level of confidence, and secondly, individual coping skills which are effective or ineffective behaviours used to deal with problems or stressors. Characteristics such as A-type personalities and an external locus of control have been found to promote inward feelings of helplessness (Hyde & Allen, 1996), and can lead to increasing one’s susceptibility to stress. People with an internal locus of control believe they are mainly in control, and through deliberate effort and hard work they will achieve particular life goals, including job position, quality of life and financial status.
Alternatively, a person with an external locus of control believes outside forces including other people, luck and fate control their character and their outcomes in life. A limitation of both personality typing and locus of control theory is that people are identified with a particular position. This all or nothing thinking does not allow for individuality and the possibility and recognition of a continuum of being.

A further criticism of coping research according to Hobfoll et al. (1998) is that it often addresses the quantity of the coping and not the quality, and therefore does not place sufficient importance on how effective the coping is. An example would be a therapist who focussed on using problem-solving strategies with individuals, while giving little attention to how well these assisted each person.

Appraisal has a role within the concept of coping, as reflected in the ways in which people manage stress. The psychological interpretation ultimately determines whether the stressor is a harm, threat or challenge, subsequently influencing whether problem focussed or emotion focussed coping is used to manage the situation. Lazarus and Folkman (1984) found that harm appraisals evoked negative emotions of sadness and anger, threat appraisals delivered anxiety and fear, and challenge appraisals assisted positive emotions of excitement, eagerness and confidence. Problem focussed methods are utilised when something can be done, and involves action and planning behaviours, whereas emotion focussed coping is predominant when a situation must be accepted. Emotion focussed strategies can increase well-being, for example, through the use of positive reframing or acceptance. Alternatively, ignoring or distracting oneself from the problem or blaming another person are emotion focussed coping methods that do not produce long term solutions to stress. AOD use can be considered emotion focussed coping because it does not focus on solving problems, but is responding to the arousal caused from the stressor. Professional experience suggests that AOD abuse is commonly used to escape reality and manage internal and external stressors, and Lazarus and Folkman (1984) have named AOD use an escape focussed coping skill.

A problem-focussed coping response such as work stress could involve cutting down on hours for example. An emotion-focussed coping perspective could include assertiveness training, improved communication skills and expressing feelings positively. Alternatively, a lack of self management and feedback loops can keep an individual in
the cycle of distress. Rather than situation specific, Susan Folkman’s (2008) revised model of coping included “meaning-focused coping” which involved the individual’s drawing on underlying beliefs, values and goals, including aspects of religious and spiritual coping. These assist in building motivation and sustaining coping and wellbeing during a stressful period. Folkman found that when the manageability outcome was adverse, the appraisal-emotion-coping-reappraisal process would repeat, and this repetition produced stress.

The role of positive emotions appeared to be overlooked in Lazarus and Folkman’s (1984) model, and Susan Folkman (2008) added this necessary dimension. It was recognised that when situations were not resolved in a helpful way, the new attempt triggered meaning focussed coping. Meaning-focussed coping brings about positive emotions, and these in turn reinstate coping resources and restore motivation to sustain problem-focussed coping over the long period (Figure 1). An illustration of this is when an individual calls on their beliefs and values, and sets meaningful existential goals to bring about and maintain coping during a distressed time.

Figure 1.
Revised stress and coping model (adapted from Folkman, 1997, as cited in Folkman, 2008, p. 6).

This important revision to the model by Susan Folkman (2008) was made during the late 1980s while researching caregivers whose life partners were dying of AIDS. Both
positive and negative emotions were found to happen during stressful times. A recommendation was made to give attention to positive emotions by accessing their sources and learning ways of generating and sustaining them. Positive emotions assist coping by playing the roles of “sustainers, breathers and restorers” (p. 4). Whereas in previous decades the focus tended to be on the negative emotions associated with stress, Susan Folkman acknowledged that “there is now substantial evidence that positive emotions are a normative aspect of the stress process and they help restore physiological and psychosocial coping resources” (p. 11).

By giving up goals that do not work and recognising when to do this, as well as substituting realistic achievements for unrealistic goals, individuals are motivated to make choices that fit with existential considerations, even when obstacles hinder the process. Recommendations by Folkman (2008) that invite meaning focussed coping and positive emotions involve goal setting, reordering priorities and infusing ordinary events with positive meaning. Goal setting involves a self-regulatory process that is adaptive to changes over time. The reordering denotes to the individual that their world has altered, and therefore can be appraised from a different point of view. Changing one’s perspective by noticing positive events, as well as reordering priorities that fit with each individual’s value base and focussing on what matters most, has been found to develop a sense of coping and a positive attitude.

**Stress Research**

Because stress is a process, it is difficult to measure accurately. Thirty years ago, Baum, Grunberg and Singer (1982) considered that stress could be measured in four basic ways. These included self report measures, performance measures, psychophysiological assessment for example by measuring muscle tension or respiration rates, and fourthly, biochemical measures such as taking measures of the endochrine system. The idea of stress being most accurately calculated by many measurements taken concurrently is therefore not a new idea, and Baum et al., believed “a multilevel research strategy involving simultaneous assessment of psychological, behavioural and physiological measurements is recommended in light of the whole body nature of the stress response”
Though many concurrent measurements will provide a clearer picture, they do not recognise stress as a process over time.

Because stress is a process and the terminology used in discussions of stress tends to be ambiguous, investigating stress is a complex business. Typically, studies of stress to date have focussed on the concepts of stress and coping, and are predominantly quantitative (Collins, Onwuegbuzie & Jiao, 2010). Results are quantified using a variety of standardised measures with the purpose of capturing outcome information that conceptualises their interrelationship, as well as their relationship with other associated constructs. These include depression, anxiety or the concept of self. This unitary focus is a relatively objective view, particularly due to the fact that “stress” is reported as both a cause and an effect within these questionnaires.

Information obtained from self-report questionnaires, however, is subjective, meaning results are confounded by a mixture of response effects. The measurements from these questionnaires are therefore arbitrary in that they do not take into account the contextual background of the participant. There is an overpowering predisposition in the research towards quantification and Putwain (2007) believed that this unitary methodological focus leads to a lack of consistency in their conceptualisations of stress and coping.

Alternatively, a mixed methods approach could provide greater insight by integrating narrative thematic ideas with the physiological conceptualisation of stress. Explorations of mixed methods research by Collins et al. (2010) found a lack of published studies around stress and coping, and they were intrigued by this, considering the growing popularity of this paradigm. Reasons include evidence that mixed research involves more time and a greater knowledge of both qualitative and quantitative approaches. Because there are relatively few mixed methods studies to date, recommendations include conceptualising stress in a more multi-faceted way (Collins et al., 2010). This gap in mixed methods studies of stress and coping provided a rationale for the use of this methodology for this research.

**Stress and wellbeing**

Stress is beneficial in challenging situations, and necessary for motivation, drive and development toward a sense of achievement. Reactions to stress come from an interplay
of cognitive (thought), physical (biological), emotional (affective), and behavioural responses that occur. Excessive stressors and correspondingly low levels of coping or resilience affect individuals’ immune and nervous systems. Health and general wellbeing are affected physically, physiologically, mentally, spiritually and emotionally (Moonmuang, 2005; Sinha & Watson, 2007). The general adaptation syndrome described by Selye (1978) comprises a physiological response triggered in a bid to protect the body from environmental challenge. Selye, along with subsequent researchers including Lazarus and Folkman (1984), Cox (1978), Moonmuang (2005), Sinha and Watson (2007), and Slavin, Rainer, McCreary and Gowda (1991), have agreed that stress is a significant contributor to increased risk of the development of illness. By promoting coping and building resilience, a more conscious attitude can be encouraged that recognises other ways of managing stress, in order to improve overall health (Lehrer, Woolfolk & Sime, 2007).

Stress has multifaceted effects by disturbing physiological and psychological wellbeing, in addition to indirectly affecting behavioural and social characteristics of the individual. In this way, psychologically as well as behaviourally, stressed and overworked students, for example, are more prone to developing illness and may try to lessen the amount of stress by avoidance of triggers, thereby procrastinating instead of studying (Moonmuang, 2005). Individuals are therefore affected “biopsycho-physiologically” he concluded (p. 18), and noted common physical symptoms experienced included headaches and stomach aches. Deckro et al. (2002) found that tertiary students who suffer distress have increased headaches, sleep problems and greater occurrences of the common cold. In my counselling career I have noticed students presenting with the concerns identified by Deckro et al. (2002) and Moonmuang (2005), and add behavioural symptoms of insomnia, changes in eating patterns, confusion and irritability.

Mental health and spiritual health problems include isolating oneself, having irrational and negative thoughts and thinking patterns. These can progress to depression, anxiety and suicidal ideation. Physical complaints may be seen in aches, pains, headaches, stomach and skin complaints, and breathing problems including asthma. Excessive and ongoing stressors contribute to mental, spiritual, emotional and physical
unwellness (Everly & Lating, 2003). The many and varied connections between stress responses and resulting psychiatric and stress-related somatic disorders were named “disorders of arousal” by Everly and Lating (2003, p. 190). They identified that this occurrence is instigated by an arousal within the body through increased neurotransmitter activity (by the three major arousal-mediating neurotransmitters, dopamine, norepinephrine and serotonin), and increased neuromuscular stimulation together with reduced cognitive excitation.

The arousal of the neurotransmitter and neuromuscular activity and diminished cognitive capability bring about a state of heightened arousal. The body requires time to relax and function in an unaroused state. Psychosomatic disease happens when a state of mind (psyche) causes actual damage in the body (soma), including for example, ulcers, asthma, headaches, arthritis, diabetes and cancer (Hyde & Allen, 1996). Hyde and Allen believed that such physical conditions could develop when a stressor triggers a physiological response, altering the biochemistry within the body. They have suggested that in order to combat stress, individuals can interrupt any one of the steps in this process. Thus the relaxation response is recommended as an anti-arousal strategy to reduce the occurrence of harmful biochemical stimulation and its effects.

Physical disorders are often stress related. Hyde and Allen (1996) reported that many authors believed that Harrison’s estimate based on the principles of internal medicine was conservative in attributing 50-80% of all physical disorders to stress, adding that it was hard to identify any physical problem not influenced by stress. Their diagram of psychosomatic stress (Figure 2, p. 28) shows an eight step linear process from sensory stimulus (stressor) to disease. A warning was given of rapid onset stressors that move from perception directly to mind/body connection (shown in the left hand arrow), missing appraisal and arousal because of the reflex action involved. An example of this is an unexpected loud noise. The diagram shows the feedback loop which sometimes occurs called the exacerbation cycle, where the disease itself brings about sensory stimulation, beginning another process of evaluation. This is indicated by the right hand arrow.
Individual difference in perceptions or understanding of stressors can influence any or every step in the psychosomatic model of stress shown in Figure 2. What one person reports as distressing may be any factor putting them under pressure, whereas another individual may not recognise distress until a number of stressors have caused them difficulties (Putwain, 2007). Altering how individuals appraise stressors through teaching new strategies, retraining their bodies to respond in a non-pathogenic way, and modifying their environment, can strengthen resistance and build resilience to stress, and therefore hinder the path toward resultant disease (Hyde & Allen, 1996).

The cyclic nature of the stress response has been considered along with health concerns. Eight common symptoms of emotional stress identified by Schafer (1996) included guilt, shame, frustration, fear, sadness, anger and depression. Accompanying these emotional states are often multiple changes in thought processes, or the psychological wellbeing of the individual, including inability to concentrate and being forgetful (Schafer, 1996). These emotional responses can be recurrent, may involve a
multidirectional relationship, and may be multifaceted (Moonmuang, 2005). The physical symptoms of headaches can interfere with study habits, in turn creating more stress as the student falls behind in their learning. Failing to keep up may bring a heightened response, generating more headaches, and alcohol or drugs may be used as an indirect coping mechanism. However, the latter have been identified as among the less healthy coping mechanisms that include illicit drug use, alcohol and cigarette use, and increased coffee or tea consumption. Maladaptive efforts to cope, including using drugs and alcohol, often increase or exacerbate symptomology (Gregson & Looker, 1994). Moonmuang (2005) noted that the homeostatic process is utilised in a bid to create balance or to gain short term relief.

Health is a term defined by the World Health Organisation (1974, as cited in Gregson & Looker, 1994) as the mental, physical, spiritual and social wellbeing of an individual. It follows that stress management strategies that focus on all four areas promote positive health and embrace the holistic nature of wellbeing. In recognition of these complexities and individual uniqueness, Lazarus (2005) has recommended a multimodal approach of short term group therapy of six to twelve sessions that provides a repertoire of strategies to deal with a range of problems, drawing from a variety of approaches. He used a map known as the BASIC ID, translating this acronym as: behaviour, affect, sensations, imagery, cognition, interpersonal relationships and drugs/biology. In the current study, this was used to extract themes for exploration.

In summary, stress is a substantial factor that impacts on health in a variety of ways and disguises itself by wearing different cloaks. It is characterised by psychological and physical changes, and can cause symptomology of anxiety or depression, illness and somatisation (Gregson & Looker, 1994). Assistance can be given to lessen potential health risks by learning prevention and stress management skills, and building resilience and coping for the inevitable life events that often involve future stressors. In order to achieve this, a holistic approach is indicated that incorporates various tools and strategies that connect with mental, emotional, spiritual and physical parts of the individual.
Tertiary Student Stress
Increasing student fees, social pressures and the current economic job crisis adds to the list of problems facing our student population today. Although stress can be beneficial to performance in some cases, and is necessary for motivation and drive (Deckro et al., 2002), the levels of stress have dramatically increased for tertiary students over the last 30 years (Pritchard, Wilson & Yamnitz, 2007). Stressors provide both stimulation and problems for tertiary students, depending on the perception, coping and resilience of each student, and students are therefore no different from the general population in this respect. However, demand overload and pressures of study, exams, finances and relationship concerns abound in the tertiary student population group. These stressors take their toll in various ways, with students’ psychological wellbeing appearing to be worse than that of the general population (Cooke, Bewick, Barkham, Bradley & Audin, 2006). Recent research by Stallman (2010) found that students’ mental health concerns were higher than the general population’s by more than 20%.

Stress is a major factor for tertiary students as they contend with academic, social and personal demands. Leaving home and starting tertiary education is a time of transition for many youth, and the successful completion of this transition stage helps establish a basis for future life goals, therefore reflecting on individual development (Brougham et al., 2009). Early adulthood can be a particularly stressful time of life during which the demanding challenge of tertiary study, involving an adaptation to a new culture, is added to the multiple challenges of financial, social, academic, relationship and health pressures (Robotham, 2008). More mature students and returning adult students have this list of stressors, and often juggle the demands of work, study, private and family life alongside complications of child care, as well as other pertinent concerns.

Tertiary institutions vary in size and institutional climate and these variables can affect stress levels. Auckland is New Zealand’s biggest city and Auckland University had over 39,000 students enrolled in April 2010. These two statistics can make the student experience impersonal and overwhelming for some students, particularly those from rural areas; I recognise this through my own personal experience. Developmentally, younger students who have entered directly from secondary school have complex issues related to forming their own identities, which often include managing a new
independence and separation from friends, family and partners, while choosing their future focus and career path.

A new culture can bring the potential for self growth, or heighten vulnerability within a lonely environment and stressful context. Walking around the city centre of Auckland there is incontrovertible evidence we live in a multicultural society. Attending Auckland University there are more than 4,700 international students from over 90 different countries, according to the webpage “Auckland University international students” (2012). These students are often in a foreign environment and culture, and may be using a second language to communicate. This multicultural, multilingual student body’s acculturation stressors can add to other tertiary concerns, putting these students at greater risk of psychological problems than other domestic students (Mori, 2000).

When international tertiary students in Australia were compared with domestic students by Khawaja and Dempsey (2008), differences in coping style were identified, with international students using avoidance, repression and other passive ways of coping with difficulties to a greater extent than domestic students. They also found that international students had less social support than others. Mori (2000) found that international students were also less likely to use student support services on campus due to social stigma and personal inhibitions.

The tertiary environment tends to be individualistic and students from collective cultures can struggle with the levels of self esteem and self confidence as well as independence that are required to navigate their way through the demands this places on them (Sinha & Watson, 2007). In their cross-cultural study with first year tertiary students, Sinha and Watson found students’ self esteem majorly influenced personal and social ways of connecting, which in turn affected students’ mental health. Crocket, Iturbide, Stone, McGinley, Raffaelli and Carlo (2007) have highlighted the need for practical social support to improve adaptation and psychological wellbeing, and suggested giving practical assistance with language and academic concerns to this vulnerable population group.

Aspects of tertiary life contribute to students’ stress. Studying itself is pressured with tertiary courses which a decade ago were taught over nine months now being squeezed into semesters of two 17 week blocks, or a summer school semester of a mere six weeks.
Together with time limitations, other external pressures abound for tertiary students, including the current global economic crisis, monetary concerns and academic challenges including exams and assessments (Robotham, 2008). Tertiary fees continue to rise as do the entry requirements, students are unsure whether there will be jobs at study completion, and they are often pressured into working to be able to keep financially afloat (Robotham). Interrole conflict can be problematic for the adult student, such as being a caregiver to others but also being stressed and needing to be cared for (Moonmuang, 2005). In addition, internal stressors afflicting tertiary students include pressure to succeed, future career concerns, and status and relationship issues (Moonmuang). In my tertiary counselling interactions to date, I have noted multiple reports of test anxiety, alcohol abuse and relationship difficulties as being common elements of concern for students suffering stress.

Academic and examination stress, along with test anxiety are avenues of concern for tertiary students. Students with traits of anxiety are predictably associated as suffering academic stress (Misra, McKean & West, 2000). A common discussion within the tertiary counselling department at Auckland where I presently work is concern about the waiting list which markedly rises during the period leading up to end of semester examinations. The common presenting problem includes academic and examination pressure, including test anxiety. The strain and distress felt by some students in response to these academic problems can be debilitating, blocking their ability to concentrate on study which is often reflected behaviourally in procrastination (Ferrari, 2001).

Some students fail to attend their examinations because of fears, including fears of overwhelming anxiety or a panic attack or having a mind blank. On the other hand, research with students by Bitsika, Sharpley and Rubenstein (2010) highlighted the affirmative aspect of study and course enjoyment. This is in direct contrast to test anxiety suffered by other students, and is a classic example of the part played by individual perception recognised in Lazarus and Folkman’s (1984) model of stress.

This variation in psychological wellbeing may affect any potential research undertaken with students who suffer test anxiety. Therefore, careful consideration must be given to the timing variable when measuring levels of stress and coping in relation to sitting exams and potential test anxiety. Abouserie (1994) and Gadzella, Masten and
Stacks (1998) agreed that the biggest stress factor for students was anxiety felt before examinations (rather than the actual test itself) which causes a range of physiological and emotional symptoms, changed eating patterns and stomach complaints, including nausea. Though short term, the effects of test anxiety can have wider effects if students are unable to attend their examinations or hand in their assignments on time.

Keogh, Bond and Flaxman (2006) discussed the findings from UK and USA studies indicating that a large proportion of students are affected by test anxiety. They delivered cognitive behavioural stress management strategies to 104 students who attended group programmes and identified as having test anxiety. Simultaneously they gave no interventions to a control group of the same size. Both groups sat examinations nine weeks later. The comparative results showed increased motivation and improved academic assessments with better performances in the group that had undergone the stress management training, when compared to the control group. These positive changes occurred by utilising cognitive behavioural stress management intervention strategies and tools that disputed and changed some dysfunctional and worrisome beliefs. A 50% dropout rate within the stress management group may have biased the results, due to who remained in the final analysis group. Other limitations include the lack of any comparative intervention given, and the fact that the results could be simply due to intervening with the group, and may not have been related to the specific stress management strategies taught. Interestingly, in both Broughman et al. (2009) and Moonmuang’s (2005) studies, academic stress was not seen as being more relevant than any other stressor identified by the tertiary student group, with no differences noted between genders.

From my experience as a counsellor, tertiary students suffering stress often do not sleep well due to ruminating thoughts and thinking patterns. This lack of sleep coupled with feelings of distress, can be accompanied by self medicating by the use of drugs or alcohol, or prescription medication, in a bid to assist sleep. During my work experience as a drug and alcohol counsellor I have noted that the most widely abused substance seems to be alcohol. This is verified by Adamson, Sellman, Futterman-Collier, Huriwai, Dearing and Robertson (2000) who found AOD treatment centres in New Zealand are
dominated by clients seeking assistance from alcohol problems, have a mean age of 31, and have an over-representation by Maori at 28%.

Alcohol is a central nervous system depressant that provides feelings of relaxation and slows down cognitive processes (http://www.cads.org.nz/), which in turn provides beneficial relief for individuals who suffer stress and anxiety. I have often been told that a common use of alcohol is to institute the feeling of relaxation and to assist the onset of sleep. The increasing level of stress noticed by tertiary students’ over the past 30 years often underlies their engagement in negative health behaviours including alcohol and drug use (Pritchard et al., 2007).

Negative costs from alcohol or drug abuse include interpersonal problems, health, financial and legal issues, interference with work or study, and other symptomology including traits of anxiety and depression (Mueser, Noordsy, Drake & Fox, 2003). These traits or symptoms may develop into clinical depression, generalised anxiety disorder and drug and alcohol dependency. Tertiary students diagnosed with anxiety disorders are two to five times more likely than students without anxiety of having AOD abuse or dependence symptoms (Seigers & Carey, 2010). Coexisting conditions may increase risk of burnout or dropping out from tertiary establishments, according to Mueser et al. (2003) who identified that individuals with dual disorders attain lower levels educationally and academically. For students with mental health disorders, substance use tends to worsen the mental illness, undermining the benefits of the medication (Mueser, et al., 2003). The course of mental illness (or wellness) was influenced by biological vulnerability, stress, medication, drugs and alcohol, coping skills and social support.

Students who begin study with a vulnerability to stress prior to attending a tertiary institution are at risk of having other health problems. The supersensitivity model which originated from the stress-vulnerability model, as outlined by Mueser et al. (2003), recognised that biological vulnerability (genetic and early environmental events) interacts with environmental stress to bring about the inception of a mental health disorder. Although the biological vulnerability must be present for a mental illness to develop, other factors including stress can heighten this vulnerability, thereby influencing the onset, severity and course of mental illness. Therefore, a person with positive coping skills will be less vulnerable. Suggestions were made that learning and utilising new
skills, drawing on social supports and engaging in meaningful activity could strengthen this susceptibility.

Stress has been identified as an impediment to student success. In 2004 it was found to be the most commonly identified problem in academic performance (Oman, Shapiro, Thoresen, Plante & Flinders, 2008). Links were found between tertiary students stress and multiple adverse effects in their lives, including depression, anxiety, and poor health (Oman et al.). The National College Health Assessment (NCHA) in the USA in 2003 ranked stress as the number one impediment to academic performance for students (Dusselier, Dunn, Wang, Shelley & Whalen, 2005), and participants in Dusselier et al.’s own study rated stress as more of a problem than ill health, sleep issues or relationship problems. The literature highlights the compounding nature of resultant problems caused by stress, including mental health problems. Dual disorders or co-morbidity affects many students, and as Mueser et al. (2003) stated “50% of clients with severe mental illness have a lifetime substance use disorder and 25-35% have an active substance abuse problem” (p. 15). It is unclear whether these resulting problems are separate, inferring that one causes the other, or if they conjointly transpire. Additionally, it is unclear whether it is preferable to manage the stress or the resultant health issue first or whether they should be managed concurrently.

Students are an at-risk population in regard to distress and mental health problems. Stallman (2010) invited all enrolled students from two large Australian Universities to participate in a web-based survey about their mental health, which was completed by 6,479 enrolled students. Results estimated mental health problems for these students at 19% and subsyndromal symptoms at 67%. These results are significantly higher than the general population, highlighting the need for early interventions to assist students’ good health. In this study, a much higher percentage of elevated distress (approximately 50%) was also found in students presenting at university health services, when compared with the general population 29%. The more distressed students in this at-risk population were characterised by lower academic achievement and greater incidence of mental health issues. This supports the findings of Cooke, et al. (2006) who found that comparisons made between students and the general population showed students’ psychological
wellbeing as worse, noting academic, financial and relationship issues as major causes of poor mental health.

New Zealand youth do not rate mental health issues as holding them back, and instead see conforming and performing as hurdles that could influence suicide risk. When 384 young New Zealanders (first year undergraduates studying psychology or mathematics at Auckland University), were asked about the causes of the high youth suicide rate in New Zealand by Heled and Read (2005), they rated external stressors as their main concerns. Pressure to conform and perform were identified as core stressors 32%, followed by financial concerns 25%, abuse and neglect 14%, alcohol and drug issues 10% and boredom 9%. Interestingly, depression and mental illness were rated 5% and 1% respectively. Recommendations from these youth included educational programmes to help young people discuss feelings and introduce ways to raise self esteem. Heled and Read discussed the findings of various studies from the general population around the world, concluding that human distress tends to prioritise adverse life events and stressful circumstances as being leading factors in youth suicide, ahead of individual pathology. Psychoeducational programmes and psychotherapeutic groups are avenues through which young people can discuss their concerns.

Losses of previous relationships and unhealthy life practices have been found to influence Australian and American tertiary students stress levels. Bitsika et al. (2010) interviewed 32 undergraduate students from various discipline areas within Bond University in Australia. The purpose was to ascertain the most positive and negative changes that had occurred to them and identify the major changes that caused stress. Their sample was representative of many background variables, and though the sample was small, they believed the findings could be generalised to the universal student body at Bond University. Results revealed that negative changes included the absence of family and friends, increased drinking, decreased exercise and healthy eating, financial strain and deteriorating mental and physical health. Positive changes were having a new purpose in life, study and course enjoyment, better organisation and time management skills and increased self esteem. High achieving American students voiced concerns about stress, balance and coping, and recommended connection with others as being essential in gaining strength and benefitting through lived experiences (Milburn, 2011).
As identified, building connections and positive relationships can be useful in assisting students who are distressed. Considering the stressors and pressures challenging tertiary students, suggestions were made by Bitsika et al. (2010) that counsellors working with tertiary students need to normalise losses of previous avenues of personal enjoyment and support, while developing strategies to build helpful responses to their present stressors. This study recognised that student relationships appeared to be affected by stress as well as being a cause of many stressful experiences. Therefore the social factor of building and maintaining positive relationships would benefit students. Dusselier, et al.’s (2005) study with 962 American undergraduate residence hall students demonstrated that having relationships with others built on mutual respect assists in stress management, and this corresponded with results obtained by Iglesias et al. (2005).

Limitations of the existing research into tertiary student stress include a predominance of participation by medical students, the quantitative nature of the studies, and a short term outlook. Stress research with tertiary students from USA and UK was reviewed by Abouserie (1994), who was surprised to find a low level of focus on university students in this field, with existing studies primarily focussing on medical students. Fourteen years later, Robotham (2008) agreed that although stress research has been extensive, research with tertiary students was not, with predominance given to medical, health and social care-related students. He also noticed a dominance of quantitative studies and a lack of longitudinal studies with the foci instead being on a short period of time or a micro approach. My own search of the literature supports the view of Abouserie (1994), Collins, et al. (2010), and Robotham (2008) that studies with tertiary students have predominantly involved medical students, including nurses.

Results from particular student groups cannot be generalised to the scholar population as a whole, because those who choose these programmes may be of a specific type and more or less prone to stress when compared with the general student population. Noticing the predominant use of a single group of students, Cooke et al. (2006) recognised this as one of the weaknesses of tertiary student research to date, along with other methodological limitations. These included relatively small sample sizes, the lack of baseline levels prior to attending tertiary study, most data collection occurring at only one point during the academic year, and not considering examination stress. The studies
have predominantly involved participants in the completion of stress measuring self-report inventories, the results of which are likely to vary according to each individual’s conceptual rating on that day. There is also an assumption that stress is measurable (Robotham, 2008). Measures used do not explain why stress exists, and nor do they show whether stress is a direct consequence of being at university, or whether it was present before university attendance (Robotham).

Recommendations by Robotham (2008) include qualitative research using in-depth interviews to seek subjective views about students stress, coping strategies and resources. Other recommendations were to note developmental changes during the course of students’ time at university, alongside their ability to manage stress throughout this phase of their lives.

In conclusion, tertiary study may entail exposure to a broad range of stressors; developmental, academic, personal and cultural. Stress and mental health coexisting disorders are common among tertiary students and require early intervention and support. The use of AOD can further complicate mental health symptomology and interfere with medication. Stress research with the tertiary population has predominantly been with medical students. The international tertiary student body are an at-risk population who have additional multicultural acclimatisation issues that could be better assisted by improved social support systems. The building of positive relationships and providing education about wellness are broadly recommended to build resilience and coping for the tertiary population.

**The cocktail of stress and substance misuse**

Key relationships between stress and the onset, continuation of and return to substance misuse were highlighted in a search of relevant literature. Stress and alcohol can be described as “playing together in an intimate dance” with alcohol sometimes taking the leading position. This relationship can be categorised into the five stages identified by motivational interviewing; precontemplation, contemplation, action, maintaining change, and possibly lapsing or relapsing into past behaviours (Rollnick, Miller & Butler, 2008).

Managing stress is often problematic and can frequently be a presenting issue for AOD users seeking assistance in making changes in their lives. There is increasing
evidence of a link between stress and vulnerability to addiction, with stress and dependency problems having significant associations in both the psychological and neurobiological models of addiction (Sinha, 2008). The former views AOD use as a coping strategy, whereas the neurobiological model of addiction acknowledges neuroadaptations in learning, reward and stress pathways which bring about cravings and a compulsion to abuse alcohol and other drugs. Because alcohol and drugs are often being used as a coping mechanism, highly stressful circumstances and resultant chronic levels of distress increase vulnerability to developing addiction (Keyes, Hatzenbuehler & Hassin, 2011), and also increase risk of relapse (Keyes et al.; Sinha, 2008).

Exposure to previous life stressors needs consideration when assessing individuals with substance use disorders. Keyes et al. (2011) reviewed the evidence from epidemiological studies regarding the relationship between alcohol outcomes and four types of stressors, namely catastrophic stressors, child maltreatment, common adult life stressful events and minority stress. They found that exposure to these can influence individual differences in risk for consuming alcohol and developing alcohol abuse and dependency problems. Additionally, distress was a trigger for relapse. Individuals with a previous history of alcohol use disorders more readily reported alcohol use as a coping mechanism, when compared to those without this background.

Along with considering past life stressors, dopamine pathways can also influence an individual’s potential for developing an addiction. These pathways in the brain can be affected by stress or AOD use. Keyes et al. (2010) discussed the genetic vulnerability of individuals to both stress and alcohol use disorders, noting the importance of this from a public health point of view. Evidence from multiple studies shows that early life stress and chronic stress affect the mesolimbic dopamine pathways, playing a critical role in adaptive learning and functioning. These same pathways are utilised in drug taking and its associated rewards, affecting dopamine pathways which play a part in drug self-administration (Sinha, 2008; Uhart & Wand, 2008). This equates to an exposure to stress early in life increasing an individual’s vulnerability to addiction. “It is somewhat puzzling that apparently opposite phenomena, such as mild stress and addictive drugs, actually have a similar effect on dopaminergic transmission” (Al Absi, 2007, p. 63).
Stressors and drugs not only independently increase dopamine release but they can also interact, for example when stressors enhance the effects of drug use. Both stress and substance abuse activate the same area of the brain, the extended amygdala, as demonstrated by brain imaging studies that identify the overlap in neural circuits when processing stress and drug cues, with identifiable activity in the corticostriatal limbic circuitry area (Sinha & Li, 2007, as cited in Uhart & Wand, 2008). Uhart and Wand have described the processes that lead to addiction, emphasising the association between stress, addiction and anxiety:

As the individual transitions from occasional drug use to drug dependence, the detrimental effects of stress and glucocorticoids ultimately lead to brain reward dysfunction and drug use escalation. During the addicted state, high levels of glucocorticoids and stress peptides associated with addiction create an internal form of stress characterised by anxiety like behaviours. (Uhart & Wand, 2008, p. 14)

The use of drugs or alcohol may initially begin as a coping mechanism to manage stress, but once AOD use becomes problematic, the substance itself becomes a stressor because of the time spent obtaining, using and recovering from the substance of choice. The time taken up by this process often interferes with other life involvements or responsibilities. These include work, relationships and other commitments, as recognised by the substance abuse and substance dependence criteria in the DSM-IV (1998), used in diagnosing AOD problems. In addition to this, alcohol dependence and withdrawal are associated with increased anxiety levels, which often lead to a further increase in drug use (Uhart & Wand, 2008).

To summarise, there seems to be a bidirectional and complicated relationship between AOD use and stress. The amount of influence stress has on drug use depends on the type and severity of the stressors, and the genetic background of the individual, plus the interplay between the positive and negative reinforcing influences of the drug and the stressor (Uhart & Wand, 2008). AOD may initially be used as a coping mechanism to manage stress and anxiety, and then progress into problematic use or misuse. Stress-related hormones activate and make changes to brain reward pathways that increase individual vulnerability to AOD use (Uhart & Wand). At the stage of AOD abuse or dependency, the user will benefit by learning other strategies that decrease adrenal
sensitivity and stress-induced cravings that could be potential triggers or risks around relapse.

**Addiction theories that recognise stress**

As indicated above, substance abuse or dependency may be used as a coping strategy to increase relaxation and reduce tension, to self-medicate and to stop withdrawal symptomology. Sinha (2008) noted that many of the major theories of addiction identify the important role served by chronic and acute stress.

The neurobiological model of addiction explains how neuroadaptations in reward, learning and stress pathways occur through the processes of stress allostasis and incentive sensitisation. These processes increase cravings and the compulsions to use, and ultimately develop into the loss of control in relation to the substance (Sinha, 2008).

Loss of control and inability to stop using the substance form a key component of addiction, as recognised in the criteria for diagnosing substance dependency (DSM-IV, 1998).

Intrusive thoughts and negative emotions caused by stress can trigger automatic addictive thought patterns and related behaviours previously used as a coping mechanism to reduce stress. Over time, these addictive behaviours become resistant to change. This is an example of a negative reinforcement model, as recognised by Addiction Treatment Research (2011), where the addiction process is triggered and reinforced through an inability to manage stress, together with the incapacity to learn other functional coping strategies. The negative emotions which include feelings of stress, anxiety and depression, appear to have a powerful influence during withdrawal, alongside the physical withdrawal symptoms associated with cravings (Uhart & Wand, 2008). Stress and negative mood can trigger the same dopamine neurons, and are recognised as being internal stimuli that are associated with craving, according to Grusser, Morsen, Wolfling and Flor (2007) who also noted that stress and resultant distress are the most powerful predictors reinforcing cravings. Learning and building a repertoire of positive coping strategies will therefore assist in managing cravings and will impede potential relapse.

The stress-vulnerability model is useful in explaining how individuals who experience mental illness are also highly sensitive to the effects of AOD. Individuals
with psychiatric illness have been found to have a biological vulnerability to mental illness from early in life. Mueser et al. (2003) identified the interaction among environmental factors including stress, social support, and coping skills, together with the biological aspects, including medication and substance use. This relationship can heighten or strengthen individual vulnerability, influencing the course and severity of a mental illness. The influence of personal history provides an explanation for why the same individuals are often affected by relatively small amounts of alcohol or drugs. Prescription medications are often prescribed to correct the chemical imbalances in the brain known as the causes of the mental illness. However, alcohol and drug use can have adverse effects on the effectiveness of the medication and can also directly affect brain chemicals, worsening the mental illness (Mueser, et al., 2003).

Recent theories highlight the role of stress in maintaining addiction and in motivating craving (Grusser et al., 2007; Sinha, 2008). The self-medication hypothesis suggests that the effects of the substance are such that they lead to the maintenance of the behaviour and are then reinforced by operant conditioning (Grueser, et al.). This is named by Uhart and Wand (2008) as “incentive sensitisation and hedonic allostasis” (p. 44). Casual or social drug use sensitises the mesolimbic reward system, thereby initiating the substance use which is perceived as attractive. The reward system is sensitised, providing motivation to use the substance again and again. This is the phase of hedonic pleasure, but over time unremitting substance use brings about a downward regulation of positive rewards. Negative affect is created, reflected in behaviours of dysphoria and anxiety, together with an escalation in cravings.

In contrast, Rice and Van Arsdale (2010) believed that previous empirical research provided mixed support for the stress reduction hypothesis, alternatively named the tension reduction hypothesis. These hypotheses propose that individuals are motivated to use AOD as a coping mechanism to reduce stress, tension, fear anxiety, conflict and frustration. They have questioned the design of previous studies, and the lack of recognition of the roles played by other variables. Earlier research by Bukstein (1995) demonstrated that these tension-reducing properties only occur within a circumscribed area of the substance dose response curve, therefore making the stress reduction theory invalid as a single factor explanation. Bukstein identified the stress response dampening
theory as a reason for use, but not the sole purpose for substance use among adolescent substance abusers. Other evidence regarding tension reduction and alcohol and drug use is mixed, ranging from no support to major support linking the two (Rice & Van Arsdale). In Rice and Van Arsdale’s own study with 354 students, they found that the association between perceived stress and drinking to cope ranged from moderate to high, yet found the relationship between stress and problems related to the drinking as being relatively small.

The aforementioned theories suggest that stressors caused by a variety of factors including mental illness may increase vulnerability to addiction, while being a contributory factor to possible relapse. This is due in part to circularity around behaviours, including operant conditioning and negative reinforcement, as well as having an inability to better manage stress. These cause or effect cyclic behaviours can create ambiguity when interpreting connections between stressors and addictive behaviours. They may complicate the question of whether the stress caused the addiction or vice versa.

**Psychoeducation and pharmacological interventions for AOD problems**

Psychoeducation or pharmacological interventions can be administered individually or con-currently to bring about change in substance use. Motivational interviewing is deemed beneficial in health care practice, and a range of skills is used to encourage individuals to take action over their substance use by setting goals and working towards maintaining those (Rollnick et al., 2008).

Maintaining any behavioural change to AOD use must be considered and facilitated purposefully and skilfully. In my professional counselling experience, psychoeducation is essential in assisting an individual in raising their consciousness around the quantity of the substance used, plus the time involved in thinking about and then using the substance and recovering from the effects from partaking. In consideration of all these aspects, the drug itself can consume a great deal of time. Recognising this in a conscious, transparent way is critical in making change, and is a common strategy employed in my counselling practice early in treatment. This demanding task of developing self awareness can cause anxiety and distress and sometimes results in the “what the hell” response, when there is
a return to the previous level of consumption. This is known as relapse, when a person delays behavioural change for another time, or alternatively returns to a precontemplative or denial stage in which an individual refuses to acknowledge a problem with AOD use (Rollnick et al., 2008).

A selection of tools will better equip individuals to face potential stressors that affect them during any stage within the transition. Sinha et al. (2011) recognised that stress and alcohol cues have a large part to play in relapse risk. They suggested using treatments that decrease stress and cue-induced alcohol cravings and anxieties, noting that this in turn would improve alcohol relapse rates.

Cognitive behavioural therapy, deep breathing and relaxation techniques are preferable to pharmacological management, but in some cases drug therapy has been recommended as appropriate for excessive stress and panic attacks. The stress chemicals noradrenaline and adrenaline can be blocked pharmaceutically by taking beta blockers, which decrease feelings of anxiety by helping to maintain a steady heart rate (Noel & Curtis, 2003). This in turn can provide biofeedback, and behavioural changes in the individual will follow. Previously, the racing heart would have served as a message of distress, causing the person to feel greater anxiety. A reduced heart rate signals less provocation to be anxious or stressed.

The combined effect of illicit drugs, prescription medication and relaxation needs to be taken into account when considering changes. Commonly abused drugs include alcohol, nicotine, marijuana and amphetamines. These activate brain pathways and stress pathways of the autonomic nervous system, causing changes in heart rate and blood pressure (Sinha, 2008). When drugs are combined - even less problematic drugs such as coffee and cigarettes - in the context of a stressful situation, an individual is activating their stress response in a significantly higher way than would be achieved by cigarette, caffeine or stress response alone. These concerns require assessing and discussing with individuals prior to administering any medication.

Medication alone can address reactions or a feeling associated with stress, but does not recognise the causes. Without recognising the origins of distress, and learning satisfactory techniques to avoid or manage these, medication may assist only a temporary partial adjustment to stress levels overall. In my counselling experience, tertiary students
who suffer acute test anxiety have benefited by the use of beta blockers, though some have openly admitted it could be the placebo effect rather than the drug itself. The drugs of choice for treating anxiety disorders, according to Noel and Curtis (2002), are the selective serotonin reuptake inhibitors (SSRI’s) because of their improved tolerability profiles and seeming lack of antihistaminic and anticholinergic effects (for example constipation, blurred vision) that are often problematic with some other anti-anxiety medications prescribed, namely tricyclic antidepressants (TCA’s).

Though drug therapy may be appropriate and beneficial, any pharmacological drug has the potential for creating dependency together with adverse side effects from the ingredients (Everly & Lating, 2003). Furthermore, the effects of medication or AOD use are intensified when the use of the relaxation response is induced simultaneously (Everly & Lating). Implications in therapeutic practice suggest that background knowledge of clients’ present AOD abuse and medication would therefore be useful prior to teaching relaxation strategies to individuals. For tertiary students, however, asking about AOD use may not be a part of existing assessments, and eliciting accurate information could be further complicated by students’ failure to recognise their AOD use as being problematic, but merely the same as their peer group.

**Stress and substance misuse – the tertiary population**

Tertiary study is often associated with a life stage where alcohol and recreational drugs are used experimentally and socially. Studies acknowledge concerns about the AOD use by New Zealand’s tertiary population, and how this affects their learning (McGee & Kypri, 2004). Other mental health concerns and co-morbidity problems further complicate matters and raise questions of how students experiencing these are best supported (Mueser et al., 2003).

The initial year at university is conceptualised as a rite of passage for many, and this new-found freedom often coincides with the coming of age to legally access alcohol, and a subsequent increase in the consumption of alcohol and drugs. A longitudinal study in the UK over three years with nearly 6000 University students by Bewick, Mulhern, Barkham, Trusler, Hill and Stiles (2008), reported higher alcohol use in year one than in the following years at university. However, consumption levels were still high for a
substantial number of students at year three of this study, particularly male students, suggesting the need for a psychoeducational programme of prevention information and follow up treatment interventions for all year groups. The negative effects of this high level of drinking were identified in the areas of their studies, finances and physical health.

Research by McGee and Kypri (2004) with 1910 New Zealand university students who had an average age of 20, showed alcohol consumption and next day effects resulted in reduced performances in terms of arriving late to lectures, missing class, or not handing in assignments. These findings are consistent with alcohol abuse criteria as described in the DSM-IV (1998) as a “failure to fulfil major role obligations” (p.112). The cumulative effects of these behaviours often have negative consequences, including adding another layer of stress to the individual. McGee and Kypri (2004) reported that binge drinking among tertiary students in New Zealand has significant consequences for individuals’ study performance, and suggested brief interventions to reduce harm in this population group.

Connections between substance abuse, anxiety and stress are shown by students who present to health services with co-morbidity problems. A study that recognised the connection between students, anxiety and alcohol was that of Seigers and Carey (2010) involving 214 clients who had accessed an American university-based mental health clinic, but who had stopped their follow up treatment over the previous three years. Seventy-six percent were tertiary students and one third of these screened positive for hazardous drinking. Of those who identified as having an anxiety disorder, these were two to five times more likely to have a diagnosable alcohol use disorder, as well as frequently binge drinking. The results revealed that hazardous drinking was associated with fewer therapy sessions and higher incidence of failure to attend appointments. These results therefore demonstrate that addiction issues interfere with and influence treatment adherence and symptomatic improvement.

Developmentally, the majority of the tertiary student population range from late adolescence to early adulthood. This developmental stage appears to be vulnerable to a high number of injury and violence related problems concerning alcohol use, receiving great media attention and coverage (Sellman et al., 2011). However, the heaviest drinkers in New Zealand are aged 25-59, and not the youth who are often misrepresented.
in the media (Sellman, Connor, Wells & Royce, 2011). The reported epidemiological data from the New Zealand mental health survey, Te Rau Hinengaro, highlighted that 64% of heavy drinkers are mostly aged between 25-59, whereas young people aged 16-20 constitute a mere 8%, and youth aged 20-24 represent 21%.

From my professional experience working in the addiction and tertiary fields, AOD and tertiary social life tend to go hand in hand for a great number of students, and experimentation with substances and amounts is seen as routine practice for many. Binge drinking appears commonplace, and often the supposed norm, particularly in the first year of university studies. When I have questioned students about the amounts they are consuming, a common response is that they use the same amount and level as their peer group. Therefore they do not recognise a problem because this behaviour is viewed as “normal.”

However, these AOD practices can cause short and long term concerns for individual students and their study practices. Their coping and vulnerability will be made more complicated for those with dual disorders, which in turn can make an individual more susceptible to AOD use. Better support could be provided by psychoeducational and follow up treatment interventions, as recommended by Bewick et al. (2008).

**Gender Differences**

Coping theory suggests that women select emotion focused rather than problem focussed coping to manage stress because it better matches females’ situational demands (Oswalt & Riddock, 2007). Female stereotyping suggests women are given a greater emotional component when compared to males, who stereotypically prefer problem focussed coping to manage their stress (Broughman et al., 2009; Chaplin, Hong, Bergquist & Sinha, 2008). In regard to students, does gender make any difference in managing stress?

The lowering of the legal drinking age has made alcohol more accessible. The availability of AOD, together with increasing levels of stress, are factors influencing tertiary students’ increasing engagement with alcohol and drug use over the past three decades (Pritchard et al., 2007). Rice and Arsdale’s (2010) study with 522 students in USA in relation to stress, drinking to cope and perfectionism noted that females had
higher stress levels and used alcohol to manage their stress more than their male counterparts. In comparison, Moonmuang’s (2005) study with Australian male university students found that the most common behaviours of stress management included avoidance, aggression, alcohol and drug use and smoking. It was suggested these methods are not specific to university life, but more generalised to the collective structure of our society. In-depth interviews showed that male university students were reluctant to use supports from family and friends, and were more undernourished and inactive when distressed. Moonmuang’s findings are supported by those of Chaplin et al. (2008) who found females responded to stress with greater sadness, anxiety and depression compared to males who were at greater risk for alcohol related problems.

Finding a supportive person and making connections with others builds emotion focussed coping, as recognised by Folkman (2008). Although the male students in Moonmuang’s (2005) study were reluctant to use supportive family and friends, in contrast Broughman et al.’s (2009) study with 166 college students in USA found that emotion focussed coping predominated over problem focussed coping for all students. Broughman et al., recommended that educational courses teach emotion regulation skills and build emotional supports. They found that women seemed to be searching for answers by more readily accessing self-help, approach and self punishment strategies than male students. Oswalt and Riddock’s (2007) study with 223 graduate students found males used vegging out (inactivity) and exercise to manage their distress, whereas females ate comfort food and talked with their friends. Though reaching out to others appears to be somewhat more important for females, both genders appear to find support through this outreach.

In this relatively small-scale search of literature on gender and stress management, no significant differences between genders were revealed. An unhealthy mechanism misused to manage stress is alcohol and drug use, and there appear to be minimal differences between genders in regard to this. Having supportive relationships with others assists coping for both genders. Either individual or group therapy could therefore be helpful in building connections, with group programmes providing more supportive relationships than found in individual therapy. When considering the options of individual or group therapy, the influences of gender socialisation need to be recognised,
including hierarchy, social roles, accessibility of resources, and their associated effects. For example, some stress-inducing practices in student faculties may have been traditionally accepted for generations (Sheehy & Horan, 2004). When contemplating gender differences and their potential influence when providing and delivering a stress management programme in a group setting, further considerations need to be addressed. These include whether individual or group therapy is more suitable for particular people, and what influences these choices or decisions.

**Individual or group therapy for stress problems?**

There are different interpretations of “group therapy.” Group therapy can mean a gathering of individuals in which the interactions among group members constitute the primary therapeutic factor. Alternatively, group therapy can be a psychoeducational group run by a facilitator (Weiss, Jaffee, De Menil & Cogley, 2004). Nevertheless, while participants gain insight and learn from others in group programmes, little attention is given to individual concerns (Mclean & Woody, 2001).

Opinions differ as to whether individual or group treatment is best suited to deal with stress issues in a variety of populations. Corey (2010) noted that the group versus individual therapy research over the past 40+ years has shown a wealth of evidence supporting group work and clients improvements in a variety of settings and situations, but recognised that little evidence is available to explain why this is. He summed up the situation by stating “the general consensus among experts is that the current knowledge of the effects of specific group treatments is modest at best” (p. 41). He encouraged future practitioner research, recommending the integration of research into group practice.

Group treatment delivers a number of benefits. Psychoeducational group programmes have a focused theme, teach information on that theme in a personalised manner, educate participants in behavioural skills in relation to the theme, and deliver this within a supportive environment (Corey, 2010). A group programme can provide a positive protective influence through open discussion with a mentor or group members that can change feelings of hopelessness, helplessness and despair into feelings of optimism and constructive behaviours (Waller, 2001). The focus of a stress management group
programme is on building resilience and increasing coping, and this can be achieved by using a multi-component programme that addresses neurological, neuromuscular and cognitive areas (Everly et al., 2003).

Observing empirical studies of 40 plus years of group work in general, Dies (1992, as cited in Corey, 2010) focussed on outcomes and found little difference between individual and group therapy. Because of the cost effective nature of group work and the inherent savings involved, Dies expressed concerns that this would make therapists need to give an explanation for why the treatment of choice was not group therapy. A simple equation of cost effectiveness is an example of one or two therapists seeing ten group members over a two hour period, versus one client with one therapist over one hour. There are benefits in providing group work when there is a waiting list, in terms of numbers being seen more immediately, thereby showing another aspect of how group therapy is more cost effective than one to one therapy (Kincade & Kalodner, 2004). These considerations will influence the offering of group therapy, individual therapy or a mixture of both.

These findings were noted alongside the varying methods of calculating the costs involved, which makes it a challenging process to assess whether group is more cost effective than one to one therapy. Kincade and Kalodner (2004) cautioned that costs considered may be direct costs only or may include insurance company, government or community costs, loss of wages, charges to health care providers, administrative and facility costs, personal costs such as transport and loss of wages for attending therapy. There would need to be a greater number of cost effectiveness studies in different contexts to enable data to be compared before any soundly-based conclusion can be drawn.

Taking monetary costs out of the equation, a different measurement criterion is the effectiveness of the treatment. A movement over the past 20 years from process research in group work to outcome studies has been noted by Corey (2010). He has recommended that group research in the future needs to inform practice and be lead by those who conduct and run the groups.
Group programmes for tertiary students

Group therapy has changed dramatically over time. Looking back, the 1960s showed the evolution of the encounter group movement, when groups were offered to individuals including university students (often over a weekend) by counselling mental health professionals (Corey & Corey, 2002). Group work was seen as an alternative to individual therapy, and used as remedial therapy. Though encounter groups produced moderate improvement for students (Kincade & Kalodner, 2004), encounter groups of that time were often remembered as unsafe cathartic experiences, leaving group participants open, raw and vulnerable (personal communication counsellors Andrea Black and Margaret Agee who counselled attendees). Group facilitators often had little or no training, and ethical issues evoked concerns (Gladding, 2003). Self help groups were refined during the 1970s and the 1980s and psychoeducational groups were re-established during this time. During this latter stage, ethical and professional standards were adopted and overall safety for group participants improved (Gladding).

Generally, the stigma, false beliefs and myths that overshadow counselling and group therapy are being slowly whittled away, shown by the increasing numbers presenting to counselling services, as reflected in tertiary institutions within New Zealand employing higher numbers of therapists over time (personal communication, Lesley MacKay). As indicated above, more clients can be managed within a group situation than in one to one therapy, making groups cost-effective interventions, and thereby promoted and recognised as an efficient use of resources (Tucker & Oei, 2007).

Benefits of groups are evident on many levels. Group members make connections with others and recognise their responses as being “normal” (Tucker & Oei, 2007). Feedback may be more acceptable or meaningful from another group member (with a similar issue), than from an individual counsellor or therapist, and valuable connections are made by meeting others who individuals may not otherwise associate with. This can be important in breaking down isolation and helping students feel less alone (Tucker & Oei). There may be learning inherent in the experience of trusting others and establishing meaningful relationships. Positive role modelling by other participants promotes a culture of expressing oneself in healthy ways, along with developing compassion and sensitivity for others.
Professional experience suggests there are many reasons for psychoeducational groups offering a unique learning advantage. These include the benefits discussed above, along with the specific focus of the group. It is a safe environment to discuss concerning issues that are universal among the participants and may be foreign to others. These conversations can strengthen individual uniqueness through affirmation, or normalise responses and reactions, for example, to a stressful situation that others in the group have also experienced.

A protective group environment fosters participants’ practice of new behaviours spontaneously without potential fear of negative consequences from an individual therapist or from others outside the group. Therefore, a group can provide a cushioning of their “comfort zone” (MacNair-Semands, 2002). Disadvantages of group therapy include possible confrontation or small-talk developing between group participants, individuals monopolising group time, the forming of sub-clusters, and less confident participants feeling discouraged or unable to have a voice themselves (Tucker & Oei, 2007).

The tertiary student group is complex and diverse because of the wide range of ages, developmental issues, cultures, programmes and courses, and career paths, lifestyles, socioeconomic standpoints, and ability level of students. Facilitated groups are often targeted toward at-risk populations, for example AOD use, social skills training, assertiveness, or grief (Kincade & Kalodner, 2004). Common groups on offer at Auckland University include psychoeducational groups targeting at-risk populations, namely depression, stress, grief, exam pressure, social skills or anxiety based groups (personal communication, Lesley MacKay). Homogeneous groups are useful in working through certain issues by normalising experiences and recognising the shared struggle by others. Delivery of a psychoeducational group is provided through a balance of content, discussion and support and has four elements consisting of a common theme, didactic teaching, educating behavioural skills and personalising information (Kincade & Kalodner).

There are many necessary considerations when facilitating a group for tertiary students. Flexibility is necessary to work around the course timetables, including exam dates and other features of the student calendar. Consideration must also be given to
developmental issues and concerns of group members, including confidentiality. Privacy matters and fear of embarrassment may stop some individuals from attending (Weiss et al., 2004). Dual relationships between group members could be either problematic or helpful due to participants belonging to the same hall of residence, same class or social group, which in turn could affect the disclosure of personal information in front of other participants. Peer group outlooks may influence group members, or alternatively, peer opinion and familiarity could be beneficial for some students. These factors may bring complications not present within a different group or community setting. Tertiary students appear particularly sensitive to comments from peers, and confidentiality and privacy are paramount in keeping group members feeling and being safe (Corey et al., 2004).

The transitional stage of tertiary level study often entails academic demands, interpersonal issues and financial concerns as discussed earlier. Tertiary students are not immune to stress, nor are they protected from the same stressors that occur in the general population, and they can profit in a number of ways by attending a group programme (MacNair-Semands, 2002). When counselling tertiary students either individually or in groups, an appreciation and respect for cultural differences needs to be held alongside bonding with fellow members through common elements of concern. Multiculturalism and diversity affects the issues the participants will recognise and bring into the group setting, whether they are ready or reluctant to explore them, and also what roles or responsibilities are assumed by the facilitator. These matters need careful consideration during group processes and also when discussing the generalisability of any research findings.

Substance use disorders (SUD’s) - individual or group therapy?

In relation to the management of substance use disorders, there are two main philosophies or streams within the field in New Zealand. These represent the abstinence focused 12 step programmes based on the disease model which recognises that the breaking down of “denial” is best administered by another person who has experienced similar issues (Weiss et al., 2004). A second school of thought is the harm reduction philosophy which motivates changes to behaviour that will consequentially cause less
harm to the user or society at large (Witkiewitz & Marlatt, 2006). Twelve step abstinence-based programmes are predominantly group focussed, whereas harm reduction treatment is provided through a mixture of group and individual therapy.

I have noticed through my work in the addiction field over the past 12 years that harm reduction treatment centres I have been involved in are gradually moving away from individual therapy and more towards group-based treatments. Group therapy is the most common form of treatment for substance use disorders (Weiss et al., 2004). Alcoholics Anonymous known as AA, and 12 step treatment programmes are group focussed; namely peer support, therapeutic and psychoeducational groups (Galanter, Kaskutas & Lagressa, 2008). AA maintains the importance of building interpersonal relationships with members with common denominators. The role of sponsor, attending meetings, and the support of each other are core elements within AA culture. Residential treatment centre programmes are predominantly group focussed, and include intensive outpatient programmes. An example is the programme run at Community Alcohol and Drug Services (CADS) based at Mt Eden Auckland, which predominantly uses group contact and facilitation with clients predominantly over one to one counselling.

However, in my professional counselling experience, individuals with substance use disorders most often present to counselling services wanting to continue using their substance of choice socially. This helps them fit in with their peer group. Most individuals do not want a pledge of abstinence, and this seems particularly true for the student population group I presently work with. This predominant group of individuals contrasts directly with the people who are unable to and cannot use socially because of constant episodes of lapse and relapse. For the latter group, 12 step programmes are essential, appropriate, validating and extremely supportive in their choice and goal of abstinence. Inflexible mandates for abstaining from AOD, as promoted by 12 step programmes, equate to seemingly unrealistic goals however for a large population group who identify as having substance use issues (Witkiewitz & Marlatt, 2006).

When comparing the relative effectiveness of groups, or of group and individual therapy, the particular focus of attention complicates matters. Traditionally, group therapy and treatment outcomes focussed on the interaction among group members, but more recently have involved the didactic skills of psychoeducation and cognitive
behavioural training (Weiss et al., 2004). A total of 24 previous AOD groups and treatment outcomes were considered, examining different types of group therapy effectiveness, as well as individual modalities, by Weiss et al. It was revealed that five common models of group therapy were delivered to clients with substance use disorder problems. The researchers were surprised that after reviewing 30 years of treatment studies they only found 24 that compared group therapy to one or more other conditions. The group models documented were 1) the education group; 2) the recovery skills group which is mainly skill based from a cognitive behavioural educational focus; 3) the group process model, involving supportive and confrontation interaction among group participants as well as involving the facilitator; 4) the check-in group with brief individual treatment with each participant and; 5) groups addressing other issues relevant to AOD use, such as stress or anger management.

As well as different group models, there are also differences as to whether new members can begin the group at any stage or whether all participants begin at the same time. These differences between open and closed groups were discussed by Weiss et al. (2004), who noted that closed groups often have time delays prior to start of group. During this time, some group members change their minds about attending because their motivation has altered during the waiting period (Rollnick et al., 2008). Closed groups increase the interdependence of group participants, and need consideration when discussing therapeutic effectiveness research data. Among other methodological and logistical problems noted were the relatively little knowledge available about group effectiveness, and about what content, type of group or length of group is favourable over another. Results identified few differences among types of therapy, supporting no particular therapy as being superior to another, and no particular content coming forth as being superior (Weiss et al., 2004).

Of the fifteen different group studies researched by Weiss et al. (2004) only three showed reliable differences between groups. Three studies comparing individual therapy to group therapy highlighted no significant differences between identical treatments delivered individually or in a group. This suggests that individual and group treatments that are similar in content, intensity and length of time, can provide the same results.
Accordingly, Weiss et al. concluded that when considering cost effectiveness, group treatment is therefore identified as being superior to individual treatment.

On the other hand, Tucker and Oei (2007) from the University of Queensland, Australia, evaluated 36 studies considering the two points of “cost and effectiveness” when comparing group CBT with individual CBT therapy. They reported differing and limited results, but in summary they concluded that group CBT treatment was less effective than individual CBT treatment in addressing substance use dependency and anxiety. A strength noted was that individual treatment provided a more individualised approach, specific to unique issues and needs. However, this focus on the self meant that individuals missed potential benefits from taking part in group dynamics.

Group composition alters research findings in many ways. Highly persuasive and overriding individuals may dominate other participants, and this needs balancing alongside the benefits of group cohesion and positive role modelling. Socioeconomic levels, culture, gender, age, treatment goals and stages of change for both participants and facilitators must be considered. In my professional experience, some groups gel and appear to work better than others for many different reasons that may only occur at that one time and in that context. For example, one or more group members may often play the part of acting as leaders or presenting themselves as positive role models to other group participants, or alternatively one disruptive group member can bring about a drop in attendance group rates, and diminish the potential benefits to others.

**Stress management programmes**

The complexities involved in comparing what group models work best for individuals with substance use disorders are also relevant when discussing stress management group programmes. There are multiple ways of presenting a stress management programme and its measureable success is made more complicated by the number of participants, the length of the programme, and whether it is an open or closed group. Literature on the effectiveness of stress management programmes appears to be increasing over time, though relatively few studies directly compare different techniques, with even fewer including post group interviews with participants or long term follow-up measures (Le Fevre, 2007). Past studies of stress management groups have mostly employed
quantitative research methods, and the dominant form of treatment has been mindfulness (Le Fevre).

The three main types of programme delivery found in the literature search are relaxation response strategies (including meditation and mindfulness), cognitive behavioural strategies, and mind-body interventions, otherwise named “holistic approaches.” Other programmes are available, but for the purpose of this study I will only discuss elements of these three popular forms.

**Mind-body interventions**

Stress management programmes based on mind-body ideas initiated since the 1980s appear to have retained important significance today and remain relatively unchanged. The first stress reduction programmes known as stress inoculation training (SIT) were designed in the 1980s by Donald Meichenbaum (1988), consisting of a combination of relaxation, cognitive restructuring, coping and time management skills. The stress inoculation training did not propose to eliminate stress, but instead taught skills to better manage stress constructively through a variety of intrapersonal and interpersonal skills.

These skills constituted a plan for implementing lifestyle changes that would bring about an improved quality of life with diminished distress. According to Meichenbaum (1988), the three overlapping phases begin with an educational introduction to the sources of stress, delivered by an educator promoting a collaborative relationship with participants. The other phases are learning strategies which include coping skills to reduce anxiety, applying the skills in daily living, together with learning relapse prevention. Meichenbaum’s stress inoculation training which began 30 years ago still holds relevance in today’s society, offering a combination of skills which recognised the need for a holistic approach to coping with stress.

A holistic model identifies stress as a process, suitably assisted by a multi-systemic approach. Similar to Meichenbaum’s stress inoculation training, and a model that is useful in collating material for developing stress management programmes is Everly’s (1989) six stages of the epiphenomenology (the process of consciousness occurring as a by-product of brain activity) of the human stress response. This model highlights an interrelationship associated with the stress reaction, by recognising that a triggering
stressor is followed by cognitive appraisal and affective integration. When the neurological triggering occurs, the physiological stress response is activated. In completion of the process, the target organs are activated, and finally, coping actions are utilised, which are used to regain homeostasis.

A stress management programme corresponding to Everly’s (1989) model would focus on improving adaptation by minimising stressors, reducing psychophysiological arousal by teaching strategies of relaxation, deep breathing and mindfulness, and encouraging improved management of the cognitive affective area by restructuring the appraisal of distressing situations. Fourteen years later, Everly and Lating (2003) confirmed that the preferred model is a multi-component stress management programme utilising mind-body techniques. This model reflects Lazarus and Folkman’s (1984) stress theory and Meichenbaum’s stress inoculation training, and the group programme being delivered in this project is based on this model.

Similar to Everly and Lating’s (2003) model, a stress management programme was piloted with 136 undergraduate students at the University of Buenos Aires by Iglesias et al. (2005). Based on comparable foundational ideas, the group programme included coping skills training, deep breathing, and a range of relaxation techniques, time management skills and cognitive restructuring. Empirical evidence showed students who completed the group programme had lower levels of stress, anxiety, anger, helplessness, neuroticism and improved breathing methods, and more readily used deep breathing instead of hyperventilating when stressed.

Another study supporting the use of mind-body techniques, used together with cognitive behavioural interventions (CBI) in a bid to better manage students’ stress was reported by Deckro et al. (2002). They delivered a pilot study group programme, consisting of six 90 minute sessions of mind body interventions and CBI techniques to 128 university students in USA. Findings showed a reduction in psychological distress, anxiety and perceived stress, suggesting that this training could assist in preventing student stress. Limitations of the study included the use of self-reporting questionnaires, a high proportion of women and a high percentage of undergraduate students among the participants, a broad age range, and a six week attendance by only 43% of the students.
The most appropriate stress management programmes are multidimensional mind-body applications that address neurological, muscular and cognitive areas (Chinaveh, Ishak & Salleh, 2010; Deckro et al., 2002; Everly et al., 2003).

**Mindfulness based interventions**

Mindfulness offers both treatment and prevention by providing new ways of thinking and being. Mindfulness based treatments have been utilised and found effective for a range of clinical disorders, including cancer, heart concerns and depression (Praissman, 2008), and chronic pain and insomnia (Yang, Su & Huang, 2009). It is similar to cognitive behavioural therapy in that it proposes to alter ways of thinking, which in turn can improve physical and mental wellbeing (Yang et al.). The difference is that cognitive behavioural therapy labels negative thoughts and provides ways of changing them to positive ways of thinking, whereas mindfulness involves developing awareness or awakening through paying attention purposefully, in the present moment and non-judgementally (Praissman). It is not the thought that causes suffering but the attachment and judgement in regard to the thought. The roots of mindfulness are embedded in Buddhism and represent insight meditation where observation of internal experiences allows the self to connect or disconnect from the automatic interpretations and subsequent experiences of stress or distress (Palmer & Rodger, 2009). In the “mindful zone” the self is better able to choose a response, instead of reacting habitually or reflexively.

My teaching of mindfulness practice has had mixed responses. Its introduction is often met with blank faces staring at me attempting to seize the concept, with apparent confusion. For those who have prior knowledge or hold willingness to a new idea, the one and a half hour slot I previously assigned (within the stress management group) to mindfulness is acceptable, otherwise I suspect it requires a longer time to assimilate its meaning. However, the introduction is a time of “seed planting” and I encourage group members to follow and continue their own research path following the group. Our continuing race, pace and necessity to multi-task in society is seemingly increasing, and the concept of slowing down and focussing as recognised and promoted in mindfulness is a contradiction to this, and a helpful construct to lowering stress symptomology.
Mindfulness encourages awareness of the complete range of each experience. It aims to teach participants to relate to external and internal sources of stress in more constructive ways than previously (Palmer & Rodger, 2009). Research by Oman et al. (2008) in the USA with undergraduates attending a meditation based stress management group for reducing stress and promoting forgiveness elicited positive results. Another recent mindfulness study with 135 first year university students, as conducted by Palmer and Rodger (2009) in the USA, found positive relationships between mindfulness and rational coping styles, showing that mindfulness brings about resilience in face of the harmful impact of stress. They found that students low in mindfulness tend to experience greater levels of perceived stress. On the other hand, Bishop (2002) warned in his critical review of mindfulness meditation that there is insufficient evidence of its effectiveness that is based on rigorous scientific methodology. Though he considered some evidence as promising, he cautioned against using mindfulness practice as a cure-all.

A lack of side effects and its harm-free nature however make mindfulness a worthwhile and safe strategy to promote to anybody, and it can be used anywhere, anytime. It increases one’s ability to better manage and cope with life (Praissman, 2008). Dialectical behavioural therapy (DBT) encompasses mindfulness as a necessary and core component teaching that assists in integrating other life skills (Linehan, 1993). Any behaviour change must be implemented mindfully in order for it to become identified as helpful, and then used habitually. Dialectical behavioural therapy and mindfulness groups are currently offered to clients with drug and alcohol issues, and programme delivery can be readily accessed through Community Alcohol and Drug Services (CADS) within the Auckland area, as advertised on their website (www.cads.org.nz). These programmes are also offered through community mental health treatment centres in Auckland, showing their growing popularity.

**Cognitive based interventions (CBI’s)**

Thinking and thought patterns influence behaviours and levels of stress. By identifying thought processes and challenging and altering thoughts through cognitive behavioural interventions, distress can be lessened. Cognitive behavioural therapy (CBT) was developed by Aaron Beck in the early 1960s, according to Corey (1996). These
interventions are highly structured, skills based, time limited and characteristically useful for group programmes. If we change the way we think about a stressor, or challenge our thinking in response to the stressor, we can change the resultant consequences; namely the negative emotional state and bring about behavioural change. The appraisal process determines whether the stressor is dangerous or not, and whether it requires modification. CBI’s have a background in rigorous quantitative testing, and are supported by many controlled trials and solid empirical findings as being highly effective in treating depression, anxiety, panic and substance abuse disorders (Beck, 1995). This form of therapy is recognised as being useful for people with different levels of education, income and backgrounds, and has been adapted and successfully used in work with individuals, couples, families and groups (Beck, 1995).

Mindfulness based cognitive therapy integrates the principles of mindfulness together with components of CBT. Based on Jon Kabat-Zinn’s mindfulness based stress reduction programme, the additional CBT component was added to assist individuals suffering with repeated periods of depression (Kabat-Zinn, 2005). The concept that thoughts are not facts, and can simply be ideas that come and go, rather than be examined and disputed, makes this approach different from the traditional CBT.

Stress management is recognised as assisting individuals to identify their stressors and the processes involved in learning and utilising strategies to better manage their distress. Opinions differ as to whether this is ideally learnt individually or in a group setting. The three main bodies of recognised stress management programmes are: mind-body, mindfulness, and cognitive behavioural interventions. This study uses a mind-body group programme that encompasses mindfulness and cognitive behavioural methodologies.
**METHOD**

**Purpose of the study**

The purpose of this study was to evaluate the effectiveness of a five week, psychoeducational mind body stress management programme, delivered to two different groups who identified stress as being problematic. One group was made up of university students and the other of clients of an alcohol and drug agency. Aims of the study included comparing the results of delivering the programme to these two different groups and evaluating its appropriateness for the university student group in particular. A near-identical programme was delivered by the researcher simultaneously to each group. Information obtained through standardised pre- and post-tests and focus group interviews following the delivery of the programme were used to assess to what degree participants’ stress and coping levels had changed over the course of the programme.

Previous feedback from clients with addictions suggested that this programme had been valuable to them. For this study, it was hypothesised that some tertiary students (either with or without alcohol or drug issues) could be assisted by using the coping methods taught in this psychoeducational group which had originally been developed and delivered in the context of a drug and alcohol community-based treatment context. Data gathered were analysed to assess whether the group content and process were effective with both these population groups in the study. If this hypothesis was supported, results would demonstrate that the group content and process were beneficial and transferable to more than one population group. Through trialling this group, any modifications that were necessary in delivering the programme to either group would become evident. This project could therefore enhance the future planning and delivery of stress management group programmes to the tertiary student population and the client group who have addiction issues.
Participants
The first ten tertiary students and the first 12 AOD clients who responded to the advertisements (Appendices E1 & E2), read and completed the participant information sheets (Appendix G) and consent forms (Appendices F1 & F2), and were willing to commit to the five week programme were accepted to the two groups. Selection criteria included that participants recognised stress as being a problem in their lives and that they were already enrolled in either tertiary study or the addiction agency involved. Exclusion criteria were the AOD participants had to have an addiction problem, and were not attending the service because of a family or friends AOD problem.

The AOD group included participants from a wide range of ages, from 29-67 years of age, with seven identifying as New Zealand European, four identified as European (not otherwise specified), and one as a Pacific Islander. All except two participants were in full time employment. The length of time abusing AOD ranged from approximately four years up to 45 years. Nine participants were presently abstinent from AOD.

In comparison, the tertiary group were a younger set of people, with ages ranging from 20-33. Some participants identified with more than one ethnic group. Two identified as New Zealand European or Māori, five as European, three as Asian/Indian while one participant identified as African American. One student worked full time, seven part time and two did not have paid work. Only one initially admitted to current use of AOD. The length of time in tertiary study ranged from one to seven years.

Methodology
The researcher’s worldview is a post-positivism one that maintains the assumption that outcomes stem from the complex selection of causative factors and their interactions. These interactions produce results that have multiple and complex meanings (Giddings & Grant, 2006). A mixed methods approach was selected to enhance the interpretation of significant findings and assist in bringing greater insight, by integrating narrative themes with conceptualisations of physiological stress (Collins et al., 2010). This approach was chosen because of the gap in the stress literature to date with stress and coping research predominantly generating quantitative data (Collins et al., 2010; Putwain, 2007).
Because of a predominance of quantitative research conducted most often at one point in time, Robotham (2008) recommended employing in depth interviews in research with students, paying attention to developmental changes that occur. In this study I have used Robotham’s (2008) suggestions to guide my interviews at completion of the two group programmes. The focus group interviews were used to provide an insight into the history of each participant with regard to stress, and to help identify any connections between this history and their present stress levels.

Quantitative and qualitative data regarding stress and coping levels both before and after the delivery of the stress management programme were therefore elicited through standardised tests and focus group interviews. The credibility of the study was strengthened by the methodological triangulation created by the use of the two methods in the data collection process (Liamputtong, 2009).

**Data Collection**

**Questionnaires**

The method for collecting quantitative data consisted of two different questionnaires, both administered at the beginning and again at the completion of the five week group. These questionnaires were chosen to gather data to ascertain depression, anxiety and stress levels, plus identify the coping strategies being presently utilised before and after the group programme. The results from these instruments were kept confidential to the researcher, who posted or emailed a graphical representation of individual results to each participant at group completion.

The first questionnaire used was a validated tool, the DASS21, which was chosen to measure the stress levels of participants (Appendix B). It is a self administered self-report instrument which measures depression, anxiety and stress levels using a Likert scale (Lovibond & Lovibond, 1995). This is a modification of a 42 point screening tool, which I did not use because I had concern about participants’ potential irritability completing many forms. I ascertained that the assessment items most closely matched measurement points of significance to my study. Lovibond and Lovibond developed this tool and described its benefits as follows: it is in the public domain, short space of time
involved in completion, no special administration skills necessary, and suitable for on-line administration. The latter point was important in case participants were not available for the follow-up interviews.

The participants rated 21 questions in relation to how much each statement applied to them over the past week. They completed the questionnaire pregroup and postgroup. There are no specific skills to administer the DASS, but Lovibond and Lovibond (1995) recommend the interpretation of results be carried out by a professional. They suggested using the DASS scores to divide samples into “low”, “normal” or “high” categories. This was seen as preferable to the harsh labels, for example “mild” or “severe,” which categorises the degree of severity in relation to the general population, and can be misinterpreted. An example of possible confusion involves the severity label of “mild” which in this test indicates that the individual is above the population average but still below the typical severity of an individual seeking assistance. It does not mean a “mild” level of the disorder.

The second questionnaire was piloted and devised for this project by the researcher, and named “use of current coping strategies” questionnaire (Appendix C). It was then added to in consultation with family, supervisors, colleagues and the ethics committee to arrive at a total of 41 items, with space for participants to add extra items (see final version: Appendix C). This tool was developed to capture specific details about the ways in which participants coped with stress in their daily lives, such as through regular exercise and household chores. When they had identified the coping strategies they were currently using, participants were asked to indicate with a plus or minus whether they considered them helpful/positive, or alternatively not helpful and therefore negative. Coping strategies that were both helpful and not helpful were marked with both symbols.

The use of standardised tests and self report questionnaires can be manipulated by participants disguising or exaggerating their symptoms, and the results can vary considerably depending on the subjective nature of individuals (Lovibond & Lovibond, 1995). People may answer questions in a socially desirable response rather than truthfully, added Gavin (2008). The advantages of questionnaires are that they can gather a large amount of data from a group of people quickly, they are easy to administer, are familiar for most people, and they are less socially intrusive than vocalising their
responses. Given the fallibility of quantitative measurement tools, the additional use of qualitative data from interviews and focus groups contributed to both the depth and rigour of the findings.

**Individual interviews and focus groups**

All group members were given the option of choosing either a focus group discussion or an individual interview with the researcher at group completion. This offer was made to aid comfort levels in relation to possible disclosure of personal information or criticism of the group programme in front of other participants. In the interviews, participants’ experiences of the group process, the delivery of the group programme and any changes they noticed in their coping with stress postgroup were discussed. Participants were also asked about their histories of experiencing and coping with stress. Focus groups are flexible methods of data collection used in a wide range of research in the field of psychology (Gavin, 2008).

The semi-structured questions offered in the interactive environment of the focus group assists twofold. They enable group participants to collectively discuss their responses, and cumulatively build upon them by stimulating further discussion within the group (Krueger & Casey, 2000). Secondly, individual feedback identifies how participants perceive themselves, reflecting their own self efficacy, as noted by Bandura (1997).

The decision to engage in either a focus group or individual interview was made in a secret ballot at the completion of week three, providing participants with the choice of whether they provided feedback in a group or individually. The length of the focus group interviews ranged from one to one and a half hours, depending on the number of interviewees, and were audio recorded. A guideline of questions was followed by the interviewer (Table 1, p. 212).

**Procedure**

The participant information sheets (Appendix G), consent forms (Appendix F1 & F2) and all other relevant documents were prepared and permission to undertake the study was
obtained from the University of Auckland Human Participants Ethics Committee and the Health and Disability Ethics Committees Northern Y Region (Appendices D1 and D2).

Participants were then recruited for two group programmes that were offered concurrently in a tertiary institution within the Auckland area, and for current clients of an alcohol and other drug treatment centre within the Auckland area. These groups will be referred to as “tertiary group” and “AOD group.”

An acknowledgement that past stress research with tertiary students has been predominantly with medical students, including nurses (Abouserie, 1994; Collins et al. 2010; Cooke et al., 2006; Robotham, 2008) lead the researcher to offer this group to any students, undergraduate and postgraduate. The aim was to obtain a broad sample in both settings, for example, of age, gender, cultures and across differing educational levels. Advertisements (Appendices E1 and E2) were placed in the waiting rooms at the AOD agency and at the student health centre. Potential participants who responded to the advertisements were contacted by the researcher directly by email or text message.

Participants were asked basic factual information and told of the structure and five week timeframe of the proposed group, to ensure their availability for the whole programme. Participant information sheets and consent forms were emailed or posted. There was no formal screening other than potential participants’ self-identifying with a concern about stress, as advertised on the flyer (Appendices E1 and E2). The only exclusions from the AOD group were family and friends of users, who did not have AOD issues themselves, but were also able to access AOD services.

The first 22 participants to volunteer were chosen for the two groups, with the AOD group having 12 and the tertiary student group 10 participants. The sample members remained exactly the same in all phases of the study, with no new members joining after the first week of attendance. Two extra participants were admitted to the AOD group in order to account for the high probability of dropout, as recognised from previous experience of working with both groups. However, all participants remained throughout the study.

Additional tertiary students who expressed interest in attending, beyond the first ten participants, were contacted and placed on a waiting list for the next group to be delivered in the following semester. Initially, there were only three volunteers for the
AOD group. Following discussion with the Team Leader at the AOD agency, the researcher was invited to speak to participants in the agency’s well-attended “Maintenance Group.” An offer was made to participants to interrupt their present group and change the focus to “Stress Management” for the following five weeks. Nine current “maintenance group” members chose to attend the stress management group programme, making a total of 12 group members. The remaining group participants continued with their same facilitator in the “maintenance group.”

Because the participant information sheets and consent forms were given to participants in both the tertiary and the AOD groups prior to attending, they arrived at the first session fully informed. At the beginning of week one the researcher introduced herself, giving her background and reasons for doing the research. A discussion of the research project and what it involved was openly shared, and space given for questions. Demographic information was collected at week one in the form of a questionnaire (Appendices A1 and A2), and was deemed important as it may have provided covert stressor information. For example, having six children or being in fulltime employ and fulltime study. Each participant was asked to choose a pseudonym for use in any written data relating to the individual. These pseudonyms were kept confidential and are only known to that particular participant and the researcher, as described in the participation information sheet. All relevant documentation was completed, including participant factual information sheet, consent forms, plus the two questionnaires.

At the end of week three, participants were invited to decide ahead of time whether they would prefer to take part in focus group or individual interviews with the researcher after the conclusion of the programme. This alternative was offered to provide environments that would be conducive to obtaining optimal feedback from participants. The consent form for this part of the process was also given out at the end of week three, and a choice of either individual or group interviews was made at that point by secret ballot among the participants in each group. The responses lead to the facilitation of a mixture of small and large focus groups and individual interviews after the conclusion of the programme, and one AOD participant chose to give feedback by email.

Focus groups and individual interviews were therefore conducted between one and four weeks following the completion of each five week group programme. Three students
were interviewed together one month after the end of group, which was relatively close to their exams. This stressor was acknowledged at the interview by two students, and the findings were somewhat influenced by the timing of these interviews. All interviews were audio taped, transcribed and then rechecked for accuracy.

**Ethical Considerations**

This was a potentially sensitive piece of research because participants would inevitably disclose private information about areas of vulnerability in their lives. This possibility was raised in both the participant information sheet and consent form (Appendices F1, F2 and G). As a counsellor in the role of researcher I knew that it was possible that I would receive disclosures of illegal drug activities. Ethically, I would only be obliged to break confidentiality in regard to these matters if there was imminent danger to the individual or someone else. This did not occur.

The participant information sheets and consent forms also advised that every effort would be made to protect participants’ confidentiality. This point was addressed at the beginning of each session. However, as a group facilitator there is reliance on the good will of the group to maintain confidentiality. Participants selected pseudonyms that have been used in this report. Although participants were given the opportunity to withdraw data from the study, this opportunity was not taken up.

For both groups, there was back up individual counselling available in the event of participants’ distress not being adequately managed in the group. This situation did not eventuate. Follow up counselling was an important consideration. On their initial “use of current coping strategies” form (Appendix C), five participants identified that they had suicidal thoughts or were using self harm as coping strategies. Aggression was also marked as a coping mechanism by seven participants pregroup. The dilemma of these disclosures was discussed in academic supervision. I reflected on the question as to whether these participants required follow up, or whether the group programme itself would be sufficient in terms of support and risk management. Another concern was whether I was the appropriate person to follow up with individuals or whether this would have a detrimental impact on the power dynamics of the therapeutic group relationship.
Discussion in supervision helped determine that safety issues could be managed within the group setting, and the decision to undertake no additional individual follow up was made. Encouragingly, postgroup measures rated suicidal thoughts/self harm and aggression as dramatically lower than pregroup ratings.

**My role as a clinician researcher: Assessing rigour in the data**

When assessing the rigour of this research, recognition is given that the background and competencies of the researcher could affect the integrity of the project. This “reflexivity” acknowledges that the researcher’s subjective prejudices influence and contribute to the interpretive process (Liamputtong, 2009). Making personal history and experiences explicit and discussing strengths and limitations within the process strengthens rigour and the trustworthiness of the research, recommends Liamputtong.

To the role of researcher I brought 16 years’ experience in the counselling profession, including a solid understanding in the fields of group work, counselling and managing presentations of stress and anxiety. This prolonged engagement in the counselling field paved the way for a trusting relationship with participants and was helpful in decreasing the likelihood of deception by group members (Liamputtong, 2009). This was further enhanced by the building of relationships through meeting weekly for five weeks facilitating the programme, and again for the interviews.

However, potential biases were possible because of the multiple roles played by the researcher, who additionally acted as the group programme manager, the facilitator, point of contact for participants, and data analyst. A conscious effort was made by the researcher to avoid influencing participants’ responses or feedback and withhold any preconceived ideas of the programme and possible results.

**Data Analysis**

Quantitative data were analysed both manually and by using SPSS. This involved transferring the data from the questionnaires to an Excel spread sheet and then on to SPSS. I used descriptive analysis including the t-test. The results are reported by means of descriptive commentary and illustrative figures in the results section.
The audio tapes were transcribed by a transcription service (transcriber confidentiality agreement, Appendix H) and checked for accuracy by the researcher. Qualitative data were analysed thematically via a process of immersion, identifying and coding and naming topics within the data set (Braun & Clarke, 2006). This involved reading the transcriptions of the interviews thoroughly a number of times for accuracy and required the researcher’s full immersion in the data. Themes were identified by using an inductive approach, in which it was ensured that themes identified had strong links to the data set (Patton, 1990). These identified themes were then checked alongside each other and against the original data set for consistency and coherency (Braun & Clarke). A coding consistency check was made by an experienced counsellor, and then discussed with both academic supervisors.

Ensuring interpretative rigour was a demanding process because the interview contents raised by participants differed considerably despite consistency in the delivery course material. After the interviews, my supervisors and I addressed my concern about the shortage of time gathering qualitative data from the main AOD focus group because the group size was 11 participants. On reflection, I realise I privileged the facilitation needs of the group over my needs as a researcher. The data set was minimally compromised. This gap is identified in the results and discussion sections.

Where the findings from both data sources were consistent, internal validity of the data increased. The “use of current coping strategies” questionnaire additionally triangulated and confirmed a significant difference in the increase of positive coping strategies used post group for the tertiary group (see Figure 1, p.23). I have confidence in the rigour brought to this study, which benefitted from both the mixed methodology and the reflexivity I brought to my multiple roles.

The group programme delivered in this study

Rationale, structure and content
Stress has multi-dimensional effects on wellness and general health. Facilitating stress management is best approached broadly using a mixture of tools and strategies that open conversations, and bring forward ideas and strategies for group members (Iglesias et al., 2005). Stress management programmes therefore involve implementing an integrated
mind-body approach that embraces the holistic nature of wellbeing. The overall group programme contained all the essential BASIC ID requirements mapped out by Lazarus (2005). These are: behaviour, affect, sensations, imagery, cognitions, interpersonal relationships and drugs/biology.

The stress management programme delivered in this study involved the integrated use of counselling theories; including existential, cognitive behavioural, client centred, systemic, and feminist. Various methods, educational strategies and techniques were used to stimulate and encourage creative participation. These included a white board, hand outs, drawing therapy, talking therapy, role play and action methods, while consecutively drawing from, acknowledging and utilising the wisdom from group members to teach one another.

A benefit of using an integrative approach is that group participants can select the strategies that they find most suitable and appropriate for their own needs and preferences. To follow only one counselling theory or type of strategy could be disadvantageous for an individual who did not consider that theory as suitable to their culture, gender, or personal value system. Using an integrated range of approaches reflects the way in which I predominantly work with groups. I name this a blending, a smorgasbord or an eclectic approach with a holistic outlook. Mind-body approaches recognise that stress is a process, and not a uni-dimensional concern (Baum et al., 1982). Incorporating an eclectic mix of interventions and offering an extensive range of mind-body options assists health promotion and the prevention of future distress (Iglesias et al., 2005).

Levels of distress are influenced by individuals’ perception of events and appraisal of their capacity to cope (Lazarus & Folkman, 1984). Therefore, stress management activities require the facilitation of opportunities to build coping skills that promote realistic appraisals which can moderate environmental distress. Considering perception and coping as being crucial in stress management, Susan Folkman’s (2008) addition to Lazarus and Folkman’s theory recommended the building of positive emotions to combat stress through promoting meaning-focussed coping. The systemic and holistic nature of stressors, individuals and their environment are thereby taken into account. Meaning-focussed coping may be more effectively achieved through participation in a group
programme involving soliciting feedback and discussion with others, rather than by
individual interventions. Through improved communication with others, enhanced
relationships will occur, lifting self confidence, building support structures and
decreasing isolation.

The role taken by the facilitator is pivotal to the success of the group. The person
centred approach of Carl Rogers (1951) emphasised the role and personal qualities of the
facilitator. Rogers believed that the relationship and attitudes promoted by the facilitator
were of more importance than the techniques that were used. In this group programme
the “presence” and the “relationship” were built through genuineness, empathy and
acceptance towards the participants, which built a trusting, safe environment.

**How the groups were run**
The groups were promoted and identified as psychoeducational and skills-based. They
had a prevention focus that enhanced skills and built awareness, by imparting knowledge
and providing education. I have over ten years’ experience of facilitating group
programmes, and facilitated similar stress management group programmes for three
years. In these groups I provided a balance between delivering content and facilitating
constructive discussion and support. I invited and welcomed feedback and conversation,
and steered the group discussions towards promoting a greater skill base while
manoeuvring away from problem-saturated stories.

A range of techniques were utilised; because of the individual and unique
characteristics of each participant, the wide range of sources of stressors identified, and
the diverse range and patterns of stressful responses. The learning materials were a
combination of mind-body interventions (visualisation, relaxation, diaphragmatic
breathing, progressive muscle relaxation, and yoga stretches), together with cognitive
behavioural interventions (challenging unhelpful thought patterns). Education around
mindfulness philosophy, as well as interactive drawing therapy and open discussion were
also included. “Combining the dimensions of thinking, feeling and doing is the basis for
a powerful and comprehensive approach to counselling practice” (Corey & Corey, 2002,
p. 8).
The holistic approach incorporated building fundamental health measures (nutritious diet, regular exercise and sleep), as well as fostering the ability to express emotions and use social collaboration and intimate relationships to one’s own benefit. Leading a balanced life consistent with individual expectations, existential beliefs and values included challenging unhelpful thinking and setting attainable and realistic goals. These “doing” challenges sat alongside the “being” challenges of having the ability to relax and focus attention mindfully without judgement. Eliciting the relaxation response through progressive relaxation, hypnosis, meditation, visualisation, or prayer have been emphasised by Everly and Lating (2003). They stipulated that these are a natural way of responding to the “disorders of arousal,” and cited research showing that a variety of diseases seem responsive to the therapeutic effect from relaxation techniques. The physiology of relaxation promotes a generalised decrease in the sympathetic nervous system, reduced heart and respiratory rates, and a reduction in cognitive stimulation (Everly & Lating, 2003).

Each group session began and ended with a mindfulness relaxation exercise to encourage deep breathing and inner calm, while drawing attention to any particular areas of muscle tension, thereby building self-awareness and mindfulness. Other mind-body interventions that instructed relaxation included diaphragmatic breathing, guided imagery, progressive muscle relaxation, mini relaxation exercises, and yoga stretches. Relaxation techniques were taught so individuals could recognise the stress physiological stress response and learn different ways to recognise the feedback to modify their response when it occurs (Gregson & Looker, 1994).

Meaning focused coping and emotion focused coping were built through conversation and the affirmation of ideas. Examples of emotion focused coping skills included assertiveness training, expressing feelings positively, and an improved communication capacity by open discussion with other group members. Positive emotions can be achieved by strengthening meaning focused coping. A repertoire of “positive reappraisal, revision of goals, spiritual beliefs, and the infusion of ordinary events with positive meaning” was recommended by Folkman (2008, p. 7). The stress management programme recognised these points directly by encouraging participants to set existential
goals and develop a greater individualised lifestyle balance (see Table 2: Key topics in the stress management programme, p.77)

The facilitator further promoted a culture that furnished emotion focused coping by providing a group space where participants were nurtured and cooperation was respected, through using client centred philosophy (Rogers, 1951). At the same time, acknowledgement and encouragement were given in response to independent and assertive behaviours, as discussed in feminist counselling practices (Chaplin, 1995). Relationships among group participants were fostered through the facilitator’s encouragement of the use of supportive and reflective communication, emotional regulation and validation of emotional responses and experiences.

Meaning focused and emotion focused skills can only be instigated in a safe environment. The healthy foundation of a trusting group atmosphere was established at week one when participants took part in a round of introductions, and then cooperatively set group guidelines. Humour was often used light-heartedly and deemed uplifting because of the serious nature of the topic of “stress management.” At week one, a group guideline was suggested by the facilitator that each group was going to “have fun.” This guideline was reinforced weekly, and there was often supportive laughter within the group environment. This never seemed inappropriate or at anyone’s expense. The group guidelines were recaptured weekly and promoted safe communication, confidentiality, and respect for all group participants and the facilitator.

Some of the tertiary group had not been in a group programme before, and as facilitator I had to work harder at building a safe environment and checking clearly that each individual felt valued and heard. Because nine members of the AOD group had already been together in “maintenance” group, but three participants were new, I was unsure about the additional members’ familiarity with group participation and dynamics. The nine participants were clearly comfortable in each others’ company. This was shown at week one when I noticed they were clearly engaged in conversation, making eye contact and using body language that was more appropriate to friends rather than strangers. The AOD group seemed to be wary of my coming into “their space.” This was evident by their not giving me full attention initially and one participant’s complaining about the amount of paperwork needing completion before we began. In
turn, I felt I had to prove myself to gain their respect and trust. This was achieved by allowing them more opportunity to impart their knowledge and wisdom, which I believed they held in abundance because they were in a maintenance group. This meant they had already made major changes to their AOD use, something I identify as a very difficult task. I called on their insights by using brainstorming and inviting open discussion.

I appeared to gain respect from the AOD group when I openly shared my previous background work in AOD, which was acknowledged as “she’s one of us” and a round of communal laughter. Alternatively, I believed the tertiary group needed time to build trust because all ten participants appeared to be unknown to one another. In response to this, I initially took more of a lead role, allowing the members to relax more into the environment, and feel more comfortable with each other.

Each meeting began with an opening round, where each participant gave voice to their week in regards to managing distress. These processes built trust and rapport among group participants, and had a profound effect on the atmosphere of the group (Corey, 2010). The issue of trust was vital to the continued development of the group, and by processing emotions and thoughts through talking openly about them, rather than avoiding them, there was a greater functional appraisal of stressors and ultimately less distress (Broughman et al., 2009).

In the role of facilitator, I further promoted a safe environment by being open, helping participants feel valued, and holding firm boundaries in regard to the group guidelines. My prior personal experience in counselling and theoretical knowledge on the topic assisted in providing a “grounded presence.” I attempted to deliver the programme with empathy and genuineness, while creating a foundation upon which participants could be resourceful and practice new ways of being with themselves and others. This foundational base fostered creativity among participants, creating a climate for each individual to reach toward their potential (Corey, 2010). Together, the effect of the facilitation, the group culture, and the programme content worked in a fine blend to contribute to the success of the group process. The key topics covered were as follows:
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<tr>
<th>Session One</th>
<th>Causes and effects of Stress</th>
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<td>Diaphragmatic Breathing</td>
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<td>Progressive Relaxation</td>
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<td>Session Two</td>
<td>Setting boundaries</td>
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<td>Assertiveness Training</td>
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<td>Lifestyle Balance</td>
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<td>Goal setting – SMART goals</td>
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<td>Session Three</td>
<td>3 States of Mind  (Dialectical Behaviour Therapy)</td>
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<td>Mindfulness practice - Mindfulness eating</td>
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<td>Body scan</td>
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<td>Session Four</td>
<td>Challenging unhelpful thinking and thoughts</td>
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<td>Visualisation</td>
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<td>Session Five</td>
<td>Feelings and Emotions</td>
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<td>Sleep Hygiene</td>
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<td>Sleep Meditation</td>
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Planning – number and length of sessions

In planning the group, consideration was given to tertiary students’ semester timetable, recognising examination pressures and holiday breaks. A decision was made to deliver a group of five weeks duration to best manage these constraints and variables, allowing the sixth week potentially for the focus group interviews. The AOD group delivery was half an hour longer each week than the student group, allowing for a cigarette and coffee break midway through the session, to assist concentration levels for participants. Alternatively, the student group had chilled water and biscuits upon their arrival at group each week because their allocated group time was near lunchtime. These subtle differences were done in recognition of the different cultural needs of the two groups, and supported by the practitioner team leaders in both environments: Lesley MacKay and Catherine Lowry-Hanlon.

Environment

Because the purpose of the group was to better manage stress, the environment of group delivery needed to be conducive to this end and as stress-free as possible. It was important the participants felt comfortable, their privacy was respected and they were relatively free from distraction (Yalom, 1995). The group delivery settings were in locations known to the group participants and this familiarity assisted in lessening their anxieties. Both group rooms were private and quiet spaces, relatively free from distractions and with outside natural lighting.

To encourage a greater connection through eye contact and body language, the seating was in a semicircle, with the facilitator closest to the white board. This altered during the focus group interviews at week six, when the seating was in the formation of a more intimate full circle which included the facilitator, with all participants sitting relatively close so the recorder could capture all the verbal feedback. By this stage, all participants were more familiar with one another and appeared to be comfortable with this more personable arrangement.
RESULTS

This chapter presents the results of the research. Firstly the demographic information will be presented, followed by the quantitative data, and finally the themes from the focus groups will be described.

Demographic information

Demographic information was deemed important by the researcher because of its potential to suggest relevant connections to stress levels. These included: age, gender, ethnic identification, and employment status, number of dependents, living arrangements, highest academic achievements and alcohol use.

Participants included 10 tertiary students and 12 AOD clients, with all remaining involved for the duration of the groups and interviews. The age range for the AOD group was evenly spread with three participants in each 10 year age grouping from 25-65. The tertiary group included six students aged under 24 and four aged 25-34. The AOD group included eight male and four female participants while the tertiary group consisted of three male and seven female participants. In total across both groups, there were 11 participants of each gender.

Both groups included a range of ethnic identities, with some participants identifying with more than one ethnic group. The tertiary group had a wider range of ethnicities. Two students identified as NZ European and Māori, five identified as European, three identified as Asian / Indian while one participant identified as African American. In the AOD group seven participants identified as NZ European, four identified as European (not otherwise specified), and one as a Pacific Islander.

The AOD group included six single persons and six in marital / defacto relationships. The tertiary group had eight single and two in marital / defacto relationships. None of the 10 members of the tertiary group had dependents, with two living by themselves, three living with others, and five living with their parents. The AOD group consisted of eight without dependents and four with dependents. Seven lived by themselves, four lived with others, and one individual lived with their parents.
The AOD group had 11 in fulltime employment and one participant without employment. While the tertiary group had one in fulltime employment, due to study commitments, the largest proportion of this group were part time workers (seven participants), and two students were not employed.

All participants in both groups had completed secondary school. The AOD group had six who left school with School Certificate or Sixth Form Certificate as their highest qualification. Two members had trade certificates and four had spent two to five years in tertiary study. The tertiary group had three students in their first year. Five students were in years two to five, while two students had completed over six years of tertiary education, and were still studying.

In the AOD group, nine participants were presently abstinent from AOD, and three chose to continue using substances. In the tertiary group, nine of the ten participants initially stated that they did not use AOD. However, during group discussions a second student talked about problems with AOD use, and during follow up interviews a third student reported having AOD problems in her past. In my clinical experience this was not typical of the tertiary population and was an unexpected finding. I expected more students to be using AOD.

**Use of current coping strategies**

The participants used tick boxes to identify their coping strategies (see questionnaire Appendix C). Total numbers of coping strategies were summarised separately for each group, both prior to the start of the group programme and following group completion (see Figure 3, p. 82). Individual coping strategies are itemised in Figure 4 (p. 83). The results will be presented for each group separately and then compared.

**Tertiary group**

The most commonly used coping skills rated by 80% of the tertiary students pregroup were: avoidance, computer, seeking help from a doctor nurse counsellor, talking to a friend or family member, and withdrawing or isolating oneself (see Figure 4, p. 83).

In comparison, the most frequently used coping skills for the tertiary students postgroup changed to: distraction, movies, self talk and challenging thoughts, all rated by
90% of students. It appeared that by the end of the group experience the tertiary group were better equipped to manage their own situations by using cognitive behavioural techniques, distracting themselves and watching movies as a form of relaxation. Other popular skills used by 80% postgroup were: deep breathing, procrastination, and withdrawing or isolating oneself, “vegging out” (meaning passive time out, for example watching television). The coping skill that did not change in rating over the course of the programme for tertiary students was withdrawing or isolating oneself, remaining at 80%.

The mean number of total coping mechanisms used by tertiary students was 15.5 pregroup and 17.8 postgroup. Coping mechanisms rated as negative postgroup were 6.4, dropping to 6.2 postgroup. Neither of these results shows a significant difference. However, coping mechanisms that were rated as being positive or beneficial for tertiary students were 10.9 pregroup and 14.3 postgroup, showing significant difference as measured by a t-test. The level set for significance was p<.005.

**AOD group**

For the AOD group, the most used coping skills rated by 83% of participants pregroup were: employment, physical activity and computer. These changed postgroup to the most used coping skills rated by 83% of participants being: deep breathing, healthy life focus, vegging out and physical activity (see Figure 4, p. 83). The coping skill that did not change over time was physical activity, rated by 83% of participants.

The mean number of total coping mechanisms used by the AOD group was 17.8 pregroup and 17.5 postgroup. Coping mechanisms identified as “negative” pregroup were 3.02, and postgroup were 2.67. Coping mechanisms identified as “positive” for AOD clients were 10.5 and postgroup 9.45. None of these results showed a significant difference.

**Most used coping strategies for both groups (see Figure 4)**

The most popular strategy used over all was physical activity and exercise, used by 77% pregroup and postgroup. The coping tool with the biggest increase in use overall was deep breathing which doubled from 41% pregroup to 82% postgroup. The next biggest increase in total scores was household chores which pregroup was used by 27%, and
postgroup 64%. In contrast, the coping tool that decreased in use overall was the computer, which pregroup was indicated by 82%, but which only 45% continued to use as a coping tool postgroup.

Considering individual and group safety, it is important to note the coping mechanisms of self harm and suicidal thinking, and aggression, both decreased over time. Self harm and suicidal thinking decreased overall from 23% pregroup, to 4% (one participant) postgroup. Aggression was indicated as a coping strategy by 32% pregroup and 4% (one participant) postgroup.

Figure 3.
*Coping Mechanisms Identified Pre and Postgroup*
Figure 4. Total number of coping skills utilised
A comparison of AOD & tertiary: pregroup & postgroup

- physical activity exercise - Pre Post
- vegging out e.g. t.v. - Pre Post
- talking to friend, family - Pre Post
- movies - Pre Post
- reading - Pre Post
- healthy life focus - sleeping eating - Pre Post
- computer - Pre Post
- avoidance - Pre Post
- self talk - challenging thoughts - Pre Post
- relaxation - Pre Post
- deep breathing - Pre Post
- procrastination - Pre Post
- dance/music - Pre Post
- withdrawal or isolation - Pre Post
- employment - Pre Post
- distraction - Pre Post
- meditation mindfulness - Pre Post
- visualisation - Pre Post
- seeking help - dr, nurse, counsellor - Pre Post
- optimism - Pre Post
- household chores - Pre Post
- sports gym - Pre Post
- spirituality religion prayer - Pre Post
- pets dog/cat etc - Pre Post
- massage - Pre Post
- self help information - Pre Post
- medication - prescribed - Pre Post
- denial - Pre Post
- journal writing - Pre Post
- creative skills/art/craft - Pre Post
- gardening - Pre Post
- aromatherapy - Pre Post
- sex - Pre Post
- aggression - Pre Post
- hoemopathy - Pre Post
- alcohol - Pre Post
- self harm - suicidal thinking - Pre Post
- yoga taichi qui gong - Pre Post
- cigarettes - Pre Post
- walking on beach - Pre only
- drug use - illicit - Pre Post
- crosswords - Post only
- socialising - Pre Post
- overeating - Pre Post
- wheatbags - Post only
- sunlight - Post only
- sudoku - Post only
- mind-mapping - Post only
- make lists - Post only
- play music - Pre only
- spending time with partner - Pre only
- pausing before making decisions - Pre only
- watching sunset - Pre only

Total number of participants
Tertiary
AOD
DASS21 Questionnaire

A Likert scale was used to collect data from both groups, measuring depression, anxiety and stress levels. The DASS21 (Appendix B) scores were collated and comparisons made between pregroup and postgroup totalled scores individually and between both groups. There was a statistically significant difference between pre and post test scores as measured by a t-test. The level set for significance was p <.005 and all were statistically significant at this level.

Results for the tertiary group are charted and discussed, followed by the AOD client group. All the charts are shown in order of the pregroup rating scores. This section is then followed by a comparison of the mean scores from both groups.

Tertiary Group: Depression

Of the 10 tertiary students, two showed a slight increase in their depression levels pre to postgroup by six and four points respectively. The remaining eight students’ depression scores reduced following group completion. The most significant drop was from 38 to 12. The mean difference was 23.4 pregroup to 14.8 postgroup. This difference was statistically significant (T test p<.005).

Figure 5.
DASS21 Depression Levels Pre and Postgroup: Tertiary Students
**Tertiary Group: Anxiety**

Anxiety levels decreased over the duration of the programme for six of the 10 tertiary students, while two students’ anxiety levels remained the same, and two students’ anxiety levels increased slightly, both by two points total gain at group completion. The results for the six students whose levels decreased showed dramatic changes: the lowest drop was a 14 point difference from 18 points pregroup to a mere 4 points postgroup. The most significant drop was an 18 point difference from 28 points pregroup down to 10 points postgroup. The mean difference was 23.0 pregroup to 14.2 postgroup. This difference was statistically significant (T test p<.005). The four participants with the highest pregroup anxiety levels improved most (participants 7,8,9,10).

Figure 6.

*DASS21 Anxiety Levels Pre and Postgroup: Tertiary Students*
**Tertiary Group: Stress**

Seven of the 10 tertiary students levels of stress decreased by the group programme completion, with one student’s stress level remaining unchanged. Two students’ stress levels slightly increased, both by a margin of two points. The most significant drop was from 32 to 6 points, representing a drop of 26 points. The mean difference was from 29.0 pregroup to 18.8 postgroup. This difference was statistically significant (T test p < .005). Stress levels of the five participants who scored the highest pregroup all dropped postgroup.

Figure 7.

*DASS21 Stress Levels Pre and Postgroup: Tertiary Students*
AOD Group: Depression

In this group one participant was an outlier because he rated both his pregroup and postgroup depression, stress and anxiety levels as zero, stating “I don’t have much stress in my life.” Although the results are included in the graphs, they have therefore been omitted from the discussion. Therefore, the results for a total of only 11 group members are considered here.

Six of the 11 AOD group participants’ levels of depression dropped over the course of the five week programme, but three participants’ levels remained the same, and two participants’ levels of depression increased. The biggest drop was from 32 points pregroup to six points postgroup. The mean difference was 11.3 pre group to 8.0 postgroup. This difference was statistically significant (T test p < .005).

Figure 8.
DASS21 Depression Levels Pre and Postgroup: AOD Group
**AOD Group: Anxiety**

Anxiety levels decreased over the five week programme for eight of the 11 of the AOD group participants with the biggest difference being a drop from 38 pregroup to 12 postgroup. Anxiety levels of one of the AOD group participants remained unchanged, while 2 participants’ anxiety levels increased during the programme, albeit by only 2 and 4 points respectively. The mean difference was 10.8 pregroup to 6.5 postgroup. This difference was statistically significant (T test p<.005).

Figure 9.

*DASS21 Anxiety Levels Pre and Postgroup: AOD Group*
AOD Group: Stress

Levels of stress decreased over the course of the programme for 10 of the 11 AOD group participants while one person reported an increase in stress levels. The biggest margin of difference was a decrease from 20 points pregroup to six points postgroup. The mean difference was 15.3 pregroup to 11.5 postgroup. This difference was statistically significant (T test p <.005).

Figure 10.

DASS21 Stress Levels Pre and Postgroup: AOD group
Comparison of mean scores of the AOD and tertiary groups

Both the AOD and tertiary groups showed a significant decrease in mean scores for all three areas of depression, anxiety and stress. Greater decreases in all three areas were evident for the tertiary group, most significantly in terms of stress, where the mean score for the group was a drop from 29 pregroup to 18 postgroup.

Figure 11.
Comparison of DASS21 Mean Scores between Both Groups
Results of the T-tests revealed significant differences between the pre and postgroup tests in all three areas of stress, depression and anxiety for both groups. These decreased pre to postgroup for both sets, as highlighted in the quantitative data analysis results (see graphs 5-11 in results section). The qualitative data supported the effectiveness of the group programme by identifying an increase in strategies being used to manage stress and build self efficacy.

**Qualitative Results: Focus Groups**

In this section, self-chosen pseudonyms identify the particular participant speaking when illustrative quotations are used. As indicated in the previous chapter, participants were offered the option of either taking part in an individual interview or a focus group following the completion of the group programme. In the AOD client group, 11 participants attended a focus group and one participant responded to the questions used in facilitating the focus groups by email. The email response gave feedback of a more concise nature than would have occurred within a group discussion.

In the tertiary student group, one participant chose an individual interview, in which she provided information of a more private nature. The nine remaining tertiary students chose a focus group. However, due to life circumstances the main focus group with these participants became a group of six. The three remaining students completed a focus group together one month later, bringing them relatively close to the exam period. This meant that they were reflecting on their group experience later than the others, at a time of increased stress for students in general. Sally commented that “three weeks ago when this should have been done it would have been quite different for me” and Liz echoed “same for me.”

As expected in focus groups, the semi-structured questioning by the researcher was conducted more in the role of a facilitator rather than an interviewer (Punch, 2005). The AOD focus group of 11 had practically half the amount of time in which to give feedback when compared to the tertiary main focus group of six because of the sheer number of participants. Partway through the AOD group interview it was apparent that there would not be sufficient time to cover all the outlined questions, and the facilitator spontaneously
decided on what line of information was most relevant in the space remaining. At this point, only the historical connection to stress and AOD use had been explored. Two open questions followed: “What did you think overall of the program?” and “Any other feedback in general about the group?” Time considerations were abandoned to allow discussion to develop between participants, encouraging some richer and more insightful information. The comfort levels of the AOD group were reflected when one participant left the room and returned with his guitar. A participant had begun to cry when recalling an abusive historical memory, and when a gap to speak was provided the “guitar man” spontaneously asked whether everyone wanted to complete the night with song.

In their respective focus groups, participants across both the AOD and tertiary groups shared their historical narrative of stress in their lives prior to tertiary study or having an addiction. However, the AOD client group spent the majority of their focus group time discussing in detail their stories of stress and any relationship it held to their addiction. Although the focus groups went in seemingly different directions, similar themes emerged across all three focus groups. The key theme that emerged most strongly for the AOD group was pre-addiction stress, and will be discussed first for both the tertiary and AOD groups. Other themes seemed equally important, and are therefore in no particular order. The results for each group are now presented according to the themes that included: pre-university and pre-addiction stress narratives; facilitator effect and psychoeducational engagement; preferred stress strategies and self efficacy. An additional topic discussed by the tertiary group was group dynamics.

**Tertiary student group: Themes**

**Pre-University stress:** “I was bombarded with stressful situations”

In commenting on historical issues and the changes to stress levels upon beginning tertiary education, students experienced similar stressors, although the specific triggers differed. Some talked about previous historical stressors that they “brought along with them in their suitcases” to begin tertiary study. Stressors included adjustment issues, the culture of study, and other mental health-related issues including substance abuse. Pre-existing stressors were present prior to beginning tertiary study for two students who acknowledged the distinctive influence of stress. “And then starting university, there
were various other factors going on aside from university and it got very stressful” (Sally). This point about the power of external stressors impacting on study was also made by Rico:

*I walked into uni (university) already having a chip on my shoulder pretty much because of things that are beyond my control…. Before I started group I was inconsolable, my anxiety and stress levels were off the charts you could say because I didn’t know what to do anymore.*

One participant recognised that the source of stress changed from one area to another according to the context and life situation.

*Pre-university there was an awful lot going on. My first year of uni was actually fairly cruisy (easy) but there were other stressors, so those other stressors that sort of faded out, were then replaced by academic stressors.* (Liz)

It was evident in students’ descriptions that the numerous pressures of young adult life impacted directly on their ability to additionally manage academic pressures. While two students identified in this group as multi-ethnic New Zealand European and Māori, issues of moving to a new country were present for some of the remaining eight participants. Alicia explained that she had to “...*get adjusted to the lifestyle, time zone, start a new programme, find a flat, begin a new study and get used to studying again.*” The lack of a known and trusted support group, established over a significant period of time with friends and family, was recognised as being an important element of the transition to studying in an environment that was not home. Marie similarly missed her support team.

*I moved to New Zealand and came to the university here. I got, I think, even more stressed or I dealt less well with it because at home I had a big support group of friends and family that I don’t have here. I don’t have the same amount of friends here, so I have in conclusion been more stressful.*

The absence of these informal support networks was a significant factor in students’ descriptions of issues that contributed to adjustment to tertiary study. The transition into starting tertiary education involved the stressor of fostering new friendships. Social anxiety could be a barrier that hindered building this potential area of support. Desiree highlighted that these additional social demands added to the adjustment process: “*Just basically the stressful situations around always meeting new people...*” John described
the multiple challenges young people often encounter, where they are confronted with
new situations at every turn; finding somewhere to live, attaining work and being
organised and set up before the study year began. “Just finding a place to flat, really,
also getting my job and everything else before Uni, getting everything settled.”

Other students added to this list the stressors of juggling work, study and relationships,
and the heaviness of many roles. Marry commented: “I work multiple jobs as well, and
full time study and a partner and everything’s stressful.” These numerous challenges
create a climate of stress. Knowledge of specific de-stressing strategies may not be
readily available.

Academic stress was identified in week one of the group for three students, and was
mentioned by two students during follow up interviews. Kara highlighted that the lack of
proactive study habits and unfamiliar tertiary study demands impacted significantly on
her distress. “Studies were pretty hard because I was pretty lazy, so I wasn’t really used
to it and assignment due dates and all that… it got really stressful.” This sense of feeling
like a “novice” unprepared for academic demands was echoed by Alicia, and starting a
new programme after 10 years since she last studied was a challenge for her. “Because I
did my undergraduate 10 years ago and I’m starting a new programme, it was quite
stressful for me.” The combination of general life stressors associated with young adult
life, beginning or undergoing tertiary study plus the complications of international
student status lead some of these students to feel ill-prepared for the additional
requirements of academic work.

Avoidance and coping strategies were used to manage stress currently and historically.
During the five week group process only Marry admitted to currently using AOD as a
way of coping with stress. She brought this up again in the focus group verbatim. “Well,
not a lot of wine, but I drink it every night, sort of. Like maybe half a bottle or
something….I often drink wine to wind down at the end of the day, which I know isn’t
good, but it helps.” However, during the focus group interview Marie and Sally also
disclosed alcohol and drug problems, with Sally divulging historical issues with illicit
drugs. She no longer partook due to illness.

I used to do a lot of recreational drugs and I’d drink a lot of alcohol which has been
sort of in the past. And actually my drinking has dropped a lot since starting uni,
because I’ve got an underlying illness that makes it not good. So yeah, I don’t do any drugs anymore and I pretty much don’t drink. So it’s just prescription drugs.

Marie recognised that the drinking culture from her country of origin influenced her social norms and expectations. She changed her drinking pattern upon finding out that not everyone in New Zealand culture drinks daily, and identified an increasing awareness around the benefits this had brought her.

Where I come from in ..., alcohol is like totally accepted, like drinking every night with dinner is something that is really normal. And yeah, so it was sort of a bit of a change realising this and actually getting out of it .... I used to drink quite frequently. Not a lot, but I would drink every single night, just have a beer after dinner, and it would become like a habit. And lately I notice that I don’t, and if I wouldn’t drink then I would feel it and I notice lately that I don’t have that feeling anymore and it’s so nice. I’m so happy with it.

Other mental health concerns were shared, and there appeared to be confusion and an overlapping between indicators of stress, anxiety and depression. Rico noticed feelings of unwellness, but struggled to pinpoint what category his problem fitted into. “I don’t know whether it’s more stress, or it feels like more anxiety than stress. So I’ve got less stressors on my life but I feel more anxious, so yeah, I’m not quite sure.” Marry didn’t recognise her anxious behaviour herself, and was surprised when a friend drew attention to it:

She said, oh, you’re so anxious all the time, can you just relax? Just have a drink. And I didn’t realise I was being really anxious, and I was like, this is just how I am at the moment. There was nothing I could do about it. But yeh, I wasn’t actually that conscious that I was being anxious in that moment, I was just being me.

The intertwined nature of depression, stress and anxiety was reflected in two participants’ accounts and they recognised that the relative severity and symptoms of depression appeared to hinder the process of utilising stress management tools. As well as Marry’s realisation about her anxiety (above), Kinesis also spoke of motivation and frustration problems.

I mean when you’re depressed, like mild or moderate, like we need to watch the severe and the perspective, but I’m not there yet. I don’t know where the line ends
For example, a simple example is getting up in the morning. I think there’s so many things I have to do. I have to get up and so on, but I just couldn’t. It’s just really, really hard. So in that way I know what I should do but I just either can’t or won’t do it…. When you’re depressed, you know, you’re just not motivated to use any of the tools. I mean I know I should, but it’s just really hard for me to.

In support of Kenesis and nodding from across the room, Marry admitted her own struggle with motivation, and also admitted to having depression. “I think I’m the same as you. I think that’s why I’m not doing them” referring to the coping skills.

The areas of student adjustment, mental health concerns, alcohol and drug use and lack of support networks had varying affects on the stress levels the student group had experienced and affected them while beginning their tertiary career.

**Facilitator effect and psychoeducational engagement:**

*Thank you for opening my eyes to a whole bunch of, a different way of looking at you know, instead of looking at stress as the enemy. I could say now it’s more like a hurdle or an obstacle that I just have to go through, instead of hide in the darkness with.* (Rico)

Rico acknowledged the importance of the facilitator role, seeing this as fundamental in his progression. The facilitation, the group programme and group processes were woven together to provide a helpful learning environment. The psychoeducational components were delivered through group discussion, interactions, comprehensive group handouts and homework activities. The wide selection and range of mind-body tools and interventions learned and utilised by students were chosen to support individual engagement.

While no specific questioning in the focus groups asked about the effect of the facilitator, and this could be seen as a limitation of this study, relevant comments were made that constituted essential feedback because of the many roles the facilitator played in the group. The importance of providing stress management strategies was identified by two participants. Kinesis acknowledged gaining strategies and considered her personal responsibility in utilising them: “You’ve given us the tools but at the end of the
day it’s still up to us to use these tools.” John agreed that the facilitator had introduced a range of coping mechanisms and had delivered them within a stress free environment.

...with the wide range of strategies that you’ve given us... coming here I feel relaxed. I can take a lot in and try and replicate that back home .... I look forward to coming here so I can experience all the things that we talk about.

Marie also spoke of feeling relaxed in the comfortable homely group environment:

So for one and a half hours you feel, you actually do feel relaxed and I liked the little relaxation exercises in the beginning and you just talk about that and you know you don’t have to worry about other things during that time. And the cookies were kind of nice, it just makes it all a kind of nice thing to do on Tuesdays. So yeah, I liked that.

The group participants were clearly from different stages within their own unique and personal development, shown by differing previous knowledge around stress, age and individual differences, length of time at university, and historical and present stressors. One participant was abusing alcohol and two openly shared depression-related problems. The lack of screening participants prior to beginning group assisted in removing a sense of separation and judgement of self and others.

It’s quite open and it’s not targeted at any particular person because you’re not making assumptions of people as they come in. It’s just the detail, people can add their own experiences to the literature that you give and then we have a picture built up in our minds at the end of the day, of things to take home .... It fits into real life, it fits into that new sphere of like, we’re actually doing it rather than having to read it then do it. Yeah, it condenses everything. (John)

Within the focus groups, all contained points of spontaneous laughter. An example of “comfortable humour” is when the participants were asked about possible improvements in the programme. The largest focus group asked for an audio recording by the facilitator of the sleep mindfulness exercise delivered in group, which resulted in five of the 10 participants actually being put to sleep, and therefore considered a worthwhile exercise. The facilitator suggested the participants make their own tape recording of this as she believed that hearing the facilitator’s voice before inducing sleep might be weird or strange. This induced raucous laughter with all participants disputing this, and Kinesis saying: “Your voice is not creepy.”
The opening round each week that encouraged participants to discuss their stress levels was identified as being therapeutic. Desiree seemed grateful that somebody else would care or show interest in her personal feelings. “And the opening at the start, like you ask how we are and go around and tell everyone how we’re feeling, or ask how we’re feeling.” Supplementary information and folders were appreciated by two participants: “…you gave us supplementary information which is good to take away. Like if we do miss points we can revisit them” (Alicia). Rico also appreciated the additional reading: “...how nice of her to give us a folder as well along with the information .... I appreciated the loads and loads full of information that’s in there.”

John commented on the practicality of the learned skills: “It fits into real life. It fits into that sphere of ‘we’re actually doing it’ rather than having to read, then do. Yeah, it condenses everything.” Marie’s increased awareness of her alcohol and caffeine intake had instigated an active change: “I’ve become more aware, more aware of drugs like alcohol and caffeine actually.” When asked if the course had instigated the resultant decrease, Marie replied: “it helped initiate it.” The facilitator’s previous experience in counselling and group skills helped her to provide a relaxing and stimulating environment. Two participants commented on this, with Rico being pleasantly surprised how quickly time passed during group: “I don’t mind going over the hour and a half limit at all because I was just learning so much and it’s just not enough time to process it all in.” Marie enjoyed the restful opportunity provided during group time: “So for one and a half hours you feel, you actually do feel relaxed .... You know you don’t have to worry about other things during that time.”

The resources and information provided were identified by four participants as being beneficial, even when some previous knowledge was familiar: “A lot of the mechanisms that we actually went over in the course I’d already come across .... But all of them very good to be reminded of” (Sally). Liz had previously acquired a knowledge base, whetting her appetite for further investigation:

I thought it was a very good level, I mean because of my background encountering some of this stuff already, but I would’ve liked a little bit more detail, but what was there is a very good foundation and a good stepping stone to research further if I really need to.
Alicia had found that the information from her previous research and reading around managing her distress was too complex and difficult to put into action. She appreciated the range of simple yet practical tools, and different weekly topics:

*I find it’s quite good that it’s well structured. You’ve got a different, we’ve got a technique every week which is really good to focus on, to go away and practice. And then next week comes up, we’ve got something else new to look forward to, and we walk away with a new tool, that’s pretty good. And simple, simple is good because sometimes the simplest things work. Why add on something more difficult when you’re already stressed out?*

Marie found even irrelevant information useful to store:

*I found basically everything useful to learn anyway, even if it’s now not directly relevant because I’m working on other problems like emotions. I’m sure that if I’ve got them in the back of my mind I know where to look it up, so that will be good.>*

The group context and the weekly topics in the programme were appreciated by Lisa: “It was nice to have it laid out in that way where every week you’re doing a different sort of topic and doing it in a group format.” The chosen weekly topics, hand outs and homework were keys in the psychoeducational engagement of participants. The topic for week one was the causes and effects of stress. Identifying the origin of distress helped Marie to use detective skills to find her source of stress, disclose it, and bring about an active change:

*When the first week when we said what is your biggest cause of stress and I said my environment that I can’t control. I actually managed to get a temporary office with natural light on the sixth floor for six months, and that is my biggest achievement of the year.*

The subsequent weekly topics added depth and strategies to assist coping, and Marie had a heightened awareness around the internal mechanisms of the resultant emotions.

*...it was good to become aware of not only how to cope with stress which was a big part of this programme, but also what is the stress? Like seeing the emotion, seeing where the wide aspects and what kind of effect it has I suppose.*
Over the course of the programme a second student John, increasingly recognised his stress responses and choices in using the most appropriate strategy in regard to the particular situation.

_I found myself becoming more aware of when I am stressed and catching myself in the moment is the best thing. And then with the range of strategies that you’ve given us, the tools, I can choose from any one of them to see which one would best suit how I feel and how I can deal with it._

This is an example of how the components and topics of the programme fitted together; namely self awareness, mindfulness practice, emotional regulation and cognitive behavioural strategies. “You’ve got them, like there, and use them when you want. That’s been the most helpful. Actually obtain the strategies and then you can choose to use them when you want” (John). Behaviour modification is a process, becoming more automatic over time the longer it is practiced. Alicia also found the process was becoming simpler over time: “And the techniques that I’ve learnt here, well basically they’re getting easier and easier to apply.”

Two other participants agreed that the material was appropriate and deemed useful and valuable for further exploration outside the group. “I think you gave us supplementary information which is good to take away, like if we do miss points we can revisit them” (Desiree). The fullness of information was seen as appropriate and enriching for Rico:

_Well I thought it was like, as in the material that we got was huge. I came into the course not knowing what to do and man, where do I look .... there must be a huge amount in this one. Even to this day, I still look at it from time to time and I just go, I can’t believe I know all of this now. I don’t think it was over the top at all. In fact I appreciated the loads and loads full of information that’s in there._

The information provided in the take home handouts provided another avenue of learning. These handouts were given at the end of each week, and reinforced the information provided on that week’s topic. Marie appreciated the new material in the handouts, and saw this as a separate educative tool:
I thought we got lots of information which I like because you can read over it again at home, but during class we didn’t just read it, we also did other things, which is really nice. I thought we covered a lot of things, very good.

Homework tasks were an additional way of weaving lessons learnt into daily life, and during the initial check in round at the beginning of each weekly group they were asked about how this had gone. Homework tasks were delivered to encourage the practice of the newly acquired skill but were not compulsory. Practicing a new skill for homework was helpful before learning a new strategy: “We’ve got a technique every week which is really good to focus on – to go away and practice. And then next week comes up, we’ve got something else new to look forward to” (John). Alicia had chosen one particular task and had benefitted by progressively using it as a daily activity.

I noticed that you gave us a checklist, we had a checklist on doing positive things (specific homework exercise). I do something, one or two, maybe three things off that list every day and I kind of keep that list in my mind. Every day something gets checked off that list.

However, digesting the information from the homework proved futile for some participants, with procrastination interfering in the procedure. Rather than accepting individual responsibility, Liz for example blamed societal lethargy: “I should’ve been going over the material that I was given but I was a little bit slack about that. I think it would have been helpful. Humans are lazy.”

Therefore some gained benefits from homework, while others had difficulties engaging. Students are already in a learning environment and are regularly set tasks or assignments to complete within time frames. The assumption that this culture would overflow into the homework tasks associated with this programme proved not entirely correct. In the focus group of six students there was a lively interactive discussion on how motivation could be built to assist homework completion to occur. Interestingly, there was no feedback that homework should not be set, and instead suggestions were made of how to assert homework completion, however no decisions eventuated.

Motivation was acknowledged as a stumbling block for two students in regards to beginning or completing their homework exercises:
I don’t think it’s too much info because yeh, I mean yes there is a lot of material but you have the whole week to read it. And yeh, it’s up to us to read it ….. I wrote most experiences, I know what I should do, but I just can’t do them. Either I can’t or I won’t. (Kinesis)

On the other hand, two students seemed ambivalent about whether the programme or some other reason stopped them from completing homework tasks.

Maybe I should’ve forced myself to do more homework or something. I’m not sure if that should be in the programme but I think it would be better if I practiced more. But then we were so busy during the week that we’re like, I don’t have time to practice things to deal with stress, and it’s just stupid of course. But I feel that I should’ve practiced more. (Marie)

Desiree questioned whether homework was yet another stressor for her:

I don’t know, with setting homework, it’s good but then it’s also like another stress because you feel like you’ve got another thing to do but then it sort of makes you do it more. I definitely would’ve liked to have gone through everything more sort of at home, and I didn’t.

The terminating of the group was different for each focus group, but involved delivering information about the possibility of repeating the group, other supportive networks, being available for ongoing consultation if needed and saying our goodbyes. Though group participants had gained rapport and closeness with one another over time there appeared to still be hesitancy in the relationships. A departing comment from the three person focus group was: “thanks for having us” (Liz). This comment hinted at politeness as having been a visitor. The unintended separation of the focus group into three different sub-groups provided a microcosm of newness and revaluation of one another, which appeared to hinder the cohesion that had been present previously.

One method of determining the success of the group is through recognition that the group drop out rate was zero, suggesting a positive engagement by all participants. In summary of evaluating the programme, confirmatory feedback was given about the group environment, resources, supplementary readings, the programme outline and different weekly topics delivered. The straightforward practical information was considered constructive because it was easily understood and readily practiced. The relaxation
exercises helped induce a calm environment which in turn assisted participants in feeling relaxed and safe. The opening round helped participants feel heard and valued. Homework was considered helpful for three students, but homework problems were noted by three other participants, who were impeded by motivation, procrastination and time concerns.

The effect of the facilitator supplemented these elements by providing a safe and relaxed space where participants were listened to and encouraged to try new behaviours. This was initiated by being authentic, empathic and delivering the programme in a way that upheld these values. The previous group and counselling experience of the facilitator assisted in conveying a group programme based on a theoretical knowledge base which included her own personal experience.

**Group dynamics**

> I’ve never sort of done a group thing before and that was quite an eye-opener, doing it like that .... I found it really beneficial to have that sort of contact, having the pooled ideas and bouncing thoughts off each other. (Liz)

Liz found the relationships and dialogue among group participants were advantageous to her learning. Building connections with others, engaging in open discussions and having positive role models provided an environment of stimulated learning and growth. Full group attendance on all five weeks suggested group cohesion. Group size and the frequency and length of meetings were recognised as other important elements in group dynamics. The size of the tertiary group in this study was 10 participants and though this figure rendered no negative comments in the feedback, several affirmations of containing the maximum number at 10 were made. “I also like the size of the group. I wouldn’t want it much bigger” (Kinesis). Nodding affirmations were given by others hearing this comment.

The five week timeframe for the group programme was specifically chosen to fit in the tertiary semester around exams and public holidays. Two participants believed the five weeks did not provide enough time, and proposed extending the number of sessions:

> I’m wondering, would it ever be possible to sort of extend the group to eight weeks instead of five .... Or maybe just have it so it’s two sessions per week. So it’s like,
because five weeks, it just seems kind of like, and it all goes by so fast and you’re just like, oh, where did it all go?  (Alicia)

A similar suggestion involved doubling the number of sessions from five to 10, using every second week to practice and receive feedback on each new strategy learnt the week before.

_I guess it went very quick. It sort of would’ve been nice to have it longer in a way ....
I don’t know whether even 10 weeks would be long enough, whether you just sort of start practicing these things and getting feedback on them, on each sort of task as it were._  (Liz)

Lengthening the programme would concretise the skill base by providing support regarding skill practice, and received nods of approval from other participants. However, when the reasoning for the five week group programme was given, which included working around semester dates and examination preparation times, the majority of participants agreed that those variables needed consideration too.

Along with the group size and frequency of meetings, the tertiary group believed being educated in the context of a relaxed group setting was a constructive learning environment. This factor could increase their ability to focus on the psychoeducation delivered.

_Coming here I feel relaxed. I can take a lot in and try and replicate that back home. It’s more difficult to replicate it back home but coming here, I look forward to coming here so I can experience all the things that we talk about. Yeh, it’s been really helpful._  (John)

The power of group dynamics were recognised by two participants who appreciated the connection with others, with mention of the preference of group process over one to one therapy, and the benefits of gathering ideas from one another.  “I think because it was in a group I think it’s better, rather than like one-on-one because you don’t feel alone”  (Desiree). Desiree recognised the value of social support in the context of the group and its influence on her individual behaviour. Her experiences were normalised which in turn decreased her sense of isolation. Liz agreed that the group supported her own process, and that there were benefits of gathering ideas and connecting with others:
“It was nice to sort of, to feel like you weren’t alone in it, that there’s other people …. It was the first group session that I had and I found it really beneficial.”

In terms of time management in the group, Marie felt too much time was spent on personal issues, suggesting to her that the group had a psychotherapeutic element instead of the desired psychoeducational focus. This was not her preference:

_I sometimes did find that it became a little bit therapy-like, like some people just kept talking about their problems or family stories, and I was kind of like, get on with it, but that’s just a partial impatience of mine. I don’t really like group therapy things but having said that I did really like this class because it wasn’t therapy like most of the times, just sometimes. I guess it’s not a big deal but I like the classes with, or the meetings with the most group interactions the least._

On the other hand, and contradictory to Marie’s comment, Kinesis wanted more connection with other group participants who had similar issues to her own.

_ I think it’s good certainly to combat stress as well, if you know other people, if you’re friends with other people who know what you’re going through …. I wanted maybe more interaction with the group members. I had this sort of fantasy that we’ll all be friends and after the group we’ll be having lunches or dinners somewhere. It’s just that we’re all stressed here in some ways and it would be good if you know, outside this group we can be friends or something._

Working together with a common purpose strengthened group dynamics. Participants felt supported and less isolated, and recognised that the space afforded within the group provided avenues to learn from each other and voice different opinions and ideas. There were suggestions of the programme running longer with additional weeks or practice time added, and capping group numbers at ten. If a longer group was deemed possible, the study calendar would need consideration.

**Preferred strategies used to combat stress**

_With the range of strategies that you’ve given us, the tools, I can choose from any one of them to see which one would best suit how I feel and how I can deal with it. And it brings, it calms everything down and makes you step back and look at it from_
your perspective. And when I do that I feel more in control. I’m really proud of that.

(John)

An acknowledgement that a wide range of strategies was necessary in order to reach unique individual preference was recognised by many participants. The most commonly employed techniques were mindfulness, deep breathing and relaxation skills. Challenging unhelpful thoughts and replacing thoughts were also highly regarded by the tertiary student group. Some participants paired up skills in an integrated manner, while for others the singular skill was beneficial. Other participants spoke of a more sophisticated and integrated level of stress management, with an increasing ability to apply strategies and skills appropriately in particular situations.

The skill of mindfulness was utilised effectively by several participants, with some using it informally and others applying it in a more intentional practice. Mindfulness of eating and mindfulness of sound were practiced during the group sessions. These exercises had been integrated into Kara’s toolbox for use outside class: “I use mindfulness, yeh mindfulness, I normally just use it when I’m eating and also when I’m listening to music.” Marie realised that focussing her attention on the present would provide her with more joy in that particular moment:

I find mindfulness particularly helpful, just focussing on one thing at a time, just makes everything a lot nicer. It makes the thing that you do at the moment nicer, you don’t stress out as much about all the other things you have to do and I thought that was really helpful.

Two participants felt empowered because they were better able to take control of their thought patterns and focus their attention in a desired direction. “I think since I’ve practiced mindfulness quite a lot now, it’s actually really helped. So I can take my mind off things and put them somewhere else” (Marry). Neither Marry nor John had known about mindfulness prior to the group, yet they seemed to grasp its concept and overall significance in regard to daily living. John spoke of the benefits to his self awareness and also the specific process he engaged in to make this occur:

The best strategy I use for me is mindfulness because I do find that becoming aware and paying attention to what I want to focus on is really important, just taking, and not assigning something positive or negative and just being with that thought for now.
And I can be with that, which is, it doesn’t require too much effort as opposed to .... If you can put the thoughts in the clouds, they just fly by and it just brings you the sense of perspective and also just coming back into the present moment. And when you come up from that you feel, just so relaxed and you lose the tension and the stress goes away.

Diaphragmatic deep breathing was also popular. Two participants rated it as their most used strategy: “…and I found that the breathing techniques worked” (Marry). The adaptability of using deep breathing anywhere and as a means of endorsing relaxation was noted: “Mainly breathing is like the main one which you can do anywhere because whenever I feel maybe it’ll be stressful, I just start deep breathing” (Kara).

Diaphragmatic breathing can be used as a stand alone technique but some participants recognised that integrating this skill with additional stress management strategies delivered even greater gains. This was recognised by two participants who combined relaxation and meditation or mindfulness: “….the relaxation techniques are really helpful, and especially when you do a meditation” (John). For Liz, conscious self awareness, or mindfulness helped her in knowing when to begin deep breathing: “I’m more conscious of the techniques that I should be using, so I’m using the deep breathing more often. I’m being mindful of what I can do to alleviate the physical symptoms” (Liz).

Alicia also used a combination of deep breathing to assist relaxation and together with mindfulness integrated this into her everyday life:

I’m getting really good at practicing some of the techniques which are becoming second nature now and I do those self checks through the day. You know, are you breathing? You know okay, or are your shoulders up? Are you doing this, okay? Stop. Let’s start breathing, let’s relax and then we’ll just take as many pauses throughout the day to make sure that I’m not tensed and things like that.

The participants in the tertiary group were at different stages in terms of their integration of the skills. Marie, for example, reported that she had slowed down her process by diaphragmatically breathing, but felt unable to integrate the next step of cognitive restructuring:
The breathing slows things down a bit but then still I have to figure out what’s wrong because if I’m just trying to relax it’s nice, but then as soon as you stop relaxing the old problems come back.

The tertiary group shared their difficulties at changing negative self cognitions. Kinesis described the process as being an “art” requiring a build up of skill level: “Yeh, I’m definitely challenging thoughts and thinking, even though I haven’t mastered the art of challenging negative thoughts and thinking.” Sally focussed on using logic to challenge her belief system:

I think again sort of the logical thing. First of all just sort of going through it in my head, sort of the reason for it so it’s not this sort of just crazy hundreds and thousands of thoughts, it’s just sort of trying to think more logically about the causes of them and why I’m feeling this way.

Building on an ability to introduce the logical mind was assisted by the use of challenging self talk. Marie used mindfulness based cognitive behavioural therapy to separate thoughts, recognising them as only a thought: “…trying to see things how they really are. I think that’s to do with what we say, like a thought is not effect and emotion is not effect.” Removing self blame from the thought equation, and looking at the situation from a different perspective was the part of thought restructuring that assisted Marry: “I’ve tried to tell myself that, you know, things like, messages like ‘that’s life and things will happen, but that its not my fault that it happens, it just happens’. And well that’s helped a bit.”

At times, participants simply referred in general terms to the tool kit available to them rather than specifying particular skills: “So I just use all the techniques that I’ve learned ... but overall that’s what I learned” (Rico). Acquiring a range of strategies provided a collection that could be drawn on in the future:

I found basically everything useful to learn anyway, because even if it’s now not directly relevant because I’m working on other problems like emotions, I’m sure that if I’ve got them in the back of my mind I know where to look it up. (Marie)

Making the connections between causal factors and their effects, while realising she had choices about easing her load, strengthened one participant’s coping capability:
I’m more aware of what is causing it, I’m thinking more about it so I’m more aware of what’s going on and what I can sort of do to alleviate it. I feel I’ve got ways to cope with it now. (Sally).

**Self efficacy**

I’m setting more time aside just to relax which is both a good thing and a bad thing because often it’s time that I should be working, but if I’m not relaxed then working isn’t going to do any good. And just being more self conscious, being more aware of my emotions, my body and actively controlling that. (Liz)

Liz identified the connections between stress management and improved study skill behaviours, and her comment reflects the way she had incorporated learnings from the programme into her life. Knowing more about the causes and the management of stress, together with applying the skills, helped raise her self awareness and increase a positive sense of being in control of her life. Feedback from other tertiary group participants also showed increases in self efficacy, and a sense of improved resilience and coping in their private lives as well as in their study habits. Levels of attentiveness, self reflection and self management had been noticeably heightened following group attendance, as noted by Sally:

I’m thinking more about it so I’m more aware of what’s going on and what I can sort of do to alleviate it …. Instead of just going oh, that’s terrible, I’m going right, well this is happening and this is happening so I’m just thinking things through a lot more clearly.

A heightened awareness of the physical symptoms they experienced were the catalyst in two participants regulating their stress levels: “I’ve noticed that now my stress levels have decreased a little. I’ve developed more skills on how to manage the physical symptoms of stress if many do arise” (Alicia). John stated: “I found myself becoming more aware of when I am stressed, and catching myself in the moment is the best thing.”

Attentiveness around breathing techniques, combined with self talk assisted Desiree in improving her self efficacy to better manage exam anxiety; an issue that had originally been a stressor and reason for her group attendance:
I’ve noticed that my stress levels have gone down a bit and the techniques that I’ve learnt here, well basically they’re getting easier and easier to apply. So if I’m stressed about an exam or anything then I can easily say, just stop, breathe, and I calm down and so it’s easier to cope.

The information discussed within the programme regarding the combination of drugs in easing stress assisted Marie in making a conscious decision to lessen her intake of alcohol and coffee. This provided her a more positive outlook for the future:

I’ve become aware, more aware again of drugs like alcohol and caffeine actually and I have been drinking a lot less..... And lately I notice that I don’t, and if I wouldn’t drink then I would feel it, and I notice lately that I don’t have that feeling anymore and its so nice, I’m so happy with it.

One participant found that the sources of his stress were present and static in his current reality, but could be better managed. This reality check and self reflection seemed to facilitate an acceptance of the situation, followed by an action:

The stress causing factors are never going to go away ... I can’t expect anything less because I’m still living with those stressors, but, you know, that’s what life’s all about. That’s my little adventure right there ... the things that are causing me stress are not really going away anytime this month, year or even this century. But I guess after doing the course I figured out that there are helpful ways to deal with it. (Rico)

The process involved in conscious behavioural change can be a difficult, time consuming and lengthy process. Marie increased her recognition of when stress was present, along with incorporating appropriate strategies to alter stress levels, but noticed that physical and emotional symptoms interfered in making a shift:

I do think I need a lot more practice with lots of these things and I just, if I’m in time, like if I get stressed and I can get there in time, then I can do these exercises. But then if not, then I just get too upset again and then I get raised heartbeat and then I find it hard to relax anyway. Like I find it hard to use the exercises when I’m already stressed.

Inviting an audience involves another type of group process, and therefore seemed relevant to this study. The participants were asked whether anybody had noticed or commented on any difference or changes by them over the five week period of the group
programme. It was apparent three students were either quite isolated, or had chosen not to
tell anyone they were attending. “I don’t really have anyone around me to notice”
(Sally). “…and no-one has noticed anything because they don’t know that I’m coming
here” (Alicia). “And I don’t think anyone’s noticed anything because none of my friends
know that I’m coming here” (Kenesis). On the other hand, three students had received
feedback from their close family and associates, and had reaped benefits from this. Marie
had openly discussed the group with her partner and he had commented on her calmer
attitude, increasing her motivation to continue building on the strategies:

Yeh, my partner has noticed. He likes that I’m a lot calmer because he finds it hard,
he finds it hard to deal with me all the time when I’m stressed out. So he likes that it’s
getting better… he is getting a bit tired of when I do actually freak out or something,
which is I suppose, extra motivation for me to try and change I suppose.

In addition to this, a disclosure to her supervisor brought empathy, a shared experience,
and probably greater support in the future.

I talked to my supervisor about this because I said I have stress problems … and she
said you know, being an academic is just really stressful, and she said I’m going to
counselling too, and she’s super successful … So that was good getting it off my chest
and hopefully I’ll get a bit more support for it in the future from her too. (Marie)

Two other participants had not discussed the group, but their behavioural changes had
been positively acknowledged by their mothers, providing encouragement. Family
problems troubled Desiree, and assertiveness training was one particular skill that had
assisted building her self esteem. Her communication with others had improved:

Yeh, and I’m mostly able to stay calm around other people and sort of look at them
straight in the eye …. I actually stood up to him (Dad) instead of just sort of, you
know, staying back and not saying anything at all.

Desiree’s mother was impressed that Desiree had finally become assertive towards her
father: “And basically I know that my Mum has noticed something …. She’s happy
because I actually stood up to him.” Verbal confirmation by John’s mother assisted in
boosting his self confidence:
Mum noticed the other day in how she credited me with not being so overwhelmed with my car being stolen…. She was like, well you’ve really got in control….. So I took that on board and I thought that was really cool that she noticed that. (John)

Affirmations by others were considered helpful in concretising behavioural changes and a preferred story. However, there were other concerns that hindered the process towards self efficacy. A lack of skill in using cognitive behavioural deconstruction sometimes increased stress rather than decreased it:

I think mindfulness is better at easing, that is opposed to challenging thoughts and thinking which I haven’t taken up so much because it does require quite a lot of – the thoughts and thinking sort of antagonise each other, so I find it can sometimes create stress rather than easing it. (John)

Another participant recognised he used coping strategies to ignore the stress: “And I think sometimes those coping strategies that are used, I think I used them more, like to ignore the stress rather than cope with it “ (Kara). However, his recognition that he was “ignoring” stress reflects heightened self awareness.

There were three students whose DASS21 scores for depression were in the severe range. One participant spoke about her depression and how she considered it the influence that stopped her completing homework tasks, therefore promoting feelings of guilt during the course:

I don’t know whether I recommend the group for depressed people .... I mean depression is really an expression of itself, there are some things that kind of made me feel guilty .... Because in my opinion, and this may offend, but there are some parts of the group that may not be that great for depressed people .... When you’re depressed you know, you’re not motivated to use any of the tools. I mean I know I should but it’s just really hard for me. (Kinesis)

There appeared to be no confirmation from the other two participants whose DASS21 scores initially were rated with “severe depression” that they agreed with Kinesis’ comments. Her comments in this regard were therefore considered an outlier from the group.
While some struggled with behavioural and cognitive challenges, other participants continued to struggle with emotional difficulties. An inability to regulate emotions hindered Marie’s process, and was noted by her as an area for further self growth:

*I think in general I still have a lot of problems with emotions so these things help. Just, for me, I think emotions just take over and being upset or stressed, being one of those emotions is kind of hard to ... once I’m already in that emotion, to then try and control the ship if I’m already .... For me personally I might need some more stuff on emotions but that’s just, that’s a personal thing. I’m not sure how many peoples’ inability to cope with stress well is related to emotion or not. I think it’s just a case, especially the case in my case ... because I find that if people say something negative to me that has an immediate impact instead of just going, oh don’t be silly or something. If I get the feeling that people are going to be angry with me, that’s enough.*

Emotion dysregulation was clearly problematic for Marie. Other feeling states affecting other participants were “wilfulness” and “shyness.” These emotions appeared to hinder and interfere with some participants using the tools or speaking out during group processes:

*That’s why there are things that I just keep to myself. Like for example, when you ask us how do you think this was? There are some things that I just keep to myself because I feel that it’s not going to apply to anyone else. (Kinesis)*

For Kinesis, her lack of confidence to speak up held her back, whereas Marie struggled with motivation and a stubborn attitude:

*The thing is that I think my motivation’s not always there. I think sometimes I don’t want to, like, even though I know those thoughts are not going to help in any way, there’s like something stubborn in me that says, like, this is what I’m thinking. But it is like this and yeah, I find it hard to actually really stop that thought.*
AOD (alcohol and other drug) client group: Themes

Written feedback was received from one participant who could not attend the focus group of 11 participants. The participants in the 11 person focus group shared openly about their life stories and histories, spending the majority of the interview time relaying how problems with AOD came into their lives, and any influence pre-existing stressors had in this regard. These tales were accompanied with tears, words of encouragement, support and some appropriate laughter from other participants. There were four identified themes that emerged from this focus group: pre-addiction stress narratives; facilitator effect and psychoeducational engagement; preferred stress strategies and self efficacy. The dominant theme was pre-addiction stress narratives. The other themes are of equal value, and are thereby presented in no apparent order. It is important to note the participants often talk about their stress levels in numerical form. The rating scale used was one to 10, with one representing nil stress and 10 indicating severe stress.

Pre-addiction stress narratives

*But unfortunately the brick wall that you divide your childhood with, your adulthood doesn’t actually do much justice for moving on in your life, because it’s still there unattended to.* (Prudence)

The majority of the participants’ historical narratives delivered similar stories in regard to adjustment issues during adolescence prior to their AOD use becoming problematic. Feelings of alienation and aloneness were accompanied with problem-saturated stories in regard to their upbringing and childhood experiences. Similar stories of relationship problems during early adulthood prevailed. Descriptive language was used to illustrate their life journeys, conveying lives enriched with colourful and full histories. Descriptive language examples include: “going through stuff” “sort my shit out” “rocky road” “issues from 25 years” “life about to implode” “just about took my life” and “a world of shit came down.”

For the group participants who conceded high stress levels prior to their AOD abuse, adolescence was a lonely and anxiety producing time. Low self esteem and self image plagued four participants during their high school years. Imogen found her mind played tricks on her:
My stress during my high school years was particularly painful because I just had an appalling self esteem, and believed what my mind told me, and I was too afraid to talk about it, how I was feeling, so I was a closed book for a long, long time.

Jackie echoed a similar story of low self image and feelings of alienation and isolation. Being estranged from her feelings and resulting low self perception had only recently been recognised for what they were: “What I came to realise now, I had pretty low self esteem. I can’t remember being praised for being emotional. So the low self esteem came from not feeling like a person.”

Other concerns during teenage years involved the pressure to conform, difficulties making positive friendships and suffering adolescent anxiety. Alcohol and drugs were used as a social lubricant to manage social anxiety concerns for Beaker: “Not so much as stress but more of adolescent anxiety, to conform to fit in or to form good friendships with my friends. And so using them (AOD) to bridge that gap.” Substances were used by Beaker to fill an empty space, or alternatively a supportive family or home could have bridged this gap. In this regard, it could be concluded that his AOD use began as a form of coping.

For one participant, a safe home was not present and multiple layers of stress in regard to lack of family and positive role models added to this instability. Both parents had mental health problems, and an abusive home life lead Prudence into being put into protective care at age six. “My mother has psychiatric problems, my father has violence and alcohol problems, and because of this I was put in care to protect us. I started drinking.” Prudence did not specify when she began her alcohol journey from abuse to dependency, but recognises the lack of love and positive role models in her life: “I found I couldn’t, didn’t know how to do stress. I had no skills, no love, no whatever is required.”

Another woman participant identified historical abuse issues that seemed to lead towards her use of AOD. Though she found it painful to initially disclose these with a counsellor, it became ultimately rewarding to have shared the load.

I found a counsellor that I really connected with and started going through stuff. And the first one I told that something had happened and it felt really good to have it out there... the pain equals gain. Some of the shit, you go home feeling absolute crap
but you wake up the next morning feeling really good that you’ve got it out of your system. (Tina)

For Imogen, who already admitted to having low self esteem during high school, showed great ability to manage and a strong resilience when she went on to complete a tertiary degree, made lots of friends and lead a successful career. It was once she had progressed successfully at her job that Imogen was subjected to work place bullying, which reignited previous feelings of low self worth which she carried with her, tucked supposedly safely away until reignited:

I climbed the ladder within my profession quite steadily and steeply and progressed to a senior level within my career very quickly. And unfortunately was subject of quite intense in-house bullying, which just about took my life basically.

Relationship problems were common denominators signalling the beginning of AOD abuse by five participants. These included relationships within the work place, and personal problems with family, friend and loving partner connections. These relationship issues provided the incentive or need to abuse alcohol and drugs as a way of coping with the loss and sadness. Living with a partner with mental health concerns proved to be very distressing for Jackie, who used work and alcohol as an escape:

As an adult I met my partner, been together 19 years ... Been through abuse of different types to the point where he was put on a risk register because he tried to take his own life. Since he’s been counselling, since he’s been on anti-depressants, and learning and understanding and coming to terms with things, I’ve tried to support him through that .... He understands what impact it’s had on me and my role is, my part of the bargain is I will give up the alcohol, which I have used over the years as a coping strategy .... Work is not a stressful part of my life, home life has been the stressful part.

Whilst being solo caretaker for his mother, Philip began drinking. When she died, Philip’s grief and loss added to his work stress. Alcohol was initially used to assist relaxation, but was also used as a way of coping with his emotions.

I was the sole caretaker for my mother and alcohol became a survival mechanism .... But in recent years my mother died. And I think that set me off on a spiral of drinking
here. And to cap it off there was work stress as well, and that’s when I kind of, my drinking escalated because of stress.

Grief played a part for a second participant, marked by the end of a relationship. This signalled the need for a new relationship, beginning with alcohol: “And I never really dealt with the relationship break up, so I covered it up with alcohol. I literally would drink myself to sleep every night” (Tina).

As identified, alcohol was used as a coping mechanism for many in this AOD group. Alcohol assisted in creating distance from facing or connecting with painful emotions and feelings. Tina reiterated the point of using AOD as a means of escaping reality in three different sections of her feedback, highlighting its significance to her. “And I think it was sort of a way of me covering up my emotions .... At the height of my drinking it was just a case of I was covering up what I was feeling.” The “emotional stress” Tina now identified was a total lack of awareness surrounding her feelings. “So a lot of my stress wasn’t stress as such. It was like an emotional stress, not knowing what I was feeling or why I was feeling it. Having a few drinks helped cover it up.” Another identified feeling was anxiety and alcohol was used as a method of inducing relaxation, thereby lessening symptoms of anxiety. What initially began as a method of beginning the “wind down” for the weekend soon became more of a habit and then a problem for Philip. “I came to realise that for me alcohol was a way of coping with stress and winding down. Thus, I was most susceptible on a Friday afternoon.”

In contrast, there were four participants who noted no pre-existence of stress prior to their misuse of alcohol and drugs: “When I started using I was young and I had no stress factor. There was no sort of issues around it and it went on for a long time” (Mark). Max agreed that prior to having an addiction, her stress levels were minimal: “I had a good, unfortunately, drinking career I call it, because I drank for quite a few years without having any crap or anything. And it was probably around a 2 or 3 level for some time.” Monty believed that stress was not a factor for him prior to or during the height of his addiction:

So at the time when I first started drinking, stress would have really been quite minimal. At the peak time just getting absolutely blotto, not knowing what I’m doing,
falling down, falling asleep on the couch, not being able to wake up at 7.30, 8 o’clock at night, I don’t know if I was really stressed at that time.

An inquisitive nature was the fourth participant’s rationale to start drinking. “I began using alcohol in 95. The main motivation was curiosity” (Philip).

Opposing the stress reduction hypothesis, which is the use of substances to reduce stress, four participants portrayed the addictive qualities and lack of control over their use of substances. They recognise their substance use was due to having an addiction.

But unfortunately when it did hit the fan, and my drinking and obsession with it took over to where I started to morning drink, which I had never done, and by 4 o’clock my body was craving it, my stress levels would’ve been well over 10. (Max)

Another acknowledged: “Yeh, and there’s still days I go home wanting to have a drink, but I don’t have alcohol in the house anymore” (Tina). Monty believed his drinking occurred because of his addiction:

I don’t think it was stress that was really making me drink it was just more an addiction I think. But I suppose the stress that I was putting on other people had a knock on effect to what I was doing.

Monty and one other participant recognised the consequential stress their drinking had put on those close to them. This awareness shows taking personal responsibility for their behaviour. “I still aren’t a stressful person. Like around me the whole sphere, and I think I’ve put more stress on my wife than anybody else” (Tony M).

Looking at addiction and stress from a different view point, one participant believed it was the pressure caused by the work itself that was the addiction, rather than an addiction to AOD.

I progressed relatively well in my chosen profession. And the stress if anything became the addiction itself. I got addicted to that buzz of being heart racing, setting myself mental challenges in my head, working horrendous hours. At the peak of my stress it was more about an addiction to the actual stress than it was to alcohol. (Mr White)

Environmental workplace stress was problematic for three participants who noted its rooted connections with their addiction. “I was a bit of a workaholic...” (Prudence). This stressor was eased by alcohol for Prudence and for two other participants:
And the job I got a couple of years later was really stressful. And it would get to the point where I would go home and you know need a drink. I might have two three or four just to help me try and cope with it. (Tina)

The third participant’s balance of work and play lead him on a downward slope:

I was really in the peak of breaking point. Breaking point means start losing everything. All my focus is working, working, working and drinking, drinking, drinking. Everything I would do – working hard and party hard. (Amani)

It was apparent in this AOD group that some participants would not have made changes without legal intervention. Contrary to Mr White believing he was managing his drinking behaviour, the breathalyser proved him to be wrong:

I had to be very good. I had lots of things in place you know. I wouldn’t drink and drive, had that all in place. Made a mistake on my birthday last year, had one too many on the way home, got caught.

Legal implications from offending and drinking marked the peak of distress as stated by the next three participants’ comments. It took four DIC’s (acronym for drunk in charge) before Mr White lost his job which impacted on other aspects of his life.

I think I had my first DIC at 21. That was the first sort of real repercussion that I had .... I think my third DIC my lawyer milked it out for 18 months before I was actually convicted .... but unfortunately it’s my fourth DIC, so needless to say a world of shit came down .... So that was all of a sudden job is gone, mortgage is up the crap, all sorts of other assorted. So pretty much my life is about to implode if I didn’t address it at that point. Stress level at that point, yeah, it was definitely still up at nine.

Similarly to Mr White, the peak of life stress was marked for Beaker at the height of engaging in illegal activity and drinking.

The peak of my stress would be four years ago with my offending and drinking and obviously subsequent actions after that. And then the repercussions of that - having to sober up and sort my life out, and today four years later sober.

Legal intervention marked the peak of distress for Mark, with the ramifications still affecting him four years later:
It really hit the nail on the head about four years ago. It was off the scale, over 10; 10 being the highest. And at the moment it’s been quite some time when I haven’t been using, but it’s still all these repercussions.

One participant was grateful the law had intervened, claiming it was auspicious:

“About three years ago the police turned up. I’ve often thought of my life, which is the best day I’ve ever had in my life. And it might’ve been the first day in my life when they turned up, because its kind of my life has shifted, it’s changed incredibly.” (Tony M)

Legal implications brought about through substance misuse were often seen as the catalyst for change. Other supportive forms of encouragement included clubs, groups and counselling. Attendance was supported by self motivation, and assisted individuals by providing incentive, support and a means of learning skills to maintain their behavioural changes and relapse prevention. Mr White recognised that he would not have made progress without assistance from others:

“...coming to these groups and obviously one on one counselling. Understanding that was how I was dealing with emotion and actually learning how to deal with it, and going forward from there so yeh, heading in the right direction, touch wood, I stay out of jail, or stay off home detention or without an ankle bracelet, but we will see.”

Monty sought individual counselling at a time when he was ready to share historical issues: “There were always issues from probably 25 years in my life or something, I imagine through that time. And then four years ago I came to ... to sort my shit out basically.” One part of timing included finding the right counsellor connection, and this was an important factor for one participant. “It wasn’t until I was in Christchurch in the 1980s that I found a counsellor that I really connected with and started going through stuff” (Tina). Having a positive experience from one particular service instils feelings of trust and comfort. For Imogen, this lead to her signing up for group work delivered in the same service. “I find a lot of the skills that we learn here at ... are really valuable when you put them in practice.”

Thus, facing legal implications and accessing supportive help through friends, family, groups, clubs and counselling were ways this group spoke about making changes to their
substance misuse. However, it is worth noting that some people made changes themselves without any additional assistance.

**Facilitator Effect and Psychoeducational Engagement**

*The course was not too technical. It was practical and the practise of strategies was most useful. Strategies were well linked to one another. Having handouts to refer to was great and then focussing on a few key things without having to cover everything was sensible.* (Philip)

Though no specific questions about the facilitator were directly asked, many participants commented positively about the facilitation of the group. Philip spoke of the numerous ways the facilitator delivered a programme that was engaging and well structured, and his parting comment was: *“Well organised!”* (Philip).

Following a disclosure that the facilitator had spent many years of counselling practice in the field of addiction, Imogen confirmed that “she’s one of us.” There were confirming laughter and nods by other participants that acknowledged the trustful connection made. Other incidents happened at the focus group interview. One relatively shy participant named Mark stayed behind after the interview and quietly said: *“I just wanted to say how important your teaching was in delivering this group programme – that’s what I really enjoyed the most.”* Another participant suggested the facilitator email any further questions that could assist with the project, signifying a continuation of the process. At this final departure and after a ritual of singing had spontaneously occurred, there seemed a lack of enthusiasm to step out of their seats, with some remaining seated for several minutes. A few held back to talk individually with the facilitator. In hindsight, participants may have wanted to give additional feedback or may simply have been reluctant for the group to end.

Providing a framework that flowed and connected week to week gave participants encouragement to continually evaluate their own progress. Tina commented on the linking of the sessions and how this helped the fluidity and continuity:

*I liked how each session related to the last as far as like fluidity and consistency. Like the first session happened and then we start at the beginning of the second session we fed back to the group how we had been working on the session before.* We
did that each time, and it gave that nice flow on effect..., rather than being like six completely different sessions.

During facilitation, there is a balancing act between following a set structure and deflecting from the topic. Beaker recognised the value that was gained by deviating from the structure, and gave credence to the broad range of mind-body strategies and activities that promoted spontaneous self expression and physical activity:

*I think the activity side of it is good. It’s always good to get people out of their chairs.... It breaks boundaries pretty quickly, and it gets rid of that fear factor, that embarrassment factor, if you’re up and about. I think you introduced that well. It wasn’t pushed on anybody .... I think it went along at a really good pace. I think you also picked up on some of the tangents we went off on. You followed us down that path and I think that was very constructive. Obviously the information is great .... I think it was a good mix between it all. Doing obviously stuff from the board and getting up and physical stuff, and the books.*

Similarly to the tertiary group, individuals acknowledged specific sections of the programme. The flexibility of the voluntary aspect of homework was positively noted by Tina, who also enjoyed the fact that handouts were not read from during group time, but instead were an extra mode of learning:

*Being given homework each week is quite good on the whole, though not everyone agrees .... It’s good to be given the option of if you want to practice or whatever you can. Whether you’ve got time or not, we know it’s good to be given the option ... And the handouts were good ... I’ve been in a group before and someone will just sit there and read the handouts.*

A recommended area of improvement was the suggestion that participants be encouraged to copy down brainstorming from the board for later use.

...what was up on the board was everyone’s brainstorming and it was a couple of days later and I was like what did so and so say? I wish I could remember that. It was kind of like if we could get a copy of that somehow so it’s all there and you don’t have to keep wondering what so and so said, and why it’s there and it’s not. That was a little frustrating at times. (Max)
This suggestion was echoed by another participant who also wanted to have captured useful information offered by group participants. “...so that would be another opportunity to write things down” (Tina). The facilitator agreed that the participant input during group exercises proved to hold insight and wisdom, and was worth remembering. This suggestion would be used in the facilitation of future groups:

What you guys presented on that week of the three minds, is the best information that I’ve ever had from a group. And I actually thought afterwards it would’ve been great if you had have written on your page because your page was empty in those three circles. .... I will add that from now on – people afterwards to write that stuff up on their own page. (Facilitator)

Previous attendance at other groups or counselling assisted comfort levels and psychoeducational engagement. This seemed pronounced in the AOD group. Nine of the 12 participants had been attending “maintenance group” together and were well known to one another. Amani was grateful for the group he had been attending for the past year: “Since I came to this programme (referring to the maintenance group) a year ago, I was really in the peak of breaking point. Breaking point means to start losing everything.” Imogen got support from different group attendance including AA (Alcoholics Anonymous), plus through developing new friendships:

“...so I’m able to kind of use groups like this and AA and friends .... So its still there, but it’s more manageable.” One to one counselling may be more appropriate initially in assisting in developing trust and Tina found this to be her case: “I found a counsellor that I really connected with and started going through stuff.” Though Tina started with individual counselling, she then added group therapy, specifically recognising Dialectical Behaviour Therapy (DBT) as being helpful:

... it’s like I had a really long fuse, but once it went – Boom! Whereas now having like been to .... and having done the DBT programme, the learning how to talk to somebody when you’re feeling what you’re feeling, not procrastinating over it ...

The agency itself making the initial approach rather than the individual being motivated enough to take the first step helped start one participant’s journey of change, showing the importance of outreach:
I think it was the third time I ended up in hospital that .... rang me and said you know, come in and talk to somebody. And yeh, we obviously can’t make you, but something in my head said this is what I need to do. And then it’s been a rocky road the last couple of years. If I look at where I am now compared to two years ago it’s a hell of a relief to be here. (Tina)

**Preferred stress strategies:** “There’s stress, but I can cope with a lot more because I’ve got those tools, and whether it’s mindfulness or going out for a walk, or whatever” (Tina).

Similar to the tertiary student group, the AOD group’s most mentioned skills were mindfulness, deep breathing and relaxation. However, in addition to these core strategies, this group commented on the usefulness of exercise and the need to challenge thoughts and practice emotion based skills. For one participant, the range of skills helped in providing choice. Rather than focusing on one skill, Imogen spoke of the value of utilising many strategies: “I find a lot of the skills that we learn here are really valuable when you put them into practice.”

Mindfulness practice was the most talked about skill in this group. Amani’s description of mindfulness was: “…to be really focussed on everyday living, and every day facing people.” Philip agreed by simply stating: “being in the moment, being mindful.” Using the skills of focussing on the present moment while separating individual body senses were identified as keys in lifting Imogen’s spirit:

... and whether it be a colour or a shape or a smell or a thought or some sensation of the moment, that there is always something that you can find that will lift your spirit a little bit .... the mindfulness exercises I use in the car a lot, while I’m driving and thinking.

Mindfulness was explained differently and used both formally and informally by participants. One participant recognised how mindfulness gave him an improved ability to separate his thoughts from his emotions: “I’ve learned a lot about mindfulness – being able to look at what you’re thinking and being able to look at your emotions” (Tony M). Rather than an internal process, mindfulness for Prudence was accomplished by focussing her attention on an external activity:
One thing I find is that when you’re racing ..., like it’s so immediate that you can’t possibly hold all that baggage in your head. You have to respond immediately and that just breaks all the unhelpful thoughts around it.

The use of a more formal attitude to mindfulness practice was achieved by Max daily: “I’ve found starting the day with mindfulness, I’ve been still doing mindfulness, and giving myself that five minutes in the morning has been a good help” (Max). The revisiting of a concept from DBT also helped Beaker use mindfulness to access his wisdom, separating thoughts from emotions: “The thing that I got out of the course I think is reaffirming the states of mind definitely. You will see the three spheres, the rational, the emotional and your wise mind.”

Deep breathing and relaxation were skills that induced a more relaxed state and reduction in anxiety symptomology. “Definitely the breathing” (Mr White). Breathing and relaxation were rated as popular skills by many participants.

The breathing especially. I don’t know if that’s to do with my smoking, I’ve been smoking forever, I have chest issues, but I have anxiety issues as well. So it really gets into my chest thing and I find that hard - so really deep breathing and chilling out. I try my best to chill out. I’m really into all of it, but those two things are very special for me, and I find they work. (Mark)

One participant found diaphragmatic breathing had not been properly described before, and found the group session explanation valuable. Daily practice of this skill had transpired with positive effects:

I can’t really remember actually ever being told to take it from your lower stomach, it had always been just breathe in, breathe out. And that never really did anything for me. And I thought that is an anomaly with me, so when you said take it from further down into your stomach and it had a lot better effect. So I’ve been using that probably once a day or something for the last couple of weeks. (Monty)

Like the formal and informal methods of mindfulness, the same occurred for the breathing techniques. While some participants formally used deep breathing, others recognised its practice in other forms. The breathing and relaxation achieved through yoga assisted stress for two participants. “I also do yoga, so that helps with the body relaxing and loses the tension. They’re the two main things. With the yoga you do sort of
relaxation at the end, and I do that at night” (Jackie). Prudence agreed that yoga was a helpful skill that assisted relaxation: “I do yoga a lot...”

Most AOD participants identified exercise as being a helpful stress management tool, and was consistent with the high rating of “exercise” in the coping skills questionnaire. Walking was a well-liked activity. “It’s quite good just when you get stressed just to go away for a walk” (Monty). Tony M agreed that daily walking assisted in removing negative thought patterning: “I’m always walking every day and that’s why it just takes all the negative thoughts away.” However, another participant found that his competitive and addictive nature was turning exercise into another possible obsession or addiction. Instead, a deeper understanding revealed during group time suggested that he required the opposite skill of relaxation, and he initiated this:

By nature the exercise thing was good, but because I’m competitive and I ended up generally increasing, it gets increasingly stressing, so I’m trying to find something else. I’ve done corporate boxing and trained for that for 3 months, and that didn’t get the stress levels out. And I was whacking shit out of all sorts of stuff. So I try and avoid the physical side of things and actually just get myself into that relaxed body. (Mr White)

Skills of emotion regulation involve a capacity to challenge cognitions. Unhelpful thinking patterns and cognitive dissonance caused personal and relationship problems for some participants. Therefore, challenging thinking and dealing with emotions were another strategic area of change. Learning skills around dealing with emotions helped Tina move forward, and involved identification of emotions, voicing, expressing and learning improved management of them:

I think probably the biggest skill I’ve learnt is that it’s okay to feel the emotions that I’m feeling and to be able to identify them .... probably the emotions one is the biggest. I feel a lot more settled knowing that what I’m feeling is okay.

Identifying and challenging cognitions in relation to his ability as a mind-reader improved one participant’s relationships:

I’m picking up and I’m thinking they’re mad at me. And that was one thing that you did that you can’t, you don’t know what they’re thinking. So I’m really trying to practice that .... and getting the thoughts out of my head. (Max)
The interwoven nature of thoughts and emotions are evident from Max’s statement and in the following quote from Tina, who realised that communicating calmly was a learning curve for her:

... being able to be rational with other people. As I said before it used to be I would hold everything in and eventually just explode. ... how to talk to people about it, and tell them how you feel and what they’ve done that’s making you feel that way, and being able to do it without getting out of control. (Tina)

**Self Efficacy**

Now I am feeling much better the last six months, starting to focus on the positive side of my life. And you know I see people who are not getting any younger any more and I know I have to do something now or nothing. It’s because I’ve got a family. I’ve got people who rely on me. My job is very important to me, and time to wake up and alcohol is not that good thing. Now I’m pretty good .... Six weeks ago I’m getting very relaxed and it’s very healthy to me. (Amani)

Self efficacy was already well established in this group because of the radical changes already made in response to substance issues. This is identified in Amani’s above comment about feeling more positive the past six months. Added to this self growth and knowledge, the stress management group had assisted Amani in learning strategies to better relax. The majority of the group participants showed heightened awareness in stress being viewed as “normal,” that it is not static, and that there are different types of stressors and different strategies in managing these. However, one participant practically denied that stress had any part of his life:

As far as stress goes, I’ve never really been a stressful person. So I really, I still aren’t a stressful person....I think when you’re drinking you’re not stressed at all because you’re relaxed and having a good time. So no stress at all. So one, one, one (rating his stress levels historically, prior to group, and after group completion). (Tony M)

Correspondingly, Tony M’s DASS21 scores substantiated this feedback, with results of zero for all three sections. He was considered an outlier from the group.

Prior to attending the Stress Management group, nine participants knew one another through attending “maintenance group” which required its members to have maintained
their substance use goal for at least one month. For this to occur, self awareness and self management is involved. Some participants had been abstinent for years, while others chose to use substances within a limited amount. All were in the action or maintenance phase and none presented in denial or the precontemplation stage. The majority of this group showed a deepened understanding in regard to their possible relapse and the necessity in having a plan to assist avoiding this. A conscious choice of whether to use substances or not, and amounts to this end had been identified, considered and put in place. “...if I’m going to a friend’s place I set the limit of a four pack, you know. And know that it’s manageable for me. I’m a lot better at feeling the stress and dealing with it as it happens” (Tina). Trial and error had assisted Tina in finding a controllable level. Progress was shown in regard to making changes to substance use by all participants, and upon completing the stress management group there was a heightened awareness around related stress, and the intertwining effect this could have on possible relapse in relation to their drug of choice:

“I went to WINZ and I stayed sober for seven months I think which is the longest in my life I have ever been. And I think stress levels then went way down obviously, but I found it very hard to live sober. So I’ve relapsed and I’ve only been sober since the 6th August. My stress levels still at the moment would be five to seven at least because I am trying to cope sober, and I find it hard. (Max)

A greater understanding of stress was noted by many participants. Three participants noticed their stress levels fluctuated daily, and at different times of the day, depending on the context: “Stress at the moment is anywhere between two and 10, just depends on what the day is and what you’re being asked to do” (Tina). Two other participants identified the variable changes to their levels of stress: “My stress fluctuates between five and 10” (Imogen). “So the stress level would be fluctuating from five to eight depending...” (Mark). The “normalising” of stress in daily existence seemed to assist Monty in accepting its presence: “And now I’ve still got stress in my life. I believe that everyone has. I believe that’s how they have to operate.” Imogen made the differentiation between the types of stressors that occurred while drinking problematically and the present day stressors which appeared to be of a more manageable type:
it’s a different type of stress now. It’s not a life threatening stress. It’s a stress that isn’t as painful as the stresses that I felt before the drinking and during my drinking days. It is, it is more sobering.

Having positive relationships and friendships provided a supportive element, whereas a lack of these was identified as an initial trigger to AOD use for many participants sharing their historical narratives. Potential for self growth involved the need to retain or build positive connections with others. This was important in setting life goals, and involved fostering trusted friendships which included being members of clubs or groups. Imogen talked about a relationship of understanding: “I find connecting with another person who understands where I’m at is good for me.” The connection could involve an empathic person, or a new type of friendship: “Friends that I’m beginning to develop, friendships just to help through the stress.”

Jackie found the benefit of building relationships through clubs was supportive: “I’m trying a couple of clubs, it just keeps me connected with people.” Self awareness around the need to improve communication skills was recognised as essential in relationship building for two participants. AOD had been used in the past to ease this process, and now communications without substance use made Beaker feel vulnerable: “...and being exposed, using that as a context for communicating with another person.” The emotional aspect of communicating about their own feelings was still difficult for some participants. This represented a follow up area of self growth that involved risk taking: “....how to talk to people about it. And tell them how you feel and what they’ve done that’s making you feel that way. And being able to do it without getting out of control” (Tina). Beaker, on the other hand, was now more able to interpret a conversation, separating the emotional and the logical parts of it more readily:

Seeing the conversation for what it is and what you’ve been talking about, as opposed to having an idea in your head of the what if’s, where is this conversation going, or how will it affect me emotionally, and if I say this now, later on down the track will it benefit me?

Instead of making assumptions, the piecing together of emotions, thoughts and actions would improve communication skills for Beaker, assisting his self confidence and self worth.
The AOD group had taken steps in their self efficacy through already choosing to make life changes to their substance use. Individual planning, together with building and nurturing relationships through friendships, groups, clubs and counselling assisted these behavioural changes. However, identified areas of further potential growth involved improved communication skills and better management of emotions. There was an acute awareness and acceptance for this group in recognising the fluctuating and changing facet of stress depending on the context and time, which can change moment to moment. It seemed that comparisons were made to previous life stressors, and things seemed more manageable in the present for this group.

The themes identified in the results highlighted the overlapping themes and connections between the two different groups of individuals. The qualitative data and interviews show some consistency in findings, bringing triangulation of data. This will be further discussed in the following section.
DISCUSSION

This study set out to investigate the effectiveness of a mind-body stress management group programme delivered to two population groups. This investigation has demonstrated that stress and anxiety can be well managed for two population groups within a group setting, using a five week mind body group programme. Secondly, participants in both groups were assisted by attending the group programme, regardless of the fact that the causes of their distress originated from different sources. Thirdly, the group programme assisted in lowering levels of stress, depression and anxiety, and additionally lowered levels of risk, shown by a reduction of suicidal ideation / self harm and aggression.

This chapter begins by highlighting some of the aspects of group work that were experienced as beneficially life-changing for participants. The usefulness of the mind-body stress management approach was affirmed. Group work was universally verified as a learning environment because of the benefits of the shared experience and the trusting relationships that were formed. This was particularly relevant because a common factor for many participants was that of historical isolation and disconnection from others that negatively impacted on resilience. The diverse tool kit of strategies was valued by participants because they were able to pick and choose what they decided worked well in their situations. The preferred interventions highlight that simple strategies are most effectively incorporated into people’s lives. Deep breathing, relaxation, mindfulness and exercise in the form of walking were most popular.

Participants reported that the formal structure of the group created safety by removing uncertainty. This included the use of handouts and homework. Structure enabled participants to engage more fully than they otherwise might. The effect of the facilitator and the psychoeducational tools and strategies were also identified as essential elements in the impact of the group programme and in the participants’ building of self efficacy. The demographic information was considered important because of potential possible relevance to present stress levels. Although no significant relevance was identified between these factors, minor differences found between the two groups are described.
The impact and value of the group programme

Mind-body psychoeducational programme

The mind-body holistic approach used in the delivery of the psychoeducational programme was regarded favourably by the participants. The usefulness of identifying the interrelationships between thoughts, feelings, physical and behavioural and psychological reactions was affirmed. In response to this, participants widely discussed the focal points of interest including deep breathing, identification of emotions, changing thought patterns, improving relationships and learning mindfulness practices. As Moonmuang (2005) noted, stress and anxiety affect individuals biopsychophysically and have multifaceted affects. The range of strategies that were adopted by the participants in this study from both groups provided credence that the mind-body approach of group therapy assists coping and building resilience by addressing the neurological, muscular and cognitive areas (Chinaveh et al., 2010; Deckro et al., 2002; Everly et al., 2003).

The multisensory, active and interpersonal nature of the programme was endorsed as encouraging everyone’s involvement, and the multi-modal delivery involved group participation in a fun and interactive way. The results therefore support previous research (Jacobs et al., 2006) in recommending this manner of delivery. The range of strategies provided participants with choices, and they increasingly learned to select when to utilise different skills. Although the group was semi-structured in its approach, the fluidity and flexibility within this structure was commented on positively by both groups.

A desirable group size will provide enough time for every participant to participate frequently, and consist of enough group members so that ample interaction can occur between participants. All tertiary group participants agreed they would like the group number kept to less than ten, supporting Corey (2010) and Jacobs et al.(2006), who believed fewer than ten was an ideal group number for a psychoeducational group. The group size allowed for deviation from the programme to respond to individual questions and concerns. This was identified as being appropriate and useful by participants from both groups. Lengthening the group programme was suggested by many in the tertiary group, though the university calendar would need careful consideration if this
recommendation was to be implemented. Corey (2010) noted that no data appear to be available about the desirable frequency and length of meetings that provide the best results, but suggested that a programme of six weeks’ duration involving 90 minute, once weekly sessions is a pattern that “may be particularly useful for group members working on specific forms of behaviour change, such as … stress management” (p. 72).

In the programme delivered in the current study, the weekly chosen topics, the mind-body information and the supplementary readings provided a broad and varied interest in the field of stress. An appreciation of the different weekly topics and range of subject matter delivered were noted by participants as being orderly and beneficial. Having knowledge around the subject and weekly topics are considered essential to the facilitator (Corey, 2010), and this was confirmed by the participants about the facilitator. Homework tasks relating to the weekly topic were followed up in the initial opening round the following week, prior to introducing the new topic. This provided continuity of themes, and was reflected in participants’ perception of the programme being well organised and constructive. Gratitude was expressed about the amount of information gifted to take away. The majority of participants, who engaged in the voluntary homework tasks and read the take home handouts, considered these complementary to the topic discussions.

An assumption that as tertiary students were in a learning environment they would be more likely to complete homework was proven incorrect. Problems with motivation, procrastination and laziness hindered homework completion for some tertiary participants and the AOD participants were more engaged in homework tasks. This may have been due to previous group attendance and expectations from the AOD participants. Whilst a number of participants reported that they did not complete their homework, it was possibly still beneficial, as recognised by Corey (2010), and Waller (2001), who considers that homework is an additional learning tool, even if it is not completed.

The group atmosphere assisted comfort levels and feelings of safety. For both groups, trusting relationships were built over the duration of the group programme, as participants became more familiar with each other and the group processes. Relaxation exercises, the opening round and the group guidelines were weekly rituals. Group feedback noted that these practices and the weekly structure helped build routine and a
calm ambience. In turn, trust and rapport were developed among participants, providing a supportive group atmosphere (Corey, 2010). This solid foundation was further stabilised by the universality that was experienced and similarity of concerns discussed (McNair-Semands & Lese, 2000; Yalom, 2005).

**Trusting relationships**
There appeared to be several dynamics working to bring about psychoeducational engagement in regard to trusting relationships. The facilitator effectively delivered a programme that was considered useful, interesting and informative due to physical engagement and a multi-modal approach. The role and personal qualities of the facilitator assisted this to occur through genuineness and unconditional positive regard, as utilised in client centred practice (Rogers, 1951). The engagement process was additionally affected by the relationships between participants, some of which were made prior to this group, strengthening connections.

Differences were apparent in the levels of closeness and intimacy that developed within the two groups. The majority of the AOD group participants were previously known to each other, with a friendship previously fostered between nine participants from the already formed “maintenance group” which they attended. Prior connections therefore assisted the development of stronger group cohesion in the AOD group. The AOD group participants showed their connection to one another in their relaxed collectivism at week one. They laughed, joked out loud and engaged immediately in the action involved in the group activities, showing little anxiety in relation to group engagement and communication. Another example of the closeness of this group was the final sing-along at completion of the interviews, initiated by one participant. Recognising feminist counselling practices, this independent and assertive action of producing a guitar, was supported by the facilitator, and an appropriate ending to our meetings (Chaplin, 1995). This spontaneous freedom of expression assisted creativity, which in turn delivered self-expression and personal growth, as supported by Corey (2010).

The transparency, openness and obvious comfort levels shown by the AOD group regarding delivery of personal information and disclosure of past stories pertaining to stress and their AOD use were enlightening during the interviews. When this occurred,
the facilitator altered from her researcher role and engaged fully as a counsellor, following the participants’ desired path and abandoning the previous line of questioning. It appeared important for participants to share their stories, and the group cohesiveness assisted an intimate depth of exploration. This partially occurred because of the group dynamics of trust already held in this group. Another possible reason for participants telling their “addiction stories” was that this followed the familiar programme set out within an Alchohols Anonymous (AA) meeting.

Some participants were AA members and may have been compelled to use the same process of an AA meeting by “telling their story” within the group. The interviews would have supported any AA members involved in step-work, admitting they were “powerless over alcohol” and reaffirmed that their “lives had become unmanageable” due to their alcohol use. This confirmation of their story supported and recognised their progress over time, supporting their goals of abstinence or controlled use. Some participants were members of AA, while others attended alternative supportive avenues, including sport clubs, yoga and counselling. Historical familial background provided another layer of universality (Yalom, 2005).

It was expected that the closer relationships noticed in the AOD group would assist in deepening participants’ learning with regard to the stress management tools. However, this was not the case, with results from the quantitative data showing greater improvements in coping and mental health levels by the tertiary group compared with the AOD group (see Figure 3, p. 82 and Figure 11, p. 90). Possible reasons for this include previous life experiences and counselling, either individually or in groups, which may have already been incorporated by individuals in the AOD group. This possible explanation is supported by the higher pregroup mean numbers of coping mechanisms identified by the AOD group compared to the tertiary group. Secondly, the AOD group’s mean number of negative coping mechanisms of 3.02 was half the mean number identified by the tertiary group, which was 6.4 (refer results Tertiary and AOD groups, pp. 81-91).

The AOD group had completed the “forming stage” and began in the “performing stage” or the fourth stage as recognised by Tuckman (1965). From the outset, they worked cooperatively and efficiently on group tasks, and acted in trusting and productive
ways in each other’s presence. This was noted by the researcher in terms of group unity and levels of comfort, which appeared more pronounced for the AOD group. The pattern revealed by this group supports the social identity theory of group formation based on the principle that what brings people together is a common social categorisation, but that interpersonal attraction enhances this connection between them (Hogg & Williams, 2000). It is through interactions that the development of group norms, roles and attitudes that define the group as a whole are achieved.

Comparatively, the tertiary group began as strangers, and by group completion did not appear to be as closely bonded as the AOD group. Most participants had never been part of a psychoeducational group before. There were differing opinions on the level of connections, ranging from wanting to be social friends after group, to wanting as minimal interaction as possible. Though the closeness of relationships grew over the duration of the group programme, they did not present with the same level of intimacy as the AOD group at group completion. The tertiary group began in the “forming stage” of the group development where members may pretend to get on with others (Tuckman, 1965). One participant, for example spoke to the researcher about one month after the interviews, confessing how embarrassed she felt disclosing within the focus group (at week six) that she drank alcohol most nights. No other participants had disclosed that they followed the same practice.

The use of role modelling, intrapersonal and interpersonal learning provided an interactive process between participants that could not have occurred in individual therapy alone. This happened within a respectful space that encouraged assertiveness, confidence and independence, as identified in feminist practices (Chaplin, 1995). The discussion and processing of emotions and thoughts provided a functional appraisal of stressors and causes, ultimately helping to lessen participants’ distress (Broughman et al., 2009). Having an audience to acknowledge a “preferred story” a vision for change or the changes occurring for an individual is recommended in narrative therapy (Freedman & Combs, 1996). This refers to social support that strengthens motivation to enact desired changes or provides acknowledgment of and affirmation for visible change. In the current study there was evidence that this occurred in other situations for individual participants, external to the group meetings. Three tertiary students reported receiving
positive feedback from their family and support people about noticeable changes in their behaviours. This acknowledgement by others increased their self efficacy. Some students however, had nobody else who knew that they had attended the group. For them, positive group dynamics assumed an even greater importance in providing a supportive environment and an audience who could acknowledge their changes.

Participants identified that having positive connections with others was essential, and this was echoed in the results of the current coping strategies questionnaire. The AOD group participants identified the need for trusting, caring relationships built on clear and open communication, and spoke about how these had assisted their changes to date. These relationships involved sharing intimate feelings which involved risk taking, but were deemed worthwhile. The AOD group members clearly identified that their future self growth included improving relationships with others, and could be achieved by improved communication skills and developing emotional regulatory skills.

**Group dynamics**

Working in a group was identified as a positive experience, with some preferring it to individual therapy. Connections among group members and normalisation of responses benefit group participants, breaking down their isolation (Tucker & Oei, 2007). In the current study, previous group experiences and existing knowledge already held appeared to influence the results of the current coping strategies questionnaire. Figure 3, page 82, shows a comparison between total “current coping strategies” used by both groups, as well as those rated as positive and negative over the course of time. The AOD group showed no significant differences over the duration of the programme in terms of the coping strategies they rated as either “positive” or “negative” or both, with only a slight drop in overall numbers in all three areas between pre and postgroup.

However the AOD group members identified a greater number of current coping mechanisms per person. This may have been due to the group composition, as members were a relatively older age grouping compared to the tertiary group, and they were influenced by previous experiences of attending other groups and individual therapy. These differences meant that this AOD participant group already held a knowledge base gained through life skills and therapy. They could be referred to as “group veterans.” In
addition, it is often said in general that people “mellow with age” and this is supported by Williams, Brown, Palmer, Liddell, Kemp, Olivieri, Peduto and Gordon (2006) whose research on brains has shown that neural reactivity to negative images declines with age. This is further supported by Kisley, Wood and Burrows (2007) who discuss the age-related change in the negativity bias. This may be reflected in the fact that the AOD group showed a much lower degree of recognition of negativity when compared with the tertiary group.

In comparison, the tertiary student group increased their total score of current coping strategies pregroup from 155 to 178 post group. Additionally, there was a significant increase in the average number of “positive” coping skills per student over the course of the programme, showing an increase of 31.2%, showing significant difference as measured by a t-test. The majority of the student group participants had not been part of a small psychoeducational group before, with several acknowledging this was their first group experience. In turn, they may not have previously considered some of the current coping strategies presented within the programme. The tertiary group could be described as “group virgins.” Additionally, the student group have chosen a path of education, and this choice is based in a learning environment. This decision possibly influenced their ability to process information differently from the AOD group and could have affected the processing of questions during focus group and questionnaire completion. The anxiety of being in a new group with total strangers while completing the questionnaires at week one could have affected participants’ comfort levels and this could therefore be a significant variable in their responses. In comparison, the AOD group participants appeared more relaxed completing the questionnaires.

Participants experienced both groups as constructive learning environments, with knowledge shared openly by the facilitator and the participants. When asked about group improvements, recommendations involved utilising the wisdom from other participants by copying down brainstorming from the whiteboard. The promotion of positive emotions through encouraging meaning focussed coping is achieved through feedback with others (Folkman, 2008). The normalisation of thoughts and feelings decreased isolation, creating a close bonding among group participants. The assistance they received from each other would not have been available in individual counselling. These
groups showed what Yalom (2005) named the social microcosm, where group participants tended to see others in ways that were consistent with their own problems. Collective ideas provided a mixture of new insights, and these were nurtured alongside personal feelings and beliefs that were normalised by others who similarly identified. However, one tertiary student participant who was sad that the group had ended said she had been hopeful of making friends from it. Her boundaries seemed blurred as to whether she saw the group as psychotherapy, psychoeducation or a place to build friendships. Openly talking about the feelings associated with ending the group and separating from other participants is part of effectively bringing a group to an end (Corey, 2010).

The effect of the facilitator

Psychoeducational engagement involved group dynamics in which the influence of the facilitator was integral. The 100% full attendance rate among participants engaging for the duration of the five week mind-body programme reflects their commitment and the recognition that they were in a safe group environment. Although participants were not directly asked about the facilitator or the facilitation, feedback showed that the collaborative relationship between participants and facilitator, together with the mind-body holistic approach assisted in constructive group engagement and maintaining a productive learning environment. The following illustrative quotations conveys the effect of the facilitator: “empathy, given us tools, asked how we were feeling, appreciated loads of information, practicality, relaxed environment, flowing and fluid, she’s one of us.” They reflect the client centred skills promoted by Carl Rogers (1951) of empathy, respect and genuineness which were used as a foundation for facilitation.

A facilitator needs both a skill base and a positive attitude to maximise the potential of a group in supporting change and growth (Jacobs et al., 2006). This happened because of the facilitator’s personal and professional knowledge base in the area of stress management, and her previous extensive experience in counselling and group facilitation. Previous group work experience assisted the facilitator in the balancing act around the division of time spent on individual and personal issues versus whether this would be beneficial for the group as a whole. This background knowledge and level of
competence encouraged discussions (Corey, 2010) about AOD abuse as a coping mechanism for stress, and was considered helpful by participants from both groups.

There appeared to be a building of trust over the course of the group programmes towards the facilitator and the facilitation of the group process. An example of this was a comment made by one participant in the AOD group who voiced that she had been worried about possible judgements from the facilitator, but now I know “she’s one of us.” This response occurred after the facilitator openly talked about her previous experience working with clients with addictions. In addition, there was some hesitation about being audio-taped during the focus groups by some participants from both groups, but open group discussions about fears and choice of options alleviated these concerns.

An integration of the personal and professional self of the facilitator showed in the delivery of the programme. In addition to acknowledging her past counselling and group work experience, the facilitator briefly recognized her own stressors, presenting both her personal and professional views on building resilience. These self disclosures highlighted a broad knowledge base. The facilitator’s previous AOD work experience gave an invitation for discussions around substance abuse, and a conversation about the role of AOD was initiated by a participant who reduced both alcohol and caffeine intake during the programme. Additionally, by authentically acknowledging present struggles with stress herself, the facilitator showed a genuine transparency, changing the power dynamics, and shifted from a position as expert to a more collaborative relationship as suggested by Rogers (1951). This further promoted a common bond and universality (Yalom, 2005). A reluctance to leave at completion of the focus groups, with members from both groups staying behind to speak individually reflected the rapport and respect gained with the facilitator.

Both groups described the relaxed setting, which included structure and light hearted humour. Opening rounds occurred at the start of each week. Relaxation exercises were used to mark the beginning and end of the group, and aided participants in feeling relaxed and valued. These rituals helped enter participants’ own worlds while the facilitator held her own individual separateness, and is identified as “facilitator empathy.” These activities aided in building a therapeutic alliance, as recommended by Corey (2010).
The lack of screening was identified as an acceptance of individual difference, and the openness and voluntary nature of speaking within the group did not target nor single out any individual. This was extremely important because of the focus on managing stress. This stress-free environment was consistent with MacNair-Semands (2002) discussion around the positive value of providing a “comfort zone” for psychoeducational groups. However, screening participants prior to starting group would have identified the outlier within the AOD group. He did not fit the criteria for attending group because he did not identify with having any stress in his life.

The dynamic nature of coping and resilience

Many in the AOD group astutely noticed that their stress levels fluctuated during the day, dependant on their situation and context. This mindfulness assisted their individual awareness that distress is an ever changing process, and demonstrates that mindfulness increases the ability to better cope with life (Praissman, 2008). To this end, it is similar to the conscious practice involved in making behavioural change. For example, making changes to substance use involves identifying a cause, making an appropriate plan of action, and deciding what the new behaviour or goal is.

Hence, during the completion of the final questionnaire, visible body language involving lack of eye contact, crying and signs of anxiety were shown by some participants in both groups and may have affected their questionnaire ratings. These upsets may have been due to the group ending, the closeness of exams, or personal issues coinciding with the interview. Coping is not static, but fluctuates and is further complicated by an individual’s coping style. According to Hyde and Allen (1996), this “coping style” is made up of both personality traits and the individual’s coping skills. Therefore, an individual’s coping will be significantly affected by other problems occurring within their internal or external locus of control, as suggested during the interviews.

The timing of one tertiary focus group involving three students took place relatively close to their exam period, possibly effecting results. Cooke et al. (2006) identified that previous student tertiary research did not recognise examination stress, and its affects on manageability levels. Therefore, self report questionnaires are influenced by subjectivity,
as recognised by Putwain (2007), and these influences require careful consideration when discussing results. Value judgements made when participants were completing pre and postgroup questionnaires are often subjective decisions which can change day to day, depending on life stressors that may be effecting the individual. “Resilience is not static” (Waller, 2001, p. 293), and resilient individuals may still be vulnerable in certain situations.

Coping strategies

Every participant identified their particular selection and range of tools and strategies they were presently able to employ depending on the situation. The smorgasbord of skills utilised supports teaching an extensive range of mind-body interventions, as recommended by Iglesias et al. (2005). Gender, ethnicity or stage of tertiary study did not appear to influence the results. Simple strategies like deep breathing, physical exercise in the form of walking and mindfulness were favoured. The power of the group and the taught strategies were additionally helpful in lowering concerns about risk for participants. One surprising and encouraging finding was that safety issues regarding self and others dropped dramatically over the course of the group programme. This has significant implications for practitioners.

Data analysis shows that the most commonly used strategies following the programme were: physical activity, deep breathing, mindfulness and relaxation (Figure 4, p. 83). These results are radically different when prior to attending the group the most utilised coping strategies by the tertiary group were: withdrawal and isolation, avoidance, computer, seeking help from a doctor/nurse/counsellor, or talking to a friend/family member. Pregroup results illustrate that the self-management skills initially used were forms of withdrawing from others or reaching out for help. These polarities in terms of stress management were replaced after group completion by simple self management strategies.

This pregroup data are particularly relevant when considering the tertiary population, whose transitory stage often involves factors that may impede students from having close interactions with others. These included; being an international student; being a new student to the environment; study and social expectations; or holding multiple roles. The
results from this aspect of the current study support Mori’s (2000) findings that being isolated and having a lack of support puts students at greater risk of psychological problems. The results also affirm that building positive relationships helps construct resilience to stress, as recognised by Bitsika et al. (2000), and Heled and Read (1990).

For the tertiary group, the coping strategies which showed the greatest increase between pre and postgroup were: deep breathing, household chores, self talk / challenging thoughts. Deep breathing was taught in session one and reiterated and focussed on a number of times during the course, so this finding was not a surprise. The early introduction of diaphragmatic breathing is significant because of feedback from participants in stress management groups that preceded this study in relation to its benefits in reducing stress and inducing relaxation. The paybacks were considered to be tenfold: as an important anxiety tool; a method to aid relaxation; a means of improving physical and mental health; and a way of assisting sleep hygiene.

The increase in doing household chores could suggest a greater sense of wellbeing and feeling of self efficacy, showed by having more pride in self care and energy levels. Supporting these findings, feedback from the focus groups similarly recognised the importance of these skills. Mindfulness, deep breathing, relaxation and self talk / challenging thoughts were commonly identified as the most accepted and readily utilised tools. The initial popular skill of seeking help from a doctor / nurse / counsellor halved in ratings postgroup, suggesting a greater learnt ability to manage their own distress by taking a more personal proactive role, with less need to seek professional help. Alternatively, the group itself may have provided relational assistance, or the individuals may have instigated an increase in their use of challenging self talk, encouraging a flow on effect to other areas.

In comparison, 83% of the AOD group rated: physical activity and exercise, employment and computer as the most popular coping skills pre group. It seemed that “doing” activities rated highly, and were very different from the “isolation versus reaching out” techniques used by the tertiary group. After completion of the programme, the preferred coping strategies by 83% of the AOD participants were: physical exercise and activity (remaining unchanged in popularity), deep breathing, having a healthy life focus including sleeping and eating, and vegging out for example, watching television.
This emphasis on a healthy life is essential when making changes to addiction patterning which reflects the opposite characteristics. Taking care of physical wellbeing by the use of exercise, and having a healthy life focus assist the modification of patterns of behaviour and maintaining change to substance use in harm reduction treatment, and are recognised as assisting favourable mental health outcomes (Read & Brown, 2003). These favoured ways of coping reflect Palmer and Rodger’s (2009) proposal that participants should learn to relate to stress in more constructive ways. Interestingly, “employment” was ticked as being popular pregroup, but dropped in numbers postgroup, yet there were no changes to employment levels in the group discussions. Rather, participants may have changed their minds about its definition as a coping strategy.

According to the “total number of current coping strategies” for both groups (Figure 4, p. 83), the most used coping tool overall was physical activity and exercise. It was surprising three students did not recognise physical activity as an important coping strategy when only one student was in full time employment, two were unemployed and the biggest group of seven worked part time. This may be an indication of the time commitment involved in tertiary study. It was expected that many students would be health conscious and bodily aware and therefore be regular gym attendees. It was therefore surprising that exercise was mentioned more in the focus groups by the AOD group than for the tertiary group. The AOD group had 11 of the 12 participants in full time employment, allowing little time for extra-curricular activities. Nevertheless, the AOD group declared physical activity the most utilised coping strategy both pregroup and postgroup. Vegging out (watching television), a situation where the body is relaxed, was rated the second most popular skill which is a form of informal mindfulness practice and relaxation.

The coping tool with the biggest increase overall was breathing which doubled in use pregroup from 41% of participants to 82% using it post group to assist coping. The benefits of deep breathing were often disclosed weekly by participants, and repeatedly given credence during the interviews. Diaphragmatic breathing is considered highly pertinent to the multidimensional mind-body applications that include a neurological, muscular and cognitive approach. This is considered most appropriate for stress management, as supported by Chinaveh et al. (2010); Deckro et al. (2002); and Everly et
al. (2003). Conversely, the two coping strategies with the biggest decreases from pre to postgroup were the computer and aggression.

The use of aggression was rated as a current coping strategy by seven participants from both groups initially. This decreased to one participant post group. Another significant finding in relation to risk issues regarding self and others for both groups were the decrease in the use of the coping mechanisms “self harm and suicidal ideation.” Initially five participants reported on the current coping strategies questionnaire using this, but dropped to only one participant postgroup. These results hold particular importance in regard to individual safety concerns as discussed in Heled and Read’s (2005) study with New Zealand youth. These researchers recommended asking youth about their suicide risk, and providing educational programmes to help youth share feelings and discuss strategies to raise their self esteem. These risk issues evoked ethical concerns about participant safety for the researcher, who discussed this with her supervisors as already indicated. As there was no overt discussion with the participants about these risk issues, the researcher can only deduce that being involved in the group programme assisted in lowering these levels.

Every participant spoke positively about having a range of strategies available to foster resilience. This characterised change occurred after taking part in the group. These results support Everly and Lating’s (2003) belief that this was achieved through using a multi-component programme with a holistic focus. Each participant preferred different strategies, or a combination of different skills to better manage their distress. Some strategies were used in different contexts and forms, for examples: formal mindfulness practice versus informal mindfulness; diaphragmatic breathing used during yoga practice. Particular combinations of skills were popular, for example diaphragmatic breathing and mindfulness. Consistent with Waller’s (2001) research, participants in the current study appeared to shift from feeling hopelessness and helplessness to increased optimism through utilising constructive behaviours.

Feedback from the focus groups was consistent with the results of the current coping strategy questionnaire in that the most preferred skills and skills used in combination, for both groups were: mindfulness, deep breathing and relaxation, followed by self talk/challenging thought. All of these skills rated highly and increased over the duration
of the programme. The use of the effectiveness of mindfulness practice in relation to managing stress has been previously recommended by Oman et al. (2008), Palmer and Rodger (2009), Praissman (2008), and Yang et al. (2009). The facilitator recognises mindfulness as a core element in stress management, because the other strategies can only be utilised from a “mindful standpoint.” In other words, mindfulness is the foundation for other strategies to be used.

Skills that warranted further integration and better management were emotion based skills. The AOD group had often used substances to manage emotions and behavioural changes meant that this crutch was no longer available. Communication and emotion regulation were areas where this group believed they were still growing. Likewise, the tertiary group identified the need for improved emotion based skills, and added an additional requirement to further integrate thought challenging processes to their repertoire. These skills may need more attention in future stress management programmes.

**Self Efficacy**

Some individuals in the tertiary group reported a heightened awareness of their stress management but struggled making the cognitive changes. Challenging one’s appraisal of a situation can help modify one’s sense of whether a stressor is dangerous (Corey, 1996). The cognitive behavioural therapy skills seemed to take longer to integrate. It is possible that more time could be afforded to explaining the intricacies of cognitive behavioural therapy when delivering future groups. Nevertheless, some participants from both groups successfully used mindfulness-based cognitive behavioural therapy to separate and identify thoughts from feelings, rather than viewing them as facts.

Self awareness was heightened for six students who became more conscious of the origin of their stress. An acknowledgment that some stressors remain static produced the need to use acceptance of the situation or alternatively better management of the distress. Other changes by the tertiary group included: an improved ability to relax more, which assisted improved study habits; using mindfulness to be “more self conscious” of bodily responses; integrating the information learnt in the group into self awareness; and making subsequent changes, for example, cutting down on coffee and alcohol intake. The
implication of this identifies the complicated nature of the integration and practicing of several skills into everyday living. This is a process that over time builds self efficacy.

Motivation, procrastination and depression symptomology interfered in some students’ ability in utilising the strategies. The depressive symptom of lack of motivation interfered for two participants in the tertiary group with their engaging the skills more fully and completing homework tasks. These two participants were among the three students with the least level of change in their DASS21 scores for the entire group. Reframing this, Everly and Lating (2003) would consider the symptoms a result of the participants’ stress, developed by the arousal-mediating neurotransmitters, neuromuscular arousal and lessened cognitive stimulation. These processes can render individuals less able to complete set tasks, and could interfere with participants’ capacity to incorporate the skills more fully in their lives.

The suggestion by students to extend the group programme for extra weeks could assist in addressing these problem areas by allocating more time and space to practice, hear feedback and learn from others. A greater emphasis could be placed on stress reduction mindfulness based therapy to concentrate on these areas. Mindfulness based cognitive therapy integrates mindfulness plus CBT to assist individual’s suffering repeated periods of depression (Kabat-Zinn, 2005).
The second part of this chapter discusses the influences of stress prior to attending tertiary study or having an addiction. A common factor for many participants was that of historical isolation and disconnection from others that negatively impacted on resilience. In this regard, the importance of building positive relationships was noted as being helpful avenues in building resilience. In particular, international students reported high levels of satisfaction with the group experience. Although the origins of the stress differed significantly between the two groups, this appeared to make little difference to participants’ utilising the skills taught in the group programme and building resilience. However, the complicated interrelationship among stress, depression and anxiety is discussed in relation to the questionnaire results and the influence of these elements in sabotaging the integrative process of using the strategies. The section ends with a discussion of the results of the group programme.

**Historical stress and its influence on the participants**

This study invited participants to reflect on their life-long relationship with particular responses to stressful events and elicited information about these. This is in contrast to previous investigations into stress, where the focus was solely on capturing the nature of stress experienced at the time when the research was conducted (Cooke et al., 2006; Robotham, 2008). One main aim of the post-programme focus groups was asking about historical and original baseline levels of stress prior to attending university or having an addiction. The majority of participants reported having pre-existing stressors and they recognised the additional stress tertiary education or addiction added to their load.

Adjustment issues, the culture of study and co-existing mental health problems impinged on their management of present stress levels when this student group entered tertiary study. This is concerning when consideration is given to the fact that this transitory stage helps establish a foundation for future life goals as part of individuals’ development (Broughman et al., 2009). The student culture entails academic pressure around meeting deadlines and coping with examination anxiety. This pressure adds to the multiple concerns that need management because stress impedes student success and is the most common problem affecting academic performance (Oman et al., 2008). Stress
can block concentration, impeding study (Ferrari, 2001), and examination stress can be related to a wide range of health concerns (Abouserie, 1994; Gadzella et al., 1998).

The tertiary group participants talked about leaving behind trusted and known supportive friends and family. They discussed the psychosocial stress experienced through this transitional change involving, for example, being independent from family and making surrogate supports. Juggling many roles related to work, study and relationships was also recognised as stressful. For international students, global disconnections from supportive relationships heightened their sense of aloneness. International students’ acculturation factors put this student group at greater risk of psychological problems than domestic students (Mori, 2000). The collectivist social orientation characteristic of many cultures is in no way reflective of the individualistic cultural environment of tertiary study, and can be very distressing for international students, according to Sinha and Watson (2007). In the current study, issues of isolation, feeling alone and lacking supports were evident for both groups.

The majority of the AOD participants were similar to the student group in their feelings of alienation and aloneness, in their case brought about through family and historical abuse, and by social concerns. Stories confirmed that a lack of self esteem during childhood, plus other systemic issues caused distress for many. Abuse may be presented in physical, emotional, sexual, mental and spiritual forms and there are complex factors that determine why some individuals are more resilient in face of these factors than others (Putwain, 2007). Resilience is shown by some individuals who are able to turn their lives around following great adversity, and many in the AOD group had achieved that. A core theme of “relationship difficulties” involved intimate partners, family members and intimate relationships, social anxiety and historical abuse, including bullying. Substance abuse was commonly used to manage and cope with these situations. For many, there were multiple stressors. Workplace stress affected three participants as adults. The feedback supports Keyes et al.’s (2011) contention that exposure to stressors is an important risk factor when consuming alcohol and developing alcohol problems. When alcohol and other drugs are used to cope and are coupled with stressful circumstances leading to chronic levels of distress, vulnerability toward addiction is increased (Keyes et al.).
The presence of supportive help was identified as being greatly beneficial in assisting the majority of participants to cope with stress, supporting the findings of Dusselier et al. (2005) and Iglesias et al. (2005). This served as an example of Folkman’s (2008) meaning making and the importance of positive emotions in the stress and coping model (see Figure 1, p. 23). The participants shared narratives support Bitsika, Sharples and Rubenstein’s (2010) recommendations to normalise previous losses of joy and support, while initiating and building strategies to address present stressors in their lives. This appeared to happen during the telling of their stories, shown through listening, laughter and tears, stimulating further group discussion (Krueger & Casey, 2000). Narrative theory recommends an audience assists by providing affirmative support when changing behaviours and building self-confidence (Freedman & Combs, 1996). Nevertheless, pre-existing mental health concerns hindered the abilities of some individuals to build resilience and better manage their distress.

Some mental health symptoms of depression, anxiety and AOD abuse hindered students' process of settling in to tertiary life due to their debilitative nature, adding another layer of stress and pressure that students were subjected to (Brougham et al., 2009; Robotham, 2008). These results tend to confirm previous research that tertiary students mental health is worse than that of the general population (Cooke et al., 2006; Stallman, 2010). Supporting the findings of Robotham’s (2008) research with students, the life challenges of the tertiary group in the present study involved: financial, social, academic, relationship and health pressures. Past historical exposure plus present stressors exacerbated overall distress, affecting mental health. This was further acknowledged in the DASS21 mean scores comparing tertiary students to AOD group (Figure 11, p. 91). This graph clearly highlights that the pregroup and postgroup levels of depression, anxiety and stress are significantly higher for the tertiary group than the AOD group.

Though not specifically identified, mental health concerns were interwoven into the historical stories of the AOD participants too. The stress vulnerability model considers both the environmental factors and biological influences prior to addiction (Mueser et al., 2003). This model was supported by the many background stories of parental, relationship and mental health issues.
When discussing the relationship between AOD and stress, the results from the two groups were very different. This was not surprising considering that the AOD group’s underpinning problem was substance abuse and dependency. Nevertheless, the researcher assumed that the tertiary group would be high consumers of AOD, because research suggests that stressful events can enhance vulnerability to developing addiction. Stress levels over the past three decades have been reciprocated by the increased use of AOD (Sinha, 2008), and AOD is an escape focussed coping skill (Lazarus & Folkman 1985). This is further maintained by Keyes et al. (2011), and Pritchard et al. (2007), who noted that increasing stress levels underlie engaging in negative health problems including AOD use. It was therefore unexpected that at the onset of the group programme, only one tertiary student admitted to presently using alcohol as a coping strategy. Consequently, this result did not seem consistent with the statistic that tertiary students with anxiety are up to five times more likely to have AOD abuse and dependency issues than students without anxiety (Seigers & Carey, 2010). It must be noted however that the current study did not involve a control group of students who were not experiencing significant anxiety or stress.

The researcher suspected AOD use would be higher, particularly with first year students, as documented by Bewick et al. (2008). However, this result seems more plausible when we look at the age range of the heaviest drinkers in New Zealand who are aged 25-59, identified Sellman et al. (2011), and not the youth as often misrepresented in the media. Six students in this study were under 24, and four were over 25. Interestingly, historical AOD abuse and dependency problems were disclosed during the interviews by two more students, both aged over 25, giving more credence to these statistics. The AOD group on the other hand, were a much older group with no participants under 25, three participants in the 25-34 age group, and an even spread of three in each 10 year age grouping to 65.

In the AOD group, four participants recounted no pre-existence of stress prior to their misuse of substances, but two of these identified how their addictions were the cause of stress to people in close relationship with them. This acknowledgement around the affects of their actions and personal responsibility would be likely to assist them in
maintaining their behavioural changes, according to motivational interviewing theory (Rollnick et al., 2008). This fits with harm reduction philosophy.

The stress reduction psychological model of addiction recognises that substance use may be a way of assisting coping (Sinha, 2008), and this was directly spoken about by five AOD group participants. Alternatively, four participants spoke of their addictive characteristics and lack of control over the use of substances, reflecting the disease or neurobiological model of addiction (Sinha, 2008; Uhart et al., 2008). The disease model promotes abstinence (Weiss et al., 2004) and is foundational for the many “twelve step programmes” including Alcoholics Anonymous (2001) of which some participants were members.

**Relationships between depression, anxiety and stress**

The use of AOD has numerous stress-related consequences although the intention of the use is often the short term management of distress. AOD abuse can interfere with study and may introduce traits of anxiety and depression (Mueser et al., 2003). By identifying and acknowledging this relationship, participants were better able to adopt strategies to disrupt it. Further complicating this aspect of the results, however, was the lack of consistency in relevant terminology used, as previously identified by Putwain (2007). This was evident in participants’ lack of clarity as to whether they had symptomology of anxiety, depression or stress.

Various personal and mental health issues sabotaged the process of utilising the stress strategies more fully. These included loss of motivation due to depression symptomology, emotion dysregulation, and the inability to deconstruct cognitions effectively. The close associations between stress, depression and anxiety were supported by the DASS21 results in this study, showing a moderate correlation. These associations were recognised by Lovibond et al. (1995) who developed the DASS21 measuring tool.

Further practice or a greater focus on homework regarding these behavioural, cognitive and emotional issues may have proven useful for these participants who believed that elements got in the way of developing greater self efficacy. Alternatively,
additional group sessions or individual counselling may have benefitted those who recognised that they identified these problems.

The effectiveness of the stress management programme

The total DASS21 mean scores showed decreases over the course of the group programme in all three areas of depression, anxiety and stress for both the tertiary group and the AOD group (Figure 11, p. 91). All six areas show statistically significant differences. These results demonstrate that the mind-body group programme offered in this study was effective in lowering levels of depression, anxiety and stress for participants in both groups. Furthermore, these results support Deckro et al.’s (2002) theory that mind-body interventions positively improve both physical and psychological wellbeing through adjusting the physiological stress response and reducing distress, anxiety and perceived stress.

The student group rated higher in their overall mean scores for the DASS21 than the AOD group both pre and postgroup, and the tertiary group scores revealed a greater reduction in depression, anxiety and stress over the duration of the programme. This pregroup finding gives some support to Cooke et al. (2006), that tertiary students’ psychological well-being and mental health is worse than the general population. However, the difference between the groups in this study could be due to a number of factors, including that the majority of participants in the AOD group had previously been attending one or more other groups and embedding these changes into their lives prior to attending the five week group programme.

The results for both groups clearly show an association between the scales of depression, anxiety and stress. These three areas pregroup for the tertiary student group initially sat firmly in the severe to extremely severe range, and the same three areas altered postgroup, moving to the mild to moderate range, according to the scale ratings outlined by Lovibond et al. (1995). The AOD group showed similar changes, with the total pregroup mean scores in these areas rating mild to moderate, and postgroup stabilising to the normal range.

This interconnectedness highlights the need to use a panoramic approach when addressing what may initially present as a single factor problem. Genetic and other
factors of vulnerability, including environmental stress, are often evident across all negative emotional states, and not simply specific to one or another. The results from this study show that the DASS21 scales of anxiety, depression and stress are moderately correlated, indicating “shared causes” as suggested by Lovibond et al. (1995).
CONCLUSION

Previous research has concluded that health is affected by stress in a variety of ways, including physically, mentally, psychologically and spiritually (Deckro et al., 2002; Moonmuang, 2005; Sinha & Watson, 2007). Mind-body group programmes can assist in building resilience and coping levels (Chinaveh et al., 2010; Deckro et al., 2002; Everly et al., 2003; Iglesias et al., 2005; Meichenbaum, 1988). The favourable results from this study support previous research that mind-body group programmes are beneficial in assisting individuals to build coping and resilience. The current study also showed that the programme can also be useful in lowering risk issues in tertiary students. Therefore, this study is important for clinicians who assist people who suffer stress, and also helpful for the population who struggle with stress and recognise how it affects their wellbeing, hindering their potential for reaching daily and life goals.

The programme delivered in this study was originally devised for AOD clients, but has been identified as being very effective also with a group of tertiary students. This was an original investigation in that it involved a comparison of the effectiveness of one stress management group programme with two different populations. By means of a mind-body five week group programme, the majority of participants in both groups were assisted in learning skills to manage their stress, and increased their capacity for coping and resilience. Key results from the DASS21 scores, as well as data from postgroup focus group interviews, clearly demonstrated a decrease in depression, stress and anxiety for the majority of participants from both groups. Results showed these three areas have a mild correlation.

Nevertheless, there were unique differences in group dynamics between the AOD and the tertiary groups, and although the psychoeducational material presented was identical, the delivery of it was altered in order to gain the most from these contrasting groupings. The mind-body programme delivered in this study assisted every participant who reported presently using the skills in an individualised manner suitable to themselves. The content of the group programme was readily transferable, but the process of delivery was different. Therefore, one key finding from this study is the recognition of the
importance of the role of facilitation in delivering group programmes, because of the unique constitution of each particular group.

The results of this study have the potential to contribute to both research and counselling practice related to the delivery of stress management programmes, and particularly with tertiary students. They need to be considered, however, in light of both the strengths and limitations of the study.

**Strengths of the study**

Previous stress and coping research has been predominantly quantitative. Tertiary studies in this field have mostly focussed on students from the medical and health sciences faculties. The mixed methodology used in the present study has therefore contributed to the stress management literature by eliciting results that include narrative accounts of the experience from the focus groups with quantitative results from the questionnaires. The student sample was randomly selected, and attended from a range of faculties, and therefore diverse disciplines. The cultural diversity of the student group was representative of the university student culture. Participants commented positively on the lack of screening prior to group attendance, which they considered would be a potential judgement on individual suitability in regard to their stress levels.

This study adds to literature on stress management for tertiary students. It is complementary to and expands on Robotham’s (2008) mind-body group programme delivered to tertiary students. In Robotham’s study, only questionnaires were used to gather data, and a suggestion was made that focus group interviews be added in future research. The focus group interviews in this research elicited participants’ subjective views about their historical and developmental issues around stress and coping in relation to beginning tertiary study and having an addiction. They also identified their current coping skills. The historical tales showed most participants had distressing pasts. Feedback from the focus group discussions confirmed that participants learned many and various skills during the group programme and utilised these to assist in improving their mental health. The focus group interviews supported the information gathered in the DASS21 questionnaire, providing evidence of the success of the group programme in lowering depression, anxiety and stress.
Hearing participants’ backgrounds and contextual stories of stress and coping provided important insights into their historical and current coping. These interviews were also beneficial to the participants by adding a further dimension to their experience of therapeutic group functioning. This continuation of the group process confirmed their progress and their increased self efficacy to date.

The success of the mind-body group programme offered in this study was reflected in the 100% retention of all participants throughout both group programmes. The data analysis also demonstrated the applicability of the programme across the two quite different participant populations. Information gathered from observations of group dynamics and discussions from focus group interviews showed that although the same curriculum was delivered to two different population groups, the processes that occurred and resulted within the groups were different. Nevertheless, every participant spoke of learnt strategies they were using to manage distress, albeit differently from each other.

The multiple roles of the facilitator / researcher provided continuity for the participants, assisting in building trust, gaining rapport and a leaning towards stronger group dynamics. The levels of intimacy in the focus groups may not have been attained nor might the discussions have reflected the same depths of disclosure if the interviewer had not been as well known to the participants. The many roles of the researcher additionally provided her with greater insight into the less obvious behaviours from group participants that a new researcher may have not noticed.

**Limitations of the study**

The role of the facilitator, and the “facilitator effect,” were not explored during focus group interviews. This was purposely omitted because of the potential bias that participants may have had towards the facilitator after spending group time together; participants may have felt obliged to give positive feedback. Instead the priority was to focus on group interactions, the information provided and utilisation of the skills instead. However, a possible limitation of the project could have been the researcher’s multiple roles in directing, facilitating, managing and interviewing the group and the group processes, including gathering and analysing the data. Previous work experience at both counselling services and the multiple roles may have affected the quality of the group and
its success or otherwise, yet there was minimal feedback on how participants experienced this.

There was difficulty initially enrolling AOD participants, and an approach was made to an existing group to see if its members would be willing to change their focus to stress management. Participants of the AOD group consisted of a much older client grouping than the tertiary students, and they had a more extensive history of group attendance. The tertiary group were strangers to one another and some mentioned they had not attended psychoeducational groups before. The participant sample in each of these groups was therefore quite different, and this could in fact be seen as both a limitation and strength.

There was a relatively small sample size overall, and this could be a contributing factor in some non-significant results. There was no screening of participants prior to attending the groups, to encourage a random mix of individuals. Eleven of the 12 AOD group participants were in full time employment and had high levels of education. My interpretation of this demographic information, derived from my professional experience, is that night time groups are attended more by the working population, often with higher academic abilities, than those who attend groups during the day. The AOD group cannot therefore be seen as representative of that population overall, and the results need to be interpreted accordingly.

Three tertiary group participants’ pregroup DASS21 screens for depression were rated more problematic than their stress levels. They may have found a group focussing on depression more useful in meeting their needs. Feedback from two of these individuals expressed the view that their symptoms of depression were responsible for their lack of motivation to utilise and integrate the strategies taught in this stress management programme. Although group participants learn and gain insight through interactions with others in similar situations, the lesser focus of attention on individualised problems may require follow-up assistance through individual therapy (Mclean & Woody, 2001). Another point of difference was that one AOD participant had zero ratings for his stress levels upon completing the DASS21, and therefore did not fill the entry criteria of “feeling stressed out” and was considered an outlier in relation to the rest of the group.
The time allocated for the AOD focus group of 11 was identical to the time given to the tertiary group of six, resulting in unequal speaking time for the participants. Due to unforeseen circumstances three students could not attend the originally planned focus group of nine, and their follow up focus group was held one month later, bringing them all closer to their end-of-term examinations. This was a time of heightened stress levels because of the looming examinations. The timing of the delivery of questionnaires is crucial in gathering valid data and time differences between focus group interviews occurring between one week and five weeks following group completion, together with the pressure of examination anxiety, may have affected the findings for the tertiary group. Two students verbalised this possibility.

A further limitation was the use of self report questionnaires, which can disguise or exaggerate symptoms (Lovibond et al., 1995). There was also the possibility that participants may have wanted to make the research prove its worth, or to show the facilitator in a favourable light, and they may have completed the questionnaires accordingly.

**Recommendations for stress management group programmes**

Confusion about the terms anxiety, stress and depression was shared by participants, who clearly substituted one for another at different times, assuming similar meanings. This ambiguity around language in relation to stress and coping has previously been identified by Collins et al. (2010). This highlights the need for stress group psychoeducational stress management programmes to provide more specific identification and transparency around language and associated meanings. A broader explanation of the process of stress could benefit participants by showing the complexities involved, for example, anxiety is only one possible response to stress, and could involve other reactions of anger, hostility, depression or efficacy (Putwain, 2007). This highlights the correlation between stress, depression and anxiety.

Prior screening of participants could be a prerequisite for attending a psychoeducational group programme. An initial screening or assessment could provide the opportunity to discuss the ambiguity around the language in relation to stress and coping and the relative appropriateness of the group in regard to each individual. This
would give an indication of whether potential mental health or other considerations were a barrier to learning. It would also provide an opportunity to check any risk issues. If so, discussions could initiate back up support or consider other ways of better meeting each individual’s unique needs. These could include one to one therapy, or a recommendation made by the individual.

In a stress management programme such as this, five two-hour sessions seemed appropriate, though many participants from both groups asked for additional sessions, with one student suggesting 12. Participants recommended that groups were limited to a maximum of ten individuals. The large number of handouts and take home information was positively acknowledged and participants recommended that this be maintained in future group programmes.

Elements of the group programme that were recommended by participants as being necessary in future stress management group programmes included the safe environment within the group, and the smorgasbord of strategies taught. The use of integrative counselling theories and the collaborative and client centred relationship with the facilitator was appreciated and recognised as helpful. Learning skills within a group environment was identified as supportive due to development of the social microcosm, being with others with similar problems.

However, although the group dynamics provided support in emotion focussed coping, it seemed that participants required further assistance with developing emotion regulation skills. Cognitive behavioural restructuring skills were also suggested as needing further integration or practice. Follow up sessions could be offered to focus on these areas.

**Recommendations for future research**

Research on a larger scale or with a different population group could further investigate the strengths of this particular stress management programme. An AOD day group could be compared to an AOD night time group to see whether different participants provide different results. Similarly, an older age group of students would illuminate different stressors and methods of coping.

This study evaluated the application of the stress management programme with two particular, very different populations. Further research could be undertaken to test the
utility of the programme with other populations as well. A future study could be made with a group of individuals having one to one stress management assistance with a therapist over the same time frame, and results compared against the group results from this study.

It is unknown to what extent the success of the programme was due to the nature and quality of the facilitation. More direct questioning to obtain participant views of the effect of the facilitator may have elicited further information about the importance of this facilitation and the relationship between the facilitator and the group members. Further research could be undertaken involving different facilitators delivering the same programme to similar groups of participants in order to ascertain further insight into the effect of the facilitation.

Future studies could also involve longer term follow-up at intervals of one, two or six months for example. These investigations could enquire as to the extent the skills were still being utilised, and secondly whether DASS21 levels had been maintained.

**Epilogue**

This research evaluated the applicability of a stress management programme that was easily implemented, readily replicated and low-cost to two different population groups. Its purpose was to lower stress and increase coping. The findings showed it significantly reduced levels of depression, anxiety and stress for the majority of participants from both groups. It also had a profound effect in reducing the levels of risk for participants who were vulnerable.

The tertiary environment provides an ideal opportunity for introducing early intervention and prevention skills addressing stress and associated mental health concerns for students. This study makes a positive contribution in supporting the delivery of mind-body stress management programmes in this context. It is particularly useful because of the stressors identified at this life stage and the levels of isolation that often accompany them. The findings bolster support for mind-body stress group programmes to foster coping and resilience, leading to psychological well-being and improved health in general.
In facilitating this group programme I benefit twofold. I practice and reaffirm the range of strategies to myself, and share in the processes of building coping and resilience with the other group participants. In this way, it can be viewed as a beneficial self care stratagem for any clinician. When I left my employment at AOD services, the delivery of the stress management group stopped. These results will support the value of offering this type of group again to AOD clients. This research project has provided evidence about the power of “the group” and encourages me in recommending it to other populations. I intend to continue the delivery of this group programme with tertiary students and hope to deliver it to other community groups, for example, single parents.
REFERENCES


Moonmuang, N. (2005). *Stress management and health promotion behaviours in young men in tertiary education settings* (Research Doctorate). School of Psychology, Faculty of Arts, Victoria University, Melbourne, Australia.


Power Point Presentation

The following power point presentation with accompanying notes has been prepared as a one hour paper for the 2013 conference, Recent Research and Innovations in Practice; cosponsored by the University of Auckland and the New Zealand Association of Counsellors Auckland branch. This one day conference is an annual event attended by counselling practitioners and researchers.

This presentation will also be given to both the tertiary and alcohol and drug organizations through which participants were recruited for this study, in order to report back on the research that was undertaken within those agencies. This will honor my commitment to report back the findings of the study. Attendees at both presentations will be given additional handout information that will include the Figures from pages 82, 83 and 90, and Table 2, page 77. These will be photocopied from the main body of the research report.
Introduction
While NZ was in the grips of rugby world cup fever I was delivering group fever of a different type – running two mind-body “Stress Management” group programmes with 12 AOD clients and 10 tertiary students.
This presentation is about “the power of the group” and the achievements that a group of people working together with a common purpose can attain for their individual self and in assisting one another.
The overview will describe why I became interested in running groups in relation to stress and coping by describing my background in counselling and my own stress and anxiety issues.

- The mixed methods used in this study will be described, along with the challenges that I met along the way.
- I will give some detail as to the 5 week group programme, its topics and focus.
- The findings will be discussed according to the six themes that emerged and the statistical data supporting these.
- Finally, I will share how this study has altered my perception as a counsellor.
My background – Happy childhood with a big family and many cousins. Popular at school. Married a man I loved. Creative outlet - building a boat and a home together with my husband. I worked part time in secretarial work, and by age 32 had three children aged 2,5 and 8. My partner and I enjoyed sailing together and travelled overseas with our children. Life ran smoothly with a healthy lifestyle balance – work, play, fun, social, spiritual, creative, intellectual outlets, and I was relatively stress free.

▪ However, I felt something was missing – I needed more, and decided on beginning a career. At age 33 I chose the path toward becoming a counsellor – fully supported by my husband. However, I added the study on top of what I already had to my full and complete life – I wasn’t willing to stop or let go of any of the other parts.

▪ Surprisingly, my partner didn’t support me and actually spent longer hours at his work. His alcohol consumption increased and he had many extra-marital affairs. The balance of my lifestyle altered. The wheels fell off.
I became a “Stress Bunny.” My life was becoming out of control and anxiety and stress were often present.

- I was in a dilemma because of the many roles I played, including student, father, mother, cleaner, cook, organiser, taxi driver, lover, friend and sister. I exercised more and slept less – waking at 2 or 3am to study while the rest of the family were asleep. I became more organised and efficient in planning the next day, week and month in advance. I was a multi-multi-tasker! I believed I was Superwoman and could “Do it all”.

I enjoyed being a student. I loved the learning, and I still do, and the 3 days each month in Auckland where I simply focused on myself felt like a retreat.

- I never communicated my concern with anyone (including my partner) because I believed I wouldn’t be understood. One of the life messages I had grown up with were: “You make your bed, you lie in it.” I believed I was coping well, but in hindsight I needed support and help, and would have benefitted myself and my family more if I had used some of the skills I now teach in my stress management group programme.
What lead me to run the Stress Management group programme? Over the past 17 years I continued studying part time while working as a counsellor in Dargaville and Whangarei. I worked in private practice, for NGO’s and district health boards as a mental health and AOD clinician. Group work has been an enjoyable and passionate part of my work. Initially I co-facilitated abuse prevention programmes for Rape Crisis where I worked as a collective member, counsellor and facilitator. I delivered anger management group programmes at Men Beyond Violence to men with protection orders against them. Additionally, I delivered community group programmes, and always enjoyed seeing others learn from each other. Groups often seemed magical areas for change.

Five years ago I moved to Auckland and began full-time work with AOD services. I felt intrigued when I was offered the chance to co-facilitate the Stress Management group. I thought this could assist my own self care and stress levels, as well as be useful for clients. I accepted, and over the years have altered and changed the group programme in line with post-group feedback. I now facilitate the programme by myself.
What happened in the group...

- Assisted relapse prevention to AOD
- Clients completed and repeated the group programme
- Basic skills built resilience
- Stress levels dropped and coping increased

What I found happened from attending the group?

- AOD clients practiced the strategies which assisted in relapse prevention. Secondly, on a personal level, I reminded myself to use these strategies, thereby assisting myself care. It wasn’t therefore surprising when clients asked to repeat the group programme.
- Many participants returned more than once and one man repeated the group four times! There can sometimes be a lack of attendance in voluntary attendance groups, but attendance rates were high, quantifying the participants were getting something out of it.
- The basic skills of mindfulness, breathing and relaxation appeared to help build resilience to ongoing stress and possible relapse.
- Group feedback was positive. I wondered whether this same group programme would be useful for other population groups. The tertiary student group has different stressors and may learn differently because their current life focus is centred within a learning environment. However, I thought the student group may have similar AOD concerns, and overlapping issues in this regard. Would these same basic skills be useful to manage tertiary students stress and build coping?
10 tertiary students and 12 AOD clients were given delivery of the Stress Management group programme. Different numbers due to possible drop-out.

- Mixed methods were chosen to measure the outcomes because previous literature has been predominantly quantitative with medical or health-related students.
- Measures: DASS21 to measure depression, anxiety and stress levels at week one and again postgroup. This is a self-report instrument of 21 questions using a Likert Scale. The second measure was a tool piloted and made by myself that consisted of 41+ possible current coping strategies that participants simply ticked pre and postgroup. They then added a + or – whether they considered each tool helpful or not.
- Focus group interviews were had after group completion. The option of individual or group interviews were given.
- Results were analysed separately and then comparatively.
Some challenges occurred:

- Ethics approval was needed from both Auckland University and also Health and Disability ethics committees. Some requirements were different, bringing complications. Approval was also needed from Waitemata Maori Research Review Committee.
- Posters and referral by clinicians were used to attract group participants. The student group was formed, but AOD clients were slower, with only 3 enrolling. Following consultation with the AOD Team Leader, the existing Maintenance Group was approached and offered the group. Their focus changed to Stress Maintenance for the next 6 weeks. They agreed, but it is worth noting these 9 participants were already well known to one another and many of them had already made major changes to their AOD use. Secondly, the group was a night time group and the majority of this group was in full time employment. Therefore, the findings cannot be generalised to the AOD population overall.
- Pregroup current coping skills questionnaire identified 7 marked aggression and 5 with suicidal ideation/self harm. This was discussed in supervision and no direct follow-up made by Theresa. Client safety in relation to follow-up counselling (if needed) was restated each session.
- Multiple roles played by Theresa – facilitator, statistician, interviewer. Concerns regarding possibility of this biasing data.
- Final group interview of tertiary student group of 3 occurred very close to exams, with potential higher levels of present stress.
As Carl Rogers noted in person-centred practice, by creating a trusting and safe group environment and teaching basic skills to better manage stress, participants will be helped. Group guidelines were compiled at week one by the group. Focus portrayed as being solutions, not problems.

Psychoeducational not therapeutic group focus.

Opening round each week discussed any stress management tools being used, homework tasks and assisted in building the tool kit. Mindfulness relaxation to begin and complete each group session. Handouts on each topic given to take home for extra information.

Refer to handout – Key Topics in S.M. Programme (Table 2, p. 68). Mixture of CBT, mindfulness, art therapy, interactive activities, individual and group tasks. Skills were practiced during group sessions e.g. diaphragmatic breathing, assertiveness training.
Six themes identified from focus group interviews. AOD group spent majority of their time on Historical Stress, following AA meeting procedure (story telling). Other themes seemed equally important for both groups.
- Four from AOD group had nil stress in their lives prior to beginning AOD, though there was recognition of the stress placed on others by their actions. This group also spoke of the addictive qualities of alcohol, rather than using AOD as a coping mechanism for stress.
- Comparatively, groups had similar stressors, though triggers differed. Tertiary – study pressure and meeting deadlines, transition stage, building friendships. International students - isolation, different cultures, transition, loss of previous supports, different ways of studying and different lifestyle. AOD – childhood and adolescent alienation and isolation, most often due to relationship issues including anxiety concerns in making friendships and abusive backgrounds. Low self esteem and self image plagued 4 AOD participants. Grief and loss was suffered by 2 participants. Workplace stress was identified by 3 prior to their addiction.
- Multiple roles caused problems for both groups – working, studying, and care giving for others.
- Mental health – Tertiary group – previous addiction, depression, anxiety and social anxiety concerns. Though AOD group didn’t mention depression, DASS21 scores confirm levels of depression and anxiety.
Some were able to pick and choose from the tool kit what was specifically needed in certain situations. Some tools were paired together in a sophisticated way e.g. mindfulness and deep breathing.

- Simple skills were spoken about as being surprisingly helpful - deep breathing, mindfulness, relaxation and exercise – in the form of walking.
- Challenging unhelpful thinking was popular.
- However, both groups similarly asked for more time on CBT and challenging thought processing, emotion management and communication skills. This highlights the difficulties of integrating these skills.
Although not specifically asked about the facilitator and what difference this made to the group, verbal feedback given identified the helpful attitudes of facilitation – some comments included:

- allowing space to divert from the topic and explore related areas.
- interactive, creative and stimulating group programme – “got people up out of their chairs”
- check-in round where individuals felt valued and heard
Engaging a group involves many aspects – “getting all your ducks in a row”.
Participants are engaged when they feel safe, heard and identify the space as having a trustful atmosphere. Participants spoke of being engaged by the flowing effect of the weekly topics and information given, including homework and handouts. Engagement was further supported by:

- informed consent prior to attendance, group guidelines (made by the group at week one and echoed weekly), weekly check-in rounds and having space for questions and feedback. Having time for food or drink together. Facilitator staying after group for any follow-up or concerns. Email contact of facilitator given.
- acknowledging that we are all unique and manage our personal stress differently – therefore confirming the necessity to choose personal strategies to add to your individual tool kit.
- Only the Tertiary group spoke about group size and identified 10 as being the ideal maximum number. They would have preferred more weeks to better concretise the skills, but agreed this was difficult to fit in with the university calendar.
- Both groups spoke about the power of being in a group with others who have similar issues and how this provided support and lessened their isolation. Trusting relationships were formed. The “universality” of learning from others in the same situation as outlined by Yalom (2005) was shown to be working.
- Mental health problems hindered some participant’s ability to speak out more during group process. Lack of motivation caused by depression obstructed some in utilising the skills and completing homework tasks.
AOD group - 9 members from the existing maintenance group had already made some major changes to their AOD use, including some having years of abstinence from AOD.

Some participants gained clarity that some stressors cannot be changed, and that they had to accept and learn to better manage the stress caused by these. Others made positive changes to identified stressors.

Self efficacy appeared to be assisted by a process of identifying change required and taking appropriate actions.

Having an audience to affirm progress was identified as being helpful for some, as identified in Narrative Therapy, Freedman & Combs (1996). This seemed to increase their sense of pride in better self management of situations. However, some hadn’t told anybody about their group attendance.

Other group attendance at clubs or talking with somebody seemed to assist self efficacy. This identifies another type of group interaction and the help it can provide. The majority in AOD group recognized help and support from friends, family, groups, clubs and counselling as essential in their changed behaviors towards AOD. It is worth noting that legal implications were essential markers in 3 participants making changes to their AOD careers.
Refer handout – current coping skills (Figure 3, p. 82) between groups. However, the only significant difference is tertiary student group increase in positive coping skills between pre and postgroup.

Refer handout – mean scores of DASS21 results (Figure 11, p. 90). Significant decreases in all 3 areas by both groups. Note higher levels in all 3 areas for tertiary group compared to AOD group – possible reasons for this could be previous group attendance and integration of skills, or older age group. Is students’ mental health worse than the general population? Refer: Stallman’s (2010) research and findings with Australian university students.

Refer handout – total coping skills (Figure 4, p. 83)
- Notice levels of suicidal ideation/self harm and aggression drops in figures postgroup.

Confirms focus group interviews that coping and self efficacy had improved for the majority of participants following group attendance.
Simple strategies work
Mindfulness based stress reduction practices assist individuals, regardless of the origin of their stress
Commitment to group work

- Consider delivering this group to other populations e.g. single parents.
- Basic low-cost and easily implemented strategies fit well into people’s lives and were the preferred tools to manage stress i.e. deep breathing and exercise. Gives recognition to clinicians: we do not need to reinvent the wheel.
- This study reinforced my confidence that a combination of mindfulness and stress reduction practices are relevant to a broad cross-section of society, regardless of the origins of their stress.
- The value for me in undertaking this research is that it confirmed what I noticed anecdotally in clinical practice and strengthened my commitment to group work
Ideas, comments or questions?
Appendix A1

Participant Factual Information  Version 1 – 27.4.11

University Student

Name ………………………………………………………………………………………………..

Age ………………………………………………………………………………………………..

Gender ……………………………………………………………………………………………..

Number of dependants …………………………………………………………………………..

Ethnicity …………………………………………………………………………………………….

Study programme …………………………………………………………………………………

Years at university …………………………………………………………………………………

Status –  single ☐, married/defacto ☐, separated/divorced ☐

Living arrangements – self ☐, parents ☐, with other/s ☐, Hall of Residence ☐

Source of income for university – parents ☐, or other persons assisting ☐, self ☐, loan ☐

Paid Employment – nil ☐, part-time ☐, fulltime ☐

Are you currently concerned about your alcohol or drug use?
   Yes ☐,  No ☐,  Don’t use alcohol or drugs ☐, choose not to answer ☐.

If so, approximate length of time abusing alcohol or drugs - ….. years … months.
Appendix A2

Participant Factual Information  Version 1 – 27.4.11

Xxx clients

Name …………………………………………………………………………………………………………

Age ………………………………………………………………………………………………………

Gender ………………………………………………………………………………………………

Ethnicity ……………………………………………………………………………………………

Number of dependants ……………………………………………………………………………

Living arrangements – self ☐, parents ☐, with other/s ☐

Status – single ☐, married/defacto ☐, separated/divorced ☐

Paid Employment – nil ☐, part-time ☐, fulltime ☐

Approximate length of time abusing drugs or alcohol ………years ………months.
Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0  Did not apply to me at all
1  Applied to me to some degree, or some of the time
2  Applied to me to a considerable degree, or a good part of the time
3  Applied to me very much, or most of the time

<table>
<thead>
<tr>
<th></th>
<th>Statement</th>
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<tbody>
<tr>
<td>1</td>
<td>I found it hard to wind down</td>
</tr>
<tr>
<td>2</td>
<td>I was aware of dryness of my mouth</td>
</tr>
<tr>
<td>3</td>
<td>I couldn't seem to experience any positive feeling at all</td>
</tr>
<tr>
<td>4</td>
<td>I experienced breathing difficulty (e.g., excessively rapid breathing, breathlessness in the absence of physical exertion)</td>
</tr>
<tr>
<td>5</td>
<td>I found it difficult to work up the initiative to do things</td>
</tr>
<tr>
<td>6</td>
<td>I tended to overreact to situations</td>
</tr>
<tr>
<td>7</td>
<td>I experienced trembling (e.g., in the hands)</td>
</tr>
<tr>
<td>8</td>
<td>I felt that I was using a lot of nervous energy</td>
</tr>
<tr>
<td>9</td>
<td>I was worried about situations in which I might panic and make a fool of myself</td>
</tr>
<tr>
<td>10</td>
<td>I felt that I had nothing to look forward</td>
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<tr>
<td>11</td>
<td>I found myself getting agitated</td>
</tr>
<tr>
<td>12</td>
<td>I found it difficult to relax</td>
</tr>
<tr>
<td>13</td>
<td>I felt downhearted and blue</td>
</tr>
<tr>
<td>14</td>
<td>I was intolerant of anything that kept me from getting on with what I was doing</td>
</tr>
<tr>
<td>15</td>
<td>I felt I was close to panic</td>
</tr>
<tr>
<td>16</td>
<td>I was unable to become enthusiastic about anything</td>
</tr>
<tr>
<td>17</td>
<td>I felt I wasn't worth much as a person</td>
</tr>
<tr>
<td>18</td>
<td>I felt that I was rather touchy</td>
</tr>
<tr>
<td>19</td>
<td>I was aware of the action of my heart in the absence of physical exertion (e.g., sense of heart rate increase, heart missing a beat)</td>
</tr>
<tr>
<td>20</td>
<td>I felt scared without any good reason</td>
</tr>
<tr>
<td>21</td>
<td>I felt that life was meaningless</td>
</tr>
</tbody>
</table>
Appendix C

Questionnaire No. 2      Version 2 – 16.6.11
Use of current coping strategies - (tick if presently using)

- Aromatherapy
- Alcohol
- Avoidance
- Aggression
- Cigarettes
- Computer
- Creative skills / art / craft
- Deep breathing
- Dance, music
- Denial
- Distraction
- Drug use – illicit
- Employment
- Gardening
- Healthy life focus e.g. regular sleep and healthy diet
- Homeopathy – natural medicine
- Household chores
- Journal writing
- Massage
- Medication – over the counter, prescribed
- Meditation or mindfulness
- Movies
- Optimism
- Pet/s  e.g. walking the dog, stroking the cat
- Physical activity – exercise
- Procrastination
- Reading
- Relaxation
- Self talk inc. challenging thinking
- Self harm, including self punishment and suicidal thinking
- Self help information or books
- Sex
- Spirituality / religion / prayer
- Sports or Gym
- Seeking help – doctor, nurse, counsellor, therapist
- Talking to someone you know e.g. friends, family
- Vegging out – e.g. watching television
- Visualisation
- Withdrawl or isolation from others
- Yoga / tai chi / qui gong
- Other/s please name

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APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 6.7.2011 for 3 years, Reference Number 2011/284

APPROVED BY THE HEALTH AND DISABILITY NORTHERN Y REGIONAL ETHICS COMMITTEE ON 7.7.2011, Reference Number NTY/11/05/053
Appendix D1

7 July 2011

Ms Theresa Martinovich
3/10 Sunnynook Road
Sunnynook
NorthShore, Auckland

Dear Theresa -

Ethics ref: NTY/11/05/053 (please quote in all correspondence)
Study title: A comparison of a five week stress management group programme
delivered to both University students and clients in an alcohol and other drug treatment
setting.
Investigators: Ms Theresa Martinovich, Dr Margaret Agee

This study was given ethical approval by the Northern Y Regional Ethics Committee on 7 July 2011.

Approved Documents
— Information sheet and Consent form version 2
— Participant factual Information (university student) version 1 dated 27/4/11
— Participant factual Information (CADS clients) version 1 dated 27/4/11
— Questionnaire No 2 version 2 dated 16/6/11
— Interview Guide version 2 dated 15/6/2011
— Flyer “Stressed Are you stressed out??” (CADS)
— Flyer “Stressed Are you stressed out??” (students)

This approval is valid until 7 July 2012, provided that Annual Progress Reports are submitted (see below).

Amendments and Protocol Deviations
All significant amendments to this proposal must receive prior approval from the Committee. Significant
amendments include (but are not limited to) changes to:
— the researcher responsible for the conduct of the study at a study site
— the addition of an extra study site
— the design or duration of the study
— the method of recruitment
— information sheets and informed consent procedures.

Significant deviations from the approved protocol must be reported to the Committee as soon as
possible.
Annual Progress Reports and Final Reports
The first Annual Progress Report for this study is due to the Committee by 7 July 2012. The Annual Report Form that should be used is available at www.ethicscommittees.health.govt.nz. Please note that if you do not provide a progress report by this date, ethical approval may be withdrawn.

A Final Report is also required at the conclusion of the study. The Final Report Form is also available at www.ethicscommittees.health.govt.nz.

Statement of compliance
The committee is constituted in accordance with its Terms of Reference. It complies with the Operational Standard for Ethics Committees and the principles of international good clinical practice.

The committee is approved by the Health Research Council’s Ethics Committee for the purposes of section 25(1)(c) of the Health Research Council Act 1990.

We wish you all the best with your study.

Yours sincerely

Amrita Kuruvilla
Administrator
Northern Y Regional Ethics Committee
Email: amrita_kuruvilla@moh.govt.nz
Appendix D2

Office of the Vice-Chancellor
Research Integrity Unit

UNIVERSITY OF AUCKLAND
HUMAN PARTICIPANTS ETHICS COMMITTEE

06 July 2011

MEMORANDUM TO:
Dr Margaret Agee / Dr Jan Wilson / Theresa Marie Martinovich
Faculty of Education

Re: Application for Ethics Approval (Our Ref. 2011 / 284)

The Committee considered your application for ethics approval for your project titled "A comparison of a 5 week stress management group programme delivered to both University students and clients in an alcohol and other drug treatment setting" on 6/07/2011.

Ethics approval has been given for a period of three years.

The expiry date for this approval is 6/07/2014.

If the project changes significantly you are required to resubmit a new application to the Committee for further consideration.

In order that an up-to-date record can be maintained, you are requested to notify the Committee once your project is completed.

The Chair and the members of the Committee would be happy to discuss general matters relating to ethics approvals if you wish to do so. Contact should be made through the secretary in the first instance, Lana Lon, I.on@auckland.ac.nz.

All communications with the UAHPEC regarding this application should include our reference number - 2011 / 284.

Lana Lon
Secretary
University of Auckland Human Participants Ethics Committee

c.c. Head of Department / School, Faculty of Education

Theresa Marie Martinovich
3/10 Sunnybrook Road Sunnybrook
North Shore
Auckland

Additional information:
1. Should you need to make any changes to the project, write to the Committee giving full details including revised documentation.
2. Should you require an extension, write to the Committee before the expiry date giving full details, along with revised documentation. An extension can be granted for up to three years, after which time you must make a new application.
3. At the end of three years, or if the project is completed before the expiry, you are requested to advise the Committee of its completion.

4. Do not forget to fill in the 'approval wording' on the Participant Information Sheets and Consent Forms, giving the dates of approval and the reference number, before you send them out to your participants.

5. Send a copy of this approval letter to: Manager, Funding Processes, Research Office if you have obtained funding other than from UniServices. For a UniServices contract, send a copy of the approval letter to: Contract Manager, UniServices.

6. Please note that the Committee may from time to time conduct audits of approved projects to ensure that the research has been carried out according to the approval that was given.
Monday, 16 May 2011

Theresa Martinovich
School of Counselling
Human Services and Social Work
Tamaki Campus
The University of Auckland

Tena koe Theresa,

RE: A comparison of a five week stress management group programme delivered to both university students and clients in an alcohol and other drug treatment setting

This is to advise that your application was discussed at the last meeting of the Nga Kai Tataki - Waitemata Maori Research Review Committee. We are pleased to advise that your application will be supported however, please note the following recommendations that arose from the members' deliberations:

1. Nga Kai Tataki – Waitemata ‘MRRC’ firmly believe that your questionnaire to be administered to participants in this research study is collecting ‘health information’ and while not directly adding to the participants medical records it is health information none the less and in saying that, the committee members’ recommend that question D7 on page 17 be answered to reflect this;
2. Please revisit question D8 page 17 of the NAF application. Research guidelines state that data from research studies must be secured and kept for at least ten years, your application states that it will be kept for only 6?

This approval is subject to the condition that before proceeding researchers must advise any Maori participants that they should seek support from their own whanau, Kaumatua or Kuia or their local Maori Health Services.
Please send Nga Kai Tataki - Waitemata ‘MRRC’ a 1-2 page summary of your findings once your research is complete.

Hei kona mai i roto i nga mihi.

Tanekaha Rosieur  
Chairperson  
Nga Kai Tataki ‘MRRC’

Giovanni Maihi Armaneo  
Maori Research Advisor  
Knowledge Centre
SEEKING … CLIENTS WHO ARE “STRESSED OUT” “FEELING SHAKY” OR “OVERLOADED” WITH … ISSUES, LIFE, RELATIONSHIPS, SELF…

Theresa Martinovich an … counsellor, is conducting research study on stress management groups and how they promote coping and resilience. Group participants only need to have a problem with alcohol and / or drugs, speak fluent English, and “feel stressed” to join the 5 week group beginning Tuesday 23 August 2011 at 6-8.00pm at … …

Participation will involve:

- attending 5x group sessions learning skills and strategies on MANAGING STRESS SKILLFULLY
- at session 1 and again at session 5 (for comparison), participants will be asked to complete 2x questionnaires rating their stress levels and asking about present coping skills used.
- 1 hour maximum interview discussing the group and interventions taught

Confidentiality and anonymity will be maintained throughout the course of this fun study. For more information or questions, contact Theresa Martinovich email: t.martinovich@auckland.ac.nz or txt your email address or phone number to 021439144, and Theresa will contact you. Numbers strictly limited to fewer than 12. APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 6.7.2011 FOR 3 YEARS, Ref. Number 2011/284 and APPROVED BY THE HEALTH AND DISABILITY NORTHERN Y REGIONAL ETHICS COMMITTEE ON 7.7.2011, Ref. Number NTY/11/05/053.
SEEKING STUDENTS WHO ARE “STRESSED OUT” “FEELING SHAKY” OR “OVERLOADED” WITH … LIFE, STUDY, RELATIONSHIPS, SELF…………

Theresa Martinovich, an … counsellor, is conducting research study on stress management groups and how they promote coping and resilience. Group participants only need to “feel stressed”, and speak fluent English to join the 5 week group beginning Tuesday 26 July 2011 at 1pm -2.30pm.

Participation will involve:

- attending 5x group sessions learning skills and strategies on MANAGING STRESS SKILLFULLY
- at session one and again at session five (for comparison), participants will be asked to complete 2x questionnaires rating their stress levels and asking about present coping skills used.
- 1 hour maximum interview discussing the group and interventions taught

Confidentiality and anonymity will be maintained throughout the course of this study. Numbers strictly limited to fewer than 10. For more information or questions, contact Theresa Martinovich email: t.martinovich@auckland.ac.nz or txt your email address or phone number to 021439144, and Theresa will contact you.

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE 6.7.2011 FOR 3 YEARS, Reference Number 2011/284, and APPROVED BY THE HEALTH AND DISABILITY NORTHERN Y REGIONAL ETHICS COMMITTEE ON 7.7.2011, Reference Number NTY/11/05/053
Appendix F1
Consent Form (Participant)
(This consent form will be held for a period of ten years)

Project Title: A comparison of a 5 week stress management group programme delivered to both University students and clients in an alcohol and other drug treatment setting.

Researcher: Theresa Martinovich

I have read the Participant Information Sheet, and have understood the nature of the research and why I have been selected. I have had the opportunity to ask questions and have them answered to my satisfaction. I have had the opportunity to use whanau support or a friend to discuss this study. I understand the voluntary nature of my participation.

- I agree to take part in this research
- I agree to not disclose anything discussed in the groups. I understand confidentiality rests with individual participants, over which I have no control.
- I agree / do not agree to be audio taped for the interview (at or after week 5).
- I understand that I am free to withdraw participation at any time. I understand I can withdraw any data traceable to me up to one week following the individual interview (at completion of 5 week group). However, I understand I cannot withdraw group interview data (because of other group members’ information on the same interview).
- I understand that Theresa or a third party who has signed a confidentiality agreement will transcribe the tapes.
- I wish / do not wish to have a copy of my transcribed interview sent to me.
- I wish /do not wish to receive the summary of findings.
- I understand that the data from this research may be used in a conference presentation or article for publication. I will be anonymous within the research writing.
- I understand that data will be kept for 10 years, after which they will be destroyed.

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APPROVED BY THE HEALTH AND DISABILITIES NORTHERN Y REGIONAL ETHICS COMMITTEE ON 7.7.2011 Reference Number NTY/11/05/053

Name………………………………………………………………………………………………………..
Signature………………………… Date……………………

_________________________________________________________________________________

A comparison of a stress management group programme delivered to two different populations – version 2.

Page 1
Appendix F2
Consent Form (Participant)
Focus Group / Interview
(This consent form will be held for a period of ten years)

Project Title: A comparison of a 5 week stress management group programme delivered to both University students and clients in an alcohol and other drug treatment setting.

Researcher: Theresa Martinovich

I have read the Participant Information Sheet, and understand the nature of the choice I am making in deciding whether to take part in a focus group discussion or an interview after week 5 of the group programme. I agree to take part in a group interview / an individual interview (delete one).

- I agree to not disclose anything discussed in the group interview. I understand confidentiality rests with individual group participants, over whom I have no control.
- I agree/ do not agree to be audio taped for the interview (at or after week 5).
- I understand that I am free to withdraw participation at any time.
- If interviewed individually, I understand I can turn off the tape at any time.
- I understand I can withdraw any data traceable to me up to one week following the individual interview (at the completion of the 5 week group).
- I understand I cannot withdraw group interview data (because of other group members’ information on the same tape). However, I can edit out from the transcript any information that may not be relevant to the study e.g. identifiable information or names.
- I wish / do not wish to receive the summary of findings.
- I understand that the data from this research may be used in conference presentations or articles for publication. I will be anonymous within the research writing.
- I understand that all data from this research will be kept in a locked cabinet at the University of Auckland for ten years, after which time they will be destroyed.

Name………………………………………………………………………………………………………..
Pseudonym Name ………………………………………………………………………………………
Signature…………………………………………………………….. Date…………………………

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 6.7.2011 for 3 years Reference Number 2011/284
APPROVED BY THE HEALTH AND DISABILITIES NORTHERN Y REGIONAL ETHICS COMMITTEE ON 7.7.2011 Reference Number NTY/11/05/053
Appendix G
Participant information Sheet

Research Project: A comparison of a 5 week stress management group programme delivered to both University students and clients in an Alcohol and other Drug treatment setting.

Researcher: Theresa Martinovich

My name is Theresa Martinovich. I am a student at the University of Auckland and am undertaking a research project to complete my Master of Counselling degree. I have practiced as a counsellor for 15+ years, including work with clients who have experienced sexual abuse, domestic violence, challenges with drugs and alcohol (7 years), and presently I work as a University counsellor. I ran a stress management group in Auckland for over two years with clients who identified as having addictions to alcohol and or other drugs. I had feedback about this group, and now want to find out whether this same group programme could be useful and effective with participants in other contexts. I hope to deliver this stress management programme in similar ways to two different groups and compare the participants’ feedback in regards to stress and coping over the 5 week period. The results can provide information to assist planning ongoing courses with these two population groups.

I invite you to be part of this project. There is no outside funding for this research, and participation is voluntary. There is no fee to attend. Participants must be fluent in speaking English. Your involvement would require you to:

a) Contact me via phone or email to discuss your interest in taking part in this group programme and this research project, including providing some factual information about yourself and your reasons for wanting to participate in this course;

b) Attend a 5 week group to learn strategies to manage stress and develop coping skills;

c) Complete two tick-box questionnaires asking about stress levels and present ways of coping – these are completed Session 1 of the group and again in Session 5 to measure changes that may have taken place for you during the group programme;

d) Once group is underway, you will choose whether to take part in either a group discussion, or a one to one interview with me about changes to your stress and coping
levels, your opinions about the course and any changes you would like to see made to the content or delivery of the programme.

The individual interview or the group discussion would be less than one hour, and would occur after the five week group. It would be audio-recorded by digital voice recorder, and the recording would then be transcribed by me or by a professional transcriber who will sign a confidentiality agreement.

Once the recordings are transcribed and checked for accuracy they will be erased. While the recordings and transcripts are in my possession, they will be stored at my home in a locked filing cabinet when I am not working on them. All data will be coded and numbered 1-22 (participant numbers). Data stored on my computer will be password protected. When my research is complete all written information will be transferred to my supervisor’s office at the University of Auckland, where it will be stored securely for a period of ten years. The consent forms will be stored separately from the transcripts in a locked cabinet in my supervisor’s office for ten years. All materials will then be destroyed.

Participants will have the right to withdraw from the project at any time without having to give a reason, and they have the right to withdraw their individual interview data from the research for up to one week after the interview. For University students, neither grades nor academic relationships with the department or members of staff will be affected by either refusal or agreement to participate. For clients in an alcohol and other drug (AOD) treatment setting, neither will relationships with the AOD treatment setting or members of staff be affected by either refusal or agreement to participate.

You will be invited to choose a pseudonym that can be used in the research report. Though I will aim to ensure confidentiality within the group process, I cannot accept responsibility for or ensure other group participants’ actions with regard to maintaining confidentiality. Utmost care would be taken to ensure your anonymity in the research report, should you decide to participate in this project, and all personally identifiable information will be kept confidential by the researcher, according to principles of the University regarding research practices, the DAPAANZ (Drug and Alcohol Practitioners Association Aotearoa NZ) and NZAC (NZ Association of Counsellors) Code of Ethics. I am a full member of both these organisations. In the research project, any identifiable information will be disguised or omitted. The only person who will see the transcripts other than the transcriber and me will be my academic supervisors, Dr Margaret Agee and Dr Jan Wilson, who are also members of NZAC.

Following the completion of the study you will have the opportunity to receive a summary of my findings, via email or post. I may use information from this study in a conference presentation or journal article.

If you have any questions about this study, please do not hesitate to contact me or my supervisors. I am hopeful the group experience will increase your ability to manage stress levels in your life and that you will learn new ways of coping with stress. Thank you very much for the time you have taken to consider being a volunteer participant in this research project. Should you choose to participate, please read and sign the enclosed consent form, and contact me by email or phone to discuss your participation and confirm a place in a stress management group. Group numbers are
strictly limited to fewer than 12. You could either post back the signed consent form and the Factual information questionnaire, or you could bring them to the first group.

Kind regards,
Theresa Martinovich

My details are:
Email  t.martinovich@auckland.ac.nz
Phone 021439144

My supervisors are:
Dr Margaret Agee and Dr Jan Wilson
School of Counselling, Human Services and Social Work,
Faculty of Education, University of Auckland
Private Bag 92601,
Symonds Street,
Auckland.
Phone 373 7599 ext. 87852 or ext. 87577
Email  m.agee@auckland.ac.nz  jd.wilson@auckland.ac.nz

The Head of School is:
Phil Harington
School of counselling, Human Services and Social Work,
Faculty of Education, University of Auckland
Private Bag 92 601
Symonds Street,
Auckland.
Phone 623 8899 ext. 48562
Email  p.harington@auckland.ac.nz

For ethical concerns please contact:
The Chair
The University of Auckland Human Participants Ethics Committee
The University of Auckland, Office of the Vice-Chancellor
24 Princess Street
Private Bag 92019
Auckland 1142.
Phone 373 7599 ext. 83711

Health and Disability Advocate:
North Shore (09) 441 9001
Auckland Central: (09) 525 2700

A comparison of a stress management group programme delivered to two different populations – version 2.
Page 3
To ensure ongoing cultural safety Nga Kai Tataki -0 Maori Research Review Committee Waitemata
DHB encourage those who identify themselves as Maori and who are participating in health research
or clinical trials to seek cultural support and advice from either Mo Wai Te Ora – Maori Health
Services or their own Kaumatua or Whaea.
For assistance please contact the Services Clinical Leader for Mo Wai Te Ora – Maori Health on 09
486 1491 ext: 2324 or the Maori Research Advisor on 09 486 1491 ext: 2553

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COMMITTEE ON 6.7.2011 for (3) years, Reference number 2011/284

APPROVED BY THE HEALTH AND DISABILITY NORTHERN Y REGIONAL ETHICS
COMMITTEE ON 7.7.2011, Reference number NTY/11/05/053

A comparison of a stress management group programme delivered to two different populations – version 2.
Page 4
Appendix H

Transcriber Confidentiality Agreement

**Project Title:** A comparative study of a 5 week stress management group delivered to ‘University students’ and an ‘alcohol and other drug’ group.

**Researcher:** Theresa Martinovich  [t.martiovich@auckland.ac.nz](mailto:t.martiovich@auckland.ac.nz) phone 021439144

**Supervisors:** Dr Margaret Agee  [m.agee@auckland.ac.nz](mailto:m.agee@auckland.ac.nz)
Dr Jan Wilson  [jd.wilson@auckland.ac.nz](mailto:jd.wilson@auckland.ac.nz)

**Transcriber:** Fidgety Digits  [fidgetydigits@xtra.co.nz](mailto:fidgetydigits@xtra.co.nz) phone 0274881197

I agree to transcribe the audiotapes for the above research project. I understand that the information contained within them is confidential and must not be disclosed to, or discussed with, anyone other than the researcher and her supervisors.

Name…………………………………………………………………………………………………………………………

Signature……………………………………………………………………………………………………………………

Date…………………………………………………………………………………………………………………………

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 6-7-2011 for 3 years, Reference Number 2011/284
**Table 1**
**INTERVIEW GUIDE  Version 2 – 15.6.2011**

**Questions for student group**

- What level of stress was in your life prior to coming to University, and in what ways did that alter once attending university? And if you gave a rating out of 10 (with 10 being totally stressed and 0 being calm, what rating would you give before and now? (noting changes to stress levels over time, comparable with quantitative research gathered)
- If alcohol and drugs have been used as a coping mechanism in the past, what changes (if any), have you noticed as a result of this course?
- In what ways has your stress changed (if it has done) since completing the 5 week course? What specifically have you, or others who know you noticed that is different? (effectiveness of the course) (comparable with quantitative research gathered)
- What strategies learnt (or already known) are deemed most useful to manage your stress? (effectiveness of the course)
- As you know, I previously ran this group with AOD (alcohol and other drug) clients. In your opinion, what do you think about the pitch or level this course is set at? Is there anything else you would like to contribute about the course? (group content)

**Questions for AOD client group.**

- What level of stress was in your life prior to having an alcohol or drug problem in your life, and in what ways did that alter once you began using drugs or alcohol? If you gave a rating out of 10 (with 10 being totally stressed and 0 being calm, what rating would you give before and now? (noting changes to stress levels over time, comparable with quantitative research gathered)
- If alcohol and drugs have been used as a coping mechanism in the past, what changes have you noticed as a result of this course?
- In what ways has your stress changed (if it has done) since completing the 5 week course? What specifically have you, or others who know you, noticed that is different? (effectiveness of the course) (comparable with quantitative research gathered)
- What strategies learnt (or already known) are deemed most useful to manage your stress? (effectiveness of the course)
- As you know, I am now running this group with University students. In your opinion, what do you think about the pitch or level this course is set at? Is there anything else you would like to contribute about the course? (group content)

**APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 6.7.2011 for 3 years, Reference Number 2011/284, and APPROVED BY THE HEALTH AND DISABILITY NORTHERN Y REGIONAL ETHICS COMMITTEE ON 7.7.2011, Ref. Number NTY/11/05/053**