Crisis Volunteers' Signs and Symptoms of Stress and Their Way of Handling Them

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Abstract- The authors used the data generated from the training entitled "Self-care and Basic Disaster Risk Reduction Management for Crisis Volunteers' and employed the descriptive approach of research design.

Research reveal that majority of the respondents (i.e., the crisis volunteers) were females, falling within the age range of 31 to more than 50 years, married with 1 to 6 children, and college graduates. Utilizing Howatt's (2000) checklist of physiological, psychological, and behavioral signs and symptoms of stress, the respondents were asked to identify the extent of their experiences with each of the items indicated therein. Under the physiological category, the crisis volunteers were found *"Sometimes"* (i.e., within the moderate scale of 1.67 – 2.33) experiencing headache/migraine, back pain, insomnia, chronic illness/flu, and excessive perspiration while anger symptom was found under the psychological category. No behavioral sign and symptom of stress was reported.

Adopting the Therapeutic Lifestyle Changes (TLCs) of Ivey, Ivey, and Zalaquet (2014), the majority of the respondents committed to include as part of their coping strategies: (1) do at least 10 minutes of exercise everyday; (2) fulfill the sleep requirement of 7 to 9 hours; (3) lessen intake of food high in salt, monosodium glutamate (MSG), sugar, caffeine, and saturated fats; (4) avoid the deadly habits of complaining and criticizing; and (5) immerse in positive self-talk; (6) develop a humorous attitude at all time; and (7) make meditations as part of their daily routine.

Index Terms- Crisis volunteers, Stress, Physiological, Psychological, Behavioral

I. Introduction

Crisis volunteers are on the frontlines of providing physical and psychological services to the victims in the aftermath of any kind of disaster. According to Bartley (2007), such efforts are truly altruistic. They are dedicated to helping those in need rebuild their lives and reach their full potential (Volunteers of America, 2010).

In an actual volunteerism experience, Regan (2014) relates that responding to the aftermath of a crisis requires meeting not only physical demands but also mental challenges. To prevent the possibility of impairment while rendering help to disaster victims, the crisis volunteers need to practice self-care. Self-care is one of the important aspects of healthy lifestyle (Mahdizadeh & Solhi, 2018) that crisis volunteers should commit themselves to practice throughout their lives and careers.

A commitment to self-care, according to Miller (2012), can simply help crisis volunteers with their physiological, psychological, and spiritual vulnerabilities. In a study conducted on volunteering, Toman and Leichtman (2010) presented Covey's (1989) idea that it is imperative to take care of one's personal needs before one can consider taking care of others. For the crisis volunteers to thrive and maintain their stamina while meeting the needs of their clients, they should strengthen their vulnerabilities by improving their coping abilities.

Corollary, a training on self-care was provided to a group of crisis volunteers. The framework of the said training was patterned after the Stress Inoculation Training (SIT) which was developed by Donald Meichenbaum, a renowned behaviorist. This training program is composed of three phases: (1) the conceptual phase, (2) the skills acquisition phase, and (3) the follow-through phase.

Similar to the conceptual process of the SIT, the training provided an opportunity to crisis volunteers to conceptualize their current level of stress on aspects of physiological, psychological, and behavioral. For skills acquisition phase, the participants were provided with various therapeutic lifestyle changes for them to explore, contemplate, and act upon. And finally, for follow-through phase, the participants were asked to make an action plan as basis in monitoring and evaluation of the aftereffect of the training.

To better understand how the participants are able to learn from the training, understand and assess their current physiological, psychological, and behavioral conditions, and make commitments to change, a deeper analysis is hereby carried out. Hence, this research.

Generally, the research aims to identify the participants' signs and symptoms of stress, and how will they handle them. Specifically, it aims to:

1. Ascertain the participants' demographic profile in terms of sex, age, marital status, number of children, and educational attainment;
2. Identify the participants' physiological, psychological, and behavioral signs and symptoms of stress, and rank-ordered them; and
3. Determine the participants' ways and schemes of adopting positive lifestyle changes in terms of maintaining an exercise program, fulfillment of sleep requirement, lessening intake of unhealthy substances, avoidance of unhealthy habits of interrelationships, immersion in positive self-talk, developing humorous attitudes, and practicing meditation.

II. RESEARCH AND COLLECT IDEA

Research Design

Basically, the study is a descriptive type of research. The data which were directly collected from the participants during the training, using survey instruments, were analyzed to describe their demographics, the stress they are currently experiencing, and the manner in which they will improve their physiological, psychological, and behavioral conditions.

Research Participants

The trainees of the first part of the training entitled "Seminar-Workshop on Self-Care and Basic Disaster Risk Reduction and Management for Crisis Volunteers" will be the subject of the research. Table 1 shows the distribution of the participants by office affiliation. As shown, the total number of participants was 42, 36 or 85.7 percent came from the Local Government Unit of Baler (LGU-Baler) while 6 or 14.3 percent came from Aurora State College of Technology (ASCOT). These participants were all involved in providing services to victims of disaster.

Table 1. Distribution of research participants by office affiliation.

OFFICE AFFILIATION	NUMBER	PERCENT
LGU-Baler	36	85.7
ASCOT	6	14.3
TOTAL	42	100.0

Survey Instrument

There were two (2) survey instruments used in the study, both of them were improvised by the researchers. The first one (see Appendix 1) was divided into two parts, namely: Part I – Demographic Information of the Participants, and Part II – Checklists of Signs and Symptoms of Stress according to Physiological, Psychological, and Behavioral. The checklists were adopted from Howatt's (2000) work; were translated in Filipino; and were added with response options scaled at 3 = High, 2 = Moderate, and 1 = Low.

The other improvised instrument (see Appendix 2) was adopted from the Therapeutic Lifestyle Changes (TLCs) introduced by Ivey, Ivey, and Zalaquett (2014). Both the instruments were self-administered.

Data Analysis

The data were tabulated and analyzed using the Software Package for Social Science (SPSS). All the demographic variables

were analyzed and presented using frequency distribution. In determining the rank-orders of the physiological, psychological, and behavioral signs and symptoms of stress encountered by the participants, average frequency was used. In examining the schemes and ways to be adopted by the participants to improve their well-being, (the) frequency distribution was also used.

Theoretical/Conceptual Framework of the Study

The study draws a lot from the Transtheoretical Model (TTM) of Change developed by Prochaska, Norcross, and DiClemente (Seligman & Reichenberg, 2014). As presented, the model provides a theory of behavior change that incorporates elements from many different theoretical perspectives (hence, the name, *transtheoretical*).

TTM is intended to apply to mental health and behavioral health problems (Seligman & Reichenberg, 2014) and is used to identify a number of stages that clients experience as they progress through lifestyle modifications (Link, 2013). Each individual's stage of change is determined using the five (5) stages of change provided by the model, and these are: (1) Precontemplation, (2) Contemplation, (3) Preparation, (4) Action, and (5) Maintenance.

Prochaska, et. al. (2013) provide the following descriptions of each stage:

1. Precontemplation Stage - Precontemplators process less information about their problems, devote less time and energy to reevaluating themselves, and experience fewer emotional reactions to the negative aspects of their problems. In therapy, these are the most resistant or the least active clients.
2. Contemplation Stage - Individuals in this stage are most open to consciousness(-)raising techniques, such as observations, confrontations, and interpretations, and are much more likely to use bibliotherapy and other educational techniques. Contemplators also profitably employ emotional arousal, which raises emotions and leads to a lowering of negative affect when the person changes. As individuals became (become) more conscious of themselves and the nature of their problems, they are more likely to reevaluate their values, problems, and themselves both affectively and cognitively.
3. Preparation Stage -Individuals in preparation begin to take small steps toward action.
4. Action Stage - During the action stage, people use higher levels of self-liberation or willpower. They believe increasingly that they have the autonomy to change their lives in key ways.
5. Maintenance Stage - Continuing to apply counterconditioning, stimulus control, and contingency management is most effective when based on the conviction that maintaining change supports a sense of self that is highly valued by oneself and significant others.

Obviously, the trainees were pre-contemplating prior to their participation ~~to~~ (in) the training. They do not consider improving their physical, psychological, and behavioral conditions. However, upon hearing lessons on understanding the importance of self-care, they begin to become aware of their physiological, psychological, and behavioral conditions. As stipulated in their action plans, the trainees were starting to take a step toward improvement.

In adopting the TTM in the study, it can be patterned that the participants had already undergone the first three stages, i.e., Precontemplation, Contemplation, and Preparation. The Action and Maintenance stages could possibly be realized later as part of the recommendation of the study, i.e., to monitor and evaluate the execution of the action plans that were prepared by the participants.

Corollary, the current study could be best pursued using the Context, Input, Process, and Product (CIPP) Model. This model was developed by Daniel Stufflebeam and colleagues in the 1960s. The idea of improving (the) health and wellness of crisis volunteers for them to become physiological, psychologically, and behaviorally prepared in performing their role as such, constitutes the **context** of the study. The proposed training or psychoeducation will form part of the **input** while the adoption and practice of the Therapeutic Lifestyle Changes (TLCs) that they will learn from the training will constitute the **process** that would result into an **output or product** of having an improved health and wellness. Figure 1 depicts the flow of the study using the CIPP Model.

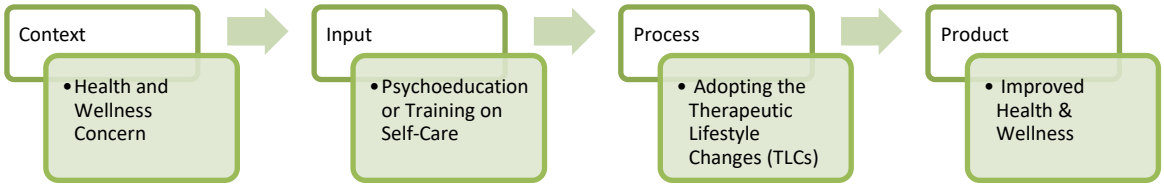

Figure 1. Paradigm of the study using the CIPP Model.

III. WRITE DOWN YOUR STUDIES AND FINDINGS

The data collected from the training were summarized, analyzed, and discussed, and were logically presented below. The first part encompasses the demographics of the participants. It includes age, gender, marital status, number of children, and educational status. These were summarized and presented using frequency distribution. The data regarding the participants' signs and symptoms of stress composed the second part. For ease of analyses, these were categorized into physiological, psychological, and behavioral, and were ranked-ordered. Lastly, the action plans of the participants within the context of therapeutic lifestyle change compose the third part. Like the data in the first part, these were also summarized and presented using frequency distribution.

I. Demographic Profile of the Participants

Gender. Table two shows the distribution of participants by gender. Of the total participants, thirty-six (36) or 85.7 percent were composed of females and only 6 or 14.3 percent were males. Such distribution is expected because majority of the participants were volunteer workers of Baler Social Welfare and Development Office who were mostly females. The result is consistent with Forsman and Barth's (2017) contention that men are underrepresented in social work careers.

Table 2. Distribution of participants by gender.

GENDER	NUMBER	PERCENT
Female	36	85.7
Male	6	14.3
TOTAL	42	100.0

Age. The ages of the respondent were grouped as indicated in table three. As shown, there were 11 or 26.2 percent of the participants who fell within the age group of 41 – 50, followed by the same number of participants (No. = 10, % = 23.8) within the age groups 31 40 and less than 50 years, and 5 or 11.9 within the age group 30 years and below. As shown in the table, 6 or 14.3 of the participants did not reveal their age. Gleaning from the results, there were about 75 percent of the participants who belonged to the age range of 31 - >50. This suggests that majority of the participants were on their adulthood stage.

Table 3. Distribution of participants by age group.

AGE GROUP	NUMBER	PERCENT
30 yrs & below	5	11.9
31 – 40	10	23.8
41 – 50	11	26.2
> 50	10	23.8
No response	6	14.3
TOTAL	42	100.0

Marital Status. Table four shows the distribution of marital status of the participants. As gleaned from the table, majority of the participants (32 or 76.2%) were married while the other participants were revealed as single (4 or 9.5%), separated (4 or 9.5%), and widow/er (2 or 4.8%).

Table 4. Distribution of participants by marital status.

MARITAL STATUS	NUMBER	PERCENT
Single	4	9.5
Married	32	76.2
Widow/er	2	4.8
Separated	4	9.5
TOTAL	42	100.0

Number of Children. The distribution of the participants by number of children is shown in table five. As revealed in the table, 20 or 47.6 percent of the participants had 1 – 3 children, followed by 11 (26.2%), 2 (4.8%), and 1 (2.4%) participants with 4 – 6, more than 6, and no children, respectively.

Table 5. Distribution of participants by number of children.

NO. OF CHILDREN	NUMBER	PERCENT
None	1	2.4
1 – 3	20	47.6
4 – 6	11	26.2
>6	2	4.8
No response	8	19.0
TOTAL	42	100.0

Educational Attainment. Table six shows the distribution of participants by educational attainment. As indicated, majority of the participants (N = 29, % = 69%) were college graduate. Others had reached college (N = 5, % = 11.9), graduated from high school (N = 4, % = 9.5), graduated from their master's degree (N = 2, % = 4.8%), graduated from doctorate degree (N = 1, % = 2.4), and had attended high school (N = 1, % = 2.4).

Table 6. Distribution of participants by educational attainment.

EDUCATIONAL ATTAINMENT	NUMBER	PERCENT
High school level	1	2.4
High school graduate	4	9.5
College level	5	11.9
College graduate	29	69.0
Master's graduate	2	4.8
Doctorate	1	2.4
TOTAL	42	100.0

II. Participants' Signs and Symptoms of Stress Following Howatt's (2000) checklist of physiological, psychological, and behavioral signs and symptoms of stress, participants' extent of experiencing these signs and symptoms of stress were assessed using the scale: 3 for "Always"; 2 for "Sometimes"; and 1 for "Never".

Physiological Signs and Symptoms of Stress. Table seven shows the rank-ordered signs and symptoms of the participants' physiological stress. As shown in the table, the number one physiological sign and symptom of stress experienced by the participants was headache/migraine, followed by back pain (Rank = 2), by insomnia, chronic illness/flu, and excessive perspiration (All = Rank 4), dizziness (Rank = 6), sexual dysfunction and overeating (Both Rank = 7.5), fatigue (Rank = 9), and pounding heart (Rank =10).

Headache/migraine was likely to come in first because most of the participants were women who were within their menopausal period. As implied in WebMD (n.d.), headache/migraine is commonly experienced by women during their menopausal stage because of hormonal changes and with stress, this gets worse. Other reported signs and symptoms of stress i.e., back pain, insomnia, chronic illness/flu, excessive perspiration, dizziness, sexual dysfunction, overeating, fatigue, and pounding heart were some underlying outcomes of the worsening physiological conditions brought about by the combining effect of hormonal changes and stress.

Table 7. Rank-ordered physiological signs and symptoms of participants' stress.

PHYSIOLOGICAL SYMPTOM	AVERAGE FREQUENCY	RANK
Headache/migraine	1.88	1
Back pain	1.83	2
Insomnia	1.71	4
Chronic illness/flu	1.71	4
Excessive perspiration	1.71	4
Dizziness	1.62	6
Sexual Dysfunction	1.60	7.5
Overeating	1.60	7.5
Fatigue	1.57	9
Pounding heart	1.52	10

Psychological Signs and Symptoms of Stress. The ranked-ordered signs and symptoms of the participants' psychological stress are shown in Table 8. As indicated, the rank-orders of the psychological signs and symptoms of stress being encountered by the participants starts with anger (Rank = 1), followed by irritability (Rank = 2), boredom and inability to concentrate (both Rank = 3.5), and guilt (Rank = 5).

The reported psychological conditions of anger, irritability, boredom, inability to concentrate, and guilt by the participants were likely to occur as a result of their previously reported physiological signs and symptoms of stress. This result is consistent with Khan's (2016) explanation that psychological symptoms are accompanied or preceded by other symptoms which could be categorized as physiological or psychological.

Table 8. Rank-ordered psychological signs and symptoms of participants' stress.

PSYCHOLOGICAL SYMPTOM	AVERAGE FREQUENCY	RANK
Anger	1.68	1
Irritability	1.44	2
Boredom	1.34	3.5
Inability to concentrate	1.34	3.5
Guilt	1.30	5

Behavioral Signs and Symptoms of Stress. Table nine shows the rank-ordered behavioral signs and symptoms of participants' stress. As shown, the order of behavioral signs and symptoms of stress reported by the participants were rapid mood swing (Rank = 1), moving in tense (Rank = 2), jerky ways and touching hair, ears, or nose (both Rank = 3.5), and biting lips and trembling hands (both Rank = 5.5).

As revealed in the table, the rapid mood swing being encountered by the participants was consistent with their psychological symptoms of anger and irritability. Based on the explanation by Silver (2018), rapid mood swings can occur due to mental health conditions and hormonal changes.

Table 9. Rank-ordered behavioral signs and symptoms of participants' stress.

BEHAVIORAL SYMPTOM	AVERAGE FREQUENCY	RANK
Rapid mood swing	1.24	1
Moving in tense	1.23	2
Jerky ways	1.15	3.5
Touching hair, ears, or nose	1.15	3.5
Biting Lips	1.12	5.5
Trembling hands	1.12	5.5

III. Respondents' Action Plan Adopting the Therapeutic Lifestyle Changes (TLCs)

During the training, seven (7) sets of Therapeutic Lifestyle Changes (TLCs) were presented and discussed to the participants. These include maintaining an exercise program, attaining the prescribed sleep requirement, maintaining proper nutrition, practicing the caring habits to attain harmonious relationships, developing positive self-talk, endorsing laughter and humorous attitudes, and practicing meditation. Knowing that these are therapeutic and helpful tips, participants were asked to prepare their action plans as part of their commitments to change and improve their physiological, psychological, and behavioral conditions.

Maintain an Exercise Program

Table ten shows the distribution of participants by scheme of their exercise program. As shown, majority of the participants (No. = 29, % = 74.4) committed to do at least 10 minutes of exercise everyday while the rest committed to do at least 10 minutes of exercise 2-3 times a week (No. = 6, % = 15.4), do at least 10 minutes of exercise once in a week (No. 3, % = 7.7), and any of the 3 choices (No. = 1, % = 2.6). These suggest that participants are committed to avoid sedentary or inactive lifestyle. According to MedlinePlus (n.d.), having an inactive lifestyle can be one of the causes of many chronic diseases and risks of premature deaths.

Table 10. Distribution of participants' response by scheme of their exercise program.

SCHEME	**NUMBER**	**PERCENT**
Do at least 10 minutes of exercise everyday	29	74.4
Do at least 10 minutes of exercise 2-3 times a week	6	15.4
Do at least 10 minutes of exercise once in a week	3	7.7
Any of the 3 choices	1	2.6
TOTAL	39	100.0

Fulfill the Sleep Requirement

The distribution of the participants' responses as to fulfillment of sleep requirement of 7 – 9 hours is shown in Table eleven. As revealed in the table, majority of the participants (No. = 33, % = 84.6) were committed to fulfill the sleep requirement of 7 – 9 hours while the remaining participants (No. = 6, % = 15.4) did not provide their responses. Not fulfilling the required or ideal number of hours of sleep may pose physiological and psychological problems. As pointed out in Mann's (2017) article:

Not only does poor sleep seriously affect your health, studies show it can also have negative effects on cognitive ability, creative thinking, memory retentions, and work performance. In short, if you're not getting the right amount of quality sleep, your daytime productivity is going to suffer badly.

Table 11. Distribution of participants' responses in fulfilling the sleep requirement.

FULFILLMENT OF THE 7-9 HOURS SLEEP REQUIREMENT:	**NUMBER**	**PERCENT**
With response	33	84.6
Without response	6	15.4
TOTAL	39	100.0

Lessen Intake of Food High with Unhealthy Substance

Table twelve shows the distribution of participants' responses in practicing healthy diet. Participants were committed to lessen intake of food high in salt (No. = 26, % = 66.7), monosodium glutamate (MSG) (No. = 23, % = 59.0), sugar (No. = 22, % = 56.4), caffeine (No. = 22, % = 56.4), and saturated fats (No. = 21, % = 53.8).

As recommended by Ohio State University Wexner Medical Center (2018), everyone should maintain a heart-healthy diet by taking in food low in saturated fats, sodium, and added sugar to help control or decrease cholesterol and triglycerides in the blood, and control or decrease blood pressure and fluid retention. A heart-healthy diet leads to healthy physiological and psychological well-being.

Table 12. Distribution of participants' responses to lessen intake of food high with unhealthy substance.

LESSEN INTAKE OF FOOD HIGH IN:	NUMBER	PERCENT
Salt	26	66.7
MSG	23	59.0
Sugar	22	56.4
Caffeine	22	56.4
Saturated Fats	21	53.8

Nurture Healthy Relationship

The distribution of participants' responses in affirming to avoid deadly habits is shown in table thirteen. Participants affirmed to avoid complaining (No. = 23, % = 59.0), criticizing (No. = 20, % = 51.3), nagging (No. =16, % = 41.0), bribing (No. = 14, % = 35.9), blaming (No. = 11, % = 28.2), threatening (No. = 8, % = 20.5), and punishing (N0. = 8, % = 20.5).

In the article prepared by Humphries (2017), these habits were termed by Dr. William Glasser, renowned psychologist and was known as the father of Choice Theory and Reality Therapy, as deadly as these either completely kill connection or destroy a relationship, at the very least, or cause it to become dysfunctional. The author further argues that to achieve healthy relationships these deadly habits should be consciously substituted by caring habits such as supporting, trusting, listening, accepting, respecting, encouraging, and negotiating differences.

Table 13. Distribution of participants' affirmation to avoid deadly habits.

AVOID DEADLY HABITS OF:	NUMBER	PERCENT
Complaining	23	59.0

Criticizing	20	51.3
Nagging	16	41.0
Bribing	14	35.9
Blaming	11	28.2
Threatening	8	20.5
Punishing	8	20.5

Immerse in Positive Self-Talk

The distribution of participants' responses to immerse in positive self-talk is presented in table fourteen. As shown, almost all of the participants (No. = 37, % = 94.9) responded to immerse positive self-talk. This suggests that participants gained insights about the importance of immersing in positive self-talk. Ford (n.d.) provides some of the benefits of immersing in positive self-talk. Among these are: (1) helps boost confidence, (2) introduces optimistic thoughts, (3) eliminates stress, (4) lowers the risk of suffering from heart diseases, and (5) improves physical performance.

Table 14. Distribution of participants' responses to immerse in positive self-talk.

IMMERSE IN POSITIVE SELF-TALK	NUMBER	PERCENT
With response	37	94.9
Without response	2	5.1
TOTAL	39	100.0

Develop Humorous Attitude

The distribution of participants' responses in developing a humorous attitude is shown in table fifteen. Almost all of the participants (No. 37, % = 94.9) responded to develop a humorous attitude at all times while only 2 or 5.1 percent failed to respond. This is a manifestation that participants agreed to include laughter and humor as part of a healthy lifestyle.

Table 15. Distribution of participants' response in developing humorous attitude.

DEVELOP A HUMOROUS ATTITUDE AT ALL TIMES	NUMBER	PERCENT
With response	37	94.9
Without response	2	5.1
TOTAL	39	100.0

Practice Meditation

Table sixteen shows the distribution of participants' responses as to the scheme of practicing meditation. As revealed, majority of the participants (No. = 35, % = 89.7) committed to make meditation as part of their daily routine while the rest reported to do meditation when needed (No. = 2, % = 5.1) do either of the scheme (No. = 2, % = 5.1). The results indicate that participants were becoming aware of the importance of meditation.

As the saying goes, laughter is the best medicine. This has been supported in lots of literature. Robinson, Smith, and Segal (2018), for example, underscore the benefits of humor and laughter. As enumerated by the authors, included among the physiological and psychological health benefits are: (1) Boosts immunity, (2) Lowers stress hormones, (3) Decreases pain, (4) Relaxes muscles, (5) Prevents heart disease, (6) Adds joy and zest to life, (7) Eases anxiety and tension, (8) Relieves stress, (9) Improves mood, and (10) Strengthens resilience.

Table 16. Distribution of respondents' response as to scheme of practicing meditation.

SCHEME	NUMBER	PERCENT
Make it as part of the daily routine	35	89.7
Do meditation when needed	2	5.1
Both	2	5.1
TOTAL	39	100.0

IV. CONCLUSION

For the demographic profile of the participants, the results reveal that majority of them were found to be females, falling within the age range of 31 to more than 50 years, married with 1 to 6 children, and college graduates. As found, their rank-ordered signs and symptoms of physiological stress include: Rank 1 - Headache/migraine, Rank 2 – Back pain, Rank 4 – Insomnia, Chronic illness/flu, Rank 6 – Dizziness, Rank 7.5 – Sexual dysfunction and Overeating, Rank 9 – Fatigue, and Rank 10 – Pounding heart.

For the signs and symptoms of psychological stress, participants' reports were rank-ordered and were found as: Rank 1 – Anger, Rank 2 – Irritability, Rank 3.5 – Boredom and Inability to concentrate, and Rank 5 – Guilt. And lastly, the rank-orders of the participants' signs and symptoms of behavioral stress were found as: Rank 1 – Rapid mood swings, Rank 2 – Moving in tense, Rank 3.5 = Jerky ways and Touching hair, ears, or nose, and Rank 5.5 – Biting lips and Trembling hands.

In their action plans, more than half to majority of the participants committed to (1) Do at least 10 minutes of exercise everyday, (2) Fulfill the sleep requirement of 7 – 9 hours, (3) Lessen intake of food high in salt, monosodium glutamate (MSG), sugar, caffeine, and saturated fats, (4) Avoid the deadly habits of complaining and criticizing, (5) Immerse in positive self-talk, (6) Develop a humorous attitude at all times, and (7) Make meditation as part of their daily routines.

Based from the foregoing results, the authors recommend the following::

1. The female participants, who were within their menopausal stage, are advised to seek medical and psychological attention and care to avoid the worsening outcomes (i.e., physiological and psychological) of such developmental concern.
2. The remarkable findings on the physiological and psychological symptoms and signs of stress would remind the participants to start liberating themselves from such conditions through lifestyle modifications.
3. It is suggested that the action plans of the participants be monitored and evaluated to determine the extent of its implementation.
4. The same instrument used in assessing the signs and symptoms of stress will be administered again to the participants to determine if there are changes in the previously found signs and symptoms of stress of the participants. The pre-test and post-test results will be subjected to statistical analysis using analysis of variance (ANOVA). The result of the analysis will serve as the basis for determining the effectiveness of the training conducted.

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