Promoting Wellbeing Among People Experiencing Homelessness: A Feasibility Study

Autora: Ana María Vucic Sánchez

Tutora: Rocío Caballero Campillo

Facultad de Ciencias Humanas y Sociales

Madrid

Mayo de 2025

Table of contents

Abstract

Women experiencing homelessness (WEH) face complex challenges that negatively impact their subjective wellbeing (SWB). This pilot study evaluated the feasibility, acceptability, and preliminary outcomes of the group intervention Think and Cope Positively (TC+) to enhance SWB among WEH. The program, grounded in positive psychology, cognitive-behavioral therapy, and acceptance and commitment therapy, was adapted to the context of a homeless shelter. Fourteen women were recruited, with 13 initiating treatment and 8 completing at least half of the sessions. Measures included standardized assessments of SWB, life satisfaction, self-esteem, self-efficacy, openness to the future, and psychological symptoms. Results indicated high feasibility, with strong in-session engagement and protocol adherence, although attendance decreased over time due to external factors such as emotional instability, substance use, or housing changes. Participant satisfaction was high, with qualitative feedback emphasizing the value of group cohesion, optimism-focused content, and emotional support. Significant improvements were observed in SWB and self-efficacy for most participants, as well as reductions in psychological symptomatology. The program was deemed safe and well-received by both participants and therapists. Findings highlight the potential of TC+ as a relevant and low-cost intervention to promote SWB among WEH. Future research should evaluate its effectiveness with larger samples and a control group, and consider shorter, modular formats to enhance accessibility. This study contributes to addressing the psychological needs of people experiencing homelessness, offering evidence-based tools to complement structural and social support services.

Key words: homelessness, homeless women, subjective wellbeing, self-efficacy, group intervention, feasibility, intervention adaptation.

Resumen

Las mujeres afectadas por el sinhogarismo (MAS) enfrentan desafíos complejos que afectan negativamente su bienestar subjetivo (BS). Este estudio piloto evaluó la viabilidad, aceptabilidad y resultados preliminares de la intervención grupal Piensa y Actúa en Positivo (PA+) para mejorar el BS en MAS. El programa, basado en psicología positiva, terapia cognitivo-conductual y terapia de aceptación y compromiso, fue adaptado al contexto de los centros de acogida y albergues. Participaron 14 mujeres; 13 iniciaron el tratamiento y 8 completaron al menos la mitad de las sesiones. Se usaron medidas estandarizadas de BS, satisfacción con la vida, autoestima, autoeficacia, apertura al futuro y síntomas psicológicos. Los resultados mostraron alta viabilidad, buena participación y adherencia al protocolo, aunque la asistencia disminuyó por factores como inestabilidad emocional, consumo de sustancias o cambios en la vivienda. La satisfacción fue alta; las participantes valoraron la cohesión grupal, el enfoque en el optimismo y el apoyo emocional. Se observaron mejoras en BS y autoeficacia, además de reducciones en síntomas psicológicos. El programa fue seguro y bien recibido por participantes y terapeutas. PA+ demuestra ser una intervención prometedora de bajo coste para promover el BS en MAS. Se recomienda investigar su efectividad en muestras más grandes y con un grupo control, y explorar formatos más breves y modulares para mejorar el acceso. Este estudio contribuye a cubrir necesidades psicológicas de personas afectadas por el sinhogarismo, ofreciendo herramientas basadas en evidencia para complementar los apoyos estructurales y sociales.

Palabras clave: sinhogarismo, mujeres sin hogar, bienestar subjetivo, autoeficacia, intervención grupal, viabilidad, adaptación de intervención.

1. Introduction

1.1 Prevalence, Definition, and Theoretical Framework: A Contextual Overview

As of 2023, 26.5% of Spanish people were at risk of poverty and social exclusion (Eurostat, 2024), with homelessness being an extreme way of experiencing these circumstances (Watson et al., 2016). In Spain, 28,552 homeless people received assistance from housing and reintegration centers in 2022 (National Statistics Institute [INE]), exemplifying the severity of the problem in the country.

People experiencing homelessness (PEH) are an extremely vulnerable population, given the numerous biopsychosocial disadvantages that negatively impact their lives (Dickins et al., 2023; Van Straaten et al., 2016). While there has been a lot of discussion around defining homelessness, the ETHOS (European Typology of Homelessness and Housing Exclusion) approach includes housing situations which lack or are compromised in either one or all three of the following domains (Amore et al., 2011): physical (referring to an adequate space to fit the person's or family's needs), social (the person may enjoy privacy and social relationships in their space), and legal (the person has exclusive legal rights over the space). Individual factors that might work as predictors for experiencing homelessness include adverse life events, physical and mental health conditions, substance abuse problems, unemployment, poverty, insecure housing, crime, violence, family instability, hindered social support, and history of incarceration (Giano et al., 2019; Nilsson et al., 2019). In Spain, specifically, the primary reason behind someone entering homelessness was having to start from scratch after arriving from another country (28.8%), followed by having lost their job (26.8%), being evicted from their house (16.1%), not being able to pay for their housing (14.7%), separating from their partner (14.1%), addiction problems (12.6%), hospitalization (11.1%), relocating (9.6%), themselves or their children suffering violence (9.6%), as well as several additional causes (INE, 2022). The long list of reasons strongly implicates the multicausality behind homelessness.

Within this population, 23.3% of PEH in Spain are women, a percentage that has increased over the last decade (INE, 2022). Although gender contributes to different experiences (Phipps et al., 2018), markedly less has been published on women experiencing homelessness (WEH) than men, particularly in Europe (Mayock & Bretherton, 2017). Trajectories into homelessness, specifically for women, commonly include a lack of income, eviction, problems with substance use, abuse, and domestic violence (Duke & Searby, 2019; Phipps et al., 2018). Women use more services than men,

although this does not indicate that their needs are better met (De Vet et al., 2019). Some challenges women have identified as interfering in their service engagement include unresolved trauma, social exclusion, poverty, lack of sustainable housing, and ineffective services (Schmidt et al., 2015).

1.2 Impact and Consequences: Effects of Homelessness on Individuals' Lives

Homelessness is linked to multiple adverse implications. The United Nations has recognized homelessness as a violation of human rights: those affected are gravely discriminated against on both personal and institutional levels, homelessness is the cause of numerous premature deaths every year, and is associated with worse health conditions (Seastres et al., 2020; United Nations, 2021). One of the major implications of homelessness is its detrimental effect on a person's mental health, as social exclusion among PEH is associated with greater psychological distress and deteriorated mental health (Van Straaten et al., 2016). The effects of homelessness on mental health can manifest themselves in various ways, such as severe mental disorders, addiction, or suicide (Moledina et al., 2021). In Spain, nearly 60% of PEH receiving assistance presented depressive symptoms. This percentage is even higher among women (67.8%), while the rates are much lower among housed people (12.9% and 16.6% respectively; INE, 2022). Both the presence of recent life stressors and a diminished sense of purpose in life have significant relationships with depression scores among PEH (Sharpley et al., 2021). When contrasting different experiences according to gender, women experience more psychological distress and lower self-esteem than their male counterparts (De Vet et al., 2019), and service providers highlight the need for more mental health care among WEH (Salem et al., 2017). They are more exposed to stressful life events throughout their lives and present high rates of posttraumatic stress disorder, which are significant risk factors for developing psychological disorders (De Vet et al., 2019; Dickins et al., 2023; Rodriguez-Moreno et al., 2020a). It is also interesting to note that some women have histories of pre-existing mental health problems that contribute to their homelessness, whereas other women develop mental health conditions as a result of being homeless (Duke & Searby, 2019).

Accordingly, a bidirectional relationship has been identified between homelessness and mental health (Padgett, 2020), indicating the importance of offering help and mechanisms to improve the mental wellbeing of PEH. Partly due to the reasons discussed, PEH tend to have a lower subjective wellbeing and quality of life than housed

people (Ahuja et al., 2020; Hubley et al., 2012). Importantly, the tendency towards a lower wellbeing appears to be greater among women, especially women of color (Ahuja et al., 2020).

1.3 The Role of Wellbeing in People Experiencing Homelessness

While access to housing is extremely important for the wellbeing of PEH (Watson et al., 2016), and may be the most effective way of eradicating homelessness (O'Regan et al., 2021), solely having a roof over one's head is not enough to guarantee the person's psychosocial wellbeing (Marshall et al., 2024). The relationship between various elements or programs and their ability to impact the wellbeing of PEH has been explored, such as social support and Housing First programs (Addo et al., 2021; Baxter et al., 2019; Miler et al., 2021a), trauma-informed designs (Ajeen et al., 2023), or harm-reduction interventions for substance abuse (Parkes et al., 2022). PEH have identified programs' features that could potentially help their health and wellbeing: programs that integrate health and social care, supportive relationships with professionals, and flexible services (Omerov et al., 2019).

Studies and literature reviews also tend to focus more on structural contributors to homelessness and psychiatric or community interventions than on psychological ones (Bodley-Scott et al., 2024; Rodriguez-Moreno et al., 2020b). Nonetheless, psychosocial interventions for PEH have proven to be effective in improving their mental health (Hyun et al., 2019). Although the psychological components receive less specific attention, it is important that PEH are given the opportunity to improve their subjective wellbeing (SWB) along with improving their living conditions and socioeconomic circumstances (Ahuja et al., 2020).

There are two principal facets to SWB, denominated as hedonic and eudaimonic wellbeing (Ryan & Deci, 2001). Hedonic wellbeing describes the dimension pertaining to positive emotions, like life satisfaction, and what we might generally consider as "feeling good." On the other hand, eudaimonic wellbeing is more persistent and sustainable over time as it relates to life purpose, autonomy, mastery over the environment, self-acceptance, positive personal relationships, and personal growth (Ryff & Keyes, 1995). Being more complex and difficult to attain, eudaimonic wellbeing may require more attention and active work in order to improve these aspects of our SWB.

Some programs designed for PEH have evaluated their impact on their SWB, and these included various noteworthy components. Studies highlight the importance of a

trusting relationship with the staff implementing the intervention as helpful for engagement (Parkes et al., 2022), solidarity and the quality of social relationships (Matulič-Domadzič et al., 2020), empowering service users and promoting agency (Toolis et al., 2022), and receiving motivational messages and working on coping strategies (Straka et al., 2022). One specific program that aims to help wellbeing among youth experiencing homelessness is the My Strengths Training for Life™ (MST4Life™ program), which is principally strength based and focuses on developing intrapersonal and interpersonal mental skills. These include working on self-regulation, confidence, and resilience, along with working in group formats, in order to practice respect for others and coping with pressure (Cumming et al., 2022). These factors may all be related to what has been identified as forming part of SWB.

Focusing first on the hedonic aspect of SWB, is the important role of positive emotions. Fredrickson (2001) demonstrated that positive emotions result in benefits for our style of thinking, specifically our automatic thoughts, promoting more flexible and adaptive thinking. This broadens an individual's momentary thought–action repertoire, which in turn can build that individual's enduring personal resources and ability to adapt to their environment. Among PEH, poor emotional regulation has been identified as a mechanism that can contribute to the maintenance of paranoia, mental health conditions, and maladaptive behavior (Powell & Maguire, 2017). Given that PEH tend to have a higher frequency of negative emotions than the housed population (Ahuja et al., 2020) and the increased levels of psychological distress in women specifically (De Vet et al., 2019), the promotion of positive emotions is crucial when trying to achieve a positive state within a person's affect balance. This would mean that positive emotions have a greater presence in the person's life than negative emotions (Bradburn & Noll, 1969). In addition, trait mindfulness helps develop resilience in PEH, which is an important factor for their SWB and is mediated by emotional states of inner peace as well as hopeful thinking (Lu et al., 2020).

SWB can be promoted through a more optimistic outlook on positive life events (Grandchamp et al., 2021). Optimism and SWB have been found to be closely related among different populations and can be described as the degree to which people have favorable expectations about their future (Carver & Scheier, 2010). Lower socioeconomic status has been linked to a more pessimistic outlook on life and perceiving the future as containing more adverse events, and PEH specifically tend to experience higher rates of paranoid thinking (Powell & Maguire, 2017; Robb et al., 2009). Very closely related to

optimism is the construct of "being open to the future," understood as a state of positive affect in which there is a strong commitment to life goals and the steps to reach them, acceptance, self-efficacy, feeling in control, and a positive outlook on what the future may hold (Botella et al., 2018). WEH themselves have identified "finding hope" as a key step in their path exiting homelessness, becoming aware of their own competence and resilience to help them overcome all the challenges they face associated with experiencing homelessness (Phipps et al., 2021). This suggests that promoting optimism among PEH might not only impact their SWB but also help motivate and empower them in their process of social reintegration and all the challenges involved.

Having a positive outlook on the future is closely related to self-compassion (Çutuk, 2021). We can define self-compassion as a healthy form of self-acceptance during difficult times, treating ourselves with kindness using positive language in our internal dialogue, recognizing and accepting discomfort (Neff, 2003). PEH are especially affected by social stigma and self-stigma, and studies have demonstrated that self-compassion can mediate the relationship between stigma and depression or anxiety, as well as improving SWB (Callow et al., 2021; Yang & Mak, 2016). Self-compassion can also mediate the relationship between exposure to cumulative interpersonal trauma and the severity of complex posttraumatic stress disorder among PEH (McQuillan et al., 2022). Given these functions of self-compassion, as well as the low self-esteem and high rates of discrimination and posttraumatic stress disorder among WEH (De Vet et al., 2019; Dickins et al., 2023; Rodriguez-Moreno et al., 2020a; Vázquez et al., 2023), working on self-compassion could provide tangible benefits to this population.

Another component pertaining to the eudaimonic side of SWB is having a life purpose. Both the presence of a meaning in life and having self-efficacy play an important role in experiencing SWB (Kyriazos & Poga, 2024). Stressful events in a person's life, like experiencing homelessness, can largely disrupt the path to our life goals and make people question their life purpose (Kring et al., 2024), indicating that it is an area that might need attention when working towards building SWB among PEH. Achieving happiness and life satisfaction, two important components of SWB, are greatly influenced by a strong sense of self and purpose (Biederman & Forlan, 2016). A logotherapy-based program aimed at empowering PEH improved their hope, meaning in life, and personal strength (Hyun et al., 2024), indicating that focusing on these lines of intervention can help to enhance them. WEH express different life goals than men do, notably regarding education, general health, and relationships with children, and service providers should

consider these factors when working with this population (Bird et al., 2017; Wenzel et al., 2018). In support of that, one specific study found that WEH find the feeling of being "connected, significant, independent, safe, and fulfilled" highly aspirational (Biederman & Forlan, 2016).

The coping mechanisms we use can help us or deter us from getting closer to this life purpose. The progression leading to homelessness is frequently marked by a gradual decline in the ability to cope with life's challenges (Mabhala et al., 2017). Shorter durations of homelessness have been associated with having better coping skills and a greater sense of self-efficacy (Caton et al., 2005; Epel et al., 1999). In addition to helping with exiting homelessness, research demonstrates that working on coping strategies and individual motivation contributes to an increase in SWB (Sanjuan & Avila, 2016). "Achieving happiness" is one of the personal reasons or drives behind positive coping that PEH have identified, along with trusting and reconnecting with themselves, the possibility of generating positive change, feeling normality, and social reintegration (Karadzhov et al., 2019). Within young adults experiencing homelessness, men have higher scores of problem-centered coping, whereas women report higher rates of avoidant coping styles and social coping (Ferguson et al., 2015). In other studies, WEH have also identified social support as a coping mechanism they tend to use (Groton & Radey, 2018; Klitzing, 2004).

Social support is crucial for the social reintegration of PEH, as homelessness tends to be accompanied by severe social isolation (Karadzhov et al., 2019; Miler et al., 2021a; Rea, 2022; Yuan et al., 2024). WEH tend to have less social support than men, even if they have larger networks, although the evidence on these gender differences is inconclusive (De Vet et al., 2019). This might be consistent with other data demonstrating that, while women receive more support from relatives than men, they also have more conflictual relationships with relatives (Winetrobe et al., 2017). Social support also plays a key role in SWB, as social support has been identified as a predictor for sustained wellbeing in PEH (Johnstone et al., 2015). Nonetheless, studies have shown that increases in SWB in PEH have more to do with their perceived social support than their frequency of social contact (Addo et al., 2021; Rea, 2022). This indicates that not all social relationships will be positive for the person, and therefore, the quality of these relationships should be considered. The complexity of using social support as a coping strategy for WEH has been explored, given that the loss of social support is a common predecessor to homelessness, that certain relationships can decrease personal resources,

and the desire many women have to help others even when their personal resources are scarce (Groton & Radey, 2018). Improving social relationships is a clear line of work because these women express that the lack of social support affects their self-esteem and mental health (Groton & Radey, 2018).

PEH with access to professional assistance may receive social support through a relationship referred to as therapeutic alliance, which is defined as a quality relationship between therapist and service user, characterized by trust and a common goal (Wampold, 2001). When studying therapeutic alliance among people who have lived experiences of chronic homelessness, results show that those who reported a higher therapeutic alliance, also reported greater perceived social support and subjective quality of life (Tsai et al., 2012). PEH highlight certain characteristics as helpful for creating a positive relationship, such as the service provider striving to minimize the power differential and the service being tailored to the specific needs of the user (Chrystal et al., 2015; Oudshoorn et al., 2012). These relationships may also be especially helpful for women, who have highlighted building connections with service providers that are particularly sensitive to their needs, as helpful in their process of exiting homelessness (Phipps et al., 2021). On the other side of this relationship, an important theme that homeless service providers identify as essential when working with WEH, is establishing a therapeutic alliance through a relationship built on trust (Salem et al., 2017).

The principal aim of this pilot study is to evaluate the feasibility, acceptability, and security of the *Think and Cope Positively* program among PEH, taking into account the attendance, satisfaction, and potential suggestions of the participants. The secondary aim of the study is to evaluate potential benefits of the program before any future randomized controlled trials, by evaluating changes in SWB, life satisfaction, self-esteem, self-efficacy, and openness to the future.

2. Methods

2.1 Participants

A convenience sampling method was used to recruit participants at a homeless shelter for women in Madrid. The inclusion criteria for participation consisted of women: a) either living at this shelter, at their assisted living homes, or being a regular user of their drop-in center; b) being above the age of 18; c) having sufficient proficiency in Spanish to be able to participate in the program; d) being interested in forming part of a group therapy focused on wellbeing. While no formal exclusion criteria were initially

established to participate in the study, participants were pre-briefed on essential behavioral guidelines to ensure group cohesion and therapeutic continuity. This temporary exclusion from sessions was applied only in cases where acute substance use compromised participants' cognitive engagement and task adherence, or when intense negative emotional states led to disruptive and defiant behavior, affecting both the facilitator's ability to guide the session and the experience of other group members.

Before entering the study, all participants were informed about the group intervention and study's aim. Ethical approval was obtained by the Universidad Pontificia de Comillas Ethics Committee, in compliance with the Declaration of Helsinki. Participants provided informed consent and completed the evaluation protocol at the shelter, lasting approximately 30 minutes.

Additional service users were allowed to drop-in to occasional sessions as well. All these attendees that were not participants in the pre-post study were informed about the intervention and study, and also provided their consent. In turn, this generated three groups among the attendees: (1) completers (study participants completing at least 50% of sessions distributed throughout the intervention's duration); (2) those with intention to treat (participants who had initiated the study; dropouts and completers); (3) all attendees (all persons attending any session, regardless of their commitment to the study).

2.2 Measures

Sociodemographic Characteristics

The following information was collected for participants: gender, age, civil status, educational attainment, current housing situation, employment status, mental health diagnosis, psychotropic drug prescriptions, disability, and years experiencing homelessness or lacking stable housing.

Therapists were asked about their gender, age, educational attainment, experience working with PEH, and experience applying group therapies with PEH.

Feasibility and Acceptability Measures

A form was developed for therapists to record the *attendance* of the participants (as "present" or "absent"), as well as *exercise engagement* both for tasks in and out of session (as "completed" or "not completed").

A 10-item form assessed *protocol compliance*, in which therapists evaluated the degree to which the session's objectives had been completed. Therapists scored each

objective on a 3-point Likert scale ("not achieved," "partially achieved," or "fully achieved").

The *participants' satisfaction* was registered session-to-session with three questions evaluating how much they felt the session's content had helped them, how much they had liked the content, and if they liked how the therapists had managed the session. They rated their answers on a 5-point Likert scale, ranging from "not at all" to "very much." Four similar questions were asked at the end of the program on a 10-point Likert scale: to what degree the group had contributed to better problem-solving, the overall rating they would give the group, the competence and knowledge they perceived in the therapists, and how comprehensive and attentive they perceived the therapists to be. Additionally, two open-ended questions inquired about suggestions for any changes, and what they had liked the most about the group. Finally, participants' satisfaction was also scored on the Client Satisfaction Questionnaire (CSQ; Larsen et al., 1979), made up of 8 questions with a 4-point Likert scale. The responses to each item are adapted to the question itself.

The *subjective experience of the participants and therapists* was assessed informally throughout the sessions, as well as at the end of the program, and suggestions were recorded on paper. Both parties were asked about their subjective perspectives on the acceptability and efficacy of the program.

Wellbeing and Clinical Measures

Wellbeing was measured through the Warwick Edinburgh Mental Wellbeing Scale (WEMWBS; Tennant et al., 2007), using its 7-item version (Sarasjärvi et al., 2023). Responses are reported on a 5-point Likert scale, ranging from "never" to "always," in which higher scores reflect greater wellbeing. The WEMWBS presented a high internal consistency (α = .95). Other constructs related to wellbeing were also measured.

Life satisfaction was assessed through the Spanish version (Vazquez et al., 2013) of the Satisfaction with Life Scale (SWLS; Diener et al., 1985). The SWLS consists of 5 items on a 7-point Likert scale, ranging from "strongly disagree" to "strongly agree," where higher scores indicate higher life satisfaction. The SWLS had a strong internal reliability (α = .81).

Optimism was measured with the Openness to the Future Scale (OFS; Botella et al., 2018). The OFS is made up of 10 items on a 5-point Likert scale, ranging from

"strongly disagree" to "strongly agree," with higher scores signifying greater openness to the future. The internal consistency of the OFS was strong (α = .90).

Self-esteem was evaluated through the Rosenberg Self-Esteem Scale (RSE; Rosenberg, 1965). The RSE consists of 10 questions on a 4-point Likert scale, with answers ranging from "strongly disagree" to "strongly agree," in which higher scores indicate more self-esteem. The internal consistency of the RSE was acceptable (α = .72).

Self-efficacy was rated through the Spanish adaptation of the General Self-Efficacy Scale (GSES; Baessler & Schwarzer, 1996). The GSES is comprised of 10 items on a 4-point Likert scale, ranging from "incorrect" to "correct," where greater sense of self-efficacy is associated with higher scores. The GSES presented a strong internal reliability (α = .93).

Finally, *psychological symptoms* were measured with the Symptom Assesment-45 Questionnaire (SA-45; Sandín et al., 2008). The SA-45 consists of 45 questions on a 4-point distress scale, ranging from "not at all" to "a lot," in which greater scores indicate greater psychological distress. The internal reliability of the SA-45 was strong overall (α = .98), and acceptable in all its subscales: Depression (α = .83), Hostility (α = .89), Interpersonal Sensibility (α = .85), Somatization (α = .83), Anxiety (α = .90), Psychoticism (α = .73), Obsessive Compulsion (α = .90), Phobic Anxiety (α = .92), and Paranoid Ideation (α = .84).

2.3 Procedure

Intervention Adaptation and Application

The first step of this study consisted in adapting the *Think and Cope Positively* (TC+) program to PEH. TC+ was developed by Caballero et al. (2025), built on previous programs (Meyer et al., 2012; Schrank et al., 2016; Valiente et al., 2021), to improve the SWB among people affected by a severe mental disorder (SMD). The program is a group therapy that integrates modules of Positive Psychology Interventions (PPIs; Seligman et al., 2005), Cognitive Behavioral Therapy (CBT; Beck, 2018; Lazarus & Folkman, 1984), and Acceptance and Commitment Therapy (ACT; Gilbert, 2019; Morris et al., 2013).

The structure of the program is based on a broaden-and-build theory (Fredrickson, 2013), that suggests that starting with the promotion of positive emotions, we can work towards activating personal resources, as well as promoting the pursuit of personal goals. The program follows this progression, focusing initially on hedonic wellbeing and moving to eudaimonic wellbeing. Specifically within the program, this translates to the

first sessions focusing on increasing positive emotions to facilitate more flexible and optimistic thinking, and eventually working on the construction of life purpose. In the TC+ program, this content is organized into six modules (see Table 1 in Appendix) that make up a total of 15 sessions. These sessions are conducted weekly and last 75 minutes, each one following a similar general structure with the in-session content and exercises (Caballero et al., 2025).

While the overall content and structure of the program remained the same as its original format, some adaptations of TC+ had to be made for PEH. First, we changed the *homework*. In the original format, session-to-session homework included both compulsory and optional tasks; however, considering the complex and often unstable daily circumstances of PEH, the structure was revised to make all activities voluntary, prioritizing engagement over compliance.

Another key adaptation involved adjusting the *therapeutic narratives* used in several sessions. Originally based on experiences of individuals affected by a SMD, these were adapted to the realities of PEH. For example, a story about the fears of joining a rehabilitation program was modified to reflect similar concerns within a shelter context. Our prior work with WEH informed our decision to adapt other *terminologies and examples* as well.

Attendance and session sequence were also made more flexible due to the instability that affects the lives of many PEH. To foster accessibility and maximize potential benefits, the program adopted a flexible approach regarding attendance—allowing late arrivals, early departures, re-entry after missed sessions, and the inclusion of non-study participants—while incorporating review sessions to support shared understanding and promote engagement among women at the shelter.

The therapists carrying out the program were either: a) on the team adapting the program's protocol and imparting the training to the other therapists, or b) received a 3-hour theoretical and practical training on applying TC+. Therapists had a meeting every 3-4 weeks to supervise any possible difficulties that may have arisen, and had direct and continuous contact with the rest of the research team to raise concerns.

Data Collection

The data collection followed a pre-post structure to address preliminary efficacy results. After signing their informed consent, participants filled out questionnaires

relating to sociodemographic, wellbeing, and clinical measures at baseline. The questionnaires were self-reported.

Every week, post-session questionnaires were filled out both by participants and therapists. Participants filled out the WEMBWS and satisfaction questions; non-study attendees did as well. Therapists completed the protocol compliance, attendance, and exercise engagement forms, to provide information on feasibility. Every 3-4 sessions meetings were held with the therapists to discuss their subjective experience with the program.

At the end of the program, after the last session, participants were asked to respond to the participants' satisfaction questionnaire. The same questionnaires from baseline evaluating wellbeing and clinical measures were collected again.

Data Analysis

First, we analyzed the *feasibility* of the intervention by evaluating participants' adherence, dropout circumstances, and protocol compliance. Subsequently, we assessed the program's *acceptability* through the quantitative and qualitative feedback participants gave on the satisfaction questionnaires, as well as additional qualitative feedback from participants and therapists expressed during sessions or meetings with the research team.

Outcome changes and *clinical scores* after the intervention were analyzed using the minimal detectable change (MDC) between pre-post scores. To estimate the MDC, the standard error of measurement was calculated using preferably test-retest reliability, or Cronbach's alpha, depending on the available data for each questionnaire. To choose the coefficient, we prioritized using data from studies with PEH before using those of studies with the general population or clinical groups. The MDC was calculated for the WEMWBS (Shah et al., 2021; Thomas et al., 2021), SWLS (Brown & Mueller, 2014), OFS (Botella et al., 2018), RSE (Calvo et al., 2018; Martín-Albo et al., 2007), GSES (Shankar et al., 2017), and SA-45 (Sandín et al., 2008). Changes in pre-post scores exceeding the MDC indicated a statistically significant change at the 95% confidence level.

Finally, changes in *SWB throughout the intervention* were analyzed descriptively using graphical representations of mean values separately among completers, those with intention to treat, and all attendees. These three analyses could offer a possible comparison between the SWB of completers and dropouts, as well as complimentary information on participants attending occasional sessions. To evaluate the progression,

we grouped the sessions into three-week periods to account for outliers and sessions with lower attendance or limited data.

Analyses were conducted in SPSS (28.0) and JASP with all tests 2-tailed and statistical significance set at $p < 0.05$.

3. Results

3.1 Feasibility

A total of 14 participants were recruited and consented to participate in the pre-post study and were assessed at baseline. One participant dropped out before the group commenced, five participants dropped out throughout the intervention, and one participant did not complete the post-treatment assessment (due to employment, being transferred to a different housing service, or substantial emotional and interpersonal dysregulation; see Figure 1). In addition, 7 different participants attended occasional sessions without being enrolled in the study.

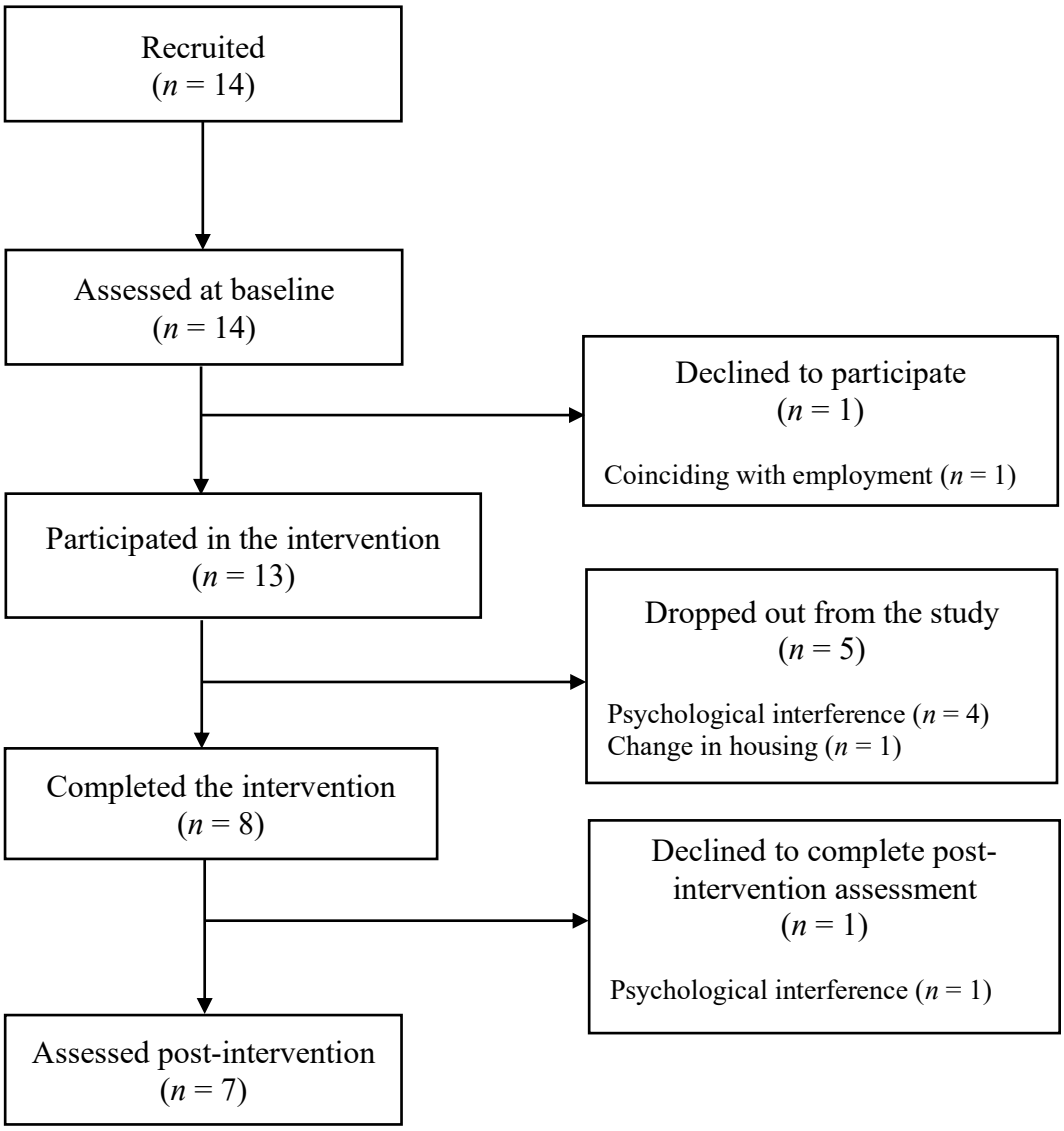
The 13 participants who decided to initiate the treatment were all women with ages ranging between 26 and 68 ($M = 54.7$, $SD = 10.3$). Other sociodemographic features of this sample are shown in Table 2, and clinical characteristics are shown in Table 3.

Three therapists, all women and psychologists, delivered the group intervention. Two principal therapists had worked three years with PEH and had previous experience heading therapeutic groups within this context, and the supporting therapist had one year of experience working with PEH. One principal therapist initiated the group and was present for the first 6 sessions. The other principal therapist took over for sessions 7 through 15. The supporting therapist, expert in the TC+ program, was present throughout the full duration of the program.

The attendance of each study participant ranged between 5 and 12 of the 15 sessions, with an average of 8.31 sessions ($SD = 2.33$). There were high attendance scores at the beginning of the group, with a notable drop after session 10 (see Table 4). Participant absences were primarily due to medical or legal appointments, intoxication or acute emotional dysregulation often linked to personal distress, delays in social benefit processing, or interpersonal tensions at the shelter. Attendance also decreased due to participant dropouts. Among non-study participants, one woman attended nine sessions, another six occasional sessions, another four, three women attended two sessions, and two women attended just one session.

Figure 1

Participant flowchart



Note. The left side of the flowchart describes the number of study participants that participated in each step. On the right, the reasons behind dropouts at different timepoints are addressed.

Table 2

Demographic and clinical characteristics of the sample (n = 13)

	N	%
Housing		
Shelter	11	84.6
Transitional housing	2	15.4
Civil Status		
Single	4	30.8
Partnered	1	7.7
Separated/divorced	6	46.2
Widow	1	7.7
Other	1	7.7
Educational Attainment		
Primary	2	15.4
Secondary	8	61.2
College	2	15.4
Employment Status		
Unemployed	12	92.3
Employed	1	7.7
Recognized disability	7	53.8
Mental Health Diagnosis	6	46.2
Personality Disorder	4	30.8
Psychotropic medication[a]	11	84.6
Antipsychotics	2	15.4
Antidepressants	8	61.5
Benzodiazepines	7	53.8
Hypnotics (not benz.)	6	46.2
Mood Stabilizers	3	23.1
Therapy Frequency		
Weekly	1	7.7
Biweekly	5	38.5
Monthly	2	15.4
Doesn't receive	5	38.5
Years experiencing homelessness/lacking stable housing		
<1	1	7.7
1-5	9	69.2
5-10	1	7.7
>10	2	15.4

Note. [a] As participants can take more than one psychotropic medication, percentages do not add up to 100.

Table 3

Baseline SA-45 scores (n = 12[a])

Subscales (range: 0-20)	M	SD
Depression	14	3.64
Hostility	6	5.12
Interpersonal Sensitivity	11	3.88
Somatization	13	4.96
Anxiety	13	4.17
Psychoticism	5	4.30
Obsessive-Compulsive	12	6.03
Phobic Anxiety	10	6.22
Paranoid Ideation	11	3.94
Global Symptom Index (range: 0-180)	97	33.12

Note. SA-45 = Symptom Assesment-45 Questionnaire.
[a] One participant did not complete the SA-45 before the intervention.

Table 4

Attendance per session

Session	Attendees
1	11
2	9
3	9
4	9
5	9
6	10
7	6
8	8
9	12
10	8
11	3
12	4
13	1
14	4
15	5

Note. The attendees reported include only those who had initially consented to participate in the study and intervention; it does not include the service users who attended occasional sessions.

The participation and in-session task performance were very high, where participants completed 98.37% of tasks in session. Meanwhile, participants did not complete any of the voluntary homework, except for that between sessions 14 and 15. This specific task was given greater weight and emphasis by the therapists, due to its importance for session 15 to function properly. Therapists reported very high protocol compliance, with nearly all session goals having been achieved.

3.2 Acceptability and Satisfaction

The satisfaction with the program was high among the participants. On the post-session questionnaires (rated 1-5), the women generally answered that they liked the session's contents (M = 4.48, SD = 0.82), the session had helped them (M = 4.0, SD = 1.10), and they liked how the therapists had managed the session (M = 4.71, SD = 0.58). Only four participants completed the satisfaction questionnaires (ratings 0-10) after session 15. These participants reported a high rating for the group overall (8.25, 1.09), the helpfulness of the group in their problem-solving (M = 8.5, SD = 1.66), and their perception of the therapists as highly competent (M = 8.75, SD = 1.09) and attentive (M = 8.75, SD = 0.83).

Qualitative feedback throughout the sessions and post-intervention was particularly positive. Participants described the group as very helpful and reported enjoying it greatly. They specifically highlighted the benefits of having a set time during the week to focus on positive emotions, working in a supportive group setting, the content focused on optimism, and they suggested the group continue with additional sessions.

Therapists reported a very positive subjective experience with the program. They described an uplifting and cohesive atmosphere within the sessions, as well as adequate content comprehension and high relevance for the participants. The therapists pointed out that this positive tone and climate were markedly different from how they observed the participants most of the time during the rest of their weeks. They valued the ease of application of the intervention, due to the organization and preparation of the program's content, as well as the absence of any costs associated with its application. Regarding areas of improvement, they reported difficulties in maintaining the participants' attendance, although this was a more prominent issue with the service users at the shelter. The therapists also had greater difficulties with the sessions that focused on negative thinking traps, stigma, and social relationships. Therapists observed that these contents

brought up memories of negative experiences and trauma, which some participants found emotionally challenging at times.

3.3 Outcome Analysis

Primary Outcomes

Seven participants completed pre- and post-intervention evaluations. Six participants experienced an increase in wellbeing on the WEMWBS, with five of these at a statistically significant level (see Table 5).

This positive progression was observed throughout the program as well. Wellbeing scores on the post-session WEMBWS increased from initial to final sessions among completers (3.18-3.80), those with intention to treat (3.07-3.83), and all attendees (3.18-3.67; see Table 6). We can observe that completers experience greater wellbeing overall throughout the sessions than the other groups. In addition, towards the end of the program, both completers and those with intention to treat showed greater wellbeing than the mean score of all attendees (Figure 2).

Table 5

Differences between pre- and post-intervention outcome scores (n = 7)

Participant	WEMWBS	SWLS	OFS	RSE	GSES
1	1.29*	0.00	1.50*	-0.20	1.70*
2	0.86*	-1.40	0.60	0.00	0.10
3	1.71*	1.40	0.90	0.50	1.30*
4	1.86*	0.80	0.50	0.40	0.00
5	0.00	-2.00*	0.80	0.20	0.50*
6	1.29*	2.00*	1.40*	0.20	1.90*
7[a]	0.14	-0.20	0.00	-0.20	----
MDC	0.58	1.60	0.93	0.74	0.48

Note. The scores represent the differences between scores before and after the intervention for each participant on each questionnaire, where positive numbers indicate improvement and negative numbers indicate worsening. WEMWBS = Warwick Edinburgh Mental Wellbeing Scale; SWLS = Satisfaction with Life Scale; OFS = Openness to the Future Scale; RSE = Rosenberg Self-Esteem Scale; GSES = General Self-Efficacy Scale; MDC = minimal detectable change.

[a] This participant did not complete the GSES before the intervention.

* Significant change at a 95% confidence level.

Table 6

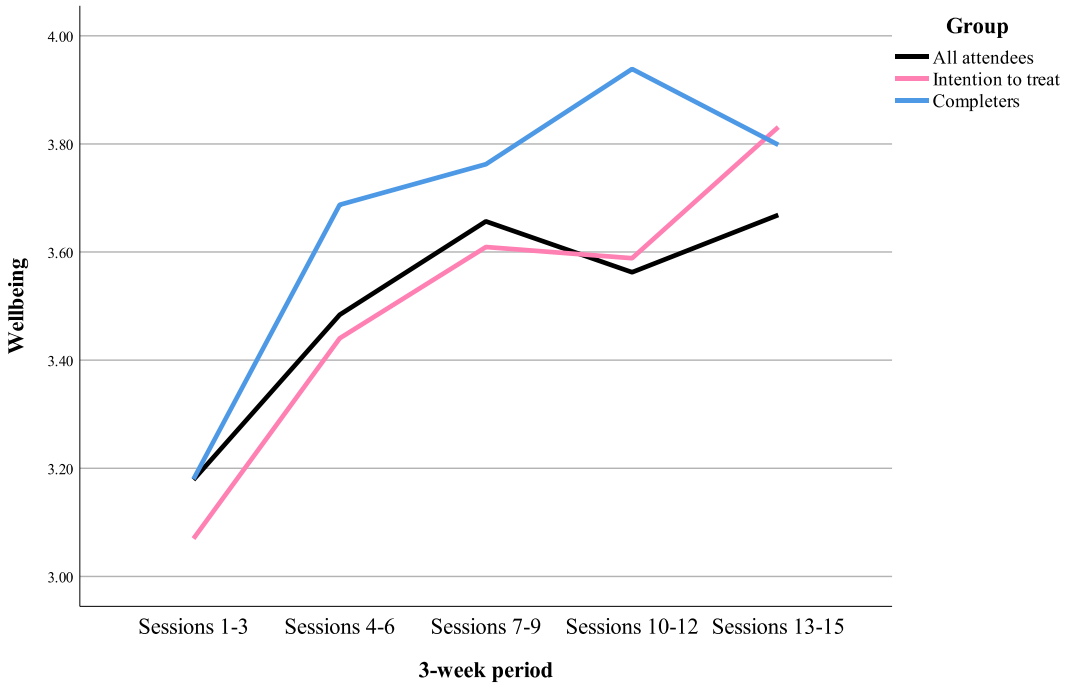
Post-session WEMWBS scores per 3-week period

	Completers		Intention to treat		All attendees	
Period	N	Mean	N	Mean	N	Mean
Sessions 1-3	11	3.18	25	3.07	29	3.18
Sessions 4-6	12	3.69	20	3.44	25	3.48
Sessions 7-9	8	3.76	14	3.61	18	3.66
Sessions 10-12	7	3.94	14	3.59	22	3.56
Sessions 13-15	6	3.80	8	3.83	14	3.67

Note. "Intention to treat" includes "Completers;" "All attendees" includes "Intention to treat" and "Completers." WEMWBS = Warwick Edinburgh Mental Wellbeing Scale.

Figure 2

Post-session WEMWBS trends throughout the program



Note. "Intention to treat" includes "Completers;" "All attendees" includes "Intention to treat" and "Completers." WEMWBS = Warwick Edinburgh Mental Wellbeing Scale.

Secondary Outcomes

There were varied outcomes among the different constructs measured, although improvement was observed in most of the participants (see Table 5). The most noticeable change was observed in self-efficacy, where five of seven participants showed a significant improvement on the GSES. Optimism increased somewhat, with three of seven participants presenting significant improvements on the OFS. On the other hand, there were contradicting results among life satisfaction, with one significant increase and decline among participants in the SWLS. Finally, no significant changes were reported in self-esteem on the RSE.

3.4 Clinical Symptomatology

Six participants completed the SA-45 before and after the intervention. For this test, we observed a general reduction of symptoms (see Table 7). One participant experienced a significant increase in her overall symptoms, as well as in various subscales. However, the other five participants all experienced significant decreases in their Global Symptom Index and in most subscales.

Table 7

Differences between pre- and post-intervention SA-45 scores (n = 6)

Subscales	Participant						MDC
	1	2	3	4	5	6	
Depression	7*	-10*	-9*	-6*	-3*	-8*	0.97
Hostility	4*	-8*	-3*	0	-3*	-5*	0.80
Interpersonal Sensitivity	6*	-7*	-6*	-9*	-6*	-12*	1.02
Somatization	3*	-7*	-12*	-4*	-1*	-10*	0.94
Anxiety	-2	-6*	-7*	-6*	-12*	-10*	0.86
Psychoticism	-5*	-3*	0	0	-2*	-12*	0.78
Obsessive-Compulsive	-1	-8*	-13*	1	0	-10*	1.09
Phobic Anxiety	1*	-9*	-6*	0	-9*	-10*	0.81
Paranoid Ideation	5*	-13*	-8*	-8*	-7*	-8*	1.10
Global Symptom Index	18*	-71*	-64*	-32*	-43*	-85*	3.26

Note. The scores represent the differences between scores before and after the intervention for each participant on each subscale, where negative numbers indicate improvement and positive numbers indicate worsening. SA-45 = Symptom Assesment-45 Questionnaire; MDC = minimal detectable change.
* Significant change at a 95% confidence level.

4. Discussion

The present study describes the adaptation and implementation of the *Think and Cope Positively* (TC+) program to improve SWB among PEH. Those affected by homelessness, especially WEH, report significantly lower levels of SWB than housed individuals (Ahuja et al., 2020). Although various programs have shown promise in improving SWB and mental health outcomes among PEH (Ajeen et al., 2023; Hyun et al., 2019; Omerov et al., 2019; Parkes et al., 2022), there is a gap between the research behind evidence-based treatments and their implementation in community services (Youn et al., 2019). This prompted us to conduct the present pilot study to assess the feasibility of the TC+ program among PEH and evaluate how to make it accessible and helpful in increasing their SWB. We hypothesized that the program could be feasible to implement, well-received by participants, and that it has a great potential to improve SWB and related outcomes. Although this was not an effectiveness trial, preliminary results indicated promising trends toward increased SWB, self-efficacy, and reduced psychological symptomatology in participants. Overall, our findings offer important insights for further adaptations of TC+ to address the needs of PEH, as well as improving the efficacy of other psychosocial programs.

Importantly, our study demonstrates the high feasibility and acceptability of the TC+ program. While attendance declined in the second half of the program, the reasons given were largely external and unrelated to the intervention content, echoing barriers identified in other studies with PEH (Marín et al., 2021; Parkes et al., 2022). Despite these difficulties, both protocol compliance and in-session exercise engagement were very high. These findings contrast with clinicians' concerns around the active engagement of PEH in treatments, and their skepticism towards their effectiveness (Youn et al., 2019). This suggests that, when participants were present at the sessions, they found value in the intervention. Moreover, satisfaction was high among participants, as indicated by both the quantitative scores and the qualitative feedback. Participants verbalized purely positive opinions about the group, said they would not change anything, and that they wished the program was longer. One aspect most prominently highlighted by the participants was the opportunity to share their life experiences in a group setting and support each other. The program addressed a crucial unmet need within the SWB of PEH, by enabling the creation of new relationships and/or enhancing existing ones (Ahuja et al., 2020). This was also supported by the therapists' observation that in a shelter setting, women are substantially more distant among themselves. On the contrary, in our group

setting the professionals enjoyed the positive and supportive climate that permeated this group of WEH.

While this was not an effectiveness study for TC+, the preliminary results are promising regarding the primary aim of the program: promoting SWB. We found a gradual increase in SWB among the participants throughout the program, and also when evaluated after the full intervention. This significant change in SWB is consistent with studies that indicate the potential benefits for PEH of working purposefully on wellbeing within an intervention (Ahuja et al., 2020). We observed mixed results in the rest of outcomes related to wellbeing, with self-efficacy being the only variable that increased overall. As coping and motivation have been identified as predictors for SWB (Sanjuan & Avila, 2016), exploring the weight of self-efficacy for PEH might be useful to inform potential pathways to improve their SWB. We found inconsistent results among the rest of outcomes: satisfaction with life, openness to the future, and self-esteem. It is worth noting that, even when PEH report high levels of satisfaction with the treatment and perceive it as useful, the outcomes in terms of effectiveness can still be inconsistent (Sauer- Zavala et al., 2018). TC+ may contribute to improving SWB and self-efficacy for PEH, but further research is needed to confirm its effects.

We found TC+ to be safe for participants, with most women experiencing significant improvements in nearly all their symptomatology. This change is likely due to the numerous factors playing a part in the lives of PEH. When we started the group, the participants presented high psychological symptom scores, well above that of the general population (Sandín et al., 2008). These scores might have been affected by the detrimental impact homelessness has on people's mental health (Moledina et al., 2021). We note that the striking improvements observed in symptom scores coincided with the time spent at the shelter, a setting where these women's basic needs are met. This is a key aspect TC+ and other programs should consider, because every person's fundamental needs should be addressed first (safe place to sleep, food availability, sense of security) before they can attend to other aspects of their wellbeing (Ahuja et al., 2020). Nonetheless, we were able to determine the program as safe for participants.

This study has some limitations. First, there is no control group to evaluate efficacy. Nonetheless, the aim of this study was to evaluate the feasibility of a psychological program for PEH, as reported in other studies (Cumming et al., 2022; Marín et al., 2021). The sample size was also very small, but currently the TC+ program is being applied at another shelter for PEH in Madrid. A larger sample will allow for a

better understanding of feasibility and acceptability results, and will inform any relevant adaptations and improvements to the program before a future larger randomized controlled trial is developed.

Regarding the program design, it was challenging to maintain attendance and adherence for each individual participant throughout the entirety of the program. This difficulty is consistent with the findings of other studies evaluating interventions for PEH, in which complex life circumstances limited the participants' ability to attend all program sessions (Marín et al., 2021; Parkes et al., 2022; Youn et al., 2019). A similar pattern was observed in the TC+ program, where various women reported external stressors that affected their ability or desire to attend on specific days. Additional authors describe the challenges that PEH face with service engagement and adherence to treatment regimens due to their living conditions (Anderson & Ytrehus, 2012). These difficulties with engagement seem to increase among PEH that also experience problem substance use (Miler et al., 2021b), which is consistent with the present group, where various women used non-prescription drugs that interfered with their ability to participate in certain sessions. It is also worth noting that, while the option to make up missed sessions was available, the therapists were rarely able to offer this service due to their high caseloads.

Building on this, the discrepancy between the attendance rates and compliance and satisfaction scores suggests a need to improve the accessibility to attend sessions. Given the high attendance at the beginning of the group, which decreased significantly towards the end of the program, we propose dividing the intervention into shorter six-session versions that might allow for participants to adhere to the full program. Following the broaden-and-build theory (Fredrickson, 2013) and the present structure of TC+, this intervention might benefit from being divided into two or three mini-interventions with one session per module, which could be more accessible to PEH. This structure would maintain the progressive growth and important cumulative effect of wellbeing, while using a format that people with very turbulent lives could integrate more easily into their schedule. With this format, a participant could attend one or more of the shortened TC+ interventions, depending on what their circumstances permit.

This study holds several strengths. First, it focuses on SWB, a field of work that is largely overlooked in PEH (Ahuja et al., 2020). Additionally, the basic format of working in a group setting at the shelter to promote positive interactions among service users is an activity that both participants and therapists have valued highly. Finally, given that the aim was to assess the program's feasibility and acceptability, we have been able

to examine the accessibility to the program and identify areas for improvement. Both quantitative results and subjective experiences of service users and therapists were recorded. This valuable feedback will enable the modification of the present TC+ program and development of future services that maximize the benefits derived by the users.

The present study offers several valuable clinical implications. We might be able to potentiate SWB by incorporating elements that promote positive emotional experiences, optimism, self-compassion, adaptive coping mechanisms, and a sense of purpose into interventions designed for PEH. The findings demonstrate the potential benefits of a holistic therapeutic framework that draws from a variety of evidence-based modalities for addressing SWB in PEH. Moreover, the difficulties we encountered with attendance and accessibility highlight how this program must be accompanied by a larger effort to support PEH. When intervening with PEH, it is important that we understand the endless complex conditions and events that have shaped a person's trajectory, which burdens their present lives, on both a personal and institutional level (Siegel et al., 2020). The participants communicated that their lack of attendance was largely due to external factors that were causing them distress and impeding their ability to attend, which we observed in tandem with relatively high rates of substance use and high symptom scores. To provide proper support to people experiencing such complex and prejudicial circumstances, it is instrumental to operate within adequate interdisciplinary and interinstitutional contexts (Anderson et al., 2023; Parsell et al., 2019; Siegel et al., 2020).

This study provides evidence that TC+ is a feasible and acceptable program to improve SWB among WEH. TC+ constitutes a safe and relevant intervention because of its great potential to improve wellbeing and self-efficacy for this highly vulnerable population. As a complimentary program to habitual treatments and services, TC+ can provide additional support to a person's SWB and path out of homelessness.

References

Addo, R., Yuma, P., Barrera, I., & Layton, D. (2021). Social networks and subjective wellbeing of adults in a Housing First program. *Journal of Community Psychology*, *50*(1), 238-249. https://doi.org/10.1002/jcop.22548

Ahuja, N. J., Nguyen, A., Winter, S. J., Freeman, M., Shi, R., Espinosa, P. R., & Heaney, C. A. (2020). Well-Being without a Roof: Examining Well-Being among Unhoused Individuals Using Mixed Methods and Propensity Score Matching. *International Journal of Environmental Research and Public Health*, *17*(19), 7228. https://doi.org/10.3390/ijerph17197228

Ajeen, R., Ajeen, D., Wisdom, J. P., Greene, J. A., Lepage, T., Sjoelin, C., Melvin, T., Hagan, T. E., Hunter, K. F., Peters, A., Mercer, R., & Brancu, M. (2022). The impact of trauma-informed design on psychological well-being in homeless shelters. *Psychological Services*, *20*(3), 680-689. https://doi.org/10.1037/ser0000724

Amore, K., Baker, M., & Howden-Chapman, P. (2011). The ETHOS Definition and Classification of Homelessness: An analysis. *European Journal of Homelessness*, *5*(2), 19–37. https://www.feantsaresearch.org/download/article-1-3327806572783182308 7.pdf

Anderson, I., & Ytrehus, S. (2012). Re-conceptualising Approaches to Meeting the Health Needs of Homeless People. *Journal Of Social Policy*, *41*(3), 551-568. https://doi.org/10.1017/s0047279412000220

Anderson, A. J., Noyes, K., & Hewner, S. (2023). Expanding the evidence for cross-sector collaboration in implementation science: creating a collaborative, cross-sector, interagency, multidisciplinary team to serve patients experiencing homelessness and medical complexity at hospital discharge. *Frontiers In Health Services*, *3*. https://doi.org/10.3389/frhs.2023.1124054

Baessler, J., & Schwarzer, R. (1996). Evaluación de la autoeficacia: Adaptación española de la escala de Autoeficacia General. *Ansiedad y Estrés, 2*, 1-8.

Baxter, A. J., Tweed, E. J., Katikireddi, S. V., & Thomson, H. (2019). Effects of Housing First approaches on health and well-being of adults who are homeless or at risk of homelessness: systematic review and meta-analysis of randomised controlled trials. *Journal of Epidemiology & Community Health, 73*(5), 379-387. https://doi.org/10.1136/jech-2018-210981

Beck, A. (2018). *Recovery-oriented cognitive therapy for schizophrenia: A personal perspective.* https://psycnet.apa.org/record/2018-01399-001

Biederman, D. J., & Forlan, N. (2016). Desired Destinations of Homeless Women: Realizing Aspirations within the Context of Homelessness. *Creative Nursing*, *22*(3), 196-203. https://doi.org/10.1891/1078-4535.22.3.196

Bird, M., Rhoades, H., Lahey, J., Cederbaum, J., & Wenzel, S. (2017). Life goals and gender differences among chronically homeless individuals entering permanent supportive housing. *Journal of Social Distress and the Homeless*, *26*(1), 9-15. https://doi.org/10.1080/10530789.2016.1274570

Bodley-Scott, E., Ward, R. J., Tarabay, J., Fagbamigbe, A. F., Barker, S., & Maguire, N. (2024). The effectiveness of psychological interventions for people experiencing homelessness: A systematic review and meta-analysis. *Journal of Community & Applied Social Psychology*, *34*(5). https://doi.org/10.1002/casp.2863

Botella, C., Molinari, G., Fernández-Álvarez, J., Guillén, V., García-Palacios, A., Baños, R. M., & Tomás, J. M. (2018). Development and validation of the openness to the future scale: A prospective protective factor. *Health and Quality of Life Outcomes*, *16*(1), 1–16. https://doi.org/10.1186/s12955-018-0889-8

Bradburn, N. M., & Noll, C. E. (1969). *The Structure of Psychological Well-being.* Chicago: Aldine Publishing Company.

Brown, C., & Mueller, C. T. (2014). Predictors of employment among sheltered homeless women. *Community Work & Family*, *17*(2), 200-218. https://doi.org/10.1080/13668803.2014.890562

Bryant, F. B., & Veroff, J. (2017). *Savoring: A new model of positive experience.* Psychology Press. https://doi.org/10.4324/9781315088426

Callow, T. J., Moffitt, R. L., & Neumann, D. L. (2021). External shame and its association with depression and anxiety: the moderating role of self-compassion. *Australian Psychologist*, *56*(1), 70-80. https://doi.org/10.1080/00050067.2021.1890984

Caballero, R., Peinado, V., Valiente, C., Vucic, A., Alonso, A., & Caperos, J. M. (2025). Think and cope positively, a feasibility and acceptability study to improve the subjective well-being of people affected by a severe mental disorder. *Psychiatric Rehabilitation Journal* (Under review).

Calvo, F., Carbonell, X., Turró, O., & Giralt, C. (2018). Connected in the street: the relation between online social networks, self-esteem and satisfaction with life among individuals experiencing homelessness. *Aloma Revista de Psicologia Ciències de L Educació I de L Esport*, *36*(1), 21-28. https://doi.org/10.51698/aloma.2018.36.1.21-28

Carver, C. S., Scheier, M. F., & Segerstrom, S. C. (2010). Optimism. *Clinical Psychology Review*, *30*, 879–889. https://doi.org/https://doi.org/10.1016/j.cpr.2010.01.006

Caton, C. L. M., Dominguez, B., Schanzer, B., Hasin, D. S., Shrout, P. E., Felix, A., McQuistion, H., Opler, L. A., & Hsu, E. (2005). Risk Factors for Long-Term Homelessness: Findings From a Longitudinal Study of First-Time Homeless Single Adults. *American Journal of Public Health*, *95*(10), 1753-1759. https://doi.org/10.2105/ajph.2005.063321

Chrystal, J. G., Glover, D. L., Young, A. S., Whelan, F., Austin, E. L., Johnson, N. K., Pollio, D. E., Holt, C. L., Stringfellow, E., Gordon, A. J., Kim, T. A., Daigle, S. G., Steward, J. L., & Kertesz, S. G. (2015). Experience of Primary Care among Homeless Individuals with Mental Health Conditions. *PLoS ONE*, *10*(2), e0117395. https://doi.org/10.1371/journal.pone.0117395

Cumming, J., Whiting, R., Parry, B. J., Clarke, F. J., Holland, M. J., Cooley, S. J., & Quinton, M. L. (2022). The My Strengths Training for LifeTM program: Rationale, logic model, and description of a strengths-based intervention for young people experiencing homelessness. *Evaluation and Program Planning, 91,* 102045. https://doi.org/10.1016/j.evalprogplan.2021.102045

Çutuk, Z. A. (2021). Mediating role of optimism in the relationship between self-compassion and subjective well-being. *Journal of Human Sciences*, *18*(2), 185-198. https://doi.org/10.14687/jhs.v18i2.6139

De Vet, R., Beijersbergen, M. D., Lako, D. A. M., Van Hemert, A. M., Herman, D. B., & Wolf, J. R. L. M. (2019). Differences between homeless women and men before and after the transition from shelter to community living: A longitudinal analysis. *Health & Social Care in the Community*, *27*(5), 1193-1203. https://doi.org/10.1111/hsc.12752

Dickins, K. A., Reed, M., Paun, O., Swanson, B., & Karnik, N. S. (2023). Biopsychosocial model of traumatic stress symptoms in women experiencing

homelessness: A Qualitative Descriptive study. *Issues in Mental Health Nursing*, *44*(6), 482–493. https://doi.org/10.1080/01612840.2023.2205522

Diener, E., Emmons, R. A., Larsem, R. J., & Griffin, S. (1985). The Satisfaction with Life Scale. *Journal of Personality Assessment*, *49*(1), 71-75. https://doi.org/10.1207/s15327752jpa4901_13

Duke, A., & Searby, A. (2019). Mental Ill Health in Homeless Women: A Review. *Issues in Mental Health Nursing*, *40*(7), 605-612. https://doi.org/10.1080/01612840.2019.1565875

Emmons, R. A., & McCullough, M. E. (2003). Counting blessings versus burdens: An experimental investigation of gratitude and subjective well-being in daily life. *Journal of Personality and Social Psychology*, *84*(2), 377–389. https://doi.org/10.1037/0022-3514.84.2.377

Epel, E. S., Bandura, A., & Zimbardo, P. G. (1999). Escaping Homelessness: The Influences of Self-Efficacy and Time Perspective on Coping with Homelessness1. *Journal of Applied Social Psychology*, *29*(3), 575-596. https://doi.org/10.1111/j.1559-1816.1999.tb01402.x

Eurostat. (2024). *Living conditions in Europe - poverty and social exclusion*. https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Living_conditions_in_Europe_-_poverty_and_social_exclusion

Feingold, A. (2009). Effect sizes for growth-modeling analysis for controlled clinical trials in the same metric as for classical analysis. *Psychological Methods, 14*(1), 43. https://doi.org/10.1037/a0014699

Ferguson, K. M., Bender, K., & Thompson, S. J. (2015). Gender, coping strategies, homelessness stressors, and income generation among homeless young adults in three cities. *Social Science & Medicine*, *135*, 47-55. https://doi.org/10.1016/j.socscimed.2015.04.028

Fredrickson, B. (2001). The role of positive emotions in positive psychology: The broaden-and build theory of positive emotions. *American Psychologist*, *56*(3), 218–226. https://doi.org/10.1037/0003-066X.56.3.218

Giano, Z., Williams, A., Hankey, C., Merrill, R., Lisnic, R., & Herring, A. (2019). Forty Years of Research on Predictors of Homelessness. *Community Mental Health Journal*, *56*(4), 692-709. https://doi.org/10.1007/s10597-019-00530-5

Gilbert, P. (2019). Explorations into the nature and function of compassion. *Current Opinion in Psychology, 28*, 108-114. https://doi.org/10.1016/j.copsyc.2018.12.002

Grandchamp, V. A. T., Gordeeva, T. O., & Sychev, O. A. (2021). Optimistic Attributional Style as a Predictor of Well-Being: Exploring the Mediating Roles of Gratitude and Savoring the Moment. *Psychology in Russia State of Art, 14*(3), 50-67. https://doi.org/10.11621/pir.2021.0304

Groton, D. B., & Radey, M. (2018). Social networks of unaccompanied women experiencing homelessness. *Journal of Community Psychology*, *47*(1), 34-48. https://doi.org/10.1002/jcop.22097

Hubley, A. M., Russell, L. B., Palepu, A., & Hwang, S. W. (2012). Subjective Quality of Life Among Individuals who are Homeless: A Review of Current Knowledge. *Social Indicators Research, 115*(1), 509-524. https://doi.org/10.1007/s11205-012-9998-7

Hyun, M., Bae, S. H., & Noh, D. (2019). Systematic review and meta-analyses of randomized control trials of the effectiveness of psychosocial interventions for homeless adults. *Journal of Advanced Nursing*, *76*(3), 773-786. https://doi.org/10.1111/jan.14275

Hyun, M., Kim, S., & Park, E. (2024). Effect of a Logotherapy-Based Empowerment Program for Achieving Self-Reliance Among Persons Living Houseless. *Issues in Mental Health Nursing*, 1-11. https://doi.org/10.1080/01612840.2024.2404691

Johnstone, M., Parsell, C., Jetten, J., Dingle, G., & Walter, Z. (2015). Breaking the cycle of homelessness: Housing stability and social support as predictors of long-term well-being. *Housing Studies*, *31*(4), 410-426. https://doi.org/10.1080/02673037.2015.1092504

Karadzhov, D., Yuan, Y., & Bond, L. (2019). Coping amidst an assemblage of disadvantage: A qualitative metasynthesis of first-person accounts of managing severe mental illness while homeless. *Journal of Psychiatric and Mental Health Nursing*, *27*(1), 4-24. https://doi.org/10.1111/jpm.12524

Klitzing, S. W. (2004). Women Living in a Homeless Shelter: Stress, Coping and Leisure. *Journal of Leisure Research*, *36*(4), 483-512. https://doi.org/10.1080/00222216.2004.11950033

Kring, L., Iversen, E., Ibsen, B., & Fehsenfeld, M. (2024). Exploring the impact of stressful life events on quality of life: meaning making and narrative reconstruction. *International Journal of Qualitative Studies on Health and Well-Being*, *19*(1). https://doi.org/10.1080/17482631.2024.2330117

Kyriazos, T., & Poga, M. (2024). Planfulness in Psychological Well-being: Mediating Roles of Self-Efficacy and Presence of Meaning in Life. *Applied Research in Quality of Life*, *19*(4), 1927-1950. https://doi.org/10.1007/s11482-024-10314-z

Larsen, D. L., Attkisson, C., Hargreaves, W. A., & Nguyen, T. D. (1979). Assessment of client/patient satisfaction: Development of a general scale. *Evaluation and Program Planning, 2*(3), 197-207. https://doi.org/10.1016/0149-7189(79)90094-6

Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping.* Springer publishing company.

Lu, J., Potts, C. A., & Allen, R. S. (2020). Homeless people's trait mindfulness and their resilience – a mediation test on the role of inner peace and hope. *Journal of Social Distress and the Homeless*, *30*(2), 155-163. https://doi.org/10.1080/10530789.2020.1774847

Mabhala, M. A., Yohannes, A., & Griffith, M. (2017). Social conditions of becoming homelessness: qualitative analysis of life stories of homeless peoples. *International Journal for Equity in Health*, *16*(1). https://doi.org/10.1186/s12939-017-0646-3

Marín, C., Guillén, A. I., Rodriguez-Moreno, S., Diéguez, S., Panadero, S., & Farchione, T. (2021). Application of the unified protocol for transdiagnostic treatment of emotional disorders among homeless women: A feasibility study. *Psychotherapy*, *58*(2), 242-247. https://doi.org/10.1037/pst0000357

Marshall, C. A., Cooke, A., Holmes, J., Bengall, J., Aryobi, S., Phillips, B., Lysaght, R., & Gewurtz, R. (2024). "It's like your days are empty and yet there's life all around": A mixed methods, multi-site study exploring boredom during and following homelessness. *PLoS ONE*, *19*(5), e0302900. https://doi.org/10.1371/journal.pone.0302900

Martín-Albo, J., Núñez, J. L., Navarro, J. G., & Grijalvo, F. (2007). The Rosenberg Self-Esteem Scale: Translation and Validation in University Students. *The Spanish Journal of Psychology*, *10*(2), 458-467. https://doi.org/10.1017/s1138741600006727

Matulič-Domadzič, V., Munté-Pascual, A., De Vicente-Zueras, I., & León-Jiménez, S. (2020). "Life Starts for Me Again." The Social Impact of Psychology on Programs for Homeless People: Solidarity Networks for the Effectiveness of Interventions. *Frontiers in Psychology*, *10*. https://doi.org/10.3389/fpsyg.2019.03069

Mayock, P., & Bretherton, J. (2017). *Women's Homelessness in Europe*. Palgrave Macmillan.

McGuire, N., Melville, C., Karadzhov, D., & Gumley, A. (2020). "She is more about my illness than me": A qualitative study exploring social support in individuals with experiences of psychosis. *Psychosis*, *12*(2), 128-138. https://doi.org/10.1080/17522439.2019.1699943

McQuillan, K., Hyland, P., & Vallières, F. (2022). Prevalence, correlates, and the mitigation of ICD-11 CPTSD among homeless adults: The role of self-compassion. *Child Abuse & Neglect*, *127*, 105569. https://doi.org/10.1016/j.chiabu.2022.105569

Meyer, P. S., Johnson, D. P., Parks, A., Iwanski, C., & Penn, D. L. (2012). Positive living: A pilot study of group positive psychotherapy for people with schizophrenia. *Journal of Positive Psychology, 7*(3), 239-248. https://doi.org/10.1080/17439760.2012.677467

Miler, J. A., Foster, R., Hnizdilova, K., Murdoch, H., & Parkes, T. (2021a). 'It maybe doesn't seem much, but to me it's my kingdom': staff and client experiences of Housing First in Scotland. *Drugs Education Prevention and Policy*, *29*(3), 231-244. https://doi.org/10.1080/09687637.2021.1926429

Miler, J. A., Carver, H., Masterton, W., Parkes, T., Maden, M., Jones, L., & Sumnall, H. (2021b). What treatment and services are effective for people who are homeless and use drugs? A systematic 'review of reviews'. *PLoS ONE*, *16*(7), e0254729. https://doi.org/10.1371/journal.pone.0254729

Moledina, A., Magwood, O., Agbata, E., Hung, J., Saad, A., Thavorn, K., Salvalaggio, G., Bloch, G., Ponka, D., Aubry, T., Kendall, C., & Pottie, K. (2021). A comprehensive review of prioritised interventions to improve the health and wellbeing of persons with lived experience of homelessness. *Campbell Systematic Reviews, 17*(2). https://doi.org/10.1002/cl2.1154

Morris, E. M. J., Johns, L. C., & Oliver, J. E. (2013). *Acceptance and commitment therapy and mindfulness for psychosis*. John Wiley & Sons, Ltd.

National Statistics Insitute. (2022). *Encuesta a las personas sin hogar*. https://www.ine.es/prensa/epsh_2022.pdf

Neff, K. (2003). Self-Compassion: An Alternative Conceptualization of a Healthy Attitude Toward Oneself. *Self and Identity*, *2*(2), 85–101. https://doi.org/10.1080/15298860309032

Nilsson, S. F., Nordentoft, M., & Hjorthøj, C. (2019). Individual-Level Predictors for Becoming Homeless and Exiting Homelessness: a Systematic Review and Meta-analysis. *Journal of Urban Health*, *96*(5), 741–750. https://doi.org/10.1007/s11524-019-00377-x

Omerov, P., Craftman, Å. G., Mattsson, E., & Klarare, A. (2019). Homeless persons' experiences of health- and social care: A systematic integrative review. *Health & Social Care in the Community*, *28*(1), 1-11. https://doi.org/10.1111/hsc.12857

O'Regan, K. M., Ellen, I. G., & House, S. (2021). How to Address Homelessness: Reflections from Research. *The Annals of the American Academy of Political and Social Science*, *693*(1), 322-332. https://doi.org/10.1177/0002716221995158

Oudshoorn, A., Ward-Griffin, C., Forchuk, C., Berman, H., & Poland, B. (2012). Client-provider relationships in a community health clinic for people who are experiencing homelessness. *Nursing Inquiry*, *20*(4), 317-328. https://doi.org/10.1111/nin.12007

Padgett, D. K. (2020). Homelessness, housing instability and mental health: making the connections. *BJPsych Bulletin, 44*(5), 197-201. https://doi.org/10.1192/bjb.2020.49

Parkes, T., Matheson, C., Carver, H., Foster, R., Budd, J., Liddell, D., Wallace, J., Pauly, B., Fotopoulou, M., Burley, A., Anderson, I., Price, T., Schofield, J., & MacLennan, G. (2022). Assessing the feasibility, acceptability and accessibility of a peer-delivered intervention to reduce harm and improve the well-being of people who experience homelessness with problem substance use: the SHARPS study. *Harm Reduction Journal*, *19*(1). https://doi.org/10.1186/s12954-021-00582-5

Parsell, C., Clarke, A., & Vorsina, M. (2019). Evidence for an integrated healthcare and psychosocial multidisciplinary model to address rough sleeping. *Health & Social Care in The Community*, *28*(1), 34-41. https://doi.org/10.1111/hsc.12835

Phipps, M., Dalton, L., Maxwell, H., & Cleary, M. (2018). Women and homelessness, a complex multidimensional issue: findings from a scoping review. *Journal of Social Distress and the Homeless*, *28*(1), 1-13. https://doi.org/10.1080/10530789.2018.1534427

Phipps, M., Dalton, L., Maxwell, H., & Cleary, M. (2021). A qualitative exploration of women's resilience in the face of homelessness. *Journal of Community Psychology*, *49*(5), 1212-1227. https://doi.org/10.1002/jcop.22574

Powell, K., & Maguire, N. (2017). Paranoia and maladaptive behaviours in homelessness: The mediating role of emotion regulation. *Psychology and Psychotherapy Theory Research and Practice*, *91*(3), 363-379. https://doi.org/10.1111/papt.12166

Rea, J. (2022). Social relationships, stigma, and wellbeing through experiences of homelessness in the United Kingdom. *Journal of Social Issues*, *79*(1), 465-493. https://doi.org/10.1111/josi.12572

Robb, K. A., Simon, A. E., & Wardle, J. (2009). Socioeconomic Disparities in Optimism and Pessimism. *International Journal of Behavioral Medicine*, *16*(4), 331-338. https://doi.org/10.1007/s12529-008-9018-0

Rodriguez-Moreno, S., Vázquez, J. J., Roca, P., & Panadero, S. (2020a). Differences in stressful life events between men and women experiencing homelessness. *Journal of Community Psychology*, *49*(2), 375-389. https://doi.org/10.1002/jcop.22465

Rodriguez-Moreno, S., Farchione, T. J., Roca, P., Marín, C., Guillén, A. I., & Panadero, S. (2020b). Initial Effectiveness Evaluation of the Unified Protocol for Transdiagnostic Treatment of Emotional Disorders for Homeless Women. *Behavior Modification*, *46*(3), 506-528. https://doi.org/10.1177/0145445520982562

Rosenberg, M. (1965). *Society and the Adolescent Self-Image.* Princeton University Press.

Ryan, R. M., & Deci, E. L. (2001). On Happiness and Human Potentials: A Review of Research on Hedonic and Eudaimonic Well-Being. *Annual Review of Psychology*, *52*(1), 141-166. https://doi.org/10.1146/annurev.psych.52.1.141

Ryff, C. D., & Keyes, C. L. M. (1995). The structure of psychological well-being revisited. *Journal of Personality and Social Psychology*, *69*(4), 719-727. https://doi.org/10.1037//0022-3514.69.4.719

Salem, B. E., Kwon, J., & Ames, M. (2017). On the Frontlines: Perspectives of Providers Working with Homeless Women. *Western Journal of Nursing Research*, *40*(5), 665-687. https://doi.org/10.1177/0193945916689081

Sandín, B., Valiente, R., Chorot, P., Santed, M., & Lostao, L. (2008). SA-45: forma abreviada del SCL-90. *Psicothema*, *20*(2), 290-296. https://www.psicothema.com/pdf/3463.pdf

Sanjuan, P., & Avila, M. (2016). Afrontamiento y motivación como predictores del bienestar subjetivo y psicológico. *Revista de Psicopatología y Psicología Clínica*, *21*(1). https://doi.org/10.5944/rppc.vol.21.num.1.2016.15401

Sarasjärvi, K. K., Elovainio, M., Appelqvist-Schmidlechner, K., Solin, P., Tamminen, N., & Therman, S. (2023). Exploring the structure and psychometric properties of the Warwick-Edinburgh Mental Well-Being Scale (WEMWBS) in a representative adult population sample. *Psychiatry Research, 328*, 115465. https://doi.org/10.1016/j.psychres.2023.115465

Sauer-Zavala, S., Ametaj, A. A., Wilner, J. G., Bentley, K. H., Marquez, S., Patrick, K. A., Starks, B., Shtasel, D., & Marques, L. (2018). Evaluating transdiagnostic, evidence-based mental health care in a safety-net setting serving homeless individuals. *Psychotherapy*, *56*(1), 100-114. https://doi.org/10.1037/pst0000187

Schmidt, R., Hrenchuk, C., Bopp, J., & Poole, N. (2015). Trajectories of women's homelessness in Canada's 3 northern territories. *International Journal of Circumpolar Health*, *74*(1), 29778. https://doi.org/10.3402/ijch.v74.29778

Schrank, B., Brownell, T., Jakaite, Z., Larkin, Ch., Pesola, F., Riches, S., Tylee, A., & Slade, M. (2016). Evaluation of a positive psychotherapy group intervention for people with psychosis: Pilot randomised controlled trial. *Epidemiology and Psychiatric Sciences, 25*(3), 235-246. https://doi.org/10.1017/S2045796015000141

Seastres, R. J., Hutton, J., Zordan, R., Moore, G., Mackelprang, J., Kiburg, K. V., & Sundararajan, V. (2020). Long-term effects of homelessness on mortality: a 15-year Australian cohort study. *Australian and New Zealand Journal of Public Health*, *44*(6), 476–481. https://doi.org/10.1111/1753-6405.13038

Seligman, M. E. P., Steen, T. A., Park, N., & Peterson, C. (2005). Positive psychology progress: Empirical validation of interventions. *The American psychologist, 60*(5), 410-421. https://doi.org/10.1037/0003-066X.60.5.410

Shankar, S., Hubley, A. M., & Zumbo, B. D. (2017). General, Health-Specific, and Housing-Specific Self-Efficacy Scales: Preliminary Reliability and Validity Evidence with Homeless or Vulnerably Housed Adults. *Journal Of Well-Being Assessment*, *1*(1-3), 57-75. https://doi.org/10.1007/s41543-018-0005-1

Shah, N., Cader, M., Andrews, B., McCabe, R., & Stewart-Brown, S. L. (2021). Short Warwick-Edinburgh Mental Well-being Scale (SWEMWBS): performance in a clinical sample in relation to PHQ-9 and GAD-7. *Health And Quality of Life Outcomes*, *19*(1). https://doi.org/10.1186/s12955-021-01882-x

Sharpley, C. F., Murcell, N., Anderson, M., Bitsika, V., Fourie, P. J., & Agnew, L. L. (2021). An exploration of recent life stress, psychological resilience, purpose in life, and optimism as correlates of depression in social housing residents in rural Australia. *International Journal of Mental Health*, *50*(3), 234-249. https://doi.org/10.1080/00207411.2021.1896079

Siegel, D. H., Smith, M. C., & Melucci, S. C. (2020). Teaching Social Work Students about Homelessness: an interdisciplinary interinstitutional approach. *Journal of Social Work Education*, *56*(sup1), S59-S71. https://doi.org/10.1080/10437797.2020.1741479

Straka, K., Blacketer, A. R., Martinez, R. L., Glover, A., Winiarski, D. A., Karnik, N. S., Schueller, S. M., & Zalta, A. K. (2022). Rates and correlates of well-being among youth experiencing homelessness. *Journal of Community Psychology*, *50*(8), 3746–3759. https://doi.org/10.1002/jcop.22869

Tennant, R., Hiller, L., Fishwick, R., Platt, S., Joseph, S., Weich, S., Parkinson, J., Secker, J., & Stewart-Brown, S. (2007). The Warwick-Edinburgh Mental Well-being Scale (WEMWBS): Development and UK validation. *Health and Quality of Life Outcomes, 5*(1), 63. https://doi.org/10.1186/1477-7525-5-63

Thomas, J., Bowes, N., Meyers, R., & Thirlaway, K. (2021). Mental well-being and physical activity of young people experiencing homelessness before and during COVID-19 lockdown: A longitudinal study. *Mental Health and Physical Activity, 21*, 100407. https://doi.org/10.1016/j.mhpa.2021.100407

Toolis, E., Dutt, A., Wren, A., & Jackson, G. R. (2022). "It's a place to feel like part of the community": Counterspace, inclusion, and empowerment in a drop-in center for homeless and marginalized women. *American Journal of Community Psychology*, *70*(1–2), 102–116. https://doi.org/10.1002/ajcp.12580

Tsai, J., Lapidos, A., Rosenheck, R. A., & Harpaz-Rotem, I. (2012). Longitudinal Association of Therapeutic Alliance and Clinical Outcomes in Supported Housing for Chronically Homeless Adults. *Community Mental Health Journal*, *49*(4), 438-443. https://doi.org/10.1007/s10597-012-9518-x

United Nations. (2021). *Homelessness and human rights*. United Nations Human Rights Office of the High Comissioner. https://www.ohchr.org/en/special-procedures/sr-housing/homelessness-and-human-rights

Van Straaten, B., Rodenburg, G., Van Der Laan, J., Boersma, S. N., Wolf, J. R. L. M., & Van De Mheen, D. (2016). Changes in social exclusion indicators and psychological distress among homeless people over a 2.5-Year period. *Social Indicators Research, 135*(1), 291–311. https://doi.org/10.1007/s11205-016-1486-z

Valiente, C., Espinosa, R., Contreras, A., Trucharte, A., Caballero, R., & Peinado, V. (2021). The feasibility and acceptability study of a positive psychology group intervention for people with severe psychiatric conditions. *The Journal of Positive Psychology*, 1-14. https://doi.org/10.1080/17439760.2021.1871940

Vázquez, J. J., Guillén, A. I., Martín, R. M., & Panadero, S. (2023). Effects of perceived discrimination on health, social support, and risk of mental ill-health among women experiencing homelessness in Spain: A longitudinal study. *Stigma and Health*, *9*(4), 529-535. https://doi.org/10.1037/sah0000453

Wampold, B. (2001). *The Great Psychotherapy Debate: Models, Methods and Findings*. Lawrence Erlbaum Associates Publishers.

Watson, J., Crawley, J., & Kane, D. (2016). Social exclusion, health and hidden homelessness. *Public Health*, *139*, 96–102. https://doi.org/10.1016/j.puhe.2016.05.017

Wenzel, S., Rhoades, H., Moore, H., Lahey, J., Henwood, B., La Motte-Kerr, W., & Bird, M. (2018). Life Goals Over Time Among Homeless Adults in Permanent Supportive Housing. *American Journal of Community Psychology*, *61*(3-4), 421-432. https://doi.org/10.1002/ajcp.12237

Winetrobe, H., Wenzel, S., Rhoades, H., Henwood, B., Rice, E., & Harris, T. (2017). Differences in Health and Social Support between Homeless Men and Women Entering Permanent Supportive Housing. *Women's Health Issues*, *27*(3), 286-293. https://doi.org/10.1016/j.whi.2016.12.011

Yang, X., & Mak, W. W. S. (2016). The Differential Moderating Roles of Self-Compassion and Mindfulness in Self-Stigma and Well-Being Among People

Living with Mental Illness or HIV. *Mindfulness*, *8*(3), 595-602. https://doi.org/10.1007/s12671-016-0635-4

Youn, S. J., Sauer-Zavala, S., Patrick, K. A., Ahles, E. M., Silvan, Y. A., Greig, A., Marques, L., & Shtasel, D. L. (2019). Barriers and Facilitators to Implementing a Short-Term Transdiagnostic Mental Health Treatment for Homeless Persons. *The Journal of Nervous and Mental Disease*, *207*(7), 585-594. https://doi.org/10.1097/nmd.0000000000001010

Yuan, Y., Knight, K. R., Weeks, J., King, S., Olsen, P., & Kushel, M. (2024). Loneliness among homeless-experienced older adults with cognitive or functional impairments: qualitative findings from the HOPE HOME study. *BMC Public Health*, *24*(1). https://doi.org/10.1186/s12889-024-18052-5

Appendix

Description of the Think and Cope Positively (TC+) Program

Table 1

TC+ description by modules, sessions, and targets

Module	Targets	Session	Session's goal	Therapy used	Previous studies
Emotions					
Welcome and Introduction	Increasing positive feelings and experiences	1	- Get to know the program, participants, rules, and materials. - Define our individual goals.	PPI	
Identification and amplification of positive emotions.		2	- Identify emotions and their function, connecting with the present moment. - Reflecting on the messages that pleasant emotions express to us.		Seligman et al. (2005)
Living positive emotions (savoring)		3	- Introduce the concept of savoring. - Amplify our positive experiences. - Generate pleasant experiences through the senses.		Bryant & Veroff (2017)
Thoughts					
Identifying my negative "trap" thoughts	Increasing optimism thoughts	4	- Identify negative "trap" thoughts. - Understand the influence they have.	CBT & PPI	Beck (2018)
Transforming my automatic thoughts into positive ones.		5	- Discuss the advantages of a more optimistic way of thinking. - Implement the keys to modify automatic thinking for a more future-oriented one.		Seligman et al. (2005)
Living Thoughts Positive Thoughts, Part I		6	- Learn specific skills to promote optimism.		Seligman et al. (2005)
Living Thoughts Positive Thoughts, Part II		7	- Learn specific skills to promote optimism.		Seligman et al. (2005)
Self-compassion					
Learning to be kind to myself	Self-compassion	8	- Understand the concept of self-kindness. - Learn to generate a kind voice towards oneself to achieve their goals.	ACT	Gilbert (2019)
Purpose of life					
Identifying a life purpose **Individual session*	Creating a life purpose	9	- Introduction to values and goals. - Identify the most essential critical areas and values for us.	ACT	Morris et al. (2013)

			- Working with the garden metaphor.		
Cope					
Identifying Coping Strategies Part I	Amplifying focused coping in SWB	10	- Know the repertoire of coping strategies.	CBT	Lazarus & Folkman (1984)
Identifying Coping Strategies Part II		11	- Identify adaptive strategies associated with well-being and those that are maladaptive and linked to discomfort.		Lazarus & Folkman (1984) Meyer (2012)
Identifying adaptive coping strategies linked to well-being		12	- Learn to think about and implement a plan of action to improve my well-being.		Lazarus & Folkman (1984) Meyer (2001)
			10		
Social Support					
Creating my life purpose with my close environment	Building quality social support	13	- Know the influence of stigma and self-stigma on my relationship with others. - Know the effect of gratitude on myself and others.	PPI	Emmons & McCullough (2003) McGuire et al. (2020)
Can you help me create my life purpose?		14	- Design what and how I want to share my life purpose with my environment.		
Sharing my life purpose with my special guests, farewell, and festivity ** Group session with the environment*		15	- Sharing our life purpose and round of gratitude.		

Note. ACT = Acceptance and commitment therapy; CBT = Cognitive behavioral therapy; PPI = Positive psychology interventions.