Emotional Psychoeducational Group for Psychiatric Inpatients. Findings from a Clinical Study

R. Lucattelli, M. Pecorari, V. Mentuccia, C. Biello, F. Riggio, T. Sagliano, G. Marino, G. Nicolò and L. Bernabei*

Mental Health Department, Piazza Aldo Moro, 1, 00034 Colleferro (RM) Italy

Abstract: This research investigates the impact of psychoeducational interventions on emotional well-being within an acute psychiatric setting. Through a comprehensive study conducted in a psychiatric ward, we assess the effectiveness of targeted psychoeducational programs in managing and improving emotional states among individuals facing acute psychiatric conditions.

Results: Repeated measures ANOVA shows significant change in emotional regulation measured by DERS, although not significantly different between group.

Discussion: Preliminary findings suggest promising results, indicating that emotional psychoeducational interventions may play a crucial role in enhancing emotional stability and fostering a more supportive environment within acute psychiatric care. This research contributes valuable insights to the evolving field of mental health interventions, with potential implications for optimizing therapeutic approaches in similar clinical settings.

Keywords: Psychoeducation, Psychiatric inpatients, Emotional dysregulation, Emotional wellbeing, Psychosocial interventions.

INTRODUCTION

Psychiatric inpatient care plays a pivotal role in the landscape of mental health, providing a dedicated setting for the assessment and management of complex conditions.

In a healthcare landscape where resources are becoming increasingly constrained, the spotlight on effective evidence-based interventions becomes crucial to ensure that psychiatric inpatient care not only serves as a refuge for individuals in crisis but also facilitates a trajectory towards sustained recovery (Voskes *et al*, 2021).

Emotions experienced and exhibited by patients in a hospital setting, which are often unpleasant and of high intensity play a pivotal role in shaping the dynamics of psychiatric wards (Roche *et al*, 2014), thus contributing to increasing conflicts or generating situations of high tension, fostering the creation of vicious cycles that result in an escalation of unpleasant emotions and sometimes aggressive acting out (Gross, 1998, 2002).

The decision-making processes leading to psychiatric admissions are intricate influenced not only by clinical assessments but also by the intricate interplay of emotional states within both patients and healthcare providers.

For these reasons, the importance of implementing psychosocial interventions in psychiatric wards is emphasized to manage such emotional dysregulation, thereby contributing to a better patient stay within the ward. One of the most widely used psychosocial interventions is psychoeducation, which enables healthcare professionals to interact directly with patients, explaining their conditions and the potential treatments to achieve a good level of well-being. International guidelines recommend psychoeducation as an integral part of the treatment for patients with severe mental illnesses, allowing them to understand their condition, improve their quality of life, enhance treatment compliance, and reduce relapses (Johnson *et al*, 2022).

Psychoeducational interventions play an important role not only in destigmatizing mental health issues, but also to know some aspects of mental health, often dark, and about social and emotional functioning (Ellis, 1998).

In the realm of psychiatric inpatient care, the integration of psychoeducation represents a paradigm shift towards a more holistic and patient-centric approach. Psychoeducation, encompassing structured and targeted education about mental health conditions and coping strategies, emerges as a valuable tool within the psychiatric ward setting (Gaine *et al*, 2022). This article explores the pivotal role of psychoeducation

*Address correspondence to this author at the Mental Health Department, Piazza Aldo Moro, 1, 00034 Colleferro (RM) Italy;
E-mail: Laura.bernabei@uniroma1.it; Laura.bernabei@aslroma5.it

E-ISSN: 2313-1047/23

in psychiatric inpatient care, shedding light on its potential to empower individuals, improve treatment adherence, and contribute to the overall efficacy of mental health interventions.

As mental health disorders continue to pose a significant global health challenge, the need for comprehensive and evidence-based interventions within psychiatric settings becomes increasingly apparent. Psychoeducation, as an integral component of this paradigm, offers a unique platform for fostering understanding, self-efficacy, and resilience among individuals navigating the complexities of psychiatric hospitalization. This exploration delves into the multifaceted benefits of psychoeducation within the psychiatric ward, emphasizing its capacity to demystify mental health conditions, mitigate stigma, and engender collaboration between patients and healthcare professionals. By imparting knowledge about the nature of psychiatric disorders, treatment modalities, and practical coping mechanisms, psychoeducation aims to empower individuals with the tools necessary for active participation in their recovery journey.

The purpose of patient psychoeducation is to promote and increase patients' knowledge, awareness and understanding of their illness and treatment. It's supposed that increased knowledge enables patients to cope more effectively with their illness. By promoting awareness among patients, their families, and healthcare professionals, these treatments contribute to the creation of a supportive and empathetic environment. Reduced stigma facilitates open communication, encouraging patients to seek assistance and engage more effectively with their treatment plans.

The psychoeducation may improve compliance with medication and the evidence shows a significant reduction of relapse rates and a possibility that psychoeducation has a positive effect on a person's wellbeing and promotes better social function (Xia *et al*, 2011).

Moreover, the hospitalization period offers a unique opportunity for intensive therapeutic interventions (Clarke and Glick, 2020). Incorporating psychoeducational components into inpatient care ensures that individuals receive a solid foundation for ongoing outpatient treatment, promoting continuity of care beyond the hospital setting. This continuity is crucial for sustained recovery and the prevention of relapses.

In conclusion, the integration of psychoeducational treatments during hospitalization is a key aspect of holistic mental health care. By empowering patients, reducing stigma, and laying the groundwork for long-term recovery, these interventions contribute significantly to the overall well-being of individuals grappling with severe mental disorders during their hospital stay and beyond.

OBJECTIVES OF THE STUDY

This article aims to explore the importance of psychiatric inpatient care as an integral component of mental health services, focusing on the validity and efficacy of evidence-based interventions within this context. The main aim is to verify the efficacy of an emotional psychoeducational group to enhancing emotional abilities during a psychiatric hospitalization. The study's design incorporates the presence of an acute phase, which may introduce additional complexities. Emotions during acute phases may be heightened or influenced by situational factors, potentially confounding the intervention's impact assessment.

STUDY DESIGN

Emotional psychoeducational group took place in the psychiatric ward of Polo Ospedaliero Leopoldo Parodi Delfino Hospital, at Colleferro (Department of Mental Health, ASL Roma 5), near Rome (www.aslroma5.info/web/spdc/spdc-colleferro). The team is specialized in the care of individuals with SMI and is trained in the administration of Cognitive Behavioral Treatment and psychoeducational protocols. Group therapies take place in a dedicated room specifically designed for group sessions. The room is equipped with sofas, tables, and a television. Patients and facilitators arrange themselves in a circle, seated on the sofas or chairs brought in from the dining throughout the entire session. Each session is attended by a facilitator, a co-facilitator, and observer.

The duration of the session varies, ranging from 45 minutes to an hour and a half, depending on the topic being discussed and the needs of the patients. Every group therapy session adheres to common rules: each participant takes turns speaking, individuals are free to leave the group at any time and can choose to remain outside or rejoin, no offensive words or phrases are

allowed towards other present users, it is important not to disturb those who genuinely wish to participate in the session, and mobile phones must be on silent.

RECRUITMENT METHOD

An open-label approach was chosen for the research conducted within a psychiatric emergency hospital department.

Regardless of their characteristics or willingness to cooperate, all patients receive treatment.

This methodology reflects more closely what is happening in the real world, where clinicians are confronted with reduced patient insight and issues related to the severity of psychopathology.

Therefore, all admitted patients to the psychiatric ward were invited to join the emotional psychoeducational group, regardless of their diagnosis and/or psychopathological status.

Patients who did not take part in the Emo.P group were recruited for the TAU.

At the time of their hospital admission, all patients gave their written informed consent to receive an integrated treatment, psychological too.

ASSESSMENT

All participants completed a psychological assessment administered by two senior psychologists, to evaluate: i) the health and social functioning (with HONOS); ii) the presence of aggressivity (with STAXI-2); iii) the ability to attribute mental state (with Eyes test); iv) the social cognition abilities (with MSCEIT); the presence of impulsivity (with Bis-11); and the emotion regulation strategies (with DERS).

HoNOS

The HoNOS (Health of the Nation Outcome Scales) is a tool developed by the Research Unit of the Royal College of Psychiatrists to assess the level of well-being in terms of functioning and health for individuals suffering from severe mental disorders. It is characterized by its brevity and simplicity, consisting of 12 items, making it suitable for routine clinical use. The instrument is structured to investigate both clinical and social aspects and is sensitive to changes over time.

The HoNOS can be completed by the clinician after an interview with the individual. It consists of 12 items that cover 4 areas:

1. Subjective mental experiences that disturb or limit the individual, such as depression, anxiety, hallucinations, and worries.

2. Deficits in basic functions, such as psychomotor slowing and cognitive and physical impairments, with their direct effects on the individual's functioning.

3. Behavioral problems that have a significant impact on the individual and/or others, such as self-directed and/or other-directed violence.

4. Environmental problems (housing, occupational, economic, interpersonal, and social support system) that may limit the functional autonomy that the individual could potentially achieve (Wing *et al*, 1999).

The severity rating is expressed on a scale from 0 to 4, where 0 corresponds to the absence of problems in that area and 4 indicates the maximum severity. The lack of information is marked as '9'. The total score generally reflects the overall severity (Wing *et al*, 1999; Lovaglio and Monzani, 2011).

State-Trait Anger Expression Inventory - 2 (STAXI-2)

The State-Trait Anger Expression Inventory - 2 (STAXI-2) provides a measure of the experience, expression, and control of anger. It includes state and trait anger, and the expression of anger involves outward anger (anger-out) and inward-directed anger (anger-in). Numerous subscales assess different aspects of state and trait anger.

Assessment is done on a scoring scale from 1 to 4, describing the frequency of experienced anger (1 = 'not at all,' 2 = 'a little,' 3 = 'moderately,' 4 = 'very much') (Spielberger, 1999).

Reading the Mind in the Eyes test (Eyes Test)

The Reading the Mind in the Eyes test, also known as the Eyes Test, was introduced by Baron-Cohen and colleagues (Baron-Cohen *et al*, 1997) to assess individuals' ability to attribute complex mental states to adults and adolescents without severe mental delays (Baron-Cohen *et al*, 2001).

The test consists of 37 black and white photographs sourced from English newspapers and magazines. The first photograph serves as a practice stimulus, while the subsequent 36 are the actual test stimuli. Each photo depicts faces of young, adult, and elderly individuals of both sexes, showing only the eye region. At the four corners, four different adjectives or terms related to

emotional expressions are presented. The participant must choose the one that best describes each of the 36 gazes. The attributes presented in each figure correspond to four different complex mental states. Since the judgments required are based on facial expressions, this test can be considered an emotion recognition test (Vellante *et al*., 2013), which is considered a fundamental component of social cognition.

Reference values for interpreting test scores vary depending on the age of the individual. Three different cut-off points have been identified based on age groups (18-40 years = 19; 41-60 years = 15; 61-93 years = 9).

Mayer-Salovey-Caruso Emotional Intelligence Test (MSCEIT)

Emotional intelligence is one of the many aspects that define an individual's personality and abilities. The Mayer-Salovey-Caruso Emotional Intelligence Test (MSCEIT) defines emotional intelligence as an ability and measures people's ability to solve emotionally charged problems or problems that require the use of emotions for their resolution (Mayer *et al*, 2002). Emotional intelligence, as measured by the MSCEIT, refers to the capacity to reason with emotions and the ability of emotions to enhance thinking.

The MSCEIT provides fifteen scores: eight task scores (Task A - Faces; Task E - Pictures; Task B - Facilitation; Task F - Sensations; Task C - Changes; Task G - Blends; Task D - Emotional Management; Task H - Emotional Relationships), four arm scores (Arm 1 - Perceiving Emotions; Arm 2 - Facilitating Thought; Arm 3 - Understanding Emotions; Arm 4 - Managing Emotions), two area scores (Experiential Area and Strategic Area), and a total emotional intelligence quotient, structured like a tree.

Scores are distributed along a scale ranging from <70 to >130, where: p<70 = very low; 70<p<90 = low; 90<p<110 = medium; 110<p<130 = high; p>130 = very high.

Barratt Impulsiveness Scale Bis-11

The Barratt Impulsiveness Scale, Version 11, has been developed for the assessment of impulsivity, understood as 'acting without thinking,' and as a lack of control over thoughts and behaviors. The BIS-11 considers three types of impulsivities: i) Motor Impulsiveness; ii) Non-Planning Impulsiveness; iii) Attentional Impulsiveness.

The BIS-11 discriminates between impulsive and non-impulsive individuals. The scale assesses personality traits, and the period explored is therefore the entire lifespan. It consists of 30 items; Items are rated on a 4-point scale, from 1 = rarely or never to 4 = almost always/always. The total score can range from 30 to 120; the average score ranges from 63.8 (±10.2) in controls, to 69.3 (±10.3) in subjects with addictive behaviours, to 71.4 (±12.6) in psychiatric patients, and to 76.3 (±11.9) in imprisoned males (Barratt, 1965).

Difficulties in Emotion Regulation Scale DERS

The Difficulties in Emotion Regulation Scale (DERS) is one of the most widely used tests for assessing difficulties in emotional regulation in the adult population (Sighinolfi, 2010). It is a self-report questionnaire that measures clinically relevant difficulties in regulating negative emotions. This tool allows for measurements regarding the potential presence of difficulties in the following dimensions: (a) awareness and understanding of emotions, (b) acceptance of emotions, (c) ability to control impulsive behaviours and act following one's goals, and (d) the capacity to use flexible emotional regulation strategies appropriate to the context and situational demands.

It contains six scales: i) NON-ACCEPTANCE, non-acceptance of emotional responses; ii) GOALS, difficulties in adopting goal-directed behaviours; iii) IMPULSE, difficulty in impulse control; iv) AWARENESS, lack of emotional awareness; v) STRATEGIES, limited access to emotional regulation strategies; 6) CLARITY, lack of emotional clarity (Sighinolfi, 2010). The score ranges from 1 to 5, where 1 = Rarely, and 5 = Almost always. The total score can range from a minimum of 36 to a maximum of 180. In the sample by Sighinolfi *et al*., the total DERS score was 61.38±15.37.

Only DERS was Administered at Baseline (T0) and after the EMO.P Group (T1)

Psychiatric Symptoms

Overall patients' psychiatric symptoms were assessed using the Brief Psychiatric Rating Scale (BPRS), which is one of the most widely used psychiatric symptom inventory for the assessment of the severity of psychopathology (Overall, 1962).

At the discharge from the psychiatric ward, every patient is asked to complete a satisfaction questionnaire specially structured to highlight the strengths and weaknesses of hospital management.

METHODS

Study Design

At admission (T0) and discharge (T1) from hospitalization, the test battery was administered. Every day, both in the morning and afternoon, a group therapy session was offered to improve the perception and management of emotions.

All patients assumed adequate pharmacological treatment with antipsychotics, mood stabilizers and/or benzodiazepines, with different combinations according to their needs of care.

Emotional Psychoeducational Group: Description of Intervention

Emotional psychoeducational groups were conducted by a therapist of psychiatric rehabilitation, with the supervision of two senior psychologists, and were held two times a day.

The content comes from the synthesis of the best evidence in this field and does not follow a specific model already manualized.

The morning session was dedicated to the psychoeducation of emotions, covering topics such as: i) what emotions are ("positive", such as *joy, happiness, love, comfort, pleasure* etc., and "negative", such as *sadness, loneliness, anguish, anger* etc.); ii) what are the physiological correlates of emotions and in which part of the body they are located (rapid heart rate and breathing, muscle tension, heaviness in the stomach, etc.); iii) understand a simple ABC of emotions (*e.g*. analyzing the history of a behavior and identifying the underlying belief); and emotional regulation strategies ("*what we do to maintain a positive emotion*" or *"what do we do when we feel sad or angry*?") (Lehay, 2002).

The afternoon session, on the other hand, was mostly experiential and alternated between mindfulness exercises and progressive muscle relaxation.

In every session, videos to help subjects to pay attention to the exercises to be performed were used. During the progressive muscle relaxation, an audio guide was used too (Table **1**).

The duration of each session varied between 45 minutes and 90 minutes, depending on the topic and the patients present.

STATISTICS

Statistical analyses were performed using Statistical Package for the Social Sciences Version 20.0 (SPSS 20.0) for Windows (SPSS Inc., Chicago, Ill). Distributions of the continuous measures were examined prior to analysis and when necessary, the data is transformed into logs; one-way between-group Analysis of variance (ANOVA) for continuous variables, and the chi-square test (x^2) for categorical variables was used to compare frequencies.

Table 1: Emotional Psychoeducational Group: Morning and Afternoon Sessions

EMOTIONAL PSYCHOEDUCATIONAL GROUP						
			Topics	***Examples***	***Instruments***	***References***
MORNING	*Therapist*	Psychoeducation on emotions	*Increase awareness and knowledge about emotions*	"What do you know about emotions?" *"What are the physiological correlates of emotions?"* *Etc..*	Group discussion Video Pc Slides	Robert Lehay James J Gross
AFTERNOON	*Therapist*	Mindfulness exercises and progressive muscle relaxation	*Promote the acquisition of relaxation and mindfulness techniques*	*Body-scan exercise* *Breath awareness* *Muscle relaxation*	Physical relaxation Video Darkroom Slides	John Kabat-Zinn Paul Gilbert Marsha Linehan

ANOVA one-way was used at the baseline to compare emotional abilities (emotional recognition, emotional management etc.) between two groups. The threshold for statistical significance was set at 0.05 (two-tailed, $p < 0.05$).

The assessments on emotional regulation strategies were analyzed using repeated measures analysis of variance (ANOVA), with the "EmoP.group" (emotional psychoeducational group VS Treatment as Usual) as the between-subject factor, followed by post-hoc pairwise comparisons. Effect sizes were calculated with partial eta-squared values (values ranging between 0.01 and 0.06 were considered as small effect, values ranging between 0.07 and 0.14 were considered as medium effect, and values higher than 0.14 were considered as large effect) (Richardson, 2011).

RESULTS

46 subjects, aged between 18-72 years (M= 38.6; DS=15.4), with a scholarity mean of 11.6 (DS= 3.3), who suffered of severe mental illness [19.57%= Psychosis (N= 9), (schizophrenia and schizoaffective disorder); 50%= mood disorders (N= 23), (bipolar disorders; major depression); 30.43%)= personality disorders (N= 14), borderline personality disorder; narcissist personality disorder, schizotypal personality disorder] (APA, 2013) were enrolled. The duration of hospitalization had a mean of 15.9 days (DS= 7.3).

Table 2: Distribution of Diagnosis

Diagnosis	Group			Chi-square test		
	Emo.P	*TAU*	*Total*	*value*	*df*	*Sig*
Mood Disorders	16	7	23			
Personality Disorders	6	8	14	3.190	2	.203
Psychosis	4	5	9			
Total	26	20	46			

Table 3: Clinical Assessment at Baseline

BASELINE	Group		t-test		
	Emo.P	TAU	t	df	Sig (2-tailed)
Eyes Test	3.1(.30)	3.2(.12)	-1.243	44	.221
Honos	3.0(.24)	3.0(.27)	.468	44	.642
STAXI_R_S§	51.23(10.9)	53.80(13.5)	-.714	44	.479
STAXI_RS_S§	52.96(15.3)	54.6(14.92)	-.364	44	.717
STAXI_RS_V§	47.53(10.91)	53.5(14.09)	-1.618	44	.113
STAXI_RS_F§	46.65(8.17)	51.20(10.43)	-1.659	44	.104
STAXI_R_T	45.77(10.3)	56.20(12.41)	-3.115	44	.003**
STAXI_RT_T§	44.84(11.75)	54.0(18.61)	-2.038	44	.048*
STAXI_RT_R	44.23(11.47)	51.7(10.16)	-2.298	44	.026*
STAXI_ER_OUT	46.0(9.31)	58.6(13.3)	-3.785	44	.000**
STAXI_ER_IN	54.0(11.95)	56.20(11.02)	-.640	44	.526
STAXI_CR_OUT	49.03(9.8)	45.10(9.4)	1.372	44	.177
STAXI_CR_IN	53.89(11.75)	49(9.4)	1.518	44	.136
STAXI_ER_INDEX	47.77(8.8)	56.7(12.1)	-2.900	44	.006**
BPRS_T0	50.73(13.01)	47.9(6,5)	.888	44	.379
BPRS_T1	30.27(6.3)	30.75(4.56)	-.289	44	.774
MSCEIT_QI_TOT	95.7(16,71)	94.15(14,9)	.325	44	.747
MSCEIT_QIEsper	99.3(17,9)	94.6(14,3)	.965	44	.340
MSCEIT_QIStrateg	92.11(15,25)	94.85(14,04)	-.624	44	.536

§: Log10 trasformation; *: < .05; **: < .01

26 subjects were assigned at Emo.P group on the management of angry; 20 subjects were assigned at the TAU group. The distribution of diagnosis within the group is not significant (Table **2**).

There were no significant differences between groups by age, years of education, gender, age of psychopathological onset, disease duration and psychopathological status measured by BPRS ($p > .05$).

In the Table **3** the results of the group comparison conducted at baseline for tests on theory of mind (Eyes Test), overall functioning (HoNOS), emotional intelligence, and aggression (STAXI) are reported. Also included in the report are the scores obtained at the BPRS upon admission and discharges from psychiatric ward.

For all statistically significant measures (STAXI_R_T, STAXI_RT_T, STAXI_RT_R, STAXI_ER_OUT, and STAXI_ER_index), the Treatment as Usual (TAU) group exhibits higher scores at baseline compared to the Emo.P group.

Repeated measures ANOVA shows a significant statistical difference within the group (Time), but not related to the Emo.P group.

To assess the acceptability of the offered emotional psychoeducation program, the scores obtained from the satisfaction questionnaire administered at the end of the hospital stay were compared.

The explored domains could be assigned a score from 0 to 4, where 0= bad and 4= excellent. They were asked to assess doctors; nurses; psychologists, technicians of psychiatric rehabilitation, and other things. The following table describes the scores obtained by the two groups at the item on psychologist and technician of psychiatrist rehabilitation. Figure **1** shows the comparison of scores obtained from the satisfaction questionnaire by the Emo.P and TAU Group. The Emo.P group scored highest in all domains investigated, suggesting a greater degree of appreciation for the care service offered.

Table 4: Repeated Measures ANOVA for DERS Total Score

	T0		T1		Repeated Measures ANOVA						
					Time		Group		Time x Group Interaction		
	PE	TAU	PE	TAU	F	P	F	P	F	P	Effect Size
DERS	95.42 (36.18)	98.15 (23.97)	79.88 (26.86)	87.45 (24.99)	14.311	.000	.487	.489	.428	.517	.923

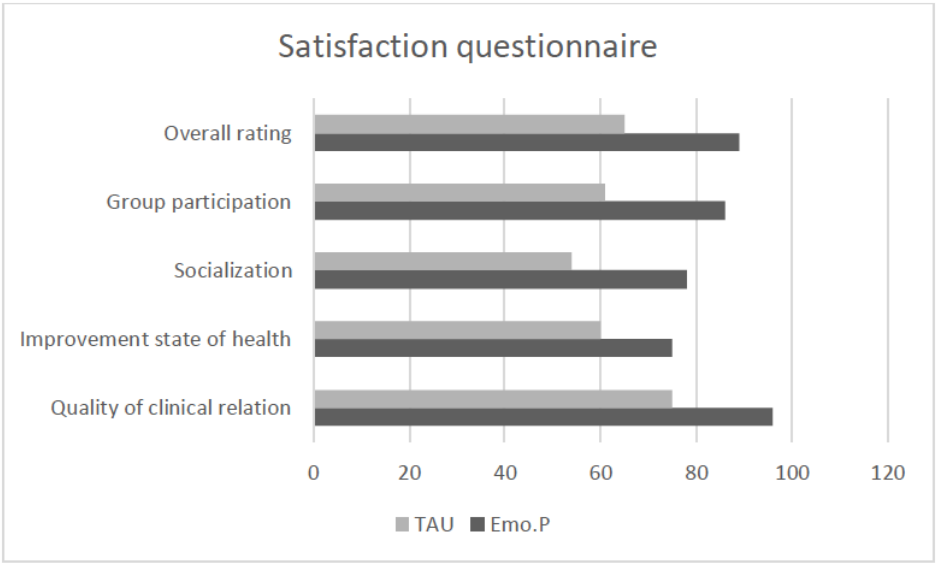

Figure 1: Graph representing differences to the Satisfaction Questionnaire.

Table 5: Satisfaction Questionnaire Scores

Satisfaction questionnaire	Emo.P	TAU
Quality of clinical relation and support received	96	75
Improvement of the state of health following therapies and treatments received	75	60
Level of socialization with other patients	78	54
Involvement and participation in groups therapy	86	61
Overall rating	89	65

DISCUSSION

Psychoeducational groups play a pivotal role in promoting emotional well-being within a psychiatric hospital setting. By providing patients with a structured platform to understand, express, and regulate their emotions, these groups contribute significantly to the overall therapeutic process. The significance of psychoeducational groups lies in their ability to enhance emotional literacy among patients. As individuals gain a deeper understanding of their emotions, including the physiological and cognitive aspects, they become better equipped to navigate the challenges of their mental health journey toward recovery (Hayes *et al*, 1999; 2004).

The group dynamics inherent in psychoeducational sessions foster a sense of community and mutual support. Patients not only learn from the facilitators but also draw strength and insights from their peers. This collective experience creates a supportive environment that can be instrumental in the healing process (Falloon *et al*, 1993).

Empowerment through knowledge is a key outcome of psychoeducational groups. As patients acquire tools and strategies for emotional regulation, they regain a sense of control over their mental health (Gross *et al*, 2003). This empowerment can have a lasting impact on their ability to cope with challenges both inside and outside the hospital setting. While individual therapy has its merits, psychoeducational groups complement these one-on-one sessions by providing a broader context for emotional understanding, above all within a hospital context (Falloon *et al*, 2004). The group setting allows for diverse perspectives and shared experiences, enriching the therapeutic landscape.

Research consistently supports the notion that psychoeducational groups have a positive and enduring impact on the recovery process (Lynch *et al*, 2010). Equipping patients with the skills to understand and manage their emotions not only contributes to their well-being during hospitalization but also serves as a foundation for continued mental health maintenance post-discharge (Sharpe *et al*, 2020). Moving forward, recognizing, and expanding the role of psychoeducational groups in psychiatric hospitals is crucial. Continued research, innovation in group formats, and a focus on tailoring interventions to individual needs can further optimize the impact of these groups on emotional well-being.

Future research with longer intervention periods would provide a more nuanced understanding of the intervention's lasting impact on emotional outcomes. Stratified analyses or subgroup examinations based on relevant characteristics might be necessary to discern the differential impact of the psychoeducational intervention on distinct subpopulations. A more comprehensive investigation into the intervention's efficacy across different phases of emotional experiences, including acute and chronic states, would enhance the study's applicability to a broader range of emotional contexts.

In conclusion, the integration of psychoeducational groups into psychiatric hospital care represents a valuable and multifaceted approach to addressing the emotional needs of patients (Falloon *et al*, 2004). By fostering knowledge, community, and empowerment, these groups contribute significantly to the holistic recovery of individuals within a psychiatric setting.

In conclusion, our study underscores the significance of psychoeducational interventions in the context of acute psychiatric care, specifically addressing emotional regulation. The findings reveal a notable positive impact on participants, as evidenced by improvements in emotional regulation strategies. The results suggest that integrating psychoeducational programs into the treatment regimen of acute psychiatric wards can contribute to a more holistic and effective approach to patient care (Gaine *et al*, 2022).

While these findings are promising, it is essential to recognize the need for continued research and exploration in this field. Future studies could delve deeper into specific components of psychoeducational interventions, assess long-term effects, and explore potential variations based on individual patient characteristics. Ultimately, this research contributes to the ongoing dialogue on optimizing mental health interventions in acute psychiatric care, to foster improved emotional well-being and overall patient outcomes (Johnson *et al*, 2022).

LIMITS

The present study aimed to explore the effectiveness of a psychoeducational intervention on emotions. While the research contributes valuable insights into the field of emotional interventions, it is essential to acknowledge and discuss several limitations that may impact the generalizability and interpretability of the findings. One significant limitation of the study is the relatively small sample size. The restricted number of participants may compromise the statistical power of the analysis, potentially limiting the ability to detect subtle but meaningful effects of the psychoeducational intervention. A larger and more diverse sample would enhance the external validity of the study and provide a more comprehensive understanding of the intervention's impact across various demographic groups. Another constraint lies in the brief duration of the psychoeducational intervention. Short-term interventions may not capture the full spectrum of potential changes in emotional well-being, and sustained effects over an extended period may remain unexplored.

The heterogeneity within the participant sample poses another limitation. Individual differences in baseline emotional states, cognitive functioning, and personal circumstances could introduce variability that obscures the true effects of the intervention.

In conclusion, while the present study sheds light on the potential benefits of a psychoeducational intervention on emotions, it is crucial to interpret the findings considering the identified limitations. Addressing these limitations in future research endeavors will contribute to a more robust understanding of the intervention's efficacy and facilitate the development of targeted and effective psychological interventions for emotional well-being.

REFERENCES

[1] APA, Diagnostic and Statistical Manual of Mental Disorders Fifth Edition. DSM-5, Washington DC 2013.

[2] Baron-Cohen S, Jolliffe T, Mortimore C, & Robertson M. (1997). Another advanced test of theory of mind: Evidence from very high functioning adults with autism or Asperger Syndrome. Child Psychology & Psychiatry & Allied Disciplines, 38(7): 813-822. https://doi.org/10.1111/j.1469-7610.1997.tb01599.x

[3] Baron-Cohen S, Wheelwright S, Hill J, Raste Y, Plumb I. The "Reading the Mind in the Eyes" Test revised version: a study with normal adults, and adults with Asperger syndrome or high-functioning autism. J Child Psychol Psychiatry 2001 Deb; 42(2): 241-51. https://doi.org/10.1111/1469-7610.00715

[4] Barratt ES. Factor analysis of some psychometric measures of impulsiveness and anxiety. Psychological Reports 1965, 16; 547-55. https://doi.org/10.2466/pr0.1965.16.2.547

[5] Clarke A, Glick ID. The crisis in psychiatric hospital care: changing the model to continuous, integrative behavioral health care. Psychiatric Services 2020; 71: 165-169. https://doi.org/10.1176/appi.ps.201900259

[6] Ellis A, Maclaren C (1998). Rational emotive behavior therapy: A therapist's guide San Luis Obispo, CA.

[7] Falloon I, Fadden G, Integrated mental health care. Cambridge University Press, Cambridge 1993.

[8] Falloon I, Montero I, Sungur M, et al, (2004). Implementation of evidence-based on treatment for schizophrenic disorders: two-year outcome of an international field trial of optimal treatment. World Psychiatry June 3: 2.

[9] Gaine GS, Dubue JD, Purdon SE, Abba-Aji A. Psychiatric hospital experiences that support and frustrate emerging adult's psychological needs: a self-determination theory perspective. Early Intervention in Psychiatry 2022; 16: 402-409. https://doi.org/10.1111/eip.13179

[10] Gross JJ (1998). Antecedent-and-response focused emotion regulation: Divergent consequences for experience, expression, and physiology. Journal of Personality and Social Psychology. https://doi.org/10.1037/0022-3514.74.1.224

[11] Gross JJ (2002). Emotion Regulation: Affective, cognitive, and social consequences. Psychophysiology. https://doi.org/10.1017/S0048577201393198

[12] Gross JJ & John OP (2003). Individual differences in two emotion regulation processes: Implications for affect, relationships, and well-being. Journal of Personality and Social Psychology, 85, 348-362. https://doi.org/10.1037/0022-3514.85.2.348

[13] Hayes SC, Strosahl K, Wilson KG (1999). Acceptance and Commitment Therapy: An-experiential approach to behavior change. New York: Guilford Press.

[14] Hayes SC, Strosalch KD (2004). A pratical guide to Acceptance and commitment therapy. Springer, New York. https://doi.org/10.1007/978-0-387-23369-7

[15] Johnson S, Dalton-Locke C, Baker J, Hanlon C, Salisbury TT, Fossey M, Newbigging K, Carr, SE, Hensel J, Carrà G, Hepp U, Caneo C, Needle, JJ, Lloyd-Evans B. Acute Psychiatric care: approaches to increasing the range of services and improving access and quality of care. World Psychiatry 2022; 21: 220-236. https://doi.org/10.1002/wps.20962

[16] Lehay RL. Resistance: an Emotional Schema Therapy (EST) approach. In Simos G.: Cognitive behavior therapy: a guide for the practing clinician, London 2002: Routledge

[17] Lovaglio PG and Monzani E. Validation aspects of the health of the nation outcome scales. International J Mental Health Systems 2011; 5-20. https://doi.org/10.1186/1752-4458-5-20

[18] Lynch D, Laws KR, McKenna PJ. Cognitive behavioral therapy for major psychiatric disorder: does it really work? A meta-analytical review of well-controlled trials. Psychol Med 2010; 40: 9-24. https://doi.org/10.1017/S003329170900590X

[19] Mayer JD, Salovey P, & Caruso D (2002). Mayer-Salovey-Caruso Emotional Intelligence Test (MSCEIT) Users Manual. Toronto, Ontario: Multi-Health Systems.

[20] Overall, J.E. and Gorham, D.R. (1962) The Brief Psychiatric Rating Scale. Psychological Report, 10, 799-812. https://doi.org/10.2466/pr0.1962.10.3.799

[21] Roche E, Madigan K, Lyne JP, Feeney L, O'Donoghue B. The therapeutic relationship after psychiatric admission. The Journal of Nervous and Mental disease, 2014; (202)3 March. https://doi.org/10.1097/NMD.0000000000000102

[22] Sharpe M, Toynbee M, Walker J, for the HOME Study Proactive Integrated Consultation-Liaison Psychiatry (Proactive Integrated Psychological Medicine Group). Proactive Integrated Consultation-Liaison Psychiatry: a new service model for the psychiatric care of general hospital inpatients. General Hospital Psychiatry 66 (2020) 9-15. https://doi.org/10.1016/j.genhosppsych.2020.06.005

[23] Sighinolfi C, Norcini Pala A, Ciri LR, Marchetti I, Sica C. Traduzione e adattamento Italiano del Difficulties in Emotion Regulation Strategies (DERS): una ricerca preliminare. Psicoterapia Cognitiva e Comportamentale 2010 April.

[24] Spielberger CD, Lushene RE, Vagg BA, Jacobs E. Manual for the State-trait Anger Expression Inventory. Consulting Psychology, Palo Alto 1983.

[25] Vellante M, Baron-Cohen S, Melis M, Marrone M, Petretto DR, Masala C, Preti A. The "Reading the Mind in the Eyes" test: systematic review of psychometric properties and a validation study in Italy. Cogn Neuropsych 2013 Jul; 18(4): 326-54. https://doi.org/10.1080/13546805.2012.721728

[26] Voskes Y, van Melle AL, Widdershoven GAM, van Mierlo AFMM, Bovenberg FJM, Mulder CL. High and Intensive care in psychiatry: a new model for acute inpatient care. Psychiatric Services 2021; 72: 475-477. https://doi.org/10.1176/appi.ps.201800440

[27] Wing JK, Curtis RH Beevor AS. Health of the Nation Outcome Scales (HoNOS): glossary for HoNOS score sheet. British J Psychiatry 1999; 174: 432-434. https://doi.org/10.1192/bjp.174.5.432

[28] Xia J, Merinder LB, Belgamwar MR. Psychoeducation for schizophrenia. Cochrane Database Syst Rev. 2011 Jun 15; 2011(6): CD002831. https://doi.org/10.1002/14651858.CD002831.pub2

Received on 27-10-2023 Accepted on 04-12-2023 Published on 14-12-2023

DOI: https://doi.org/10.12974/2313-1047.2023.10.10