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Psychoeducation Intervention for the Mental Health of College Students

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Abstract: In terms of incidence and severity, mental health issues among college students are on the rise. At the same time, the number of high school graduates enrolling in colleges and universities is rising, making college a perfect time to address current and emerging mental and psychological issues. Traditional counseling center services, while successful, are not appropriate for all students and require too many resources to satisfy the complete needs of the college population. To meet the growing demand for mental health services among college and university students, innovative strategies are required that are resource-efficient, can reach a broader range of students by overcoming treatment barriers, can effectively address current mental health concerns, and can effectively prepare students for the mental and emotional challenges they will face in today's world. The use of diverse psychoeducational approaches to the treatment of common mental health difficulties, as well as the building of resiliency for the protection against future challenges, is supported by available research. By incorporating psychoeducational approaches into a semester class under the umbrella of psychoeducational resources, this study offers a viable solution to the growing demand for mental health care. This course combines physiological and psychological understandings of stress and stress management, problem-solving, cognitive restructuring, and assertiveness, all of which are effective not only in the treatment of stress but also in the treatment of common mental illnesses like anxiety and depression. This course also includes a set of skills that are compatible with the positive psychology literature on resilience development. Instructors, intervention presentations, intervention modules, and reading, homework, and practice recommendations are all provided and grouped into individual modules to make it easier to adapt to different formats.

Keywords: Psychoeducation, Cognitive Behavioral Therapy, Social Cognitive Theory, College Students, Mental Health Issues

1. Introduction

While evidence suggests that therapy can help with mental health concerns [10] many counseling centers are unable to keep up with demand [2]. and many students are unable to access traditional mental health treatments. To fulfill the rising need for mental health services and to reach students who might not otherwise seek treatment, innovative solutions are required.

It makes sense to focus on the most prevalent problems that college students confront and to teach methods that can be used to treat or prevent a variety of disorders. Process, connection, and insight-oriented therapies all need intensive psychotherapy and a large investment of therapist time, therefore teaching strategies that are helpful in the treatment of numerous disorders would be ideal. The focus of this review will be on treatment modalities that are effective for treating illnesses, lend themselves to a psychoeducational approach, and require minimal therapist engagement. These treatments must not involve intense therapist-client interactions, such as those that rely on the therapeutic connection, insight, or interpretation, to be resource-effective. These methods are more likely to concentrate on developing skills that are useful in treating and avoiding mental illnesses. This technique may also avoid the stigma associated with traditional therapeutic approaches, making it more suited for students who are uncomfortable with traditional treatment and want a more self-directed or educational approach to coping with their mental health issues. Of course, this technique will not work for all students, and many will require the more intensive and personal experience of a therapy relationship as well as professional guidance to address their psychological challenges.

College campuses are no new to stress management classes [6] investigated the effects of a six-week program (one 90-minute group session per week) on 128 college students' subjective stress levels. They offered a study program called "Maximize Your Potential" and provided a $25 stipend to students who applied. The experimental group (n=63) and the control group (n=65) were assigned at random. Pedagogy, group discussion, and experiential mind/body skills were among the interventions. Relaxation techniques, mindfulness, cognitive restructuring, goal setting, and the physiology of stress were among the topics covered. When compared to students in the control group, the researchers discovered that those who participated in the group had lower levels of psychological discomfort, anxiety, and stress perception. This study provides a successful way of teaching students stress management techniques that also work to reduce anxiety.

Course on coping with depression. Several studies have been undertaken on the “Coping with Depression” (CWD) course developed by [11], which is a 12-week course based on a social learning theory of depression. This course is based on effective cognitive-behavioral treatments for depression, is beneficial across a range of demographics, can be given cost-effectively, and has the potential to reach students who would not otherwise seek help for their depression. Here's a look at a few studies, including one meta-analysis that includes the findings of all the studies accessible at the time. According to [11], the CWD course has 12 units, with two units devoted to explaining the treatment rationale and self-change methods, eight units devoted to teaching specific skills (two units each for social skills, distorted thinking, pleasant activities, and relaxation), and two units devoted to integration and maintenance. This study, on the other hand, provides some evidence for the course's efficacy in treating depression.

Another study, conducted by [17] looked at the effectiveness of a psychoeducational program in enhancing teenage self-esteem and lowering the likelihood of high school dropout. A total of eighty 14 to 16-year-old adolescents from a non-clinical community population were included in the study. The eight-week psychoeducational program dramatically increased teenage self-esteem and reduced dropout rates, according to the study. The study also discovered that these increases in self-esteem lead to benefits in other aspects of mental health, including a significant reduction in teenage depressed cognitions. However, there was no control group in this study, and no follow-ups were done to see if the significant benefits were maintained.

Psychoeducation may assist teenagers to cope with their depressive cognitions, which may lead to improvements in adolescent depression. "Helping Adolescents Cope," a psychoeducation program, focuses on creating coping resources and limiting the use of poor coping mechanisms. A preliminary evaluation of the program's effectiveness included 112 participants divided into three groups. This psychoeducational program was found to reduce teenage depressive symptomology and poor coping mechanisms, as well as improve adolescents' coping techniques and resources. Depression symptoms worsened in the two control groups, whereas adolescents in the treatment group reported an improved ability to cope with their depressive symptoms and stressful situations [8].

According to another study, improving teenagers' awareness of the symptoms and possible outcomes of depression may be part of the reason why psychoeducational practices are beneficial. [14] investigated the impact of a psychoeducational program on enhancing adolescent knowledge, attitudes, coping skills, and emotions of hopelessness related to suicidal thoughts. There were 172 non-clinical volunteers in the study, with an average age of 15.6. The program was found to be successful in boosting teenagers' awareness about suicidal thoughts and gestures, despite no changes in coping and despondency. Furthermore, adolescent views toward suicidal people improved; the authors believed that boosting the adolescents' knowledge aided in altering their attitudes about suicidality [14]. The authors acknowledged that adolescents in all four groups had very high initial assessments of hopelessness and poor coping techniques, demonstrating that pessimism and inefficient coping were ingrained in the adolescents' functioning when addressing the results on coping and hopelessness. The authors also stated that the program was created to address teenage knowledge rather than coping or hopelessness.

Using psychoeducational strategies to help teenagers understand their symptoms and why they are feeling the way they are often led to a sense of empowerment and, as a result, a reduction in maladaptive symptoms. The "Girls Circle" psychoeducational program aims to promote adolescent girls' self-efficacy, perceived body image, and social connections to enable young women to be actively involved in their adolescent development and to form healthy and stable interpersonal relationships. According to [9]."Girls Circle" does instill a sense of empowerment among teenage girls, and is thus useful in lowering psychopathology symptoms during the adolescent years. However, it's worth noting that only qualitative evaluations have been used to assess the program thus far; quantitative research utilizing an experimental design is currently being conducted.

The "Adolescent Depression Empowerment Psychosocial Treatment" (ADEPT) is a psychoeducational program that aims to instill a sense of empowerment in adolescents to lessen depressive cognitions. This method combines cognitive-behavioral therapy, interpersonal therapy, and family systems therapy to help people gain a better understanding of their symptoms and use that understanding to operate within their families. According to preliminary studies on the efficacy of this program, [13] ADEPT is beneficial in enhancing teenage empowerment and reducing depressive cognitions. However, some drawbacks are noted, including the use of small samples and pre-test/post-test designs with no control groups in previous investigations. The authors also point out that ADEPT was created as an intervention for African-American kids, thus the preliminary findings are unlikely to be generalizable across ethnic groups

Psychoeducational strategies have also been demonstrated

to be useful in increasing performance. Interpersonal communication perceptions and awareness, psychopathology symptoms, and a variety of other unfavorable settings and situations in an adult sample of community residents, [4] investigated the effects of psychoeducation on perceived social support. The 51 participants in this trial, who ranged in age from 19 to 69, were randomly assigned to either a 13-week psychoeducational intervention focusing on social skills training and cognitive reframing and restructuring with self and social perspectives, or a wait-list control group. Participants who finished the psychoeducational course had significantly improved opinions of themselves and the social support offered by their families compared to those in the control group, according to the study. Unfortunately, because this study used an adult sample rather than an adolescent sample, it does not apply to the current study.

Psychoeducation is useful in raising mental health symptom awareness. [5] found that children with obsessive-compulsive disorder (OCD) aged 11 to 16 who participated in a six-week psycho-educational group focusing on symptom awareness and understanding, as well as establishing and increasing social support, showed significant improvements in symptom identification and awareness. As a result of this insight, people have reported feeling more confident in their ability to cope with OCD. It's worth noting that this study had a relatively small sample size (only seven adolescents took part), and only qualitative measurements were used. There were also no reported improvements in OCD symptoms.

Depressed adolescents frequently have unfavorable perspectives of interpersonal relationships and living conditions. Psychoeducational approaches have been shown to help adolescents with depressive symptomology improve their perspectives. [15] investigated the impact of a family psychoeducational program on families with a teenager suffering from Major Depressive Disorder. Thirty-one 13 to 18-year-olds who satisfied the criteria for Major Depressive Disorder were included in the study. Adolescents and their families who received family psychoeducation had better evaluations of family social support and their capacity to function within a social group, according to the study. Adolescents who got family psychoeducation also claimed that their opinions of their relationships with their parents had improved. The results were found to have been sustained after a three-month follow-up. It's worth noting that the authors didn't test improvements in depression symptoms in this study; however, they expected that improved perceptions of social support and family ties would lead to improvements in depressive symptoms

Psychoeducational strategies have been proven to improve children's impressions of their parents' behavior, even though research in this field is sparse. [7] Investigated the impact of family psychoeducation groups on children with mood disorders such as anxiety and depression. The study included 35 families with children ranging in age from 8 to 11 years old and a variety of clinical histories.

Children and their families were randomly allocated to one of two groups: a treatment group receiving six sessions of family psychoeducation in addition to family therapy, or a control group receiving only family therapy. When compared to children who received only family therapy or were on the waiting list, children who received family psychoeducation reported significant improvements in mood disorder symptoms, as well as improvements in family interactions and perceptions of parental support.

2. Purpose

The objective of this study was to examine the effects of a psychoeducation program on the mental health of college students.

3. Research Hypothesis

The main research hypothesis of this study was that a brief psychoeducation intervention would have a positive effect on the mental health of the students who received the program, compared with those who did not.

4. Methods

4.1. Design

A Nonrandomized controlled trial was implemented to examine the effects of a brief psychoeducation program on depression, anxiety, and stress [16]. Participants were assessed twice: before the intervention (pretest), immediately, and 3 months after the intervention (posttest).

4.2. Sample and Setting

Volunteers were recruited using fliers posted on the campus and an advertisement on a Web site. Undergraduate students were included in this study.

The participants (n=60) were allocated to either the experimental group (n=30) or the control group (n=30. The participants in the experimental group and 30 in the control group completed the posttest. Among them, 30 experimental and 30 control participants completed the 3-month follow-up assessment.

4.3. Intervention Procedure and Structure

Table 1 summarizes the components and theoretical foundations of the sessions. CBT and social cognitive theory were important sources in the design of the intervention. Cognitive restructuring, emotion regulation, interpersonal skills, and self-regulation were the elements targeted by the intervention. Before beginning the intervention, the researchers created a structured worksheet for the participants and a module for the facilitators. During all of the sessions, a variety of strategies were utilized to induce change, including lectures, group discussions, role-plays, and offering worksheets for the participants to put their opinions on. Each session of a psychoeducation program was meant to last two hours. The intervention was provided daily for five days in the seminar room of a university with a 10-minute break after each hour. After the study was completed, the

worksheet was also given to the control group.

Table 1. *Components of the Psychoeducation Program.*

Session	Theoretical Base	Implementation strategies
Cognitive Reconstruction	Cognitive Behavioral Therapy [3]	Identify automatic thought. Address cognitive distortions. Employ Socratic questions. Reframing.
Emotion Regulation	Cognitive Behavioral Therapy	Identify emotion. Dealing with anger. Recognize danger signs. Dealing with anxiety. Recognize anxiety signs. Dealing with stress. Recognize stress signs.
Interpersonal Skill	Cognitive Behavioral Therapy	Communication skills. Assertiveness. Problem-solving & decision making.
Self-Regulation	Social Cognitive Theory [1]	Goal setting. Time management. Self-management skills

4.4. Measures

DASS 21 stands for Depression, Anxiety, and Stress Scale. The second questionnaire was the DASS-21, which is used to assess depression, anxiety, and stress in young adults and is frequently used in non-clinical studies to assess mental health issues. Syd and Peter Lovibond of the University of New South Wales designed the questionnaire in 1995 [12].

Hopelessness, dysphoria, self-deprecation, lack of interest, devaluation of life, anhedonia, and inertia are all assessed on the Depression Scale in the DASS. Situational anxiety, autonomic arousal, skeletal muscle responses, and subjective perception of anxious affect are all assessed using the Anxiety Scale. In the DASS, the Stress Scale measures nervous alertness, trouble relaxing, and being easily upset/ agitated, impatient, and irritable/ over-reactive.

The DASS-21 scale is a four-point Likert scale that assesses depression, anxiety, and stress, three major mental health concerns. Each item on the DASS-21 questionnaire has a response range of zero (did not relate to me at all) to three (applied to me very much). The cumulative scores of seven-item subscale responses define the severity level of the three domains of mental health disorders.

4.5. Procedure and Ethical Considerations

Data were collected between August to October 2017 after obtaining approval from the Institutional Review Board of the University College. After ensuring that each participant met the study inclusion criteria, the information about study aims, design, procedure, rights as participants, anticipated benefits, and possible adverse effects of participation. They were also informed that they were free to withdraw their consent at any time. We obtained written informed consent from all the participants and carried out the recruitment procedure keeping their identities confidential. The participants were compensated for their time and effort in the study with small gifts.

After the completion of the program, participants were asked for post-program feedback, such as “Did you find the program helpful?” and “If so, how did it help you?”

4.6. Statistical Analysis

The descriptive statistics used in the analysis of data collected were Mean, Standard Deviation, Inferential statistics, Probability, Paired t-test, independent t-test, Pearson’s correlation coefficient, Effect Size, and Chi-square were used to summarize the demographic and mental health variables of the participants. The statistical analysis was carried out using the globally accepted statistical software IBM SPSS Statistics 22.0. Microsoft Word and Excel were used for the generation of tables and graphs. SPSS is widely used in the statistical analysis of data, especially the data that has been collected during the research.

5. Results

Out of the 60 participants enrolled in the study, completed both the pre-and postintervention assessments (30 from the experimental group and 30 from the control group).

Table 2. *Frequency report on Level of Depression measured in the experimental group before and after the intervention.*

Level of Depression	Pre-Intervention Phase		Post-Intervention Phase	
	Frequency	Percentage	Frequency	Percentage
Normal (0-9)	12	40	22	73.3
Mild (10-13)	7	23.3	4	13.4
Moderate (14-20)	9	30	4	13.3
severe (21-27)	2	6.67	0	0

Before and after the intervention, the table 2 displays the number of students that were depressed at each level. The fact that more than 73.3% of the students are in the Normal group indicates that the intervention was successful in bringing them back to a normal life. The rest of the students were only in groups with mild to moderate disruptions. None of them appeared to be dealing with anything serious.

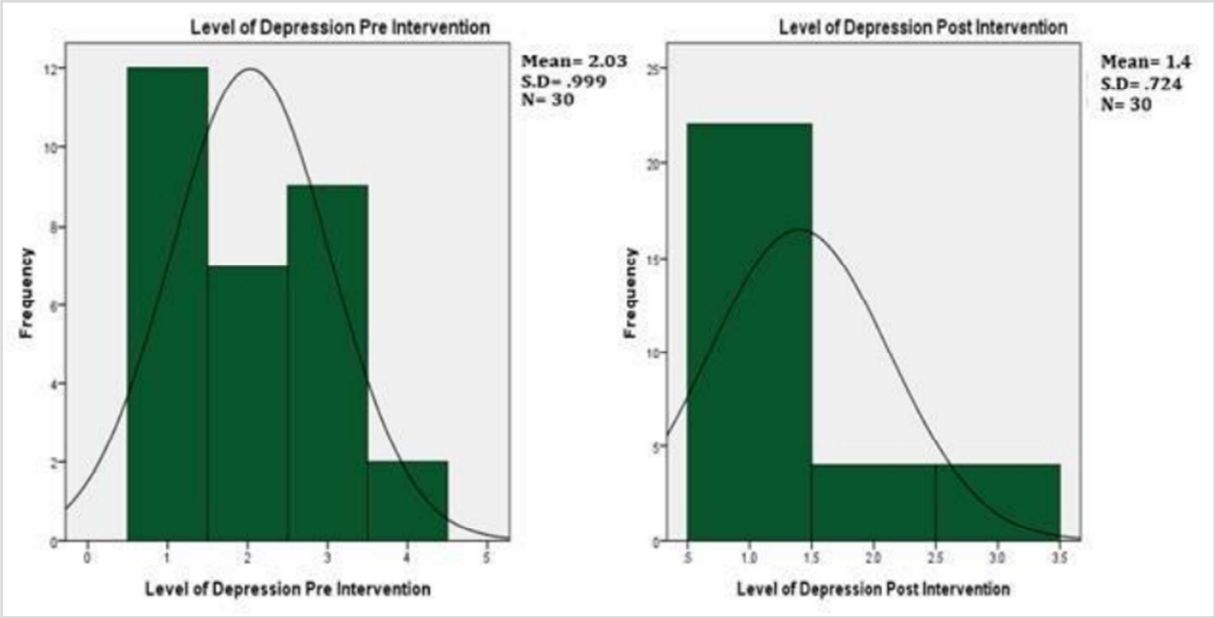

Figure 1. *Histograms representing the Level of Depression measured in the experimental group before and after the intervention.*

Figure 1 shows that the level of depression was lower post-intervention than it was during the pre-intervention phase. The experimental group's participants learn about what impacts their depression, what triggers it, what makes it worse, and how to treat themselves during the psychoeducation program. This, in turn, benefits students in avoiding relapse, i.e., preventing them from being depressed again, and assisting them in managing their psychological health difficulties. The above histograms show that students who received the psycho-educational intervention had reduced levels of depression once the intervention was completed.

Before and after the intervention, the table 3 illustrates the number of children experiencing each level of anxiety. However, it is clear from the above that anxiety levels were moderate for half of the student sample population before the start of the intervention, while around 20% were in the very severe group. Only around 13.3% were found to be normal, while about 6.7 percent were found to be severely affected. Around ten percent of individuals were found to have mild anxiety. Surprisingly, there was a significant change in the post-intervention phase, with more than 66.7 percent of the student sample population being normal and fewer than 23.3% having moderate anxiety. None of the students were suffering from severe or extremely severe anxiety.

Table 3. *Frequency report on Level of Anxiety measured in the experimental group before and after the intervention.*

Level of Anxiety	Pre-Intervention Phase		Post-Intervention Phase	
	Frequency	Percentage	Frequency	Percentage
Normal (0-7)	4	13.3	20	66.7
Mild (8-9)	3	10	3	10
Moderate (10-14)	15	50	7	23.3
severe (15-19)	2	6.7	0	0
Extremely Severe (20+)	6	20	0	0

Table 4. *Frequency Report on Level of Stress Measured in the Experimental Group Before and After the Intervention.*

Level of Stress	Pre-Intervention Phase		Post-Intervention Phase	
	Frequency	Percentage	Frequency	Percentage
Normal (0-14)	15	50	28	93.3
Mild (15-18)	8	26.7	2	6.67
Moderate (19-25)	7	23.3	0	0

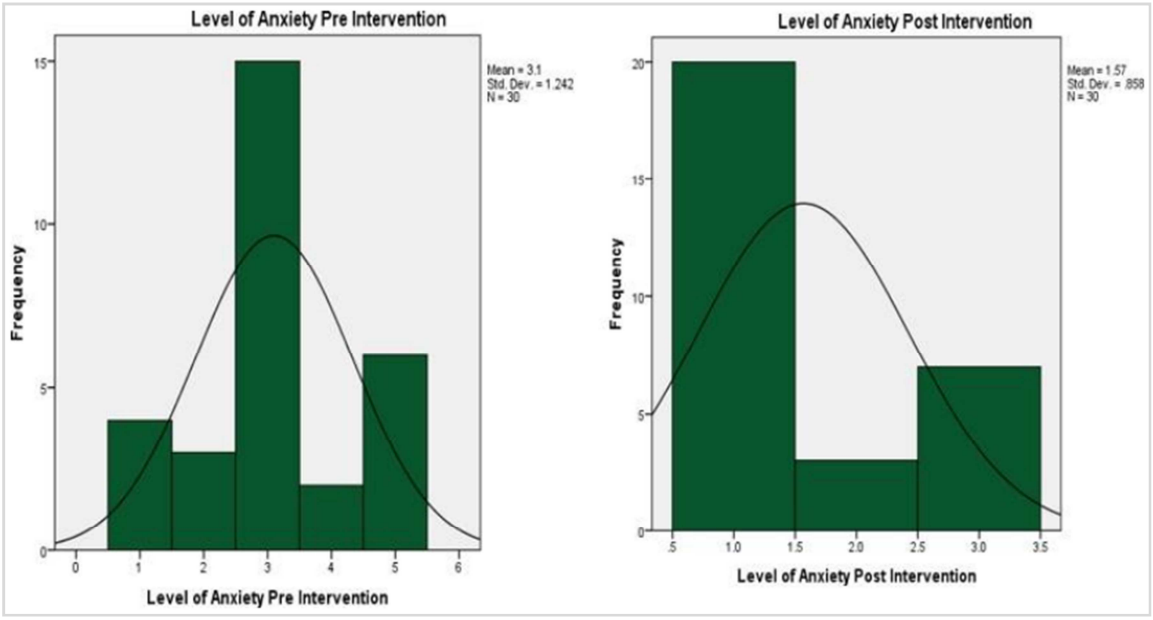

Figure 2. *Histograms Representing the Level of Anxiety Measured in the Experimental Group Before and After the Intervention.*

Figure 2 show that anxiety levels were lower post-intervention than they were before the intervention. The psychoeducation intervention procedures also incorporated informative components for the experimental group's participants to learn about anxiety symptom control abilities, anxiety-related elements, and anxiety-related approaches. The above histograms show that students who received the psychoeducational intervention had lower anxiety levels once the intervention was completed.

Note. Before and after the intervention, the table 4 displays the frequency and percentage of participants classified in various degrees of stress. As can be seen in the graph above, only half of the students had a normal level of stress before the intervention, however, after the intervention, more than 93.3 percent of the students had a normal level of stress. After the intervention, none of the children showed even moderate signs of stress.

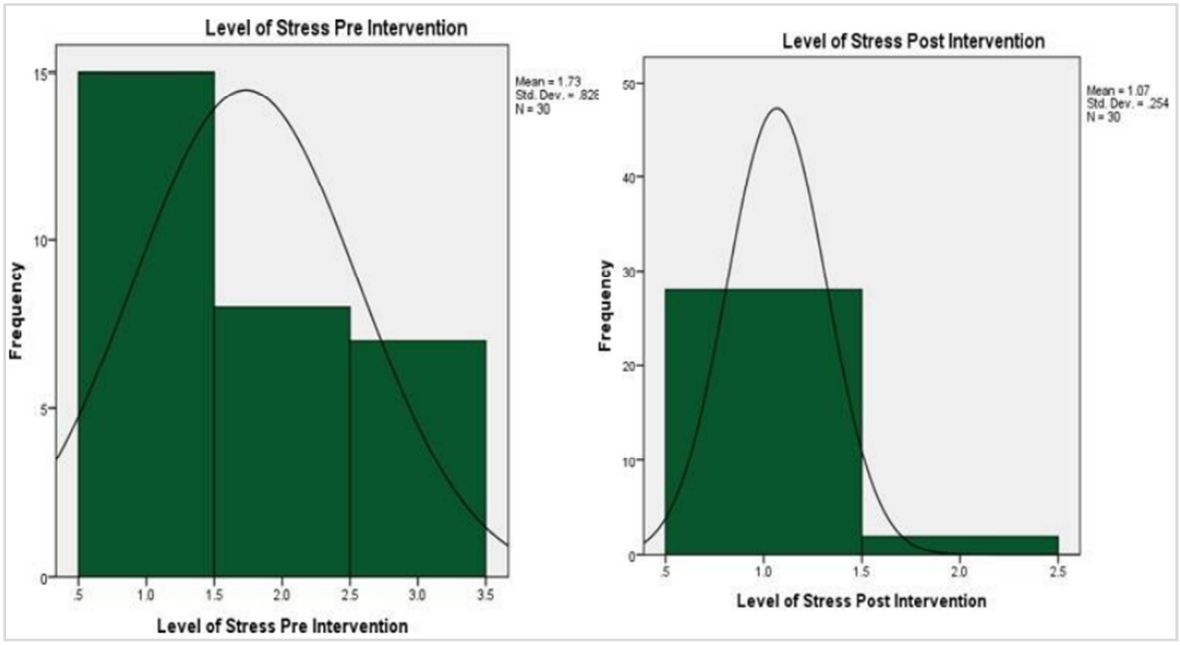

Figure 3. *Histograms representing the Level of Stress measured in the Experimental Group Before and After the Intervention.*

Figure 3 show that stress levels were lower post-intervention than they were before the intervention. The psychoeducational intervention also includes sessions for participants to learn about the variables that cause stress and how to deal with it in various ways. The above histograms show that students who got the psychoeducational intervention had reduced stress levels once the intervention was completed.

6. Comparison Between Experimental Group and Control Group on Various Study Variables in the Post-Intervention Phase

A Chi-square test has been done on the data to determine whether there is any significant difference in the level of depression, anxiety, and stress to the sociodemographic characteristics. A Chi-square test has been done on the data to determine whether there is any significant difference in the level of depression, anxiety, and stress concerning the socio-demographic characteristics (Refer Tables 5, 6, & 7).

Table 5. *Association between Sociodemographic Characteristics and Level of Depression in Students.*

Sociodemographic Characteristics	Depression			Sociodemographic Characteristics	Depression		
	Chi^2	df	p		Chi^2	df	p
Gender	1.45	3	0.693*	Monthly income of Father	38.57	15	.001**
Living Situation	31.02	6	.000**	Monthly income of Mother	17.64	12	.127*
Father's Highest Education	23.55	12	.023**	Type of Family	40.05	3	.000*
Mother's Highest education	24.6	12	.017**	Number of Siblings	16.15	12	.185*
Employment Status of Father	31.88	15	.007**	Participation in Sports Activities	14.84	9	.095*
Employment Status of Mother	51.84	18	.000**	Stressors	23.59	12	.023**

Note. *Since p> 0.05, hypothesis is rejected. **Since p< 0.05, hypothesis is accepted.

Table 6. *Association between Sociodemographic Characteristics & Level of Anxiety in Students.*

Sociodemographic Characteristics	Anxiety			Sociodemographic Characteristics	Anxiety		
	Chi^2	df	p		Chi^2	df	p
Gender	11	4	.027**	Monthly income of Father	35.65	20	.017**
Living Situation	18.63	8	.017**	Monthly income of Mother	16.54	16	.416*
Father's Highest Education	24.99	16	.070*	Type of Family	4.13	4	.389*
Mother's Highest education	34.15	16	.005*	Number of Siblings	37.05	15	.002**
Employment Status of Father	23.56	20	.262*	Participation in Sports Activities	23.34	12	.025**
Employment Status of Mother	44.55	24	.007**	Stressors	45.07	16	.000**

Note. *Since p> 0.05, hypothesis is rejected. **Since p< 0.05, hypothesis is accepted

Table 7. *Association between Sociodemographic Characteristics & Level of Stress in Students.*

Sociodemographic Characteristics	Stress			Sociodemographic Characteristics	Stress		
	Chi^2	df	p		Chi^2	df	p
Gender	1.957	2	.376*	Monthly income of Father	23.61	10	.009**
Living Situation	12.62	4	.013*	Monthly income of Mother	11.82	8	.159*
Father's Highest Education	11.29	8	.186*	Type of Family	3.64	2	.162*
Mother's Highest education	20	8	.010**	Number of Siblings	15.85	8	.045**
Employment Status of Father	13.45	10	.200*	Participation in Sports Activities	20.99	6	.002**
Employment Status of Mother	14.1	12	.294*	Stressors	19.02	8	.015**

Note. *Since p> 0.05, hypothesis is rejected. **Since p< 0.05, hypothesis is accepted

7. Discussion

By delivering a sequence focusing on evidence-based treatments for treating anxiety, stress, and depressive mood disorders, the produced course achieves the project's objectives. These tactics work best when they're delivered in a psychoeducational format and can keep individuals interested in the course of the session. This program is for students and other individuals who are currently experiencing mental health issues or who have risk factors for mental health concerns. This method is cost-effective because it allows a single trained instructor to treat ten to twenty students in a single class time over a semester. Finally, this course not only teaches skills, but also familiarizes students with tried-and-true self-help resources that they can use indefinitely to cope with stress, anxiety, despair, and other unpleasant feelings and situations. While the skills taught in this course were chosen primarily for their demonstrated effectiveness in alleviating stress, depression, and anxiety symptoms, their application is also consistent with the literature on resiliency, so it is expected that the course will be beneficial in the future as well as now.

8. Conclusion

There are various other possible benefits to this approach that has yet to be proved. Primarily, the goal of this course is to equip students who are already suffering from mild to moderate anxiety and emotional concerns with the knowledge and resources they need to address their problems. Second, this program may appeal to students who would not otherwise seek standard mental health care for a variety of reasons. Third, it is intended that through teaching individuals stress management

skills and developing behavior patterns that confer resiliency to life's challenges and disappointments, this curriculum will aid in the development of resiliency in students. These difficulties and disappointments are unavoidable for all students, and knowing how to cope with stress, anxiety, and avoidance, confront difficult situations, overcome procrastination, correct negative thinking, and beliefs, tolerate painful emotions, develop intimate relationships based on equality, and speak up for oneself are skills that have been shown to assist most people in overcoming these difficulties. Fourth, it is believed that interactions with mental health ideas and theories may minimize the stigma associated with seeking professional help for those students who do not benefit from this program. Finally, it is believed that by taking this course, more students would complete their education, get jobs, form healthy relationships, and develop high self-esteem and self-efficacy, allowing them to achieve their present and future goals.

Declaration of Competing Interest

The authors declare that they have no competing interests

Compliance with Ethical Standards

Conflict of Interest the authors declare that they have no conflict of interest.

Acknowledgements

This manuscript is dedicated to my loving and caring daughter.

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