Recognizing emotions in oneself and in others is a delicate subject to confront with psychiatric tools, as it refers to an ability that is already compromised and that causes many daily struggles. The proposed year long work consists of a weekly group project with Intermediate Rehabilitation Structure of ASL Napoli 3 Sud-District 56 participants and evaluated through the TAS-20 (Toronto Alexitimia Scale) and the ESCQ-45 (Emotional Skills & Competence Questionnaire). The arguments of the study range from the emotional recognition based on mimicking described facial emotions and the sharing of fears and desires, to the recognition of the body parts involved in emotions and meetings dedicated to managing anger and awareness of one’s reactions. The involved group consists of 10 participants with a chronic schizophrenia diagnosis and variable comorbidity with anxiety disorders; the sample is homogeneous by age range and pharmaceutical dosage.
range from the recognition of emotions based on facial expressions to the description and sharing of fears and desires, passing through the recognition of the parts of the body involved in an emotion; very important for these patients were the meetings dedicated to anger management and awareness of their own personal way of reacting to it.

■ DESCRIPTION OF THE SAMPLE OF PATIENTS INVOLVED

The chosen sample for the path of emotional literacy consists of 10 users, of which 7 are men and 3 are women, homogenous in that they are all residents, and of the diagnosed pathology (psychosis), albeit with different types of comorbidities. Table 1.1 illustrates the main characteristics of the sample involved.

| Initials | Age | Gender | Schooling | Marital Status | Years of Illness |
|----------|-----|--------|-----------|----------------|-----------------|
| A.N.     | 49  | M      | 8 years   | unmarried      | 15              |
| C.L.     | 49  | M      | 8 years   | unmarried      | 28              |
| C.M.     | 42  | M      | 13 years  | unmarried      | 24              |
| I.G.     | 60  | M      | 13 years  | unmarried      | 29              |
| M.A.     | 53  | F      | 8 years   | married        | 20              |
| M.D.     | 50  | M      | 8 years   | unmarried      | 27              |
| M.J.     | 61  | F      | 11 years  | separated      | 23              |
| P.G.     | 47  | M      | 13 years  | unmarried      | 17              |
| V.A.     | 51  | M      | 8 years   | unmarried      | 15              |
| V.G.     | 51  | F      | 10 years  | Separated      | 21              |

Tab. 1.1 - Description of the sample patients involved

The entire central team worked together to choose these patients for the emotional literacy study. The selection criteria took into consideration each patient’s psychopathological compensation condition and their difficulty in recognizing and managing emotions, and as a result of this the patient’s need of a path that addresses these issues. In addition to this, the ability to support this work from start to finish without suspensions and or a necessity to exit the project was also taken into consideration. Each patient deemed as a suitable recipient of the proposed work was then informed about the start of the path, the topics that would be covered, the timing and purpose of the project, and gave his or her consent to take part to his or her healthcare professional.

■ ANALYTICAL EVALUATION SCALE

The analytical evolution scale used to monitor the results of the emotional literacy study, which were administered at the beginning and end of this work, were the T.A.S. - 20 1 (Toronto Alexitimia Scale – 20 Item) and the ESCQ - 45 2 (Emotional Skills & Competence Questionnaire – 45 Item).

The questionnaires were individually administered and filled out by the involved patients, but some requires help to fully understand some parts. All of the participants gave answers consistent with what was then demonstrated by them during the course they took, and expressed the difficulty they felt in recognizing and verbalizing their own and others’ emotions with varying intensity.

■ THE STRUCTURE OF THE EOTIONAL LITERACY INTERVENTION

The emotional literacy course, which participants attended weekly in a space dedicated to rehabilitation groups from S.I.R. who hosted the participants, was created by a team that believed in the idea of gradual progress. The topics covered and the tasks assigned were of increasing difficulty, starting from the definition of emotions necessary to be able to manage themselves and interpersonal relationships. The entire project lasted one year, and all the patients followed the project one meeting at a time with view absences and with growing interest as time passed, motivated by the possibility of using the new skills gained in everyday life. There were several moments where it was necessary to remind and encourage participants of their goals to keep the group homogeneous and avoid that temporary moments of personal crisis that could affect participation in the group and affect the

1 Taylor G.J., Bagby R.M., Parker J.D.A., Toronto Alexithymia Scale, 1992
2 Takšić V., Mohoric T., Duran M., Emotional Skills & Competence Questionnaire, 2001
continuity of the work carried out, but these moments overall had a positive effect and the group remained united from the beginning to the end of the proposed work. In the course of this year each participant continued to follow other project associated with S.I.R. and maintained individual psychological and psychiatric appointments, where it was possible to assist, monitor and support the emotional literacy project.

At the beginning of each meeting each participant was asked to fill out the following form to reflect on their current emotions and to verify that patients were more aware of their own emotions, and that adequate recognition of those emotions was gradually being acquired. After filling out the sheet, each participant could choose to share their work with the group, and in so doing themselves up to the group, or to send them to the project operators without comment. This was also used as a way to note gradual changes in participants.

**EMOTIONAL RECOGNITION**

After the first one on one meeting and administration of analytical evaluation scale, the course began with the identification of 6 primary emotions in order of complexity: happiness, sadness, dear, surprise, anger and disgust. Each of these emotions was described using facial images that express that emotion and the underline the physical characteristics of these emotions (open or closed lips, corners of the eyes turned up or down, eyebrows arched or raised etc.); below each face depicting the emotion the interventions of the patients were reported regarding:

- what do I feel when I feel this emotion
- on what occasion do I feel this emotion
- when I feel this way

The 6 primary emotions along with the participants comments are used in the following sheets, filled out by each participant as a way to report all the interventions, and then place them on a notice board for illustrative purposes; each participant, on the other hand, had a personal form where they could record their own responses. The sheets of each participant were then collected in a personal file, which later would attest to the progress and reactions of each participant in a clear and intuitive way. This first work was completed over an arch of meetings for each emotion described, each of them lasting about 60 minutes. Only the appropriate responses for identifying emotions were reported in the general form, but it should be emphasized that not all interventions were congruous and that often a description of a state of mind or an experience did not match with the emotion under examination, demonstrating the initial confusion experienced by patients. The attempt put in place was therefore to bring order, reporting on the form the contributions deemed appropriate and at the end illustrating the result of the joint work: the description of the emotion and self-reflection on the personal moments their were the protagonist of.

Sadness and fear were the emotions that evoked the most immediate and numerous responses, some of them with disarming clarity; with other emotions, like disgust and surprise, the group experienced more difficulty and required a clearer guide. On the whole, useful schemes were obtained for framing each specific emotion, which were also subsequently used to quickly review the notions learned and to add adequate content as the participants’ awareness of their emotions was increasing.

The results obtained are shown below. We then worked by showing patients different faces and asking them to identify the emotion depicted so they could memorize each characteristic and expression. Other forms instead asked for emotions elicited by certain sentences; in this phase the participants worked on the sentences over several different meetings, using a profile of each of the 6 fundamental emotions. Form 1.8 is an example of this.

Particular attention was paid to the sentences referring to contexts that allowed the manifestation of multiple emotions at the same time (eg “I fought with my brother” - anger / sadness), talking about them at length and underlining how it would be possible to use more than one emotion while handling a similar situation. The theme of emotional ambivalence was also introduced in this phase, and with this how it could happen that people might have contrasting emotions in the same situation, which was particularly hard for the participants. While the coexistence of two emotions at the same time, like anger and sadness or joy and wonder, was easy for participants to accept, not all participants were ready to accept the complexity of ambivalent emotions, which generally evoked amazement and disbelief. It was therefore decided to proceed step by step and return to the topic later.

**HANDLING ANGER**

Three meetings were dedicated to anger, to its definition and how to handle it, as was necessary as it was strongly felt in all the participants. Given this emotion was so complex and difficult to manage for the participants, these meetings also took place in the presence of the Service psychologist.

After quickly repeating the expressions that characterize an angry face and speaking about what situations can result from this emotion, the participants were asked to remember particular moment in which they had been overcome by this emotion. They were able to think of an instance of anger with little difficulty, and sometimes felt the emotion resurface as they explained the situation to the group. This created the opportunity to for them to describe their personal
reactions to anger which was different for each of them, and an opportunity to think of way to better confront similar situation. Form 1.9 was proposed to identify emotions and mental states that hide behind anger which trigger and angry reaction.

In this way it was possible to identify two contrasting behaviors in response to anger, described by patients in a clear way: an explosive reaction, expressed by fights, a short temper and breaking things, and a submissive reaction, characterized by closed oneself off, isolation and silence. From the description of these two reactions to anger, a rich discussion was born that went beyond simple handling of anger. It was difficult to make participants understand that there was another way to reaction besides their usual reactions, and most of all it was difficult to make the patients with “explosive” reactions understand the “submissive” reactions and vice versa, which was in line with definition of “anger” even if they don’t share common characteristics.

From that point an alternative way to handle angry reactions was searched for, leading to a middle road between the two types of anger, which were divided into the following steps:

1. I try to calm down;
2. I speak to the person who made me angry;
3. I explain what made me angry and how this action made me feel;
4. I listen to his point of view and, if possible, try to clarify it; if not, I go away.

As result a conversation begun about each participants preferred way to calm down: listening to music, taking a walk, resting or speaking to someone about what had happened. Each of them expressed their personal preferences along with their personal difficulties, drawing inspiration from the suggestions introduced by others.

The implementation of the modeling by the psychiatric rehabilitation technician and the psychologist, and the role play by a couple of patients who self-applied
to the experience, was very important in depicting the steps proposed above. This allowed the group to elaborate their own experiences regarding the meetings dedicated to anger management, and at the same time created a playful atmosphere that soothed the moods that the previous discussion had rekindled.

Each meeting regarding anger lasted about 90 minutes given that wealth of ideas expressed and the conversations and debates that grew from it. The entire group of participants were more involved and engaged, and reacted well to the proposed stimuli.

**EMOTIONAL NUANCES**

After having described and recognized the base emotions, the moment had arrived to broaden viewpoints by exploring the horizon of the infinite emotional nuances that define the moods that everyone experience. In the same scope, each participant was asked to complete a form about the most common secondary emotions. The participants were asked to associate each secondary emotion with a situation or event, as they had done for the original 6 emotions.

**THE REHABILITATION TREATMENT OF PATIENTS WITH PSYCHOSIS OF THE RESIDENTIAL STRUCTURE**
event, as they had done for the original 6 emotions. Other forms and exercises required participants to place secondary emotions in the right categories, recognizing the macro-areas they belong to and stimulating the identification of numerous nuances of daily experience.

PHYSICAL MONITORING OF EMOTIONS

Every emotions, be it positive or negative, has a personal physical positioning; you belly or the knees can avert us to fear, just as sadness can involve the heart or the head. The work carried out in order to stimulate self-observation and recognition in the body part most affected by each emotion was very engaging for the group, who felt free and listened to their body in each way. Here there was no wrong answer, as the physical perception of emotions is subjective and extremely variable between people; the participants took part in this group with total autonomy. To express the physical aspect of emotions, an activity was created that involved cutting out, pasting and placing the chosen emotions along a large outline of the human body. Each participant took their own outline representing themselves, and cut out from numerous cards with the names of the emotions most felt in that moment; each name was then glued to the area of the body where the patient believed to have felt that emotion.

Physical monitoring of emotions created an occasion to, in a playful and dynamic way, pass time dedicated to self-observation and reasoning. From the outside, it was good to see the patients touching their heads, bellies, to see them put their hands on their hearts and close their eyes, as a way to show their understood that they would find the emotion right there. Patient feedback on the proposed exercise was positive, and was confirmed by the precision with which most of the templates were “filled in”.

In some cases, the participants asked for clarification about the meaning of certain terms, but never tried to “copy” the placement of the cards on the template from one another. Once the task was completed, the comparison regarding the results obtained was complete and not without food for thought both for participants and for us operators.

Fig. 1.13 shows the outline built by C.M., in which the choice of exclusively negative emotions and the placement of the word “angry” on the foot stands out; M. was one of the patients who showed, in fact, an “explosive” reaction to anger while working on conflict management.

ANXIOUS STIMULI

A meeting was dedicated to reflection on the situations that represent the main sources of anxiety for many patients in the group, the most common comorbidity among the participants. Anxiety often leads to avoidance, implemented by many patients in a massive and generalized way, as can be seen in form 1.14, compiled by P.G. It strongly represents his state of being and the isolation that this condition induced in him. The form requires participants to assign a number from 1 to 10 to the various situations or places proposed, where number 10 is representative of the situation most avoided and the number 1, least feared. By filling out this form, apparently simple and
easy to understand, rich discussion between the patients involved was stimulated, which allowed the opportunity to address ideas not previously addressed within the group. Some were surprised by the answers given by fellow participants, trying to convince the others that they shouldn’t fear certain situations; others felt relief in confronting the group about their problems, as if this could be a way to warn the other

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**Fig. 1.12** - The heart of emotions, M.D.

Shows M.d.’s exemplary results, who was one of the patients who had shown more difficulty in understanding the coexistence of conflicting emotions.

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**Fig. 1.13** - Physical monitoring of emotions, C.M.

Shows the outline built by C.M., in which the choice of exclusively negative emotions and the placement of the word “angry” on the foot stands out; M. was one of the patients who showed, in fact, an “explosive” reaction to anger while working on conflict management.

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**Fig. 1.14** Anxious stimuli

| LE SITUAZIONI CHE MI RENDONO ANSIOSO |
|--------------------------------------|
| Molte persone si confrontano con la propria ansia e con gli attacchi di panico quotidiano, ed arrivano ad evitare le situazioni o i luoghi che maggiormente causano loro questi stati d’animo. Il primo passo per imparare a gestire l’evitamento è riconoscere le situazioni in cui lo mettiamo in atto. Leggi con attenzione quelle di seguito proposte, ed assegna un numero da 1 a 10 ad ognuna di loro, dove 10 corrisponde alla situazione che ti crea più ansia e che quindi eviti sempre, mentre 1 alla situazione che riesci ad affrontare più facilmente. |

|  |  |
|---|---|
| 1. Aeroplani  | 1. Feste o altre occasioni sociali  |
| 2. Metropolitane  | 2. Piazze  |
| 3. Bus o tram  | 3. Ristoranti  |
| 4. Barche o navi  | 4. Musei  |
| 5. Teatri  | 5. Ascensori  |
| 6. Centri commerciali  | 6. Spazi chiusi  |
| 7. Supermercati  | 7. Gallerie  |
| 8. Stadio  | 8. Guidare la macchina  |
| 9. Camminare per strada  | 9. Palazzi o luoghi alti  |
| 10. Viaggiare lontano da casa  | 10. Stare da solo in casa  |

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about situations in which they would not want to be involved. The purpose of the meeting was certainly not to solve the problems presented, but rather to stimulate the group’s participants to open up to the other, to share and confront each other.

**FEAR**

Another noteworthy meeting dedicated to fears and the strategies implemented to deal with them. Here too, the discussion was rich and stimulating, where an ever greater openness on the part of patients as palpable as the path of emotional literacy progressed. Introduced by form 1.15, which depicted some of the most common fears with their most tangible solutions, the topic was then addressed by each participant in the group individually, drawing their fear and writing something about it. The discussion expanded with the personal contribution of each participant about the moments in which the fear in question was experienced, and the ways to cope without reaching a personal limit. The origins of each fear and how they arose was also discussed.

Fig. 1.15 - Make fear go away

Patients had revealed themselves to be, at this stage of the journey, already more mature and aware of their moods; confrontations were more fluid, uncertainty and confusion were less, and all were now dedicated to the proposed work with greater willingness. The commitment made during the journey is evident and we noticed the habit of getting together in groups and talking about something that unites them, of dealing with issues in a more natural way. They started to accept experiences that are different from their own and perhaps with conflicting ones as well.

Fig. 1.16 - My fears, I.G.

1 Di Pietro M., *L’ABC delle mie emozioni*, Erickson, 2015.
Fig. 1.17 - My emotions today, C.L. e P.G.

Shows a brief description of C.L.’s mood after he had spent the night with tachycardia, and of P.G., who shares his sadness. This exercise includes the recognition of the emotion you are experiencing, the representation of the face that characterizes it, the description of what you feel and the physical monitoring of the chosen emotion.

Fig. 1.18 - The Emotion Cards

moods; confrontations were more fluid, uncertainty and confusion were less, and all were now dedicated to the proposed work with greater willingness. The commitment made during the journey is evident and we noticed the habit of getting together in groups and talking about something that unites them, of dealing with issues in a more natural way. They started to accept experiences that are different from their own and perhaps with conflicting ones as well.

THE GAME

To encourage socialization, natural connections and personal openness between participants and operators, games and other expressive activities with an emotional theme were introduced to the group.

As a result, a real card game was created using the emotion cards shown in sheet 1.18; the game consisted of cutting out the cards, shuffling them by placing them in a pile to be turned over on the table, and taking turns drawing a card from the deck. Depending on the emotion that each participant drew, they would then have to stage it by mimicking their face or depicting an event that would evoke that emotion. This game proved to be both useful and fun, and was very much appreciated by the group; the operators also took part in it, contributing both to a modeling action and to the creation of a playful group atmosphere, in which getting involved would not have involved any kind of judgment. Some patients at first preferred not to take part in the game, remaining as observers, but all of them then gradually entered during the game or participated in the meetings proposed later, on different days. At the end of the course, everyone in the group caught at least one emotion, even the most introverted like P.G.

Card 1.19 instead shows an expressive activity in which patients were asked to write down the prevailing emotion at the time of the exercise, draw something related to it and assign it a music or a song, to be listened to all together during the execution of the drawing. The use of music was often proposed along the way, and it helped emotions to come out, to take shape, and to be shared without the need to be verbally described.

M.D., in the card shown, started with the choice of music (Ludwig Van Beethoven’s Symphony No. 5) and linked the composer’s drawing and the emotion aroused, sadness. Before the end of the meeting, D. then added a cartoon that clarified the choice completed work: “When I was little I listened to Beethoven’s symphonies and even my father Filippo cried”. A memory, a piece of music, an emotion and a drawing.
RESULTS AND CONCLUSIONS

The ESCQ-45 scale, on the other hand, shows a marked improvement in V.G., who shows a difference of 32 points between T0 and T1, and so is the user who has obtained the greatest increase in emotional and social skills.

With reference to the partial results obtained from the subscales, the “expression and recognition of emotions” subscale was the one recorded in V.G. the greatest improvement (T0 = 15, T1 = 22).

On the other hand, the one who recorded the lowest score increase with the ESCQ-45 was I.G., in accordance with the results obtained by the same patient at the TAS-20.

Also from the analysis of the results obtained with the compilation of the ESCQ-45 it appears that all patients have reported improvements as a result of the emotional literacy process, to a greater or lesser extent. The analysis of the subscales also shows a correlation between the items of the TAS-20 and those of the ESCQ-45: a high score in the “difficulty in identifying feelings” subscale of the TAS-20, for example, is often combined with a low score in the ESCQ-45 “expression and recognition of emotions” subscale.

In addition to improving their emotional skills, the group of patients involved in the emotional literacy path has shown, in my opinion, to be more aware of their skills as well as their shortcomings. It happened, for example, that some items of the evaluation scales that at T0 indicated a sufficiently high competence, recorded a “worse” score at T1 not for a lack of results, but for a greater awareness of the meaning of each request and of the personal limits of each one.

The participant who most has been shown to have achieved improvements in the recognition, identification and knowledge of emotions, as well as in the ability to “look inside”, was C.L., as evidenced by the results of the TAS-20. The music therapy course certainly supported the result achieved, visible to the naked eye and very important for the path that the patient is carrying out in S.I.R. C.L. followed the entire process assiduously, with a great motivation for change, and with a personal and cultural background that allowed him to carry out an effective job. To date, he is more attentive to the state of mind of others, more aware of his emotions and better able to manage them adequately.

The patient who instead reported the least evident results was V.A. who, already of an outgoing and self-confident character, has not always managed to participate in a relevant manner in the meetings held. At the end of the course the patient seems to report a greater theoretical knowledge about emotions, but the personal involvement expected and experienced by others is still far away.

All the participants were involved, at the end of the course, in a restitution meeting in which they discussed results obtained together and their perception of their own path within the group. Most of the patients reported the feeling of greater openness to one another, while almost all observed an increase in the ability to self-observe and recognize their emotions.

| Patient | Points T0 | Points T1 |
|---------|-----------|-----------|
| A.N.    | 63        | 61        |
| C.L.    | 84        | 61        |
| C.M.    | 68        | 64        |
| I.G.    | 88        | 79        |
| M.A.    | 59        | 57        |
| M.J.    | 76        | 71        |
| M.D.    | 79        | 70        |
| P.G.    | 88        | 84        |
| V.A.    | 59        | 59        |
| V.G.    | 84        | 82        |

Table 1.1 shows the results obtained by individual patients at T0 and T1 according to TAS-20.

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