Cognitive group therapy for depressive students: The case study

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Abstract
The aims of this study were to assess whether a course of cognitive group therapy could help depressed students and to assess whether assimilation analysis offers a useful way of analysing students' progress through therapy. "Johanna" was a patient in a group that was designed for depressive students who had difficulties with their studies. The assimilation of Johanna's problematic experience progressed as the meetings continued from level one (unpleasant thoughts) to level six (solving the problem). Johanna's problematic experience manifested itself as severe and excessive criticism towards herself and her study performance. As the group meetings progressed, Johanna found a new kind of tolerance that increased her determination and assertiveness regarding the studies. The dialogical structure of Johanna's problematic experience changed; she found hope and she was more assertive after the process. The results indicated that this kind of psycho-educational group therapy was an effective method for treating depression. The assimilation analysis offered a useful way of analysing the therapy process.

Key words: Depression, cognitive group therapy, psycho-education, assimilation analysis, case study

Introduction
Clinical depression is one of the most common mental disorders (Kessler, Berglund, Demler et al., 2003). Approximately 5-6% of Finns suffer from depression (Isometsä, 2001; Isometsä, Aro & Aro, 1997). Students suffering from depression often have difficulties in coping with their studies (Brackney & Karabenick, 1995; Kessler & Walters, 1998; Lyubomirsky, Kasri & Zehm, 2003), and a strong association has been found between depressive symptoms and stress (Mikolajczyk, Maxwell, Naydenova, Meier & Ansari, 2008). According to their own estimation, 53% of American college students had suffered from depression during their studies (Furr, Westefeld, McConnell & Jenkins, 2001). Over half of those who had experienced depression stated that problems related to studying were the most important depression-inducing factor. Therefore, there is a close connection between depression and studying difficulties.

According to Isometsä et al. (1997), of those who suffer from depression, 50% feel they need mental health services. Of depressed students, 17% seek help for their problems (Furr et al., 2001). Depression diminishes a person's ability to act through various mechanisms. Being depressed has a lowering effect on a student's sense of self-efficacy (Beck, 1976) and it lowers the expectations of doing well with one's studies (Brackney & Karabenick, 1995). A depressed student may feel that he/she will not complete his/her studies like everyone else. The fatigue, the powerlessness and the lack of concentration that accompany depression also reduce the student's ability to function.

Depression affects academic performance and ability to act through the students' motivation and their use of studying strategies (Brackney & Karabenick, 1995; Lyubomirsky et al., 2008). Often, depressed students are not able to plan their studies efficiently or observe their own work. They may have difficulties in sufficiently regulating their time-use, their study environment or the amount of work they pour into their tasks. Cognitive-behavioural therapy resulted in a significant improvement in perceived stress, depressive symptoms, reduced use of avoidance coping strategies, and more use of
approach coping strategies among university students (Hamdan-Mansour, Puskar & Bandak, 2009).

Persons with depressive symptoms often seek validation for their own needs and actions from other people (Clark & Beck, 1999). In this manner, they strive to prove their worth, their competence or their likeableness. Those suffering from depression often have limited social skills (Segrin, 2000). This leaves a student in an adverse position, because there is an inseparable social side to student life.

Sometimes a depressive person is troubled by the aspiration to be extremely competent and efficient. Perfectionist tendencies involve high expectations of oneself, and an individual’s self-respect is based on the perception of one’s own efficiency and competence (Chang & Sanna, 2001; Cox & Enns, 2003). Perfectionists have difficulty working with others and find asking for help very difficult (Brackney & Karabenick, 1995). In a student, high expectations of competence may be manifested as, for example, a great amount of work done, good marks and dissatisfaction with a performance that did not reach the desired level and is not consistent with one’s self-image.

There has been quite a lot of research on the effects of cognitive-behavioural group therapy as a treatment for depression. According to the extensive mapping by DeRubeis and Crits-Christoph (1998), treating depression with cognitive-behavioural group therapy is efficient and useful. Kush and Fleming (2000) have had similar results. In their therapy, they tried to teach the patients skills that diminish depression and anxiety. For example, they tried to develop the patients’ problem-solving skills. Treating depression with cognitive-behavioural group therapy has proven efficient and useful (Bright, Baker & Neimeyer, 1999; DeRubeis & Crits-Christoph, 1998; Kush & Fleming, 2000; Kwon & Oei, 2003).

Cognitive behavioural group therapy has led to a reduction in the levels of depression, negative automatic thoughts, and students’ dysfunctional attitudes (Hamamci, 2006). It has been proven that the symptoms of depression lessen during therapy.

Brackney and Karabenick (1995) stated that psychotherapy aimed at students suffering from depression should contain instruction on structuring one’s studies and on life-control skills. The patients should also be taught means of mood-control to improve their concentration and they should be encouraged not to ruminate and wallow in their depression (Lam, Smith, Checkley, Rijsdijk & Sham, 2003). Certain group-members’ individual factors can predict their benefit from group therapy: mild depression in the beginning of the group work, a feeling of being in control of the situation, the group’s cohesiveness and the ability to function as a group (Hoberman, Lewinsohn & Tilson, 1988).

According to Pace and Dixon (1993), short-lived cognitive therapy lessens the depressive symptoms and also helps the schemata related to a more positive self-image.

Greenberg (2002) has stated that the change happens by activating an unadaptive schema to which an adaptive feeling is then attached. For instance, an unadaptive schema created by loss can be changed by grieving, that is, by adding the feeling of grief to the schema. According to Guidano (1991), the superficial and deep level change-processes do not exclude each other; in fact, superficial changes may promote deep level changes. In the assimilation model (for example Stiles, 2002; Stiles et al., 1990; Stiles et al., 1991), the change occurs by the assimilation of problematic experiences into a particular schema or schema chart. This can be described in eight different stages.

The change has been described in stage theories. The transtheoretical model posits that health behaviour change involves progression through six stages of change: precontemplation, contemplation, preparation, action, maintenance, and termination (Prochaska & Velicer, 1997). Precontemplation is the stage wherein individuals are not aware of their problems, and they are resistant to change. In the contemplation stage, they are aware of their troubled behaviour but they are not committed to action. In the action stage, they change their behaviour and in the maintenance stage they try to prevent relapse. The assimilation model is more detailed and the description of cognitions and emotions is more specific. With the aid of the assimilation analysis, it is possible to delve into the cognitive and emotional changes that occur in the patient’s problematic experiences and to evaluate the change process. The analysis is not just about the final result of the therapy: the problematic experience and the stages of changes the individual goes through are observed and assessed at different phases of therapy (Stiles et al., 1990, 1991; Stiles & Osatuke, 2000).

A series of case studies has been executed using assimilation analysis (e.g. Brinegar, Salvi, Stiles, & Greenberg, 2006; Leiman & Stiles, 2001; Stiles et al., 2006). Assimilation analysis allows for focus on the focal points of the process. Using a case study has some advantages, e.g. the possibility to describe detailed process in psychotherapy, but there are some limitations. Behaviour can be described, not explained, and a case study cannot be representative of the general group or population. However, there is a need for process descriptions when we want to find a means to help depressive students who have problems in their studies. The evaluation of the case can also be susceptible to mistakes. For example, the researcher can see the change more positively or in
the perception that other psychological phenomena can happen. In the evaluation, one must indeed be conscious of this, and be able to change a perspective for a subject so that mistakes in the evaluation do not take place (Montgomery & Willen, 1999).

This study depicts the change process of a student’s psyche. The aims were to assess whether a course of cognitive group therapy could help depressed students with their problems affecting their studies and to assess whether assimilation analysis offers a useful way of analysing students’ progress through therapy. This study was carried out using assimilation analysis to try to interpret and understand the contents of the subject’s problematic experiences and the change she underwent through the sessions.

Research methods

Procedure

The basic materials of this study are Johanna’s (the name has been changed) discussion contributions that were singled out from taped group sessions. Johanna is a university student suffering from depression.

The group consisted of six students suffering from depression and studying difficulties. Altogether, the group met 16 times and the sessions lasted two hours each. In its final form, the group was composed of five women and one man. One student stopped attending the course after four times. The members’ ages varied from just over 20 to a little over 40 years of age. Five of the members were at the final stages of their studies, and one was at the beginning of them. Some students were receiving treatment elsewhere, but we had no exact information about other care or treatment. Those who were at the final stages of their studies had particular difficulties with their theses and their studies had been delayed. The research subjects were referred to take part in the course and in this research by the Turku branch of Finnish Students Health Service (FSHS).

In the beginning of the course, the goal was to activate the participants. At a later stage, more attention was paid to the feelings of helplessness and powerlessness and how these feelings affected the participants’ studying performance. The contents of the group sessions and the themes covered in each of them are depicted in Table I. In the beginning of the course, students made exercises in problem-solving methods. The basic elements in cognitive therapy are behaviour techniques, methods for studying beliefs and thoughts and techniques for managing emotions and feelings. The students analysed the things that hinder their studies and goals.

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<th>Cognitive group therapy for depressive students: Course program and contents.</th>
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<tbody>
<tr>
<td>1.</td>
<td>How does depression manifest itself, and how does it affect the readiness to study?</td>
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<tr>
<td>2.</td>
<td>Problems that hinder studying; introduction of a problem-solving method and exercises.</td>
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<tr>
<td>3.</td>
<td>The goal of becoming an actor; things that hinder or complicate my studies and my goals.</td>
</tr>
<tr>
<td>4.</td>
<td>Which activities constitute my working day? My time-use, activities that improve my mood, and their effect on my willingness to study. How much time do I spend on studying daily? Establishing a daily schedule that promotes studying.</td>
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<tr>
<td>5.</td>
<td>The effect of thoughts on my actions and my studying.</td>
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<tr>
<td>6.</td>
<td>My social network and utilizing it when encountering studying difficulties.</td>
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<tr>
<td>7.</td>
<td>Interaction skills and making use of them in the student world: assertiveness exercises and the significance of giving feedback.</td>
</tr>
<tr>
<td>8.</td>
<td>Troubling feelings that make studying difficult: the effects of the feelings of helplessness and powerlessness on studying.</td>
</tr>
<tr>
<td>9.</td>
<td>How do I improve my abilities of coping with the feelings of helplessness and powerlessness while studying?</td>
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After that, they analysed their daily activities and planned new strategies for their actions and studies. They analysed the effect of thought and worked with their beliefs and thoughts. They made assertiveness exercises and learned new strategies for managing their emotions. At the end of the course, they evaluated what they had learned and what they have to do in the future.

The criteria for participating in the course were: (1) depression (at least 13 points on the BDI-scale); and (2) constant absences from lectures or delay of studies. It was stipulated that suicide risk, bidirectional affective syndrome and acute crisis would prevent participation in the course. In addition, it was expected of the attendees that they possess enough concentration to carry out the assignments required by the course programme.

The preliminary interviews were conducted to assess who could benefit from this short-term, psycho-educative course. To have successful group therapy, preliminary interviews and the composition of the group have to be carried out with utmost care (Bernard et al., 2008). The group meetings were referred to as a course instead of group therapy, because its purpose was to be as non-labelling and as easily approachable as possible. The interviews and the composing of the group were conducted by the group leader.
The course consisted mainly of different assignments that the participants completed on their own time. At the sessions, the group leader led discussion about the assignments. The participants were given assignments such as mapping out their social network and thinking about problems that complicated their studies. The assignments were based on a book of exercises called Depressiokoulu (Depression School) by Koffert and Kuusi (2003). The depression school introduced in the book consists of ten lessons that were used in the course when planning the 16-session programme. The group leader's role was active and encouraging.

The therapist had six years of therapy education in cognitive therapy, and six years of education in family therapy. Furthermore, he had experience from working with the groups. The supervisor had qualifications of the trainer psychotherapist (cognitive therapy) and the work supervision was carried out during the group process.

Subject

The case discussed in this study was chosen on the criteria of informativeness and representativeness compared to other group members. Johanna (the name has been changed) was a university student suffering from depression. At the beginning of the course, Johanna was just under 30 years of age and living with her significant other. She was a student of natural sciences and her studies were at the stage where she was to write her thesis.

Johanna’s studies had been stuck for 18 months. Carrying out the studies seemed utterly overpowering to her. She had found other things to do instead of studying, such as household chores. Johanna felt that she no longer had any ambition to study and in addition, her motivation to study her chosen field was running low. This was, at least in part, due to the lack of jobs in the field.

Johanna felt that she had fallen hopelessly behind from her fellow students. She avoided meeting her course mates and spoke to virtually no one about her studying difficulties. She said that she lacked concentration. Johanna felt she was lazy and inefficient. She described herself as bad and a failure, both as a student and as a person. She had worked during the summers and the work had gone well.

Depression represents a mode that has been named loss or deprivation mode (Clark & Beck, 1999). There were indications of each of the schemata included in the mode in Johanna. In Johanna’s case, feelings of hopelessness and the loss of pleasurable feelings (motivational scheme) were particularly noticeable, in addition to passiveness and withdrawal (behavioural scheme). Johanna felt dispirited (affective scheme) and she had difficulty in coping with her studies (physiological scheme). The threat of loss (cognitive-conceptual scheme) was only suggestive, which in Johanna’s case would have meant possibly giving up her studies entirely.

Measures

The subject’s depression was assessed with the Beck Depression Inventory self-assessment form that had been translated into Finnish (Beck et al., 1961) that comprised of 21 items. In each item, there are 4–7 alternative statements that have been awarded points from 0 to 3. The items depict attitudes and symptoms related to depression and the severity of the depression from neutral to severe (0 = neutral, 1 =mild, 2 =relatively severe, 3 =severe). The full score of the BDI is 63. The clinical norms of the Inventory are: neutral or not depressed (0–9 points), mildly depressed (10–18), relatively severely depressed (19—29) and severely depressed (30 to 63) (Beck, Steer & Garbin, 1998). The form is a reliable and valid tool for assessing the severity of depression (Beck et al, 1988; Beck, Ward, Mendelson, Mock & Erbaugh, 1961). The indicator also gives information on changes in the severity of depression, so it is also a reliable aid when examining the effects of therapy (Beck et al., 1961).

The BDI-form was used to gather information in the middle of the course, both midways through it and at the end of it. The subjects were also given a form to fill out approximately two months after the group sessions had ended. In the initial measuring, Johanna’s BDI score was 25. According to the BDI-indicator, her depression was relatively severe.

Assimilation analysis is a research methodological trend used for measuring the effects of psychotherapy. According to Stiles et al. (1990; 1991), the client’s troubling experiences assimilate into already existing knowledge structures in successful psychotherapy. In the course of the therapy, the client aims to give his/her experience new meanings and the experience integrates into a part of the client’s schema structures. The assimilation model takes into account both emotional and cognitive change processes. To analyse the stages of assimilation, we can use the APES (Assimilation of Problematic Experiences Scale) developed by Stiles et al. (1990; 1991). The stages of assimilation are demonstrated in Table II.

Assimilation can be examined as a continuum in which the assimilation of the problematic experience progresses with the progression of therapy. Assimilation progresses in stages and it is notable that the patient’s assimilation process can be at any stage when the therapy begins (Stiles et al., 1990; 1991).
Assimilation does not progress rigidly and systematically; there can be regressions. The closer the client is to understanding the problem, the more focal the problematic experience becomes in his/her consciousness (APES 4, Table I). From this stage onward, the amount of conscious effort aimed at the problematic experience begins to decline. The neutral state of mind in the beginning of the assimilation process reflects a successful denial of the problem. As the client becomes increasingly aware of the problematic experience, the tone of the emotions becomes more negative. As the assimilation progresses, the anxiety will gradually lessen and the mood becomes more positive: the problem is understood and solved. When the problem is under control, emotions regarding it become neutral.

TABLE II. Summary of the stages of assimilation of problematic experiences scale (APES).

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
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<tbody>
<tr>
<td>0.</td>
<td>Warded off. The content of the client’s problematic experience is not defined, and he/she is not aware of the problem. The client may be only mildly anxious having successfully avoided the problem.</td>
</tr>
<tr>
<td>1.</td>
<td>Unwanted thoughts. The client prefers not to think of his/her problematic experience. The subjects arise from the therapist’s initiation or because of some external event. The client’s feelings are often clearer than the actual content of the problematic experience. The feelings manifested may be, for instance, anxiety, grief, anger or fear. The feelings can be vaguely targeted and their connection to the content of the experience can be unclear.</td>
</tr>
<tr>
<td>2.</td>
<td>Vague awareness/emergence. The client begins to recognize the existence of a problematic experience. The client describes the unpleasant thoughts related to the experience, but is unable to clearly define the problem. The client’s feelings reflect anxiety when the problematic thoughts and experiences are discussed.</td>
</tr>
<tr>
<td>3.</td>
<td>Problem statement/clarification. The client recognizes and clearly voices the existence of a problematic experience. The problem becomes something that can be worked with. The client’s feelings are still negative, but tolerable and not panic-like.</td>
</tr>
<tr>
<td>4.</td>
<td>Understanding/insight. The client’s problematic experience has been set on a certain schema. The experience has been formulated and understood; in addition, connections to other experiences have been found. The client’s feelings can be quite conflicted. They can have unpleasant tones, but also pleasant curiosity and surprise elements.</td>
</tr>
<tr>
<td>5.</td>
<td>Application/working through. The client uses the acquired understanding to work on the problem. He/she actively tries to solve the problem. The client may express that he/she is considering different options or methods. Feelings are positive and optimistic in tone.</td>
</tr>
<tr>
<td>6.</td>
<td>Problem solution. The client achieves a solution to a specific problem. The tone of the emotions is positive. The client is happy and proud of his/her achievement. As the problem is resolved, the tone becomes more neutral.</td>
</tr>
<tr>
<td>7.</td>
<td>Mastery. The client applies the solution successfully in new situations. The fact that this occurs increasingly often is mainly automatic, not the result of conscious efforts. The tone of emotions is neutral.</td>
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Data collection

The assimilation analysis can be carried out in many different ways (Stiles & Angus, 1999; Stiles & Osatuke, 2000). However, it is possible to separate four steps that one can follow to ease the process.

I Getting to know the data and listing. In this study, the basic data consisted of videotapes, consisting of approximately 30 h of footage. The analysis was begun by watching all the tapes through carefully (carried out by JK, the other author of this article). He noted the topics the subject addressed in the order they were discussed. The topics noted were attitudes or actions directed at a specific object. The topic could be, for instance, hopelessness in regards to writing the thesis and studying. The main purpose of this work stage is that the researcher acquaints himself with the data as much as possible.

II Recognizing and choosing the themes. The theme that will be examined can be a repeatedly expressed attitude or object (Stiles et al., 1991; Stiles & Osatuke, 2000). The research problem directs the choice of theme. The researcher can choose a theme that is (a) focal or important in the therapy, regarding which; (b) there has been remarkable progress, regarding which; (c) there has been little or no progress; or (d) some other interesting theme. It is best to describe the chosen theme’s contents as clearly as possible, for example, by using certain key words.

In this study, the themes were chosen on the grounds that these topics seemed to emerge as focal and important for the subject. In this subject’s case, her relationship with herself as a student was most prominent, because the subject brought this topic up constantly when she spoke up. The course dealt with many factors related to studying difficulties. Mainly because of that, the central themes, such as problematic experiences of the subject, were related to studying and difficulties therein.
III Separating parts related to the theme. At this stage, the parts of the material that deal with a certain theme or problematic experience are collected from the material (Stiles & Angus, 1999; Stiles & Osatuke, 2000). In practice, at this stage the footage was viewed again. By now, the material had already been quite well outlined since the subject’s topics had been listed. At this stage, the subject’s addresses were actually transcribed word for word.

IV Description of the assimilation process. At the final stage of the analysis, the assimilation is examined from a theoretical point of view. The examination is based on what happened to the problematic experience during therapy. In this study, the examination was performed by classifying the parts that dealt with the themes according to the theoretic stages of assimilation (APES).

Ethical considerations

Names and identification data were changed so that the person is not recognizable. The students were told that the sessions were videotaped for the purpose of the study and the data would be published in a scientific forum. After that, all information would be destroyed. The information was also given in the paper, and they signed on the dotted line.

Results

We named Johanna’s problematic experience as a difficult relationship with herself. In the beginning, this was unclear. Johanna’s APES was 1/7: she preferred not to think about her problematic situation and her feelings were anxiety and anger. The connection between Johanna’s feelings and the problematic experience was unclear. In the fourth session, the problematic experience was identified for the first time. In the seventh and eighth sessions, her understanding of her problematic experience increased. Her understanding fluctuated back and forth. At the end of the course, her attitude gradually became assimilated into her schemas: she found new perspectives on her academic problems. The connection between intervention and its results can be found by describing the therapy process and reporting the relevant utterances (McLeod, 2001). In the next section, we describe the process by showing some of Johanna’s comments during different sessions (APES number shows the stage in assimilation model, Figure 1).

In the first session, Johanna expressed her hopelessness regarding her thesis. In her speech, there was also an emphasis on her sensitivity to criticism and to other people’s advice. The connection between Johanna’s feelings and the problematic experience was unclear (APES 1: unwanted thoughts):

Johanna: …I’ve been studying seven years or started these studies seven years ago. And the thesis I’ve been doing for a bit over a year [is] going nowhere. It’s like that no one can say anything about it. I can’t listen to any advice on it and the like. And no one close to me can say anything like now I’ll get so down if I can’t get it done. And then I really can’t get it done.

In the second session, Johanna expressed that she was very critical of herself and of her progress in her studies (APES 1.5: unwanted thoughts and vague awareness):

Johanna: …Now I’ve totally been lazin’ and stuff. Like I left my job last year so that I could work on that thesis. I haven’t been working on it. I haven’t been able. Then it becomes like kinda … that you can’t like … like, you can’t allow anything nice to yourself, you know. It’s like I should be doin’ it now that I got the time.

Therapist: Let me clarify, you mean that when you feel you haven’t done enough, then you can’t like enjoy yourself or just do nothing.

During the third session, the group discussed the fact that it would be good to commend oneself every day for the things one has done. Johanna found it quite hard to give herself credit (APES 1.5: unwanted thoughts and vague awareness):

Therapist: How can you give credit? What could you tell yourself, for example, Johanna?
Johanna: I dunno.
Therapist: Try it. … Or think about it.
Johanna: Well maybe like that you’ve been doin’
stuff all day. That you haven’t like ran outta steam in the middle.
Therapist: Yeah. So you could say daily that you’ve done well.

In the fourth session, Johanna disclosed that she felt she lacked the self-discipline required to write the thesis. The problematic experience began to take shape (APES 2: vague awareness/emergence):

Therapist: Johanna, would you like to say something to this?
Johanna: I dunno, I got like … that thesis; it’s like mainly the self-discipline. … That I’d like have enough discipline to, like, take a hold of it. Cos sure I’d rather be somewhere else doin’ somethin’ fun.

The difficulty that Johanna experienced in giving herself credit came up again during the fourth session. She expressed the existence of a problematic experience quite directly (APES 3: problem statement/clarification):

Therapist: And Johanna, have you remembered (to give yourself credit)?
Johanna: [Shakes her head] No.
Therapist: You haven’t?
Johanna: It’s somehow not. … It goes against my nature. I don’t know how. … I can’t.
Therapist: That, that when you try, then you’ve done so much everyday stuff. Then you do a huge amount. It’s like an employer not paying salary. So then … You get through so many, many difficult things.

In the seventh session, Johanna told the group that undone work dampened her spirits and paralyzed her from acting. Her understanding of the problematic experience was improved (APES 4: Understanding/insight):

Johanna: My last week was like, that I was sick on the weekend and early in the week … Therapist: When you got better, what was the biggest obstacle that you didn’t touch those papers?
Johanna: I dunno. Maybe it was a kinda feeling of incapability that just like took me with it.
Therapist: Did you then have this feeling like everything’s gone to waste or?
Johanna: Yeah. Not when I was sick, then I just didn’t have the energy. So that, I just let slide. But um then that … Then after it I’d just lost that whole week. It’s like, it’s gotta start with Monday or it won’t start at all. I just got that feeling.

Therapist: It’s funny, that it’s kinda like a sort of programming. But d’you think that this thought of everything going to waste paralyzed you?
Johanna: Yeah, probably.

In the eighth session, Johanna groped for words as she tried to describe her new views on studying and writing her thesis that she had learned from the course. Here, Johanna’s newly-found tolerance toward herself and her behaviour was apparent. Writing her thesis no longer seemed completely mandatory; instead, Johanna felt that she could do other things, even if she was not working on her thesis. She worked on her problematic experience further (APES 5: application/working through):

Johanna: … I got a lot of new views from others and stuff to think about.
Therapist: Which new views did you get?
Johanna: Well … The one about that um … you do little by little and then you can like rest. And like that when you don’t give yourself permission to do. That it would be like important just so that you can stay in shape and then work again.
Therapist: Wait, did I get this right, that when you something, you’d do it. But then on the other hand you’d give yourself permission to do other stuff and enjoy that too. Was that what you meant?
Johanna: Wait a sec … I meant that like, if you’re not doing the thesis, it’s still okay to do something else.

In the ninth session, Johanna felt that giving herself positive feedback was quite difficult. She was, however, able to give herself some positive feedback, but negative thoughts and criticism took over her mind very easily. This depicted Johanna’s severity on herself (APES 4.5: understanding and working through).

When the group had met ten times, Johanna had been able to become more active with her thesis. She still felt, however, that the more she focused on studying, the lower and the more desperate she felt. Criticism and severity could be heard in Johanna’s speech (APES 3.5: problem statement and understanding).

In the eleventh session, Johanna said that she needed instruction on her thesis, but she was afraid of going to meet her instructor. Here, Johanna’s feelings of hopelessness with her studies and her thesis became apparent. Alternatively, it seemed that she was ashamed that she had not achieved what she thought was enough (APES 4: understanding/insight):
Johanna: I'd really probably need like my own field's point of view at this stage and ... I just somehow don't dare to go to the department. ... I just don't dare go there.

Therapist: What scares you?

Johanna: I dunno. It just makes me feel like that, I'm a loser and I'm so totally lousy, and now it's been so long, and more time just keeps passing. It's like this endless circle ... or kinda like, it's too late now.

Later in the same session, Johanna said that she felt she got support from the group. She worked on her experiences some more. The emotional tone was positive and optimistic (APES 5: application/working through):

Therapist: What do you hope from us (the group)?

Johanna: Well, I hear all kinds of ... well I hear stories here, survival stories. [Laughs.]

Therapist: [Laughs.] This is a survivors' club.

Johanna: Maybe that kinda gives hope, that maybe I'll be brave enough to go there [to the instructor], because now I've got it figured out what my next step is, that I should take to get forward.

In the twelfth session, Johanna reflected upon her determination to work on her thesis (APES 5: application/working through):

Therapist: ... Now that you've been more active, what's helped you?

Johanna: Well just that like you've decided once and for all that now you gotta do it. That I ... well first of all, I went to see the professor right then, that week [Therapist: Yeah.] when we talked here.

Therapist: Good, great. Yeah. And you didn't get eaten there.

Johanna: Right. And now I have this like ... or that kinda feeling that it's now or never. That otherwise it will just stay here, and I can't leave it now. It'd be even harder to start.

Therapist: So does that mean that you've made yourself an action plan?

Johanna: Well, a bit like that, yeah. That I don't have to have like a schedule [Therapist: On how you'll go on.] but just so that ....

Johanna: Every day I should get something done.

In the thirteenth session, Johanna brought up the fact that she could get studying done little by little. She had learned to have mercy on herself (APES 5.5: application/working through and problem solution):

Therapist: How about your studies this week?

Johanna: Well. I studied stuff on Tuesday and Wednesday.

Therapist: Great.

Johanna: But then I've had these gap days.

Therapist: Have you given yourself credit?

Johanna: Well, I have tried or at least be happy even if I don't do a lot. Cos I get something ... like reading stuff.

Therapist: This sounds great. So what's your recipe now?

Johanna: Like one day at a time. If it feels bad, then you can like ... give it a rest, you know, and do something else.

In the fourteenth session, Johanna listed her short-term priorities. Her short-term aims reached the time-line of approximately six months. In addition to working on her thesis, Johanna mentioned recovering even further from her depression as a goal. In addition, the fact that Johanna was happier with herself was clear; this had increased during the group sessions (APES 5.5: application/working through and problem solution):

Therapist: How about Johanna?

Johanna: Well I pretty much have the same things [as the others] that I've put down. I wanna have the thesis like up and running, so that it kinda takes care of itself or that like ... I could see the end of it already. And that I'd move past the depression, that I'd be like rid of it already. I dunno. That I'd be happy with myself.

Therapist: You have that too, to be happy with yourself.

Johanna: Yeah. Or like, yeah.

Therapist: Yeah. Do you feel that it's increased during this group, that being happier with yourself?

Johanna: Yeah, probably.

The fifteenth and the sixteenth meetings of the course were held together as a single four-hour session. During this session, it came up that Johanna was less critical of herself. She said she could write her thesis gradually (APES 6: problem solution):

Therapist: What have you done lately when you said 'I've done'?

Johanna: And that um ... I've been reading. Reading some of the stuff I got, some materials. And then I've just written straight to the computer. And that text doesn't matter at this stage that it's just like some text.

Therapist: Yeah.

Johanna: That I can like mould it later into what I want. That's just it, cos it's that starting up that's hard for me, that writing is kinda hard. I could
really think about one sentence for half an hour. Then it's just gonna go nowhere. So I'll just write then, even if it's not perfect language yet.

Therapist: It's probably good that you do it like that. Johanna: It's like I get something done. I get that kinda …

Therapist: So is this a new method that you've developed, that you just write ahead?

Johanna: Well, yeah. I think it kinda is. The whole time it just kinda gets more fluent and like um … the text [Therapist: Yeah.] and the like, the way it comes out. [Therapist: Yeah.] And it's probably the reading too that does it, the more familiar the thing is the easier it gets, of course and the easier it maybe is to write.

Johanna felt that her beliefs regarding her own actions had changed. She had found new perspective and relief for her problems from the group (APES 6: problem solution):

Therapist: But Johanna, is it kinda like, you've seen that these kinda things don't have to knock you down, that you've then changed your beliefs on your own actions?

Johanna: Yeah. Or like … That this [problems with the thesis and depression] isn't such a big monster anymore. Then when here you've had to and it's been okay to talk about it, then it's no. … It's like easier to take that thing. It's not so big anymore. That you can talk about it. You gotta bring it up once a week anyway, it gets smaller. I don’t really know.

As the course went on Johanna was increasingly vocal about having mercy on herself and being happy with herself. She spoke about having received support from the group and was learning to commend herself. Little by little, she became less critical toward herself. She had more room in her inner world. Her tolerance toward herself had a positive impact on Johanna's ability as an actor. She began to work on her studies gradually and it also became easier for her to do other things besides studying.

Finding the ability to be merciful led, in Johanna's case, to increased determination and assertiveness regarding her studies. She wanted to finish her thesis and felt that the thesis was no longer "some monster." In other words, Johanna got more motivation to continue her studies and to finish them. These new views formed another self-state in Johanna. Johanna's symptoms of depression eased and her ability to act improved.

In the initial measuring, Johanna's BDI score was 25. According to the BDI-indicator, her depression was relatively severe. Four months later, the score was 23 and two months after that, it was 19. At this point the course was finished. A follow-up measuring three months later showed the score was 12, which meant that Johanna was, according to the BDI-indicator, only mildly depressed. Johanna’s BDI-score kept decreasing throughout the course, and also after it. She felt that her depression eased during the group meetings.

Johanna’s problematic experience (APES) progressed as the meetings continued from level 1 (unpleasant thoughts) to level 6 (solving the problem) (Figure 1). In the beginning, Johanna’s problematic experience manifested itself as severe and excessive criticism toward herself and her study performance. The assimilation of Johanna’s problematic experience was facilitated by learning different methods of depression control in the group.

**Discussion and conclusions**

During the course, Johanna directed her energy toward surviving depression, finishing the course and carrying out the assignments given in the group. If working helped in recovering from depression, we can assume that after the course, Johanna had even more resources to direct her actions at, for instance, her studies and particularly on writing her thesis.

Johanna expressed plenty of severe and excessive criticism aimed at herself during the course. According to Guidano’s (1991) theory, “I” represents the experiencing and reacting side of the human mind and “self” represents the evaluating and observing side. In Johanna’s case, “me” was very rigid and severe, even merciless. This side of her mind attributed that the lack of progress in her studies and other negative experiences were her own fault. Depressive, negative attribution style is a central method of self-regulation in depression (Beck, 1976; Beck, Rush, Shaw & Emery, 1979). In Johanna’s case, the rigid and severe “me” produced negative, permanent inner attributes. These assessments were the source of the severity and harsh critique she directed at herself. By examining this according to Guidano’s (1991) theory, Johanna became more lenient in the assessments “me” made of the actions of “I”. This was seen in Johanna’s case as the depressive, negative attributions becoming less prevalent.

Of the schemata belonging to the loss or deprivation mode, the behavioural scheme, in particular, changed in Johanna’s case during the course. Passiveness and withdrawal made way for her new determination and assertiveness toward her studies. The feelings of hopelessness seemed to go away, so the motivational scheme can also be said to have changed for the better. Alternatively, Johanna reported that her role as an
actor regarding her studies remained rather passive throughout the course. The contents of the affective and physiological schemata also underwent a positive change. Johanna’s melancholia eased and she gained strength to continue her studies.

The assimilation of Johanna’s problematic experience was facilitated by her learning different methods of depression control in the group. Treatment aimed at depressed students would do well to teach structuring one’s studies and methods of mood-control and life-control skills (Brackney & Karabenick, 1995; Lam et al., 2003). The approach of this course was specifically psycho-educative. Johanna felt that she had also received peer support from the group: she had heard how the other group members had managed to get their studies started.

One of the focal questions in this study was whether or not finishing the course helped in combating depression and studying difficulties. The results indicate that the subject’s depressive symptoms eased and her role as a student became more active. In the group, mood-improving techniques were also taught. The depression-control skills taught were important.

When examining the change process, we can distinguish two kinds of change processes: superficial and deep changes (Guidano, 1991). The group members’ troubling feelings were not discussed at great length in the group. This can be a sign that the achieved changes happened mainly on the superficial level of the psyche. Deep level change cannot take place without active work on the emotions related to the problematic experience (Greenberg, 2002; Greenberg & Paivio, 1997; Guidano, 1991). Thus, the achieved changes are not necessarily very permanent. In the follow-up meeting, the subject’s BDI-score had continued to decline, although she was still, according to the BDI, mildly depressed.

In Johanna’s case, the conceptualized problematic experience could have been, for instance, hopelessness regarding studying, and the effect of negative thoughts on studying or getting support from other people. In this case, the research problem directed the choice of themes. Furthermore, the problematic experiences had to be such that they could be conceptualized into suitable units.

Johanna’s problematic experience became less restrictive through the course. This led to more lenience toward herself and more determination and assertiveness toward her studies.

The downside of working in a group was the fact that the attention of the therapist and of the whole group was divided among six people. At times, it seemed that none of the group members had the opportunity to express and work on their issues adequately in the session time frame. The therapist took an encouraging and supportive approach: he actively strove to pay attention to each group member and to include them all in the discussions. On several occasions, however, it seemed that the two-hour session was far too short a time for this group.

Some of the group members were receiving treatment elsewhere while they attended the course. Consequently, in this study we could not control, for instance, the effects of medication on the lessening of a person’s depressive symptoms. In addition, some group members had a discussion contact with a mental health professional outside the group.

In assimilation analysis, determining the subject’s APES stages was sometimes rather difficult. At this point, the summary of the stages of assimilation (Table II) was quite helpful. It was often so that a seemingly essential utterance by the subject was found, but determining the APES stage was difficult nonetheless. Eventually, seemingly correct stages were found for all excerpts. Finding the correct APES stages was aided by repeatedly reading the subject’s utterance and assessing the excerpt according to the amount of cognitive processing and in light of the emotional content. However, the final text probably contains utterances that could have been rated otherwise. Thinking critically, the data achieved by assimilation analysis could be said to be, in all its detail, merely approximate and dependent on the researcher’s interests. Alternatively, we should, of course, bear in mind that the APES stage given to a single utterance is not very significant in the scale of the entire change process.

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The fact that the analysed data is mainly linguistic can be seen as a weakness of the assimilation analysis. This deficiency is a drawback with most qualitative research methods. The verbal descriptions of the subjects do not always accurately convey the relevant contents of the meanings or the emotions related to them. However, if the analysis is to be successful, it has to recognize the subtle nuances and feelings from the material. That is why we used videotapes: the chance to check the process in video deepens the researchers’ understanding.
The very concept of a problematic experience can easily be challenged. In this study, the subject's problematic experiences were the themes that were discussed often and at length. However, other criteria could have been used to choose the problematic experience. The themes conceptualized as problematic experiences could also have been, for example, themes for which there was great progress or for which there was little or no progress at all. Alternatively, another interesting theme could have been chosen.

From an economical point of view, it must be mentioned that with a course such as this, a large number of people can be treated relatively quickly. Nowadays, there is pressure to treat depression as cost-effectively as possible (Bright et al., 1999). Group treatment is substantially less costly than individual treatment. The studied group had 16 gatherings, and sessions were two hours each. If they had each had an individual appointment 16 times, there would have been 96 meetings altogether.

One viewpoint is that coping with depression can be taught. One outlook could be introducing depression school as a part of general, basic health care, for instance at schools. The aim could be to teach mood-control skills to persons predisposed to depression, before they become ill. It would be reasonable for the sake of these people themselves, because it would save them from a great deal of human suffering. In addition, this practice would be sensible for society as well, because economically, it would be much less costly than long-term treatments and sick leaves. However, more research is needed to determine this.

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