

# Hükümlülerin Psikiyatrik Belirtiler Yönünden Değerlendirilmesi

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## Özet

*Bu çalışmada 35 cezaevinde bulunan ve ilk kez hüküm giymiş 368'i erkek 23'ü kadın olmak üzere toplam 391 hükümlü genel psikiyatrik belirtiler yönünden değerlendirilmiştir. Psikiyatrik belirtilerin saptanabilmesi için hükümlülere Genel Sağlık Anketi (GSA), Belirti Tarama Listesi (SCL 90R) ve Çokyönlü Depresyon Envanteri (ÇDE) uygulanmıştır. Hükümlülerde psikiyatrik belirtilerin yaygınlığını belirlemek için her üç ölçekten hükümlülerin aldıkları genel puan ortalamalarına bakılmıştır. Psikiyatrik belirtiler ile yaş ve alınan ceza süresi arasında bir ilişki olup olmadığı ve psikiyatrik belirtilerin cinsiyet, eğitim düzeyi, medeni durum, işlenen suç türü gibi değişkenlere göre farklılık gösterip göstermediği de araştırılmıştır. Hükümlülerin her üç ölçekten de aldıkları puan ortalamaları yapılan başka araştırmalardaki hükümlü olmayan grupların ortalamalarından daha yüksek bulunmuştur. Sonuçlar yaş arttıkça ÇDE ile ve SCL 90R' dan alınan puanların anlamlı bir şekilde düştüğünü göstermektedir. Alınan ceza süresi ile ölçeklerden alınan puanlar arasında bir ilişki bulunmamıştır. Kadınların her üç ölçekte erkeklerden anlamlı düzeyde daha yüksek puan ortalamalarına sahip olduğu görülmektedir. Eğitim düzeyi ve suç türü açısından yapılan analizler yalnızca ÇDE'de anlamlı farklılıklar olduğunu göstermektedir. Eğitim düzeyi düşük olanların, eğitim düzeyi yüksek olanlardan; hırsızlık suçundan hüküm giyenlerin, uyuşturucu ve dolandırıcılık suçlarından hüküm giyenlerden daha yüksek ÇDE ortalamasına sahip oldukları görülmektedir. Medeni durum açısından her üç ölçekte anlamlı fark bulunmamıştır.*

**Anahtar sözcükler:** Hükümlü, psikiyatrik belirtiler, psikiyatrik değerlendirme

## Abstract

*In this study, the psychiatric symptoms of the 391 prisoners (368 male, 23 female), who were sentenced for the first time, were assessed. The Symptoms Check List (SCL 90R), General Health Questionnaire (GHQ), and Multiscore Depression Inventory (MDI) were administered to all subjects in order to assess psychiatric symptoms. Gender, age, education level, marital status, type of crime, duration of sentence were also investigated. Results showed that the scores of the prisoners for the three instruments were higher than non-prisoner subjects of other studies. Age was negatively and significantly correlated with the MDI and the SCL 90R scores. Period of sentence was not correlated with the SCL 90R, the GHQ, and the MDI. Females scored higher than males on the three instruments. The MDI scores differed significantly with education level and type of crime. Participants with lower education had higher MDI scores than those with higher education. Also, those sentenced for theft had higher MDI scores than those sentenced for swindling and drug use, sale, or purchase. No significant differences were obtained for marital status.*

**Key words:** Prisoner, psychiatric symptoms, psychiatric assessment

Çağlar boyunca insanlar bir arada uyum içinde yaşayabilmek için çeşitli kurallar koymuşlardır. Bu kuralların amacı toplumdaki bireylerin birbirlerine karşı olan davranışlarını düzenlemek ve toplum düzenini sağlamaktır. Toplumlardaki davranışları belirlemek amacıyla konulan bu kuralları, her toplumda ve her çağda bozan bazı kişiler çıkmıştır. Konulan kuralları bozan davranışa göre de toplumlar çeşitli şekil ve şiddetlerde tepki göstermişlerdir. Toplum düzenini sağlamak amacıyla gelenekler, örfler gibi yazılı olmayan kuralların yanı sıra, hukuk kuralları gibi yazılı kurallar da oluşturulmuştur. Toplumdaki hukuk kurallarına uymayan kişilere "suçlu" adı verilerek toplumu korumak, bu kişilerin bir bedel ödemesini sağlamak ve ıslah edebilmek amacıyla, para cezası, hürriyeti bağlayıcı cezalar gibi çeşitli yaptırımlar uygulanmıştır.

Evrensel bir olgu olan suç, tarihsel gelişim süreci içinde bütün toplumlarda, her türlü sosyal yapıda ve her zaman rastlanmaktadır. Bu nedenle, suç önemli toplumsal sorunlardan biri olarak görülmektedir. Daha önceleri yalnızca ceza hukukunun ilgilendiği suç olgusuna, günümüzde değişik bilim dalları tarafından açıklamalar ve çözümler getirilmeye çalışılmaktadır. Suç davranışının aydınlatılmasına katkı sağlayan bilim dallarından biri de psikolojidir. Psikoloji tarihçesinde yer alan çeşitli kuramlarda suç, ruhsal bozukluk, psikolojik yapı ya da kişilik sorunu gibi değişik biçimlerde açıklanmaktadır. Psikolojik kuramların değişik açıklamalarına karşın ortak noktaları, suçu bir tepki ya da bir yardım çağrısı; suçlu kişiyi de 'hasta', 'uyumsuz' veya 'patolojik' kişi olarak ele almalarıdır (Gibbons, 1970).

Suç alanında yapılan araştırmalarda yer verilen konulardan biri hükümlülerin psikiyatrik belirtiler yönünden değerlendirilmesidir. Araştırmalarda psikiyatrik belirtilere sahip kişilerde suçluluk oranının yüksek olduğu ortaya konmaktadır. Jerell ve Komisaruk (1990) hükümlülerin psikiyatrik belirti ölçeklerinden genel nüfusa oranla daha yüksek puan aldıklarını bulmuşlardır. Ayrıca yargılanan kişilerde psikotik belirtilerin yaygın olduğunu ve

yargılama sistemi içinde davranış bozukluğu gösteren, ancak tanı konulmayan kişilerin sayısının fazla olduğunu ileri sürmektedirler. Robertson, Dell, James ve Grounds (1994) tarafından da hükümlülerde psikiyatrik belirtilerin yüksek olduğu saptanmıştır.

Fido, Razik, Mizra ve El Islam (1992), tarafından yapılan araştırmada ise, psikiyatrik değerlendirilme istenilen hükümlülerin üçte birinin daha önceden bir sabıkası olduğu ve yaklaşık yarısının geçmişte psikiyatrik tedavi gördüğü belirlenmiştir.

Son zamanlarda ruhsal bozukluk gösteren kişilerin kurumlara kapatılması yerine, toplum içinde iyileştirilmesi eğiliminin artmasıyla, ruhsal bozukluğu olan kişilerin suç işleme sıklığının arttığını vurgulayan "ruhsal sorunları olanların suçluluğu" kavramı hem ABD'de hem de İngiltere'de birçok ruh sağlığı uzmanı tarafından yaygın bir biçimde kullanılmaktadır. Bu kavram, ruhsal bozukluklardan bazılarının suç işleme nedeni olduğunu; özellikle benzer suçların ruhsal bozukluk gösteren kişiler tarafından normal kişilerden daha fazla işlendiğini; ayrıca, cezaevine yeni gelen hükümlülerin çoğunluğunun psikiyatrik bir geçmişe sahip olduğunu ifade etmektedir. Suçlulara yönelik polis kayıtları ile arşiv çalışmaları bu olgunun varlığını destekler niteliktedir (Teplin, 1983).

Ülkemizde İstanbul Üniversitesi Ceza Hukuku ve Kriminoloji Enstitüsü tarafından hazırlanan raporda (1958), toplumda ruhsal bozukluk gösteren kişilerin ve işledikleri suçlar nedeniyle tehlike olasılıklarının arttığı, toplumun bu tehlikeden korunması için bu kişilerin suç işlemekten saptanmasının gerekliliği vurgulanmıştır. Geçen zaman içerisinde bu konuda gerekli önlemler alınmadığı gibi, ruhsal bozukluk ve suç ilişkisini araştıran çalışmaların sayısının azlığı dikkati çekmektedir.

Ülkemizde yapılan suç işleme nedenlerini belirlemeye yönelik araştırmaların bazılarında hükümlü gruplarında psikiyatrik belirtiler saptandığı bildirilmektedir (Birsöz, Gücer ve Büyükberker, 1988; Yavuzer, 1981; Yavuzer, Güngörmüş ve Minibaş, 1988). Hükümlülerin psikiyatrik

belirtiler yönünden değerlendirilmesi konusunda yapılan çalışmalarda da psikiyatrik belirtilerin yaygınlığı dikkati çekmektedir (Aydın, Bogenç ve Bilge, 1990; Kaya, 1993; Öy, Ünal ve Yurdakul, 1989). Ancak, ülkemizde yapılan çalışmalara genel olarak bakıldığında çoğunluğunun gençler üzerinde yürütüldüğü, genellikle tek bir cezaevini kapsadığı ve araştırmaya alınan denek sayıları açısından yeterli bir örneklem oluşturulmadığı görülmektedir.

Bu araştırma, ülkemizdeki cezaevlerini ve hükümlü özelliklerini yansıtacak bir örnekleme suçla bir bağlantısı olduğu öne sürülen psikiyatrik belirtilerin yaygınlığını saptamak amacıyla planlanmıştır. Araştırmada ayrıca, psikiyatrik belirtilerin yaş ve alınan ceza süresi ile ilişkili olup olmadığı ve cinsiyet, eğitim düzeyi, medeni durum, suç türü gibi değişkenlere göre değişip değişmediği de incelenmiştir.

## Yöntem

### Denekler

1721 sayılı Hapishane ve Tevkif Evlerinin İdaresi Hakkında Yasanın birinci maddesi, her mahkeme bulunan yerde bir cezaevi kurulmasını öngördüğünden ülkemizde toplam 565 cezaevi vardır. Bunların çoğu ilçelerde bulunan küçük cezaevleridir. Ağır ceza merkezi olarak adlandırılan büyük cezaevi sayısı 126'dır.

Hükümlülerin kurum dışından gelen insanlara sağlıklı bilgiler vermeyeceği, kurum psikologlarının hükümlülerle ölçek uygulamalarını da içeren çeşitli çalışmalar yürüttükleri düşünüldükçe, ölçeklerin uygulamasının psikologlar tarafından yapılmasına karar verilmiştir. Böylece bünyesinde psikolog bulunan toplam 35 ağır ceza merkezi cezaevi uygulama kapsamına alınmıştır.

Cezaevlerinde bulunan bireyler haklarında verilmiş olan kararlara göre ikiye ayrılmaktadır: Suçlu oldukları düşünülerek özgürlüğünden yoksun bırakılan fakat, suçlulukları kesinleşmeyen tutuklular ile suç işlediği yargı kararı ile kesinleşen hükümlüler. Ağır ceza merkezlerinde bulunan cezaevleri kapasite ve bina yapı tipi

olarak farklılıklar göstermelerine karşın, cezaevlerinde tüzük ve yönetmeliklere göre belirlenen hükümlülerin uyması gereken kurallar ve tanınan haklar yönünden benzerdir.

Literatürde cezaevlerinin kişilerin bedensel ve ruhsal sağlıkları açısından olumsuz etkileri olduğu belirtildiğinden, daha önce cezaevi yaşantısına sahip olmanın araştırmada karıştırıcı etkisi olacağı düşünülmüştür. Bu nedenle, daha önce herhangi bir suçtan dolayı tutuklanan ya da hüküm giyen hükümlüler ile yargulamaları devam eden, suç işledikleri kesinleşmeyen, cezaevlerinde hükümlülerden farklı haklara sahip olan tutuklular örnekleme alınmamıştır. Araştırmanın örneklemini seçilen cezaevlerinde bulunan ve yalnızca ilk kez suç işleyerek, bu suçtan ceza alan 391 hükümlü oluşturmaktadır.

Araştırmaya katılanların 23'ü kadın, 368'i erkektir. Katılımcıların 33'ü tahsilsiz, 32'si ilkökulu; 233'ü ortaokul, 47'si lise, 45'i yüksekokul ve üstü mezundur. Medeni durumlarına bakıldığında, deneklerin 163'ü bekar, 193'ü evli, 35'i ise duldur. Deneklerin yaşları 13 ile 67 arasında değişmekte olup, grubun ortalama yaşı 30.2, standart sapması ise 10.1'dir. Araştırmaya alınan hükümlülerden 306'sı 0-6 ay, 56'sı 7-12 ay, 9'u ise 13-18 ay tutuklu olarak cezaevinde kalmışlardır.

Araştırmada açık uçlu olarak toplanan suç türüne ilişkin bilgiler yedi grupta toplanmıştır. Gruplandırma, suçun özelliği dikkate alınarak Adalet Bakanlığı'nda görevli beş tetkik hakim tarafından yapılmıştır. Bu gruplandırmaya göre 'öldürme' grubu (n = 86) kasten, kazaen ya da trafik gibi bütün öldürme fiillerini kapsamaktadır. 'Yaralama' grubu (n = 46) öldürmeye teşebbüs suçunu da içermektedir. Kız kaçırma, ırza geçme, ırza tasaddi, namusa tasaddi, küçüklerle cinsel ilişki ve zina 'cinsel suç' (n = 30) kapsamına alınmıştır. 'Hırsızlık' grubunda (n = 90) gasp ve yağma gibi suçlar da yer almaktadır. Uyuşturucu maddelerin kaçakçılığı, kullanımı ve satışı 'uyuşturucu madde' (n = 38) olarak adlandırılmıştır. 'Dolandırıcılık' grubu (n = 38) sahtecilik ve emniyeti suistimal suçlarını da içermektedir. 'Diğer' grubu (n = 62) kapsa-

mına rüşvet, irtikap, meskene tecavüz, orman suçları, gıda maddeleri tüzüğüne aykırı hareket vb. gibi suçlar alınmıştır.

### **Kullanılan Ölçme Araçları**

Araştırmada hükümlüler hakkındaki tüm kişisel bilgiler araştırmacılar tarafından geliştirilen bir bilgi toplama aracıyla elde edilmiştir. Psikiyatrik belirtilerin saptanabilmesi için ülkemizde geçerliği ve güvenilirliği yapılmış Genel Sağlık Anketi/GSA (General Health Questionnaire), Belirti Tarama Listesi/SCL 90R (Symptom Check List 90R-) ve Çok Yönlü Depresyon Envanteri/ÇDE (Multiscore Depression Inventory) kullanılmıştır. Psikiyatrik tarama çalışmalarında kullanılmak üzere geliştirilen GSA ile ülkemizde yapılan çalışma sayısı azdır. Hükümlüler üzerinde yapılmış çalışmaya rastlanmamıştır. Bu nedenle, psikiyatrik belirtilerin saptanabilmesi için hükümlülerle çalışma yapılmış SCL 90R ve GSA birlikte kullanılmıştır. Literatürdeki hükümlülerde depresyonunun yüksek olduğuna ilişkin bulgular göz önüne alınarak, depresyonu saptayabilmek amacıyla ÇDE uygulanmıştır.

Araştırmada psikiyatrik belirtilerin yaygınlığına bakıldığından, sınıflandırmaya yönelik incelemelere gidilmemiş, alt ölçeklere sahip olan SCL 90R ve ÇDE ölçeklerinin de yalnızca genel belirti puanları değerlendirilmeye alınmıştır.

### **Genel Sağlık Anketi (GSA).**

Dünyada yaygın bir biçimde kullanılan bir tarama testidir. Toplumda ve psikiyatri dışı klinik ortamlarda karşılaşılan davranış bozukluklarını saptamak amacıyla geliştirilmiştir ve 12, 28, 30 ve 60 maddelik biçimleri vardır.

Dünya Sağlık Örgütü ile işbirliği içinde yürütülen "Genel Sağlık Hizmetlerinde Ruhsal Bozukluklar" araştırmasının bir parçası olarak 12 ve 28 maddelik biçimlerinin geçerlik ve güvenilirlik çalışması Kılıç (1992) tarafından yapılmıştır. GSA'daki her madde belirli bir yakınmaya ilişkin sorudan oluşmaktadır. Uygulanan kişi son onbeş gün içindeki durumunu göz önüne alarak bu soruları 'her zamankinden az' ile, 'her zamankinden çok fazla' arasında dört şıklı bir ölçek üzerinde değerlendirmektedir.

GSA ilk iki şık negatif, son iki şık pozitif olmak üzere iki şıklı bir ölçek gibi puanlanmaktadır. GSA'dan alınan puanların artması davranış bozukluğu olasılığını arttırmaktadır (Kılıç, 1992).

Ülkemizde ölçeğin 12 ve 28 maddelik biçimlerinin geçerlik ve güvenilirlik çalışması sonuçları her iki biçiminin de güvenilirlik ve geçerliğinin yeterli düzeyde olduğunu göstermektedir (Kılıç, 1992). Daha kısa olmasının uygulamada kolaylık getireceği düşünüldüğünden, bu çalışmada 12 maddelik ölçek kullanılmıştır.

**Belirti Tarama Listesi (SCL 90-R).** Görünüşte 'normal' kişilerdeki belirti düzeyini saptama amacıyla geliştirilmiştir. Ölçeğin geliştirilmesinde normal kişilerde gözlenen psikopatoloji düzeylerinin ve bunlarda kısa zaman aralıklarındaki değişimlerin gözlemlenmesi amaçlanmıştır. SCL 90R ölçeği 90 cümleden ve 9 alt test ile bir ek ölçekten oluşmaktadır. Denekler, cümlelerdeki belirtilerin son bir ay içinde kendilerinde olup olmadığına göre, Hiç (0), Çok Az (1), Orta Derecede (2) Oldukça Fazla (3) ve İleri Derecede (4) olarak puanlanmaktadır. Bu ölçekten alınan 0 ile 0.99 arası Genel Semptom İndeksi (GSİ) puanları normal olarak kabul edilirken, 1.0'ın üstündeki puanlar patoloji belirtisi olarak değerlendirilmektedir (Dağ, 1990). Dağ tarafından yapılan çalışmada ölçek güvenilir ancak, yalnızca GSİ yönünden geçerli bulunmuştur.

**Çok Yönlü Depresyon Envanteri (ÇDE).** Ölçek toplam 118 cümleyi içermektedir. Denekler her cümleyi 'Doğru' (Genellikle geçerli) ve 'Yanlış' (Genellikle geçersiz) boyutunda kendi kendilerine değerlendirmektedirler. ÇDE; Düşük Enerji Düzeyi, Bilişsel Güçlük, Suçluluk, Düşük Kendilik Değeri, Sosyal İçedönüklük, Kö-tümserlik, Huzursuzluk, Kederli Duygu Durum, Araçsal Çaresizlik ve Öğrenilmiş Çaresizlik olmak üzere 10 alt ölçekten oluşan bir ölçektir. ÇDE'deki cümleler depresyonun varlığı doğrultusunda puanlanmaktadır. Yani bir maddede verilen "Doğru" ya da "Yanlış" yanıtları depresyonun varlığını gösteriyorsa, bir puan verilmektedir. ÇDE'den alınabilecek en düşük toplam puan 0, en yüksek toplam puan 118'dir. Öl-

çekten alınan puanın yüksekliği depresyonun ciddiyetini, düşük puan ise depresyonun yokluğunu belirtmektedir. Ölçekle ilgili yapılan çalışmalar ölçeğin güvenilir ve geçerli olduğunu göstermektedir (Aydın ve Demir, 1988).

### İşlem

Bilgi toplama aracı ve ölçekler kurumda görev yapan psikologlar tarafından uygulanmıştır. Uygulamada birliği sağlamak amacıyla tüm psikologlara bir yönerge gönderilmiştir. Uygulamalar bireysel olarak yapılmıştır. Uygulamada Kişisel Bilgi Formu, Genel Sağlık Anketi, Belirti Tarama Listesi ve Çok Yönlü Depresyon Envanteri tüm deneklere aynı sıra takip edilerek verilmiştir.

### Bulgular

Bu çalışmada hükümlülerin üç ayrı ölçekten aldıkları genel puanların ortalama ve standart sapmaları belirlenmiştir. Yaş ve alınan ceza süresi ile ölçek puanları arasındaki ilişkiye korelasyon ile bakılmıştır. Cinsiyet, eğitim düzeyi, medeni durum ve suç türüne göre üç ayrı ölçekten aldıkları genel puanların ortalama ve standart sapmaları her değişken için ayrı ayrı hesaplanmıştır. Gruplar arası ortalama farklarının anlamlı düzeyde olup olmadığına ikili gruplarda *t*-testi, ikiden çok gruplarda tek yönlü varyans analiziyle bakılmıştır. Anlamlı farkın bulunduğu değişkenlerde bu farklılığın hangi gruplar arasında olduğu Tukey testi kullanılarak belirlenmiştir.

Araştırmaya katılan tüm hükümlülerin her bir ölçekten aldıkları toplam puan ortalamaları hesaplandığında, GSA puan ortalaması 4.37 ve standart sapması 3.29, SCL 90R puan ortalaması 0.92 ve standart sapması 0.61 ve ÇDE puan ortalaması 44.87 ve standart sapması 22.21 olarak bulunmuştur.

Yaş ile SCL 90R ( $r = -.13$ ;  $p < .005$ ) ve ÇDE ( $r = -.12$ ;  $p < 0.005$ ) puanları arasında anlamlı ve negatif bir ilişki bulunmuştur. GSA puanları ile yaş arasında anlamlı bir ilişki olmadığı saptanmıştır ( $r = -.05$ ). Alınan ceza süresi ile üç ölçek puan-

ları arasında anlamlı bir ilişki bulunmamıştır.

Hükümlülerin cinsiyet, eğitim düzeyi, medeni durum ve suç türüne göre ölçeklerden aldıkları puan ortalama ve standart sapmaları hesaplanmış ve Tablo 1' de sunulmuştur.

Tablo 1 incelendiğinde kadın hükümlülerin her üç ölçekten de erkeklere göre daha yüksek ortalamaya sahip oldukları görülmektedir. Kadın hükümlülerin ( $N = 23$ ) erkek hükümlülerden ( $N = 368$ ) oldukça az sayıda olması nedeniyle, varyansların homojen olup olmadığı test edilmiş, elde edilen değerin ( $F_{1,389} = 1.26$ ,  $p > .05$ ) anlamlı düzeyde olmadığı görülmüştür. İki grup arasındaki farkın *t* testiyle test edilmesinin uygun olduğu kararına varılmıştır. Yapılan *t* test analizi bu farklılığın GSA ( $t = 2.08$ ,  $p < .05$ ), SCL 90R ( $t = 2.21$ ,  $p < .03$ ) ve ÇDE ( $t = 3.07$ ,  $p < .01$ ) için anlamlı düzeyde olduğunu göstermektedir.

Eğitim düzeyi açısından GSA için en yüksek ortalamaya okur-yazar grubu ( $\bar{X} = 5.27$ ) en düşük ortalamaya ise lise mezunu ( $\bar{X} = 3.65$ ) grubu sahiptir. Diğer grupların ortalamaları birbirine yakındır. Yapılan varyans analizi sonuçları gruplar arasında anlamlı bir fark olmadığını göstermektedir ( $F_{4,385} = 1.51$ ,  $p > .05$ ). SCL 90R puan ortalamaları incelendiğinde en yüksek ortalamaya ilkökul mezunu ( $\bar{X} = 1.0$ ) grubun, en düşük ortalamaya ise yüksek okul mezunu ( $\bar{X} = 0.57$ ) olan grubun sahip olduğu diğer grup ortalamalarının birbirlerine yakın olduğu gözlenmektedir. Varyans analizi sonucu, SCL 90R için eğitim düzeyine göre grup ortalamaları arasındaki farkın anlamlı düzeyde olmadığını göstermiştir ( $F_{4,385} = 1.83$ ,  $p > .05$ ). Hükümlülerin eğitim durumlarına göre ÇDE puanlarına bakıldığında eğitim düzeyindeki artmaya paralel olarak ÇDE puanlarının da düştüğü görülmektedir. Varyans analizi sonucu da gruplar arasındaki farkın anlamlı düzeyde olduğunu göstermiştir ( $F_{4,385} = 6.37$ ,  $p < .01$ ). Bu farklılığın hangi gruplar arasında olduğunu belirlemek amacıyla yapılan Tukey testi sonuçları okur-yazar ( $\bar{X} = 57.4$ ), ilkökul mezunu ( $\bar{X} = 53.7$ ) ve ortaokul mezunu ( $\bar{X} = 45.7$ ) grupların üniversite mezunu ( $\bar{X} = 29.1$ ) grubundan, aynı şekilde okur-yazar

ve ilkokul mezunu grupların lise mezunu ( $\bar{X}$  = 37.2) grubundan anlamlı düzeyde yüksek

ÇDE ortalamasına sahip olduğunu göstermektedir.

**Tablo 1**

*Deneklerin Cinsiyet, Eğitim Düzeyi, Medeni Durum, Suç Türüne Göre GSA, SCL 90R ve ÇDE'den Aldıkları Puanların Ortalamaları ve Standart Sapmaları*

Değişkenler	GSA		SCL 90R		ÇDE		
	n	$\bar{X}$	SS	$\bar{X}$	SS	$\bar{X}$	SS
Cinsiyet							
Kadın	23	5.95	3.28	1.16	0.54	58.4	21.9
Erkek	368	4.48	3.28	0.90	0.61	44.0	22.0
Eğitim Düzeyi							
Okur-Yazar	33	5.27	3.42	0.77	0.37	57.4	19.1
İlkokul	32	4.68	2.97	1.00	0.52	53.7	19.0
Ortaokul	233	4.71	3.31	0.97	0.65	45.7	21.5
Lise	47	3.65	3.24	0.85	0.63	37.2	21.4
Y. Okul	45	4.24	3.31	0.57	0.43	29.1	17.5
Medeni durum							
Bekar	163	4.26	3.15	0.90	0.58	44.4	21.2
Evli	193	4.66	3.40	0.93	0.65	43.8	22.8
Dul	35	5.57	3.80	1.10	0.43	52.3	23.5
Suç türü							
Öldürme	86	3.92	3.41	0.89	0.58	43.5	21.9
Yaralama	46	4.86	3.42	0.96	0.69	45.7	21.6
Cinsel Suç	30	4.23	3.49	0.86	0.55	43.0	24.5
Hırsızlık	90	5.28	2.77	1.07	0.64	52.3	21.4
Uyuşturucu Madde	38	4.58	3.41	0.83	0.53	39.1	18.4
Dolandırıcılık	38	4.42	3.61	0.74	0.59	36.2	20.1
Diğer	62	4.56	3.31	0.89	0.61	45.4	23.9

Medeni durum açısından bakıldığında GSA puan ortalamaları arasında bekar ( $\bar{X}$  = 4.26) grubun en düşük ve dul grubun ( $\bar{X}$  = 5.57) en yüksek ortalamaya sahip olduğu görülmektedir. Varyans analizi sonuçları gruplar arası farklılığın anlamlı düzeyde olmadığını göstermiştir ( $F_{2,388} = 2.89$ ,  $p > .05$ ). SCL 90R puanları incelendiğinde, bekar ( $\bar{X}$  = 0.90) grubun en düşük ve dul ( $\bar{X}$  = 1.10) grubun en yüksek ortalamaya sahip olduğu görülmektedir. Varyans analizi sonucunda gruplar arasında anlamlı bir farkın olmadığı bulunmuştur ( $F_{2,388} = .91$ ,  $p > .05$ ). ÇDE puanı açısından en yüksek puan dul ( $\bar{X}$  = 52.3) grupta en düşük puan evli ( $\bar{X}$  = 43.8) gruptadır. Gruplar arasındaki fark-

ların ÇDE açısından anlamlı olmadığı bulunmuştur ( $F_{2,388} = 2.19$ ,  $p > .05$ ).

Suç türüne göre, GSA'da en yüksek ortalamaya ( $\bar{X}$  = 5.28) hırsızlık suçundan hüküm giyenlerin, en düşük ortalamaya ( $\bar{X}$  = 3.92) öldürme suçundan hüküm giyenlerin sahip olduğu ve diğer grupların ortalamalarının birbirlerine yakın olduğu görülmektedir. Gruplar arasında yapılan varyans analizi sonucu GSA açısından gruplar arasında anlamlı bir fark olmadığını göstermiştir ( $F_{6,383} = 1.38$ ,  $p > .05$ ). SCL 90R için en yüksek ortalama ( $\bar{X}$  = 1.07) hırsızlık grubunda, en düşük ortalama ( $\bar{X}$  = 0.74) dolandırıcılık grubunda olup, diğer grupların ortalamaları birbirine yakındır. Grup orta-

lamaları arasındaki farkların anlamlı olmadığı yapılan varyans analizinde bulunmuştur ( $F_{6,383} = 1.68, p > .05$ ). ÇDE ortalamalarının en yükseği ( $\bar{X} = 52.3$ ) hırsızlık grubunda, en düşüğü de ( $\bar{X} = 36.2$ ) dolandırıcılık grubundadır. Gruplar arası ortalama farkları ÇDE açısından anlamlı düzeydedir ( $F_{6,383} = 3.29, p < .05$ ). Bu farklılığın hangi gruplar arasında olduğunu belirlemek amacıyla yapılan Tukey testi sonuçları, Hırsızlık ( $\bar{X} = 52.3$ ) suçu işleyen grubun Uyuşturucu madde ( $\bar{X} = 39.1$ ) suçu ve Dolandırıcılık ( $\bar{X} = 36.2$ ) suçu işleyen gruptan anlamlı düzeyde daha yüksek ÇDE ortalamasına sahip olduğunu göstermektedir.

### Tartışma

Hükümlülerde psikiyatrik belirtilerin yaygınlığına bakılan bu çalışmada; genel belirti ölçekleri açısından hükümlülerin aldıkları puan ortalamalarının yüksek olduğu görülmektedir. Ülkemizde GSA ile ilgili olarak yapılan çalışmalarda değişiklik göstermekle birlikte, genellikle ruhsal bozukluğu gösterdiği kabul edilen kesme noktası 3.00 ve üstü puandır (İren-Akbiyık, Önder, Gökçurt ve Sümbüloğlu, 1996). GSA'nın hükümlü grubundaki puan ortalamasının 4.37 olduğu görülmektedir. SCL 90R için patalojiyi gösterdiği kabul edilen 1.0'ın üstündeki ortalama puan, hükümlü grubunda 0.92 olarak bulunmuştur. Bu sonuçlar ülkemizde ve yurtdışında yapılan çalışmalarda olduğu gibi, hükümlü gruplarında psikiyatrik belirtilerin yaygın olduğunu göstermektedir. Henüz önemsenmemesine karşın, cezaevine kapatılan ruhsal bozukluk gösteren kişilerin sayısının artması beraberinde bir sürü sorunu da getirecektir. Bu nedenle, cezaevlerine alınan kişilerin iyi bir psikolojik değerlendirmeden geçirilmesi yoluyla kendileri veya diğerleri için varolan tehlikenin azaltılabileceği düşünülmektedir.

Aydın ve Demir (1988) ÇDE ile yaptıkları çalışmalarında normal grubun ortalamasını 36.22 ve nörotik depresyon tanısı almış grubun ortalamasını 64.12 olarak bulmuşlardır. Bu çalışmada hükümlülerin ÇDE'den aldıkları ortalama puan 44.87 olarak bulunmuştur. Bu sonuca göre, hü-

kümlü grubun ortalamasının normal grubun ortalamasından yüksek; depresif grubun ortalamasından düşük olduğu söylenebilir. Suçlular üzerinde yürütülen çalışmalarda suçluların büyük bir kısmının suç işlediği anda duygusal çöküntü içerisinde olduğu, hükümlülerde depresif belirtilerin yaygın olduğu ve bundan da hükümlülerin daha depresif olduğu sonucuna ulaşabileceği belirtilmektedir (Lucas ve Newmark, 1993). Ülkemizde Öy ve arkadaşları (1989) tarafından Ankara Yarıaçık Cezaevinde bulunan 174 hükümlü üzerinde yürütülen çalışmada da depresif belirtiler yüksek bulunmuştur. Gordon (1983) bu yaygınlığın hükümlülük sürecinde aileden, arkadaşlardan ayrıma, iş ve prestij kaybıyla ilgili olabileceği gibi, daha önceden de varolan depresif belirtilerden kaynaklandığını ileri sürmektedir.

Yaşa ilişkin sonuç incelendiğinde, yaş arttıkça SCL 90R ve ÇDE puanlarının anlamlı bir şekilde düştüğü görülmektedir. Yaş ve suç konusunda çeşitli gruplar ile yapılan araştırmalar ve istatistikler suçların büyük bir çoğunluğunun ergenlik çağında işlendiğini, ergenliğin başlangıcı ve bitişi arasında en şiddetli devreye ulaştığını, otuz yaşından sonra suç işleme eğiliminde düşüş başladığını, kırk yaşından sonra bu düşüşün hızlandığını göstermektedir. Bu nedenle, yaşın gençlik bunalımlarının bir yansıması olarak suçta etken olduğu kabul edilmektedir (Millham, 1993; O'Shaugnessy, 1992). Psikiyatrik belirtilerin yaygınlığına ilişkin araştırma sonuçları da ruhsal bozuklukların genel olarak en sık 25-44 yaşları arasında görüldüğünü, bu yaştan sonra belirtilerin azaldığını göstermektedir (Öztürk, 1994). Bu çalışmada yaş ve psikiyatrik belirtiler arasında bulunan ilişki belirtilen görüşlerle tutarlılık göstermektedir.

Hükümlülerin aldıkları ceza süresi açısından yapılan analizler yurtdışında yapılan çalışma bulgularıyla tutarlılık göstermemektedir. Yurtdışındaki çalışmalarda (Clark, 1972; Kalinch, Embert ve Senese, 1990; Robertson ve ark., 1994; Teplin, 1984) uzun süre ceza alanlarda psikiyatrik belirtiler daha fazla bulunurken, bu çalışmada her üç ölçek ile alınan ceza süresi

arasında bir ilişki bulunamamıştır. Bu sonucun cezaevi yaşantısındaki olumsuzlukların yansımaması amacıyla, uygulamaların hüküm kesinleştikten sonra yapılmasından kaynaklandığı düşünülmektedir. Erem (1977), hüküm giydikten sonraki ilk günlerin zor olduğunu ve cezanın en etkili döneminin bu ilk günler olduğunu belirtmektedir. Erem'e göre, bütün insanlarda varolan en zor koşullara uyum yeteneği, cezanın etkisinin hükümlülük süresince aynı şiddette duyulmasını engellemektedir.

Cinsiyet açısından yapılan analizler kadın hükümlülerin GSA, SCL 90R ve ÇDE ortalama puanlarının anlamlı bir şekilde erkeklerin puanlarından yüksek olduğunu göstermektedir. Kadın hükümlülerin erkek hükümlülere göre, daha fazla psikolojik sıkıntılara sahip olduğuna işaret eden bu bulgu, cinsiyet farklılığını araştıran çalışma bulgularıyla tutarlılık göstermektedir (Hodgins, 1992; Levis ve ark., 1991; Lindqvist ve Allebeck, 1990; Wessely, Castle, Douglas ve Taylor, 1994). Kadın suçluluğu konusunda yapılan çalışmalarda, kadınların önceden planlı ve bilinçli olmadan ve daha çok kendilerini savunmaya yönelik anlık suçlar işlediği ve suç işledikten sonra pişmanlık düzeyleri ile ruhsal sorunlara sahip olma oranının yüksek olduğu belirtilmektedir (İçli, 1995; İl, 1990). Ayrıca, psikiyatrik belirtilerin yaygınlığı konusunda yapılan tarama çalışmaları kadınların psikiyatrik hastalıklara daha eğilimli olduklarını ortaya koymaktadır (Öztürk, 1994). Bu durumda bu araştırmada gözlenen cinsiyetler arasındaki ortalama puan farklarının yalnızca hükümlülük durumuna bağlı olarak yorumlanamayacağı düşünülmektedir. Kadınların toplumsal değerlerden daha fazla etkilenmekte olduğu ve cezaevinin kadınlar açısından daha olumsuz olan koşulları göz önünde bulundurulduğunda, kadınların daha fazla psikiyatrik belirti göstermeleri ve her üç ölçekten de erkeklerden daha yüksek ortalamaya sahip olmaları açıklanmaktadır.

Eğitim düzeyi GSA ve SCL 90R puanları açısından bir fark yaratmamaktadır. Ancak, ÇDE açısından yüksek okul mezunları "okur-yazar", "ilkokul" ve "ortaokul" mezunu gruplardan anlamlı düzeyde daha

düşük ÇDE puan ortalamasına sahiptirler. Aynı şekilde lise mezunu grup, "okur-yazar" ve "ilkokul" mezunu gruplardan daha düşük ÇDE ortalamasına sahiptir. Genel olarak hükümlülerde eğitim düzeyi arttıkça ÇDE puanları azalmaktadır. Bu bulgu Öztürk'ün (1994) eğitim düzeyi düştükçe ruhsal bozuklukların arttığı saptamasıyla tutarlılık göstermektedir. Bu sonuç aynı zamanda depresif belirtilerin bilişsel açıdan daha net bir şekilde kabul edilmesinin eğitimle sağlandığı şeklinde yorumlanabilir.

Görüldüğü gibi demografik değişkenlere ilişkin analizlerden elde edilen bulgular, genel psikiyatrik belirtilerin toplumdaki dağılımlarıyla benzerlik göstermektedir. Bu benzerlik de bu sonuçların hükümlü olmaktan bağımsız olarak toplumda var olan sosyal eğilimleri yansıttığını akla getirmektedir.

Suç türü açısından gruplar arası ortalama puanlara bakıldığında, GSA, SCL 90R ve ÇDE'de en yüksek ortalamaya hırsızlık suçundan hüküm giyenlerin sahip olduğu görülmektedir. Yapılan varyans analizinde ölçeklerden sadece ÇDE açısından hırsızlık suçundan hüküm giyenler ile uyuşturucu madde ve dolandırıcılık suçlarından hüküm giyenler arasında bu fark anlamlı bulunmuştur. Uyuşturucu madde kullanımının ruhsal bozukluklara neden olduğu kabul edilmektedir (Öztürk, 1994). Uyuşturucu madde bağımlılığı konusunda yapılan çalışmalarda bazı kişilik bozukluğuna sahip kişilerin bu maddeleri kullanmaya daha yatkın olduğu saptanmıştır (Özden, 1992). Bu bilgiler ışığında daha yüksek belirti göstermesi düşünülen bu suç türünde elde edilen puan ortalamalarının düşüklüğünün nedeninin, araştırmada kullanılan genel belirti ve depresyonu saptamaya yönelik ölçeklerle kişilik bozukluğu grubunun tanımlanamaması olduğu düşünülmektedir.

Araştırmada dolandırıcılık suç türünde sınıflandırılan bireylerin ortalama puanları da düşük olarak bulunmuştur. Organize suç kapsamında değerlendirilen dolandırıcılığın kamu yönetiminin zayıfladığı ve yasal yollardan ulaşılamayan maddi değerlere, yasal olmayan yollardan ulaşma olanaklarının arttığı sosyal çözülme dö-

nemlerinde görüldüğü belirtilmektedir (Yücel, 1994). Dolandırıcılık grubunda bulunan kişilerin psikiyatrik belirtileri nedeniyle değil, bilinçli ve istemli olarak bu suçları işledikleri, ayrıca kendilerini bu suçları işlemeye hakkı gördükleri ve bu ruhsal durumlarının ölçeklerden aldıkları puanlara yansdığı düşünülmektedir.

Mala yönelik suçlardan olan hırsızlık, birçok riski olmasına rağmen, çalışmadan ve toplum tarafından para kazanma için kabul edilen becerilere sahip olmadan para kazanma yoludur. Suçlular üzerinde yapılan istatistik çalışmalarında en fazla tekrarlanan suç türünün hırsızlık olduğu görülmektedir. Hırsızlığın heyecan, başkalarının malını ve parasını kullanma gibi kişiye psikolojik getirilerinin bulunduğu belirtilmektedir (İçli, 1994). Hüküm aldığı anda hırsızlık suçunu işleyen kişi maddi kazancının yanı sıra, bu işten sağladığı psikolojik getirileri de kaybetmektedir. Buna ilave olarak, cezaevlerinde var olduğu söylenen hükümlü alt kültüründe adam öldürme, yaralama gibi bazı suçlar daha kabul görürken, hırsızlık suçu kabul görmeyen ve horlanan suçlar arasındadır. Bu yönlere bakıldığında hırsızlık suçu işleyenlerin, diğer gruplardan daha fazla depresif belirtiler göstermesi açıklik kazanmaktadır.

Ruh sağlığı alanında çalışanlar ruhsal bozuklukların yaygınlığının ve bunun toplumsal yaşantıya yansımalarının arttığına dikkati çekmektedirler. Yurtdışında yapılan çalışmalar ruhsal bozuklukları olanların daha çok adli sistem içinde sorunlar yaşadıklarını göstermektedir. Ülkemizde sağlıklı istatistik bilgiler olmaması nedeniyle, suç işleyip de cezaevi yerine akıl hastanelerine kapatılan, hatta savunmasını yapamayacağı gerekçesiyle yargılanamayan ruhsal bozukluğu sahip kişiler hakkında bilgilere erişilememektedir. Yalnızca suç işlemiş ve bu suçtan hüküm giymiş bireyler üzerinde yürütülen bu çalışmada hükümlülerde genel psikiyatrik belirti ve depresyon puanlarının yüksek olduğu görülmektedir.

Ruhsal bozuklukları olanların suçluluğu kavramına açıklık getirilebilmesi için daha kapsamlı araştırmalara gerek vardır. Özellikle hükümlü grupları üzerinde bu tür

tarama çalışmalarına daha fazla yer verilmesi gerektiği düşünülmektedir. Toplumumuzda varolan genel kanı nedeniyle, cezaevindeki kişilerin çoğunluğu da sorunlarını görmezden gelmekte ya da kendi kendilerine çözüm bulmaya çalışmaktadırlar. Bu durum gerçekten yardıma gereksinimi olan bireylerin başvuruda bulunmaması nedeniyle, yardım almasını engellemektedir. Bu tip tarama çalışmalarıyla ruhsal bozukluk nedeniyle suç işleme konusuna bir açıklık getirilebileceği gibi, oldukça yapay bir ortam olan cezaevinde gelişme çağlarının en kritik dönemlerini geçiren çocuk ve gençlerle, en verimli yıllarını geçirmek zorunda olan yetişkinlere koruyucu ruh sağlığı hizmetlerinin götürülmesini ve adalet sistemi içinde psikologların hak ettikleri yeri almalarını sağlayacağı umut edilmektedir.

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## Summary

# Assessment of Psychological Symptoms of Prisoners

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### Introduction

Different sciences have tried to explain and resolve the phenomenon of crime, which is considered to be one of the most important problems of society. One of the branches of science that has contributed to the understanding of criminal behavior is psychology. Throughout the history of psychology certain theories like mental disorders, psychological structures or personality problems have been inferred to reveal crime. Although each theory has different explanations, the point they have in common suggests that crime be taken up as a reaction or a call for help; and that the criminal be defined as an "ill", "incompatible" or "pathological" person. (Gibbons, 1970).

One of the issues that is investigated in crime research is the evaluation of the criminals in terms of their psychiatric appearances or in other words the symptoms. Studies have shown that the people with these symptoms have a greater crime rate than those who do not (Fido et. al., 1992; Jerrell & Komisaruk, 1990; Robertson et.al., 1994).

Recently, instead of locking up those people with mental disorders, they are placed in society provided that their inclination to heal in society develops. The term "the guilt of those with mental disorders", which has been adapted by many mental health specialists in the U.S.A and Great Britain, is used to emphasize the fact that the frequency of committing crime in those with mental disorders has risen (Teplin, 1983).

Studies on the reasons of committing crimes or the evaluation of criminals in terms of their psychological profiles in Turkey have emphasized the prevalence of the psychiatric symptoms (Aydın et al., 1990; Birsöz et al., 1988; Kaya, 1993; Öy et al., 1990; Yavuzer, 1981). The present study was carried out to investigate the presumed link between crime and the prevalence of the psychiatric symptoms. In addition, the relationships between psychiatric symptoms and the duration of the sentence received, the type of crime committed, and demographic factors (age, sex, level of education, marital status) were investigated.

### Method

#### Subjects

The study took place in 35 prisons with large numbers of inmates and psychologists on staff. Because the literature indicates that living in prison has a negative effect on people in terms of their physical and mental health, prior prison experience was seen as a possible confounder for this study. Therefore, prisoners with a prior conviction were not included in this study. The subjects of this study were 391 convicts who had only been convicted once.

#### Measures

All of the personal data obtained from the convicts were collected using a questionnaire. In order to measure psychiatric symptoms, General Health Questionnaire, Symptom Check List 90R (SCL 90R) and Multiscore Depression Inventory were

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used. All of these measures have been adapted into Turkish and there is evidence to support their reliability and validity.

### Procedure

The psychologists working in the institution were asked to administer the questionnaire to each convict individually. The questionnaire included a demographic form, the General Health Questionnaire, the Symptom Check List and the Multiscore Depression Inventory which were administered to all subjects in the same order.

### Results and Discussion

The average scores in terms of the general symptom scales that the convicts got in this study were noticeably high. Taking 3.00 as a cutoff indicating a general tendency to have a mental disorder in Turkey (İren-Akbiyik et al., 1996), the convicts in this sample averaged above the cutoff ( $\bar{X} = 4.37$ ). The convicts' mean score on the SCL 90 ( $\bar{X} = 0.92$ ) was also just below the score of 1.0, the cutoff above which scores are taken to indicate pathology. In studies carried out in Turkey and abroad it is shown that psychiatric symptoms are prevalent among the convict groups. The present findings agree with findings from other studies indicating a close relationship between crime and the prevalence of psychiatric symptoms.

The psychiatric symptoms in the long-term convicts are found to be greater in studies done abroad (Clark, 1972; Kalinch et al., 1990; Robertson et al., 1994; Teplin, 1984). In the present study, there was no relationship between the length of the convicts' sentences and psychiatric symptoms.

It was found that with increasing age the SCL 90R and MDI scores decrease. Also, female convicts have higher scores in GSA, SCL 90R, and MDI than male convicts do. This finding, which is a prominent indi-

cator of the fact that female convicts face greater psychiatric symptoms than male convicts, is in line with other findings on the differences between sexes (Hodgins, 1992; Levis et al., 1991; Lindqvist & Allebeck, 1990; Wessely et al., 1994).

Level of education is not significantly related to the GSA and SCL 90R scores. However, it is related to the MDI scores. Convicts with a college degree earned lower scores on MDI than those who are literate with no formal education and those with primary school or middle school education. Similarly, convicts with high school education have lower scores than those who are literate with no formal education or those with primary school education. In general, as the level of education of a convict increases the MDI score decreases. This finding is in line with Öztürk's (1994) finding that there is an increase in psychiatric symptoms as level of education decreases.

It is evident that the relationship between psychiatric symptoms and the demographic variables in the present sample are similar to the relationship observed in the general non-convict population. This similarity suggests that the present results also reflect general trends in the society that affect convicts and non-convicts alike.

The relationship between psychiatric symptoms and the type of crime committed reflects a general tendency of those convicted of theft to have higher scores on all three scales. In the ANOVAs, however, the only significant difference was found for MDI: Post-hoc analyses indicated that convicts convicted of theft have higher scores than those who were convicted of narcotic charges or of swindling.

This study, which was carried out only on individuals who committed and were convicted of a crime, indicates that there is a relationship between general psychiatric symptoms and committing a crime.

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# Cognitive Therapy For Depression: Conceptual and Empirical Issues

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## Abstract

*The guiding principle of cognitive models of depression is that the way in which an individual interprets an event determines how he/she will respond to that event. In the most well-known cognitive model of depression, Beck and his colleagues propose four specific cognitive processes to explain the phenomenon of depression: The cognitive triad, cognitive errors, depressogenic cognitive schemata, and the cognitive-personality vulnerability factors of sociotropy and autonomy. Cognitive therapy has been proven effective in treating a wide variety of psychopathological conditions, and its scope continues to broaden. However, Dobson and Pusch (1993) also raised two fundamental issues with respect to cognitive therapy. First, they expressed concern about the empirical status of cognitive therapy. Second, they expressed concern that applications of cognitive therapy may be pushing beyond the conceptual boundaries. This article will provide an updated review of the first issue with respect to unipolar depression. The purposes of this article are to review the empirical status of cognitive therapy for unipolar depression, to address theoretical issues regarding cognitive therapy, and to recommend areas and issues which require further study and consideration.*

**Key words:** Cognitive therapy, research status, depression.

The guiding principle of cognitive models of depression is that the way in which an individual interprets an event determines how he/she will respond to that event. That is, one's affect and behavior are largely determined by the way in which one structures the world via cognitive processes. Cognitive processes, such as negative or distorted thinking, are proposed to be related to the onset, maintenance, and/or alleviation of depression (Beck, 1963, 1964; Beck, Rush, Shaw, & Emery, 1979; Kovacs & Beck, 1978). In the most well-known cognitive model of depression, Beck and his colleagues propose four specific cognitive processes to explain the phenomenon of depression: The cognitive triad, cognitive errors, depressogenic cognitive schemata, and the cognitive-personality vulnerability factors of sociotropy and autonomy (Beck, 1983; Beck et al., 1979).

Cognitive therapy is an active, direct, structured, short-term, psycho-

educational psychotherapy based upon the theoretical rationale that cognitive processes largely determine one's affect and behavior (Beck et al., 1979). Cognitive therapy attempts to identify, evaluate, and modify faulty information processing and cognitive processes, as a core assumption of cognitive therapy is that the way in which an individual processes information must be modified in order to effect real change in psychological functioning and prevent the recurrence of psychopathology. In cognitive therapy, clients are taught that the content and process of their thinking style mediates emotional distress, that they can learn to systematically evaluate their beliefs and information-processing styles, and that modification of their thoughts can make them more objective and result in therapeutic changes in affect and behavior. Cognitive therapy focuses on assisting clients to examine and understand the way in which they perceive themselves, their

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world, and the future, and to experiment with more adaptive ways of responding in cognitive, emotional, and behavioral modes. Although a variety of cognitive models have been proposed, therapy models within the cognitive tradition share the following basic assumptions: "(1) Cognitive activity affects behavior; (2) Cognitive activity may be monitored and altered; (3) Desired behavior change may be affected through cognitive change" (Dobson, & Block, 1988, p.4).

Dobson and Pusch (1993) clearly articulated the reasons for the rapid growth of cognitive therapy. These arguments have not changed, and clearly cognitive therapy continues to enjoy overwhelming popularity and success. Cognitive therapy has been proven effective in treating a wide variety of psychopathological conditions, and its scope continues to broaden (Alford, & Beck, 1996). However, Dobson and Pusch (1993) also raised two fundamental issues with respect to cognitive therapy. First, they expressed concern about the empirical status of cognitive therapy. Second, they expressed concern that applications of cognitive therapy may be pushing beyond the conceptual boundaries. This article will provide an updated review of the first issue with respect to unipolar depression. The purposes of this article are to review the empirical status of cognitive therapy for unipolar depression, to address theoretical issues regarding cognitive therapy, and to recommend areas and issues which require further study and consideration.

### **The Empirical Status of Cognitive Therapy for Unipolar Depression**

Cognitive therapy for unipolar depression is undoubtedly the most popular and most studied of the psychotherapies. This interest likely stems from the fact that cognitive therapy for depression details a well-defined model of the psychopathology, specifies a well-defined therapeutic approach, and has been empirically validated as an effective treatment for unipolar depression (Alford, & Beck, 1996; Blackburn, & Davidson, 1995; Chambless et al. 1996;

Dobson, 1989; Dobson, & Pusch, 1993; Scott, 1996).

The present state of knowledge suggests that cognitive therapy is as effective, if not more effective, than other modes of psychotherapy and pharmacotherapy. Empirical studies have consistently demonstrated that cognitive therapy of depression is comparable to or superior to other forms of therapy and even pharmacotherapy (DeRubeis, & Feeley, 1990; Dobson, 1989; Evans et al., 1992). Although more recent research indicates that the initial reports of clear superiority of cognitive therapy may need to be attenuated, it remains to be seen whether cognitive therapy holds promise in preventing relapse and that this may be where the superiority lies (Blackburn, Eunsion, & Bishop, 1986; Dobson, Pusch, & Jackman-Cram, 1991; Simons, Murphy, Levine, & Wetzal, 1986). Even more encouraging has been the growing consensus that cognitive therapy is effective even for severely depressed individuals (Bowers, 1990; Miller, Norman, Keitner, Bishop, & Dow, 1989; Thase, Bowler, & Harden, 1991).

### ***Cognitive Therapy vs. Other Psychotherapy***

Results of recent studies indicate that cognitive therapy is at least as successful, if not more successful, in the treatment of unipolar depression as compared to other modes of psychotherapy. Shapiro et al. (1994) assigned depressed individuals with varying severity of symptoms to either 8 or 16 weeks of cognitive-behavioral therapy or psychodynamic-interpersonal therapy to compare the effects of therapeutic modality, length of treatment, and severity of depressive symptomatology on the effectiveness of the treatments. They found that cognitive-behavioral therapy and psychodynamic-interpersonal psychotherapy both produced substantial improvement in depressive symptomatology, and were equally effective in treating depression, regardless of severity of the depression. This study also found that cognitive-behavioral therapy did not produce more rapid treatment effects than psychodynamic-interpersonal psychother-

apy, nor did the effectiveness of therapy differ as a result of the number of sessions. However, the authors caution that it is possible that therapy may have been adjusted to fit the time available. Additionally, improvement was stable and relatively equivalent at a 3-month follow-up after completion of treatment. Consistent with previous studies, cognitive-behavioral therapy demonstrated a significant advantage when the Beck Depression Inventory (BDI) was used as the outcome variable, with cognitive-behavioral therapy producing greater reductions in BDI scores than psychodynamic-interpersonal therapy.

Gallagher-Thompson and Steffen (1994) compared the efficacy of cognitive-behavioral and brief psychodynamic psychotherapy with a group of depressed family caregivers. Both groups demonstrated substantial reductions in depressive symptomatology upon completion of treatment, with no significant difference between the two treatment conditions. However, there was a significant interaction of treatment condition and length of time as a caregiver. That is, individuals who had been involved in long-term caregiving (i.e., more than 44 months) exhibited a better treatment response to cognitive-behavioral therapy, whereas individuals who had been involved as caregivers for a relatively short period of time (i.e., less than 44 months) exhibited a better treatment response to brief psychodynamic therapy. The results of this study indicate the need to further evaluate client characteristics which predict differential treatment response.

The NIMH collaborative study (Elkin et al., 1989) compared the efficacy of cognitive therapy, interpersonal therapy, pharmacotherapy plus clinical management, and placebo plus clinical management in the treatment of depression. Results indicated that all four treatment conditions produced equivalent rates of improvement of depressive symptomatology. However, a number of cautions have been voiced regarding these results. For example, the rate of improvement in the placebo condition was considerably higher in this study than in other comparable studies, whereas the

average rates of improvement for the active treatments were comparable to other studies. Also, questions have been raised about the competence of the therapists across the sites involved in this study. It has been recommended that until these issues are addressed in future research, the results of the NIMH collaborative study on depression should be interpreted with caution (Hollon, Shelton, & Davies, 1993; Scott, 1996).

O'Leary and Beach (1990) compared the effectiveness of cognitive therapy, behavioral marital therapy, and a no-treatment control group in treating couples who presented with both marital distress and depression. Results indicated that both active treatments were more effective than the no-treatment control group, however, behavioral marital therapy was more successful than cognitive therapy in reducing marital distress.

Jacobson, Dobson, Fruzzetti, Schmalzing, and Salusky (1991) compared the effectiveness of cognitive-behavioral therapy, behavioral marital therapy, and a combination of these two therapies in the treatment of depression in the wives of maritally distressed and nondistressed couples. Results indicated that all three treatments produced both clinically and statistically significant reductions in depressive symptomatology, as measured by both the Beck Depression Inventory and the Hamilton Rating Scale for Depression. However, using the Beck Depression Inventory as the outcome variable, it was found that cognitive-behavioral therapy was more effective than behavioral marital therapy in reducing depressive symptoms of wives in maritally nondistressed couples, whereas in maritally distressed couples the effectiveness of the therapies for depression were equivalent. Jacobson et al. (1991) raise the possibility that the effectiveness of the combined therapy condition may have been limited by the way in which the two component treatments were combined.

Teichman, Barel, Shor, Sirota, and Elizur (1995) suggest that previous studies (i.e., Jacobson et al., 1991; O'Leary, & Beach, 1990) indicate that cognitive therapy and behavioral marital therapy are

equally effective in alleviating depression, but that the difference appears to arise as a function of marital distress. That is, behavioral marital therapy seems to be more effective in treating maritally distressed couples. Further, Teichman et al. (1995) recognized the limitations of the combined cognitive and behavioral marital therapy condition featured in the Jacobson et al. (1991) study, and proposed and tested an integrated cognitive marital therapy featuring both a cognitive and a systemic focus. This study compared the effectiveness of individual cognitive therapy, cognitive marital therapy, and a no-treatment control group in the treatment of depression in maritally distressed couples. Results indicated that cognitive marital therapy was more effective in reducing depressive symptomatology than either cognitive therapy or the no-treatment control group, which did not significantly differ upon completion of treatment. However, at the 6-month follow-up assessment, rates of recovery for cognitive therapy and cognitive marital therapy were roughly equivalent, and both active treatments were superior to the control group. The authors of this study suggest that cognitive marital therapy appears to provide the same results as standard cognitive therapy in maritally distressed couples, but effects this change within a shorter time frame.

Beach and O'Leary (1992) randomly assigned couples who were reporting marital discord and in which the wife met diagnostic criteria for major depressive disorder or dysthymia to either behavioral marital therapy or cognitive therapy. Results indicated that both therapeutic modalities were effective in reducing the wives' depression compared to the waiting list control group, with no significant advantage of one therapy modality over the other. Also, only the behavioral marital therapy treatment produced significant improvements in the wives' ratings of marital satisfaction, with cognitive therapy and behavioral marital therapy producing similar increases in the husbands' ratings of marital satisfaction.

The US Department of Health and Human Services (1993, as cited in Scott,

1996) conducted a meta-analysis comparing the efficacy of cognitive therapy, behavior therapy, interpersonal therapy, and waiting list controls. Cognitive therapy was found to be roughly equivalent in efficacy to behavior therapy and interpersonal therapy, whereas cognitive therapy did have a slight advantage to treatment using pharmacotherapy alone. Individual cognitive therapy was effective in treating acute depression in approximately 50% of cases, while group cognitive therapy was effective in approximately 39% of cases.

In a review of the literature, Matheney, Brack, McCarthy, and Penick (1996) conclude that the effectiveness of cognitively-based treatment approaches to depression is similar to the effectiveness of psychotherapy in general. However, they argue that the strength of the cognitively-based approaches lies in their applicability to managed care situations, by virtue of their structured, short-term approach and long-lasting maintenance of change.

Stuart and Bowers (1995) conducted a meta-analytic review of research on cognitive therapy with depressed inpatients to evaluate its applicability to this population. Results suggest that cognitive-behavior therapy is an effective treatment, both on its own and as an adjunct to pharmacotherapy, for depressed inpatients. The authors concur with Matheney et al. (1996) that cognitive-behavioral treatments are well-suited to the current demands of inpatient and managed care settings. However, the authors also recommend that further controlled outcome studies be conducted with this population to confirm their findings.

Scott, Scott, Tacchi, and Jones (1994) developed a modified form of cognitive therapy in an abbreviated format to determine whether the addition of this treatment to standard treatment for depressed inpatients substantially improved the recovery of these individuals. The seven individuals involved in this pilot study demonstrated moderate success, with only one of the seven continuing to meet diagnostic criteria for depression upon completion of treatment. The authors are currently

evaluating the effects of this abbreviated treatment package within a randomized clinical trial.

### ***Cognitive Therapy vs. Pharmacotherapy***

Studies have also compared the effectiveness of cognitive therapy to pharmacologic interventions using antidepressant medications in the treatment of unipolar depression. Bowers (1990) compared the effectiveness of pharmacotherapy alone, relaxation plus pharmacotherapy, and cognitive therapy in combination with pharmacotherapy (i.e., nortriptyline) in the treatment of a group of depressed inpatients. Results indicated that the combined cognitive therapy and pharmacotherapy treatment was superior to relaxation plus pharmacotherapy, and to pharmacotherapy alone in the reduction of depression.

Hollon, (1992) and Evans et al. (1992) compared the effectiveness of cognitive therapy, pharmacotherapy (using imipramine), and a combination of cognitive therapy and pharmacotherapy in the treatment of depression. Results indicated that there was no significant difference in the effectiveness of cognitive therapy and pharmacotherapy, and also indicated that combining these two approaches did not result in significantly enhanced effectiveness. Further, initial severity of depression was not related to outcome. That is, the common conception that more severely depressed patients respond better to pharmacotherapy than to cognitive therapy was not supported.

In their reviews of research comparing psychological with pharmacological treatments of depression, Antonuccio, Danton, and DeNelsky (1995) and Hollon, Shelton, and Loosen (1991) concluded that cognitive-behavioral therapy is at least as effective as anti-depressant medication in the treatment of depression, and more effective in reducing the risk of relapse of depression, regardless of depression severity. Antonuccio et al. (1995) conclude that both cognitive-behavioral and interpersonal psychotherapy should be considered the

treatments of choice for depression.

The US Department of Health and Human Services (1993, as cited in Scott, 1996) meta-analysis indicated that combining cognitive therapy with antidepressant medication does not produce significantly improved results compared to either treatment alone. However, the attrition rate decreases significantly (i.e., by 50%) with this combined therapy compared to pharmacotherapy alone, a finding that should be evaluated further.

### **Issues Regarding Cognitive Therapy for Depression**

A variety of issues have been raised with respect to cognitive therapy for depression. These are summarized in the table below, and will be discussed further.

**Table 1**

#### *Theoretical Issues Regarding Cognitive Therapy of Depression*

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1. Applicability of cognitive therapy to severe cases of depression
  2. Active ingredients of cognitive therapy
  3. Declining effect sizes for cognitive therapy over time
  4. Role of client characteristics
  5. Role of life stress in depression
  6. Adaptations of cognitive therapy which take cognitive-personality modes into account
  7. Role of protective factors in preventing a depressive shift
  8. Role of cognitive therapy in preventing or reducing relapse of depression
  9. Methodological issues and limitations of current research
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#### ***Severity of Depression***

A debate has evolved regarding the applicability of cognitive therapy to more severe cases of depression. Research has produced conflicting results in this regard. For example, a number of well-controlled studies have demonstrated that cognitive therapy is as effective with severe cases as

with more moderate cases of depression (Antonuccio et al., 1995; Bowers, 1990; Evans et al., 1992; Hollon et al., 1991; Hollon et al., 1992).

However, at least two studies contradict the above findings. Elkin et al. (1995) provided additional analyses of the original NIMH data, and found that initial severity of depression predicted differential response to treatment, with more severely depressed patients responding better to pharmacotherapy (i.e., imipramine) than to cognitive therapy or interpersonal therapy. Also, more severely depressed patients exhibited better responses to interpersonal therapy than to cognitive therapy on some outcome measures. However, two caveats must be considered in regard to these findings. First, the finding of differential treatment effects was dependent upon the outcome criterion. This analysis used the Global Assessment Scale (GAS) to define severity, rather than using a standard measure of depressive symptomatology. Previous research that has found support for the effectiveness of cognitive behavioral therapy has typically relied on the Hamilton Rating Scale for Depression (HRSD) or the Beck Depression Inventory (BDI) as the outcome criterion. These authors argue that the GAS differs from the HRSD or BDI by taking impairment in functioning into account, and that this may be the reason for the difference in results from the original analysis. Second, the differential treatment effects do not extend beyond the treatment period. That is, at an 18-month follow-up assessment, there were no differences across groups in terms of who recovered and remained recovered.

The second study which contradicts the findings that severity is not relevant to the effectiveness of cognitive therapy for depression (Thase, Simons, and Reynolds, 1993) suggests that there are subtypes of depressive symptom presentations that predict poor response to cognitive-behavioral therapy. Specifically, they found that extremely severe symptomatology as manifested by a Hamilton Depression score of 20 or above, disturbed EEG sleep profiles, and/or hypercortisolism, was predic-

tive of poor response to cognitive-behavior therapy. The authors suggest that the combination of increased symptom severity and such neurobiological markers may serve as an indication for the use of pharmacotherapy, either alone or in combination with cognitive-behavior therapy.

Two other studies investigating the effects of biological markers alone in predicting treatment response have produced conflicting results. McKnight, Nelson-Gray, and Barnhill (1992) examined the utility of a proposed biological marker, the dexamethasone suppression test (DST), in predicting differential responsiveness to pharmacological and cognitive therapies. Results indicated that DST was not useful in predicting differential response to treatment, but was useful in predicting response to treatment in general. That is, abnormal DST results predicted poor response to both treatment modalities, and the two treatments were equally effective in normalizing DST response at the end of treatment. This finding suggests that DST response may serve as an indication of poor response to treatment in general, one not specific to cognitive therapy.

Simons and Thase (1992) investigated the effects of cognitive therapy on individuals with four types of sleep EEG abnormalities, and found that therapeutic outcome was not associated with any of these characteristics. This finding lends further support to the possibility that biological markers, such as sleep EEG abnormalities, are not associated with response to cognitive therapy. Whisman (1993) also concludes that research has not supported the hypothesis that endogenous types of depression are related to poorer outcome with cognitive therapy. Results to date provide conflicting information regarding the issue of the effectiveness of cognitive therapy for more severe cases of depression. Further research is required to clarify this issue.

### ***Active Ingredients of Cognitive Therapy***

A second issue involves the ingredients of cognitive therapy which are respon-

sible for its effectiveness. The cognitive theory of depression specifies components of cognitive therapy which are hypothesized to be responsible for the successful outcomes of cognitive therapy for depression. Factors which have been investigated include aspects of cognitive therapy, including behavioral activation, provision of coping skills to deal with negative automatic thoughts, and schema-focused interventions. Other factors include common therapeutic factors such as therapeutic alliance, client involvement in therapy, therapist competence, and adherence to the therapeutic framework.

**Unique aspects of cognitive therapy.** Jacobson et al. (1996) conducted a component analysis of cognitive-behavioral therapy for depression to determine the active ingredient(s) responsible for successful outcome. The following components were examined: 1) Behavioral activation alone; 2) behavioral activation plus modification of automatic thoughts, but not including components of cognitive therapy aimed at modifying core schemas; and 3) full cognitive therapy treatment (involving behavioral activation, modification of automatic thoughts, and modification of core schemas). Results indicated that the full cognitive therapy package was no more successful in treating depression or reducing short-term rates of relapse than the two components of cognitive therapy (behavioral activation alone, and behavioral activation plus modification of automatic thoughts). These findings do not support the cognitive model of depression proposed by Beck, which emphasizes the importance of modifying the core depressogenic schema in order to successfully treat depression. However, interpretation of the longer-term follow-up data will be important to evaluate the effect of the three treatment conditions on longer term relapse of depression.

Hayes, Castonguay, and Goldfried (1996) evaluated the role of therapist focus on cognitive, interpersonal, and developmental or vulnerability factors for depression in the outcome of cognitive therapy. Results indicated that therapeutic inter-

ventions which focused on changing intrapersonal and interpersonal cognitions were not associated with improvement in depressive symptomatology. In fact, a focus on changing interpersonal cognitions was associated with poorer global functioning, whereas a focus on behavioral change in the interpersonal domain was associated with better global functioning upon completion of treatment. Finally, a focus on developmental origins of depression (i.e., experiences with parents) was associated with better outcome both in terms of reductions in depressive symptomatology and in terms of global functioning at a two year follow-up. The authors conclude that a focus simply upon changing one's cognitions about the self and others is too superficial to produce lasting change, and that a focus on the schema level or developmental origins of such cognitions seems to be the active ingredient for successful outcome of cognitive therapy for depression. This finding suggests that integration of therapeutic modalities which emphasize developmental factors (e.g., cognitive, interpersonal, psychodynamic) may represent a logical next step for research in this area.

The issue of mediators and moderators of change in cognitive therapy has been examined. Whisman (1993) concludes that changes in cognition not only covary with changes in depression, but also precede changes in depressive symptomatology. Therefore, cognitive change is supported as a mediator or mechanism of change in cognitive therapy of depression. With respect to the specificity of this relationship, Whisman has evaluated the results of studies which have compared behavioral and cognitive components of cognitive therapy, as well as cognitive therapy and other treatments. Although results of these comparisons indicate at least limited support for the specificity of the relationship, Whisman concludes that methodological difficulties inherent in the available literature limit the conclusions that can be drawn, and proposes that stronger support would be found if, for example, studies possessed greater power to detect true differences.

An extension of this issue involves an evaluation of the empirical evidence for the cognitive theory of depression as evidenced in studies evaluating cognitive therapy of depression. That is, does the cognitive therapy of depression validate the cognitive theory of depression? Oei and Free (1995) investigated three questions with respect to this issue: 1) Is cognitive change produced by cognitive therapy? 2) If so, is improvement in depression associated with this cognitive change? 3) Is the relationship between cognitive change and symptom alleviation specific to cognitive therapies? Data from outcome studies published between 1970 and 1990 on the treatment of depression (including cognitive-behavior therapy, pharmacotherapy, other psychological treatment, and wait list control) were analysed. Results indicated that all treatments, including the wait list control, were associated with reductions in maladaptive cognitions, although the active treatments were associated with significantly greater reductions than the wait list control. However, there were no significant differences in amount of change of maladaptive cognitions among the active treatments. Further analyses revealed that cognitive change was positively associated with reductions in depressive symptomatology for the cognitive-behavior therapy and other psychological treatments groups, but not for the drug treatment or wait list control groups. Oei and Free conclude that although cognitive change does occur in cognitive therapy, it also occurs in other psychological treatments and pharmacological treatment. Whether the active ingredient in producing cognitive change varies across these active treatments, or whether there is a common "third factor" remains to be seen. They suggest that each of these treatments may simply be intervening at different points of the same circular process model, with change at one point effecting change at the other points as well. They also recommend that future research evaluate the mechanisms of cognitive therapy that produce change in cognitions, whether these mechanisms are the most effective means of producing cognitive change, and whether

cognitive change is the common crucial factor in recovery from depression across active treatments for depression.

Barber and DeRubeis (1989) review a variety of models of cognitive therapy and evaluate the research evidence for each model. They propose a compensatory skills model of cognitive therapy in which the active ingredient responsible for effectiveness is the provision of a set of metacognitive and planning or problem-solving skills which can be used by clients to deal with and to halt negative thinking both during the depressive episode and following remission. Research is required to evaluate this model empirically.

***Nonspecific factors in cognitive therapy.*** The equivocal results regarding the unique factors of cognitive therapy may be due, at least in part, to the moderating influence of nonspecific therapeutic factors. The role of common or nonspecific therapeutic factors such as therapeutic alliance, client involvement in therapy, therapist competence, and adherence to the therapeutic framework has been investigated to determine their contribution to the effectiveness of cognitive therapy.

Therapeutic alliance has been found to be predictive of successful outcome across a variety of different types of psychotherapy (Horvath, & Luborsky, 1993; Horvath, & Symonds, 1991). Krupnick et al. (1996) analysed data from the NIMH collaborative study to investigate the role of therapeutic alliance in treatment outcome with depressed outpatients. The treatment outcomes for cognitive-behavior therapy, interpersonal therapy, pharmacological treatment with clinical management, and placebo with clinical management were compared. Results indicated that therapeutic alliance had a significant impact on outcome in all treatment conditions. The authors conclude that therapeutic alliance is an important nonspecific factor which deserves further study.

Carroll, Nich, and Rounsaville (1997) investigated the role of the therapeutic alliance in a comparison of cognitive-behavior therapy for cocaine abusers and a clinical management control condition. Re-

sults indicated that therapeutic alliance was rated as significantly higher in the cognitive-behavior therapy condition than in the clinical management condition. More importantly, outcome was not significantly associated with the unique cognitive therapy interventions. Rather, there was an interaction of level of cognitive interventions and therapeutic alliance. Although this study used a sample of cocaine abusers, the findings of this study suggest that the relationship between unique and common factors is a valuable area of research and needs to be investigated further with depressed subjects.

Further evidence for the relationship between therapeutic alliance and cognitive therapy interventions comes from a study by Raue, Goldfried, and Barkham (1997). They compared the quality of the therapeutic alliance in cognitive-behavior therapy and psychodynamic-interpersonal therapy and found that the quality of the therapeutic alliance was rated as significantly higher in the cognitive-behavior therapy condition. This finding suggests that the strength of cognitive therapy may be due, at least partly, to the quality of therapeutic alliance attained.

Burns and Nolen-Hoeksema (1992) examined the role of therapeutic empathy in the outcome of cognitive therapy of depression. Results indicated that therapist empathy was significantly associated with reduction in depression, even after controlling for relevant factors such as initial depression severity and homework compliance.

Castonguay, Goldfried, Wisner, Raue, and Hayes (1996) investigated the role of therapist attention to the client's intrapersonal functioning on outcome of therapy. A focus on intrapersonal functioning involves the therapist assisting the client to make links between distorted thoughts and depressive symptoms, as well as between the client's behavior and mood. Attention to intrapersonal functioning, a hallmark of cognitive therapy, was compared with two nonspecific therapy factors, that of therapeutic alliance and the client's emotional

involvement in, or experiencing of; the therapy process. Results indicated that both therapeutic alliance and the level of client's experiencing of treatment were positively correlated with improvement of depressive symptomatology and overall functioning across all treatment groups. However, attention to intrapersonal functioning was negatively correlated with reduction in depressive symptomatology. Thus, two factors thought to be common to most forms of psychotherapy (i.e., therapeutic alliance, client experiencing) were positively associated with outcome, whereas a factor specific to cognitive therapy (i.e., focus on intrapersonal consequences) was negatively associated with outcome. The latter finding may be explained by a mediating factor of poor therapeutic alliance, as the relationship became nonsignificant once therapeutic alliance was controlled.

Whisman (1993) evaluated available research on the role of therapeutic alliance as a moderating variable in the context of cognitive therapy for depression. Despite the widely accepted notion that a positive therapeutic alliance is important, if not necessary, to change in cognitive therapy, Whisman concludes that the results of research evaluating this notion are as yet equivocal.

DeRubeis and Feeley (1990) investigated the role of adherence to the cognitive model of therapy in treatment outcome, and found that adherence was positively associated with reduction in depressive symptomatology, but only when assessed in the early stages of therapy. Whisman (1993) recommends that further research is required both to confirm this finding and to further investigate methods of assessing adherence to the therapeutic model.

Regarding therapist competence, results of available studies strongly support the association between competence and reduced depressive symptomatology (Whisman, 1993). For example, Burns and Nolen-Hoeksema (1992) found that treatment outcome for clients of novice cognitive therapists was worse than for clients treated by experienced cognitive therapists.

### ***Declining Effect Sizes***

A third issue involves the decline in effect sizes for cognitive therapy over time (Dobson et al., 1991). Gaffan, Tsaousis, and Kemp-Wheeler (1995) argue that early studies (e.g., Dobson, 1989) investigating the effectiveness of cognitive therapy show stronger effects than more recent studies. That is, earlier studies provide evidence for the clear superiority of cognitive therapy over other psychotherapies, whereas more recent studies indicate that cognitive therapy is not always superior. Additionally, in those cases where cognitive therapy remains superior, the gap has narrowed considerably, especially that between cognitive therapy and behavior therapy. Dobson and Pusch (1993) raised two possible issues that may be responsible for this "sliding effect size phenomenon" (p. 138), including researcher allegiance and increasing effectiveness of comparison treatments. Gaffan et al. (1995) also provide possible explanations for this phenomenon. First, it is possible that the comparison treatments in these studies are becoming more effective than they historically have been. A related possibility is that with increasing integration of therapies, pure forms of cognitive and behavioral therapies no longer exist. If cognitive and behavioral therapies have become more alike than they are distinct, behavior therapy would no longer be a valid comparison treatment. Second, it is possible that the widespread adoption of cognitive therapy has produced vast numbers of researchers who are not as competent in the provision of cognitive therapy as were the original group of researchers. Third, it is plausible that a publication bias existed for these early studies, such that studies which demonstrated convincing results for the effectiveness of cognitive therapy were more likely to be accepted for publication. Fourth, researcher allegiance (i.e., the preference of an author for one therapy over another) may have been responsible for the strength of these findings in earlier studies. However, results from the Jacobson et al. (1996) component analysis were contrary to what would be expected according to the

allegiance effect. A final possibility which is suggested by the Jacobson et al. findings is that the decline in effect sizes is valid. That is, it is possible that the effectiveness of cognitive therapy is actually decreasing. Research is urgently needed to address this possibility.

### ***Client Characteristics***

Client characteristics have also been investigated to determine whether the success of cognitive therapy is related to characteristics of the clients it is used with, rather than to some feature of the therapy itself. Analysis of such aptitude-by-treatment interactions could provide information about the processes of change in psychotherapy, and also may allow matching of client characteristics to appropriate therapeutic components or modalities (Addis, & Jacobson, 1996). A variety of client characteristics have been investigated, most notably personality characteristics, individual explanations for becoming depressed, and coping styles. An additional client characteristic that has been investigated is cognitive-personality factor (i.e., sociotropy and autonomy), which is discussed in a later section of this chapter.

In the Treatment for Depression Collaborative Research Program, Barber and Muenz (1996) found that cognitive therapy and interpersonal therapy were differentially effective according to personality characteristics. That is, depressed patients who also presented with heightened levels of avoidant personality characteristics responded better to cognitive therapy than to interpersonal therapy. Conversely, depressed patients with heightened levels of obsessive personality characteristics responded better to interpersonal therapy.

Whisman (1993) found that the available research suggested that the presence of a personality disorder does seem to be associated with a poor outcome. However, more recent studies (e.g., Hardy et al., 1995; Ilardi, Craighead, & Evans, 1997) have not found this relationship.

Using data from the Jacobson et al. (1996) component analysis of cognitive therapy for depression, Addis and Jacobson

(1996) investigated whether the client's pre-treatment reasons or explanation for their depression would predict outcome of cognitive therapy. Results indicated that subjects who gave "characterological" reasons (i.e., reasons which reflected a stable or ingrained explanation for their depression) had worse outcomes both with standard cognitive therapy and with the behavioral activation component. On the other hand, subjects who gave "existential" reasons (i.e., dissatisfaction with the meaning of one's life) had better outcomes with standard cognitive therapy and worse outcomes with the behavioral activation component. Also, subjects who gave relationship-oriented reasons for their depression had worse outcomes with standard cognitive therapy, but there was no association between relationship-oriented reasons and outcome with the behavioral activation component. There was also no significant relationship between childhood reasons for depression and outcome. Although tentative, these findings suggest that the reasons that clients give for their depression may have utility in determining the most appropriate treatment.

Beutler et al. (1991) compared the effectiveness of group cognitive therapy, a form of group experiential therapy called focused expressive therapy, and supportive self-directed therapy in treating individuals with major depressive disorder. Results indicated that subjects coping styles and levels of defensiveness were associated with the type of therapy that was most effective in treating their depression. Specifically, subjects who used externalization as a coping style or who were low in defensiveness responded better to cognitive therapy than those without such a coping style or those high in defensiveness.

These findings lend further support to the recommendation that more research be conducted which addresses possible aptitude by treatment interactions (e.g., Barber, & Muenz, 1996; Shohan-Salomon, & Hannah, 1991). Methodological difficulties inherent in this discussion include power issues and the small sample sizes used to test this aptitude by treatment interaction. Further, pure random assign-

ment may not be the most appropriate method for assigning subjects to treatment conditions. Stratified random assignment, in which subjects are pre-selected on the basis of certain characteristics (e.g., personality, intelligence) and then randomly assigned to treatment conditions, may provide a better test of the aptitude by treatment interaction (Barber, & Muenz, 1996).

### **Role of Life Stress**

Dobson and Pusch (1993) recommended that the role of life stress in depression, as well as the interaction of life stress and personality factors in precipitating a depressive shift, be considered in future research. In general, results of research on the role of life events in depression indicates that risk of onset as well as risk of relapse of depression is significantly increased following stressful life events (e.g., Billings, & Moos, 1985; Paykel, & Cooper, 1992). The most consistent finding and strongest relationship appears to be the association of depression with "threatening" or undesirable life events of all types. That is, severe life events which require major adjustment, and to a somewhat lesser extent, severe chronic life difficulties, predict the onset of clinical depression (Andrews, & Brown, 1988; Brown, Bifulco, Harris, & Bridge, 1986; Brown and Harris, 1978; 1989; Dohrenwend et al., 1987; Surtees et al., 1986). With respect to relapse, only negative events which occur after recovery from the index episode of depression distinguish between relapsers and non-relapsers (Belsher, & Costello, 1988; Kessler, 1997).

In a review of the role of stressful life events in depression, Kessler (1997) concludes that an association between exposure to stressful life events and major depressive episodes clearly exists. However, he also concludes that the strength of the association between life events and subsequent depression varies depending on at least two factors. The first factor is the method of assessment of stressful life events, with use of "contextual" measures resulting in stronger associations than use of life event checklists. Second, more severe

life events have a stronger relationship with subsequent depression than less severe events.

Additionally, despite the statistical significance of the relationship between life events and depression, the effect is only moderate to weak, and it is likely that the simple cause and effect relationship between life events and depression is oversimplified (Andrews, 1978; Paykel, 1994; Paykel, & Hollyman, 1984; Segal, Shaw, Vella, & Katz, 1992). Also, while stressful life events are a common occurrence, only a small proportion of individuals exposed to stressful life events experience depressive episodes (Kessler, 1997). Based on these considerations, it is important to begin to look at the possibility of moderating or mediating variables in the life event-depression relationship in order to explore more complex relationships among stressors, cognitive factors, and behavioral and emotional outcomes.

A second issue with respect to the role of life stress is the question of how stress factors interact with personality to result in a depressive shift. That is, is the diathesis-stress model proposed by the cognitive theory of depression supported by the research literature?

Beck (1983, 1987; Beck, Epstein, & Harrison, 1983) has proposed a cognitive diathesis-stress model of depression featuring the cognitive-personality vulnerability variables of sociotropy (valuing close interpersonal relationships) and autonomy (valuing independence, achievement, and freedom of choice). Beck's diathesis-stress model posits that these cognitive-personality constructs are predisposing vulnerability factors for the onset of depression. Specifically, the constructs of sociotropy and autonomy specify the types of stressors predicted to activate depressogenic schemata to result in depression. Highly autonomous individuals are likely to become depressed if an event is perceived as a loss or limitation of independence, control, or achievement. Highly sociotropic individuals, on the other hand, are likely to become depressed in response to an event that is interpreted as involving threatened

or actual loss of a social nature. Analogous concepts (i.e., dependency, self-criticism) have also been evaluated by researchers interested in this relationship (e.g., Blatt, Quinlan, Chevron, McDonald, & Zuroff, 1982; Hammen, Marks, Mayol, & deMayo, 1985; Segal, Shaw, & Vella, 1989; Segal et al., 1992; Zuroff & Mongrain, 1987).

While the research in this area has produced conflicting results, at present there is tentative support for the congruence of sociotropic personality and interpersonal life events in nonclinical samples (e.g., Clark, Beck, & Brown, 1992; Hammen et al., 1985; Robins, & Block, 1988; Zuroff, & Mongrain, 1987) and for the congruency of autonomous personality and achievement life events in clinical samples (e.g., Hammen, Ellicott, & Gitlin, 1989; Hammen, Ellicott, Gitlin, & Jamison, 1989; Segal et al., 1992). It remains for future research to fully evaluate the congruency hypothesis with both clinical and non-clinical samples.

### ***Adaptations of Cognitive Therapy Which Take Cognitive-Personality Modes into Account***

The relevance of the sociotropy/autonomy distinction is found in adaptations of cognitive therapy that are tailored to this distinction. To date, only three studies have evaluated the utility of tailoring cognitive therapy to these vulnerability factors. Peselow, Robins, Sanfilippo, Block, and Frye (1992) found that depressed subjects who were highly autonomous exhibited a better response to antidepressant medication than did those who were highly sociotropic. The authors also found that these cognitive-personality modes were a stronger predictor of response to pharmacotherapy than the endogenous/nonendogenous distinction.

Zettle, Haflich, and Reynolds (1992) investigated the hypothesis that depressed subjects who are highly sociotropic would derive greater therapeutic benefit from group cognitive therapy, whereas depressed subjects who are highly autonomous would derive greater therapeutic benefit from individual cognitive therapy. Although both groups demonstrated relatively equivalent

success in alleviating depression, the hypotheses were supported. That is, depressed subjects who were matched to treatment format (e.g., sociotropic in group format) based upon their cognitive-personality modes achieved greater reductions in depressive symptomatology than did mismatched subjects (e.g., sociotropic in individual format). Zettle and Herring (1995) further evaluated the treatment utility of matching individuals to cognitive therapy according to their cognitive-personality vulnerability using more stringent a priori hypotheses regarding outcome. Whereas the Zettle et al. (1992) study randomly assigned subjects to treatment formats regardless of their sociotropy/autonomy score, the Zettle and Herring (1995) study utilized a stratified random assignment to treatment formats. Results indicate modest effectiveness of this treatment format, as all groups attained significant and statistically equivalent reductions in depressive symptomatology, although marked improvement was noted in a significant number of matched subjects.

### **Role of Protective Factors**

Dobson and Pusch (1993) recommended that future research investigate the role of protective factors in preventing a depressive shift. The majority of research on protective factors in depression has investigated social support and coping strategies.

**Social support.** Research investigating the role of social support in depression has found a relationship between diminished social support and the presence of depressive symptomatology in both clinical and community samples (e.g., Barnett, & Gotlib, 1988; Paykel, & Cooper, 1992). Studies which have investigated the role of social support in onset of depression have produced mixed results with some studies finding support for the buffering hypothesis while others find support for the main effect of social support (e.g., Bolton, & Oatley, 1987; Brown, Andrews, Harris, Adler, & Bridge, 1986). Studies which have investigated the relationship between social support measured during the index episode

and subsequent outcome in terms of recovery or relapse indicate that social support is predictive of outcome, although the nature of this relationship (i.e., direct or indirect) is not always specified (e.g., Brugha et al., 1990; George, Blazer, Hughes, & Fowler, 1989).

Overall, results indicate that social support plays a role in depression. Further research is required to evaluate the role of social support in preventing onset and/or relapse of depression, as well as the relationship between social support, cognitive variables, and cognitive therapy interventions.

**Coping strategies.** Research on the role of coping strategies in depression has clearly demonstrated that the way in which individuals cope with stressful experiences is significantly associated with onset, course, and severity of depression (Abramson, Seligman, & Teasdale, 1978; Aldwin & Revenson, 1987; Billings & Moos, 1981; Collins, Baum, & Singer, 1983; Folkman, Lazarus, Gruen, & DeLongis, 1986; Fondacaro & Moos, 1987; Pearlin & Schooler, 1978). A recent focus of research has been on the role of coping styles in mediating the impact of stressful life experiences on depression. Although few longitudinal studies have examined the role of coping strategies in the prediction of onset or outcome of depression, available results provide tentative evidence that coping responses add significant power to the prediction of subsequent depression (e.g., Swindle, Cronkite, & Moos, 1989). For example, avoidance coping styles have been found to be related to recurrence of depressive symptomatology (Sherbourne, Hays, & Wells, 1995). Further research is required to clarify those coping strategies which have protective value in preventing a depressive shift. Additionally, more complex relationships with other protective factors and life stressors must be evaluated in the prediction of course and outcome of depression. Also, the relationship between coping strategies, cognitive variables, and cognitive therapy interventions must be addressed.

### **Role of Cognitive Therapy in Reducing Risk of Relapse**

An eighth issue involves the possibility that the value of cognitive therapy lies in its ability to prevent or reduce the likelihood of relapse of depression. As previously mentioned, cognitive therapy has been found to be superior to pharmacotherapy in terms of preventing relapse (Blackburn et al., 1986; Kovacs, Rush, Beck, & Hollon, 1981; Simons et al., 1986). Hollon and Najavits (1988) found that at one- and two-year follow-up, relapse rates for cognitive therapy were 30%, compared to more than 60% for a pharmacotherapy group. Two more recent studies (i.e., Evans et al., 1992; Shea et al. 1992) address this issue, and conclude that cognitive therapy is nonsignificantly better than maintenance pharmacotherapy in prevention of depressive relapse.

Blackburn and Davidson (1995) presented a table of studies comparing cognitive therapy and tricyclic antidepressant in the treatment of depression. An analysis of the data for three studies which featured a one-year follow-up revealed a 12-month weighted average relapse rate of 40% for cognitive therapy, 33% for combined cognitive therapy and tricyclic antidepressants, and 66% for tricyclic antidepressants alone. These findings provide tentative evidence that cognitive therapy, either alone or in combination with antidepressant medication, is more effective than antidepressant medication alone in terms of preventing relapse of depression.

Given this finding, future research should investigate which components of cognitive therapy are responsible for this relatively low relapse rate. Results of the Jacobson et al. (1996) component analysis of cognitive therapy of depression indicated that the full cognitive therapy package was no more successful in reducing rates of relapse than the two smaller components of cognitive therapy (behavioral activation alone, and behavioral activation plus modification of automatic thoughts). Further research is required to clarify this issue.

### **Methodological Limitations of Current Research Literature**

A final issue is the possibility that methodological limitations in the available research are responsible for the many questions that remain unanswered. It is recommended that these limitations be addressed in future research in order to adequately investigate the efficacy of cognitive therapy. Margison and Shapiro (1996) suggest that further manualization of cognitive therapy needs to occur, as does evaluation of more integrated therapy models (i.e., cognitive-behavioral, psychodynamic-interpersonal) in order to better reflect actual clinical practice. Further, they argue that comorbidity needs to be further investigated and its impact on outcome studies evaluated. According to Scott (1996), a variety of methodological changes are required, such as the inclusion of pill-placebo control conditions, increased sample sizes in each treatment condition, and better monitoring of antidepressant medication regimes.

An important limitation of current research has been the exclusive reliance on tricyclic antidepressants as the pharmacological comparison treatment. Future research should evaluate the newer generation of antidepressant medications such as the SSRIs, and the combinations of the SSRIs and norepinephrine (e.g., effexor). Further, maintenance treatment with antidepressant medications is becoming increasingly common in clinical practice. The effects of maintenance dosages of antidepressants on treatment outcome and relapse rates needs to be investigated in future research.

A final methodological limitation in the cognitive therapy literature has been the reliance on self-report measures of cognitive factors. Jacobson et al. (1996) noted that their findings may have been different if different measures had been used. Further, Segal and his colleagues (e.g., Segal, & Swallow, 1994) have recommended that information-processing measures (e.g., modified Stroop task, self-referent encoding task) may be useful in understanding the schema notion and its contribution to the effectiveness of cognitive therapy.

## Conclusions and Future Directions for Research

Cognitive therapy is an effective treatment for depression. However, an issue identified by Dobson and Pusch (1993) was the application of cognitive therapy to more chronic forms of disorder and dysfunction. Logical extensions include application of cognitive therapy to disorders such as dysthymia and the depressed phase of bipolar disorder. An in-depth assessment of this issue is beyond the scope of this chapter. However, it is noteworthy that the schema-focused therapy developed by Jeffrey Young (1990) has not yet been empirically evaluated. This modification of cognitive therapy which focuses on deeper schemas related to psychopathology would seem to be a good candidate for application to these more chronic conditions. Controlled outcome studies of schema-focused therapy are required.

Further extensions of cognitive therapy include application to more chronic disorders such as schizophrenia and personality disorders, as well as multicultural and religious adaptations of cognitive therapy. Evaluation of such extensions of cognitive therapy continues to be required. The results of numerous studies indicate that cognitive therapy is an effective treatment for depression. Further, it has been found to work as well or better than other psychotherapies or pharmacological treatment. However, there are a number of critical issues which must be clarified. We have attempted to identify these critical issues and provide directions for future research on cognitive therapy for depression.

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