Hükümlülerin Psikiyatrik Belirtiler Yönünden Değerlendirilmesi

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Özet


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 Multi-score 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

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Fido, Razik, Mizra ve El Islam (1992), tarafından yapılan araştırmada ise, psikiyatrik değerlendirmeye istenen hükümülerin üçte birinin daha önceden bir sabıktı olduğu ve yaklaşık yarısının geçmişte psikiyatrik tedavi gördüğü belirlenmiştir.

Son zamanlarda ruhsal bozukluk gösteren kişilerin kurumlar kapatılması yerine, toplum içinde iyileştirilmesi eğiliminde artmasyla, ruhsal bozukluğu olan kişilerin suç işleme siklığının arttuğu vurgulanıyor "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 bazalarının suç işleme nedeni olduğu; özellikle bensor suçların ruhsal bozukluk gösteren kişiler tarafından normal kişilerden daha fazla işlendiğini; ayrıca, cezaevine yeni gelen hükümülerin çoğunlüğunu psikiyatrik bir geçmişe sahip olduğunu ifade etmektedir. suçlulara yönelik polis kayıtları ile arızs çalışmalarını 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 arttuğu, toplumun bu tehlikeden korunması için bu kişilerin suç işlemedi saptanmasının gerekli olduğunu 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 bazalardında hükümüler grublarında psikiyatrik belirtiler saptandığı bildirilmektedir (Birsoz, Güçer ve Büyükbecker, 1988; Yavuzer, 1981; Yavuzer, Gungormus ve Minbaş, 1988). Hükümlülerin psikiyatrik

Bu araştırma, ülkemizdeki cezaevlerini ve hükümlü özelliklerini yansıtıacak bir örneklemde suçla bir bağlantısı olduğu öne sürulen psikiyatrik belirtilerin yaygınlığını saptamak amacıyla planlanmışdır. Araştırımda ayrıca, psikiyatrik belirtilerin yaş ve alman 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 Evinin İdaresi Hakkında Yasanan birinci maddesi, her mahkeme bulunan yerde bir cezaevinin kurulmasını öngördüğünden ülkemizde toplam 565 cezaevi vardır. Bunların çoğu ilçelerde bulunan küçük cezaevleridir. Ağır ceza merkezi olarak adlandırılan büyüük cezaevi sayısı 126'dır.

Hükmüllerin kurum dışından gelen insanlara sağlanlı bilgiler verileceği, kurum psikologlarının hükümlüleri ölçek uygulamalarını da içeren çeşitli çalışmaları yürütüklüleri düşünmektedir, ölçeklerin uygulaması psikologunun yapılmıştır. Böylece bünüyesinde psikolog bulunan toplam 35 ayrı ceza merkezi cezaevi uygulama kapsamına alınmıştır.

Cezaevlerinde bulunan 'bireyler hakında verilmiş olan kararlar göre ikiye ayrılmaktadır: Suçlu oldukları düşünülenlere özgülgünden yoksun bırakılan fakat, suçlulukları kesinleşmemeyen tutuklular ile suç işlediği yarar karar ile kesinleşen hükümlüler. Ağır ceza merkezlerinde bulunan cezaevleri kapasite ve bina yapısı tipi olarak farklılıklar göstermelerine karşın, cezaevlerinde tutuk ve yönetmeliklere göre belirlenen hükümlülerin uyması gereken kurallar ve tanımlı haklar yönünden benzerdir.


Araştırımla katılanların 23'ü kadın, 368'i erkek. Katılımların 33'ü tahsilsiz, 32'si ilkokul; 233'ü ortaokul, 47'si lise, 45'i lisekokulu; 35'i ise duduk. Deneklerin yaşları 13 ile 67 arasında değişmek olup, grubun ortalaması 30.2, standart sapması ise 10.1'dir. Araştırıma alınan hükümlülerden 306'sı 0-6 ay, 56'sı 7-12 ay, 9'u ise 13-18 ay tutuklu olarak cezaevinde kalmışlardır.

Araştırımda açık uçlu olarak toplanan suç tutunu ilişkin bilgiler yedi grupta toplanmıştır. Gruplandırma, suçun özelliği dikkate alınarak Adalet Bakanlığı'nda görevli beş türdük hakim tarafından yapılmıştır. Bu gruplandırmaya göre 'öldürme' grubu (n = 80) kasten, kaza ya da trafik gibi bütün öldürme fiillerini kapsamaktadır. 'Yaralama' grubu (n = 46) öldürmeye teşebbüs suçunu da içermektedir. Kız kaçırma, irza geçme, irza tasadi, namus tasadi, küçüklerle cinsel ilişki ve zina 'cinsel suç' (n = 30) kapsamına alınmıştır. 'Hirsizlik' grubunda (n = 90) gasp ve yağma gibi suçlar da yer almaktadır. Uyuşturucu madde-lerin kaçakçılığı, kullanımı ve satış 'uyuşturucu madde' (n = 38) olarak adlandırılmıştır. 'Dolandırıcılık' grubu (n = 38) sahteçilik ve emnieti suistimal suçlarını da içermektedir. 'Diğer' grubu (n = 62) kapsa-
myna ruşvet, irtikap, meskene tecavüz, orman suçları, gıda maddeleri tüzüğüne ayıkları hareket vb. gibi suçlar alınmıştır.

Kullanılan Ölçme Araçları

Araştırmada hükümetler hakkında ki tüm kişisel bilgiler araştırmaları tarafından geliştirilen bir bilgi toplama aracıyla elde edilmiştir. Psikiyatrik belirtilerin saptanabilmesi için ülkemizde geçerli ve güvenilirliği yapılan Genel Sağlık Anketi/GSA (General Health Questionnaire), Belirti Tarama Listesi/SCL 90R (Symptom Check List 90-R) ve Çok Yönlü Depresyon Envanteri/ÇDE (Multiscore Depression Inventory) kullanılmıştır. Psikiyatrik tarama çalışmaları yanında kullanılan ve üzerine geliştirilen GSA ile ülkemizde yapılan çalışma sayısı azdır. Hükümlüler üzerinde yapılan çalışmalara rastlanmamıştır. Bu nedenle, psikiyatrik belirtilerin saptanabilmesi için hükümetlerle çalışma yapılan SCL 90R ve GSA birlikte kullanılmıştır. Literatürdeki hükümetlerde depresyonun sıklık ve özeleşiklikli bir bulgul�arı bulunması, genel belirti puanları değerlendirilmesi alınmıştır.

Genel Sağlık Anketi (GSA).

Dünya yaşam bir biçimde kullanılan bir tarama testidir. Toplumda ve psikiyatri dışı klinik ortamlarda karsıştıran davranış bozukluklarını saptamak amacıyla geliştirilmiştir ve 12, 28, 30 ve 60 maddelik bir biçimlendirilmiştir.


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

Ülkemizde ölçeğin 12 ve 28 maddelik biçimlerinin geçerli ve güvenirlik çalışması sonuçları her iki biçiminin de güvenilirlik ve geçerlinin yeterli düzeyde olduğunu göstermektedir (Kılıç, 1992). Dahâ kısa olmasının uygulamasında 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 bunlardan kısa zaman aralıklarındaki değişimlerin gözlenmesini amaçlamaktadır. SCL 90R ölçeği 90 cümleden ve 9 alt test ile bir ölçekten oluşmaktadır. Denekler, cümlelerdeki belirtilerin son bir ay içinde kendi kendileri olup olmadığıne göre, Hıç (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 Sempptom İndeksi (GSI) puanları normal olarak kabul edilirken, 1.0'un üstündeki puanlar pataloji belirtisi olarak değerlendirilmektedir (Dağ, 1990). Dağ tarafından yapılan çalışmada ölçek güvenilir ancak, yalnızca GSI yönünden geçerli bulunmuştur.

Çok Yönlü Depresyon Envanteri (ÇDE).

Ölçek toplam 118 cümleyi içermektedir. Denekler her cümleyi 'Doğru' (Genellikle geçerli) veya 'Yalan' (Genellikle geçersiz) boyutunda kendi kendilerine değerlendirilmektedir. ÇDE; Düşük Enerji Düçeyi, Bilişsel Güçlük, Suçluluk, Düşük Kendilik Değeri, Sosyal İçindenlik, Kötüsumerlik, Huzursuzluk, Kederli Duygu Durum, Araçsal Çaresizlik ve Öğrenilmiş Çaresizlik olmak üzere 10 alt ölçekten oluşan bir ölçek olarak değerlendirilir. ÇDE'deki cümleler depresyonun varlığı doğrultusunda puanlanmaktadır. Yani bir maddede verilen "Doğru" ya da "Yalan" yanıtlan depresyonun varlığını gösteriyece, bir puan verilmektedir. ÇDE'den alınabilecek en düşük toplam puan 0, en yüksek toplam puan 118'dir. Öl-
çektiken alınan puanın yüksekliği depresyonun ciddiyetini, düşük puan ise depresyonun yokluğunu belirtmektedir. Özedede ilgili yapılan çalışmalar ölçüğün güvenir ve geçerli olduğunu göstermektedir (Aydın ve Demir, 1988).

İşlem


Bulgular

Bu çalışmada hükümlülerin üç ayrı ölçekteki algılarını genel puanların ortalama ve standart sapmalarını belirlenmiştir. Yaş ve alınan ceza süresi ile ölçek puanlarını arasındaki ilişkiye korelasyon ile bakılmıştır. Cinsiyet, eğitim düzeyi, medeni durum ve suç türüne göre üç ayrı ölçekteki algıları genel puanların ortalama ve standart sapmaları her değişik için ayrı ayrı hesaplanmıştır. 

Gruplar arası ortalamalar farklılıkların anlamli düzeyde olup olmadığı ikili gruplarda t-testi, ikiden çok gruplarda tek yönlü varyans analiziyle bakılmaktır. Anlamlı farkın bulunduğu değişkenlerde bu farklılığın hangi gruplar arasında olduğu Tukey testi kullanılarak belirlenmiştir.

Araştırmaya katılan tüm hükümlülerin her bir ölçekteki algıları 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) puani arasında anlamlı ve negatif bir ilişki bulunmaktadır. GSA puanları ile yaş arasında anlamli bir ilişki olmadığı saptanmıştır (r = -.05). Alınan ceza süresi ile üç ölçek puanları arasında anlamlı bir ilişki bulunmamıştır.

Hükümlülerin cinsiyeti, eğitim düzeyi, medeni durum ve suç türüne göre ölçekerden algıları puan ortalamaları ve standart sapmaları hesaplanmış ve Tablo 1’de sunulmuştur.

Tablo 1 incelediğinde kadın hükümlülerin her üç ölçekte de erkeklerde göre daha yüksek ortalamaya sahip olduklarını görülmektedir. Kadın hükümlülerin (N = 23) erkek hükümlerden (N = 368) oldukça az sayıda olması nedeniyle, varyansların homojen olup olmadığı test edilmiş, elde edilen değerler (F1,389 = 1.26, p > .05) anlamli düzeyde olmadığı görülmüştür. İki grup arasındaki farkın t testiyle test edilmesinin uygun olduğu kararına varılmıştır. Yapılan t test analizi bu farkın GSA (t = 2.08, p < .05), SCL 90-R (t = 2.21, p < .03) ve ÇDE (t = 3.07, p < .01) için anlamli düzeyde olduğunu göstermektedir.

Eğitim düzeyi açısından GSA için en yüksek ortalamaya okur-yazar grup (X = 5.27) en düşük ortalamaya ise lise mezunu (X = 3.65) grup sahiptir. Diğer grupların ortalamalarını birbirine yakından. Yapılan varyans analizi sonuçları gruplar arasında anlamli bir fark olmadığını göstermektedir (F3,388 = 1.51, p > .05). SCL 90R puan ortalamaları ise en düşük ortalamaya ise yüksek okul mezunu (X = 0.57) olan grubun sahip olduğu diğer grup ortalamalarının birbirlerine yakın olduğunu göstermektedir. Varyans analizi sonuçu, SCL 90R için eğitim düzeyine göre grup ortalamaları arasındaki farkın anlamlı düzeyde olup olmadığını göstermiştir (F3,388 = 1.83, p > .05). Hükümlülerin eğitim düzeyine göre ÇDE puanlarına bakıldığında, eğitim düzeyindeki artma paralel olarak ÇDE puanlarının da düştüğü görülmektedir. Varyans analizi sonuçu da gruplar arasındaki farkın anlamlı düzeyde olup olmadığını göstermiştir (F3,388 = 6.37, p < .01). Bu farklılığın hangi gruplar arasında olduğu nun belirlenmesi amacıyla yapılan Tukey testi sonuçları okur-yazar (X = 57.4), ilkokul mezunu (X = 53.7) ve ortaokul mezunu (X = 45.7) grupların üniversite mezunu (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

<table>
<thead>
<tr>
<th>Değişkenler</th>
<th>GSA</th>
<th></th>
<th>SCL 90R</th>
<th></th>
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<tbody>
<tr>
<td></td>
<td>n</td>
<td>(\bar{X})</td>
<td>SS</td>
<td>(\bar{X})</td>
<td>SS</td>
<td>(\bar{X})</td>
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<td>23</td>
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<td>3.28</td>
<td>1.16</td>
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<td>0.74</td>
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<td>Diğer</td>
<td>62</td>
<td>4.56</td>
<td>3.31</td>
<td>0.89</td>
<td>0.61</td>
<td>45.4</td>
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</table>

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

Hükümlülerde psikiyatrik belirtilerin yaygınlığına bakılan bu çalışmada; genel belirli ölçüleri açısından hükmüllerinaldikları puan ortalamalarının yüksek olduğu görülümsütedir. Ülkemizde GSA ile ilgili yapılan çalışmalarında değişiklik göstermekle birlikte, genellikle ruhsal bozukluğu gösterdiği kabul edilen kesme noktası 3.00 ve üstü puandır (Iren-Akbyuk, Önder, Gökkurt ve Sümülböлю, 1996). GSA'nın hükmüllü grubundaki puan ortalamasının 4.37 olduğu görülmütedir. SCL 90R için patolojiyi gösterdiği kabul edilen 1.0'ın üstündeki ortalamı puan, hükmüllü grubunda 0.92 olarak bulunmuştur. Bu sonuçlar ülkemizde ve yurt dışında yapılan çalışmalarında olduğu gibi, hükmüllü gruplarnda psikiyatrik belirtilerin yaygın olduğunu göstermektedir. Henüz önemsenmemesi karşın, cezaevine kapalı ruhsal bozukluk gösteren kişilerin sayısıın artması beraberinde bir sürüş sorunu da getirecektir. Bu nedenle, cezaevlerine alınan kişilerin iyi bir psikolojik değerlendirme gerektirdiği, çerçevesi yoluyla kendileri veya diğerleri için var olan tehlikinin azaltılabileceğini düşündümsütedir.


Hükümlülerin aldıkları ceza süresi açısından yapılan analizler yurt dışında yapılan çalışma bulgularıyla tutarlılık göstermektedir. Yurt dışındağı çalışmalarla (Clark, 1972; Kalinch, Embert ve Senese, 1990; Robertson ve ark., 1994; Teplin, 1984) uzun süre ceza alanlarında psikiyatrik belirtiler daha fazla bulunurken, bu çalışmada her üç ölçekte ile alınan ceza süresi


Görüldüğü gibi demografik değişkenler ile ilişkin analizlerde edilen bulgular, genel psikotik belirtilerin toplumdaki dağılımlarla benzerlik göstermektedir. Bu benzerlik de bu sonuçların hükümül olmaktan bazı olması olarak toplumda var olan sosyal eğilimleri yansıttığını akla getirmektedir.


Araştırmada dolandırıcılık suç türünde sınıflandırılmış bireylerin ortalama puanları da düşük olarak bulunmuştur. Organize suç kapsamında davranışları dolandırıcılığın kamu yönetimini zayifladığı ve yasal yollardan ulaşlamayın maddi değerler, yasal olmayan yollardan ulaşma olanaklarının arttığı sosyal çözümde do
HÜKÜMLÜLERDE PSIKIYATRİK BELİRTLER

...nelerinde görüldüğü belirtilmektedir (Yücel, 1994). Dolandırıcılık grubunda bulunan kişilerin psikiyatrik belirtileri nedeniyle değil, bilinci ve istemeli olarak bu suçlular işledikleri, ayrıca kendilerini bu suçları işlemede haklı gördükleri ve bu ruhsal durumların ölçelerden aldukları puanlarla yansıdığını düşünülmektedir.


Ruh sağlığı alanlarındaki çalışanlar ruhsal bozukluklarının yaygınlığının ve bunun toplumsal yaşamı yansıma biçimlerini, yurtʟsphere yapılan çalışmalarda hırsız bozuklukları olanların daha çok adli sistem içinde sorunları yaşadıkları göstermektedir. Ülkemizde sağlıklı istatistik bilgiler olmaması nedeniyle, suç işlemeyi de cezaevi yerine akiller hastanelerine kapatılan, hatta savunmasını yapamayacağı gereksizle yargılanamayan ruhsal bozukluğu sahibi kişiler hakkında bilgileri erişilememektedir. Yalnızca suç işlemiş ve bu suçtan hüküm giymiş birleye üzerinden yürütülen baatanın araçtırmada hukuksal olarak psikiyatrik belirti ve depresyon puanlarının yüksek olduğu görülmektedir.


Kaynaklar


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; Jerell & 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 (Aydin et al., 1990; Bırsoz 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
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 Multiscoring 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 (İrem-Akbyık et al., 1996), the convicts in this sample averaged above the cutoff (X = 4.37). The convicts’ mean score on the SCL 90 (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 indicator 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.
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, Eunson, & Bishop, 1986; Dobson, Pusch, & Jackman-Cram, 1991; Simons, Murphy, Levine, & Wetzel, 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 psychothera-
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 (Holton, 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, Schmaling, 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, behavioral 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 pharma-therapy 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 pharma-therapy, 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 a trial design 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**

| 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 |

**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

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 predictive 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 dexa-methasone 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 DeRubels (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-
results 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, Wiser, 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, Tsoras, 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
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 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 congruence of autonomy personality and achievement life events in clinical samples (e.g., Hammen, Ellicot, & Gitlin, 1989; Hammen, Ellicot, 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, Sanfilipo, 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, Haefich, 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; Pearl & 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 presenting 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.

References


