

## Martin Seligman Forum on Depression

### Summary:

In this forum recorded in 1994 respected American Psychologist Martin Seligman discussed the rise in the rate of depression in the last 30 years. He blames among other things the rise in individualism in our society and the self-esteem movement. He discusses various treatments, including the selective use of optimism as a form of psychological immunisation. He also talks about the need for children to experience sadness.

### Transcript

Martin Seligman: I'm going to begin by talking about an epidemic of depression, and the word 'epidemic' as I'll try to demonstrate, is appropriate to what we have in front of us, and I'm going to ask the question, What can we change about the epidemic of depression; what can't we change about it; and what our hope is. The point in general of the book, what you can change and what you can't, is to locate leverage, where in our own lives do we have the most leverage for change. And I'm going to try to do that with the most prevalent problem of mental illness, depression, tonight.

There is a paradox I think we have to face. We've seen in our lifetimes, a positive change in the quality of the world. Stalinism is dead, almost dead, Fascism is dead, the age of the tyrant may be coming to an end; there are fewer people dying on battlefields by count, than any time since the Boer War. There are fewer children dying of starvation today than at any time in recorded history. Yet in spite of opportunities in the world that I think have not existed before, we are in the grip of an epidemic of depression and pessimism which is also unprecedented.

Starting about 15 years ago, four large scale studies were done in the United States which surprised all of the statisticians. These were studies of the rate of depression, depending on when you were born. The largest study involved 10,000 people, chosen randomly. Each of them was given a psychiatric interview, and because the sample was so large, one was able to chart, over the course of the century, what the likelihood of depression was. And in brief, if you're born around World War I, in your lifetime the prevalence of depression, severe depression, is about 1%. If you're born around World War II the lifetime prevalence of depression seemed to be about 5%. If you were born starting in the 1960s, the lifetime prevalence seemed to be between 10% and 15%, and this is with lives incomplete.

The ratio of depression was such that in two generations, there's a tenfold increase in the amount of depression. Well first we thought this was some sort of statistical anomaly, and then people did a study of the relatives of 500 people who had been hospitalised with depression, 2,500 relatives, a large enough sample so again you could look at the risk for depression at different ages. Again you found between a 10:1 and 20:1 ratio over two generations.

Two more studies have just come out in the States in the last two years, and they increase our alarm further about this. They're studies of what age does this begin. A generation or two generations ago, if you became depressed, your first bout was likely to be at about age 34 or 35. In these last two studies, both of 2,000 high school and middle school students, the mean age is 14 years for the first bout of depression. And since depression is a recurrent problem, on average if you have depression, it's likely to occur once every three or four years, you're talking about an ocean of tears in the difference, if it starts at 14, as opposed to 34.

So we have I think a well-documented increase in the amount of depression, and we have this paradox in societies like Australia and the United States, which has never been richer. We have unprecedented depression and pessimism.

One thing we know is not a cause of this, it's not a biological phenomenon. There hasn't been a change in our hormones or our genes in two generations. The ozone layer, our nutrition, does not account for this phenomenon, as best as we can tell. And I've argued, and I won't repeat the argument now, because I want to concentrate on yet a third factor. I've argued that two factors that have contributed to the epidemic of depression. One is an increasing individualism, a rampant individualism, in which we tend to regard ourselves like children regard themselves as I'm all there is, and depression is, I believe, a disorder of individual failure, an individual helplessness, and if you think you're all there is, you're set up for it.

In the past, when we failed, as fail we must, there was spiritual furniture we could fall back on for consolation. Our relationship to God, our patriotism, extended families, community, and systematically in the two generations in which depression has increased so drastically, we've seen a waning of all these spiritual furnitures. But I'm not going to repeat those, I'm going to say something to you that I think I've not said before. And it has to do with what you can roughly think of either as the self-esteem movement or the feel good society, as a third factor.

I've been for the last couple of years, looking at children's books, looking at primers that kids read in first grade and second grade, over this century. And if you look at them, something surprising emerges. Two generations ago, the children's books are about doing well in the world, they're about achievement, "The Little Engine That Could", a typical example. The primers today are much less about good commerce with the world and much more about feeling good, about high self esteem. Now the aim of many forms of therapy today, the aim of the recovery movement, is to increase self esteem, to make people feel good. Indeed the California Legislature has mandated that all California schools must teach self esteem, to get rid of welfare dependency and drug abuse, teenage pregnancy, unemployment and the like. Now self esteem and feeling good, while undeniably desirable things are goals that I have reservations about, and I want to express those reservations to you, and then I want to say how I think paradoxically they're related to a massive increase in depression.

I think these are over-inflated ideas, and my thinking comes out of working with depressed people. Depressed people have four symptoms, four sets of symptoms: first their behavioural symptoms, they're passive, they're indecisive, they're

helpless; they have emotional symptoms, they're sad; they have bodily symptoms, appetite diminishes, sleeping diminishes, jokes aren't funny any more; and finally they have thinking symptoms, cognitive symptoms, they think life is hopeless and think they are worthless. The last half-symptom, thinking you're worthless, is about self esteem. And I've come to believe that that low self esteem, thinking you're worthless, is the least of all of these worries in depression. Once a depressed person becomes active and hopeful, self esteem always improves. Bolstering self esteem without changing hopelessness, without changing passivity, accomplishes nothing.

I had the misfortune of making myself read very large literature on self esteem recently, and the large self esteem literature is replete with correlations between self esteem and how kids and adults do. Ugly kids have low self esteem, high achievers have high self esteem, good athletes have high self esteem, kids who fail in school have low self esteem. But the question is, does failure cause low self esteem, or is it self esteem that's the cause of the failure? And when you look, what you find is that self esteem seems to cause nothing at all, rather self esteem is caused by the whole panoply of successes and failures in the world.

So what I want to say about self esteem is that it's a consequence of poor commerce with the world, and what needs improving in kids with low self esteem is not directly how they feel, but the skills for good commerce with the world. The self esteem movement cares more for feeling good than for doing well, and it's confluent with a much larger change, both in America and I believe in Australian society as the deeper change. In two generations, our societies have switched from doing well societies to feeling good societies, and it's quite odd that in these two generations, national depression got worse by all measures. The element in the feeling good self esteem movement that I think is insidious, has to do with the cushioning of dysphoria.

We've come to believe that we should try to banish dysphoria, anxiety, anger, sadness. But feeling bad has three crucial uses. The first has to do with the messages contained in feeling bad. Anxiety, depression and anger have long evolutionary histories in which they're trying to tell us something. Depression, feeling sad, tells us we've lost something. Anger alerts us to trespass, anxiety alerts us to danger. All of these messages, by their very nature, carry pain, and it's this pain that makes them impossible to ignore and goads us to get rid of them. They're an alarm system, they're not a flawless alarm system, they're very often wrong, but insofar as we jump in and try to dampen the system, we can lose the message. So the first good use of bad feeling is that it contains messages about how our commerce with the world is going.

The second goodness of bad feeling has to do with the notion of flow. I'm not going to be sophomoric enough to stand here and try to say something about what I think happiness is, but there is one aspect of happiness that's been well studied, and it's the notion of flow. Ask yourselves, when for you does time stop? When are you truly at home, wanting to be no place else? This is the state that each of you probably can recognise, it's called flow, and the conditions for it are now quite well

known. Flow occurs in your life when your highest skills are matched to challenges, that quite exactly meet them. If the challenge is too high and the skill is too low, you get helplessness, depression, frustration. If the skill is too high and the challenge too low, you get boredom. But you can see that a life in which high self esteem, confidence, ebullience, getting rid of challenge, frustration occurs, one is deprived of flow. These negative emotions are necessary for flow.

The final good use of bad feeling has to do with overcoming helplessness. If you think of the thing in your life that you're most proud of, your greatest success, it was almost certainly something that involved a large number of sub-failures, each one of which you had to do something to overcome. Each failure involves the negative emotions, to the extent we step in and attempt to alleviate, prematurely, negative emotions. We deprive our children, our charges, of persistence. What I am trying to say is that we need to fail, children need to fail, we need to feel sad, anxious and anguished. If we impulsively protect ourselves and our children as the feel good movement suggests, we deprive them of learning persistence skills. So it's no accident, in my view, that the feel good ethic in general and the self esteem movement in particular had the untoward consequence of producing low self esteem, and depression on an epidemic scale. By cushioning bad feeling, made it harder for us, for our children, to feel good and to experience flow. By circumventing feelings of failure, it made it more difficult for our children to feel mastery. By blunting warranted sadness, warranted anxiety, it created children at high risk for unwarranted depression. By encouraging cheap success, it produced a generation of very expensive failures.

So this is my analysis of what's gone wrong. The existence of the epidemic of depression is not speculation, the analysis I've given is. And I now want to say something about what we can do and what we can't do, just a brief summary of what we know about alleviating depression, and then let's ask the question, Can we apply it to the epidemic.

There are essentially three ways of alleviating serious depression. There are two sets of drugs, tricyclics, and serotonin, Prozac-like drugs, which produce marked relief from depression in 60% to 70% of people. The second tactic that's used in depression is electroconvulsive shock, in severe depression, this probably produces marked relief from depression in 75% to 80% of people. There's something to be said about both those techniques. While they both produce fairly good relief of depression, they do nothing about recurrence or relapse. Your risk for recurrence and relapse is unchanged by experience with drugs or ECT. There are two psychotherapies that produce similar relief: interpersonal therapy, and cognitive therapy, both of these are practiced widely in the States and in Australia, they're both 12 to 16 session therapies which work 60% to 70% of the time, roughly the same as Prozac and the tricyclics, and then have the slight edge of cutting down recurrence, cutting down relapse. That is, you learn skills, interpersonal skills, and cognitive skills, so that the three years down the line when your life threatens to fall apart again, you can trot them out and do something preventative, whereas with drugs you have to start the drugs again.

Will these things end our epidemic of depression? And I think not. I think the drugs are certainly palliatives, the two psychotherapies get at some of the underlying problems, but I think they're also somewhat palliative as well. I was fortunate enough to be with Jonas Salk on the 30th anniversary of the polio vaccine, and I asked Dr Salk if he were a young man starting out in science again on that day, what he'd be doing? And he said, I'd be doing immunisation, but I'd do it psychologically rather than biologically. And indeed, this is what I've been up to the last five years, and this is what I think we can change about the epidemic of depression.

Cognitive therapy works with depression about 70% of the time. I think psychologists can do better than taking people who are already depressed and teaching them the tools of disputation. I think we can take normal people, people at risk for depression who are not depressed, and teach them in advance the skills of cognitive therapy. So starting five years ago we have done two sets of large scale studies, one with college freshmen and one with 10 year olds. Here's what we do. When you get admitted to the University of Pennsylvania, along with your admission certificate, you now get a questionnaire which looks at your pessimism or optimism. We score it, we invite the bottom quartile, the most pessimistic quartile, to participate in a workshop when they become freshmen, in which we teach them the skills of cognitive therapy. We've now followed them for two years after the course, and we find relative to a matched control group, that the prevention procedure significantly cuts down depressive symptoms and anxiety symptoms. The size of the effect is small to moderate, which brings me to my vision and my hope.

We did the same study on 10 year olds. We chose 10 year olds because we had been following a group of 700 8 to 12 year old kids, and we found that about a quarter of them had their first serious episode of depression during our observing them; we found there were two risk factors for which kids were going to get depressed. One was parents fighting and another was showing mild symptoms of depression. So we selected kids from school districts around Philadelphia whose parents were fighting or who were showing mild symptoms of depressions. We took cognitive therapy and we reduced it to the 10 year old level. And now we've followed these kids for 2-1/2 years. And what we find is that after 2-1/2 years, the rate of moderate to severe depression in the kids who've had prevention treatment is less than half the rate in the kids who had not.

There's one thing more that I want to tell you about this hopeful endeavour. I'd been interested in therapy studies for many years, and there's a universal finding when you test a therapy or a drug against a control group. If you get an effect at the end of therapy, you've got the difference between people who've had the therapy and people who have not. Over time, after the therapy's over, the difference collapses, and in fact the longer the difference remains, the better the drug works, or the better the therapy. In this day, that doesn't occur. The curves diverge. As the kids become 12, their team go through puberty, go through the ages of rejection and challenge and failure that you can all remember and the exquisite pain of those

endeavours, that children start using the skills they learned at age 10, and the untreated kids get more and more depressed, the treated kids two years after prevention, are getting less and less depressed.

So let me then conclude about what I've had to say about depression. I said first we had an epidemic of it that is produced by three very large societal factors about individualism, about the loss of the commons, and about the importance of feeling good, that we probably can't do very much about. There are therapies that work on undoing depression, they work moderately well. But we now have the first sign of prevention, which may indeed end our international epidemic of depression.

Thank you.

APPLAUSE

Geraldine Doogue: If anyone would like to ask some questions, we have three stand mics. We'd like you to come down please and ask questions, and identify yourself if you feel so inclined.

John Hunt: The name is John Hunt, Centre for Conflict Resolution, Macquarie University, and I'm interested Professor Seligman in your concept of immunity, and when you talk about normal people doing cognitive therapy with them, and giving them immunity through the cognitive therapy skills, does that mean you get them to change their overall perception of the world? And supplementary, does the fact of doing that kind of work, help to remove the propensity to have fear and anxiety?

Martin Seligman: Well let me take the larger issue that I think underlies the question. Those of you who have read 'Learned Optimism' from part of what I've said tonight, probably think that I'm an advocate of optimism. I'm not. There's a cost benefit analysis about optimism, and let me go through the cost benefit analysis with you now. There seem to be three benefits of optimism which I talked about one of them tonight. The first is it's apt to make your life noticeably less depressed, it fights depression. The second benefit of optimism, second benefit of learning disputation, learning cognitive therapy, learning optimism, is that it increases your achievement, so if you look at grade point average, or performance on the sports field, or how many insurance policies people sell, what you find is that optimistic people do better than they're predicted to do, and pessimistic people achieve less. And the third benefit of optimism is physical health. There's good reason to believe that the immune system among optimistic people is perkier than among pessimists. The rate of infectious illness is lower among optimists, the probability of death from second heart attack is markedly lower among optimists. So it gives you three things.

But there's one thing that pessimists do better than optimists. I tried to brush this under the rug for years, it doesn't brush under the rug. And it's that pessimists know the score. Pessimists are more realistic than optimists, they know when there's danger there. There's a large number of experiments which show that pessimists are more accurate than optimists about how much control they have, that

they are more accurate in their memories about success and failure, that their belief systems are generally more accurate. So three benefits of optimism, one benefit of pessimism. What kind of sense do we make of that?

What I'm an advocate of is flexible optimism. Here's my rule of thumb for it, for my own life, and the best I can do with it. Ask yourself what is the cost of failure in the situation you're confronting? If the cost is small - you can meet a member of the opposite sex who you think is interesting and you'd like to say Hello, the cost of going up and saying Hello is failing, it's one more rejection in life's long series of rejections, if you're a sales person and you're thinking about having trouble making the next call, then the cost of failure is another rejection, wasting ten minutes' effort. In those situations, use optimism. If the cost of failure is potentially catastrophic, use pessimism. If you're thinking about getting involved in an affair, which if your spouse finds out would end your marriage, use pessimism.

So my long-winded answer to your question is that optimism is a tool with a certain clear set of benefits: it fights depression, it promotes achievement and produces better health. It does not produce wisdom or compassion or good scientists or good journalists. What we want is the ability to recognise the difference between situations that call for optimism, trying harder, and the situations that call for realism and pessimism.

Woman: I'm in a situation where a patient is severely depressed, I mean absolutely clinically in a black hole. Do you see a place for drug rehabilitation followed then by cognitive therapy to get over that absolute worst part?

Martin Seligman: Yes, I think that the law among most knowledgeable psychiatrists and psychologist is that when you get severe depression, talking to people doesn't really get through, and with severe depression, it is the practice, although I must say it's not documented, I wish there were better evidence for it, that one uses medication, electroconvulsive therapy and then when people become communicative, when they can start to think about their own thinking process, then you move into either interpersonal therapy or cognitive therapy. That's what we do, I wish it was better documented that that's what we should do.

Geraldine Doogue: And the gentleman over here on the left, thanks.

Bruce Haddon: Thank you. Bruce Haddon, advertising writer, Professor Seligman. I was fascinated with your earlier remarks that the increase in depression is not environmental or necessarily biological, and I'd like you to help us reconcile that with the remarkable, effective Prozac-type drugs.

Martin Seligman: First I think I want to deny that the effects of Prozac are remarkable. Unlike the media hype, and unlike Peter Cramer's book on listening to Prozac, when you actually read the literature and treat patients with Prozac, what one finds is a 60% to 70% take rate, with moderate to marked change of symptoms. That's almost exactly the same take rate and same degree of recovery that occurs with the earlier antidepressants, the tricyclic antidepressants, the NAO inhibitors.

There's a different side effect profile for Prozac than for the NAO inhibitors which are quite strong drugs, and the tricyclates. So more people can take them but their effects are, I would use the term, moderately good.

If you look at the heritability of depression, it's a similar kind of story. That is, if you look at bipolar depression, manic depression, identical twins are much more concordant for manic depression than are fraternal twins. It tells you it's quite heritable. Uni-polar depression, the kind of depression we've been talking about tonight is weakly heritable. That is, identical twins are somewhat more concordant than fraternal twins. So unlike you, I'm inclined to regard uni-polar depression as a problem in living, and I regard bipolar depression as a biological illness.

Man: There is another strategy for integrating optimism and pessimism. I'm curious as to how effective you might think it is. I don't know how far back the saying can be traced, that what is needed is optimism of the will and pessimism of the intellect, but two names spring to mind, Bertrand Russell and Albert Camus. The former seemed to have at least in his writings, much more warmth and cheerfulness, but that was probably more a matter of temperament; the latter was very much the stoic whose favourite myth was the myth of Sisyphus. I would like to believe that apart from the very sensible strategy that you suggested of switching in time, that at the one time a person can simultaneously be realistic, and if that requires pessimism, then so be it, and yet still cheerfully plug on when the situation is hopeless, you know, take the next step.

Martin Seligman: What a good question. Optimism of the will and pessimism of the intellect. If you think about a big company, the division of labour in a big company, there are some jobs in a company that require optimism. The sales force needs it, the marketers need it, the planners need it. There are other jobs in a company that require pessimism of the intellect if you will. The safety engineers, the CPAs, the Financial Vice President. A successful company also has a CEO, that is, someone who attempts to balance the charge ahead mentality of the optimism of the will, of the sales force, against the Jeremiahs of the CPAs.

Now if you think about your own life, there are some tasks in life that require optimism to do well, finding love I think is one of them, creating things that work. And there are other tasks in life that require pessimism, and I think there is a force equivalent to the CEO which is neither intellect nor will, which sits over those and decides which to use on a given occasion.

Stella Cornelius: Stella Cornelius, the Conflict Resolution Network. Dr Seligman welcome to Sydney, we're very glad of the opportunity of having you here, and my question is, I'm wondering if you could put us in touch with any researchers that might help our further understanding of is there any effect of the prevalence of stimulants, tea, coffee, Coke, alcohol, drugs, with their temporary boost and long-term or later depression.

Martin Seligman: I have no good answer for the stimulants, but I do have something to say about the relationship of alcohol to depression. One of those interesting facts about depression in developed countries is that it's roughly a 2 to 1 female to male problem. I spend a good deal of my time working on and thinking about why that might be. And it's also quite interesting that substance abuse, alcohol in particular, is 2 to 1 the other way. There is some reason for thinking that women react to troubles by thinking, by ruminating, by being cerebral, Where did this trouble come from? And if my analysis of depression as a disorder of thinking is correct, that feeds directly into depression. Whereas men statistically react to troubles by escape. They drink, they beat someone up, they go out and distract themselves, play basketball or whatever. So there are some people who argue that the 2 to 1 ratio of alcohol of alcoholism from men is a depressive equivalent of the 2 to 1 ratio for depression in women, and that men abusing substances have the same underlying problem. It's the one reaction I have to it.

Woman: I find it interesting, actually very optimistic that you said that childhood trauma wasn't necessarily a bad and terrible thing and didn't have to have disastrous consequences, and that would suggest to me that if you have been the subject of sexual abuse or whatever childhood trauma, you don't necessarily have to be an unhealthy, neurotic adult. Is that what you're really saying?

Martin Seligman: Yes, it is, very much what I'm trying to say; I think you said it better than I said it. We become a world of victims. Part of the unfortunate carry over of the myths of childhood and a childhood trauma is that we're prisoners of the past. But what I think about therapies that work, therapies that I do, therapies that we teach, therapies that have good outcomes for depression and sexual problems of anxiety, these are not therapies that endlessly review what happened in childhood and regard you as prisoners of them, rather they're forward looking therapies that take your problems here and now, that give you homework to work on them, that makes you take responsibility for changing your life, and are forward looking. So part of the consequences of letting go finally of the power of childhood, I think is more freedom. We're not prisoners of the past.

Geraldine Doogue: Well thank you Professor Seligman, very much indeed. I'm going to quote from Chapter 14 in your book, Shedding the skins of childhood. You say 'There are I believe, only two great seasons in life: the season of expansion and the season of contraction. The season of expansion begins at birth, whereas' you say, 'I suspect the average reader of this book' (and I'm just having a quick look around the audience) 'is between the ages of 30 and 45, and thereby coming into the height of your powers, roughly half-way through life and entering the season of contraction.' And you go on to say that In this business of making this transition from one season to the next, offers enormous opportunities (I'm now paraphrasing, clearly) Enormous opportunities. And it is perilously easy to fail at making this transition to allow what happened to you in the first season to cripple you in the second, but success is common, contrary to those who would have us believe we are prisoners of childhood. Growth, even huge leaps, occur throughout adulthood. I dedicate what follows to your change and to your growth.

I felt that was a marvellous eloquent testimony to what I suspect is your fundamental message, which as you say, is a message of hope. And I think we've all been extremely impressed at how you have chosen your words carefully, given that words are like bullets in this area, as they are in diplomacy. And I want to thank you very much indeed for entertaining us and informing us tonight, with I suppose, your wisdom and your willingness to admit what you don't know. It's a rare treat. Thank you for joining us tonight.

APPLAUSE

Guests on this program:

Dr Martin Seligman

Professor of Psychology at The University of Pennsylvania

Publications:

A Selection of Books

Author: Martin Seligman

Learned Optimism (Knopf, 1991),

What You Can Change & What You Can't (Knopf, 1993),

The Optimistic Child (Houghton Mifflin, 1995),

Helplessness (Freeman, 1975, 1993) and

Abnormal Psychology (Norton, 1982, 1988, 1995, with David Rosenhan).