Brief Therapy Approaches to Treating Anxiety and Depression

Edited by
MICHAEL D. YAPKO, Ph.D.

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Publisher's Note

The publisher has gone to great lengths to ensure the quality of this reprint but points out that some imperfections in the original may be apparent.

This book is dedicated to
Jeffrey K. Zeig,
with appreciation, affection, and respect.
His knowledge of gliding and boulder dodging
has proved to be most inspirational.

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SECTION THREE: INTERVENTIONS FOR ANXIETY

SECTION FOUR: THERAPEUTIC APPROACHES FOR ANXIETY AND DEPRESSION

Preface

The Milton H. Erickson Institute of San Diego conducted its *Fourth Annual Conference on Hypnotic and Strategic Interventions,* March 4–6, 1988, on scenic Mission Bay in San Diego. The three prior conferences had been successful in promoting an awareness of and interest in hypnosis and briefer psychotherapies, but none of them had a specific focal point. (The edited proceedings from the first conference are contained in a volume entitled *Hypnotic and Strategic Interventions: Principles and Practice,* edited by Michael D. Yapko, Ph.D., and available from Irvington Publishers.) For the fourth conference, it was decided that awareness of general principles and techniques of hypnosis and brief therapy had grown sufficiently to warrant developing a focused attention on specific clinical disorders. The idea was to promote advances in clinical practice by exploring new, innovative ways to address the problems that clinicians routinely face.

Recent survey data from the National Institute of Mental Health suggested that among the most common disorders from which Americans suffer are anxiety and mood disorders. Of course, this is not news to the practitioner. One is likely to be in clinical practice only a few minutes before the first client is seen who presents anxiety and/or mood disturbances as part or all of the presenting problem. Yet as common as these disorders are, treatment remains largely a "hit or miss" proposition.

The field of psychotherapy is undoubtedly going through a marked change. Many of the dogmatic principles in which we were academically trained are falling by the wayside as an emphasis on pragmatism emerges. The increasing interest in doing therapy that not only *works* but works as reliably as possible is rooted in a practical, outcome-oriented framework. There are many controversial aspects to promoting outcome-oriented, briefer approaches to therapy. For one, the area can become a therapeutic *Name That Tune* game where one therapist competes against another by challenging, "I can name that cure in three notes (sessions)."

I am actually quite conservative in my considerations of brief therapy, knowing that many therapies will inevitably be long and difficult. However, I also know that many of the problems that we in this profession have treated as "long and difficult" are not. Rather, the approaches used have focused on nonsalient dimensions of the client's experience, or have even unwittingly reinforced the most dysfunctional aspects of the client's problem. An obvious example is the therapist who offers depressed clients endless opportunities to describe their emotional pain and terrible life histories. Therapy has traditionally emphasized verbal expression of one's feelings, and so this seems a reasonable intervention. However, knowing what we now know about depression, thanks to people such as Martin Seligman, Aaron Beck, and Gerald Klerman, we understand that such a passive and past-oriented approach delays or even prevents recovery.

Thus, the focus of the March 1988 conference became *"Brief Psychotherapies in the Treatment of Anxiety and Depression."* This title reflects a commitment to expanding the range of interventions that can be applied for the benefit of the client, and emphasizes the reality that good work can be done briefly. It seems imperative to continue to grow as a field through challenges. I do not think therapy could have advanced as much as it has in the past decade had it not been for the individual thinkers who have had the audacity to ask "Why?" when they were told how therapy "should" proceed. The faculty of this important conference obviously agree, because each presents a different way of conceptualizing and treating the clients for whom anxiety and depression are problems.

There are at least two ways for the reader to respond to the valuable works contained in this volume. One is to take them at face value and attempt to duplicate described approaches. However, this is less preferable than the second way, which is to see them as examples of ways to identify and challenge one's own assumptions about the nature of therapy. What should a therapist *always do?* What should a therapist *never do?* When should one take a passive approach? A directive one? Growth comes from stepping outside one's usual frame of reference. Thus, these contributions are offered with an implicit suggestion to evolve a willingness to explore and discover practical alternatives in the context of conducting psychotherapy.

As a field, we have not yet come to terms with the recognition that whatever has the ability to be therapeutic has an equal ability to be antitherapeutic. Doing therapy on the basis of either traditional formu-

las or nontraditional intuitions is a reliable way to avoid making real contact with the subjective world of the client. The common emphasis of the skilled practitioners who are making their work available here is on the individual client. This is a vital focus that I think will have significant impact on the growing awareness that therapy can be conceived and practiced as an outcome-oriented, directive process emphasizing a strong and positive alliance between therapist and client. I hope this volume motivates, enlightens, and challenges you, the reader.

Michael D. Yapko, Ph.D.
San Diego, California

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Conference Overview and Objectives

The Fourth Annual San Diego Conference on Hypnotic and Strategic Interventions was a three-day conference featuring highly acclaimed presenters addressing the subject of brief, directive psychotherapies in treating anxiety and depression. The conference featured workshops, short courses, and original papers by acknowledged experts in the fields of strategic psychotherapy, communication, and clinical hynosis.

The conference—which was organized and administered by the Milton H. Erickson Institute of San Diego—was of great interest to those practicing mental health professionals and students of human behavior especially involved in designing and delivering briefer and more efficient problem-solving therapeutic interventions.

The program featured 28 leading practitioners of hypnosis and strategic psychotherapy. Participants had the opportunity to (1) learn practical methods for use in their own clinical practices, (2) observe demonstrations of the presenter's clinical techniques, and (3) ask questions and discuss points of particular interest. The program's emphasis was on the treatment of anxiety and depressive disorders, which represent the most common disturbances clinicians are asked to treat. The main objective was to share active and innovative ways of intervening in such problems. With the exception of the keynote address, multiple events were scheduled at all times in order to provide a choice of activities for participants to attend.

The Institute continues to hold annual conferences. Write or call the Institute if you would like to be notified of future events.

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Acknowledgments

Until you have experienced what it is like to organize and run a conference where 200 not-so-easily entertained professionals gather to focus on the less-than-uplifting subjects of depression and anxiety, you can only guess what goes into making it as successful as this conference was. It takes a great deal of organizing and reorganizing, and the efforts of many people. These people deserve to be acknowledged.

My associates at the Institute are the ones who helped define "grace under pressure." The individual who is most often thrown into the center of the conference storm is my administrative assistant *Linda Griebel.* Linda is a unique woman with a perspective on life that can only be called "different." She is a very skilled organizer, and the conference literally could not have been a success without her.

David L. Higgins was and continues to be quite exceptional in his ability to orchestrate that which needs to be done. His computer wizardry came in very handy on several hundred occasions. *Brita A. Martiny* is the strong, wonderful, silent type who knows what needs to be done and goes about doing it without much fanfare. Her many contributions did not go unnoticed, however, and are gratefully acknowledged.

My wife, *Diane Yapko,* is an exceptional woman who seems to suspend all else to make room in her busy schedule for our annual conferences. Her single-minded devotion to my efforts is invaluable to me, and is greatly appreciated. My good friend *John Koriath* lent his mind as well as his back to help make this conference happen, and as always, he did it with class.

Our volunteer staff helped out in so many ways that their contributions were indispensable. *Deanna Dahl, Marianne Friedman,* and *Karen Stolz* gave generously of their time and energy, for which I am grateful.

I would especially like to thank *Jeff Zeig* and *Ernie Rossi.* They have attended all four of our conferences and have generously given their time and energy, the value of which I cannot state in words. On both

personal and professional levels, these men have contributed to me, and my appreciation is boundless.

Finally, I would like to thank *Natalie Gilman,* my editor, for doing such a thorough job on a difficult project. Coordinating multiple authors' responses and writing styles is no easy job even though she made it look that way.

M.D.Y.

About The Milton H. Erickson Institute of San Diego

The Milton H. Erickson Institute of San Diego was established in 1983 by Michael D. Yapko, Ph.D., under the guidelines of its parent organization—The Milton H. Erickson Foundation in Phoenix, Ariz. The Institute was formed for the general purpose of promoting and advancing the important contributions of Milton H. Erickson, M.D. In that regard, the Institute performs the following functions:

- Conducting the annual meeting in San Diego each March, in which well-known experts present their most recent innovations in the practice of directive psychotherapy.
- Providing clinical training to qualified professionals (e.g., M.D., Ph.D., M.A., etc.) in the use of clinical hypnosis and directive psychotherapies. The Institute is authorized by the California Board of Behavioral Science Examiners to provide the required hypnosis education and supervision to California marriage, family, and child counselors who want to become certified to use hypnosis in their clinical practices. Training workshops are offered on a scheduled basis locally, and on an on-demand basis elsewhere, both nationally and internationally.
- Providing high-quality clinical services to the community of which we are a part.
- Stimulating research in hypnosis and brief psychotherapy.

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Conference Faculty and Presentation Titles

KEYNOTE ADDRESS

Martin E. P. Seligman, Ph.D. — Philadelphia, Pa.
Optimism and Pessimism: Depression, Lyndon Baines Johnson, and the Harvard Class of 1939

INVITED WORKSHOPS

Raymond A. Fidaleo, M.D. — San Diego, Calif.
Cognitive Therapy of Depression

Stephen G. Gilligan, Ph.D. — Encinitas, Calif.
Reorganizing Attentional Strategies with Anxious and Depressed Clients

John J. Koriath, Ph.D. — Phoenix, Ariz.
Michael D. Yapko, Ph.D. — San Diego, Calif.
The Up Side of Being Down

Joyce C. Mills, Ph.D. — Los Angeles, Calif.
No More Monsters and Meanies: Multisensory Metaphors for Helping Children with Fears and Depression

Ernest L. Rossi, Ph.D. — Los Angeles, Calif.
The Psychobiology of Affective Disorders

Jeffrey K. Zeig, Ph.D. — Phoenix, Ariz.
Values in Ericksonian Approaches

INVITED SHORT COURSES

Norma Barretta, Ph.D.
Philip Barretta, M.A. — San Pedro, Calif.
Reframing Anxiety and Depression Through the Use of Submodalities

Christopher J. Beletsis, Ph.D. La Jolla, Calif.
Trance-Forming Anxiety: Hypnotic and Strategic Approaches to Treatment

Paul Carter, Ph.D. Encinitas, Calif.
Reframing Depression

David L. Higgins, M.A. San Diego, Calif.
Anxiety as a Function of Perception: Treatment as a Perception of Function

Irving S. Katz, Ph.D. Del Mar, Calif.
Critical Incident Process and Treating Depression

Brita A. Martiny, Ph.D. San Diego, Calif.
The Use of Symbolic and Metaphorical Communication in the Treatment of Anxiety and Depression

ACCEPTED PAPERS

Russell Bourne, Jr., Ph.D. Ashland, Va.
From Panic to Peace: Recognizing the Continua

Pamela Duffy-Szekely, M.A. La Jolla, Calif.
Utilization of Creative Cognitive Strategies: Reframing the Pain Experience

Ronald M. Gabriel, M.D. Regina, Sask., Canada
Childhood Depression

Brent B. Geary, Ph.D. (Cand.) Phoenix, Ariz.
Integrating Ericksonian Strategies in Structured Groups for Depression

Paul Genova, M.D. Portland, Me.
The Utilization Approach in Depression: Two Case Reports

Harriet E. Hollander, Ph.D. Piscataway, N.J.
Hypnotherapeutic Approaches to the Treatment of Panic Disorder

Allan Jacobson, Ph.D. Greenbrae, Calif.
Treatment of Depression: An Ericksonian-Strategic Approach

Sandi Janson-Selk, M.A. San Diego, Calif.
Tapping Inner Resources in the Service of Positive Change

Lynn E. Seiser, M.A.
Karen Cauffman, M.A. Long Beach, Calif.
Treatment of Anxiety and Depression in Child Abuse Victims

Robert Schwarz, Ph.D. Philadelphia, Pa.
The Treatment of Anxiety and Depression in Pain States

Christie Turner, L.C.S.W. San Diego, Calif.
Depression and Dysfunctional Families

John L. Walter, M.S.W. Chicago, Ill.
Jane E. Peller, M.S.W.
When Doesn't the Problem Happen?

MODERATORS

David L. Higgins, M.A. San Diego, Calif.
Brita A. Martiny, Ph.D. San Diego, Calif.
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SECTION ONE

Keynote Address

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Chapter 1

Explanatory Style: Predicting Depression, Achievement, and Health

Martin E. P. Seligman

Martin E. P. Seligman, Ph.D., is a Professor of Psychology at the University of Pennsylvania. As the originator of the "Learned Helplessness" model of depression, he remains one of the most knowledgeable and generative researchers and theorists in the field of psychology.

Michael D. Yapko: Martin Seligman is a name that I am sure virtually all of you recognize. I do not think you can take even an introductory level psychology class without being exposed to Dr. Seligman's theories and the research that he has done for over twenty years now. He has been so influential in shaping perspectives about the nature of depression that you really cannot read about the subject without his name coming up repeatedly. Dr. Seligman received his Ph.D. from the University of Pennsylvania in 1967 and he has been on its faculty in the psychology department since 1972. When we started talking about putting together this book, Dr. Seligman sent me his vita thick with the list of his publications, which are generally related to his "Learned Helplessness" model of depression. Over the course of the last few years, he has been revising the Learned Helplessness model. The area of interest that he has recently developed is one he calls "attributional style." It is rooted in the recognition that reality is ambiguous. How we interpret the world is not a reflection of the way the world really is. Life is an ambiguous stimulus, it's an "experiential Rorschach," and basically

what we do is project onto it our understanding of things. The relevant question is, "How do these understandings that we develop either help or hurt us?" Dr. Seligman calls this "explanatory style" or "attributional style," and this is the topic he will be addressing.

Martin E. P. Seligman: I want to start out with a projective test. I want you all to take a projective test right now, but you don't have to tell me the answer to it. It's an unusual projective test—it's one none of you has ever taken before. As Michael was introducing me, what was the word in you heart about what I was going to say and what it would do for you? Was it "no," or was it "yes?"

I want to suggest to you that it's a meaningful question, but that we don't often frame our interactions with people in this way, believing that we carry around a word in our heart. When a patient walks through your door for the first time, there is a word in his or her heart. Is it "no?" Is it "yes?" Can you detect it? Can you measure it? Can you change it? When you received your high school diploma and you walked up to the podium, what was the word in your heart when the principal or the guest speaker shook your hand? Was it "no," or was it "yes?" Well, that's what I'm going to be talking to you about today. I'm going to suggest to you that there really is such a thing. It's a lifelong habit, it's measurable, well quantifiable and there is a science of the word of the heart. I'm also going to suggest to you that it can be changed, although not easily.

What are the long-term consequences of the word in your heart being "no?" Conversely, what are the long-term consequences of the word in your heart being "yes?" There are three arenas in which I'm going to talk about the consequences. I'm first going to talk about *depression.*

I'm going to suggest to you that people who are pessimists, believe projectively that when a bad event occurs, "It's me. It's going to last forever. It's going to undermine everything I do," aka internal, stable, and global. If you are one of those people, if the word in your heart in that sense is "no," then you may be okay now, but your risk for depression is much greater than the person sitting next to you. So, first I'm going to look at the effect of pessimism on depression.

Then I'm going to ask the parallel question for *achievement.* I'm going to ask if you believe, "It's me. It's going to last forever. It's going to undermine everything I do," then what happens to your

achievement over a lifetime? What happens to your high school grades and to your college grades, to your productivity? Then I'm going to ask some far-out kinds of achievement questions about Presidents of the United States and the like.

Then, finally, I'm going to ask some questions about *ill health.* Do pessimists get sick more easily? Do their immune systems function more poorly? Do they die younger? These are the things about which I'll be talking. Last, I'm going to tell a joke.

Let me tell you how I got interested in the question of optimism, pessimism, and its effects on depression, achievement, and health.

About twenty-five years ago, I became interested in the phenomenon which has come to be called "Learned Helplessness." I worked for about ten years with animals and humans on what the consequences were of receiving uncontrollable events in the laboratory (Maier & Seligman, 1978) such as: inescapable shock, inescapable noise, unsolvable cognitive problems, and Bill Cosby records that went on and off regardless of what you did. We found over the years, both in animals and humans, that when you gave these inescapable events to them, there were a set of symptoms that occurred that looked very much like the symptoms of depressed patients who walked into my office with. Such uncontrollable events produced passivity, cognitive retardation, a lowering of self-esteem, sadness, anxiety and hostility, diminished aggression, diminished appetite, and a variety of brain changes that look very similar to those brain changes that are evident in naturally occurring depression. We're not going to talk about physiology, but I mention it because I could never get all the people and animals to do what I wanted them to do.

There was always about one out of ten, people and animals, who walked into the laboratory, and became helpless before I even gave them inescapable noise, just by being told "I'd like you to be in a laboratory experiment." There were other people, one out of three on average, who, no matter what I did to them, did not become helpless. So, what I started to worry about over ten years ago was the question, "What does a person bring to, or project onto, a situation that either makes him or her invulnerable to helplessness or supervulnerable to helplessness?" I'm going to suggest that the way that people habitually think about tragedy in their lives is an important determinant of who collapses immediately when in the face of inescapable events, versus those who bounce back instantly.

Let's begin with the theory of chronic habits of construing causality (Abramson, Seligman, & Teasdale, 1978). When we began to worry about the systematic ways in which we think about good events and bad events, it occurred to us that there were three dimensions that made a difference for depression. The first is one you all know about; it's the traditional "internal–external" dimension. It's the question, "If a bad event strikes, did I cause it, or was it caused by other people or circumstances?" So, if you're rejected by someone you love, you might say, "I'm unlovable, I'm worthless." That's an internal event. On the other hand, you might say, "He's a bastard!" That's an external event—it's he who is doing it. That's the most obvious dimension and by far the least important. The only reason it's even in the theory is that it has to do with self-esteem. The theory says that if you face a major bad event and you habitually believe that you cause bad events, then you're going to show low self-esteem, worthlessness, and self-blame. If, on the other hand, you habitually blame bad events on others, then you're going to show the constellation of depression and helplessness, but you're going to show it without the self-blame, low self-worth, or low self-esteem.

You can pretty much ignore this dimension from now on—I'll be considering it again, but the important dimension is "unstable-stable." I want you to think about the question of hopelessness for a moment, because what you're really reading about is a "Hopelessness Theory" for depression. What do we mean when we say someone is hopeless? When we take our present misery, i.e., our present bad situation , and we project it endlessly into the future, that's half of hopelessness. That's the unstable-stable dimension. The other half of hopelessness is the "specific-global" dimension. If, for example, I believe that the hostility of an audience to which I am giving a talk is not only going to occur with every audience I face over the next ten years (that would be stable), but is also going to face me everytime I interact with people, whether it be in the form of a speech, a cocktail party, or a date, then that's global. I suggest to you that what *hopelessness* is, is taking your present helplessness, and *projecting* it *far into the future,* projecting it across *all endeavors of your life.*

Unstable-stable addresses the question, "Is the cause of this present bad event something that is transient?" If you fail an examina-

tion, for example, you might say, "I was tired. I was hung over." Those are causes that go away in time. Some people have the habit of making those kinds of causal statements. On the other hand, you might fail and say, "I'm stupid." "I have a hang over" and "I'm stupid" are both internal. But, stupidity abides. It's the kind of cause that's going to hurt you far into the future, on later examinations. That's the reason that this dimension is important.

If, for example, you have a patient who's a tax accountant, and she's been fired from her job, it's important to know whether or not she's going to start looking for another job soon or whether she's apt to be knocked out for a long time. The unstable-stable dimension tells you that. If she chronically believes that bad events are stable, then she's not going to be resilient from depression. If, on the other hand, she believes they're unstable, then she's going to bounce back more quickly.

Now, let's move to "specific-global." That involves the question, "Is it going to hurt me just in this one situation? Or, is this something that will undermine all my endeavors?" For example, if you take an examination and you fail it you might say, "I'm stupid," which is global.

You might say, "I'm stupid at math," which is specific because it's just about that one kind of subject matter. If you're rejected by a woman you love, you might say, "She's a bitch," which is just about her. Or, you might say, "Women are impossible!" which is about women in general. Now, take your accountant. You want to know where her depressive symptoms are going to show up. Is she going to be unable to look for a new job, and not do her own income tax? Or, will she also lose her sense of humor, lose her libido, and not go to social gatherings anymore? The theory says that to the extent that she makes habitually specific explanations to that event, she'll just not do her income tax or look for another job. To the extent that she believes that bad events are caused by global factors, depressive symptoms are going to occur across the board.

That's the theory, basically. If you put these three dimensions together and ask yourself, "What is the worst way of walking around the world as far as predicting depression goes?", it is people who say, chronically, "It's me. It's going to last forever. It's going to undermine everything I do." Such people should, in this theory, be at highest risk for depression when they come across bad events.

So, the theory we're going to look at is a simple one. It says that if you can identify these people, and then look at depression, achievement, and ill health, you can predict that these are the people who are most at risk for depression, most at risk for not living up to their potential, and most at risk for getting physically ill. Conversely, people who say, "You did it to me. It's going to go away quickly," and "It's just this one thing," should be the people most resistant to depression, most likely to live up to their potential in achievement, and most likely to be physically healthy.

Well, given that theory, we now ask, "How do you *measure* the word in the heart? Is there a way you can quantify attributional or explanatory style?" So, we did what all of you would do, we devised a questionnaire. It's called the Attributional Style Questionnaire (ASQ) (Peterson, Semmel, von Baeyer, & Seligman, 1982). It's a 20-minute questionnaire. On this questionnaire, there are 12 different scenarios. This is a projective test in the classic sense of projective; it gives you 12 hypothetical situations that might have happened to you, and you're asked, "If this did happen to you, what would the most likely cause of it be?" Six of the scenarios are good ones, and six of them are bad. I will consider just the bad ones here.

One of the questions is, "You've been looking for a job quite unsuccessfully for some time. Think for a moment. If that happened to you, what would the most likely cause be?" Well, you might write down, "There are too many psychologists in California." Then you're asked to answer questions about the internal, stable, and global dimensions of the cause you gave. So, the first question is, "Is the cause of your unsuccessful job search due to something about other people or circumstances," (which is a 1 on the scale), "or totally due to you" (which is a 7)? Well, "too many psychologists in California" is attributing it to other people or circumstances. But, *you* chose to be a psychologist, so you might give that a 1, 2, or 3. Then you're asked, "In the future, when looking for a job, will this cause again be present?" Is this glut of psychologists something that's going to continue far into the future, or is it going to change? "Well, economic trends and fashions in Ph.D.'s come and go. So, on a scale from "will never again be present" to "will always be present," you're probably going to give that a 4.

Finally, the global-specific dimension. "Is the cause of too many psychologists in California something that just influences looking for a job, or does it also influence other areas in your life?" It is

rated from, "It influences only this particular situation" to, "It influences all situations in my life." Well, "too many psychologists in California" probably just affects your professional life and doesn't affect your love life or athletic life. So, you'd probably give that a 1, 2, or 3. What you then do with the questionnaire is take all the bad items, average them together, and you get a profile. I won't bore you with the psychometrics, but they're decent, and as you'll see, the scale seems to do what it is supposed to do.

About seven years ago, after we had done 50 studies on the questionnaire, it occurred to us that there are quite a number of people whose behavior, achievement, depression, and whose longevity we wanted to predict, who won't answer questionnaires. Presidents of the United States, athletic celebrities, and the dead, are all examples of people who won't do that. No, *that's* not the joke! So, we asked the question, "Could you validly measure the word in the heart by reading something that someone wrote or listening to something that someone said?" This is what I spend most of my time doing these days—looking at archival documents: therapy transcripts, diaries, presidential press conferences, nomination speeches and the like, and asking, "Can you quantify the optimism and pessimism?"

Let me show you how we do this. Imagine that you're an undergraduate rater and you're reading through a therapy transcript. Your job is to find a bad event and then find causal statements in which the person tells you what caused the bad event. So, let's consider part of a therapy transcript from a depressed patient in Minnesota undergoing cognitive therapy. She says, "About four months ago, he called me on the telephone from where he's been working. He told me our relationship was over." Underline the bad event ". . . our relationship is over."

Now you scan the transcript for the cause. What does she think is the cause? "I felt devastated." No, that's a consequence. "I tried to argue, but what could I say? I still flipped out." Now, she gives you the cause: "I guess I'm just no good at relationships. I've never been able to keep a man interested in me." So, what you do is you take that event and the cause, and you put it on an index card and you give it to a panel of raters. The panel of raters is blind to who this is, what else this person has said, and even to what study it's from. They just have a bulk pack, basically, in which therapy statements, presidential statements, and statements from cancer patients are all

shuffled together. Here's what the judges do. It's the judges' job to treat the item on the index card as if it were a questionnaire item and to rate it on the three dimensions on the 1 to 7 scale.

First they have to rate whether it was a good or bad event. "Our relationship is over" is, to this woman, clearly a bad event. Then she says, "I'm just no good at relationships, I've never been able to keep a man interested in me." You have four raters. To what extent is that attribution external—i.e., not due to the person? Or, to what extent is that internal? She says, "*I'm* just no good at relationships." The judges give it 6s and 7s.

Then, on the next dimension, which is unstable-stable, she says, "I've never been able to keep a man interested in me." She uses the word "never." The judges have to rate for stability. Is this cause something that goes away in time? Or, is it something that's going to go on far into the future? Well, the tense of the verb and the word "never" tells us it's stable. She believes it's going to last for a long time, so all judges give that 7s.

Finally, is "not being able to keep a man interested in me, not being good in relationships," something that hurts you just with men, or is it something that hurts you across all domains of your life? The judges give that 1s, 2s, and 3s. So, what you do then is take all the causal statements, put them together, and form a profile for the person's explanatory style. It turns out that the profile coincides pretty well with what a person would have done on the questionnaire. Thus, from now on, I will refer to the results from natural speech—we call this "CAVE" (Content *A*nalysis of *V*erbatim *E*xplanations) (Peterson, Luborsky, & Seligman, 1983)—and to the results of the Attributional Style Questionnaire interchangeably. Those are the two ways of identifying attributional style.

Now, I want to offer a brief discussion of *depression*. The proposition we'll be looking at is that people who chronically believe that bad events are internal, stable and global—even if they're not depressed now—when they come across bad events, are at significant risk for becoming depressed. That is, an internal, stable, and global attributional style is a risk factor for depression in exactly the same way smoking cigarettes is a risk factor for lung cancer. To begin to address this question, we gave the questionnaire to a bunch of students, looked at their depressive symptoms, and asked the question, "Are people who have depressive symptoms also pessimistic on the explanatory style questionnaire?" The study shows that depressed

students are more likely to believe, "It's me, it's going to last forever, and it's going to undermine everything I do," than are non-depressed students. There are a number of studies that bear this out.

After a little while, we began to ask the question, "Is this also true of severely depressed patients (i.e., the suicidal, unipolar depressed patients who show you the same internal-stable-global attributional style profiles)?" There are about 30 studies on patients now. The latest one has 45 unipolar depressed patients, ten manic-depressives during the depressed phase, and a large number of controls. What it tells you is that both unipolar depressed and bipolar depressed patients are significantly more pessimistic than are controls. In addition, what the high correlation tells you is that the more depressed they are, the more pessimistic they are. There's one other thing worth mentioning about this kind of data: If you want to predict statistically the length of the episode of depression from when a patient walks into your office, you look at the stable dimension. How stable bad events are generally in her life is correlated about 0.65 with length of episode. So, as the theory suggests, the length of the depressive episode is well predicted by the stability dimension.

One of my main interests these days is prepubescent children (Nolen-Hoeksema, Girgus, & Seligman, 1986). There is an Attributional Style Questionnaire for children. It's a forced choice questionnaire in which, if they did well on a test, they're asked, "Is the cause because you're smart, or because you're smart at math?" They get to pick a response. Now, this is a group of children who self-report depressive symptoms from a childhood depression inventory. They take the childhood scale, and, indeed, depressed children are more internal, stable, and global than are non-depressed children.

About two years ago, someone undertook a meta-analysis of 104 studies involving 15,000 subjects of the question of what the relationship of attributional style is to depression (Sweeney, Anderson, & Bailey, 1986). It was found that the style, "It's me, it's going to last forever, and it's going to undermine everything I do," is very reliably correlated in a moderate-sized effect across these large numbers of studies. One of the things calculated is the "File Drawer Statistic." That's a cute statistic that tells you how many negative results, i.e., research papers, would have to be sitting unpublished in peoples' file drawers in order to overturn the results. It would

have to be about 10,000 or so! So, that suggests that this is indeed a fact—that when you're depressed, you're more internal, stable, and global about bad events.

That really is not a very exciting fact, if you think about it for a moment. The interesting hypothesis is that having this way of looking at bad events, "It's me, it's going to last forever, and it's going to undermine everything I do," *precedes* and *puts you at risk for* depression. But, these are all correlational studies that merely show you that when you're depressed, you're also pessimistic. Now, there are a lot of possibilities other than the risk factor possibilities compatible with these data. One is that you're optimistic, you suddenly become depressed, and depression makes you a pessimist. So here, causation goes the other way. Another possibility is that there may be some third variable, like the way you handle anger, or your catecholamine level that makes you *both* pessimistic and depressed. The worst possibility of all is that it's just a tautology.

Part of the way we diagnose whether or not people are depressed is that they tell us, "It's me, it's going to last forever, and it's going to undermine everything I do." In the jargon, it's just "common method variance." All the rest of the studies I'm going to talk about are studies that separate out the interesting causal possibility, i.e., the risk factor possibility, from all the other uninteresting possibilities. They're all studies of the form in which you first measure a person's optimism or pessimism, and you measure their depression. Then you try to predict what's going to happen to them in the future from the earlier style. Now, the ideal way of doing such a study is called an experiment of nature. Get a town on the gulf coast of Mississippi, measure everyone's explanatory style and measure everyone's depression, and then wait until the hurricane hits. Then, see if you can predict who's going to lie there in the mud versus who is going to get up and rebuild the town. Now, there are ethical and funding problems to studies of this sort.

I was stymied as to how you would actually test this theory until one of my undergraduate students said, "Gee, Dr. Seligman, there are natural disasters that hit your classes twice a year!" Those are my midterm and final examinations. I'm the last person in my university to curve at "C." My examinations are very hard, and it seemed that this was a good way in which to test the theory. In the first natural disaster experiment, when people came to my class in September, they filled out depression inventories and Attributional

Style Questionnaires (Metalsky, Abramson, Seligman, Semmel, & Peterson, 1982). Six weeks later in October, as the midterm approached, we asked them, "What would count for you as a failure on the midterm?" Students said "B+," on the average. That was very good, because what it meant was that almost everyone was going to be a subject in this experiment! A week later, they get their midterm, and they moan and groan. A week after that, they get their midterm back with their grade, along with the Beck Depression Inventory to fill out. Then, six weeks later, they get all this stuff again. Here, we're looking at large changes in depression. We're asking the question, "Who becomes clinically depressed?" following failure on a midterm in their own eyes.

The probability of showing strong changes in depression, given that you fail the midterm in your own eyes, is about 30 percent. What's the probability of becoming depressed, given that you're a pessimist in September? That probability is also about 0.3. Now, the crucial probability is the probability of becoming depressed given that you *both* failed the midterm in your own eyes, and you were a pessimist to begin with. That's about 0.7. So, that tells you that statistically you can predict in advance who is most vulnerable to developing depressive symptoms when they fail in the classroom—it's the pessimists.

Let's go to another experiment of nature. Several of us are doing a five-year longitudinal study of four hundred children that was started when they were in the third grade at age eight (Nolen-Hoeksema et al., 1986). There are 700 parents involved as well. Every six months the children get the Kiddie Attributional Style Questionnaire, depression ratings, popularity ratings, and life event ratings. Their parents do similar ratings. What we're trying to do here is predict which children will become depressed over the course of the next five years, and which children will do poorly in school, at least more poorly than they should. These are results from the first few waves of the study. If you're a third grader and you come into school in September and you're not depressed, and you're an optimist, the chances are you're going to remain nondepressed. If you come into school in September and you're a pessimist and you're not depressed, the chances are that you're going to get depressed. If you're an optimist and you come in depressed, the chances are you're going to get better. If you're a pessimist and you come in depressed, the chances are you're not going to recover.