CBT for depression and Martin Seligman

How CBT treats depression, what the learned helplessness experiments showed, and why their authors turned the theory around fifty years later

DRAFT this text has not yet been approved by the author and may change.

18 chapters ~41 min read

How solid is each fact

Proven by research | Clinical consensus | In the author's own words | Interpretation / disputed | Documented fact | Not verified

In short

- **Depression is not laziness or a bad mood.** It is a state in which low mood or loss of interest lasts most of the day, nearly every day, for at least two weeks. The WHO describes its causes as a complex mix of social, psychological and biological factors.
- **The treatment and the model came from different people.** The protocol for cognitive therapy of depression was set out by Aaron Beck and colleagues in 1979. Martin Seligman did not write it: he gave depression an experimental model ("learned helplessness") and a theory of why some people give up while others keep going.
- **The "helplessness" in the first experiments did not last.** In one 1967 paper, the effect of a single session was gone within two days, and about a third of the animals in those years' experiments never became passive at all.
- **How you explain a setback matters.** "It's me, it's forever, it's everything" is reliably linked to depression. But that is a link, not a proven cause, and certainly not a personal failing.
- **Fifty years on, the authors turned their theory around.** In 2016 Maier and Seligman wrote that passivity under prolonged stress is not learned; it is the default. What is learned, and detected, is control. These are animal data, and the authors call the implications for therapy speculative.
- **In CBT for depression, action often comes first.** Behavioural activation, a structured return to activities that give a sense of achievement or pleasure, did as well as full CBT in trials, without working on thoughts directly.
- **CBT works, but it is not the best of all.** Against no treatment the effect is clear; against other proper psychotherapies the difference is close to zero. Psychotherapy as a whole is on a par

with antidepressants, and the two together beat either alone.

- **Seligman's story has a dark chapter.** He lectured on helplessness at a military conference and met CIA psychologists; an independent review found too little information to say what he knew. Below we separate what is documented from what is not.

Timeline

Two lines, one clinical and one experimental, and the research that tested them.

1959–1961 — Beck studies the dreams of depressed patients and finds themes of loss and defeat rather than "anger turned inward"
COGNITIVE LINE

1967 — Beck's book on depression: automatic thoughts, the cognitive triad, schemas
COGNITIVE LINE

1967 — Seligman, Maier and Overmier: inescapable-shock experiments with dogs
BEHAVIOURAL LINE

1975 — Hiroto and Seligman: a similar effect in people, in the lab
BEHAVIOURAL LINE

1977 — Rush, Beck and colleagues: the first randomised trial of cognitive therapy against an antidepressant
EVIDENCE

1978 — Abramson, Seligman and Teasdale: the attributional reformulation
COGNITIVE LINE

1979 — Beck, Rush, Shaw and Emery: *Cognitive Therapy of Depression*
COGNITIVE LINE

1986 Meta-analysis of 104 studies: the way people explain setbacks is linked to depression

EVIDENCE

1989 Abramson, Metalsky and Alloy: hopelessness theory

COGNITIVE LINE

1996 Jacobson and colleagues: the behavioural part of CBT does as well as the full package

BEHAVIOURAL LINE

2000 First trial of MBCT, mindfulness-based cognitive therapy for preventing relapse

THIRD WAVE

2005 Hollon and colleagues: fewer relapses after cognitive therapy ends than after medication is stopped

EVIDENCE

2016 Maier and Seligman, "Learned helplessness at fifty": the theory turned around

BEHAVIOURAL LINE

2016 The COBRA trial: behavioural activation is not inferior to CBT

EVIDENCE

2022 UK NICE guideline on depression in adults (NG222)

EVIDENCE

2023 Meta-analysis of 409 trials of CBT for depression

EVIDENCE

The lines are a way of telling the story, not a strict classification. Seligman's positive psychology (from 1998) and the CIA controversy are not on the timeline; each has its own chapter below.

How to read these notes

Every key claim carries a label in brackets showing how solid it is. **Proven by research**: randomised trials (participants are assigned to groups by chance and compared) or meta-analyses (studies that pool many trials). **Clinical consensus**: clinical guidelines such as the UK's NICE, or the WHO's position. **The author's own account**: what the researcher or their centre says; not independently checked. **Interpretation**: a reading of the facts, including ours. **Documented fact**: dates, publications, posts. **Sources disagree**: both versions are given. **Not verified**: we could not open the primary source. Numbers are given as in the source, with the year.

> Important This is education, not therapy or diagnosis. These notes do not replace a doctor or therapist and are not a guide to treating severe depression on your own. They mention suicidal thoughts and hopelessness. If you are struggling right now, or having thoughts that you don't want to live, see If you need help now.

What depression is, and what it isn't

Before talking about treatment, it helps to agree on what we mean: clinical depression is not the same as a sad day.

In everyday speech, "depressed" can mean feeling low after a bad week or being unable to work for months. Clinically, it means the second. The WHO describes a depressive episode as low mood, or loss of interest and pleasure, for most of the day, nearly every day, for at least two weeks **clinical consensus; WHO, 2026**. Other signs usually come with it: disturbed sleep and appetite, tiredness, poor concentration, guilt or worthlessness, hopelessness.

The WHO estimates that depression affects about 5% of adults (5.2%) and is about one and a half times as common in women as in men **documented fact; WHO, 2026**. It describes the causes as a complex interaction of social, psychological and biological factors **clinical consensus; WHO, 2026**.

Example. After losing his job, a man barely leaves the house for two weeks, stops answering friends, wakes at 4 a.m. and thinks "it's all over". That is not a whim or a weak character. It is a reason to see a professional, not to "pull yourself together".

> Myth vs fact **Myth:** depression is laziness; just make an effort. **Fact:** the WHO describes depression as the result of a complex interaction of social, psychological and biological factors, and an episode differs from ordinary ups and downs in how long it lasts and how much it gets in the way of life **clinical consensus; WHO, 2026**. "Pull yourself together" usually adds shame and delays seeking help (interpretation).

When you need a doctor, not only a psychologist

Severe depression, psychotic symptoms, high suicide risk, past episodes of mania, no improvement with treatment, and any decision to start or stop medication call for a psychiatrist **clinical consensus; WHO, 2026; NICE, 2022**. NICE advises tapering antidepressants gradually, over months rather than weeks, and only together with a doctor **clinical consensus; Kendrick et al., 2022**.

Two lines: who gave us the treatment, and who gave us the model

Seligman's name is often put next to CBT for depression. That is only half right.

CBT for depression has two family trees, and they often get merged.

The clinical line: Aaron Beck. In the late 1950s this University of Pennsylvania psychiatrist set out to test the psychoanalytic idea that depression is "anger turned inward". In his own account, he expected more hostility in his patients' dreams and found instead themes of loss, defeat, rejection and a view of oneself as defective **the author's own account; Beck, 2008**. The cognitive model of depression grew out of that, and in 1979 so did the manual by Beck, Rush, Shaw and Emery, *Cognitive Therapy of Depression*: the treatment protocol itself **documented fact; Beck Institute, 2021**. Two years earlier, the first randomised trial had compared cognitive therapy with an antidepressant **documented fact; Rush et al., 1977**. Beck's story is told in Episode 1.

The experimental line: Martin Seligman. He worked at the same university, but in the lab. Animal experiments produced the model of "learned helplessness", then an attributional theory in people (more below) and school prevention programmes. This line never became a treatment protocol for depression **documented fact; Maier & Seligman, 1976; Abramson et al., 1978**.

In a sentence: Beck gave depression a treatment; Seligman gave it an experimental model and a question, why some people give up and others don't (interpretation).

Myth vs fact **Myth:** Seligman created CBT for depression, or co-wrote it with Beck. **Fact:** the protocol for cognitive therapy of depression is Beck, Rush, Shaw and Emery, 1979 **documented fact; Beck Institute, 2021**. Seligman developed the helplessness model, co-authored the attributional theory and led prevention programmes.

Who is Seligman

Martin Seligman graduated in philosophy from Princeton in 1964, earned his PhD in psychology at the University of Pennsylvania in 1967 and was president of the American Psychological Association (APA) in 1998. He is now a professor at Penn and director of its Positive Psychology Center **documented fact; Positive Psychology Center, Penn**. In his memoir *The Hope Circuit* (2018), according to a note on the book, he writes that he struggled with depression as a young man

the author's own account; Princeton Alumni Weekly. We did not read the whole book for these notes, so other biographical details are left out.

The dogs that didn't jump: the 1967 experiments

Where "learned helplessness" began, and what usually gets left out of the retelling.

The triadic design

In the mid-1960s Seligman and Steven Maier, then graduate students at Penn, ran an experiment with three groups of eight dogs documented fact; Maier & Seligman, 1976:

Group	What happened	What happened next
Control over shock	Received shocks and could stop them by pressing a panel	Quickly learned to escape
"Yoked"	Received exactly the same shocks but could do nothing about them	Six of eight never learned to escape
No shock	Received no shocks in the harness	Quickly learned to escape

The next day all the dogs were placed in a box with a low barrier: jumping to the other side stopped the shock. The yoked group is the clever part of the design. It got the same shocks as the group with control; the only difference was being able to do something about them. So the authors concluded that "not the shock itself, but the inability to control the shock" produced the passivity documented fact; Maier & Seligman, 1976. The original theory described three consequences of uncontrollable events: lower motivation, difficulty learning that a response works, and emotional changes such as anxiety and low mood the author's own account; Maier & Seligman, 1976.

The everyday example usually used to illustrate it. Someone sends out a hundred CVs and gets a hundred rejections. After a while they stop applying, even when a good vacancy appears. This is an analogy, not evidence: the experiment was on animals.

Two details that rarely make it into the retelling

First, in Overmier and Seligman's paper from the same year, helplessness after a single session was temporary. Tested 24 hours later, 50% of the dogs failed to escape; at 48, 72 and 144 hours, 12.5%, the same as dogs that had no shock at all proven by research, small samples; Overmier & Seligman, 1967.

Second, by the authors' own summary, of roughly 150 dogs given inescapable shock in 1965–1969, about two-thirds did not learn to escape documented fact; Maier & Seligman, 1976. So about a third

did not give up. Same shock, same procedure, different outcome. "Why do some give up and others don't?" became a running question in Seligman's work (interpretation).

Myth vs fact **Myth:** learned helplessness is permanent. **Fact:** in a 1967 experiment, the effect of one session faded within 48 hours, and about a third of the dogs never became helpless **proven by research; Overmier & Seligman, 1967; Maier & Seligman, 1976**.

On ethics

The experiments used electric shocks on dogs; in Overmier and Seligman's second experiment some animals were immobilised with a drug **documented fact; Overmier & Seligman, 1967**. Today such research raises serious ethical questions (interpretation). We found no document showing whether it breached the standards of its time, so we claim neither.

Why some people give up: from helplessness to explanatory style

The "dogs and shocks" model explained human depression poorly. The answer was that what matters is not only the event but how a person explains its cause.

Helplessness in people

In 1975 Donald Hiroto and Seligman tested 96 students. Some heard a loud noise they could not switch off; others worked on problems with no solution. Afterwards they did worse on a new task: switching off a noise with a different device, or solving anagrams. The effect appeared in all four experiments, including when the type of task changed **proven by research; Hiroto & Seligman, 1975**. The authors noted that this was a lab finding and that how long it lasts in real life was unknown.

The 1978 reformulation

By the late 1970s it was clear the old model did not fit people. In a paper with a frank title, "Learned helplessness in humans: Critique and reformulation", Lyn Abramson, Seligman and the British researcher John Teasdale named its weak points **the author's own account; Abramson et al., 1978**:

- it did not distinguish **universal** helplessness ("nobody could change this") from **personal** helplessness ("others could, I can't");
- it did not explain why depressed people think so poorly of themselves;
- it said little about why helplessness sometimes spreads across life and becomes chronic.

Their answer: people look for the cause of a setback, and that cause varies on three dimensions. An **attribution** is an explanation of why something happened; **attributional (explanatory) style** is a person's habitual way of making such explanations.

Dimension	Poles	What it shapes, according to the theory	Example
Internal vs external	"Me" or "the circumstances"	Whether self-esteem drops	"I'm stupid" vs "the test was unfair"
Stable vs unstable	"Forever" or "right now"	Whether helplessness becomes chronic	"I'm always like this" vs "I didn't sleep last night"
Global vs specific	"Everything" or "this area"	Whether it spreads to other areas	"I'm useless at everything" vs "sales isn't my thing"

the author's own account; Abramson et al., 1978

Example. Two people fail a job interview. One thinks: "I'm a failure, I'll never find work, nothing I do works out." The other: "I prepared badly for the numbers questions, and this company cares about numbers." Same event, different explanations. According to the theory, the first person is more at risk of the setback turning into helplessness.

What testing showed

A 1986 meta-analysis by Sweeney, Anderson and Bailey pooled 104 studies with nearly 15,000 participants. Attributing negative events to internal, stable and global causes had a reliable and significant association with depression; for positive events the links were weaker proven by research; Sweeney et al., 1986.

But these are correlations: they show that this style and depression go together, not that the style causes depression (interpretation). Depression may itself colour the explanations. So it is fair to speak of explanatory style as a vulnerability, not a fault.

> Important If you recognise yourself in "it's me, forever, everywhere", that does not mean you "think wrong" or are to blame for how you feel. The link between explanatory style and depression is correlational proven by research; Sweeney et al., 1986. It is something to notice, not something to criticise yourself for.

This line of work produced the Attributional Style Questionnaire (ASQ) and CAVE, a method for rating explanatory style from texts such as interviews or letters documented fact; Positive Psychology Center, Penn.

Hopelessness theory (1989)

Abramson, Metalsky and Alloy took the idea further, without Seligman. In hopelessness theory, vulnerability consists of three habits: putting bad events down to stable and global causes, expecting more bad consequences to follow, and drawing negative conclusions about oneself. In the authors' words, this vulnerability is "neither necessary nor sufficient" for depression: it works together with stress **the author's own account; Abramson et al., 1989, via the UNED review**.

In the Temple–Wisconsin project, students at high cognitive risk had a lifetime history of major depression in 42% of cases, compared with 17% of low-risk students **proven by research; via the UNED review**. These data are retrospective, collected after the fact, and do not prove causation.

Hopelessness also matters clinically: in Beck's tradition it is one of the key signs of suicide risk, and in 1974 Beck developed the Hopelessness Scale (BHS) to measure it **documented fact; see Episode 1**. This is why a good clinician always asks about thoughts of death when someone is depressed. It is part of safety, not a formality.

Fifty years on: "we got it backwards"

In 2016 the authors of learned helplessness revised its central idea.

In "Learned helplessness at fifty: Insights from neuroscience", Maier and Seligman wrote: "Passivity in response to shock is not learned. It is the default, unlearned response to prolonged aversive events" **the author's own account; Maier & Seligman, 2016, p. 349**. They described the original theory as having it backwards.

What changed, in brief **proven by research in animals; Maier & Seligman, 2016**:

	The 1967 theory	The 2016 revision
What is learned	The animal learns that nothing it does matters, and becomes passive	Passivity is the default response to prolonged stress; what is learned, and detected, is control
Mechanism	An expectation that responding is useless	Passivity is linked to activity in the dorsal raphe nucleus in the brainstem; when control is present, part of the prefrontal cortex "detects" it and inhibits that response
Key line	—	"It is the presence of control, not the absence of control, that is detected" (p. 353)

The **prefrontal cortex** is the front part of the brain involved in appraising situations and regulating responses. In rat studies, earlier experience of control protected against passivity later, even in a different, uncontrollable situation; the authors call this "immunisation" proven by research in animals; Maier & Seligman, 2016. Maier had put it simply in 2009: the brain's default is to assume that stress is not controllable the author's own account; Dingfelder, 2009.

An analogy. A child who has managed a hard task on their own a few times finds it easier to take on the next one, even an unfamiliar one. That is an analogy, not a transfer of rat data to people.

What the revision does not prove

- These are animal data. The authors themselves call the implications for human therapy speculative the author's own account; Maier & Seligman, 2016.
- The revision has critics: in their view the data are not enough to rule out learning, and helplessness after repeated failure is plainly seen in people (interpretation; Journal of Psychological Science, 2021).
- The idea that "control has to be learned, so the experience of acting helps" fits well with behavioural activation (below). But that is our interpretation, not the finding of a clinical trial (interpretation).

Myth vs fact **Myth:** helplessness is learned. **Fact:** in 2016 the theory's authors wrote that passivity under prolonged stress is the default and that control is what gets learned the author's own account; Maier & Seligman, 2016. The conclusion comes from animal studies, and it has critics.

How cognitive therapy for depression works

Beck's protocol: what changes in therapy, and in what order.

The cognitive model of depression

Beck's model rests on three ideas clinical consensus; Padesky, 2004; Beck, 2008:

- **The cognitive triad**: a negative view of oneself, the world and the future. For example: "I'm a failure, nobody cares, nothing will change."
- **Automatic thoughts**: quick appraisals that pop up on their own and feel true. For example, "I've ruined everything again" after being five minutes late.
- **Schemas**: deep, lasting beliefs that switch on under stress that matches their content. For example, "I'm unlovable" waking up after a break-up.

What is debated: the model describes how depression is maintained better than why it starts, and negative thinking is partly a symptom in itself (interpretation). More on the cognitive model in Episode 2, and on thinking errors in Episode 3.

The order of work

Following the classic description of the protocol clinical consensus; the 1979 manual by Beck et al. was not checked page by page for these notes:

1. Assessment, explaining the model, and building an overall picture of the case, known as case conceptualisation (Episode 4).
2. **Behavioural methods first**, especially when depression is marked: tracking what the person does through the day and how their mood changes; planning small activities; rating each one on two scales, achievement ("mastery") and enjoyment ("pleasure"); gradually making tasks harder (Episode 6).
3. **Cognitive methods**: catching an automatic thought, writing it in a thought record, checking what it rests on, finding a more accurate explanation, testing it in a behavioural experiment (Episode 5).
4. Work on deeper beliefs, and relapse prevention.

The working principle is **collaborative empiricism**: therapist and client test a thought together as a hypothesis rather than arguing about it clinical consensus; Padesky, 2004.

Example. A client with depression barely gets off the sofa. The therapist does not start with "why do you think that about yourself?" Instead, together they plan one ten-minute task for tomorrow, and the client rates their mood before and after. Only once there is a little more energy do they turn to thoughts like "I'm good for nothing".

> Myth vs fact **Myth:** CBT teaches positive thinking. **Fact:** CBT teaches you to check a thought for accuracy. Sometimes the thought turns out to be true, and then the conversation is about what to do about it clinical consensus; Padesky, 2004. And behavioural activation does not dispute thoughts at all, yet does as well as CBT proven by research; Uphoff et al., 2020.

Common mistakes the clinical tradition warns about: starting to "challenge thoughts" in severe depression without a behavioural phase; replacing the checking of thoughts with positive slogans; setting tasks that are too big and reading failure to do them as "resistance" rather than a symptom; not asking about suicidal thoughts (interpretation, general clinical tradition).

Action first: behavioural activation

One part of Beck's protocol turned out, in trials, to be as good as the whole thing, and became a method in its own right.

Taking the protocol apart

In 1996 Neil Jacobson and colleagues randomly assigned 150 outpatients with major depression to three conditions: behavioural activation alone; behavioural activation plus skills for working

with automatic thoughts; or full cognitive therapy, including work on core schemas. Four experienced cognitive therapists delivered all three, sticking closely to protocol. The full package did no better, either at the end of treatment or six months later. What is more, the behavioural component changed negative thinking and attributional style as much as the full therapy did **proven by research; Jacobson et al., 1996**.

This is one of the places where Seligman's ideas were tested directly inside a CBT trial: attributional style predicted outcome in the behavioural activation group but not in the full cognitive therapy group **proven by research; Jacobson et al., 1996**.

The lesson for theory: better thinking does not necessarily require working on thoughts directly. That argues against the simple chain "change the thoughts, and the mood will follow" (interpretation).

What behavioural activation is

Behavioural activation (BA) starts from the idea that depression is kept going by avoidance. You feel bad, so you stop doing the things that used to give you a footing and some enjoyment; life gets narrower, and you feel worse. In therapy, client and therapist spot these loops together and step by step return to activities that matter to the person, without waiting for the mood to "arrive" first **clinical consensus, general description; Uphoff et al., 2020**.

Example. Instead of spending the whole evening on the phone in bed because "I've got no energy", the person goes for a planned ten-minute walk and notes their mood before and after. The energy may not come straight away. The point is to test it rather than wait.

What the research shows

Study	Who took part	Result
Dimidjian et al., 2006	241 adults with major depression; BA, cognitive therapy, antidepressant, placebo	Among more severely depressed patients, BA was comparable to the antidepressant, and both outperformed cognitive therapy
Ekers et al., 2014	Meta-analysis of 26 trials, 1,524 participants	Against control conditions, SMD −0.74; most studies were of low quality, with short follow-up
COBRA, Richards et al., 2016	440 people: 221 BA, 219 CBT	At 12 months, the mean depression score on the PHQ-9 was 8.4 in both groups (difference 0.1); BA was not inferior to CBT
Uphoff et al., 2020 (Cochrane)	53 studies, 5,495 participants	No difference from CBT (RR 0.99; 95% CI 0.92–1.07); moderate certainty, mostly short-term data

proven by research; sources in the table

The most surprising detail in COBRA is who delivered the therapy. BA was given by junior mental health workers with no formal psychotherapy training; CBT by professional psychological therapists **proven by research; Richards et al., 2016**. The cost of the intervention itself was lower for BA (per The Mental Elf's summary, which gives no percentage).

The UK's NICE guideline ranks individual behavioural activation third for more severe depression, and group behavioural activation third for less severe depression **clinical consensus; NICE, 2022**.

Important A simple method does not mean severe depression can be treated alone from a checklist. In the trials, BA was delivered by trained staff following a protocol, with monitoring. For severe depression, this is work to do with a therapist and, as a rule, a doctor.

Therapy, pills or both: what the data say

Numbers from the largest meta-analyses and from UK guidelines.

How well CBT works

The meta-analysis by Cuijpers and colleagues (2023) covered 409 trials with 52,702 patients **proven by research; Cuijpers et al., 2023**. **g** here is a standardised difference between groups: 0 means

no difference, about 0.2 is small, about 0.5 medium, 0.8 large.

Comparison	Result
CBT vs no treatment or usual care	g = 0.79 (95% CI 0.70–0.89); still present at 6–12 months
CBT vs other psychotherapies	g = 0.06 (0–0.12); small, and non-significant in most stricter analyses
CBT vs antidepressants at 6–12 months	g = 0.34 in favour of CBT, but based on few trials and not significant in all analyses
CBT plus medication vs medication alone	g = 0.51 short term, 0.32 long term
Unguided CBT self-help	g = 0.45
Children and adolescents	g = 0.41

The takeaway: CBT is the most studied method, not the only right one. Other proper psychotherapies work about as well (interpretation; Cuijpers et al., 2023).

A 2020 network meta-analysis (101 trials, 11,910 patients) compared psychotherapies as a group with medication: response rates did not differ (RR 0.99), and the combination beat both medication alone (RR 1.25) and psychotherapy alone (RR 1.27) **proven by research; Cuijpers et al., 2020**. The authors say long-term effects need more research.

There is also a worry that CBT has become less effective over the years. A reanalysis that added 30 trials concluded that this decline was most likely a spurious finding **proven by research; Cristea et al., 2017**.

The effect that outlasts therapy

Hollon and colleagues (2005) followed 104 people with moderate to severe depression who had responded to treatment. Over the next year, 30.8% of those who had finished cognitive therapy relapsed; 76.2% of those switched from an antidepressant to placebo; and 47.2% of those who stayed on medication. Therapy differed significantly from placebo but not from continued medication. The authors concluded that "cognitive therapy has an enduring effect that extends beyond the end of treatment" **proven by research; Hollon et al., 2005**.

Limitations: the sample was small, and the trial ran at centres where cognitive therapy was being developed (interpretation). This does not mean pills are worse. It suggests the skills stay with the person.

What NICE recommends (2022)

The UK guideline splits depression into "less severe" (mild and subthreshold) and "more severe" (moderate and severe) clinical consensus; Kendrick et al., 2022.

Less severe depression (recommended order)	More severe depression
1. Guided self-help	1. Individual CBT + antidepressant
2. Group CBT	2. Individual CBT
3. Group behavioural activation	3. Individual behavioural activation
4. Individual CBT	4. Antidepressant
5. Individual behavioural activation	5. Individual problem solving
6. Group exercise	6. Counselling
7. Group mindfulness and meditation	7. Short-term psychodynamic psychotherapy
8. Interpersonal psychotherapy	8. Interpersonal psychotherapy
9. SSRI antidepressants	9. Guided self-help
10. Counselling	10. Group exercise
11. Short-term psychodynamic psychotherapy	

clinical consensus; NICE, 2022

For less severe depression any option can come first, but the least intrusive one, guided self-help, should be considered first; antidepressants are not offered routinely as a first-line treatment unless the person prefers them. In both cases, if someone has a clear preference or a good past experience with a treatment, that choice is supported clinical consensus; NICE, 2022. **Guided self-help** means working through CBT-based materials with regular support from a practitioner, not reading a book alone.

Myth vs fact **Myth:** therapy is for mild depression; for severe depression only pills help. **Fact:** for more severe depression NICE puts CBT plus an antidepressant, and CBT alone, at the top, and for less severe depression it does not routinely offer an antidepressant first clinical consensus; NICE, 2022. Therapy and medication are not rivals: together they work better proven by research; Cuijpers et al., 2020.

When depression comes back: MBCT and CBASP

For some people depression recurs. There are dedicated methods for that, and one of them links back to Seligman's co-author.

Relapse means depression returning after improvement.

MBCT: seeing thoughts rather than arguing with them

Mindfulness-based cognitive therapy (MBCT) was developed by Zindel Segal, Mark Williams and John Teasdale, the same Teasdale who co-wrote the 1978 reformulation documented fact; Segal et al., 2002. It is delivered in groups. Its idea is not to test whether thoughts are true but to learn to relate to them as events in the mind, known as **decentring** the author's own account; Segal et al., 2002. For example: not "I'm a failure" but "I'm having the thought that I'm a failure".

Study	Result
Teasdale et al., 2000	In people with three or more past episodes, MBCT significantly reduced the risk of relapse over 60 weeks
Ma & Teasdale, 2004	With three or more episodes, relapse fell from 78% with usual care to 36% with MBCT; no benefit was shown for people with two episodes
Kuyken et al., 2016	Individual patient data from 9 trials (1,258 people): lower risk of relapse over 60 weeks than without MBCT (HR 0.69) and than with other active treatments, including antidepressants (HR 0.79)

proven by research; sources in the table

A **hazard ratio** (HR) of 0.69 means that at any point during follow-up the risk of relapse was roughly a third lower. According to Kuyken and colleagues, MBCT seems to help more those who had more pronounced residual symptoms before starting proven by research; Kuyken et al., 2016. NICE recommends group CBT or MBCT to prevent relapse in people with recurrent depression clinical consensus; Kendrick et al., 2022. More on MBCT in Episode 13.

CBASP: for chronic depression

James McCullough's Cognitive Behavioral Analysis System of Psychotherapy (CBASP) was designed for chronic depression. It focuses on the consequences of a person's behaviour in relationships, including the relationship with the therapist, and on solving interpersonal problems the author's own account; Keller et al., 2000.

In the trial by Keller and colleagues (2000), with 681 adults with chronic depression, 48% responded to medication alone (nefazodone), 48% to CBASP alone and 73% to the combination

proven by research; Keller et al., 2000. But in the REVAMP trial (2009), adding CBASP or supportive psychotherapy to a medication that had not worked gave no significant advantage proven by research; Kocsis et al., 2009, as summarised in American Family Physician, 2010. The honest summary: combined with medication, CBASP did well; as an add-on after medication failed, it did not (interpretation).

Seligman after helplessness: positive psychology and resilience programmes

Seligman's next big project, and how it fares against the data.

Positive psychology

As APA president in 1998, Seligman launched a programme he called positive psychology: studying not only illness but strengths and well-being. The 2000 manifesto he wrote with Mihaly Csikszentmihalyi opens with a story. Seligman was weeding the garden with his five-year-old daughter Nikki and snapped at her. She reminded him that she had recently stopped whining and said that if she could stop whining, he could stop being such a grouch. "I was a grouch," Seligman admits, and he writes that he realised then that raising children is far more than fixing what is wrong with them. He carried the same thought over to psychology the author's own account; Seligman & Csikszentmihalyi, 2000.

How well do positive interventions, such as gratitude exercises, work? A reanalysis of meta-analyses (White, Uttl & Holder, 2019), after correcting for small samples, found a small effect on well-being (around r = 0.10), while the effect on depression was unstable and, overall, non-significant proven by research; White et al., 2019.

> Myth vs fact **Myth:** positive psychology means "think positive and smile". **Fact:** it is a research programme on strengths and well-being the author's own account; Seligman & Csikszentmihalyi, 2000. Its interventions turned out weaker than first reported proven by research; White et al., 2019.

The Penn Resiliency Program

Seligman's group, with Jane Gillham and Karen Reivich, created the Penn Resiliency Program (PRP) for schools. Young people learn to notice and test their thoughts, look for alternative explanations, solve problems and stand up for themselves documented fact; Positive Psychology Center, Penn. In essence, these are CBT skills used for prevention.

A 2009 meta-analysis (17 studies, 2,498 young people) found a small effect: at 6–12 months, slightly fewer depressive symptoms than with no programme (d from 0.11 to 0.21), but no fewer than with another active programme, and no significant effect on diagnoses of depression

proven by research; Brunwasser et al., 2009. One of the meta-analysis authors is a developer of the programme. PRP is prevention with a small effect, not a treatment for depression (interpretation).

The army's CSF programme

Building on this approach, the US Army launched the Comprehensive Soldier Fitness resilience programme in 2009, and the University of Pennsylvania trained sergeants for it documented fact; Burling, 2009. Reported costs vary, from 100 to 140 million dollars over different periods sources disagree; Burling, 2009; Coalition for an Ethical Psychology, 2012. Critics argued that the programme was rolled out without being tested: PRP had never been studied with soldiers or for preventing PTSD, and the only evaluation was an internal report with tiny effects (interpretation, peer-reviewed review; Steenkamp et al., 2013).

The dark chapter: Seligman and the CIA interrogation programme

It is easy to say more here than the documents support. So let us separate what is documented, what the investigation concluded, what Seligman says and what his critics say.

What the documents show

- According to the independent review for the APA (the Hoffman Report, 2015), psychologists working with the CIA, including James Mitchell, met Seligman at his home to understand the theory of learned helplessness; Seligman was invited to speak about it at a conference of SERE, a military programme that trains personnel to survive captivity and resist interrogation documented fact; Hoffman et al., 2015, pp. 44, 49.
- The lecture took place on 17 May 2002 in San Diego documented fact; Seligman, 2018.
- According to the 2014 report of the US Senate Select Committee on Intelligence, two contract psychologists based the "enhanced interrogation techniques" on the theory of learned helplessness; neither, the report says, had interrogation experience documented fact; via the peer-reviewed article by Aggarwal, 2015. Seligman is not named in the quoted passages. We did not open the Senate report itself.

What the investigation concluded

The Hoffman Report states: "we do not have enough information to know what Seligman knew or thought at the time." Alongside this, the authors add that it would be difficult not to suspect that one reason for the CIA's interest in learned helplessness was how it might be used in interrogations documented fact; Hoffman et al., 2015, p. 49. The review found no link between this and the APA's actions and did not pursue the question further documented fact; Hoffman et al., 2015, p. 49
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What Seligman says

- At the lecture he "spoke in detail about the scientific literature on learned helplessness", including how captured American personnel might resist; "there was no mention of detainees" **the author's own account; Seligman, 2018**.
- "If I had known about the methods employed, I would not have discussed learned helplessness with them" **the author's own account; Seligman & Shaw, 2016**.
- "Brutality is not the same thing as learned helplessness" **the author's own account; Seligman, 2018**.
- His only contract with the CIA, he says, was in the early 1980s, analysing world leaders' speeches for optimism and pessimism **the author's own account; Seligman, 2018**.

What critics say

The philosopher Tamsin Shaw called his claim of ignorance "extraordinary" (interpretation; Seligman & Shaw, 2016). Other critics wrote that if Seligman was kept in the dark, he was evidently deceived (interpretation; Soldz et al., 2008).

How to put it fairly: Seligman lectured on helplessness and met CIA psychologists; that is documented. What he knew about how it would be used, the investigation could not establish. He denies involvement. Neither "he designed the torture" nor "he was fully cleared" matches the sources (interpretation).

> Myth vs fact **Myth:** Seligman designed the CIA's torture methods. **Fact:** documented are a lecture on helplessness at a SERE conference in 2002 and meetings with CIA psychologists; according to the Senate report, the methods were built by two other contract psychologists; the Hoffman Report says there is not enough information on what Seligman knew; he denies involvement **documented fact; Hoffman et al., 2015; Seligman, 2018; Aggarwal, 2015**.

What follows from all this

Putting it together, and how knowing about helplessness can be useful in ordinary life.

Helplessness, reversed

If passivity is the default response to prolonged stress and control has to be detected, then in depression it is not enough to talk yourself out of "negative thinking". What is needed is fresh experience that acting changes something. That, in effect, is what behavioural activation does. To repeat: this is our comparison, not the finding of a clinical trial (interpretation; Maier & Seligman, 2016; Jacobson et al., 1996).

A second useful point comes from attributional theory. An explanation of a setback is a hypothesis, not a verdict. Three questions can help you observe yourself: is the cause entirely in

me? Is it forever? Is it everywhere? These are prompts for attention, not a treatment technique (interpretation; Abramson et al., 1978).

Example **One act of control.** Choose a five-minute task you can definitely influence: wash one cup, reply to one email, step out onto the balcony. Rate your mood from 0 to 10 before and after. Expect nothing; just notice whether anything changed. This is what the very first element of activity scheduling in therapy looks like **clinical consensus; Uphoff et al., 2020**. It is not treatment and does not replace therapy.

Important If low mood or loss of interest lasts more than two weeks and gets in the way of life, see a professional. If you have thoughts of death or of not wanting to live, don't stay alone with them: see If you need help now.

Myths at a glance

Myth	Fact	Label
Depression is laziness	A complex interaction of social, psychological and biological factors	**Clinical consensus**
Seligman created CBT for depression	The protocol is Beck and colleagues, 1979; Seligman gave the helplessness model and attributional theory	**Documented fact**
Learned helplessness is permanent	One session's effect faded within 48 hours; a third of the dogs didn't give up; in 2016 the authors called passivity the default	**Proven by research / the author's own account**
CBT is positive thinking	Thoughts are checked for accuracy; behavioural activation doesn't dispute them at all	**Clinical consensus / proven by research**
Therapy for mild depression, pills for severe	For more severe depression NICE puts CBT plus an antidepressant, and CBT alone, first	**Clinical consensus**
CBT only helps for a while	Relapse within a year: 30.8% after cognitive therapy vs 76.2% after switching medication to placebo	**Proven by research**
Seligman designed the CIA's torture	The lecture and meetings are documented; what he knew is not established; he denies involvement	**Documented fact / the author's own account**

Check yourself

1. **Who wrote the protocol for cognitive therapy of depression?** Beck, Rush, Shaw and Emery, 1979. Seligman did not.
2. **Why did the 1967 experiment need a "yoked" group?** It received the same shocks as the group with control but could not affect them, which showed that the passivity came from lack of control, not from the shock.
3. **What does each of the three attribution dimensions shape?** Internal causes affect self-esteem, stable ones chronicity, global ones spread to other areas. The link with depression is reliable but correlational.
4. **What changed in the theory in 2016?** Passivity under prolonged stress came to be seen as the default; what is learned, and detected, is control. These are animal data.
5. **What did the COBRA trial show?** Behavioural activation delivered by staff without psychotherapy training was not inferior, after a year, to CBT delivered by professional therapists.

Key takeaways

- Beck gave depression a treatment; Seligman gave it an experimental model and the question of why some people give up and others don't.
- An "it's me, forever, everywhere" explanatory style is linked to depression, but it is a vulnerability, not a fault.
- The authors of learned helplessness revised their own theory: by their animal data, passivity under prolonged stress is the default, and control has to be detected.
- In CBT for depression, action often comes first, and behavioural activation does as well as full CBT.
- CBT works but is no better than other proper psychotherapies; psychotherapy and medication are comparable, and together they work better.
- Relapse is less common after cognitive therapy ends than after medication is stopped; for recurrent depression, MBCT helps.
- Severe depression, suicidal thoughts and decisions about medication call for a doctor.

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