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I just can't stop thinking about it! Rumination, avoidance and depression

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Introduction

Rumination or "overthinking" (e.g., Nolen-Hoeksema, 1987) is a passive focus on feelings, symptoms and thoughts which appears to maintain and exacerbate depressed mood. Although originally conceptualised to have specific deleterious effects on depression, there is growing evidence to suggest that rumination may also be associated with worry, avoidance behaviours, impaired problem solving and interpersonal problems.

In this article, we review research on rumination and consider the association between rumination and depression. We highlight recent research that indicates an interesting association between rumination and avoidance and outline treatments that implicitly or explicitly target rumination. We also summarise strategies for reducing rumination.

Nolen-Hoeksema (1987) suggests three ways that a ruminative style of coping can exacerbate and perpetuate negative mood and contribute to depression. It may be that engaging in this passive coping strategy makes it more likely that people will not engage in more active ways to cope with their depressed mood (e.g., seeking positive reinforcement from the situation or leaving the negative situation). Also, negative mood is more likely to make the person encounter other negative memories through semantic connections in memory (e.g., Bower, 1981). Finally, Nolen-Hoeksema (1987) suggests that rumination may amplify depressed mood by making the ruminating person more likely to generate helpless explanations for their situation and thus perpetuate their belief that they are depressed.

The empirical support for the relationship between rumination and depression has come from experimental, community and clinical studies. The tendency to engage in rumination has typically been assessed with a scale developed by Nolen-Hoeksema and Morrow (1991), the Response Style Questionnaire, a self-report measure (see Table 1 for sample items).

Table 1.
Sample items from the Response Style Questionnaire.

I think about my feelings of fatigue and achiness
I think about how passive and unmotivated I feel
I think "I won't be able to do my job/work because I feel so badly"
I think about how I don't feel up to doing anything
I think about how hard it is to concentrate
I think about how alone I feel

Note: Questions are answered with "never", "sometimes", "often" or "always"

There is evidence that depressed individuals can reliably assess their own responses to depressive symptoms, regardless of severity (Kuehner & Weber, 1999; Nolen-Hoeksema & Morrow, 1993; Nolen-Hoeksema, Parker, & Larson, 1994) and that this self-report is correlated with actual behaviour (Just & Alloy, 1997). The tendency to ruminate appears to be stable over time, and this stability remains evident even when symptom status changes (Just & Alloy, 1997; Kuehner & Weber, 1999; Nolen-Hoeksema, Morrow, & Fredrickson, 1993; Nolen-Hoeksema, Parker, & Larson, 1994), including when depression has remitted (Roberts, Gilboa, & Gotlib, 1998).

Clinical implications of rumination

Most studies find that a ruminative response to low mood and other depressive symptoms is associated with increased severity and duration of depression (Butler & Nolen-Hoeksema, 1994; Morrow & Nolen-Hoeksema, 1990; Nolen-Hoeksema & Morrow, 1991; Trask & Sigmon, 1999). In individuals with depression, rumination has been associated with a poorer outcome, irrespective of initial depression severity (Ezquiaga et al., 2004; Hoffman, Baldwin, & Cerbone, 2003; Kuehner & Weber, 1999) and with higher levels of hopelessness and interpersonal distress (Lam, Schuck, Smith, Farmer, & Checkley, 2003). In addition, Nolen-Hoeksema, Parker and Larson (1994) have shown that people who engaged in more rumination following the loss of a loved one were more depressed six months following the loss.

Nolen-Hoeksema and others have also reported that women are more likely than men to ruminate (Butler & Nolen-Hoeksema, 1994). Rumination may provide an explanation for why women experience more frequent and more severe depressive episodes than men (e.g., Nolen-Hoeksema & Morrow, 1991; Nolen-Hoeksema, Morrow, & Fredrickson, 1993). However, although gender differences in depression are evident in clinical samples, gender differences in rumination have only been reported in community samples, not in clinical samples (Bagby et al., 1999; Kuehner & Weber, 1999).

Rumination also seems to impair problem-solving abilities. Lyubomirsky and Nolen-Hoeksema (1993) found that individuals chose to ruminate (and refused to engage in distracting activities) because they felt that this strategy allowed them to gain more insight into their problems and to generate better solutions to their problems even when they thought they would enjoy the distracting activities. In addition to poorer problem solving, ruminators rate their problems as more severe, have more negative thoughts, more critical thoughts and blame themselves more for their problems, than non-ruminators (Lyubormisky, Tucker, Caldwell and Berg (1999). Rumination has also been linked to negative interpersonal effects. Individuals who ruminate have been found to be more likely to need and seek social support, but view the interpersonal support they receive as inadequate and unsatisfying (Nolen-Hoeksema & Davis, 1999; Nolen-Hoeksema, Parker & Larson, 1994).

Rumination is not (always) unhelpful

Although initially conceptualised as being unitary, Treynor, Gonzalez and Nolen-Hoeksema (2003) demonstrated that rumination has two components: a reflective, analytic component and a brooding component. Brooding (but not self-reflection) is associated with negative emotions. Similarly, Watkins (2004) has

suggested "modes" of rumination and demonstrated that ruminators who think about problems in an abstract, evaluative, overgeneral way, rather than a concrete, specific, problem-focussed way, are more likely to experience depressed mood (Moberly & Watkins, 2006; Watkins & Moulds, 2005).

Rumination, worry and avoidance

Jacobsen, Martell and Dimidjian (2001; Martell et al., 2001) suggest that rumination is a form of avoidance that disallows actively being involved in one's environment and actively engaging in problem-solving. By repetitively focussing on thoughts (but not engaging in problem-solving), rumination may also prevent contact with the emotional experience (Moulds, Kandris, Star, & Wong, 2007; Watkins & Moulds, 2004). One theory is that rumination is an emotional regulation strategy associated with incomplete processing of thoughts (Starr & Moulds, 2006). Avoidance may maintain this incomplete processing. Consistent with this theory, Moulds et al. (2007) found that rumination was associated with more behavioural and cognitive avoidance. It may be that rumination with its focus on the *content* of material prevents processing the emotionality of events. In other words, although ruminators talk and think about events that have happened, a focus on the verbal or more cognitive aspects of an event might distance them from the experience associated with the event. Without emotional experiencing it is possible that one cannot habituate to these or process them (c.f. Acceptance Commitment Therapy - ACT e.g., Hayes, Strosahl, & Wilson, 1999).

Clinical questions

No studies have yet examined rumination within the context of therapy. Therapists may have had the experience of a client who ruminates and noticed that although there is much intellectual discussion about a problem (and perhaps emotional reactivity), there is little emotional change or active problem-solving. If rumination is an avoidance strategy then an intellectual discussion may prevent emotional processing. It is also possible that some therapies, for example traditional cognitive behavioural approaches, increase rumination in some clients by asking them to focus on the content of their thoughts and the meaning of these thoughts, potentially providing the client with "better tools to ruminate".

Treatment and rumination

Interventions targeting rumination are emerging in the literature. In her book "Women who think too much" Susan Nolen-Hoeksema (2003) has outlined a number of strategies individuals can use to reduce rumination or over thinking. These are summarised below. A common focus of the third wave of cognitive therapies e.g. Mindfulness Therapy (Teasdale et al., 2000), Acceptance and Commitment Therapy (Hayes, e.g., Hayes et al., 1999) and Meta Cognitive Therapy (Wells, e.g., 2005) is to assist the individual to disengage from their ruminative thinking processes.

Mindfulness Therapy is based on the assumption that individuals who are depressed are more likely to begin a ruminative pattern triggered by feelings of sadness. The aim of mindfulness therapy is to help the individual become aware of this thinking pattern (Ma & Teasdale, 2004). By focusing on the reduction of rumination, mindfulness training significantly reduces the chance of relapse (Ma & Teasdale, 2004; Teasdale et al., 2000). Of note, mindfulness therapy was

developed as an intervention aimed at reducing relapse.

Metacognitive Therapy (e.g. Wells, 2005) was initially developed for the treatment of anxiety, but given the association of rumination and depression, has also been applied to depression. Rumination is seen as an inflexible means of coping which is maintained by both positive and negative beliefs about the impact of ruminating. The goals of metacognitive therapy are to socialise the client to the idea that rumination is one source of current problems, to facilitate abandonment of ruminative thinking, to enhance flexible control over cognitions and to challenge metacognitive beliefs.

Although not explicitly addressing rumination, Acceptance Commitment Therapy (ACT)[1] aims to teach individuals alternative strategies for managing thoughts, other than thinking about them or attempting to avoid thinking about them. The focus is experiencing (rather than avoiding) emotions in the pursuit of personally relevant values. Blackledge and Hayes (2001) note that it is not unpleasant emotions (or thoughts) that are distressing, but rather, it is the attempt to avoid these emotions that causes distress. They note (as other researchers have done) that attempts to avoid these emotions increase the frequency and severity of these emotions. ACT also focuses on the role of language in perpetuating distress. Individuals respond to words as if the words themselves are unpleasant stimuli (Blackledge & Hayes, 2001) and a similar avoidance occurs. Rumination can thus be conceptualised as a cognitive strategy for maintaining anxiety and avoidance.

Recently, Watkins et al. (in press) have developed "rumination-focussed cognitive behaviour therapy" targeted at residual symptoms of depression. Rumination is conceptualised as an avoidance strategy and treatment aims to reduce avoidance while increasing other behaviours. Clients are taught to recognise when they are ruminating and to shift their thinking. Some techniques to shift thinking include imagery exercises (clients imagine a time when they were thinking in a different/more helpful way) and behavioural experiments. Initial pilot data indicates significant clinical benefits of reducing rumination.

Conclusion

Recent years have seen a dramatic increase in research on rumination. Research indicates that rumination is an important clinical construct which not only exacerbates depression but has a number of other negative intra- and inter- personal consequences. Recent interventions that implicitly and explicitly address rumination show promising results.

Key References[2]

Jacobson, N. S., Martell, C. R., & Dimidjian, S. (2001). Behavioral activation treatment for depression: Returning to contextual roots. *Clinical Psychology: Science and Practice, 8*, 255-270.

Ma, S., & Teasdale, J. D. (2004). Mindfulness-Based Cognitive Therapy for Depression: Replication and Exploration of Differential Relapse Prevention Effects. *Journal of Consulting and Clinical Psychology, 72*, 31-40.

Moulds, M. L., Kandris, E., Starr, S., & Wong, A. C. M. (2007). The relationship between rumination, avoidance and depression in

[1] See David Mellor's article about ACT in the Winter 2006 volume of the Journal.

[2] A full list of references is available from Kumari Fernando: kumari.fernando@chmeds.ac.nz

a non-clinical sample. *Behaviour Research and Therapy, 45*, 251-261.

Nolen-Hoeksema, S. (1987). Sex differences in unipolar depression: Evidence and theory. *Psychological Bulletin, 101,* 259-282.

Nolen-Hoeksema, S. (2003). *Women who think too much*. New York: Henry Holt.

Teasdale, J. D., Segal, Z. V., Williams, J., Ridgeway, V. A., Soulsby, J. M., & Lau, M. A. (2000). Prevention of relapse/recurrence in major depression by mindfulness-based cognitive therapy. *Journal of Consulting and Clinical Psychology, 68*, 615-623.

Watkins, E. (2004). Appraisals and strategies associated with rumination and worry. *Personality and Individual Differences, 37*, 679-694.

Watkins, E., Scott, J., Wingrove, J., Rimes, K., Bathurst, N., Steiner, H., et al. (2007) Rumination-focused cognitive behaviour therapy for residual depression: A case series. *Behaviour Research and Therapy*, doi:10.1016/j.brat.2006.09.018.

Watkins, E., & Moulds, M. (2005). Distinct modes of ruminative self-focus: Impact of abstract versus concrete rumination on problem solving in depression. *Emotion, 5,* 319-328.

Wells, A. (2005). The metacognitive model of GAD: Assessment of meta-worry and relationship with DSM-IV generalized anxiety disorder. *Cognitive Therapy and Research, 29*, 107-121.

Appendix A

Strategies for dealing with Overthinking (Rumination)

The following strategies are summarised from Nolen-Hoeksema (2003; pages 78-79; 102-104). Please refer to this book for a more detailed description of each strategy.

Table 2.
Strategies to deal with Rumination

Realise overthinking is not useful.
Take a break/distract yourself from overthinking.
Do physical activity to distract yourself from overthinking.
Use thought stopping.
Appreciate that you can control your thoughts.
Use worry time scheduling – have a time set aside for overthinking.
Pray/Meditate.
Talk to friends/supportive others about your overthinking.
Write the thoughts onto paper.
Find enjoyable activities that increase positive feelings.
Is there an alternative/healthier perspective on this.
Accept your emotions.
Find simpler explanations for negative feelings first.
Are you judging yourself or comparing yourself to others?
Accept responsibility for changing what you can about the situation.
Brainstorm all the solutions you can to a problem.
Identify your values and see how you can move towards these.
Start a small action that moves you towards overcoming the problem.
Examine whether your standards are realistic.