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Assessing maladaptive repetitive thought in clinical disorders: A critical review of existing measures

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HIGHLIGHTS

- Repetitive thinking is a maintaining factor across clinical disorders.
- We highlight disorder-specific and transdiagnostic measures of repetitive thinking.
- Most measures assess disorder-specific thinking (e.g. depressive rumination).
- Measures show small-to-moderate correlations with symptoms of psychopathology.
- Transdiagnostic approaches may aid advances in theory and treatment.

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ABSTRACT

Rumination and worry have recently been grouped under the broader transdiagnostic construct of repetitive thought (Watkins, 2008). The purpose of this review is to provide an overview of scales used to assess repetitive thinking across a broad range of contexts: depression, anxiety, trauma, stress, illness, interpersonal difficulties, positive affect, and so forth. We also include scales developed or adapted for children and adolescents. In the extant literature, measures of repetitive thinking generally show small-to-moderate correlations with measures of psychopathology. This review highlights problems with the content validity of existing instruments; for example, confounds between repetitive thought and symptomatology, metacognitive beliefs, and affect. This review also builds on previous reviews by including newer transdiagnostic measures of repetitive thinking. We hope that this review will help to expand our understanding of repetitive thinking beyond the mood and anxiety disorders, and suggest ways forward in the measurement of repetitive thinking in individuals with comorbid conditions.

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1. Introduction

Repetitive thought (RT) is defined as thinking in a repetitive, frequent, attentive manner about oneself and one's world (Segerstrom, Stanton, Alden, & Shortridge, 2003). It may be adaptive (such as planning), benign (such as daydreaming) or maladaptive (such as worry). Rumination, worry, and post-event processing are examples of maladaptive RT. Alongside intrusive memories, safety behaviors, and metacognitive beliefs, RT has been identified as a definite transdiagnostic maintaining factor (Harvey, Watkins, Mansell, & Shafran, 2004). RT has been shown to play a role in the maintenance of disorders such as depression (Just & Alloy, 1997), anxiety (Wells & Carter, 2001), insomnia (Harvey, 2000), as well as psychosis and eating disorders (Ehring & Watkins, 2008).

The main purpose of this review is to provide a guiding framework for clinicians and researchers in clinical psychology who wish to assess some form of (maladaptive) RT. There is a wide range of scales available with which researchers and clinicians can assess RT, in the form of cognitive processes such as rumination, worry and post-event processing. However, surprisingly few reviews have been conducted on this topic (Nolen-Hoeksema, Wisco, & Lyubomirsky, 2008; Smith & Alloy, 2009).

Previous reviews have also been restricted to focusing on RT as related to one particular disorder, such as depressive rumination (Smith & Alloy, 2009). To our knowledge, no review to date has included transdiagnostic scales that measure RT. A transdiagnostic construct is one that plays a role in multiple disorders (such as safety behaviors and intrusive memories; see Harvey et al., 2004, for a review). The use of transdiagnostic scales of RT in particular could reduce patient burden, and provide information about the frequency of RT regardless of the nature of a client's primary diagnosis, and/or the presence of comorbidity. For example, an individual may present with clinical levels of depression and generalized anxiety disorder and sub-clinical levels of an eating disorder. Instead of administering one measure of rumination and one of worry at various points during treatment, a clinician could administer a single measure of RT that is transdiagnostic. This would reduce the time spent completing questionnaires, and would result in simpler tracking of the general tendency to think repetitively, thereby resulting in some insight into how repetitive thinking plays a role in maintaining symptoms across all three of the presenting problems. Previous reviews have discussed various definitions of rumination and how rumination relates to other constructs such as negative automatic thoughts (Smith & Alloy, 2009), the relationship between rumination, worry and coping mechanisms such as problem solving (Nolen-Hoeksema et al., 2008), and the consequences of various forms of RT (Watkins, 2008). The rationale behind conducting this systematic review is to provide a broader overview of measures of RT across a range of disorders (such as depression, anxiety, trauma, insomnia), contexts (such as stress, illness, and work), age groups, and types (content vs. process).

In Section 2 we present a brief outline of the theories and empirical studies that have focused on RT across various disorders. In Section 3 we outline the literature search strategy, and the criteria employed for including and excluding search results. In Section 4 we outline measures that index RT in its various forms and critically review these measures, in order to aid the selection of measures for research and practice. Finally, in Section 5 we provide a general discussion of the major issues related to measurement, and discuss future directions.

2. Background information

A review of the now expansive theoretical and empirical literature in this area is beyond the scope and the goal of this review. However, in order to provide some key background information, a brief overview of theoretical models of RT and some key empirical work that has been carried out is given below.

Most theoretical work on RT to date has centered on depressive rumination. Depressive rumination is defined as thinking focused on oneself, one's depressive symptoms, and the implications of the symptoms (Nolen-Hoeksema, 1991). The majority of these theories focus on rumination in response to sad mood or unattained goals. For instance, the Response Style Theory (Nolen-Hoeksema & Morrow, 1991) proposed that rumination is triggered by sad mood and maintains depressive symptoms. The core hypothesis of this theory is that rumination leads to longer periods of depressed mood compared to distraction by promoting cognitive biases and by inhibiting individuals from using distraction and problem solving. Experimental research has shown that the self-rated frequency of depressive rumination predicts depression severity and onset, even after controlling for baseline depressive symptoms (Just & Alloy, 1997).

Goal progress theory (Martin & Tesser, 1989, 1996) and the impaired disengagement hypothesis (Koster, De Lissnyder, Derakshan, & De Raedt, 2011) both propose that ruminative thoughts stem from a discrepancy between one's goals and current state. These ruminative thoughts are negative and self-focused, and generate conflict with one's positive self-views in most cases. The impaired disengagement hypothesis (Koster et al., 2011) further states that when this conflict is raised, it leads to disengagement, distraction or re-appraisal. However, sometimes this conflict may not occur due to the presence of schemas, or may occur but still lead to rumination due to limited attentional control. Rumination in turn leads to impaired problem solving, task impairments and negative affect, which can lead to further rumination and depressive episodes. Thus, the impaired disengagement hypothesis proposes that rumination is primarily related to an inability to switch attention away from negative emotional material. Accordingly, Koster et al. (2011) propose that attention control training may be a useful addition to verbal therapies (such as Cognitive Behavior Therapy) in the treatment of depression. In addition, mindfulness-based cognitive therapy was developed on the theoretical premise that teaching individuals with a history of depressive episodes to shift out of ruminative thinking and attend to the present moment would reduce the likelihood of depressive relapse (Teasdale et al., 1995). There is growing evidence that MBCT reduces the likelihood of relapsing into depressive episodes (Kuyken et al., 2016).

Other relevant theoretical models have focused on worry in generalized anxiety disorder, such Borkovec's cognitive avoidance model, which proposes that worry is mostly verbal rather than visual, and represents an attempt to problem solve (Borkovec, Ray, & Stober, 1998). The core hypothesis of this theory is that worry serves as a cognitive avoidance strategy and inhibits emotional processing of material. On this basis, it follows that exposure to the feared stimulus may be used to address this avoidance mechanism and in turn reduce anxiety.

In the context of social anxiety, Clark and Wells' (1995) cognitive model states that RT in the forms of anticipatory and post-event