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If I Only Knew Why: The Relationship Between Brooding, Beliefs About Rumination, and Perceptions of Treatments

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People who tend to engage in brooding, the maladaptive subtype of rumination, are at risk to develop depression. Brooders often endorse metacognitive beliefs that self-focused ruminative thinking is beneficial. In the current study, we examined whether brooding and positive beliefs about rumination are associated with perceptions of and preferences for treatments for depression. Participants (N = 118) read descriptions of two different clusters of treatments for depression, Insight-Oriented (IO) treatments and Activation-Oriented (AO) treatments. They then rated treatment efficacy and credibility and completed self-report measures of rumination (including brooding and reflection subscales), beliefs about rumination, and depression. Brooding and metacognitive positive beliefs about rumination were associated with positive perceptions of IO (but not AO) treatments. Positive beliefs about rumination contributed to the prediction of perceptions of IO treatments (but not AO treatments) beyond the effect of brooding. We discuss the implications of these findings for individuals' decision-making processes regarding which type of treatment to seek.

Keywords: rumination; brooding; metacognitive beliefs; treatment preference; treatment credibility

Approximately 1.16 million internet queries with the keyword "depression" were recorded per month in the U.S. in 2006 (Fu, Wong, & Yip, 2010). Depression, the "world wide burden in the 21st century" (Üstün, 2001), is one of the most common psychiatric conditions (Riolo, Nguyen, Greden, & King, 2005), and it drives millions of people to search for help. Help seeking for mental health is not an easy task. A wealth of competing treatments is available, and people are required to evaluate and choose the best treatment for themselves. Different psychological treatments may share common therapeutic factors (Castonguay, 1993; Frank, 1971) but some theoretical approaches are exceptionally dissimilar. The goal of the present study is to investigate whether cognitions that characterize depression bias people's preferences and perceptions of two different clusters of treatments for depression, Activation-Oriented (AO) treatments and Insight-Oriented (IO) treatments.

The rationale behind the AO cluster of treatments is that depression results from a significant reduction in positive behaviors that have previously led to positive emotions and a sense of accomplishment (Rokke, Carter, Rehm, & Veltum, 1990; Rokke & Scogin, 1995). Therefore, a primary intervention according to the AO approach is behavioral activation (Jacobson et al., 1996; Martell, Addis, & Dimidjian, 2004), whereby therapists encourage constructive behaviors and pleasurable activities in order to decrease feelings of depression. In contrast to the AO approach, the rationale behind the IO cluster of treatments is that depression occurs because of negative feelings and experiences that are generally outside of the person's awareness. A key therapeutic element according to the IO approach is therefore introspection, whereby therapists help clients become aware of the underlying causes of their depression. Clients who manage to gain better understanding of the reasons for their depressed feelings can then improve their ability to

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cope with distressing life events (Rokke et al., 1990; Rokke & Scogin, 1995).

Both treatment clusters can be helpful for depression (e.g., Leichsenring, 2005), but the treatment of choice for individuals who tend to engage in depressive rumination, a main predictor of depression, includes AO strategies (Nolen-Hoeksema, Wisco, & Lyubomirsky, 2008). Rumination is a maladaptive form of self-focus (Mor & Winquist, 2002; Watkins, 2008) in which people repeatedly think about their symptoms, and the causes and consequences of these symptoms (Nolen-Hoeksema & Morrow, 1991). This maladaptive style of thinking enhances depressive feelings and thoughts and exacerbates depressive symptoms (Nolen-Hoeksema et al., 2008). One major negative effect of depressive rumination is the inhibition of instrumental behavior (Ward, Lyubomirsky, Sousa, & Nolen-Hoeksema, 2003). Instead of engaging in instrumental behavior, individuals who tend to ruminate often remain stuck in a vicious cycle of stress and negative thoughts. They find it difficult to produce effective solutions to their problems (Lyubomirsky & Nolen-Hoeksema, 1995), and even when they do identify possible solutions, ruminating about their negative mood reduces their "willingness to tackle" their problems (Lyubomirsky, Tucker, Caldwell, & Berg, 1999).

The AO cluster of treatments aims to break the negative habitual cycle of rumination, mainly through methods of behavioral activation and problem solving (Nolen-Hoeksema et al., 2008). However, the reduction in ruminators' motivation to cope with their problems and their tendency to avoid instrumental behaviors may lead them to have negative views of activation-oriented treatments. Addis and Carpenter (1999) found that (a) people who ruminate are more likely to provide a large number of reasons for their depression, (b) reason-giving for depression is associated with negative reactions to the AO treatments' rationale, and (c) rumination is linked to a negative view of AO treatments. These findings are important because an unfavorable view of AO treatments might lead to the avoidance of a beneficial and well-established therapy for depression (Butler, Chapman, Forman, & Beck, 2006; Tolin, 2010). The relationship between depressive rumination and treatment preferences could therefore be partially explained by the reduction in ruminators' motivation to engage in instrumental behaviors. However, the question of *whether and why* ruminative people endorse positive perceptions about IO treatments has yet to be answered.

Two important factors that were not examined in Addis and Carpenter's original study (1999) may be associated with positive perceptions about IO treatments. The first factor is the distinction between two subtypes of rumination, reflective pondering (reflection) and brooding (Armey et al., 2009; Treynor, Gonzalez, & Nolen-Hoeksema, 2003). Reflective pondering is a general and less judgmental self-reflective tendency. In this form of self-reflection, people turn inward to engage in cognitive problem solving in order to alleviate their depressive symptoms (e.g., "I go someplace alone to think about my feelings."). In contrast, brooding is defined as a tendency to focus on obstacles (e.g., "Why can't I handle problems better?") and engage in a negative self-reflective process (e.g., "What am I doing to deserve this?"), as well as to passively compare current situations with unattainable standards. Brooding (and not reflection) is considered to be the main predictor of depressive symptoms (Schoofs, Hermans, & Raes, 2010) and to be associated with cognitive biases (Bernblum & Mor, 2010), emotional distress (Whitmer, 2010), and multiple behavioral difficulties (e.g., Rawal, Park, & Williams, 2010; Willem, Bijttebier, Claes, & Raes, 2011). Thus, brooding is distinguished as the maladaptive component of rumination that could influence perceptions of treatments. To our knowledge, the relationship between perceptions of treatments and brooding has not been examined separately from reflection.

A second factor that is particularly relevant to treatment preferences is the positive beliefs held by an individual about his or her tendency to ruminate. According to the Self-Regulatory Executive Function model (S-REF; Wells & Matthews, 1996), maladaptive thinking styles, such as rumination, are initiated and maintained by metacognitions that control thinking processes (Wells, 2008). Metacognitions are the implicit knowledge, assumptions, and beliefs people hold about their own cognitions. In this top-down model, metacognitions activate a cognitive-attentional syndrome (CAS) that consists of maladaptive repetitive thinking, such as worry and rumination; the CAS, in turn, maintains emotional disorders. In the case of rumination, many individuals endorse metacognitive beliefs that ruminative thinking could help them understand their difficulties and solve their problems (Papageorgiou & Wells, 2001a; Watkins & Baracaia, 2001). Positive beliefs about rumination may increase the maladaptive tendency to ruminate (Moulds, Yap, Kerr, Williams, & Kandris, 2010), and are especially common among people who are prone to depression (Papageorgiou & Wells, 2001b; Watkins & Moulds, 2005). Moreover, recent findings suggest that positive beliefs about rumination reflect a maladaptive transdiagnostic construct (Harvey, Watkins, Mansell and Shafran, 2004) that is found in other psychological disorders, such as anorexia nervosa (Rawal et al., 2010) and social anxiety (Wong & Moulds, 2010).