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Received: September 1, 1999
Accepted: November 5, 1999

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Metacognitive Beliefs About Rumination in Recurrent Major Depression

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Wells and Matthews (1994, 1996) proposed that perseverative negative thinking, such as depressive rumination and anxious worry, is supported by metacognitive beliefs concerning the functions and consequences of these styles of thinking. However, to date no studies have investigated metacognitive beliefs about rumination. This study examined the presence and content of metacognitive beliefs about rumination in patients with recurrent major depression. To achieve this aim, a semistructured interview was conducted with each patient. The results showed that all patients held positive and negative beliefs about rumination. Positive beliefs appear to reflect themes concerning rumination as a coping strategy. Negative beliefs seem to reflect themes concerning uncontrollability and harm, and interpersonal and social consequences of rumination. The conceptual and clinical implications of the results are discussed.

RUMINATION is a thinking style that typifies depression and has been linked to the maintenance of depressive episodes (e.g., Nolen-Hoeksema, 1991; Teasdale & Barnard, 1993). Wells and Matthews (1994, 1996) have advanced a metacognitive model of emotional vulnerability in which perseverative negative thinking, such as depressive rumination and anxious worry, is supported by metacognitive beliefs concerning the functions and consequences of such thinking. Metacognition refers to beliefs and appraisals about one's thinking and the ability to monitor and regulate cognition. Ruminative thinking can be viewed as symptomatic of depression, but may also represent a strategy intended to cope with depression.

Recently, Papageorgiou and Wells (1999a, 1999b) ex-

Cognitive and Behavioral Practice 8, 160–164, 2001
1077-7229/01/160–164$1.00/0

Continuing Education Quiz located on p. 210.

plored the process and metacognitive dimensions of rumination and worry. Similarities and differences emerged in a number of dimensions. Moreover, a metacognitive dimension reflecting negative appraisals of thinking was associated with depressed and anxious affect even when the overlap between depression and anxiety was controlled. These data support the idea that depressed individuals negatively appraise their own thinking processes, and this is not solely dependent on anxiety.

In Wells and Matthews's (1994, 1996) Self-Regulatory Executive Function (S-REF) model of emotional disorders, perseverative processing is viewed as a coping strategy or a preferred means of appraisal that has several negative consequences for emotional self-regulation. For instance, worrying following stress appears to incubate intrusive images (Wells & Papageorgiou, 1995). Active and perseverative thinking, in the form of rumination or worry, is linked to positive and negative metacognitive beliefs about these processes (Cartwright-Hatton & Wells, 1997; Wells & Carter, 1999; Wells & Papageorgiou, 1998). This concept has been developed in a recent metacognitive model and treatment of generalized anxiety disorder (GAD; Wells, 1995, 1997).

To date, no studies have tested the prediction that positive and negative metacognitive beliefs about rumination are held by depressed individuals. Although several authors have previously linked rumination to the maintenance of depression (e.g., Nolen-Hoeksema, 1991; Teasdale & Barnard, 1993), the nature of the knowledge base responsible for the selection of rumination as a coping strategy has not been considered outside of the S-REF model. Therefore, in this preliminary study, we aimed to systematically examine the presence and content of positive and negative metacognitive beliefs about rumination in depression.

Method

Participants

In order to investigate metacognitive beliefs in depression, we elected to restrict the sample to individuals with recurrent major depression without concurrent Axis I disorders. In total, 75 individuals who had been consecutively referred for psychological treatment of depression were screened. Fourteen patients (7 women, 7 men) met *DSM-IV* (American Psychiatric Association, 1994) criteria for recurrent major depressive disorder (MDD) and did not meet criteria for concurrent Axis I disorders. Diagnoses were made following administration of the Structured Clinical Interview for *DSM-IV* Axis I Disorders–Patient Edition (SCID-I/P; First, Spitzer, Gibbon, & Williams, 1997). Table 1 shows patients' characteristics, including age, duration of current episode, and number of recurrent episodes. None of the patients had received previous psychological treatments for depression. All of the patients had been stabilized on antidepressant medication for at least 3 months prior to participating in the study.

Table 1
Demographic and Clinical Characteristics of Patients ($N = 14$)

Variable	*M*	*SD*	Range
Age (years)	38.5	9.9	22 to 55
Duration of current MDE (months)	11.5	5.4	3 to 20
Number of recurrent MDEs	3.6	1.3	2 to 6
BDI	31.7	8.9	21 to 50
BAI	17.2	4.6	9 to 24

Note. MDE = Major Depressive Episode; BDI = Beck Depression Inventory; BAI = Beck Anxiety Inventory.

Measures

In order to assess the severity of depressive symptoms, patients were asked to complete the Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961). In addition, since anxious symptoms are commonly found in MDD, the Beck Anxiety Inventory (BAI; Beck, Epstein, Brown, & Steer, 1988) was administered to assess the level of anxiety. Table 1 shows patients' mean BDI and BAI scores. These scores indicate that patients' severity of depressive and anxious symptoms fell within the severe and mild-to-moderate range, respectively.

Procedure

Following assessment and diagnostic screening, a brief semistructured interview was conducted with each patient. The interview was based on a metacognitive profiling interview developed by Wells and Matthews (1994) in order to determine cognitive and metacognitive processes during "on-line" negative emotional experiences. For purposes of this study, only a specific section of the metacognitive profiling interview was extracted and used. This section is concerned with eliciting metacognitive beliefs about negative self-processing.

Rumination can be viewed as symptomatic of depression, but may also represent a strategy intended to cope with depression.

At the beginning of the interview, patients were asked to "think about the most recent time in which you felt particularly depressed and you were ruminating." Since two patients were uncertain about the meaning of *ruminating,* they were provided with alternative words in an attempt to assist them with the task. The words *dwelling* and *brooding* proved to be