How rumination could hold you back

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Abstract

Rumination seems to be a core characteristic of depression and depressive symptoms. Everybody ruminates from time to time but not all develop depression or suffer immensely. What seems to make the difference is that those who believe their repetitive negative thoughts, often also seem to engage more in ruminative thinking and hence suffer from depression and/or depressive symptoms.

The phenomenon has interested psychologists, practitioners, and researchers – some more than others. In the metacognitive theory and therapy rumination as a term is an integrated aspect of both theory and intervention according to the S-REF model (self-regulation executive function) of psychological disorder, whereas in the psychodynamic theory and practice, rumination as a term is seldom to be found. Nonetheless, rumination seems to play a big role in the development of mental disorders in both traditions although their definitions and etiologies seem to differ. In the psychodynamic approach rumination can be characterized as a maladaptive defense mechanism which is removing the patient's attention from dealing with more painful circumstances.

In order to apply both metacognitive theory and psychodynamic theory into practice, I have chosen two cases – a metacognitive case example of "Leif" and a psychodynamic case example of "Mr. A". Both patients were suffering from rumination and from depression, but the two traditions offer different etiology and treatment. These differences will be further explored in relation to the concept of rumination and will also be discussed using the opposite theoretical lens so to have a fruitful dialogue.

In conclusion, a synthesis will be made in which the two approaches will be understood in the context of therapeutic work and therapeutic alliance.

Rumination – the subject of interest and inquiry

The medical description of rumination is as following: "rumination (sometimes called *merycism)* is the chronic regurgitation of previous ingested food and drink, followed by re-swallowing" (Singh, 2016, p. 677). In psychological terms rumination indicates repetitive negative thinking-style that goes in vicious cycles, because there seems to be no exit from the chattering or at times: "loud mind". Patients has often described it as "I am caught up in my own head" and a result of that they felt isolated or prisoned within themselves which sometimes led to further statements like these: "I can't stop my thoughts from racing, and it is driving me crazy". These statements were commonly heard among my clients when I was doing my internship. They described it as a feeling of being so self-conscious and self-aware almost to a degree where they felt caught up in their own mind and accordingly felt that they were forced to both listen and react to their ruminative thinking. This often led to feelings of hopelessness and despair which are seen as symptoms of depression (Panayiotou & Charis, 2021)

Academia has also had an interest in this phenomenon for a while especially because of its relation to depression (Panayiotou & Charis, 2021; Nolen-Hoeksema, 1991; Spinhoven et al., 2005; Wells & Fisher, 2015). Rumination is described as "repetitively focusing on the fact that one is depressed; on one's symptoms of depression and on the causes and meanings and consequences of depressive symptoms" (Nolen-Hoeksema, 1991, p. 569). Furthermore, rumination is one of the depressive symptoms which have been found to lead to significant disappointment with the self and others which additionally lead to negative interpretations about events that are believed to be caused by oneself (Panayiotou & Charis, 2021). This activity of ruminating can also be understood as self-focused attention and is in some ways similar to the medical description:" a tendency to focus on and regurgitate negative thoughts and evaluations about the self (which) is part of a vicious cycle that maintains depression and other emotional disorders" (parentheses added, Panayiotou & Charis, 2021, p.111). Because of the unresolved and/or ambiguous nature of rumination, "the depressed person believes that they are helping their situation when in fact one does nothing to change one's life" (Panayiotou & Charis, 2021, p.111) and thus keeps engaging in this vicious cycle. By rethinking the past to identify faults and limitations one might get caught in the illusion that one is doing something active when in fact one is doing nothing at all (Panayiotou & Charis, 2021). In turn, high levels of self-focused attention increase the negative affect by making it more salient, while higher negative

affect has also been found to increase self-focused attention (Brown & Vrana, 2007 according to Panayiotou & Charis, 2021). Wells & Matthews (1996) describes rumination as a problematic self-regulation strategy.

Rumination has also been characterized as Repetitive Negative Thinking (RNT) which seems to be a core characteristic and most prominent factor of depression (Alloy et. al., 2000). Accordingly Repetitive Negative Thinking (RNT) is shown to be a transdiagnostic factor representing a common feature across anxiety and depressive disorders (Harvey et al., 2004) to which rumination is one of the most often investigated forms of RNT, whereas worry is the other common Repetitive Negative Thinking (Spinhoven et al., 2005). Spinhoven and colleagues (2005) hypothesized in a cross-sectional study of 2143 adult participants that an underlying common dimension of RNT would be more strongly linked to depressive and anxiety disorders. They found a significant correlation between the common dimension of RNT depressive and anxiety disorders. Moreover, rumination showed a significant relationship with Major Depressive Disorder whereas worry was positively correlated with Generalized Anxiety Disorder (Spinhoven et al., 2005).

Clarification of concepts

Although clarification of concept is crucial for the problem formulation and for the general structure of the thesis, the concept of "worry" cannot easily be distinguished from rumination, as they seem to inhabit similar features – "both involve recurrent thinking about negative themes" and both predict anxiety and depressive symptoms (Harvey et al., 2004, p. 201). Additionally, studies show that both are highly correlated with each other with an index of repetitive thinking (Spinhoven et al., 2015, p.45). But as the study of Spinhoven et al. (2005) showed – rumination is *mostly* linked to Major Depressive Disorder. This distinction – even though it is delicate – makes the delimitation of the research object clearer because of its correlation to depression.

The process of analysis already begun in search for theoretical and empirical psychodynamic literature. Therefore, I had to look for other words and analyze the meaning instead. The process of literature research has both been guided towards the keywords of "rumination", "depression", and "depressive symptoms" – rumination being one of the depressive symptoms. I have used databases such as: PsychInfo, APA Psych Articles, APA PsycTest, and APA PsychTherapy. Whenever

"rumination" was not explicitly formulated – I found that it was often described in terms of depressive symptoms. This made the dialogue and discussions between the two theories easier, but initially I had to analyze the meaning of the symptoms and look for synonyms to the descriptions of rumination.

In order to outline a focused problem formulation, one must ask relevant research question and assess the consequences of the choices because when a choice in made in the research project, other choices are necessarily eliminated (Flick, 2008).

Problem formulation

The subject of interest and the problem formulation in this thesis is as follows:

> *What role does rumination play according to Metacognitive theory/therapy and how is similar phenomena treated in the Psychodynamic theory/therapy?*

Differences that need to be addressed at this point

At this point the research question forms the basis of further dialogue about the noticeable differences that I must consider.

There seems to be a large amount of data and meta-analysis supporting the efficacy of metacognitive therapy (Callesen et al., 2010; Callesen, 2020; Cano-López et al., 2021; Wells & Fisher, 2015). Whereas comparable studies exist on the efficacy of cognitive therapy versus metacognitive therapy (Callesen, 2021; Nordahl et al., 2018; Solem et al., 2021), fewer comparable studies exist to test and compare psychodynamic therapy and metacognitive therapy. A reason for that might be that generally fewer empirical studies exist to test psychodynamic therapy, which is often not time-limited or manualized (Charis, & Panayiotou, 2021; Busch, 2021; Schön, 2006; Norman et al., 2014). Although studies such as Wampold et al., (2008) show that psychodynamic therapy is indeed effective.

The reasons that these differences in both theory and practice are substantial is that the two psychological perspectives are resembling different psychological traditions using different models that address and explain the etiology and persistence of depressive symptoms such as rumination. This can create an additional difficulty in making comparisons but will likely also create fruitful dialogues and a meaningful synthesis of theoretical and empirical literature in the analysis and discussion.

Method

The aim of the thesis is to examine the subject of rumination using both a metacognitive approach and a psychodynamic approach. The methods - being the two approaches – will be applied in the two cases and will further be analyzed and discussed. The thesis will begin with a theoretical section in which a description of the metacognitive theory and psychodynamic theory will be presented. The theories will be applied to the subject of inquiry having in mind that rumination as a term is both treated and understood differently. Secondly, the two theories will be applied in practice which will consist of analysis of two cases - which will be analyzed and understood through the initial theoretical perspective used. In the discussion-passages the same cases will be analyzed and understood through its "opponent theory" in order to have a meaningful dialogue about theoretical and therapeutic differences in relation to rumination.

Metacognitive theory

Metacognitive therapy and theory (MCT) are based on the information processing model of self-regulation. This model is called Self-regulation Executive Function (S-REF) and was developed by Wells (2019). S-REF is based on a broader model of emotional disorders and suggest that the activation and continuation of rumination together with its association with depression, are dependent on metacognitive beliefs (S-REF; Wells, 2019; Wells & Matthews,1996). According to this approach,

metacognitive beliefs are prediction factors in rumination and depression (Wells, 2019). Metacognitive beliefs refer to the beliefs people have about their own cognitive system, which influence, control and/or asses the cognition (Wells, 2019; Wells & Matthews, 1996). MCT deals with the separate level of cognition rather than by representations, schemas or general beliefs which is often seen in cognitive behavioral therapy (Wells & Fisher, 2015). The name "metacognition" means: "cognition applied to cognition" (Wells & Fisher, 2015,p.134) which is that cognitive aspect of information processing that monitors, controls and organizes cognition (Wells & Fisher, 2015). The idea that cognition can be controlled and monitored by another part of cognition implies that there are two levels of cognition (Wells & Fisher, 2015). Instead of monitoring the non-metacognitive level which Wells and Fisher (2015) names the "ordinary cognitive content", the metacognitive therapist is working in the metacognitive system (p. 135). The metacognitive challenges the beliefs people have about their own cognitive system, which influence the control, monitoring, and appraisal of cognition (Wells & Fisher, 2015, Callesen, 2021).

Early measures to test the model of S-REF was included in the Thought Control Questionnaire (TCQ; Reynolds & Wells, 1999). TCQ assesses the individual's tendency to select maladaptive strategies such as rumination, worry, self-punishment, reappraisal, and the Anxious Thoughts Inventory which measures different negative thoughts such as worry and rumination, and metacognitive thinking such as ruminating about rumination (Reynolds & Wells, 1999). Furthermore, in the metacognitive model, two different scales have been developed to assess positive and negative metacognitive beliefs: the Positive Beliefs About Rumination Scale (PBRS; Papageorgiou & Wells, 2001b) and the Negative Beliefs About Rumination Scale (NBRS; Papageorgiou & Wells, 2001a). These tests have shown good psychometric validity to measure metacognitive beliefs about rumination (Luminet, 2004; Watkins & Moulds, 2005).

S-REF is derived from existing literature on how attention and emotion play a central role in developing psychopathological diseases including emotional disorders and some mental illnesses (Wells & Fisher, 2015). According to Wells & Matthews (1996) the symptoms of disorders occurs because of abnormalities in the selection of thought content, since the individual's focus of attention will form that person's view of self and the world. Put it differently, the symptoms of emotional disorders seem to be associated with biases and/or abnormalities in the selection and/or maintenance of some thoughts over others. Wells & Matthews (1996) For instance, in the case of depression, the attention is allocated mainly to the cognitive activity of worry and rumination. Rumination involves

thoughts about the causes of depressive symptoms (Wells & Matthews, 1996). According to the self-regulation executive function (S-REF), emotional disorders are a result of a specific style of thinking in response to negative thoughts which leads to an extension of negative internal experiences of thoughts, emotions and beliefs. A central clinical implication in metacognitive therapy is that removal of the "negative" thinking will allow the patient to exit the recurrent cycle of processing that maintain the disorder in the first place (Wells & Matthews, 1996).

The MCT therapist is not so concerned with and interested in the individual's content of thought, belief, and feeling. Instead, the therapist is concerned with is mainly the way the patient reacts to negative thoughts, beliefs and emotions since the aim in MCT is to reduce the thinking and fixation (Wells & Fisher, 2015).

'Rumination' according to metacognitive perspective

Wells and Matthews (1996) identified the cognitive attentional syndrome (CAS) which they viewed as a general and universal pattern of thinking and cognitive processing that occurred in psychological disorders. In CAS, the individual is focusing his or her attention mainly on sources of threat, rumination, worry, and thus developing unhelpful coping behaviors because those coping strategies interfere with effective self-regulation and/or impair the change in perception and knowledge (Wells & Matthews, 1996). According to the authors many of the strategies of coping are metacognitive in nature in that they are intended implicitly or explicitly to alter the status of cognition (Wells & Matthews, 1996). For instance, a depressed patient often ruminates or worries because he or she believes that the function of rumination is in fact helpful in order to avoid future threats. Also, he or she will reduce the activity level to spend more time analyzing the reasons underlying personal failure and sadness (Wells & Matthews, 1996). This tradition views rumination as a coping strategy by which the individual use rumination to anticipate, plan or even avoid potential danger or unwanted events to happen. The potential sources of threats are often internal and involve sensations, thoughts, and emotions (Wells & Matthews, 1996).

In the S-REF model, rumination is seen as evaluation-based coping strategy, but they are problematic for self-regulation in the long-term since it will affect the control of distressing emotions and thus lead to a failure in the abandonment of distressing ideas (Wells & Fisher, 2015). The anxious

or depressed person monitors for certain thoughts or feelings that might signal danger. As noted earlier, threat monitoring in the CAS model involves focusing or/and maintaining internal attention on sources of threat. By observing for symptoms of depression, Wells & Fisher (2015) noticed that individuals had many false alarms along with a sustained sense of threat and worry. Ruminating, that is dwelling on the individual's own sense of inadequacy leads to sustained analysis of the self (Wells & Fisher, 2015).

Psychological disorder is according to MCT a direct result of the extent of distressing thoughts and emotions which are recycled and extended rather than a feeling of psychological relief of letting go. According to metacognitive therapy - CAS is the driving cognition in the metacognition which is why the CAS is crucial in the theory of MCT (Wells & Fisher, 2015; Wells & Matthews, 1996).

Positive and Negative Metacognitive Beliefs

As was mentioned, MCT deals with two different subtypes of metacognitive content which exist at the belief level: positive and negative beliefs (Wells & Fisher, 2015; Papageorgiou & Wells, 2001). A positive belief concerns the psychological need or advantage of rumination, but will eventually lead to more unwanted emotions, loss of energy and catastrophizing thinking about oneself (Wells & Fisher, 2015). A negative metacognitive belief concerns thoughts about the uncontrollability of mental processes and the threat instructed by thoughts. The negative metacognitive belief might be of greater harm to the individual as it is seen as the "turbocharger" of emotional distress (Wells & Fisher, 2015, p. 136). Believing that ruminating, worrying and conceptual processing is a symptom of patient's psychological illness rather than a voluntary strategy under their control is specifically harmful.

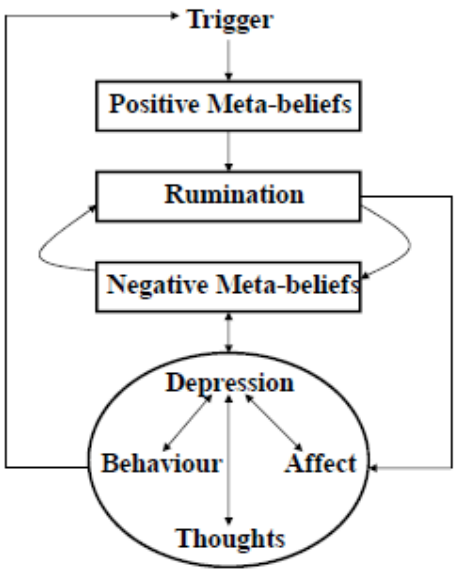
> "Some systems of therapy reinforce this unhelpful model of psychological functioning by presenting the idea that depression or anxiety is a consequence of chemical imbalance in the brain or the result of automatic unconscious psychological processes" (Wells & Fisher, 2015, p. 136).

The authors propose that processes of rumination and the feature of CAS is under the individual's control as they are part of coping strategies. However, believing that these processes are overpowering or uncontrollable leads to failure in the attempt of controlling them and therefore the

negative processing will also be extended and remained (Wells & Fisher, 2015). This coping mechanism prevents the individual from adapting and discovering more helpful ways of self-regulation. Furthermore, uncontrollability regarding negative belief about metacognition is recognized in patients with depression or anxiety (Wells & Fisher, 2015). These individuals tend to believe that worry or ruminating can lead to psychological breakdown and therefore they "worry about worry" (Wells & Fisher, 2015, p. 137).

The S-REF model (Figure 1.)

The S-REF model (self-regulation executive function) of psychological dysfunction is illustrated in the figure below by Wells (2009) according to Wells & Fisher (2015, p.137). This model shows maintenance of the CAS and the mechanisms linking the CAS to symptoms of depression.



Source: Wells (2009)

Lowering of mood and negative thoughts are experiences of everyday life for human beings but not but for most people, they are transitory experiences, lasting minutes, hours, or days. Put it differently, everyone has negative thoughts, and everyone believes their negative thoughts sometimes, but not everyone develops depression or psychological suffering (Wells, 2019). However, a person with depression becomes locked into experiencing persistent and extended episodes of this

kind of thinking as is illustrated in the Figure 1 (S-REF model). In such cases, the person is unable to stop oneself from analyzing the causes of experienced failure or sadness (Wells & Fisher, 2015). As described earlier, what characterizes cognitive attentional syndrome (CAS) is such ruminative thinking.

As Figure 1. shows, several psychological variables are involved in this process. Firstly, the trigger-thought can rise out of feelings of fatigue, sadness or loss of motivation and can take the form: "why do I feel this way?". This initial trigger-thought can then activate positive metacognitive belief about the value or need to ruminate as a way of gaining understanding over one's psychological distress (Wells & Fisher, 2015). The typical triggers for more intense rumination episodes are negative thoughts. In some instances, patients believe that emotional self-regulation can be attained through positive metacognition (Wells & Fisher, 2015). A few examples of positive metacognitive belief are as following: "If I analyze why I have failed I will be able to prevent failure in the future", "if I work out why I'm depressed I will be able to get better", "dwelling on how bad I feel will make me feel worse and force me to get better" (Wells & Fisher, 2015, p.138). These types of thinking increase the awareness and feelings of sadness and prolongs the negative thinking.

Rumination and other features of CAS are insidious processes, and their intensity and duration are modulated by metacognition. Negative metacognitive beliefs concern the uncontrollability of ruminating or worrying. Here the person might think that he/she has lost their minds or that he/she has lost control of thinking and that there is nothing one can do about it. Patients might feel weak for being like that (Wells & Fisher, 2015). Reasons for these kinds of negative metacognitive belief might be a result of a biological disease or because patients have learned about depression through contact with the medical system. In result, this can generate a sense of loss of control and feelings of hopelessness which only enhances the negative metacognitive belief in the first place which is interpreted by the individual as personal weakness (Well & Fisher, 2015). The last-mentioned authors write: "these beliefs contribute to failures to disrupt rumination and to control unhelpful coping patterns whose suspension could ultimately alleviate the depressed mood" (Wells & Fisher, 2015, pp. 138-139).

To conclude: "rumination has a negative effect on cognition and leads to the persistence of symptoms" (Wells & Fisher, 2015, p.138). Besides rumination, "threat monitoring and worry" are also considered unhelpful coping strategies along with the use of intoxicants and through social withdrawal (Wells & Fisher, 2015, p. 138). The process of maladaptive metacognitive thinking may

have occurred for so long that the person is unaware its pervasive nature. This in turn diminishes meta-awareness of rumination and repeats the negative cycle as shown in Figure 1.

A Metacognitive case example of "Leif"

The original case used in this example can be found within Callesen's book: *Live More Think Less – Overcoming Depression and Sadness with Metacognitive Therapy* (2020, pp 170-120). The full case will also be linked in the appendix in order to make references easier, for instance when I refer to a specific line (see appendix 1). The case will be analyzed with a metacognitive model of depression and will in the later chapters – after the psychodynamic theory and case have been presented - be discussed using a psychodynamic approach. The case of "Leif" follows an example of a metacognitive treatment setting where the metacognitive model of S-REF in relation to CAS will be applied. Leif was suffering from depression but overcame his illness with help from a metacognitive therapist– who is both the author, a psychologist who is trained in metacognitive therapy, and was his former therapist (Callesen, 2020). Leif story will be followed by the therapist's commentaries and analyzed. The case is not a conversation between the therapist and patient. It is a firsthand story written by "Leif" according to Callesen (2020). It takes the form of being a personal story written in first person singular.

Leif's story

Leif was convinced that he had to "process the dark thoughts in order to move forward" (see appendix 1, p.1,l:1) and had suffered with depression since his teenage years (Callesen, 2020, p.117). He was especially ruminating about death though he managed to get a job, got married and had children but he continued to ruminate about the dark thoughts which centered around death especially. He came to think of this repetitive negative thinking as "his lot in life" (see appendix 1, p.1, l:3-4). There were periods in his life where he was in a vicious circle within his own mind:

> "I couldn't escape from the thought that I was going to die. But I did nothing about it. I believe that at some level I accepted that I should go through life being afraid of this. I

> got on with my work and family life and never received any treatment." (see appendix 1, p.1, l:5-8).

He found some consolation in his job life and got good results: "Work was my medicine. It kept my energy levels up" (see appendix 2, p.1, l:13-14). But things got worse when he didn't work especially in holidays: "I was straight away hit by worries and anxieties, and I felt terrible. All I wanted to do was to go back to work" (See appendix 2, p.1, l:12-13). But after some years the depressive tendencies could not only be solved by working and he ended up having to take a sick leave:

> "My doctor diagnosed me with depression; I got some medication and began to talk to a psychologist. The discussions with the psychologist were just like having a general chat with someone, which I don't feel I got a lot out of. But I did get better and believed that the medication was helping, until I had a relapse on a holiday." (See appendix 2, p. 1, l:16-20)

It is not clear from Leif's statement what kind of therapy he received after he got diagnosed with depression: "The discussions with the psychologist were just like having a general chat with someone, which I don't feel I got a lot out of" (see appendix 1, p.1, l:18-19). The statement can indicate that it was a therapy based on expressing the clients' feelings and experiences which could sound like a psychodynamic approach. Furthermore, the statement indicates that it was not metacognitive therapy, since he had never encountered metacognitive therapy before: "When I was introduced to metacognitive therapy, I also had my reservations. The basic premise stated that everyone has negative and dark thoughts but not everyone cultivates them" (see appendix. 1, p.2, l:33-34).

In the following years Leif's working life was unstable. He moved to another town where he got a new job with reduced hours. He also started studying but he kept struggling "the whole time with dark thoughts and anxiety around death. These thoughts filled (his) head to an extreme degree" (parentheses added, see appendix 1, p.1, l:23-15). In the following passages we get a vivid description of the experience of rumination and how it led to depression:

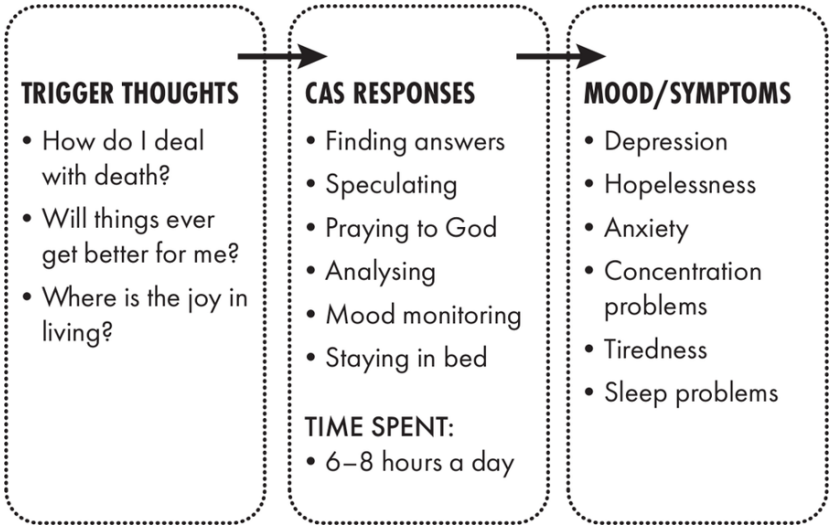
> "I was afraid to die, and it was like a self-fulfilling prophecy. Because I was going to have to die, I also had to think about it. That is what it was like for me. But I wasn't

> living my life. The thoughts took over everything. It was like a living death. I felt as though I was in hell. When you are in a state of depression, it takes over and becomes problematic in itself" (see appendix 1, p. 1, l:25-18).

Leif's story according to the Metacognitive approach

Thinking about death and the fact that one is going to die inevitably can be characterized as repetitive negative thinking (RNT) which is repetitively given attention to one's depressive symptoms and the negative thinking in general which is one of the maladaptive tendencies that lead to depression (Spinhoven et al., 2005, Nolen-Hoeksema, 1991). This repetitive thinking style includes an overgeneralization on the negative aspects of one's life and self-focused attention (Callesen, 2020).

According to the metacognitive model of S-REF (see figure 1.) Leif's depression was initiated by trigger thought (Callesen, 2020; Wells & Fisher 2015, p.137). The model showed maladaptive self-regulative responses such as maintenance of the CAS and the mechanisms linking the CAS to symptoms of depression. According to Callesen (2020), Leif's trigger thoughts were: "How do I deal with death?", "will things ever get better for me", and "where is the joy in living?". The initial trigger thought is often a positive metacognitive belief about the value and need to ruminate as a way of gaining understanding over one's psychological distress and of overcoming depression (Wells & Fisher, 2015). These trigger thoughts led to further CAS responses such as "finding answers", "speculating", "praying to God", "analyzing", "mood monitoring", and "staying in bed" (Callesen, 2020, p.121). In search for a solution, Leif would spend around "eight hours of rumination" (Callsen, 2020, p. 121), but ultimately did not find a solution to his problems. The model illustrating the below in borrowed from Callesens, 2020, p. 121.



His condition became worse as he would further develop depressive symptoms such as: "anxiety", "depression", "concentration problems", "tiredness" and "sleep problems" (Callesen, 2020, p. 121) which are also some of the key symptoms of depression (Callesen, 2020; Charis, & Panayiotou, G. (2021). What is characterized for people with depression is that they get locked into the vicious circle of lowering mood and negative thoughts though these symptoms are considered to be experiences of everyday-life as they are transitory experiences (Charis, & Panayiotou, 2021; Wells & Fisher, 2015). However, a person with depression becomes locked into experiencing persistent and extended episodes of this kind of thinking (Charis, & Panayiotou, 2021; Wells & Fisher, 2015) In Leif's case, he was unable to stop or pause from analyzing the causes of experienced failure and sadness. As described earlier, what characterizes cognitive attentional syndrome (CAS) is such preservation of thinking.

To sum up: According to the metacognitive therapist, Leif's main problem and distress seems to the fact that he used to believe his thoughts especially the negative ones which were also his focus point according to CAS. As noted earlier, these types of thinking increase the awareness and feelings of sadness and prolongs the negative thinking which are modulated by metacognition (Wells & Fisher, 2015). Because Leif was so absorbed rumination, he would not be able to stay present with others and at the same time he believed that he had to ruminate when in fact his experiences with rumination was that no solution would come out of the speculations. A reason for that might be that the process

of maladaptive metacognitive thinking may have occurred for so long that Leif was unaware of its pervasive nature which is also highlighted by Wells & Fisher (2015).

The metacognitive intervention

The metacognitive therapist is trained to have a conceptualized understanding of the maintenance of depression based on the metacognitive model of S-REF (Callesen et al., 2020). According to this model, depression is maintained by the difficulty in controlling rumination. The intervention aims to improve cognitive attentional syndrome (CAS) and modify maladaptive metacognitive beliefs (Callesen et al., 2020; Wells, & Matthews, 1996); Wells & Fisher, 2015).

The treatment is manualized in a way that it follows an order of understanding and newfound techniques for the client to integrate. The treatment usually begins with Attention Training Technique (ATT) "to enhance the sense of flexibility and control over thinking" (Callesen et al., 2020, p.3, Callesen, 2020). ATT is an awareness exercise which is meant to show that clients can shift their attention independent of outside factors and independently from inner factors such as the person's thoughts and feelings (Callesen, 2020, Callesen et al., 2020). Thereafter *detached mindfulness* can be integrated which is described as "passive awareness of thought stream – the opposite of rumination" (Callesen, 2020, p. 167). Detached mindfulness is integrated in daily practice in order to foster an alternative relationship with trigger-thoughts (which was introduced in the theoretical introduction of MCT as thoughts that trigger the person to ruminate) and to challenge metacognitive beliefs – especially negative metacognitive beliefs about the uncontrollability of ruminative responses (Callesen et al., 2020; Wells & Fisher, 2015). The treatment likely challenges positive metacognitive beliefs about the advantages of rumination "and other maladaptive mind control strategies such as thought suppression, avoiding stress, and the use of rest and sleep to cope with thoughts and emotions" (Callesen et al., 2020, p.3). The treatment follows a dialogue with the patient on a metacognitive level and thus challenges both negative and positive metacognitive beliefs about rumination and worry (Callesen, 2020; Callesen et al., 2020).

Therapeutic change

Leif tried several types of therapy, but he still could not handle the overwhelm of thoughts and was "convinced that (he) should spend time on them when they came. Otherwise, why would they come?" (See appendix 1., p.1, l:29-30) Then he says that he was introduced to metacognitive therapy: "the basic premise stated that everyone has negative and dark thoughts but not everyone cultivates them" (see appendix 1, p.2, l:33-34). The fact that he realized that he did not need to process his ruminative thinking indicates that it must have been an insight for him. An *insight* can be characterized in two ways: *intellectual insight* and *emotional insight* (Hill, 2014, p. 454). According to Hill (2014) insights are:

> "Seeing things from a new perspective, making connections between things, or having an understanding of why things happen as they do. Intellectual insight refers to having a cognitive understanding or explanation, whereas emotional insight refers to having connected affect to intellect such that there is a sense of personal involvement and responsibility for the understanding (Hill, 2014, p. 454).

Leif realized that he had a choice - he did not need to ruminate and analyze thoughts the way that he had done before: "the turning point came when, after a few sessions, I discovered that I was actually succeeding in letting the thoughts come and go, without it spoiling my day – and without things developing into a dark downturn" (see appendix, 1, p. 2, l:42-44). It seems that Leif gained intellectual insight onto the term of rumination. He realized that he did not need to ruminate and that he could just observe the thoughts without reacting to them (detached mindfulness, Callesen, 2020).

In the last passage, Leif writes:

> "I still believe that I will encounter sadness. But I am better at moving forward, which means I am not afraid of having another episode of severe depression. My life is not ruined by a couple of dark thoughts. I have managed to release the dark thoughts and move on. They do still come. And sometimes they come often, but I get on with my life and my stuff. I don't need to sit and wallow in them. I used to believe this was something

> I had to do. The idea that I didn't have to do this was very new to me. I have now completely escaped from depression. I have a stable job, greater emotional reserves and greater self-esteem" (See appendix 1., p.2, l:43-50)

Leif's new thinking strategy and biggest insight was that he no longer had to believe his negative thoughts and therefore did not process them by ruminating. His symptoms of mood monitoring (checking negative thoughts and behavior) and social withdrawal dismissed as well (Callesen, 2020). He developed a more relaxed attitude toward his thought and could let them come and go without the ruminating taking over and overwhelming him.

Psychodynamic theory

Freud's contribution to the psychodynamic theory

Psychoanalytic/psychodynamic teaching is based on theories that goes back to Freud (1900) with the term *unconsciousness*. Concepts such as: the unconscious and the conflicts derived from it, defense theory, affects, transference and countertransference, drive and motivation theory, makes psychodynamic theory both very descriptive and rich (Hill, 2014). Because of the theoretical richness of concepts, a delimitation process was necessary in order to relate it to the subject of inquiry, and furthermore relate the relevant psychodynamic theory to the case of Mr. A who suffered from depression and ruminative thinking, but first - a short introduction to Freud's concepts of id, ego and superego are needed to distill a core set of psychodynamic factors.

Freud characterized the unconscious or the *Id* as a psychological mechanism whose function was to keep conflicting ideas, impulses, feelings and desires away from the conscious mind in order to relieve neurotic stress (Freud, 1961, 1993). According to Freud, this did not relieve the person in the long run but only made them more neurotic because the person was instead suppressing affects, thoughts or behavior (Freud, 1961, 1993). The concept of unconsciousness is linked to defense-mechanisms since defenses such as suppression aim to hinder painful feelings from being conscious to the ego (Freud, 1961, 1993; Bienenfield, 2006). Although defenses can seem like a protective

mechanism which is preserving and defending the ego, this happens at the expense of psychological well-being (Freud, 1961, 1993). *Id* being the most primitive mental structure contains sexual and aggressive drives in their most unfiltered form according to Freud (1961, 1993). Furthermore, id or the unconscious is the nonverbal and unconscious mental structure as it originates in the earliest stage of mental development which is one of the reasons why early development concerning attachment is crucial in the psychodynamic theory (Freud, 1961,1993). *Ego* is also sometimes called "the self" and lays the structure of the personality which is in many ways constrained by – first parental norms and later - by societal restrictions and norms which is called the superego (Freud, 1961). *Superego* is the structure that regulates acceptable ways for drives to be satisfied or discharged. It consists of both ideals toward which ego strives and conscience, which limits drive-motivated behavior (Freud, 1961, 1993).

Two notions that formed the fundamental hypotheses of psychoanalysis were *psychic determinism* and the notion of *dynamic unconsciousness* (Freud,1993). The idea of psychic determinism is that mental activity is not random, instead Freud believed that each process in the mind was linked to thoughts and events that preceded it (psychic determinism) although these processes were unconscious (Freud, 1993). This notion thus necessitated that the greater part of mental activity works outside of conscious awareness, and because all our mental activity is linked to other mental processes (psychic determinism), but we cannot see most of these links, then there must be a world of mental activity unavailable to the conscious mind (dynamic unconsciousness) (Freud, 1993)

Although many of the specifics of Freud's derivations have been modified or challenged, these two fundamental principles of psychic determinism and dynamic unconsciousness remain at the basis of most psychodynamic theories which is why they are described in this chapter (Bienenfeld, 2006; Hill, 2014).

The Psychodynamic approach to depression and depressive symptoms

Object Relations

Psychodynamic therapists have developed several models that address and explain the etiology and persistence of depressive symptoms.

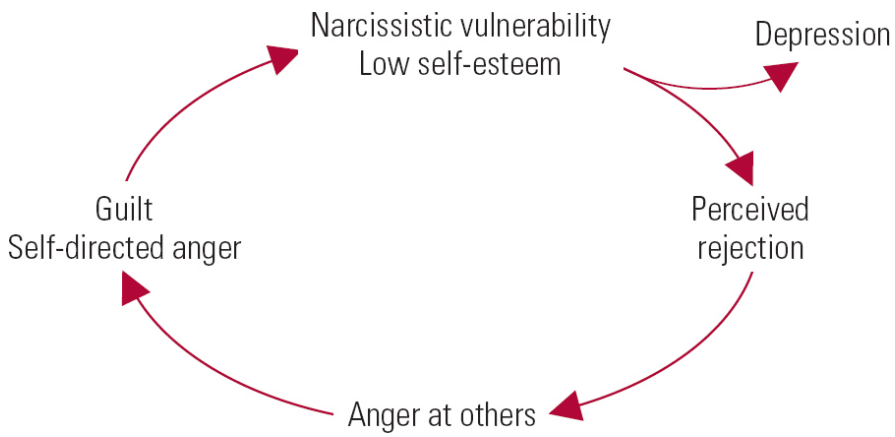
One of the theories relevant to the problem formulation and the psychodynamic case example is *Object Relations psychology* which states that we have basic needs growing up and if these needs are not met in the first years of life, the person can become susceptible to depression (Fonagy & Target, 1997; Bowlby, 1988). The perceived or experienced trauma will then lead to the development of neurotic conflicts (Freud, 1993). Moreover, this theory states that internal representation of self and others which were acquired in childhood are later played out in adulthood (Fonagy & Target, 1997; Bowlby, 1988; Thuesen, 2014). Accordingly in the therapy, it is known in the psychodynamic tradition that patients repeat old object relations and transfer their needs, desires and motivation unto the therapist (Freud, 1993; Hill, 2015; Thuesen, 2014). Therefore, the projections can indeed be helpful in a therapeutic setting because once they are conscious, they can be dealt with (Thuesen, 2015). These defenses are projected unconsciously in order to heal or master aspects of one's personality which is the concept psychodynamic concepts of transference and counter- transference (Thuesen, 2015; Hill, 2014).

Repressed anger

When it comes to the subject of psychological distress such as rumination and depression, the psychodynamic concepts of unconsciousness and its defenses are also relevant in answering the problem formulation, namely the idea that depression resulting from hostility towards others will eventually become self-directed, and the notion of an imbalanced superego or perfectionist ego ideal will be leading to increased susceptibility to depression especially when the ego cannot live up to the standards and ideals defined by the superego (Freud, 1938/1993; Busch, 2021). An imbalanced superego can attack the self/ego for many reasons both aggressive, sexual, or competitive which then are lowering the self-esteem and can lead to depression as we will be shown se the case of Mr. A

(Busch, 2021). Aggression seems to play a big role in the dynamics of depression. Some of the triggering points for the accumulated anger may be loss, narcissistic injury, helplessness leading to feelings of guilt and shame (Freud, 1938/1993; Thuesen, 2014; Busch; 2021). In result, they contribute to the self-defeating cycle of self-denigrating thinking, feeling, and behavior, and thus reinforcing the cycle of depression and depressive symptoms which is illustrated in figure 2 below, borrowed from Charis, & Panayiotou (2021) in *Depression Conceptualization and Treatment: Dialogues from Psychodynamic and Cognitive Behavioral Perspectives* (pp.53-62).

Figure 2. The psychodynamic model of depression



This model shows that depression and depressive symptoms can be triggered because of 1) aggression toward others will ultimately be directed toward the self, and 2) difficulties with self-esteem in patients whose expectations of themselves and others far exceed the capacity to live up to them (Busch, 2021). These two core dynamic aspects for depression typically trigger the vicious cycle of rumination since they lead to different negative thinking pattern along with negative feelings and behavior. In each formulation, narcissistic vulnerability and low self-esteem are seen as fundamental to the susceptibility to depression (Freud, 1938/1993). A severe superego develops to compensate for low self-esteem. When patient cannot live up to the moral expectations and narcissistic goals that the super ego has formulated, a loss of self-esteem and self-worth can occur thus leading to the repetition of the vicious cycle as shown in Figure 2 according to Busch (2021). Recurrent lowering of self-esteem in the case of conflicted anger is turned inward which in turn is triggering depressive

symptoms. Patients who feel frightened and guilty about their repressed feelings such as anger, hatred, or fear, project it externally (Busch, 2021, Jacobson, 1954; Thuesen, 2015). Then they feel resented or hated by others and explain this dislike of being caused by their inadequacy and their own negative attributes (Busch, 2021, Jacobson, 1954)

Furthermore, psychodynamic theory suggests that such experiences and feelings during formative developmental (Object Relations) stages are especially critical on the perception individuals' have of themselves and others and thus creating dynamic susceptibilities to depressive disorders, including narcissistic vulnerability, conflicted anger, excessively high expectations of self and others, and maladaptive defense mechanisms (Hills, 2014; Thuesen, 2015; Busch, 2021; Fonagy & Target, 1997; Bowlby, 1988).

'Rumination' according to the psychodynamic approach

Defense-mechanisms

Rumination is not a term that is often used in the psychodynamic literature. The process of analysis already begun in the search for theoretical and empirical psychodynamic literature. Therefore, I had to look for other words and analyze the meaning instead. In this tradition it can be viewed as a depressive symptom which can be characterized as maladaptive defense mechanism, furthermore it can be viewed as self-focused attention or worry used as an avoidant emotion and thinking regulation strategy. Put it differently, rumination can be seen as a defense mechanism which is removing the patient's attention from dealing with more painful circumstances.

Defense mechanisms work in a way that they hide or repress psychological pain by excluding them from the individual's awareness or consciousness (Freud, 1993; Panayiotou & Charis, 2021; Thuesen, 2015). This is unconsciously done by individuals, because insights that eliminates these defenses can be experienced as hurtful or even shocking since insights often reveal painful truths about one's life (Hill, 2014; Thuesen, 2015). If prior experiences and feelings are experienced as too painful or overwhelming, such individuals can develop defense mechanism instead to keep painful feelings out of consciousness (Hill; 2014, Thuesen; 2015). Defense mechanisms, like worrying excessively, are in the psychodynamic traditions viewed as initially triggered to cope with painful feelings or fantasies, but they lead to the exacerbation of depressive symptoms (Busch, 2021).

Rumination like worry can in the psychodynamic tradition can be viewed as one of the more passive and self-directed defense mechanisms which is directed inward rather than outward to outside factors.

To sum up, the psychodynamic therapist must pay closely attention to the defenses that patients employ – rumination being one of these defenses (Busch, 2021; Jacobson; 1954). When defense mechanisms are recognized and understood by patients through insights, they can find more effective and helpful ways of coping with their feelings. Identifying defenses help to gain insight to underlying intrapsychic conflicts (Busch; 2021, Thuesen; 2015, Jacobson; 1954; Schön, 2006).

A psychodynamic case example of "Mr. A"

The original case used in this thesis is to be found within "Psychodynamic theory and approaches to depression" (Busch, 2021, pp. 62-66) in *Depression Conceptualization and Treatment: Dialogues from Psychodynamic and Cognitive Behavioral Perspectives* edited by Charis & Panayiotou, G. (2021, pp. 62-66). For the sake of making references easier, the case is also linked as apppendix 2, which I will refer to in the following passages. The passages that are notes from the psychodynamic therapist are furthermore all written in italics in the appendix 1, in order to make a clear dinstinction between Mr. A's statements and the therapist's own observations. The case follows an example of a psychodynamic treatment of depression and depressive symptoms in which the patient: Mr. A – a 46-year-old white businessman had been suffering from depressive symptoms of rumination, self-doubt, and down mood for about 4 months. Even though this case does not explicitly mention "rumination", it is clear that Mr. A engages in ruminative thinking as will be further explored. Mr. A was also tormented by disruptions in "mood, energy, sleep and concentration", but had no suicidal ideation (Busch, 2021, pp.62-66).

Mr. A's story

In exploring the onset of the depressive symptoms in the earlier stages of the therapy, Mr. A described how his depression was triggered after one of his stores had to close abruptly, since one of his former sponsors and friend withdrew from their agreement:

> Mr. A: “I don’t get why John did this. I’ve really admired his business skills, best in the profession. He’s been helpful with advice when I was anxious about some deals. So it’s really disturbing that he would pull his support so suddenly. I don’t get it, and I’ve felt devastated” (see appendix 2., p.1, l:10-13)

Already in the onset of the therapy, it is clear that Mr. A is rumination in a way that “devastates” him. He is anxiously thinking about all the reasons that his former friend and mentor, John, pulled out his support because it happened so unexpectedly. The unresolved part of: “I don’t get it” - makes rumination an attractive choice of defense mechanisms because - as we have seen in the former chapters – rumination is characterized as being unresolved and therefore unsatisfactory in nature (Nolen-Hoeksema, 1991). For instance, by ruminating and rethinking the past to find solutions or resolutions gives a sense that one is doing something actively when one is in fact doing nothing at all Charis, & Panayiotou, 2021). It seems that Mr. A. is stuck in his mental representations of what went wrong and that makes him feel “devastated”, because no resolution is found in the rumination. As Mr. A. expresses further the lines: “What did I do to screw this up? What did I do that caused him to withdraw? It makes no sense.” (see appendix 2., p.1, l:18-19) This passage shows that Mr. A keeps engaging in the vicious cycle of worry and rumination which is giving him the false sense that he will eventually come to a resolution.

The therapist mirrors and recognizes Mr. A’s feelings when he says: “it sounds terrible that somebody whom you admired so much pulled out like this” (see appendix 2, p.1, l:14-15) and is furthermore asking if the patient is mad at John, because as we have seen in the psychodynamic model of depression - anger is considered one of the main triggers of depression. Therefore, the therapist insists on talking about the theme of anger in the sessions.

Overall Mr. A remembered his childhood as positive only until the birth of his sister at age 5. He tells the therapist that he remembered feeling angry and jealous about the attention that his sister received from his parents. He also remembered that his parents viewed him as the “bad” child and his sister was “the good one” (see appendix 2, p.2, l:4-5) which made him feel “isolated and lonely in response to his parents’ attacks, “as they sometimes would not speak to him for a day or two in response to his behavior” (see appendix 2, p.2, l:6-7). In reviewing why his parents were so critical of Mr. A as he was growing up, it emerged that many of the criticisms were about his tendency toward assertiveness and taking chances that subsequently aided him in being a successful business owner.

For instance, at age 14, he took his father's car for a spin without telling them. He was grounded for 2 weeks but also was castigated for being a "rotten" kid who "would come to no good" (see appendix 2, p.2, l:11-12) As an adolescent, he pushed restrictions and often avoided his studies, leading to his parents' contempt, in part to work in stores where he gained valuable experience. The therapist notes that "none of his actual behavior explained the degree to which he felt his parents perceived him as "bad" and favored his sister" (see appendix 2, p.2, l:14-15). As therapy progressed, Mr. A seemed to come to the realization that his "parents were highly rigid and conservative who were heavily influenced by their own traumatic histories, including growing up in poverty" (see appendix 2, p.2,l:16-17).

Mr. A's story according to the Psychodynamic approach

According to the psychodynamic model of depression, anger that was directed outward to an idealized other - which was then lost or rejected - will eventually become inward directed anger in the form for self-blame and minimized feeling of self-worth. The anger is then turned inward and comes in the form of self-blame, worry and rumination (Busch, 2021). With this understanding in mind, the psychodynamic therapist notes:

> "Instead of being angry at John, he blamed himself, believing he must have done something "bad" that caused John's action. He became catastrophic, frightened that "my whole business is going to fall apart," even though he owned several stores and was losing just one of them. Indeed, he was already in touch with another potential backer. Rather than feeling relieved by this reality Mr. A was already caught in the cycles of depression. He was deeply hurt, and his self-esteem injured by the withdrawal of his friend and believed he did not live up to his own business standards; his anger at John became directed toward himself." (see appendix 2, p.1, l: 22-30)

According to the psychodynamic model of depression, narcissistic injury can cause ego defense which eventually becomes self-directed (Busch, 2021). The patient begins questioning himself as a successful business owner even though the therapist notes that Mr. A owned several stores and was already in contact with a potential financier. The therapist therefore suggests that they ought to examine the history of Mr. A since the sense of failure and self-criticism is felt as much more

overwhelming for the patient than the circumstances call for. The therapist therefore suggest: “Let’s talk about your history to see if that might help us to understand your reactions better” (see appendix 2., p.2, l:1-2). The psychodynamic tradition places a big importance on past childhood experiences since an unhealed trauma can cause injury to the ego or sense of self especially if the trauma happened in childhood. For instance, unhealed anger towards an idealized person, object or concept can cause the ego to defend itself using maladaptive coping strategies like repressing anger (Busch, 2021; Thuesen, 2015).

As the therapy progressed further, Mr. A still devaluated himself and was full of self-blame even when he told the therapist about his success in the real estate business, though it was not perceived that way by the patient. He worked for John and his companions and considered himself a minor player: “I’m not really in the big leagues. I’ve had some accomplishments, but they really pale in comparison to these guys” (see appendix 2, p.2,l:26-27). According to the psychodynamic model of depression, Mr. A’s idealization of John was causing him to devaluate himself: “Mr. A: I still don’t get why John pulled out. I keep obsessing about it. I assume he thinks I’ve made some bad decisions. But I don’t know what those could be” (see appendix 2, p.2, l:30-31). As this passage shows, Mr. A kept ruminating about what went wrong, even after they viewed the patient’s history. Therefore, the therapist continued to address Mr. A’s “devaluation and self-blame, in part by encouraging mentalization” (See appendix 1, p.2,l:27-29. *Mentalization* is a term that is used as the mental operation people have of exploring the meaning of other’s actions in order to meaningfully label their psychological experiences (Fonagy & Target, 1997). In this passage, the therapist challenges Mr. A’s stream of negative, repetitive thinking and is offering a more nuanced way of understanding why Mr. A stopped their agreement. Their conversation goes: “Th: What makes you think he pulled out based on what you did rather than some other reason of his own?” (See appendix 2., p.3, l: 1-2)

> “Mr. A: It feels that way. But I know how he works, and he doesn’t tend to let personal matters cloud his decisions. He probably needed the money for a bigger venture. But I’m worried when this gets around people and they are going to think there’s something bad about me or my business.
> Th: That designation sounds very familiar from your childhood.
> Mr. A: Yes that’s true.
> Th: I believe part of why his withdrawal hurts so much is because you really idealized him to make up for bad feelings you had about yourself, and because you felt he really

> understood you. He recognized your business acumen. That makes it all the more disappointing now that he's pulled back.
>
> Mr. A: I did overestimate him. I mean I never would have expected he would behave in this way." (See appendix1., p.3, l:3-14)

The therapist is using mentalization to question how Mr. A can be so sure about Johns intentional stance and that John's decision was based on what Mr. A did rather than some other reason of his own. Then the patient further ruminates "but I'm worried when this gets around people" and the therapist then links anxious feelings of being the "bad" child to his current situation with John, when he replies: "that designation sounds very familiar from your childhood". There are different interpretations to why Mr. A is feelings so hurt. Firstly, there is the abrupt ending of a friendship and business relation with John, who was deeply admired by Mr. A to a point where he degraded himself. According to the therapist, Mr. A idealized John to make up for the bad feelings he had about himself (Busch, 2020). Secondly, there are childhood memories of neglect and of being the "bad" child who is let down which is triggered by Mr. A's current situation of rejection.

According to object relations and the concept of mentalization, people that have had insecure or ambivalent attachment styles "will attempt to externalize this false part of their self-representation and manipulate the behavior of others around them so these match the incongruent self-representation" (Fonagy & Target, 1997, p. 686).

Mr. A's idealization of John also represents his own idealized view of himself. To put it with other words: Mr. A seems to be very hard on himself. When losing the view of himself as one who is working with people like John who seems to be one of best in real state, he is at the same time losing his sense of self-worth and begins to question himself as a successful businessman though according to the therapist seems "irrational" (see appendix 2, p. 3, l:21). Once the repressed emotions are dealt with and understood in therapy, the recovery can begin because the patient will no longer replicate the depressive symptoms of rumination, anger and sadness (Busch, 2021). The therapist notes: "As the idealization was addressed, he began to more realistically access his friend and became more aware of his anger" (See appendix 1., p.3, l:24-25). Though rumination seems to continue in Mr. A's case.

> "Mr. A: I guess one thing I don't understand is why he didn't tell me about this move before making it. What would have been the problem with that? And that at least would give me some time to prepare for what happened. I wouldn't have been caught up short.

> Th: Well I know you previously denied being frustrated but as you talk you really sound quite mad at him. Particularly about the way he handled it.
> Mr. A: I do see what you're saying. And maybe I am becoming more aware of being angry. I was just blaming myself for what happened.
> Th: According to the idea of you being the bad one.
> Mr. A: Yeah, but the more I think about it, the more I feel he could have worked with me. I mean he could have told me what he thought the problem was, and I could have addressed it. Or he could have said "there's no problem: I just need to use the money for a new venture." And he did create a lot of trouble for me, unnecessarily.
> Th: I think you have been suppressing a lot of your anger and directing it at yourself.
> Mr. A: I think that's true but that's changing." (see appendix 2, pp. 3-4, l:26-32 & l: 1-7).

The therapist is validating and mirroring the patient's feeling of unallowed feelings like anger. In a way, Mr. A's sense of self or ego grew stronger during the therapy. His anger at others was repressed because the patient unconsciously believed that it would cause damage to his relationships starting from his parents and mentor, John. Rumination then worked as a self-directed "badness" in the form of guilt, self-criticism and a sense of being the "bad" one again. That happened when he lost the parents approving view of him and when he lost John, another idealized figure. According to the psychodynamic model of depression, idealizing others help to cope with narcissistic vulnerability but when that bond is cut, the anger becomes self-directed (Busch, 2021). In Mr. A's case it eventually led to disappointment and led him to believe that he would not be capable of achieving the same level of success as John.

Therapeutic change

In the treatment, Mr. A seems to develop a more realistic sense of self especially in the form of recognizing the success already present in his life. There almost seem to be a shift in perception when Mr. A is encouraged to not view himself as the "bad" one and also to be critical of the people in his life that he had idealizing. Once the anger was identified even though the patient didn't recognize it at first – because according to this approach it was unconscious – there emerges a bigger tolerance for those "forbidden" feelings. When anger was justified, Mr. A felt less threatened by it. Once shed

light on his childhood and on the unrealistic and idealized view he had of John, he felt encouraged and relived. Reducing the need to idealize others as a way of protecting them from his feelings.

Sub-conclusion

Freud hypothesized that every hysterical symptom has its origin in some psychologically traumatic event, and when the meaning of the symptoms is revealed, the patient loses the need to experience them (Freud, 1993, 1961). When the meaning of these hypothesis or interpretations are revealed for the patient, the symptoms will stop accordingly (Freud, 1961). When applied to this thesis it would mean that when the symptoms of Mr. A's rumination are revealed, he would no longer feel the need to ruminate. Rumination being a symptom of repressed anger according to the psychodynamic case (Busch, 2021). The psychodynamic therapist has a hypothesis about repressed anger being the main cause of low-self-esteem and rumination. As was illustrated in the former chapters, the psychodynamic model of depression proposes that when anger initially directed outside the self is not expressed and accepted, the patient will experience anger towards the self and hence suffer from low self-esteem.

Generating hypothesis' and assigning meaning in the psychodynamic therapy

- In relation to the case of Mr. A

Even though "Mr. A initially denied being angry at him (John)", the therapist insists on several occasions that Mr. A's main problem is repressed anger. According to the therapist, the repressed anger stems from Mr. A's childhood where he was seen as the "bad" child and later had to make up for it by belittling himself and at the same time idealizing others, for instance by idealizing his friend and mentor, John. The therapist again notes: "as the idealization was addressed, he began to more realistically assess his friend, and became more aware of his anger" (see appendix 2, p.3, l:24-25).

In the sessions with Mr. A, the psychodynamic therapist focuses on enhancing the ego or the sense of self by acknowledging the patient's underlying anger and at the same time finding causes for his depression and negative thinking patterns in former attachment styles to the patient's parents. But I also noticed how the therapist on several occasions illuminated the theme of repressed anger, even though Mr. A did not express it, and even denied it initially. When asked if Mr. A was "mad at

him (John)", he answered: "maybe a little bit but mostly at myself. What did I do to screw this up? What did I do that caused him to withdraw? It makes no sense."

Because of the resolved nature of John's withdrawal, it makes sense that Mr. A began to engage in ruminative thinking, probably thinking that he would eventually come to a resolution of why John cancelled their agreement if he just thought long enough. By ruminating he was also trying to regulate his emotions although it did not work since his thinking was mostly negative. In my opinion Mr. A's thoughts does not necessarily indicate that he is mad at John but since the model of depression indicates that repressed anger is one of the main triggers to depression, the psychodynamic therapist might seem to draw conclusions mostly based on the theory rather than what Mr. A expresses in therapy. And further down the lines in the conversation with Mr. A, the therapist again suggests the theme of repressed anger: "Well I know you previously denied being frustrated but as you talk, you really sound quite mad at him. Particularly about the way he handled it" (see appendix 2, p.3, l:29-30).

Therapists can get eager when formulating hypothesis about their patient's problems and therefore one needs to be aware of suggestion bias and confirmation bias (Flick, 2018). When a hypothesis is continually presented or suggested to the patient, the patient might feel the need to accept the therapist's hypothesis. When Mr. A says: "I do see what you're saying. And maybe I am becoming more aware of being angry. I was just blaming myself for what happened", it can indicate that he is accepting the therapist hypothesis about repressed anger because it is presented by the therapist on several occasions even though initially denied by the patient. According to Høstmællingen (2010), therapist can sometimes use "silent knowlegde" ("taus kunnskap") which is the form of knowledge that cannot easily be explained by words but can be a sense or an intuitive feeling (p.47). When therapists are using silent knowledge in order to draw hypothesis and understanding about their patient's conflicts, it can be difficult for an outsider to understand how they got their knowledge or how they came up with their conclusions. This is especially the case in the "reflective practitioners" work when the novice therapists become confused and frustrated about his supervisor, who is reflecting-in-action ("refleksion-i-handling") by using his intuition and former experiences but does not share how he came up with his analysis (Schön, 2006). Similarly, I do not know the psychodynamic therapist's silent knowledge and might therefore not be able to see the conclusions other than from a psychodynamic theoretical viewpoint.

Sub-conclusion

On many levels, it is clear from the psychodynamic case example that the therapist draws hypothesis and conclusions - for instance about repressed anger - from different aspects of the psychoanalytic/psychodynamic school of tradition. For example, *ego psychology* which derives from Freudian psychology and focuses on enhancing and maintaining the constructions and functions of the ego in accordance with the demands of reality (Freud, 1938; Bienenfeld, 2006). And by using object relations which states that the internal representations of self and others are acquired in childhood and are later played out in adult relations. This theory states that individuals repeat old object relationships to master them and become freed from them (Thuesen, 2015; Hill, 2014; Jacobson, 1954; Schön, 2006).

The notion of psychic determinism - which is the understanding that all mental activity is connected to thoughts and events that preceded it - draws a picture of the psyche being determined by other thoughts and feelings which are largely uncontrollable because they are mostly unconscious. Furthermore, Freud's idea of dynamic unconscious indicates that one does not have control of the greater part of mental activity since it proceeds outside of conscious awareness (Freud, 1938; Schön, 2006). These two Freudian notions together form a psyche that is mostly unconscious and therefore uncontrollable to the conscious mind or "the ego", but in therapy patients can get clearer about their unconscious motives, desires, emotions or thoughts (Thuesen, 2015).

A critique of this understanding might be that patients can become depended on the interpretations and hypothesis generated by the psychodynamic/ psychoanalytic therapist within the context of therapy since last-mentioned is more 'trained' in detecting unconscious motives (Schön, 2006; Hill, 2015). This can generate a sense of helplessness both because the theory states that most of the psyche is unconscious and because the patient can get depended on the therapeutic alliance in order to move forward in his or her life.

The psychodynamic method

The psychodynamic practice is characterized to follow the order: defining the patient's problem, 'challenge and construct interpretations, and to try out and test hypothesis and explanations

when they are thought out' (Schön, 2006, p. 107). Among psychodynamic therapist's there is seldom agreement about how to solve a particular case, since all cases are understood as unique examples. Therefore, psychodynamic therapy is not manualized or standardized, since it can be compared to the work of an artist – who can handle big amount of information, construct it in complex ways, and accordingly view things from many angles without losing the focus or track of the examination (Schön, 2006). Accordingly, the therapeutic situation is viewed as dynamic, hence the psychodynamic therapist must work in "reflection in action", ('refleksion-i-handling', Schön, 2006, p.113) which is experimentally testing in the situation.

The method is accordingly that the psychodynamic therapist must be curious to ask why-questions. If related to this thesis - why is the patient ruminating or worrying excessively? How does this behavior seem to be helping the patient to cope with life on one level? (Busch, 2021; Schön, 2006; Hill, 2014). This can for instance be done by careful analysis and observation both in the interaction between the therapist and the patient, and within the therapist herself through illuminating processes of transference and countertransference (Thuesen, 2015; Schön, 2006).

In the danish translation of Freud's last work (1938/1993): *Psykoanalysen i grundtræk* ("Abriss der Psychoanalyse"), he formulated: "Psykoanalysens lære er baseret på en uoverskuelig mængde af observeringer og erfaringer, og kun den, der gentager disse observationer på dig selv og andre, vil kunne træffe en selvstændig dom" (Freud, 1938/1993, p. 12). Hence the psychoanalytic/ psychodynamic treatment is based on generating hypotheses and in order to that, the analyst/therapist must have a framework of theory that provides a sort of map to the patient's mind and the psychoanalytic/psychodynamic tradition offers a model for that (Freud, 1938/1993; Schön, 2006). Freud's citation, though it is short, assumes that the psychoanalytic/psychodynamic treatment is a rather complex and longitudinal method because - not only does this treatment seek to illuminate the unconscious dynamics within the patient who is seeking treatment – it also involves multifaced factors such as the ongoing analysis and observation, and the dynamics within the therapist or herself (Freud, 1938/1993). Not only does the therapist play a role in the patient's script, but she is also part of the patient's tale so to speak (Schön, 2006; Thuesen, 2015). The therapist within this tradition must therefore pay close attention to her own emotions, so she doesn't transfer them into the patient script. Freud stated that since an analyst is a human, the therapist can easily if she is not conscious and have done self-analysis - let her emotions unto the client (Freud: 1938/1993). Therefore, self-analysis is required so the therapist works on herself in illuminating the unconscious motives within (Thuesen, 2015). These are the notions of *countertransference* and *transference,* and they are still playing a

crucial role in the psychodynamic treatment today (Gabbard, 2001; Thuesen, 2015; Hill, 2014; Busch, 2021).

Generating hypothesis – biases to be aware of

In the psychodynamic theory the idea is that the therapist must be able to generate hypotheses. In order to generate accurate hypotheses, the therapist must have a framework of theory (Schön, 2006). According to Bienenfeld (2006), psychoanalysis with the interpretative form of assigning meaning to the seemingly random symptoms of hysterics made psychic determinism an attractive hypothesis. When the meaning was communicated to the patient, the patient gained further understanding of his or her notion of self and the world, and thus the notion of psychoanalytical method gained further credibility (Bienenfeld, 2006; Freud, 1993) As Binenfeld (2006) notes: "with enough mental effort and creativity, it is possible to assign meaning to all our thoughts, feelings, behaviors, dreams, and mistakes" (p.7).

The psychoanalysis and the psychodynamic therapist must hence make sure that these generated hypotheses and the interpretations about the patient's motives and wishes are both meaningful and accurate for the patient, therefore the hypothesis must be tested ongoingly (Schön, 2006; Casement, 1991) so that biases can be hindered (Flick, 2008). The therapist must have a sense of where the conflict lies (Schön, 2006). In *Den reflekterende praktikker* (2006), the supervisor warns the novice therapist against forming interpretation and links in the patient's history of psychological distress where there might be none or where the connections might be vague. Therefore, the novice therapist must be very careful before trying to fit the pieces into a whole puzzle consisting of the patient's main conflicts (Schön, 2006; Casement, 1991). The notion in the psychodynamic treatment is that the patient is a series which one ought to understand through unique circumstances and life-events (Schön, 2006). Accordingly, the psychodynamic therapist must be aware that he or she does not have the right to test and form reconstructions and hypotheses before he or she is sure that these parts can make sense in the bigger context of the life of the patient (Schön, 2006). These interpretations can only be valid when they are meaningful and make sense for the patient once presented in the therapeutic alliance (Schön, 2006). If these reconstructions do not make sense to the patient, they can indicate wrongful analysis or suggestion bias which are biases that both researchers and clinicians ought to be aware of (Flick, 2018). A good psychologist must hence balance between theoretical knowledge and practical knowledge, the latter being based on the therapist's experience gained in the

therapeutical setting (Høstmælling, 2010). The novice therapist in Schön's text (2006) does not yet have the practical experience and the intuitive sense of generating accurate hypothesis because he is too eager to make conclusions and gain understanding. Similarly, he is eager to use his theoretical knowledge to fit the puzzle, but without an intuitive sense of where the "real" conflict lies in the patient's life, the hypothesis generated will only contain fragments of possibilities (Schön, 2006) Accurate hypothesis are best generated with patience and curiosity as the supervisor notes (Schön, 2006) or "conscious curiosity" as was a term used by Kvale & Brinkmann for qualitative researchers (2009, p.349) . Therapists and psychologist must note that every situation is unique and at the same time the helper must use his or her repertoire of experiences, knowledge and skills both personally and professionally. According to the psychodynamic method it is not possible to be completely objective and rational, since the context is affecting the dynamics between therapist and patient along with other uncontrollable variables (Schön, 2006; Thuesen, 2015; Freud, 1993).

This understanding of generating hypothesis and conclusions can remind of a hermeneutic circulative understanding that ideas, concepts and the like are dynamic and changes according to one's perspective affecting the parts and the whole (Schön, 2006). The practical situation between the patient and therapist is not something the therapist can form as he or she pleases as it then can become a self-fulfilling prophecy. The practitioner must hence deal with his or her own insecurity, confusion and the like when generating hypothesis that might be incorrect (Feilberg, 2019). In order to ensure the therapeutic alliance, Høstmællingen (2010) suggests feedback forms in which the patient can report back about possibly experienced problems within the alliance, so that the therapy can be adjusted, for instance if the patient does not feel understood. This can be done in both therapeutic traditions and can likely be a good learning experience in expanding self-awareness in therapists (Høstmælling, 2010). An example of such a questionnaire for recording therapeutic alliance is the "Working Alliance Inventory" by Hovarth & Greenberg (1989).

MCT and psychodynamic therapy – a dialogue

How is *Rumination* treated in the two cases?

In a metacognitive session, the therapist would have paid more attention to the fact that Mr. A was ruminating and kept ruminating, whereas in the psychodynamic therapeutical setting, the therapist focuses on the feelings - especially negative emotions like repressed anger.

Mr. A keeps ruminating about why his mentor and financial supporter, John had to withdraw from their projects so suddenly (see appendix 1). The answer to John's withdrawal is never solved in the therapy and we do not actually know if Mr. A stopped ruminating about it. What we do know from the conversation between the psychodynamic therapist and Mr. A especially in the end of their session, is that the patient felt more confident in himself and optimistic about the future. In the last conversation the therapist says: "I think you have been suppressing a lot of your anger and directing it at yourself" (see appendix 2., p.4, l:6) whereupon Mr. A says: "I think that's true but that's changing" (see appendix 2, p.4, l:7). It is not clear what is changing though one cannot completely assume that the ruminative thinking is changing. It is more accurate to assume that what is changing is his self-esteem and his ways of self-belittling, and in order to compensate for that, he idealized others. From the therapy he seemingly gained greater understanding of his family history and of his childhood. Supposedly Mr. A had a great deal of suppressed anger stemming from his childhood of being the "bad" kid because from the sessions it seems that once the suppressed anger was understood and analyzed, it could be handled in more helpful ways than directing the anger inward and was initially done by Mr. A (Busch, 2021). Put it differently, once the meaning behind the ruminative behavior was understood, the symptoms of rumination also stopped (Freud, 1938).

In the metacognitive theory and therapy, we see that this tradition treats rumination directly, whereas rumination is treated more indirectly in the psychodynamic approach. This means that it is easier to connect the term of rumination to the metacognitive domain, since rumination is considered one of the metacognitive beliefs that maintain psychological disorders and can be a symptom of depression (Wells & Matthews, 1996). In the case of Leif, we assume that he has now knowledge about maladaptive metacognitive strategies since he expresses that he is no longer "convinced that he has to process the dark thoughts in order to move forward" (see appendix 1, p.1, l:1). Callesen (2020)

> "Now I learned that I didn't have to go into these dark thoughts, that I should just release them and wait to see if they returned. I learned that I could sit in an armchair at home and tell myself that I didn't want to cultivate them" (see appendix, 1, p.2, l:29-41)

Whereas before he believed that he had to analyze the dark thoughts and that he "had absolutely no choice about it" (see appendix 1., p.2, l:38). He even states that he is "not afraid of having another episode of severe depression" (see appendix 1, p.2, l:46). This can be seen as a big accomplishment since it indicates he is not afraid of negative thoughts and feelings. Therefore, Leif will be less likely to attend to the negative thoughts since they are not "triggering" him, and would also be less likely to engage in rumination. Whereas in the psychodynamic approach, the patient is encouraged to express negative thoughts and feelings and therefore also attend to them as they are seen as means for insights (Hill, 2014). Negative thoughts are seen as main triggers of psychological dysfunction in MCT whereas in psychodynamic perspective it is mostly unconscious thoughts, feeling, and motives that is derived from past experiences especially from unhealed trauma in childhood (Hill, 2014; Thuesen, 2015).

Knowing that thoughts do not need to be attended towards gave Leif the freedom of choice. I am curious to understand if knowing that he had control over his thoughts made him less reactive towards his "negative" thoughts and emotions to a degree where it might not be beneficial in the long run. For instance, a psychodynamic critique of Leif's case might be that shutting off the negative thoughts and emotions, one can thereby risk getting emotionally closed off both inwardly and outwardly because also the negative emotions can indicate that one needs to react and make some changes in one's life, or to understand a situation or dynamic more deeply. Sometimes negative or dark thoughts and emotions needs to be attended towards instead of neglecting them as rumination. Also, one might suppress emotions when categorizing them as just thoughts that "come and go" (Leif, see appendix 1, p.2, l: 43). Callesen (2021) uses the analogy of a running sushi table to compare with the stream of thoughts, where one can just let the thoughts pass. I would argue that clients can get fixated on the "good bites" so much to a degree where all "negative thoughts" are passed by and thereby get closed off to the many faceted dimensions of human life. As Hill (2014) noted, the idea in the psychodynamic treatment is not to make the clients feel better, but to make them experience and reexperience emotions. A metacognitive argument might be that patients can get entangled in ruminative thinking and therefore multiply one's own suffering when thinking about the painful

emotions and expressing them (Callesen, 2020). To be able to "release the dark thoughts and move on", as Leif managed, is indeed an important learning in regulating one's emotions. But sometimes the dark thoughts and emotions need to be attended to in order to move forward.

Exploring emotions and past experiences without attaching a stable meaning

From an evolutionary standpoint, emotions are seen as essential for our survival because they inform us whether to fight or flight (Workman & Reader, 2008). Therefore, it has been crucial for our survival to pay close attention to our emotions (Workman & Reader, 2008). But the question is if one can pay so much attention to the painful emotions that it becomes psychologically unhealthy?

Can we pay so much attention to our emotions and our past experiences that we can become too self-aware and self-involved in a way that leads to rumination? Especially if we pay more attention to the negative or dark emotions so that it develops into rumination. The two case-examples of Leif and Mr. A both show that this can happen though it is explained differently according to MCT and psychodynamic therapy. As the metacognitive case example shows, Leif was used to self-monitoring by focusing on negative feelings and thoughts. Mr. A accordingly kept on focusing on the negative side of things instead of the fact that he was still a successful business owner.

In the psychodynamic approach, exploring emotions are of big importance for the therapeutic healing practice (Hill, 2014; Thuesen, 2015). Exploring emotions with loving acceptance can indeed have a positive and healing effect and so can the feeling of being understood and "seen" even by a good friend or a therapist (Hill, 2014). But if the focus is mainly on negative emotions, thoughts will soon be accompanied and chances are high that we get sucked into ruminative thinking accompanied with a spiral of painful emotions (Callesen, 2020). And I would argue that this can happen especially if we assign a meaning and a narrative to these emotions and events that happened in the past. For instance, Leif had a narrative about his thoughts on death as his "lot in life" (see appendix 1., p.1, l:1) which then enhanced negative metacognitive belief that he had no control over it. When assigning meaning to a personal narrative which is also negative – I would argue that it is more complex to let go of the story because one can get entangled in it as it become part of one's identity. Experiencing the dark thoughts which were experienced as his "lot in life", Leif got more hopeless about his future. Placing importance on emotions are important in the psychodynamic literature for several reasons. Emotions and feelings are energetically transitory experiences (Hill, 2014; Workman & Reader,

2008), but when one is attaching a narrative (meaning) to these events, one might get attached to them as part of one's identity and therefore they might not feel like transitory experiences. It is important to take responsibility for the experienced emotions without resisting them or repressing them (Hill, 2014), but I would also argue that it is important to look at emotions as they are – transitory experiences without attaching a stable meaning to them, as stories and identity constructions need to be fluid for change to happen. Human life is complex, and change seems to be the norm especially as technology progressed. Therefore, I agree that exploring the emotions and past life experiences are indeed helpful and healing (Hill, 2014; Thuesen, 2015; Busch, 2021), but one must be adaptable for changing and changes without attaching too much and making the former the former life-events and experiences the core of oneself or one's identity because chances are high that if that construction falls apart, one will become miserable as happened with Mr. A. He had attached so much importance to the story of him part of other successful people's life. His identity was in many ways based on how these people perceived him, and when that identity construction fell apart, Mr. A became depressed which was in a way a good thing, because then he could start placing more value in himself and become more authentic. The psychodynamic treatment was helpful because he realized that he suffered from low-esteem and underestimated himself like his parents had done (see appendix 2).

The psychodynamic therapy is encouraging patients to feel and explore the emotions; hence it might be helpful to become fully absorbed in them for a while in the therapy for instance– especially for some patients who feel alienated or disconnected from their feelings and apathy towards them, but in my opinion – balance is key. There needs to be a balance between exploring the emotions and getting absorbed in them without necessarily making them part of one's whole identity, otherwise negative thoughts which are often attached to negative emotions can lead to rumination and other negative metacognitive coping strategies and/or defense-mechanisms.

Can self-analysis lead to rumination?

Insight and problem resolution are key factors in the psychodynamic therapy, because the goal in the psychodynamic treatment is often to change an aspect of one's identity or personality or to integrate key developmental learning missed in the past where the patient was stuck at an earlier stage of emotional development (Hill, 2014; Thuesen, 2015). Therefore, the psychodynamic treatment is often also a long-term therapy (Schön, 2006).

I would argue that in order to heal from a traumatic event that happened in the past, patient might also be aware of what had happened and if some hurtful emotions were repressed, patients ought to safely and openly express these hidden emotions and thoughts in a safe space like a therapeutic setting. The psychodynamic therapy is often linked to the notion of catharsis because of the cleansing effect it has when one openly and freely shares painful feelings such as shame, loss or neglect (Freud, 1938; Hill; 2014). The question is how much and for how long is one to dwell unto these painful emotions and the thoughts attached before they become part of one's story or sense of self? The treatment ought to change an aspect of one's identity or personality, but by focusing on the things that were hurtful or negative, one might get entangled into a new story of for instance being a victim.

Mr. A realized that his parents could not show him the love and support he needed at that time. They often called him the "bad" and "rotten" kid because Mr. A went his own ways and because they understood life in a different way than him. The fact that Mr. A was neglected especially when his sister was born might have led to a feeling of victimhood and hopelessness – especially if that story was repeated in therapy and became part of his identity - but because there were other factors such as John's withdrawal – the theme of neglect did not become the full focus of attention. Additionally, Mr. A's therapist underlined that he already had success in his work, thereby retelling a story about Mr. A as a success which became part of his newfound identity. The psychodynamic therapist notes:

> "Mr. A felt guilty about his competitive wishes and he experienced John's withdrawal as punishment. This guilt was linked to the intensity of the anger he felt toward his sister for being the focus of his parents' attention. Easing the threat from his competitive wishes diminished his guilt about assertiveness, helping to increase his efforts on his own behalf. This shift also enabled him to be more comfortable recognizing his own success, further reducing his narcissistic vulnerability." (Busch, 2021, pp.64-65).

In treatment of Mr. A, the therapist identified how he idealized his old mentor and other real estate geniuses which triggered rumination about his low self-esteem and made him believe that he was "not capable of achieving their level of success". The therapist highlighted these excessive self-expectations and helped him to "develop a more realistic sense of his success relative to others. This shift in perceptions also helped to relieve his view of himself as "bad"". Furthermore, the therapist notes:

> "Identifying his anger at others led to conscious recognition and greater tolerance of these feelings. He came to believe that anger at his parents and his old mentor were justified and felt less threatened by it" (Busch, 2021, p.65).

This passage indicates that Mr. A learned better ways of anger management as he reduced the need to idealize others and at the same time belittling himself by "protecting them from his feelings" of anger. By mirroring and recognizing Mr. A's feelings, he felt that his anger was "justified and therefore might not had felt the need to engage in suppressing his feelings as he had done before. In my opinion all emotions are justified if one does not react on for instance anger automatically. If emotions like anger is justified to a degree, were they become part of one's coping strategies it is not considered healthy or helpful because of the fatal consequences anger can have on the individual himself or herself and others if reacted to unconsciously. According to the therapist: "better management of his anger reduced the need to idealize others as a way of protecting them from his feelings" (Busch, 2021, p.65).

A critique often found in the metacognitive therapy is that self-analysis can lead to rumination (Callesen, 2021; Wells & Fisher, 2015) Examining the patient's history and assigning meaning to the emotions attached to these events can lead to extended self-analysis which can be seen as a way of rumination – that is: a way of dwelling on the individual's sense of inadequacy which can lead to sustained analysis of the self. By trying to find causes for low moods, one can get entangled into ruminative thinking and fall into symptoms of depression. According to Callesen (2020) thought processing and analysis can be a way of enhancing depressive symptoms – especially if these are mainly negative or dark as we have seen in the case example of Leif and even in Mr. A's case. The former kept on rumination about death and the fact that he was going to die one day, and the latter kept rumination about why his mentor cancelled their agreement. Both patients were unable to find a solution to their problems by ruminating and both men felt hopeless about their situation. Ruminating about their problems, did not give them a sense of relief, instead they kept on getting entangle in the negative thinking and feeling patterns. Similarly, the metacognitive theory underlines that most psychological disorders are a direct result of the extent of distressing thoughts and emotions which are recycled and extended rather than feeling the psychological relief of letting go (Wells & Fisher, 2015). Therefore, MCT therapist is not involved or interested in the content of the patient's thought and beliefs about themselves, instead the metacognitive therapist is focused mainly on how the patient

reacts to negative thoughts, beliefs and emotions since the aim in MCT is to reduce the thinking and fixation maladaptive metacognitive strategies (Wells & Fisher, 2015). According to this tradition, there is a high chance that patient's sense of psychological vulnerability is extended when thinking about the self and verbalizing the thoughts attached to the self or personality. MCT does not directly connect past experiences to present ones and does not therefore analyze and examine thoughts and feelings in the same way the psychodynamic approach does. Instead Wells & Matthews (1996) points out that what makes people depressed is how they deal with negative thoughts and not the content of thinking. Instead of reacting and analyzing negative thinking patterns and placing meaning onto the negative content of thinking – which is done in rumination - they suggest a rather passive or objective observation of thinking (Wells & Matthews, 1996; Callesen, 2020). This is because the metacognitive theory and therapy shares the belief that the mind has the capabilities to heal and regulate itself and this is best done in a relaxed state which is the opposite of ruminating (Wells & Matthews, 1996; Callesen, 2020). Even though metacognitive theory argues that analysis and dwelling on painful thoughts and feelings are unnecessary and can lead to rumination - because of already active healing properties of the mind once unhelpful metacognitive strategies are let go of (Wells & Mathews, 1996; Callesen, 2020) - it is important to note that there lies a wisdom in emotions.

Emotions as a gateway to compassion?

Emotions ought to be explored in order to transform (Hill, 2014) When therapist has the capacity and courage to explore and understand human pain – firstly within the therapist himself or herself – I would argue that this can indeed create a strong therapeutical alliance because the patient might feel a stronger sense of being understood, heard and seen since therapist's have an understanding about human suffering. In short, the patient might feel the healing power of compassion. In order to understand another human being on a deeper, it is necessary to have a "holistic understanding" ('helhedsforståelse') which both contains the social and cultural understanding of life-worlds and at the same time includes the individual himself or herself (Feilberg (2019, p.108).

Compassion can arise when therapist's work with themselves in an almost cathartic way (Hill, 2014) – especially in the psychodynamic tradition - where the psychodynamic therapist's work to illuminate the shadow sides of the self – thoughts, feelings, ideas, motives and the like that are unpleasant and therefore shut out of consciousness or "the ego". In order to understand another

person, we must think and feel as that person so to gain a holistic perspective (Feilberg, 2019, p.108). The psychodynamic therapist is encouraged to work with his or her own maladaptive needs and relational dynamics among other themes so that the therapist does not engage in destructive processes of transference and countertransference especially in the therapeutic setting (Thuesen, 2015). If worked constructively and openly, I would argue that this can lead to a sense of more compassion to other human's suffering which might indeed be helpful in the therapeutical alliance rather than a feeling of hopelessness and a tendency to engage in rumination and other maladaptive strategies as was argued in the metacognitive approach (Wells & Fisher, 2015; Callesen, 2020). Thuesen (2015) notes that most of errors therapist's makes are mainly caused because of ignorance of not knowing oneself. Once therapists know himself or herself because of the inner work they have done, they are also less likely to project unconscious needs and issues onto the patient (Thuesen, 2015). The notion of countertransference and transference can hence be very helpful in the therapy as they are illuminated. The idea in the psychodynamic approach is that as human beings we repeat old relational patterns and dynamic until we are conscious or aware of these (Thuesen, 2015; Schön, 2006).

Controlling versus experiencing

Psychodynamic theory has less to do with an attempt to directly control thoughts and emotions and more to do with the experiencing and reexperiencing of emotions. Thereby giving a sense of agency and control since patients would become less likely to react on painful emotions once they were experienced deeply and consciously in a safe setting and with the therapist as witness and helper (Hill, 2014).

Oppositely, the CAS- model in the metacognitive theory underlines that one can gain direct control over thinking – not the content of thinking and what thoughts occur, but what thoughts one decides to place attention (Wells & Mathews, 1996). These statement sounds relatively simple and logical and once they are mastered, they can evoke a sense of control and agency as was clear with "Leif", but might also lead to a sense of failure if one fails in letting go of unwanted thoughts and feelings. Metacognitive therapy is about self-regulation and emotional regulation in respect to "the choice of attention" according to the CAS model. For instance, one can choose to spend less time on thinking and believing the trigger-thoughts which trigger unhelpful emotional responses and behaviors. The metacognitive therapist ought to inform the patient that he or she does not need to

spend a lot of time on ruminating but to focus more on the present moment (Callesen, 2020). MCT challenges the notion that unprocessed thoughts and emotions can lead to depression and is offering knowledge of problem-solving strategies, for instance knowledge about rumination and the fact that this metacognitive thinking style leads to more contemplation, worry and overthinking. Accordingly, the metacognitive beliefs believed in patients will determine whether patients fall into ruminative thinking or not (Callesen, 2020). In short: a lot of responsibility is placed on the client because according to this theory it is individuals themselves that get themselves into ruminative thinking (Callesen, 2020;Wells & Matthews, 1996).

To conclude: Whereas some patients or clients might benefit in deeply engaging and exploring hidden or painful emotions in order to gain acceptance, understanding and to evolve emotional intelligence, others might need more hands-on techniques like detached mindfulness in order to gain mental clarity. I would argue that there lies a beauty and a possibility of deep learning both when patients are encouraged to explore emotions in a deep way without necessarily reacting to them in an objective manner, and at the same time there lies a beauty in getting absorbed in emotions for a while similar to the work of an actor or actress.

A holistic approach

As a long-term student of academia, first; comparative literature and later; psychology, I have become aware that by becoming too focused and engaged in one school or tradition in particular, the chances were high that I would get inflexible, narrowminded, and eventually lose track of the whole perspective. In my internship, I was mentored and supervised by an authorized psychologist who worked similarly to a metacognitive approach. She is the author of *Dit Selvhelbredende Sind* (2017). I found that many of the techniques and practices learned in the internship were helpful along with the understanding of how ruminative thinking affected both mental, emotional, and physical responses in my clients. But I was also aware that I should not close myself to other approaches so to not become one one-sided about the approach that I practiced. By favoring one approach researchers might get blind-sided towards other approaches and perspectives, which is biases to be aware of as a

student as well as practitioner (Flick, 2008). Theoretical or psycho-therapeutical favoritisms can create binary oppositions (Schön, 2006). Furthermore, I realized that though my personal and professional experiences with the approach of *the three principles* - which is in many ways similar to the metacognitive understanding and approach to cognition and ruminative thinking – I somehow sensed that some patients might indeed benefit from deeply exploring emotions and that there lies a wisdom and intuition in the feelings (Høstmællingen, 2010).

According to Morten (2010) the psychologist needs to be integrated in all the forms of science since: ”psykologi som fag befinder sig mellem naturvidenskab, humaniora og samfundsvidenskab og omfatter ideelt set alle tre måder at forholde sig til tilværelsen på” (p. 128). Furthermore, he notes that the psychologist ought to work with themselves in both professional, practical and personal areas (Morten, 2010). In order to ensure quality in the work of the therapist or the practitioner, the whole or entirety must be included for instance through experiences, pre-understandings, and a continuation of the most beneficial understandings within the traditions (Høstmælingen, 2010; Feilberg, 2019). This is what Feilberg (2019) names “professionsfaglig habitus (p. 109) or when translated into English ’professional habitus’ which is that the professional work is based on independent reflection. Furthermore Feilberg (2019) notes that the professional habitus is integrated in self-awareness in a way where the practitioner has worked with his or her own blind spots - as was also noted by Thuesen (2015). One way to work with one’s blindsides is to open to new understandings and perspectives (Flick, 2008). By comparing and discussing two seemingly opposite traditions in relation to the subject of inquiry, I was in a way forced to open to new ways of thinking as I could tell that indeed both in theory and in practice, the metacognitive and psychodynamic school had some interesting and meaningful ideas and practices but when used and understood together they might form an even more meaningful blend and understanding of both knowledge about metacognitive strategies and a understanding of emotions and unconscious needs. According to Feilberg (2019) “the educated habitus” is when the researcher or psychologist has worked with his or her own blind spots and at the same time has the courage to keep exploring new ideas and understandings in order to keep developing and learning (pp. 121-123). “Self-reflection” which Feilberg (2019) refers to is accordingly an important quality for researchers and psychologist to develop so that one has the courage to question and criticize one’s own scientific knowledge, methods and ideologies. Likewise, Spring (2007) notes that: “evidence-based practice in psychology is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences” (Spring, 2007, p.612). And after all it is the contact in the therapeutic relation that is

healing independent of the intervention (Thuesen, 2015). In the Ethical Principal declaration of Nordic Psychologists (EPNP, 2016) it is mentioned that psychological practices in its essence is an interpersonal relation between psychologist and patient which in itself is a dynamic term, where the psychologist has to take different aspects about the patient life into consideration – as was noted by Spring (2007).

Conclusion

The metacognitive and psychodynamic approach differ in essential ways in which they relate to rumination. The chapters showed that they differed in the degree to which they rely on empirical data to support their effectiveness, their proposed understanding of disorder etiology, and the concept of therapeutic change. This creates difficulties in making comparisons but at the same time also leading to fruitful discussions.

Psychoanalytic/ psychodynamic theory and therapy has a rich description about the development of personality and treatment based on the unconscious processes such as feelings, desires, and drives of people (Hill, 2014), but when it comes to rumination, psychodynamic theory has not directly formulated a theory about this phenomenon. Therefore, I had to search for other keywords and synonyms of depressive symptoms such as: "worry, contemplation, self-doubt or self-criticism" which can have similar characteristics of rumination because these activities seem to enhance the vicious cycle of repetitive negative thinking. Another reason that rumination is not often found in the psychodynamic literature might be that this tradition is known to illuminate the unconscious motives, drives, and defenses that maintain psychological distress (Freud 1938/ 1993; Thuesen, 2015; Hill, 2014; Busch, 2021; Jacobson, 1954). The psychodynamic treatment might dwell on dynamics outside of the patient's immediate awareness, and since rumination is often something that the patient is aware of doing (Panayiotou & Charis, 2021), the psychodynamic psychotherapist will often be more interested in the reason behind why patients are rumination and not the symptom of rumination as was shown in the psychodynamic case example of "Mr. A". Accordingly, rumination might be viewed as a defense-mechanism.

In opposition, Metacognitive Therapy (MCT) has indeed been interested in the phenomenon of rumination and has formulated a theoretical framework of rumination and its causes – being one of

the symptoms of depression and maladaptive metacognitive strategies (Wells & Matthews, 1996; Nolen-Hoeksema et. al, 2008, Roelofs et. al., 2007). Wells and Matthews (1996) identified the cognitive attentional syndrome (CAS) that according to them was a general and universal pattern of thinking and cognitive processing that occurred in psychological disorders. In CAS, the individual is focusing her attention mainly on sources of threat, rumination, worry, and thus developing unhelpful coping behaviors because those coping strategies interfere with effective self-regulation and in result impair the change in perception and knowledge (Wells & Matthews, 1996). MCT considers rumination a cognitive vulnerability factor in the development and maintenance of depression (Wells & Matthews, 1996; Charis, & Panayiotou, 2021; Cano-López et al., 2021). The metacognitive model of rumination and depression suggests that the development of rumination and its association with depression partly depends on metacognitive beliefs (Wells & Matthews, 1996; Wells, & Fisher, 2015). In the metacognitive case, "Leif" came to understand his ruminative thinking style as a maladaptive metacognitive strategy and learned about detached mindfulness as a way of coping with rumination (Callesen, 2020).

Human beings have different needs and might likely benefit from different traditions. Whereas some clients might benefit from metacognitive therapy and a more technical and rational understanding of cognitions – especially the metacognitive beliefs - others might benefit from psychodynamic therapy where clients can explore and express emotions that are hidden or unconscious. These traditions do not eliminate each other but adding more complexity and richness to psychology. As was discussed earlier, the two approaches both have pros and cons. Therefore, I would argue that the middle way is to prefer, that is – balancing between different theoretical knowledge, personal experience and intuition, and furthermore tuning in with the contextual situation which is also dynamic.

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