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Pathological Worry and Rumination According to Control-Mastery Theory

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The aim of this article is to propose an interpretation of pathological worry and rumination based on the control-mastery theory (CMT), an integrative, relational cognitive-dynamic theory of mental functioning, psychopathology, and psychotherapy process developed by Joseph Weiss and empirically verified by Weiss, Harold Sampson, and the San Francisco Psychotherapy Research Group over the last 50 years. In the first part of this article, we will introduce the basic concepts of CMT and how this theory integrates dynamic and cognitive concepts into a relational theoretical frame. Then, we will review several definitions of pathological worry and rumination and their clinical features and consequences. We will differentiate these processes from the normal reflection processes aimed at solving problems and mastering traumas and will review research data supporting this differentiation. Finally, we will discuss some of the more important cognitive theoretical models for explaining pathological worry and rumination. In the last part of this article, we will describe how CMT can help understand pathological worries and ruminations and their functions. According to CMT, pathological worry and rumination are distortions of normal reflexive thinking often caused by pathogenic beliefs that support interpersonal guilt, and their unconscious aim is often self-punishment. Three clinical vignettes will help us show how CMT can help us understand and treat pathological worry and ruminations.

Keywords: worry, rumination, control-mastery theory, guilt, self-punishment

If a person has good reasons to think that something bad may happen to her/him or to a person s/he cares about, we find normal that s/he is worried, and we find this worry inevitable and even useful because, even if it is unpleasant, worry may help this person to find useful ways to deal with the problem and its emotional consequences. However, we may expect that this worry will subside if the feared negative event does not occur or if a solution is found. However, some people may worry a lot even if the feared negative event is very unlikely to occur, and their worry may persist even if the feared negative event does not happen or if a solution has been found. In this case, we may say that worry becomes pathological.

Along the same line, we think that it is normal and adaptive that a person keeps on ruminating about negative and painful past experiences, and we think that this kind of reflection, even if connotated by negative emotions, is the basis of our ability to learn from experience and to master adverse experiences. But in some people this process becomes very long, and it seems to have long-lasting negative consequences on their mood and their capacity to solve present problems. In cases such as these, we may talk about pathological rumination.

The aim of this article is to introduce the reader to recent advances in knowledge and hypotheses about pathological worry and rumination and to how control-mastery theory (CMT; Gazzillo, 2016; Silberschatz, 2005; Weiss, 1993; Weiss, Sampson, & The Mount Zion Psychotherapy Research Group, 1986) may help us understand them. Given that, to our knowledge, there is no empirically supported dynamic model explaining pathological worry and rumination, we hope that this article can be a little step to bridge this gap.

The Basic Concepts of CMT

CMT (Gazzillo, 2016; Silberschatz, 2005; Weiss, 1993; Weiss et al., 1986) is an integrative, cognitive-dynamic relational theory of mental functioning, psychopathology, and therapeutic processes. Its core hypotheses were developed by Joseph Weiss and have been empirically verified by Joseph Weiss, Harold Sampson, and the San Francisco Psychotherapy Research Group over the last 50 years. The name control-mastery theory derives from two of its basic assumptions: 1) People are consciously and unconsciously able to control their conscious and unconscious mental functioning; and 2) they are autonomously motivated to solve their problems and master their traumatic experiences. Consistent with recent developments in social cognition, experimental psychology, infant research, and evolutionary psychology (Bargh, 2017; Dijksterhuis & Aarts, 2010; Weinberger & Stoycheva, 2019), CMT stresses how we are able to unconsciously perform many of the same complex mental functions that we perform consciously.

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According to this higher mental functioning hypothesis, we can unconsciously set and pursue goals, assess reality, make inferences, develop, test, and modify or abandon our plans on the basis of the results of their implementation, and so on (e.g., Gassner, Sampson, Brumer, & Weiss, 1982; Weiss, 1990; for reviews, see Silberschatz, 2005, 2017). The basic principle that we follow in order to regulate our mental functioning is a safety principle (Weiss, 2005), and our overarching motivation is to adapt to our environment in order to pursue healthy and evolutionary-based developmental goals. From the beginning of our lives, we consciously and unconsciously try to assess whether and to what extent it is safe for us to try and pursue these adaptive goals, and this motivation to adapt to our environment implies the necessity of, above all else, establishing sufficiently secure relationships with relevant others (Beebe & Lachmann, 2013; Gazzillo, Dazzi, De Luca, Rodomonti, & Silberschatz, 2019) and developing reliable knowledge about reality and morality and about ourselves, other people, our relationships, and the world (Gopnik, Meltzoff, & Kuhl, 1999; Silberschatz, 2005; Stern, 1985; Weiss, 1993). This knowledge can be conceptualized as a system of beliefs that we try to make as coherent, comprehensive, and economical as possible. Some of our beliefs are conscious and explicit, and others are implicit, procedural, or unconscious; they all store the contingencies that we detect in our experiences and may be formulated following an "if . . . then" format (Tarabulsy, Tessier, & Kappas, 1996). For example, "If I cry, my mother will come and sooth me"; or "If I smile at another person, that person will smile back at me." Given that we start to develop our system of beliefs during our developmental period, many of our core beliefs are influenced by the cognitive and emotional peculiarities of our childhood mental functioning: the tendency to overgeneralize, the lack of experience, the need to see our parents and siblings as good and wise—and believe that they love and are happy with us—and the tendency to assume responsibility for everything that happens to us and the people we love.

When faced with adverse experiences and shock and stress traumas that make us lose our sense of safety, we try to understand why these events happened, how we could have prevented them, and how we can prevent them in the future. In other words, we reflect about them in order to learn from them how to adapt to them. In such situations, given our childhood tendency to attribute responsibility for what happens to ourselves and to preserve a good enough relationship with our own caregivers, and their images as good and wise (Bush, 2005; Gazzillo et al., 2020; Shilkret & Silberschatz, 2005; Zahn-Waxler, Kochanska, Krupnick, & McKnew 1990), we tend to develop beliefs that associate our pursuit of adaptive goals with dangers to ourselves and the people we love. In other words, we may develop beliefs that could be called pathogenic because they are grim, constricting, and might cause inhibitions, suffering, and symptoms. These pathogenic beliefs obstruct our desire to pursue adaptive goals, or make us feel afraid, ashamed, or guilty when we try to pursue them (Sampson, 1990, 1992; Weiss, 1997).

As recently suggested by Gazzillo, Genova, et al. (2019) there are four main strategies that are associated with pathogenic beliefs: 1) *complying* with the pathogenic belief in order to feel safe; 2) *noncomplying* with the pathogenic belief in the attempt to pursue the goals they obstruct; 3) *identifying* with the caregivers whose attitudes and behaviors were traumatizing and gave rise to the pathogenic beliefs, shifting from a passive to an active role (see also Foreman, 2018); 4) *counteridentifying*[1] with the traumatizing caregivers to show what one would have needed to receive, and did not receive, by the traumatizing caregivers. Pathogenic beliefs, and the affects and the strategies connected to them, give rise to *pathogenic schemas*. For example, a person who has the pathogenic belief that if s/he expressed her or his needs, they would be rejected because this was the way her or his mother reacted to her or him may 1) avoid as hard as s/he can to express her or his needs and feel frustrated and lonely (compliance with the pathogenic belief); 2) try as hard as s/he can to express her or his needs and feel anxious and pessimistic about their satisfaction (noncompliance with the pathogenic belief); 3) generally reject other people's needs (identification with the rejecting parent); or 4) always be welcoming and caring with other people's needs (counteridentifications with the rejecting parent). Thus, pathogenic schemas are relatively stable psychic structures connecting pathogenic beliefs, affects, and behavioral strategies.

CMT, anticipating recent developments in moral and evolutionary psychology (Gazzillo et al., 2020; Haidt, 2012; O'Connor, 2000; Zahn-Waxler et al., 1990), and in line with the hypotheses of some U.S. analysts (Asch, 1976; Loewald, 1979; Modell, 1965, 1971; Niederland, 1981), has deepened our understanding of five kinds of interpersonal guilt supported by pathogenic beliefs (Gazzillo et al., 2017, 2018; O'Connor, Berry, Weiss, Bush, & Sampson, 1997): *survivor guilt*, experienced by people who feel that having more success, satisfaction, good fortune, or other positive qualities than important others may hurt them; *separation/disloyalty guilt*, based on the belief that separating physically or psychologically from loved ones and becoming independent can cause them harm; *omnipotent responsibility guilt*, based on the belief that one must—and has the power to—make loved people feel happy, so that putting the satisfaction of own needs to the fore means being selfish; *burdening guilt*, derived from the pathogenic belief that one's emotions and needs are a burden to loved people, and that if one's own problems and fragility are expressed, other people are burdened by them; and, *self-hate*, based on the conviction that one is bad, flawed, inadequate, and worthless. Unlike the other kinds of guilt, self-hate is self-accusation directed at what one is, not at what one has done or could potentially do, and its interpersonal origin derives from the fact that in the presence of ill-treating, neglecting, or abusive parents, it is safer for a child to think that she or he deserves the mistreatment rather than feeling dependent on parents who are actually bad (Fairbairn, 1943).

Starting from these premises, according to CMT, inhibitions and symptoms may be thought of as expressions of pathogenic beliefs and schemas.

The Therapeutic Process According to CMT

Given the intrinsic motivation to adapt to one's environment and pursue adaptive goals, people are intrinsically motivated to become conscious of and disprove the pathogenic beliefs that obstruct them (Silberschatz & Sampson, 1991). The principal way in which we try to disprove our pathogenic beliefs is by testing them.

[1] By counter-identification we mean an (unconscious) attempt to be completely different from another person who hurt us or toward whom we had strong negative feelings.

With the term "tests" (Gazzillo, Genova, et al., 2019), CMT refers to conscious and unconscious attempts to disprove pathogenic beliefs by trialing actions, communications, and attitudes to test whether the reaction of the other person confirms or disproves them. It is possible to distinguish two different testing strategies: *transference tests* and *passive-into-active tests*. With the first testing strategy, the person assumes the role of the traumatized child and gives to the other the role of the potentially traumatizing other. In passive-into-active tests, in contrast, the person assumes for her- or himself the role of the potentially traumatizing caregiver while giving to the other the role of the traumatized child. Moreover, as recently suggested by Gazzillo, Genova, et al. (2019), both transference and passive-into-active tests may involve compliance or noncompliance with the pathogenic belief tested. In transference testing by compliance, the patient exhibits an attitude or behavior that shows her or his compliance with the pathogenic belief tested, while in the transference test by noncompliance the patient displays attitudes or behaviors that show her or his noncompliance with her or his pathogenic belief. Let us give an example. A male patient who—having seen his parents always unhappy because of their marital problems—believes that if he had a satisfying love relationship, he would hurt his parents by making them feel inferior (survivor guilt), may test this belief by using any of the strategies shown in (Table 1).

Although virtually any behavior, attitude, or communication on the part of the patient might have a testing dimension, there are some indicators that may help us understand whether a patient is testing the therapist (Weiss, 1993, p. 95): (a) She or he arouses powerful feelings in the clinician; (b) she or he pushes the clinician to intervene; or (c) she or he behaves in a way that is particularly absurd, illogical, provocative, or extreme.

Given that patients, when testing their pathogenic beliefs, expose themselves to the danger of being retraumatized, they tend to be more anxious and less relaxed during the testing phase. Conversely, when the therapist passes their tests, they tend to feel relieved, less anxious, and less depressed, more involved in the therapeutic process and therapeutic relationship, and bolder and more active in pursuing their goals. They may also gain new insight, bring forth previously repressed or dissociated contents, and test the therapist more vigorously. When the clinician fails their tests, they tend to become more anxious and depressed and may retreat from pursuing their goals, change the topic, or become silent, and the therapy may end in a stalemate (for empirical research data supporting these hypotheses, see Horowitz, Sampson, Siegelman, Wolfson, & Weiss, 1975; Silberschatz, 1986; Silberschatz & Curtis, 1993; Weiss et al., 1986).

Finally, according to CMT, patients will come to therapy with an unconscious plan (Curtis & Silberschatz, 1986; Silberschatz, 2008; Weiss, 1998) aimed at pursuing healthy goals; disproving the pathogenic beliefs that obstruct them; mastering the traumas and adverse experiences that gave rise to those pathogenic beliefs; looking for specific responses, relational qualities, and attitudes from the therapist in order to have their tests passed; and hoping to obtain some insight into the nature, origins, and sense of their difficulties. Goals, pathogenic beliefs, traumas, tests, and insight are the core components of the patient's plan. Patients want to feel safe in pursuing their developmental and adaptive goals, and so their plan may also specify which goal should be pursued first and which pathogenic belief must be disproved before working on the others. A patient's plan is like a blueprint or a compass that signals the direction to follow, with a degree of detail and structure varying among different patients. The plan formulation method (Curtis & Silberschatz, 2007), a research method with empirically validated operationalization, shows that it is possible to formulate a reliable patient plan on the basis of the first 2–10 sessions; the plan formulated in this manner is a good guide for the therapist. Indeed, therapists' communications and responses that support patients' plans have immediate and long-term positive effects on the outcome of psychotherapy (for empirical research data supporting these hypotheses, see Curtis, Silberschatz, Sampson, & Weiss, 1994; Curtis, Silberschatz, Sampson, Weiss, & Rosenberg, 1988; Foreman, Gibbins, Grienenberger, & Berry, 2000; Horowitz et al., 1975; Silberschatz, 1986, 2005, 2017; Silberschatz & Curtis, 1993; Silberschatz, Curtis, & Nathans, 1989).

Thus, CMT can be considered a dynamic model of mental functioning because of the centrality it gives to higher-level unconscious mental functioning; to the sense of safety; to unconscious motivations and moral emotions such as guilt and shame; to the role of childhood object relationships in shaping personality development, and to the therapeutic relationship in the clinical process. Quoting what we wrote in a previous article (Gazzillo et al., 2020),

> CMT, even if born from American ego psychology, is more in line with the hypotheses of British relational theorists like Winnicott (1958, 1963) and Fairbairn (1952), of attachment researchers (Cassidy & Shaver, 2018), of self-psychologists (Bacal & Newman, 1989), and of contemporary relational and intersubjective theorists (see, e.g., Mitchell, 2000; Stolorow & Atwood, 2002)

Table 1
Examples of the Different Possible Strategies for Testing a Pathogenic Belief

Testing strategies	By compliance	By non-compliance
Transference test	Avoiding women, starting relationships with unsatisfying women, or sabotaging his relationship with potentially satisfying women hoping that the therapist will help him understand that he deserves a satisfying love relationship.	Being very selective in choosing women to go out with, or very sensitive toward any possible flaw in a woman he is starting to meet, hoping that the therapist will legitimize his right to have a satisfying love relationship.
Passive-into-active test	Making the therapist feel guilty for her/his satisfaction with her/his loving relationship, hoping that s/he will not be upset by that behavior and keep on showing to feel entitled to have a satisfying love life.	Always being careful in supporting the right of the therapist to be satisfied with her/his love relationships, hoping that the therapist will appreciate this attitude.

> than with classical Freudian and Kleinian psychoanalysis. All these authors, in fact, hypothesize a basically relational orientation in human psyche, abandon the hypothesis of a death instinct and give a central role to real experiences in psychic development and change. . . . Finally, in line with contemporary infant researchers (see, e.g., Stern, 1985), CMT stress how children, far from being narcissistic and incapable of differentiating the self from the mother and of being interested in external reality, are since the beginning intrinsically interested in developing and testing hypotheses about how the world works (see Silberschatz, 2005, pp. 224–230). However, CMT share with cognitive psychology the overarching role it gives to constructs such as pathogenic beliefs and schemas in explaining psychopathology. (p. 44)

As we will see in the last part of this article, according to CMT, psychotherapy needs to be case-specific in order to be effective because therapists have to help their patient carry out their own specific plan for psychotherapy. For this reason, it is impossible to develop a manual that describes a CMT therapy in general or specifies, a priori, if the couch should be used or not or how many sessions per week are needed in a treatment. However, the basic hypotheses of CMT about the therapeutic process have been empirically tested and verified (see Silberschatz, 2005 for an overview; and Silberschatz, 2017 for a recent study). For this reason, CMT can be adopted as a therapeutic model per se, but can also be integrated with different theoretical and technical approaches that share its basic hypotheses. The existing CMT training programs, held both in the U.S. and in Italy, are based on a theoretical part where the basic concepts of CMT are taught, and on a clinical part based on the plan formulation method and its application to the clinical material of the trainees.

Pathological Worry and Rumination: Definitions and Descriptions

Worry and rumination are very common in both clinical and nonclinical populations (Davey & Tallis, 1994) and can be considered transdiagnostic processes (Kertz, Bigda-Peyton, Rosmarin, & Björgvinsson, 2012; Watkins, 2008) and risk factors for the maintenance and exacerbation of negative emotions and moods (Nolen-Hoeksema & Watkins, 2011; Watkins, 2009). They are part of many emotional problems (Wells & Matthews, 1994, 1996), such as anxiety disorders, (Barlow, 2002; Starcevic et al., 2007), panic disorders (Mohlman et al., 2004), obsessive–compulsive disorders (Gladstone et al., 2005), and depressive disorders (Gladstone et al., 2005; Starcevic, 1995). Even behaviors such as binge eating or binge drinking may be used to temporarily find relief from worry (Nolen-Hoeksema & Harrell, 2002; Nolen-Hoeksema, Stice, Wade, & Bohon, 2007).

Over time, different definitions of these two concepts have been proposed, particularly by cognitive–behavioral scholars. Worry has been defined as a relatively uncontrollable chain of negative thoughts and images. It represents an attempt to engage in mental problem-solving on issues whose outcomes are uncertain but probably negative. Thus, worry is also closely related to fear (Borkovec, Robinson, Pruzinsky, & Depree, 1983) and the attempt to devise coping strategies aimed at dealing with a dreaded negative outcome. However, these strategies are largely unsuccessful, and worry produces significant additional problems (Borkovec, 1985; Roemer & Borkovec, 1993).

On the other hand, Rippere (1977) defines "rumination" as a form of persistent, circular, and depressive thinking, and a common reaction to a negative mood. According to Nolen-Hoeksema (1991), ruminating means being repetitively focused on the fact of being depressed—and on depressive symptoms and their causes, meanings, and consequences—and has been considered an emotional regulation strategy or a metaemotional cognitive process (Gross, 1999). According to Papageorgiou and Wells (2004), rumination refers to a difficulty in controlling repetitive thoughts on personal problems; Martin and Tesser (1989, 1996) think that rumination is an effect of the failure to progress sufficiently toward important goals (Martin, Tesser, & McIntosh, 1993).

These definitions indicate that worry and rumination have much in common and are interrelated (Fresco, Frankel, Mennin, Turk, & Heimberg, 2002; Segerstrom, Tsao, Alden, & Craske, 2000; Sibrava & Borkovec, 2006; Watkins, 2004; Watkins, Moulds, & Mackintosh, 2005). First, both are repetitive, self-focused, and perseverative forms of thought (Barlow, 2002; Borkovec, Alcaine, & Behar, 2004; Segerstrom et al., 2000) and often reflect an overgeneralizing and abstract way of thinking (Stöber, Tepperwien, & Staak, 2000; Watkins & Teasdale, 2001) that is characterized by cognitive inflexibility and an attention focused mainly on negative stimuli (Hazlett-Stevens & Borkovec, 2001; Nolen-Hoeksema & Davis, 1999). They determine attention and concentration difficulties, performance deficits, and an impairment in problem-solving activities (Lyubomirsky & Nolen-Hoeksema, 1995; Watkins & Baracaia, 2002; Watkins et al., 2005). They are associated with an exacerbation of anxiety and depression (Abbott & Rapee, 2004; Barlow, 2002; Fresco et al., 2002; Harrington & Blankenship, 2002; Nolen-Hoeksema, 2000) and an inhibition of effective emotional processing (Segerstrom et al., 2000).

Although empirical studies found that worry and rumination partially overlap (from 16% to 21%; i.e., Segerstrom et al., 2000), they also have some important differences. Rumination is more past-oriented, focused on losses and failures, on the reasons why something happened, and on the attribution of meaning and causes to what happened (A. T. Beck, 1967, 1976; McLaughlin & Nolen-Hoeksema, 2011; Nolen-Hoeksema, Wisco, & Lyubomirsky, 2008; Watkins, 2004; Watkins et al., 2005). Worry is more future oriented and is aimed at avoiding and preventing dangers and threats (Borkovec, Hazlett-Stevens, & Diaz, 1999) by considering and planning different options. It seems that people who worry are uncertain about their capacity to control events and cannot tolerate this uncertainty (Dugas, Gagnon, Ladouceur, & Freeston, 1998). In fact, by worrying, they try to anticipate possible threats and how to deal with them, but even if nothing bad happens, the worry does not come to an end (Borkovec et al., 2004). Nolen-Hoeksema et al. (2008) suggest that people who have the tendency to worry have some belief that they could prevent negative outcomes if they just worry more (Alloy, Kelly, Mineka, & Clements, 1990). While they are ruminating, they believe that important outcomes are definitely impossible to reach (Lyubomirsky, Tucker, Caldwell, & Berg, 1999). However, worry and rumination are substantially similar,

and both derive from similar metacognitive beliefs about the utility of such repetitive way of thinking (Wells, 2009).[2]

Worry and Rumination Versus Reflection

It is important to differentiate adaptive self-reflection versus pathological worry and rumination. To a certain extent, it is adaptive for people to muse on relevant negative past experiences, or on possible future dangers, and try to understand what they could have done to cause them or what they should do if a feared negative event does occur. These processes are useful for mastery and problem solving. Thus, even if normal reflection on negative events and possibilities temporarily supports a negative mood, when used in a flexible way and in combination with other coping strategies, it may help adaptation (Mor & Winquist, 2002; Papageorgiou & Wells, 2004; Trapnell & Campbell, 1999).

It is likely that the extent to which reflection remains an adaptive cognitive process, or becomes a form of maladaptive worry or rumination, depends partially on additional psychological factors, such as individual beliefs (Takano & Tanno, 2009). Szasz (2011), for example, found that stronger irrational beliefs predict greater psychological distress, and that only rumination mediates the relationship between irrational beliefs and psychological distress. Worry and rumination might be more strongly related to irrational beliefs due to the negative and self-critical nature of these irrational beliefs, a low sense of mastery, and a high level of chronic stress and strain (Nolen-Hoeksema & Davis, 1999; Rude, Maestes, & Neff, 2007; Trew & Alden, 2009), and are associated with neuroticism, while reflection is associated with openness to experience (Silvia, Eichstaedt, & Phillips, 2005; Trapnell & Campbell, 1999). Treynor, Gonzalez, and Nolen-Hoeksema (2003) highlight that self-reflection and rumination are correlated, but the first process is connected to an intentional, inward oriented attention aimed at problem solving, with the effect of experiencing more depression in the moment but less depression over time. Worry and rumination, on the other hand, reflect a passive comparison of one's current or past situation with some unachieved standard. They are associated with more depression—both concurrently and in the long term.

According to an elaboration of control theory (Watkins, 2008), rumination focused on goals may be useful if it makes the progress toward these goals easier. In our opinion, it would probably be better to talk about reflexive thinking, and not rumination, when describing this process. On the contrary, rumination tends to be harmful because it obstructs goal achievement. Furthermore, according to the habit-goal framework (Watkins & Nolen-Hoeksema, 2014), depressive rumination—even if similar to the normal reflexive thought processes aimed at problem solving—is characterized by rigidity and favors negative mood, obstructs the pursual of goals, and reduces the capacity to flexibly adapt coping strategies to a changing reality.

Understanding Pathological Worry and Rumination: Cognitive Perspectives

One of the more important cognitive models for understanding pathological worry is the response style theory (RST) developed by Nolen-Hoeksema (1991).[3] According to the RST, the tendency to activate rumination in the presence of a negative mood would be a stable individual feature (Nolen-Hoeksema & Davis, 1999) that persists even when the depressive mood improves or disappears. Rumination would intensify the effect of the depressive mood and increase access to negative memories and negative emotions, which then negatively affect the understanding of the present situations and the self. Rumination would interfere with effective problem solving by making thoughts more pessimistic; it also interferes with instrumental behaviors and, when too pervasive, can lead to a loss of social support (Nolen-Hoeksema & Davis, 1999; Schwartz & McCombs, 1995). Indeed, chronic ruminators seem to behave in a counterproductive manner toward others (Lyubomirsky & Tkach, 2004) and to take undue responsibilities for the well-being of others (Nolen-Hoeksema & Jackson, 2001). They describe themselves as dependent and needy ("I often think about the risk to lose someone that I love"; "I feel the urgent need of things that only others can give me"; Spasojević & Alloy, 2001), desire revenge after insults, and tend to feel more aggressiveness after provocations ("I want to see you suffer"; Collins & Bell, 1997; McCullough, Bellah, Kilpatrick, & Johnson, 2001). Nolen-Hoeksema (1998) also suggests that future ruminators were children who did not succeed in learning active coping strategies and experienced a poor environmental control, or were children of intrusive and critical parents and tended to show helplessness and passivity when agitated (Nolen-Hoeksema, Wolfson, Mumme, & Guskin, 1995). Spasojević and Alloy (2002) suggest that having a parent who was rejecting and hyper-controlling, as well as a history of sexual, psychological, and physical abuse, may correlate with the tendency to ruminate. These factors tend to hinder the development of a sense of mastery over the environment, so that these individuals believe that they can control only their own thoughts and emotions (see also Alloy et al., 1990).

According to the goal progress theory developed by Martin and Tesser (1989, 1996, 2006), rumination has an adaptive function related to the achievement of fundamental human needs, even if it is often experienced as unpleasant and counterproductive and may occur when it is believed that nothing more can be done to reach a specific goal. People become particularly focused on mental activities aimed at pursuing an important goal when feedback about it is neither clear nor coherent. Among these mental activities are looking for alternative ways to reach a goal and trying to understand if reaching that goal is desired or how it is possible to reach a different goal. According to this model, whose basis is the Zeigarnik effect (Zeigarnik, 1938),[4] the function of rumination would be to keep on thinking about important goals not yet reached (Schooler, Fallshore, & Fiore, 1995). Moreover, people would ruminate both when they fail to reach a goal and when, in order to reach it, they need more time than expected (Carver & Scheier, 1990); the more important the unattained goal for the person, the greater the tendency to ruminate (Lavallee, & Campbell, 1995). Individuals would stop ruminating when they attain the goal, feel they have made enough progress toward it, or have

[2] Even if obsessive doubt and indecision are often intertwined with worry, in this article we will not focus on them.

[3] We were not able to find any empirically supported psychodynamic model specifically focused on worry and rumination.

[4] The information connected to a task not yet completed tends to automatically stay in memory longer than those related to an already accomplished task.

decided to give it up (Martin, Shrira, & Startup, 2004; Martin & Tesser, 1996).

Partially in line with this last theory, Wells and Matthews (1994, 1996) proposed a self-regulatory executive function model (S-REF; see also Matthews & Wells, 2005; Wells, 2000) that links rumination to self-regulation. The authors highlighted the role of metacognitive beliefs and their effects on thoughts and coping strategies. Rumination is supported by metacognitive beliefs that suggest that ruminating is useful to solve problems (Papageorgiou & Wells, 2001a). Different from standard cognitive behavioral therapy (J. S. Beck, 2011), Metacognitive Therapy (MT) focuses on metacognitive beliefs (beliefs about ways of thinking and thoughts) as well as on a cognitive attentional syndrome that involves worry, rumination, focused attention, and dysfunctional self-regulation and coping strategies. The authors distinguish between negative and positive metacognitive beliefs (Papageorgiou & Wells, 2001b) about worry and rumination, where the first ones refer to the uncontrollability of worry and rumination, while the second ones stresses their usefulness. Worry and ruminations start from the perception of a threat to the self or of inconsistencies within the self, or from feelings of worthlessness and low efficacy, are supported by metacognitive beliefs, and, in turn, maintain maladaptive cognitions (Wells & Matthews, 1994). Attentional biases generate a process of threat monitoring (Wells & Matthews, 1994), strategies aimed at controlling thoughts (e.g., suppression of thought), and cognitive, emotional, and behavioral avoidances. Worry and rumination are counterproductive because they lead to a distorted perception of self and reality, maintain uncertainty, exploit attentional resources, and undermine the ability to think clearly in stressful conditions. Finally, ruminating and worrying are so self-reinforcing that the individuals may end up not recognizing when they are using these strategies, a phenomenon that in turn might give them the impression of losing control of their own mental processes (Wells, 2009).

Finally, Borkovec et al. (2004) suggested that even if the conscious aim of worry is to find the solution of a problem, its nonconscious function is to avoid dealing with negative emotions and aversive images. The nature of worry, however, is mainly linguistic, and this fact may limit conscious access to vivid or painful images and thus reinforce worry itself.

Pathological Worry and Rumination According to CMT

According to CMT, pathological worry and rumination are consequences of pathogenic beliefs such as that the world is dangerous, that we are doomed to fail, that we are weak and powerless, that our worry will prevent negative events to occur, that we have lost or ruined some important opportunity, and so on. More in particular, however, according to our hypothesis, pathological worry and rumination may be often understood as distortions of normal reflection processes that—from being aimed at solving possible future problems or at mastering events that threaten an individual's sense of safety—become self-punishing activities. This change happens when individuals are trying or have been able to pursue an adaptive goal obstructed by a pathogenic belief that supports guilt. The contents of pathological worries and ruminations—and the affects associated with them—reflect the pathogenic beliefs that obstruct that goal, the compliance of the individuals with these pathogenic beliefs, and/or their identification with the caregivers involved in the traumatic situations or relationships where the pathogenic beliefs come from. Given their self-punishment aim, worries and ruminations are always centered on negative contents and possibilities. Moreover, they do not stop neither if nothing more can be done about the negative event, nor if the dreaded negative event, contrary to person's expectations, does not happen. Their manifest contents may change, but the process does not stop.

Some Clinical Examples

Francine and the Problem of Her Inadequacy

Francine is a 23-year-old patient who decided to start psychotherapy because she felt that she needed to "re-start from 0." She had a heroin addiction and showed traits of borderline and narcissistic personality disorder. After a seven-year love story with the boyfriend who had introduced her to illegal drug use, she had a period of sexual promiscuity and academic failures. She was socially isolated.

The core of Francine's problems was a deep sense of being undeserving, unlovable, and unworthy, all of which stirred up in her feelings of depression, performance anxiety, and social anxiety. She tried to cope with these feelings by the use of substances, and she shifted from attitudes of arrogance, devaluation of other people, and heightened enthusiasm, to harsh self-criticism, depressive feelings, and social withdrawal.

When, after a period of a five-sessions-per-week control-mastery therapy with a male therapist, Francine started to go out with new people and pass university exams, she developed a strong tendency to ruminate. While she was in social situations, she was constantly focused on her "performance," as well as other people's possible reactions to her. She believed that in order to be accepted and liked, she needed to appear as an outgoing, smart, and self-confident girl, and was constantly afraid that other people could find her inadequate and unsecure. Moreover, she thought that the only way to pass an exam, and not be humiliated by the professors, was to be perfect. During social interactions or academic exams, Francine started reliving in her mind those moments or responses that, in her view, showed her inadequacy. She felt an intense shame and condemned herself for those behaviors and responses while reviewing them in slow motion in her mind. These repetitive thought processes strengthened her sense of inadequacy and shame, generating a vicious circle: She also ended up feeling inadequate for her ruminations that sometimes became discourses she verbalized to herself. She became shy and withdrawn.

Francine's negative representation of herself—and her fear of being negatively judged and rejected by other people—derived from her relationship with her mother, who since she was a little child despised and offended her by saying things like she was a burden, a whore, incapable of doing anything by herself, rude, and the cause of all the family's suffering, and nobody could ever love her. Her mother often criticized—complaining and screaming—all of Francine's behaviors. Moreover, when Francine had any success at school or realized she was liked by some nice person, her mother reacted saying that she herself was better than Francine, that she would have been better than her if she had had the same

opportunities, or that Francine's success was due to her advice or God's will.

On the basis of these experiences, Francine developed the beliefs of being inadequate and unlovable (self-hate),[5] and that if she had had success, she would have hurt her mother by making her feel inferior (survivor guilt). It is worth noting that Francine's mother suffered from the same lack of self-esteem; she herself shifted from being a harsh and devaluating tyrant in her family to appearing to be a shy, submissive, and introverted woman when she was with other people. Furthermore, Francine's mother used to feel uncomfortable when she realized that she had something more than her sisters or other loved people.

On this basis, Francine's ruminations can be read as a consequence of a conflict between her goals to feel worthy of love and appreciation, as well as having success in widening her social life and at work on one side, and her pathogenic beliefs of being unworthy and unlovable, and that her success would have made her mother feel humiliated, on the other side. These ruminations were a way of punishing herself out of a strong survivor guilt toward her mother. Due to this survivor guilt, she ended up identifying with her shy and insecure mother. Complying with the image that her mother gave of herself, Francine kept repeating to herself how inadequate she was as a way of restoring her mother's authority and self-esteem.

Asia and the Legitimacy of Fantasizing About Other Men

Asia is a 38-year-old woman who looked for a therapy because she was unable to leave her husband, even though their relationship was very unsatisfying. After eight months of her one-session-per-week psychodynamic psychotherapy with a control-mastery female therapist, she was able to quit this relationship, and after a couple of years, she found a man with whom she developed a stable and satisfying relationship. However, Asia kept having a symptom that has tormented her since she was an adolescent. Anytime she realized that a nice man who is not her boyfriend looks in her eyes, and she looks back at him, she starts feeling in danger and guilty, and ruminates about this fact for days. She keeps repeating to herself that she is bad and a whore, and should break off the relationship with her boyfriend because her pleasure of being the object of another man's desire implies that she no longer loves her boyfriend. And her ruminations inhibit the sexual pleasure she normally experiences during the intercourse with her boyfriend.

Asia describes her parents saying that they "always stayed together and did everything together." They were "the example of a well-functioning couple", with the father as the emotional center of the family and the mother the one who dealt with all their practical necessities. Moreover, both the parents shared a rigid system of values: Their daughter should be always polite, clean, humble, and correct. When she found a man with whom she wanted to share her life, she should be faithful to him even if unsatisfied; no good reason existed for breaking a marriage. Asia knew that, in order to make her parents happy and proud of her, she had to comply with their values and requests. Thus, she ended up being "the prototype of how my parents wanted me to be." Asia loves her father and often talks about him during her sessions. She describes him as "completely dedicated to his family" and says that neither she nor her mother could live without him. Asia's father appears to be quite a controlling man who feels entitled to give advice about anything Asia wants to do, and he expects that his daughter will follow it. One of his favorite sentences was, "If you give in to a temptation, everything will fall apart." Asia's mother seems to be more peripheral and is described as a rigid and introverted woman. From her relationship with her parents, Asia developed the pathogenic belief that if she did not follow her parents' roles and moral values, and if she did not need their support anymore, they would feel betrayed and hurt (disloyalty guilt).

Seen from this perspective, Asia's ruminations are a way of punishing herself when she is flattered by the attention of another man and fantasizes about betraying her boyfriend. Enjoying this attention and betraying her boyfriend in her fantasy, she also shirks her parents' values, and for this reason she needs to punish herself by complying with their warnings and her pathogenic belief. Now she thinks and feels that she does not really love her boyfriend and no longer deserves to enjoy her romantic relationship with her boyfriend. Everything is falling apart.

Robert and His Worry About Physical Health

Robert is a 45-year-old man who for the first two years of his one-session-per-week control-mastery therapy with a male therapist was constantly worried about the possibility of having some physical illness. He first complained about the conditions of his intestines, focused his attention on any sensation he felt from that part of his body, and spent his time developing diagnostic hypotheses about the nature of his illness and its possible cures. When medical examinations disproved his hypotheses, Robert changed his diagnosis without stopping his worrying. He started to focus on the sensations that he felt from his head; he would develop hypotheses about the nature of his illness and look for the necessary cures. Again, when the doctors excluded the pathologies he was afraid he had, he changed the nature of his diagnoses or the problem he thought to have. He could spend all his days tracking the sensations he felt in the part of his body he thought to be ill, developing hypotheses about his pathology by navigating into the Internet and looking for a cure. This process increased his anxiety level, as well as its physiological correlates; tachycardia, tachypnea, headache, and sleep difficulties were thought to be further evidence of his physical illness. Thus, his worry escalated. Moreover, due to the energies absorbed by his worrying, Robert felt weak, and thought that being weak was an additional problem, something he could not accept in himself. For this reason, he looked for food supplements aimed at contrasting his feelings of weakness and then interpreted their inefficacy (or their supposed side effects) as further evidence of a possible illness. His deepest fear was to have a severe illness. He became a pronounced hypochondriac.

Robert had a tragic history. His father, an ostensible authoritarian but actually a fragile and introverted man, committed suicide when Robert was in his early adulthood. For a long time, his father treated him as a confidant to whom he talked about his preoccu-

[5] For two empirical studies stressing the link between self-hate and shame and rumination, see Giammarco and Vernon (2015) and Orth, Berking, and Burkhardt (2006).

pations. The day his father committed suicide, Robert had noticed "something strange" in his attitude, but he decided to go out and spend time walking and reading the newspaper in a park. He was fed up with being his father's confidant. However, when he went back home, he found his father hanged and was devasted because he thought that he should and could have saved his life. Several years later, his brother developed cancer, and Robert thought that he had the possibility to redeem himself by saving his brother's life. Thus, when his brother died, he thought that even this death was one of his failures.

Robert's pathogenic beliefs had their roots in his early relationship with his family. His father always had depressive problems, while the relationships between his parents had always been so unsatisfying that Robert thought that that was one of the main causes of his father's depression—and it was clear that his mother wanted him to be of help to the father. His brother, on the other hand, had a congenital pathology, and thus he was allowed to do anything he wanted, being considered the "genius" of the family. According to Robert, however, while his brother thought he was superior to him, he knew that he was superior to his brother and had to hide this fact to protect his self-esteem. Finally, Robert's mother appeared to be so burdened by all these problems that he felt he could not have burdened her with other requests.

Seen from our perspective, Robert's worries about his health were a way of punishing himself for the fact that he had not been able to save his family, in particular his father and his brother (omnipotent responsibility guilt); this punishment was mediated by his identification with his ill parents and brother. Given that he was unable to cure their pathologies and survived his beloved brother, showing himself to be stronger than him (survivor guilt), Robert now felt he deserved to die because of a pathology that nobody could cure.

Treating Worry and Rumination in a CMT Framework

As we have seen in the first part of this article, according to CMT the patient unconsciously sets the agenda for her/his treatment. S/he establishes, on the basis of safety considerations, which goals s/he wants to pursue first; which pathogenic beliefs to be disproved first in order to feel safer; which trauma must be mastered first; how to disprove the pathogenic beliefs; the kind of responses and attitudes required from the therapist in order to feel safer and get better (Gazzillo, Genova, et al., 2019; Sampson, 2005); and which insights s/he wants to reach. The task of the therapist is to help the patient carry out her or his plan (see also Weiss, 1994); there is no technique to be prescribed or proscribed, and the only relevant point is how much the therapist and her or his techniques can help patients carry out their plan in a way they feel is useful for them.

Pathological worry and rumination are often self-punishments that derive from guilt-inducing pathogenic beliefs developed from developmental traumas. They obstruct patients in the pursuit of their goals or in enjoying this pursuit. Given these constraints, patients want to be helped by their therapists to achieve these goals, master their traumas, disprove the pathogenic beliefs developed to adapt to them, become aware of the origins and functions of those pathogenic beliefs, and contrast with their communications, behaviors, attitudes, and authority their guilt feelings and their manifestations. Seen from this perspective, many of the therapeutic indications based on cognitive models of pathological worry and ruminations make perfect sense and can be useful even from a CMT perspective. RST, for example, suggests that positive distractions may be useful to interrupt ruminations, leading to a lower level of negative thoughts and to a better problem-solving ability (Lyubomirsky & Nolen-Hoeksema, 1993, 1995). According to Nolen-Hoeksema (1996), any treatment that offers ruminators an explanation of the reason why they ruminate may interrupt rumination and contrast its negative emotional consequences. Furthermore, the techniques proposed by MT to modify cognitions that support worry and ruminations, and to develop a more flexible use of attentional resources (among them, detached mindfulness [DM; Wells & Matthews, 1994], attention training techniques, and situational attention refocusing), can be very useful. However, within a CMT framework, all these techniques and suggestions are useful only insofar as patients feel that they help them carry out their plan. If this is not the case, they will be useless, or even harmful. We provide some examples below.

Carol is a 21-year-old patient whose main pathogenic belief is that she needs to remain little, weak, and dependent in order not to hurt her parents (separation guilt). Carol is constantly worried about her health and focused on her body sensations, ready to interpret them as signs of some severe physical illness or of her "congenital" weakness. During her first months of treatment, she ruminated during the sessions with the unconscious aim to understand whether her therapist also needed her to be fragile and needy in order to feel useful.[6] Her ruminating during the sessions was a transference test by compliance. It was very useful to teach Carol DM techniques for reducing her worries, and this approach occurred within the context of a therapeutic work aimed at helping her become conscious of her separation guilt in an interpretive way, and contrasting this guilt with the overall therapist attitude and passing her tests.

On the other hand, let us think about a patient with a strong self-hate who was severely mistreated by her mother, such as Francine. If she ruminates during her sessions about how her mother treated her because she is (unconsciously) trying to master her childhood traumas and disprove the pathogenic belief that she deserved her mother's mistreatments (transference test by noncompliance), it would likely be wrong to use techniques aimed at distracting her from those thoughts. In fact, she would be unconsciously asking her therapist to help her understand that she did not deserve these mistreatments, that her mother mistreating her was not her fault, and that she had and has the right to be listened to and protected when in pain.

A CMT therapy must always be case-specific and tailored according to the specific plan of the patient in therapy, the specific pathogenic beliefs she or he is testing in a given moment of the therapy, the specific testing strategy she or he is adopting, and the specific goals she or he is trying to pursue in any given session. No specific technique is always good or bad.

[6] During a session from the first month of her therapy, Carol said, "When I was a child, the only way I was able to get the attention of my parents was being ill or appearing fragile, and sometimes I have thought that also you will allow me to come here only if I keep on having problems."

Conclusions

According to CMT, pathological worries and ruminations, as any symptom, are expressions of pathogenic schemas developed for adapting to developmental traumas and adverse experiences. Patients often worry and ruminate when, in the attempt to pursue a healthy goal obstructed by pathogenic beliefs supporting interpersonal guilt, they are able to achieve it, or incur situations that undermine their sense of safety. When this event happens, adaptive reflexive thought processes aimed at mastering negative events and/or solving possible future problems are transformed in a form of self-punishment. The self-punishing function of worries and ruminations may explain why these processes are perseverative and not affected by evidence that contrasts them and have maladaptive consequences.

摘要

本文旨在对病理性担忧和思绪反刍提出一种基于控制-掌控理论(CMT)的解释,控制-掌控理论是一种关于精神功能、心理病理学及心理治疗过程的综合的关系的认知动力学理论,是由Joseph Weiss发展出来,由Weiss, Harold Sampson 和旧金山心理治疗研究小组在过去50年中进行了实证验证的。在本文的第一部分,我们将介绍CMT的基本概念,以及该理论如何将动力学和认知的概念整合入一个关系理论框架。然后,我们将回顾几种病理性担忧和思绪反刍的定义,及其临床特征和影响。我们将把这些过程和旨在解决问题掌控创伤的正常的思考过程区分开来,我们还将回顾一下支持这一区分的研究数据。最后,我们将讨论一些更为重要的用来解释病理性担忧和思绪反刍的认知理论模型。在本文的最后一部分,我们将描述CMT何以帮助理解病理性担忧和思绪反刍及其功能。根据CMT, 病理性担忧和思绪反刍是正常反射性思维的扭曲,往往是由支持了人际内疚感的病理性信念造成的,其无意识目标经常是自我惩罚。三个临床片断可以帮助我们看到CMT是如何帮助我们理解和治疗病理性担忧和思绪反刍的。

关键词: 担忧, 思绪反刍, 控制-掌控理论, 内疚感, 自我惩罚

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