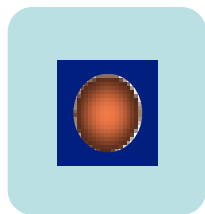


Metacognitive Therapy: Basics

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Why Metacognitive Therapy (MCT)?

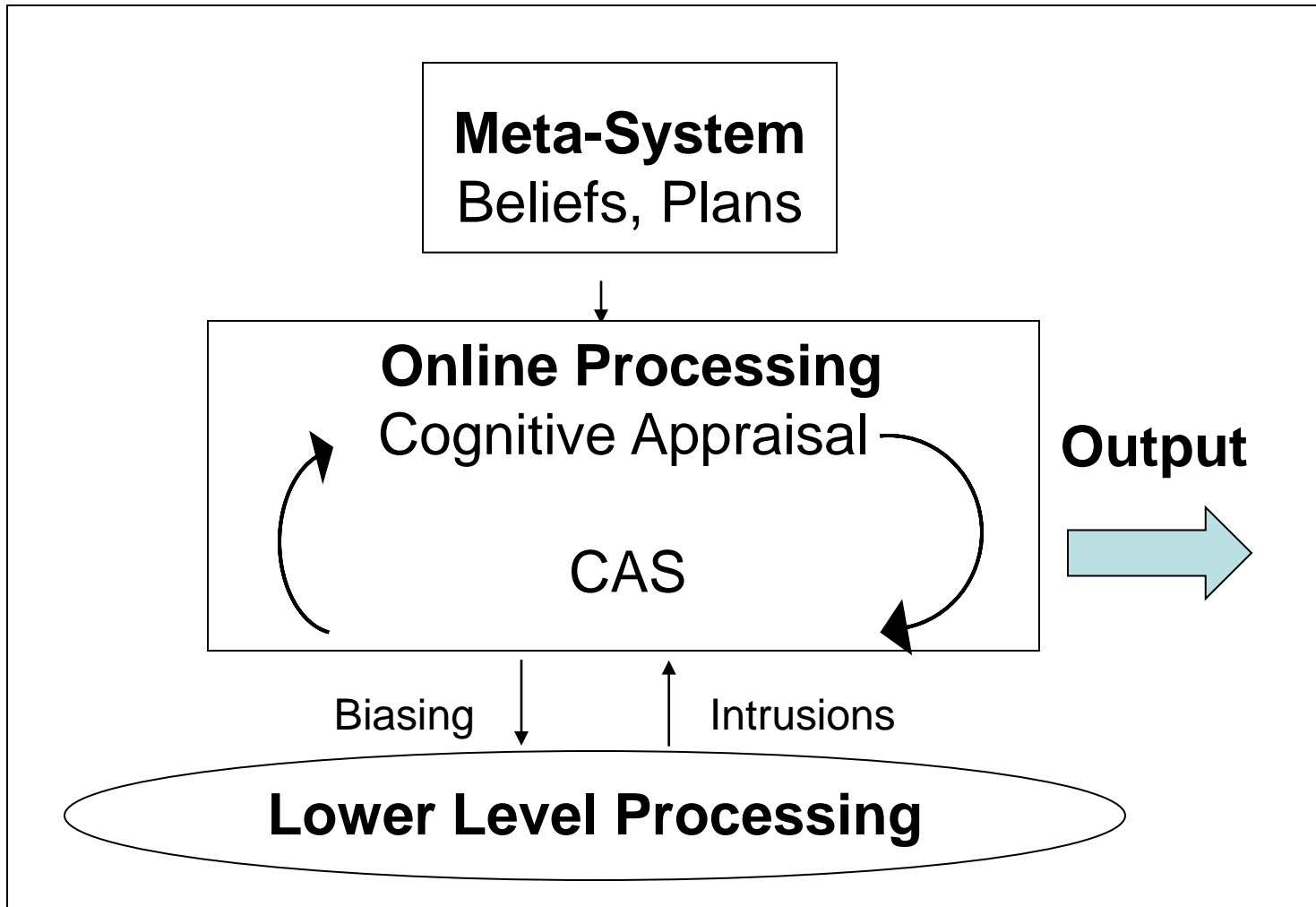
- High rates of relapse in depression
- Behavioral exposures are aversive for many patients
- Many patients after therapy for anxiety disorders are still highly symptomatic
- Metacognitive approaches have proven promising in small scale trials

Challenging Problems in
Cognitive Therapy are due to
faulty information processing
(J. Beck, 2005)

Metacognitive therapy has an
innovative focus on changing
faulty information processes

Definition of Metacognition

- Cognitions that are responsible for monitoring, controlling and appraising thoughts, learning, and memory. (Flavell, 1979)
- Thinking about thinking; 3 components
- Knowledge
- Experiences
- Strategies/Skills

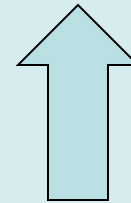
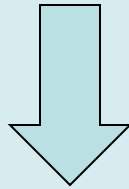


S-REF Model

2 Levels of Cognition

META - LEVEL

Thoughts are mental phenomena



OBJECT - LEVEL

Thoughts & Feelings are reality
Threat and arousal must be reduced

S-REF model Wells & Mathews (1994)

- Disorder is linked to Cognitive-Attentional Syndrome CAS: loss of cognitive flexibility
- *A Transdiagnostic model similar to Barlow's Unified Treatment Protocol*
 - Perseveration (worry/rumination)
 - Threat monitoring
 - Maladaptive coping behaviors
 - Internal self-focused processing

CAS is caused by

- The control that Metacognition imparts on thinking, is facilitated by:
 - **Negative Meta-Beliefs:** my worry is uncontrollable, my thoughts mean I'm bad, thoughts could harm me
 - **Positive Meta-Beliefs:** worry helps me cope, focusing on threat keeps me safe, I must control thoughts or else I'll go crazy

Treatment Implications

The aim is to modify thinking processes- the how- rather than only the what (content)

Modifying declarative beliefs is useful, but changing processes may speed up learning

Cognitive Therapy

“How much do you believe you are
unlikeable?”

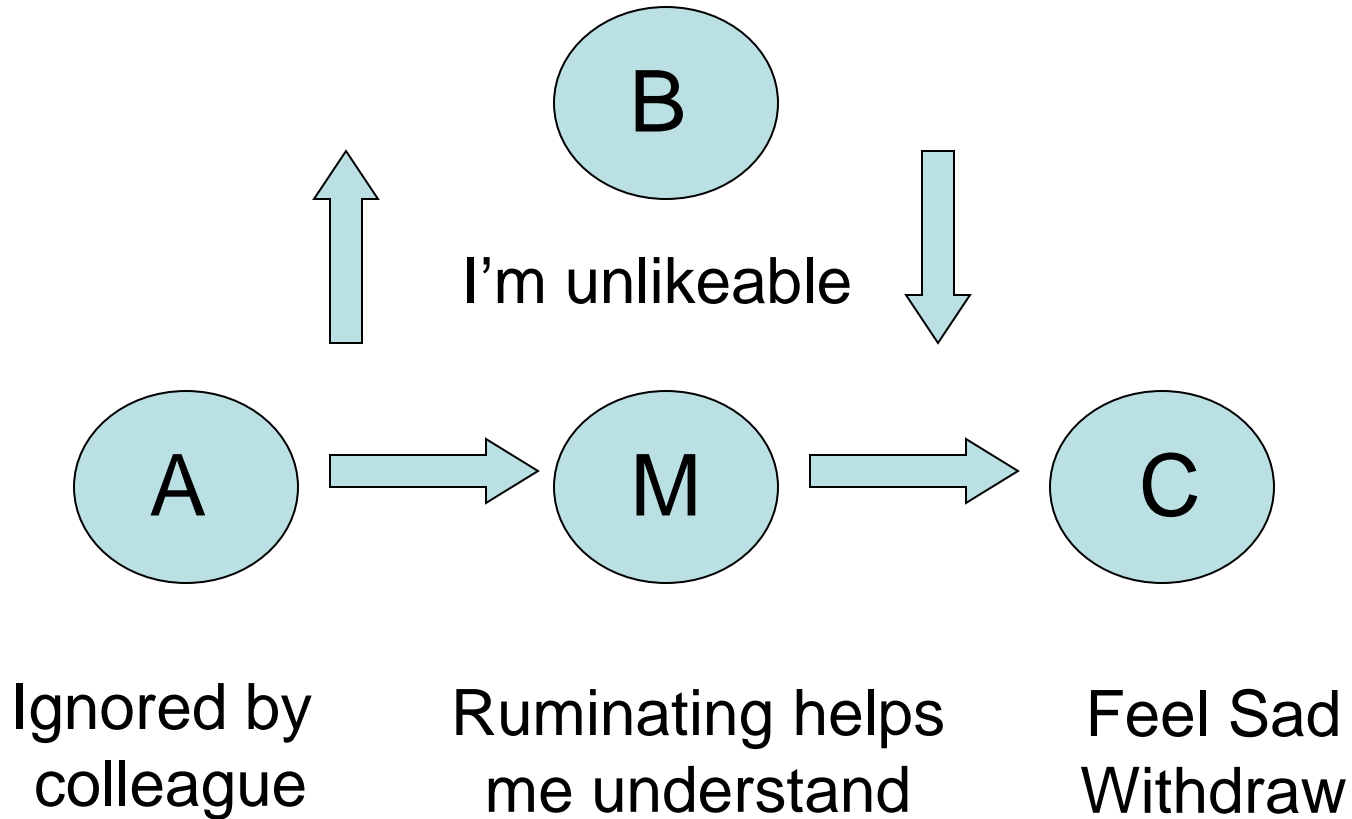
What is your evidence to support this?”

Metacognitive Therapy

“What’s the use of thinking about being unlikeable?”

Can you reduce that activity?”

Modified ABC theory



CAS

CAS Problem 1: Worry/Rumination

- Uses up cognitive resources
- Blocks adaptive emotional processing
- Maintains threat processing

CAS Problem 2: Focus of Attention

- *Increases fixation on threat:*
 - Internal threat in depression
 - External threat in post traumatic stress PTSD
- *Increases Self-focus*
 - Use of internal data for judgements in social phobia (emotional reasoning)

CAS Problem 3:

Maladaptive coping (backfires)

- Avoidance
- Rituals
- Decreased activity
- Safety Behaviors

MCT: Primary Focus

- Removing the CAS
- Modifying metacognitive beliefs
- Enhancing metacognitive (executive) skills
- *Procedural as well as Knowledge-based skills*

MCT Treatment Strategies: Individual case conceptualization

- Removal of CAS
 - Worry/Rumination Postponement
 - Attention Training (ATT)
 - Detached Mindfulness (DM)
- Modification of Metacognitive Beliefs
 - *Negative Metacognitive Beliefs first*
 - *Positive Metacognitive Beliefs later*

Assessment CT and *MCT*

- When was the last time you were anxious/depressed?
- What was the initial thought you had?
- *What happened to your thinking?*
- *Did you worry/dwell?*
- *What did you pay attention to?*
- *What are the advantages/disadvantages?*

Foundational Skills Build on CBT Skills

- Socratic dialogue to uncover CAS & beliefs
- Behavioral Experiments: PETS
- Prepare-Expose-Test (disconfirmatory)-
Summarize
- Metacognitively Delivered Exposure: OCD
to challenge Thought Fusion adding DM

Changing Metacognitions more important in ERP for OCD (Solem et al.,2009)

- 84 OCD patients treated behaviorally
 - Responsibility and Perfectionism Cognitions reduced after treatment
 - No longer related to outcome when controlling for Metacognitions, “Thoughts are dangerous”, “Worry is useful”
 - But metacognitive changes related to outcome when controlling for reductions in Responsibility and Perfectionism

Detached Mindfulness

- Awareness of inner thoughts
- Disengagement from processing or coping
- Separation of self from thought
- No meditation practice
- No bodily awareness (breath)
- Not for distraction or coping

DM techniques

- Free association task: tree, summer, birthday, beach, chair
- Lion task
- Suppression - Counter suppression
- Metaphors: clouds, train, naughty child, healing

Attention Training (ATT)

- Self-attention rating

• -3 -2 -1 0 +1 +2 +3



Entirely

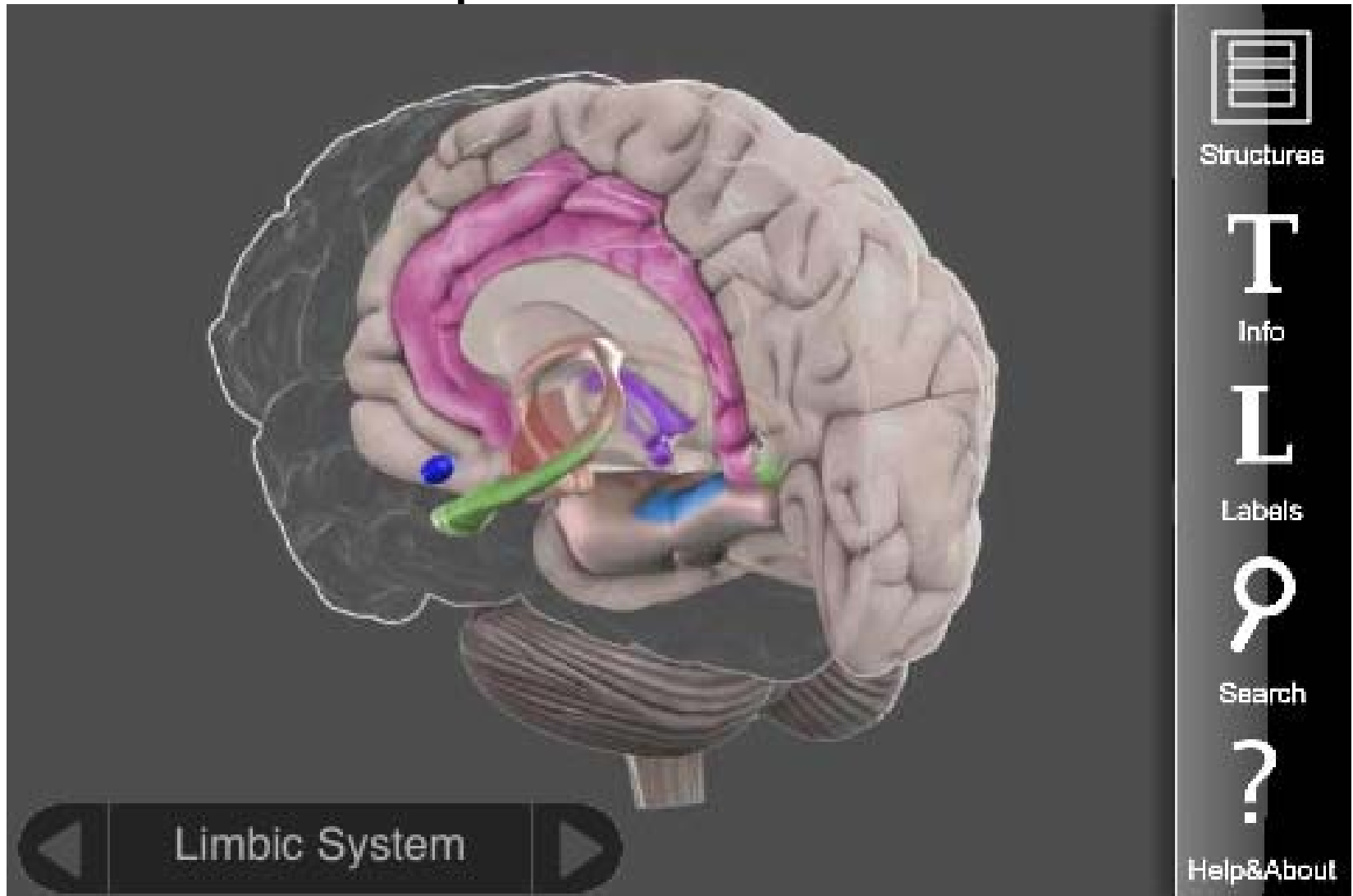
Equal

Entirely

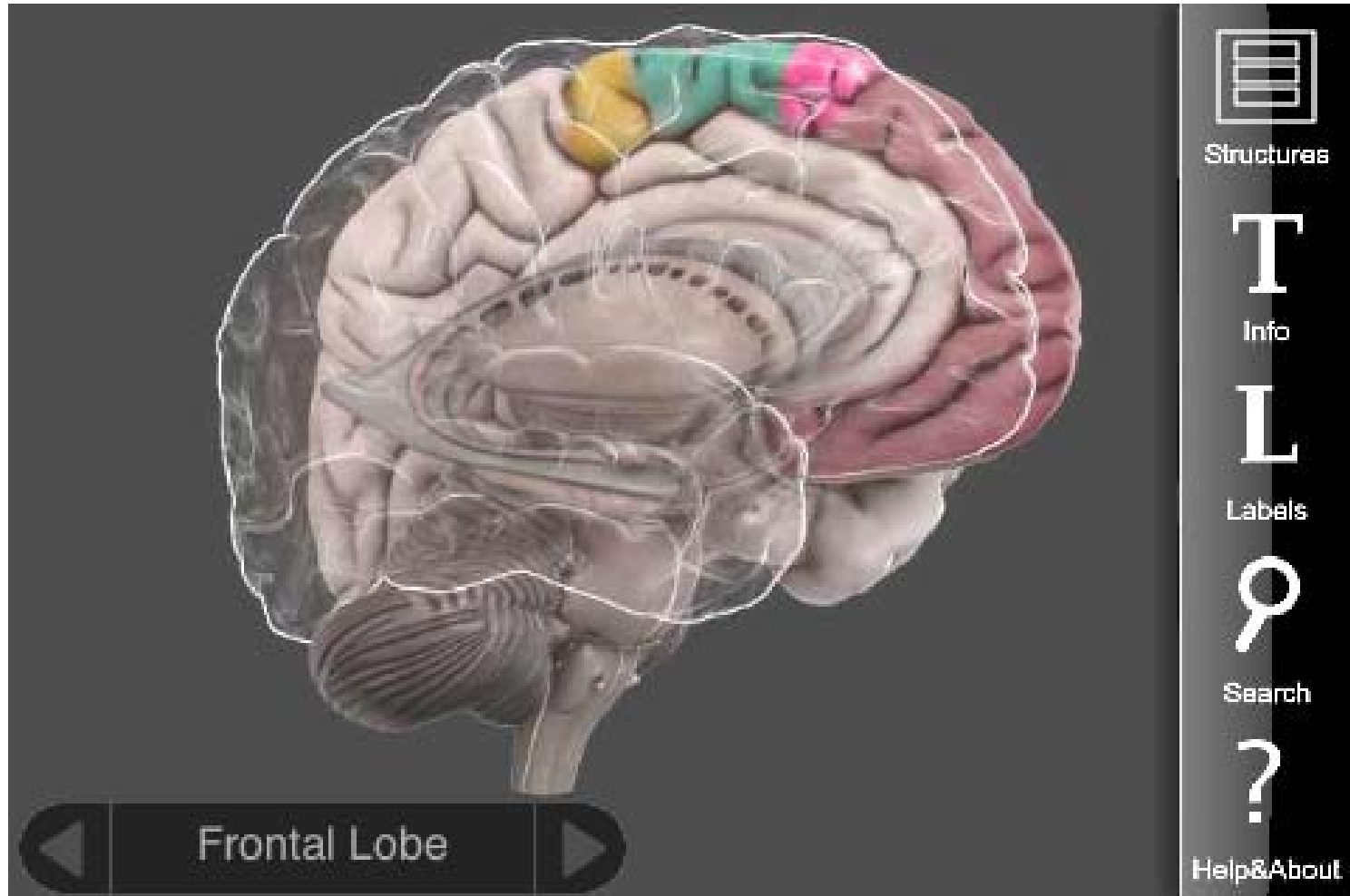
Self-focused

Externally focused

Rationale for ATT: Increase control of attentional processes in limbic areas



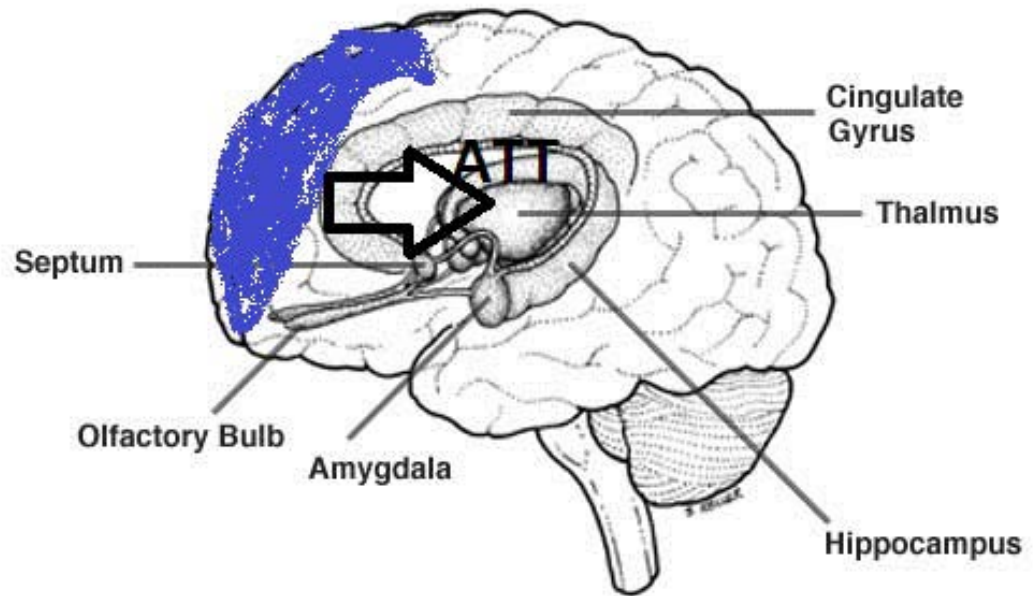
Rationale for ATT: Increases executive control of cognitive processes



ATT

Rationale

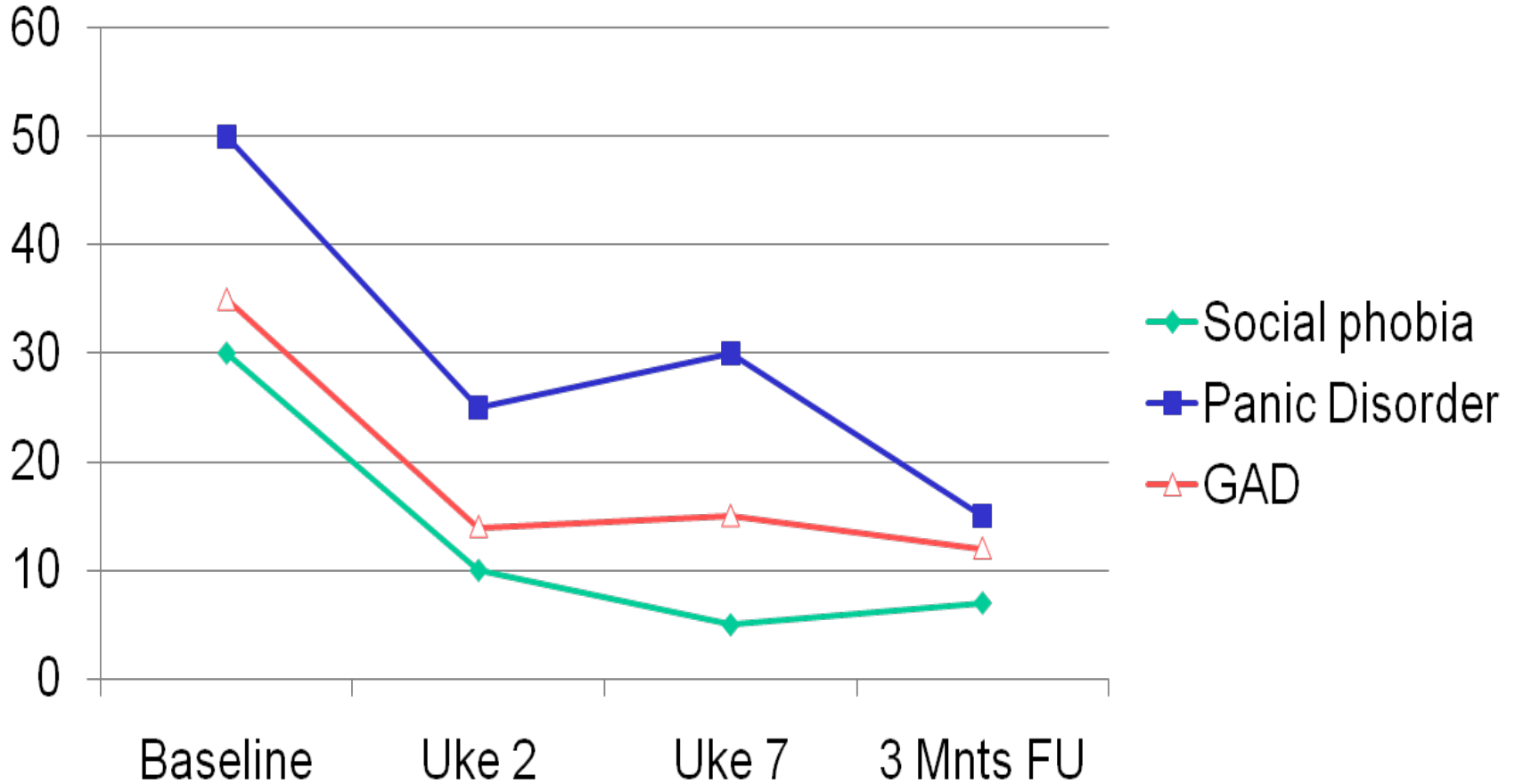
- Interrupts self-focused processing
- Increases flexible control of attention
- Aids new processes (DM)
- Facilitates acquisition of new beliefs (PETS)



ATT components

- Selective Attention
- Attention Switching
- Divided Attention
- *Practised when non-anxious*
- *Homework: 2 x practise per day*

ATT effect across disorders (Wells, 1997)



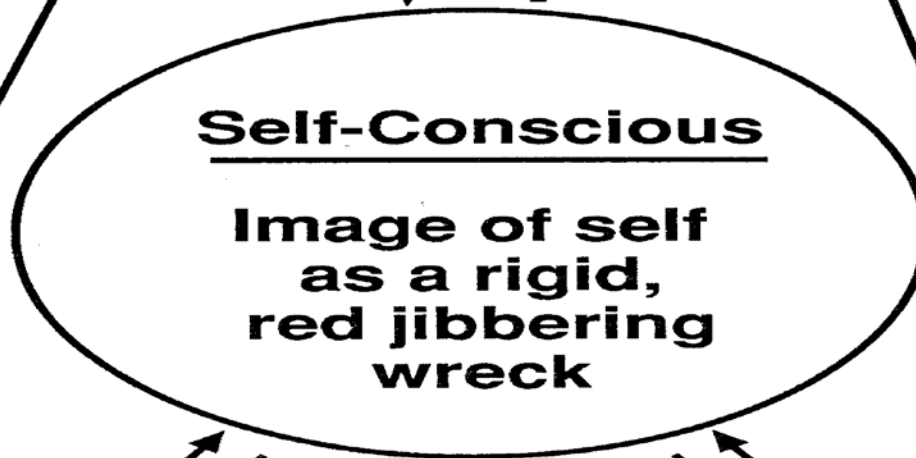
Example: Social phobia

- Patient changes to an internal focus on themselves and how they think others view them
- They use information from their bodily reactions to judge how they appear to others E.g. Image: warm cheeks = "Red as a tomato".
- They use safety behaviors that backfire
 - A. Rehearse everything they say so can't follow the conversation (fear saying something out of place)
 - B. Avoid eye contact fear others laugh at them (appear standoffish and never test their belief)

Speaking to a group

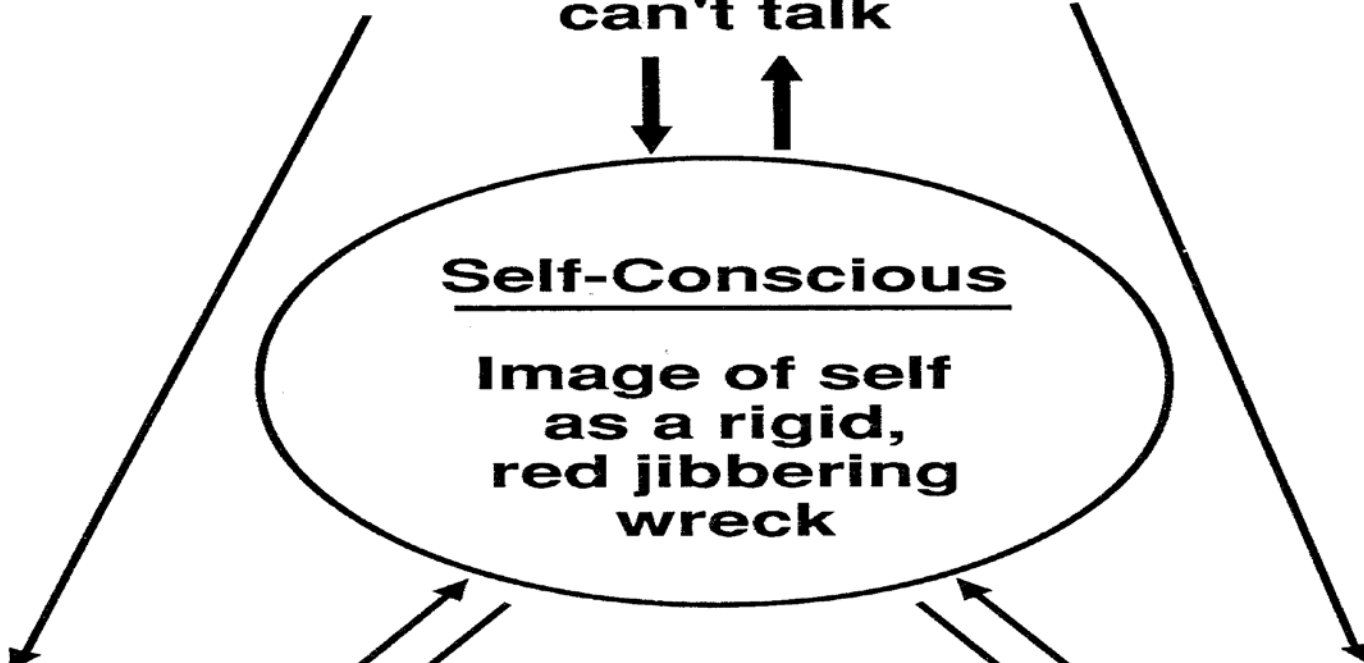


**What if I freeze and
can't talk**



Self-Conscious

**Image of self
as a rigid,
red jibbering
wreck**



**Ask questions
Avoid looking
Keep still
Grip hands tightly
Rehearse sentences
mentally**

**Tension
Shaking
Hot
Breathless
Difficulty
concentrating**



Safety Behavior



MCT new developments for SOSF

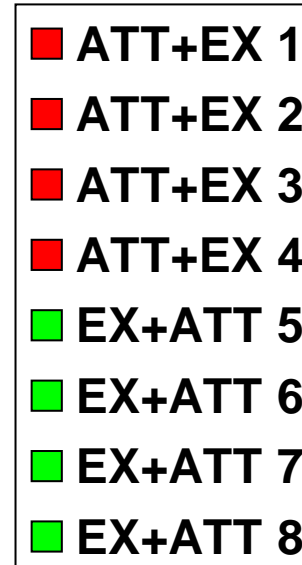
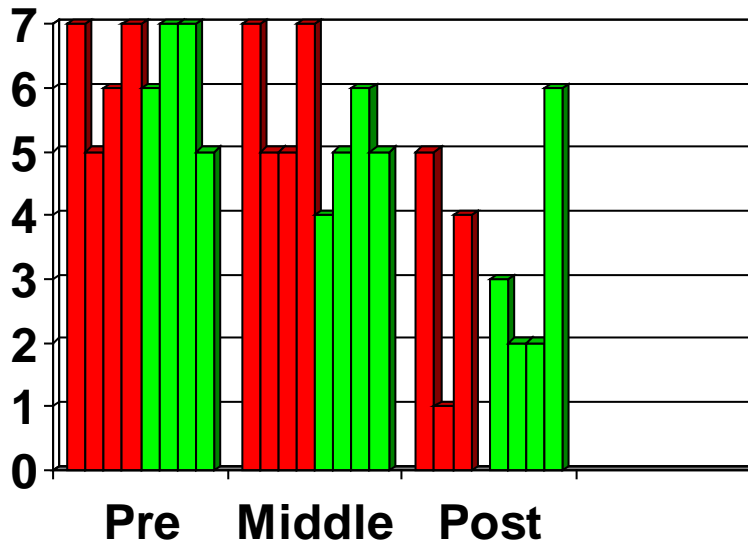
- Add ATT to social exposure with external focus for 8 patients with moderate to severe social phobia. Inexperienced student therapists
- 4 weekly sessions of Social Exposure (talk to one person or groups, spill food) and test other's reactions (no discussion of content whatsoever)
- Then 4 sessions of ATT with home practice
- EX+ATT. Half got reverse order ATT+EX
- What do you think happens with chronic social phobia?

Results

- Some reductions after 4 weeks
- But 4 of 8 patients no longer diagnostic after 8 weeks
- Most gains for patients receiving ATT after Social exposure (3 of 4)
- Patients receiving ATT after exposure achieve shift at meta level

ADIS CSR (0-8)

4 = diagnosis



Conclusion

MCT based on S-REF model

Views disorder as result of CAS

Metacognitions control CAS

Treatment must modify cognitive control

Treatment must modify meta-beliefs

Disorder specific models are used

Therapists work at the meta level



Until we meet again