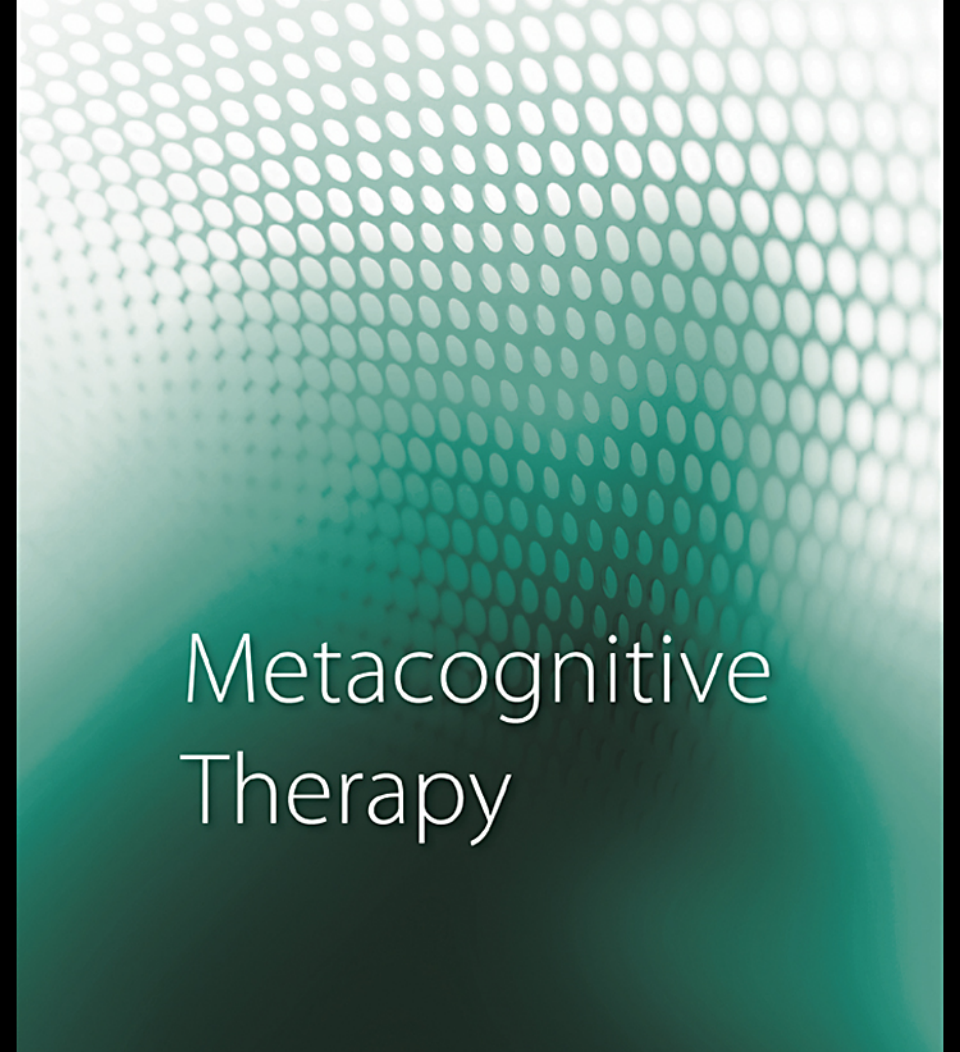




Metacognitive Therapy

The CBT Distinctive Features Series
Series editor: Windy Dryden

Peter Fisher
and Adrian Wells

Metacognitive Therapy

Metacognitive therapy is based on the principle that worry and rumination are universal processes leading to emotional disorder. These processes are linked to erroneous beliefs about thinking and unhelpful self-regulation strategies.

Metacognitive Therapy: Distinctive Features is an introduction to the theoretical foundations and therapeutic principles of metacognitive therapy. Divided into two parts, *Theory* and *Practice*, and using 30 key points, the authors explore how metacognitive therapy can allow people to escape from repetitive thinking patterns that often lead to prolonged psychological distress.

This book is a valuable resource for both students and practitioners wishing to develop a basic understanding of metacognitive therapy and how it compares and contrasts with traditional forms of cognitive-behavioural therapy.

Peter Fisher is a Lecturer in Clinical Psychology at the University of Liverpool and a Clinical Psychologist with Manchester Mental Health and Social Care Trust.

Adrian Wells is Professor of Clinical and Experimental Psychopathology at the University of Manchester and Professor II in Clinical Psychology at Norwegian University, Trondheim.

Cognitive-behavioural therapy (CBT) occupies a central position in the move towards evidence-based practice and is frequently used in the clinical environment. Yet there is no one universal approach to CBT and clinicians speak of first-, second-, and even third-wave approaches.

This series provides straightforward, accessible guides to a number of CBT methods, clarifying the distinctive features of each approach. The series editor, Windy Dryden, successfully brings together experts from each discipline to summarize the 30 main aspects of their approach, divided into theoretical and practical features.

The CBT Distinctive Features Series will be essential reading for psychotherapists, counsellors, and psychologists of all orientations who want to learn more about the range of new and developing cognitive-behavioural approaches.

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Metacognitive Therapy

Distinctive Features

Peter Fisher and Adrian Wells

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Introduction

Metacognitive therapy (MCT) originated with Adrian Wells after he identified a common set of processes in patients suffering from psychological disorder. The approach developed from attempts to explain laboratory findings on biases in attention, and reconcile these with clinical observations of patients who described particular styles of processing as a means of coping. These processes were excessive self-focused attention, attentional bias, worry and rumination.

In the late 1980s and early 1990s, the prevailing view was that attentional bias and worry were automatic processes. It was also the case that mood and anxiety disorders were linked to the content of negative thoughts rather than to specific styles of thinking. In contrast to this explanation, attentional bias and worry were viewed by Wells and colleagues (e.g. Wells & Matthews, 1994) as linked primarily to the person's conscious strategies for appraising and dealing with threat. Furthermore, the content of thoughts was seen as less important than the style and control of thinking in causing psychological disorder. Content does matter in MCT but this is the content of meta-cognition rather than the content of ordinary cognition.

The integration of laboratory findings with clinical observation culminated in an information processing model of psychological disorder, the Self-Regulatory Executive Function model (S-REF; Wells & Matthews, 1994). The S-REF is the generic basis of disorder-specific metacognitive models and the foundation for MCT.

This book describes the key distinctive theoretical and practical features of MCT and contrasts this approach with cognitive-behavioural therapy. Although both approaches deal with cognition, they provide different accounts of how cognition maintains disorder and they focus on different aspects of thinking. Specifically, MCT asserts that it isn't *what* people think that counts, but *how*.

Part 1

THE DISTINCTIVE THEORETICAL FEATURES OF MCT

A focus on metacognition

Metacognition is a term used to refer to a specific category of thinking and cognition. It is essentially cognition applied to cognition. Thinking requires metacognitive factors that monitor and control it. For instance, the process of memorizing a new telephone number depends on knowledge of strategies that can be used to modify memory (e.g. rote rehearsal). It requires the initiation and regulation of the rehearsal strategy, and depends on monitoring when it is time to stop rehearsal. In addition, it requires the subsequent accessing of information that drives retrieval of the number as and when required. In this small example of cognition, the act of memorizing requires multiple aspects of metacognition to make it possible. Beyond this example, metacognition is involved in the cessation, perpetuation and modification of thinking, which encompasses the dysfunctional thinking that maintains psychological disorder.

Traditional cognitive-focused treatments such as cognitive-behaviour therapy (CBT; Beck, 1976) and rational emotive-behaviour therapy (REBT; Ellis, 1962) emphasize the role of cognitive bias and distorted or irrational beliefs rather than the control of thinking. Moreover, these are beliefs outside the metacognitive domain such as beliefs about the world, and the social and physical self. For example, Beck (1976) describes cognitive distortions such as arbitrary inference (jumping to conclusions), catastrophizing, and personalization as cognitive distortions that are evident in negative automatic thoughts. These are different from the thinking styles that are given central prominence in metacognitive therapy (MCT; Wells, 2000). In MCT, maladaptive thinking styles refer to a preponderance of verbal conceptual activity that is difficult to control and occurs

in the form of worry and rumination. These styles can be identified independently of their content, as extended forms of brooding and dwelling and analysing information.

In contrast to standard CBT that focuses on a wide range of beliefs about the self and world and says little about metacognitions, metacognitive therapy (MCT) gives metacognitions and metacognitive beliefs a central role in psychological disorder. Unlike CBTs, MCT does not assume that distorted cognitions (i.e. thoughts) and coping behaviours emanate from ordinary beliefs, but specifies that thought patterns are the result of metacognition acting on thinking processes.

Until the advent of metacognitive therapy, research on metacognition was confined largely to the field of developmental psychology and research on human memory. However, Wells and Matthews (1994, 1996) and Wells (2000) developed a general theory of psychopathology that explicitly placed metacognition at centre stage. This approach has led to the development of MCT that aims to change the way individuals experience and control thinking, and the beliefs they hold about cognition. MCT differs from earlier forms of CBT because it does not focus on beliefs and thoughts about the social and physical self, or thoughts and beliefs about others and the environment. Instead, it deals with the way in which people respond to these other cognitions and the mental processes that repeatedly give rise to erroneous and unhelpful views of reality. For example, in cognitive therapy the therapist deals with a patient's cognition about failure by asking, "What is the evidence that you will fail?" but the metacognitive therapist asks, "What is the use in worrying about failure?" The aim in MCT is to modify the thinking processes that support biased failure-oriented processing and the nature of the person's unhelpful reaction to cognitions of this kind.

If we assume that cognition in psychological disorder is biased, as do all cognitive and MCT theories, then it is necessary to identify the source of that bias so that it may be treated. The nature of bias emphasized in CBT, REBT and MCT is

different. In the former two approaches it resides in the schemas or irrational beliefs or in the content of negative automatic thoughts. In contrast, in MCT the bias occurs in the style that thinking takes and this is derived from metacognitive knowledge stored as a library of information and plans or programmes that direct processing.

The MCT approach proposes that psychological disorder is linked to a specific style of thinking, involving recurrent, recyclic ideation in the form of worry and rumination and fixating attention on threat. The bias in processing is therefore in how the person thinks rather than in what the person thinks. The content of worry and rumination may show considerable within-individual variation but the process itself remains a constant variable. This process arises from and is controlled by the person's metacognition.

In contrast to this assertion, Beck's schema theory (e.g. 1976) attributes the control of cognition to more general beliefs, which are thought to introduce bias, but this bias is in content rather than in style. Earlier approaches have not attributed a role to metacognition or differentiated between different thinking styles, making MCT distinct in these important respects.

