

The 3rd International Conference of

Metacognitive Therapy



Milan 2016

Programme and Abstracts

Pre-Congress Workshops 7th April 2016

Conference 8th-9th April 2016

Venue: Palazzo Mezzanotte

Contents

Conference Committees	3
Welcome Statement	3
General Information	
Registration	4
Poster Sessions	4
Exhibition Area	4
Security	4
Refreshments	4
Conference Reception & Party	4
Badges	4
Pre-congress Workshops & Conference Overview	5
Pre-congress Workshops	7
Symposia	13
Abstracts	
Keynote Addresses	20
Master Clinician Presentations	25
Symposia	27
Open Papers	48
Posters	56

Third International Conference of Metacognitive Therapy
Palazzo Mezzanotte: 7th-9th April 2016

Conference Organising Committee:

Prof. Adrian Wells (Chair), University of Manchester, UK
Prof. Hans Nordahl (Chair), University Science and Technology Trondheim, Norway
Dr. Sandra Sassaroli, Studi Cognitivi, Cognitive Psychotherapy School and Research
Alison Colton, Milan (Conference Secretary)

Scientific Committee:

Prof. Adrian Wells (Chair), University of Manchester, UK
Prof. Hans Nordahl, University Science and Technology Trondheim, Norway
Dr. Sandra Sassaroli, Studi Cognitivi, Cognitive Psychotherapy School and Research
Center, Italy
Prof. Ezio Sanavio, University of Padova, Italy
Prof. Marcantonio Spada, London Southbank University, UK
Dr. Costas Papatheodorou, Priory Hospital Altrincham, UK
Dr. Peter Fisher, University of Liverpool, UK
Lora Capobianco (Secretary), University of Manchester, UK

Dear Delegates,

A very warm welcome to Milano and the Third International Conference of Metacognitive Therapy.

The scientific programme covers a broad range of psychological disorders and processes including Metacognitive Therapy in physical health conditions. There are keynote addresses and master-clinician presentations and poster sessions alongside the symposia and open-papers to maximise exposure to new research, developments, and skills.

For the first time at this conference we have chosen to run parallel sessions. Whilst this creates some dilemmas in deciding which presentations to attend and can reduce numbers at each presentation this has been a necessity to accommodate the high volume of quality MCT research.

Please take full advantage of the scientific and social programme to update your knowledge and skills and develop and strengthen alliances and help us to make this conference another professionally valuable, memorable, and enjoyable experience.

Hans M. Nordahl, Ph.D (Conference Chair)
Adrian Wells, Ph.D (Chair of the Scientific Committee)

In association with the MCT Institute: www.mct-institute.com & Studi Cognitivi
www.studicognitivi.net

General Information

Registration

All delegates must register and pick up their conference packs and badges. The conference registration desk is located in the foyer. Registration will be open at the following times:

Thursday April 7 th (08.00 -18.30)	Pre-Congress Workshop
Friday April 8 th (08.00 -18.30)	Conference
Saturday April 9 th (08.00 -18.30)	Conference

If you need to pay for the conference dinner or pay for conference registration you may do so at the registration desk at the following times:

Thursday: 08:00 – 10:00 / 12:30 – 14:00

Friday: 08:00– 16:30 (closed between 11:30 – 12:45)

Saturday: 08:00– 13:00

Poster Sessions

Poster submissions will be on display throughout the conference. Posters should be mounted on the display boards in the display area before the first refreshment break (**11:15 am**) on Friday April 8th. Delegates are free to view the posters at any time during the conference. Authors should attend their posters and be available for discussions during the refreshment breaks.

Security

Please do not leave valuables in the workshop rooms or the conference hall during the refreshment and lunch breaks. It is important that badges are worn at all times.

Refreshments

Tea, coffee, and water are provided free of charge to all delegates in the morning and afternoon. Refreshments will be served in the balcony area overlooking the Parterre Hall.

Lunch is not provided but there is a wide selection of restaurants, cafes, and bars for purchasing snacks and meals in the area surrounding Palazzo Mezzanotte.

Conference Reception and Party

A happy hour and buffet dinner has been organized at the Bacchanale Restaurant on Via Gaetano Negri, 4 (50 meters from Palazzo Mezzanotte). An evening composed of Good Italian wine, traditional Milanese cocktails and plenty of great Italian Food! The cost is €30 per person. Tickets can be purchased at the registration desk.

Badges

A badge is provided with your conference pack. You must wear your badge at all times during the conference. Admission to the symposia and social events will be restricted to badge holders only. If you lose your badge contact the registration desk for a replacement.

Conference Secretariat: Allison Colton, a.colton@studicognitivi.net or 0039 024150998 (from 09.00 to 18.00)

MCT Conference: Overview

Pre-Congress Skills Based Workshop (7th April)

Presenter	Morning Sessions (09.00-12.30)	Presenter	Afternoon Sessions (13.30-17.00)
Adrian Wells & Hans M Nordahl	Core principles and techniques in MCT	Adrian Wells	MCT for generalized anxiety and obsessive compulsive disorder
Robin Bailey	MCT of Health Anxiety	Costas Papageorgiou	Metacognitive therapy for depression in individual and group formats
Peter Fisher	Metacognitive Therapy for Emotional Distress in Physical Illness	Hans M Nordahl	Metacognitive Therapy in Complex Trauma

Conference (8th & 9th April)

Friday April 8th

Parterre

Sala Blu

9:00 AM	Keynote- Hans Nordahl	
9:45 AM	Symposium- MCT for Obsessive Compulsive Disorder	Symposium- Metacognition & Borderline Personality Pathology
10:30 AM	Keynote- Sandra Sassaroli	
11:15 AM	Tea & Coffee Poster Session	Tea & Coffee Poster Sessions
11:45 AM	Symposium- Ruminative Processes & Metacognition	Open Paper- Metacognition
12:15 PM	Open Papers- Mental Health Disorders	Open Papers- Eating Disorders
1:00 PM	Lunch	Lunch
2:00 PM	Symposium- MCT for Depression	Symposium- Effectiveness of MCT & Processes of Change

2: 45 PM	Master Clinician- Costas Papageorgiou	
3:30 PM	Tea & Coffee	Tea & Coffee
4:00 PM	Keynote- Adrian Wells	

7:30 PM **Conference Aperitivi**

Saturday April 9th

Parterre

Sala Blu

9:00 AM	Keynote- Marcantonio Spada	
9:45 AM	Symposium- Metacognition & the CAS in Addiction	Symposium- Effectiveness of MCT in Anxiety & Depression
10:30 AM	Open Papers- Addictions	Open Papers- Psychosis
11:15 AM	Tea & Coffee Poster Session	Tea & Coffee Poster Sessions
11: 45 AM	Keynote- Thomas Fergus	
12:15 PM	Symposium- Metacognition in Psychosis	Symposium- MCT for Cardiac Rehabilitation
1:00 PM	Lunch	Lunch
2:00 PM	Master Clinician- Anthony Morrison & Sophie Parker	Symposium- MCT in Physical Health Conditions (1)
2:45 PM	Symposium-Metacognitions in Children and Adolescents	Symposium- MCT in Physical Health Conditions (2)
3:30 PM	Tea & Coffee	Tea & Coffee
4:00 PM	Keynote- Peter Fisher	

Pre-Congress Workshops 7th April

These workshops are designed for therapists and researchers at all levels who want to learn the basic MCT model and how to apply this in developing case conceptualizations and implementing meta-level changes. Workshops will use a combination of didactic presentation and video/role play in shaping therapeutic experiences and skills

You will receive a certificate of attendance following the workshops that can be used as proof of continuing professional development.

Workshop 1: Core Principles & Techniques of MCT



Presented by: Adrian Wells, Ph.D, University of Manchester, UK & Hans M. Nordahl, Ph.D, NTNU Trondheim, Norway

In this workshop the core principles of MCT will be presented. MCT focuses on modifying repetitive negative thinking styles of the Cognitive Attentional Syndrome and enhancing flexible control in response to negative thoughts and beliefs. It is important that the clinician has a deep understanding of MCT principles

and how working purely in a metacognitive mode rather than using eclecticism can prevent incompatibility with some of the main techniques of CBT. The major techniques for producing change in thinking styles at the metacognitive level will be illustrated with reference to a range of clinical disorders. These techniques are: meta-level Socratic dialogue, detached mindfulness, attention training technique, and metacognitive experiments.

Workshop participants will learn

1. The core conceptual framework underpinning MCT
2. How MCT differs from and is incompatible with major aspects of CBT
3. Specific Techniques for reducing maladaptive thinking styles
4. Techniques for modifying metacognitive beliefs

Workshop 2: MCT for Health Anxiety



Presented by: Robin Bailey, University of Manchester & University of Central Lancashire, UK

Recent advances have demonstrated that metacognition is an important variable in the maintenance (Bailey & Wells, 2013; Bailey & Wells 2015) and treatment (Bailey & Wells, 2014) of health anxiety. In this workshop the metacognitive model of health anxiety will be presented and participants will learn how to use this as a basis of case conceptualisation. Participants will be guided through the treatment protocol and learn specific MCT techniques to manage: worry and rumination about illness and health, threat monitoring for thoughts of illness and physical signs of illness, and behavioural

coping strategies that aim to control illness based thinking. The workshop will also focus on how to modify underlying metacognitions problematic in health anxiety, such as: ‘Beliefs about biased thinking’, ‘Beliefs that thoughts can cause illness’, and ‘Beliefs that thoughts are uncontrollable’.

Workshop participants will learn:

1. The metacognitive model of health anxiety.
2. How to formulate health anxiety
3. Techniques for removing maladaptive thinking styles and behaviours
4. Techniques for modifying health anxious metacognitive beliefs
5. Relapse prevention

References:

Bailey, R., & Wells, A. (2013). Does Metacognition Make a Unique Contribution to Health Anxiety When Controlling for Neuroticism, Illness Cognition, and Somatosensory Amplification? *Journal of Cognitive Psychotherapy*, 27(4), 327-337.

Bailey, R., & Wells, A. (2014). Metacognitive therapy in the treatment of hypochondriasis: a systematic case series. *Cognitive Therapy and Research*, 38(5), 541-550.

Bailey, R., & Wells, A. (2015). Metacognitive Beliefs Moderate the Relationship between Catastrophic Misinterpretation and Health Anxiety. *Journal of Anxiety Disorders* (in press).

Workshop 3: Metacognitive Therapy for Emotional Distress in Physical Illness



Presented by: Peter Fisher, Ph.D University of Liverpool, UK

Approximately 25% of patients with a physical illness experiences clinically significant levels of emotional distress. Psychological morbidity in physical illnesses is a significant clinical concern because it reduces quality of life for the patient as well as those close to them, intensifies physical symptoms including pain, reduces treatment adherence and increases healthcare costs. Clinical guidelines therefore state that effective psychological intervention should be available for those patients who need it if high quality care for patients with a physical illness is to be achieved. This workshop will illustrate how Metacognitive Therapy (MCT) can be used to treat emotional distress (e.g. anxiety, depression, trauma related symptoms) in patients with a physical illness. MCT is based on a transdiagnostic information processing model of psychopathology (Wells and Matthews, 1994) which means the same intervention can be used with patients with different presenting complaints across a range of physical illnesses. In this workshop, the transdiagnostic metacognitive model and treatment will be described in detail. Illustrative clinical examples will be used throughout the workshop and participants are encouraged to bring their own case material for discussion. The workshop will involve didactic presentation, video demonstrations and role plays.

Workshop participants will learn:

1. To begin to develop assessment skills providing the foundation to deliver MCT for clinically significant distress in physical illnesses.
2. To understand and practice developing transdiagnostic formulations from a MCT perspective
3. To understand how to design and implement a range of metacognitively focused treatment strategies aimed at modifying metacognitive beliefs and the cognitive attentional syndrome in patients with physical illness.
4. To understand the distinctive theoretical underpinnings and treatment components of MCT.

Key Reference

Wells, A. (2009). *Metacognitive Therapy for Anxiety and Depression*. New York: Guilford Press.

Additional References

McNicol, K., Salmon, P., Young, B., & Fisher, P.L. (2013). Alleviating emotional distress in a young adult survivor of adolescent cancer: a case study illustrating a new application of metacognitive therapy. *Clinical Case Studies* 12 (1) 22–38.

Fisher, P.L., McNicol K, Young B., Smith, E., & Salmon, P. (2015) Alleviating Emotional Distress in Adolescent and Young Adult Cancer Survivors: An Open Trial of Metacognitive Therapy. *Journal of Adolescent and Young Adult Oncology*. 4, (2) 64-69.

Fisher, P.L., & Wells, A. (2009). *Metacognitive Therapy: Distinctive Features*. Hove: Routledge.

Workshop 4: MCT for Generalized Anxiety and Obsessive Compulsive Disorder



Presented by: Adrian Wells Ph.D, University of Manchester, UK

In this workshop the metacognitive models of GAD and OCD will be described and participants will be guided in using them to construct individual case formulations. The process of socialisation and the stages and techniques of treatment in each of the disorders will be explained. The workshop will use videotape demonstrations of therapy and role-play practise. The main techniques for changing the clients' direct experience of intrusions and challenging beliefs about the uncontrollability and danger of worrying that are central to GAD, and for modifying fusion-related meta-beliefs in OCD will be described and illustrated.

Workshop participants will learn:

1. MCT models of GAD and OCD
2. How to generate case formulations in these disorders
3. How to socialise the patient
4. Techniques for modifying GAD-specific and OCD-specific metacognitive beliefs

Reference:

Wells, A. (2009). Metacognitive therapy for anxiety and depression. New York: Guilford Press.

Workshop 5: Metacognitive therapy for depression in individual and group formats



Presented by: Costas Papageorgiou, Ph.D, The Priory Hospital Altrincham, UK

Growing empirical evidence supports the implementation of metacognitive therapy (MCT) for rumination and depression in both individual (Wells et al., 2009, 2012) and group (Dammen, Papageorgiou & Wells, 2014; Papageorgiou & Wells, 2015) formats to maximise therapeutic effectiveness, prevent depressive relapse or recurrence, and address fundamental limitations of current treatments. MCT for depression aims to remove the metacognitive causes of rumination, which is a core process implicated in the maintenance and perpetuation of depression. The overall objective of this skills-based clinical workshop is to outline the components of individual MCT for depression (Wells, 2009; Wells & Papageorgiou, 2004) and highlight effective practical adaptations for its delivery in group formats. The following areas will be covered: overview of depressive rumination; the clinical metacognitive model of rumination and depression; assessment/measurement of rumination and associated constructs; case conceptualisation and socialisation; facilitating abandonment of rumination; enhancing flexible control over cognition using attention training and detached mindfulness; modifying negative and positive metacognitive beliefs; decatastrophising emotion; developing new plans for processing and relapse prevention. A combination of lecture, discussion,

experiential, role-plays, and case presentations will be used to facilitate this workshop.

Workshop participants will learn:

1. To gain up-to-date knowledge of the phenomenology of rumination and its relationship with depression
2. To understand the principal features of the metacognitive model and therapy of rumination and depression
3. To become familiar with the specific metacognitive treatment strategies and techniques for depression
4. To gain insight into effective adaptations of MCT for depression for its implementation in group formats

References:

- Dammen, T., Papageorgiou, C. & Wells, A. (2015). An open trial of group metacognitive therapy in Norway. *Nord J Psychiatry*, 69, 126–131.
- Papageorgiou, C. & Wells, A. (2015). Group Metacognitive Therapy for Severe Antidepressant and CBT Resistant Depression: A Baseline-Controlled Trial. *Cognitive Therapy and Research*, 39, 14-22.
- Wells, A. (2009). *Metacognitive therapy for anxiety and depression*. New York: Guilford Press.
- Wells, A., Fisher, P. L., Myers, S., Wheatley, J., Patel, T., & Brewin, C. R. (2012). Metacognitive therapy in treatment-resistant depression: A platform trial. *Behaviour Research and Therapy*, 50, 367–373

Workshop 6: Metacognitive Therapy in Complex Trauma



Presented by: Hans M Nordahl, Ph.D, NTNU, Norway

In complex PTSD patients suffer from long term problems with trauma symptoms, severe dissociation, emotional instability, avoidance and difficulties in their social functioning and partnerships. Currently the recommended psychosocial treatments for C-PTSD are exposure based therapy, medication and/or supportive stabilising therapy. A majority of patients achieve improvement, but a substantial minority either drop out of treatment or fail to improve or even get worse. A non-exposure based alternative is offered by MCT which is well tolerated and effective treatment for these patients (Wells, et al. 2015). MCT is based on allowing the patient to deal with symptoms in new ways so the recovery process is facilitated. To achieve this, it is necessary to reduce the maladaptive coping strategies called the CAS (i.e. rumination, memory dwelling, threat monitoring, avoidance, substance abuse) and modify the metacognitive beliefs regulating the CAS. In addition, a ‘no coping strategy’ rationale is formulated and implemented, as complexity is related to maladaptive forms of strategies used (avoidance, dissociation, self-harming behaviours, suicidal threats). In this workshop you will learn how to apply the principles of MCT in complex trauma, to deal with metacognitive beliefs about symptoms and emotions and also learn how to

help the patient change the set of maladaptive strategies and respond in new ways that support the recovery process. Our own randomised controlled trial (Nordahl, et al in prep) comparing MCT with EMDR in patients with C-PTSD shows that MCT works well demonstrating that MCT is a well tolerated and effective approach in treating these patients.

Workshop participants will learn:

1. Learning to identify the CAS and metacognitions in complex trauma
2. How to work with metacognitive beliefs and how to stay in a metacognitive dialogue with the patient
3. Learning the steps in MCT and how to modify attention in complex trauma

References:

Wells, A. Walton, D., Lovell, K. & Proctor, D. (2015). Metacognitive therapy versus prolonged exposure in adults with chronic post-traumatic stress disorder: A parallel randomized controlled trial. *Cognitive Therapy and Research*, 39, 70-80.

Symposia

Symposium 1: Metacognitive Theory and Therapy for Obsessive Compulsive Disorder

Convenor: Samuel G. Myers

1. The Importance of Metacognition in Understanding and Treating Obsessive-Compulsive Disorder: A Review.

Stian Solem¹

Norwegian University of Science and Technology, Norway¹

2. An Empirical Test of the Metacognitive Model of Obsessive Compulsive Disorder in a Large Clinical Sample.

Samuel Myers¹, Torun Grøtø², Svein Haseth³, Ismail Guzey², Bjarne Hansen⁴, Patrick Vogel¹, Stian Solem²

The Israel Center for the Treatment of Psychotrauma, Israel¹, Norwegian University of Science and Technology, Norway², St. Olav University Hospital, Norway³, University of Bergen, Norway⁴

3. Improving Treatment Outcomes for Obsessive Compulsive Disorder: The Potential of Group Metacognitive Therapy.

Peter Fisher¹ & Adrian Wells²

University of Liverpool, UK¹ & University of Manchester, UK²

Symposium 2: Metacognition, Anger and Borderline Personality Pathology

1. Metacognitions As Predictor of Anger: A Prospective Study

Alessia Offredi¹, Gabriele Caselli^{1,2,3}, Francesca Martino^{1,4}, Davide Varalli⁵, Giovanni Ruggiero^{1,2}, Sandra Sassaroli^{1,2}, Marcantonio Spada³

Studi Cognitivi, Italy¹, Sigmund Freud University, Italy², London South Bank University, UK³, University of Bologna, Italy⁴, University of Pavia⁵

2. Anger, Rumination, And Aggressive Behaviour in Borderline Personality Disorders

Francesca Martino^{1,2}, Gabriele Caselli^{1,3,4}, Domenico Berardi², Francesca Fiore¹, Erika Marino⁵, Marco Menchetti², Elena Prunetti⁵, Giovanni Ruggiero^{1,3}, Anna Sasdelli², Edward Selby⁶, Sandra Sassaroli^{1,3}

Studi Cognitivi, Italy¹, University of Bologna, Italy², Sigmund Freud University, Italy³, London South Bank University, UK⁴, Private Hospital Villa Margherita, Italy⁵, Rutgers University, USA⁶

3. The Role of Metacognition and Beliefs About Emotions in Predicting Borderline Symptoms

Simona Girui¹, Renata Bedini¹, Alessandra Brugnoli¹, Chiara Manfredi^{1,2,3}, Alice Mannarino¹, Giovanni Ruggiero^{1,2}, Sandra Sassaroli^{1,2}

Studi Cognitivi, Italy¹, Sigmund Freud University, Italy², University of Pavia, Italy³

Symposium 3: From Ruminative Processes to Metacognition

Convenor: Sandra Sassaroli

1. Validation of the Anger Rumination Scale (ARS) in an Italian Sample

Marco Baldetti^{1,2}, Francesca Fiore^{1,3}, Claudio Bartolozzi^{2,4}, Gabriele Caselli^{1,3,5}, Carmello La Mela^{1,2}, Sandra Sassaroli^{1,3}

Studi Cognitivi, Italy¹, Scuola Cognitiva, Italy², Sigmund Freud University, Italy³, University of Florence, Italy⁴, London South Bank University, UK⁵

2. Irrational And Metacognitive Beliefs As Mediators Between Dysfunctional Beliefs (Schemas) And Anxiety

Giovanni Ruggiero^{1,2}, Andrea Bassanini^{1,2}, Maria Chiara Benzi^{1,2}, Elisabetta Caletti^{1,2}, Antonio Di Tucci^{1,2}, Francesca Fiore^{1,2}, Elena Moioli^{1,2}, Sara Marsero^{1,2}, Marco Telesca^{1,2}, Elena Ponzio^{1,2}, Walter Sapuppo^{1,2}, Sara Zizak^{1,2}, Sandra Sassaroli^{1,2}

Studi Cognitivi, Italy¹, Sigmund Freud University, Italy²

3. Worry As An Adaptive Strategy in Healthy Controls but Not in Pathological Worriers

Cristina Ottaviani¹, Rostia Borlimi^{2,3}, Gianni Brighetti^{2,3}, Gabriele Caselli^{3,4,5}, Ettore Favaretto⁶, Irene Giardini⁴, Camilla Marzocchi⁴, Valeria Nucifore², Daniela Rebecchi⁴, Giovanni Ruggiero^{3,7}, Sandra Sassaroli^{3,4}

IRCCS Santa Lucia Foundation, Italy¹, University of Bologna, Italy², Sigmund Freud University, Italy³, Studi Cognitivi, Italy⁴, London South Bank University, UK⁵, Azienda Sanitaria di Bolzano, Italy⁶, Scuola Cognitiva, Italy⁷

Symposium 4: MCT for Depression: Effects on Depression Types, Long-Term Outcome, and Neuropsychology

Convenor: Costas Papageorgiou

1. Impact of Metacognitive Therapy on Cognitive Dysfunction in Depression

Jennifer Jordan^{1,2}, Samantha Groves³, Richard Porter¹, Christopher Frampton¹, Janet Carter⁴, Virginia McIntosh², Kumari Fernando³, Roger Mulder⁴, Cameron Lacey⁴, & Peter Joyce⁴

University of Otago, New Zealand¹, Canterbury District Health Board, New Zealand², Groves University of Otago, New Zealand³, & University of Canterbury, New Zealand⁴

2. A 2-year Follow-Up Study of Group MCT for Depression
Toril Dammen¹, Costas Papageorgiou², & Adrian Wells^{3,4}

University of Oslo, Norway¹, Priory Hospital, UK², University of Manchester, UK³, & Norwegian University of Science and Technology, Norway⁴

3. Metacognitive Therapy in the Treatment of Current and Treatment-Refractor Major Depression

Lotta Winter¹, Julia Gottschalk¹, Janina Nielsen¹, Adrian Wells², Ulrich Schweiger³, Kai Kahl¹

Hannover Medical School (MHH), Germany¹, University of Manchester, UK², & University of Lübeck, Germany³

Symposium 5: The Effectiveness of Metacognitive Therapy and Processes of Change.

Convenor: Lora Capobianco

1. Metacognitive Therapy versus Cognitive Behaviour Therapy for Depression: A Randomised Clinical Trial

Pia Callesen^{1,2} & Adrian Wells¹

University of Manchester, UK¹, CEKTOS, Denmark²

2. Metacognitive Therapy in Transdiagnostic Groups

Carsten Juul¹, Pia Callesen^{1,2}, Lora Capobianco², & Sisse Find Nielsen¹

CEKTOS, Denmark¹, University of Manchester, UK^{1,2}

3. Modelling the Causal Relationship Between Change in Psychological Processes and Symptom Improvement in Metacognitive Therapy

Lora Capobianco¹, Pia Callesen^{1,2}, Carsten Juul², Sisse Find Nielsen², & Adrian Wells¹

University of Manchester, UK¹, CEKTOS, Denmark²

Symposium 6: Metacognitions and the Cognitive Attentional Syndrome in Addictive Behaviours

Convenor: Marcantonio M. Spada

1. The Metacognitions About Smoking Questionnaire

A.V. Nikčević¹, Gabriele Caselli^{2,3}, Adrian Wells⁴ and Marcantonio M. Spada³

Kingston University, UK¹, Studi Cognitivi, Italy², London South Bank University, UK³ & University of Manchester, UK⁴

2. Profiling Metacognition in Gambling Disorder

Marcantonio M. Spada¹, Bruce A. Fernie², Lucia Giustina³, Silvia Rolandi⁴ and Gabriele Caselli^{1,5}

London South Bank University, London, UK¹, King's College London, UK², Servizio Tossicodipendenze, AUSL, Italy³, Università di Pavia, Italy⁴ & Studi Cognitivi, Italy⁵

3. A Test of a Metacognitive Model of Desire Thinking and Craving
Gabriele Caselli^{1,2} and Marcantonio M. Spada²

Studi Cognitivi, Italy¹ & London South Bank University, London, UK²

Symposium 7 : The Effectiveness of MCT on Anxiety and Depression: The Trondheim Randomized Controlled Trials

Convenor: Odin Hjemdal

1. Randomized Controlled Trial of Cognitive Behaviour Therapy, Metacognitive Therapy and Wait List of Patients with Generalised Anxiety Disorder (GAD): A Two-Year Follow Up Study

Hans Nordahl¹, Roger Hagen¹, Leif Edward Ottsen Kennair¹, Odin Hjemdal¹, Stian Solem¹, Bjarne Hansen², Svein Haseth³, Thomas Borkovec⁴, & Adrian Wells⁵

Norwegian University of Science and Technology, Norway¹, University of Bergen, Norway², St. Olavs Hospital, Norway³, Penn State University, USA⁴, & University of Manchester, UK⁵

2. A Randomized Controlled Trial Of Metacognitive Therapy and Eye Movement Desensitization and Reprocessing for Posttraumatic Stress Disorder: A Study of Effectiveness, Mediators, and Moderators

Hans Nordahl¹, Joar Halvorsen², Bjørn Aasen², Odin Hjemdal¹, & Adrian Wells³

University of Science and Technology, Trondheim, Norway¹, St. Olavs Hospital, Trondheim, Norway², University of Manchester, UK³

3. Metacognitive Therapy for Depression: A Randomized Controlled Trial.

Roger Hagen¹, Odin Hjemdal¹, Stian Solem¹, Leif Edward Ottesen Kennair¹, Hans Nordahl¹, & Adrian Wells²

Norwegian University of Science and Technology, Norway¹, University of Manchester, UK²

Symposium 8: Metacognition in Psychosis: Theory and Treatment

Convener: Sophie Parker

1. Metacognitive Theory and Therapy for Psychosis: An Overview
Anthony Morrison¹

University of Manchester, UK¹

2. The Beliefs about Paranoia Scale: Validation of a Metacognitive Approach to Conceptualizing Paranoia in People Experiencing Psychosis
Elizabeth Murphy¹, Melissa Pyle^{1,2}, Anthony Gumley³, David Kingdon⁴, Matthias Schwannauer⁵, Douglas Turkington⁶, & Anthony Morrison^{1,2}

Greater Manchester West NHS Trust¹, University of Manchester, UK², University of Glasgow, UK³, University of Southampton⁴, University of Edinburgh, UK⁵, & Newcastle University, UK⁶

3. An Investigation of Attention Training Technique in Psychosis
Sophie Parker^{1,2}, Adrian Wells², Heather Law¹, Measha Bright¹, Eilish Burke², Lucy Carter¹, Lee Mulligan¹, Jasper Palmier-Claus¹, Rachel Sellers¹, & Elisabeth Zabel²

Greater Manchester West NHS Trust¹, University of Manchester, UK²

Symposium 9: Adapting Metacognitive Therapy for the Cardiac Rehabilitation Pathway: The PATHWAY Trial

Convenor: Rebecca McPhillips

1. “It’s kind of like, life changing for me”: A Qualitative Investigation of Cardiac Patients’ Experiences of Group-Metacognitive Therapy as Part of The PATHWAY Trial.
Rebecca McPhillips¹, Peter Salmon², Adrian Wells³, & Peter Fisher²

Manchester Mental Health and Social Care Trust, UK¹, University of Liverpool, UK², & University of Manchester, UK³

2. Are Metacognitive Beliefs Transdiagnostic: A Comparison of Cancer and Cardiac Patients Experiencing Anxiety and Depression
Rebecca Anderson¹, Peter Fisher², Hannah Gaffney¹, Helen Morley¹, & Adrian Wells³

Manchester Mental Health and Social Care Trust, UK¹, University of Liverpool, UK², & University of Manchester, UK³

3. Key Considerations in the Development, Implementation and Evaluation of a Metacognitive Therapy Intervention for Anxiety and Depression in the Cardiac Rehabilitation Pathway: The PATHWAY Trial
Hannah Gaffney¹, Rebecca Anderson¹, Helen Morley¹, Gemma Shields², Peter Fisher³, Peter Salmon³, Linda Davies², David Reeves², & Adrian Wells²

Manchester Mental Health and Social Care Trust, UK¹, University of Manchester, UK², & University of Liverpool, UK³

Symposium 10: Metacognitive Therapy and Theory in Physical Health Conditions

Convenor: Peter Fisher

1. The Influence of Metacognitive Beliefs on Positive and Negative Affect in Parents of Children with Cancer

Enrico Toffalini¹, Cesare Cornoldi¹

University of Padova¹

2. The Association of Metacognitive Beliefs with Symptoms of Anxiety and Depression in Type 1 and Type 2 Diabetes Mellitus

Rebecca Purewal¹, & Peter Fisher¹

University of Liverpool, UK¹

3. Metacognitions as Predictors of Treatment Outcomes in Chronic Fatigue Syndrome

Ana Nikčević¹, Bruce Fernie², Adrian Wells³, & Marcantonio Spada⁴

Kingston University, UK¹, Kings College London, UK², University of Manchester, UK³, & London South Bank University, UK⁴

4. Metacognitive Therapy for emotional Distress in Cancer Survivors: A Case Series

Peter Fisher¹, Peter Salmon¹, & Angela Byrne¹

University of Liverpool¹

5. The Role of Metacognitions in Parkinson's Disease

Bruce Fernie¹, Richard Brown¹, & Marcantonio Spada²

Kings College London, UK¹ & London South Bank University, UK²

6. The Metacognitions about Symptoms Control Scale

Marcantonio Spada¹, Bruce Fernie², & Ana Nikčević³

London South Bank University, UK¹, Kings College London, UK², & Kingston University, UK³

7. Integrating Group-Metacognitive Therapy Into Cardiac Rehabilitation Pathways: Practitioner Perspectives

Rebecca McPhillips¹, Peter Salmon², Peter Fisher² & Adrian Wells³

Manchester Mental Health and Social Care Trust, UK¹, University of Liverpool², & University of Manchester, UK³

Symposium 11: Metacognitions in Children and Adolescents: Theory and Treatment.

Convenor: Michael Simons

1. A Pilot Investigation of MCT versus CBT for Children with Generalised Anxiety Disorder

Barbara Hoff Esbjørn¹, Nicoline Normann¹, Monika Walczak¹, & Marie Louise Reinholdt-Dunne¹

University of Copenhagen, Denmark¹

2. Moderating Effects of Attention Control on Generalized Anxiety Disorder in Children: Metacognitive Therapy vs Cognitive Behavioural Therapy

Marie Louise Reinholdt-Dunne¹, Andreas Blicher Skanborg¹, Nicoline Normann¹, & Barbara Hoff Esbjørn¹

University of Copenhagen, Denmark¹

3. Testing a Transdiagnostic Metacognitive Model of Emotional Disorders in Youths
Michael Simons¹ & Andrea Zahn²

RWTH Aachen University, Germany¹, University of Bonn, Germany²

Abstracts
Keynote Addresses

Keynote 1: Controlled clinical trials of MCT: The Trondheim studies



Professor Hans M Nordahl, Department of Psychology, Norwegian University Science and Technology Trondheim, Norway

Since 2004 the Trondheim group have conducted a series of important clinical trials comparing MCT with other treatments for various psychological disorders such as social phobia, GAD, borderline personality disorder, depression, and PTSD.

The social phobia study (2004-2012) compared metacognitively enhanced CBT with SSRI and their combination in a pre to post comparison with one year follow up. A randomised controlled trial (RCT) of GAD (2006-2014) was conducted comparing Borkovec's CBT for GAD with MCT at post treatment and at 2 years follows up. The study investigating Borderline personality disorder was initiated in 2007. This study was a systematic replication study including 10 patients, who were subsequently treated with the ERIS protocol (2007-2012), which is based on MCT. The patients were assessed at post treatment and at 1 and 2 years follow up. Recently, an RCT of major depression has been complete (2010-2015), which compared MCT with a wait-list condition at post treatment and at 1 year follow up. Finally, a large RCT for PTSD (2011-2016) with and without complex features was conducted comparing MCT with EMDR at post treatment and 1 year follow up.

An overview and of these studies and the results of the efficacy and outcomes of these off-site studies will be the topic of the key note, and suggestions for further studies will be presented.

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Keynote 2: Worry and Control as Self-Regulatory strategies in Eating Disorders: preliminary metacognitive hypotheses



Dr. Sandra Sassaroli
Studi Cognitivi, Cognitive Psychotherapy School and Research Center,
Milano (Italy)
Psicoterapia Cognitiva e Ricerca, Cognitive Psychotherapy School and
Research Center, Milano (Italy)
Sigmund Freud University, Wien (Austria) and Milano (Italy)

Fairburn's first cognitive-behavioural therapy (CBT) model provided an explicative model for bulimia nervosa and focused on beliefs related to eating, weight, self-esteem and perfectionism and provided a full and lasting recovery to around half of the bulimic patients (Fairburn, 1981; NIMH, 2004; Wilson & Fairburn, 2007). However, Fairburn's model overlooked the role played in eating disorders (ED) by control related beliefs (Masheb & Grilo, 2002; Eiber et al., 2005; Sassaroli, et al., 2008; Serpell et al., 1999; Shearin et al., 1994; Waller, 1998) and repetitive negative thinking (RNT) processes such as worry (Kerkhof et al., 2000; Sassaroli et al., 2005; Scattolon & Nicky, 1995; Wadden et al., 1991), rumination (Hart & Chiovari, 1998; Nolen-Hoeksema et al, 2007; Troop & Treasure, 1997) and metacognitive factors (Cooper et al., 2007; McDermott & Rushford, 2011; Olstad et al., 2015; Woolrich et al., 2008). The proven impact of control and RNT mechanisms on the psychopathology of ED encourages the development of related interventions tailored for ED. This work reviews the scientific literature regarding the role played by RNT processes in ED and shows preliminary data regarding their assesment and treatment in ED clients.

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Keynote 3: Metacognitive Therapy: A ‘State-of- the-Art’ Address



**Professor Adrian Wells,
University of Manchester, UK**

In this keynote address evidence for metacognitive theory and an analysis of the effectiveness of metacognitive therapy (MCT) will be presented. The last five years has seen a burgeoning of research supporting the mechanisms and processes in the S-REF model that cause and maintain disorder. The latest evidence demonstrates core relationships between metacognitive factors and psychological distress in both adults and children. In parallel research, component-based analyses of the effects of individual MCT techniques of attention training and detached mindfulness reveal these techniques to be effective, more effective than thought challenging, and to produce clear and predicted effects on objective indices of brain and executive function. MCT has also proven to be effective when delivered in a group format and in treating anxious or depressed patients who are medication or CBT resistant. In an exciting development early data suggests that MCT is more efficient and/or more effective than cognitive-behaviour therapy in specific disorders. The keynote will conclude with a consideration of areas that require future research if MCT is to become the first line of recommended treatment.

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Keynote 4: Metacognition in Addictive Behaviours: The Present and Beyond



**Professor
Marcantonio Spada
London South Bank University, UK**

Over the last twenty years metacognitive theory has provided a novel framework, in the form of the Self-Regulatory Executive Function (S-REF) model, for conceptualizing psychological distress. The S-REF model proposes that psychological distress persists because of unhelpful coping styles which are activated and maintained by metacognitive beliefs. In this keynote address I will illustrate the application of the S-REF model to addictive behaviours and review evidence consistent with this approach. I will also outline how Metacognitive Therapy may be adapted to treat addictive behaviours.

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Keynote 5: The Cognitive Attentional Syndrome: Distinctive Features, Mitigating Factors, and Treatment Implications



**Professor Thomas Fergus
Baylor University, USA**

Central to the metacognitive theory of emotional disorders is the cognitive attentional syndrome (CAS), a construct that pertains to the sustained processing of thoughts, threat, and emotions. Two core components of the CAS are rumination and worry, which are transdiagnostic forms of negative self-referential processing found to exacerbate emotional distress and diminish responses to cognitive-behavioral therapies. As such, and as proposed by metacognitive theory, the CAS is an important variable to target in the service of improving outcomes for individuals suffering from emotional disorders. Despite the purported importance of the CAS, its distinctiveness from related constructs and possible mitigating factors remain largely unexamined. This keynote will discuss research findings indicating that the CAS is distinct from psychological inflexibility, a construct central to acceptance and commitment therapy (ACT). Next, research findings suggesting the possible mitigating impact of attentional control on the relation between the CAS and emotional distress will be discussed. This keynote will conclude with a discussion about using the attention training technique (ATT) – a component of metacognitive therapy – as a standalone intervention to strengthen attentional control, reduce the CAS, and improve functioning for individuals suffering from emotional disorders.

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Keynote 6: Overcoming the Challenge of Treating Emotional Distress in Physical Illness. A Metacognitive Therapy Solution



**Dr. Peter L. Fisher,
University of Liverpool, UK**

Improving treatment outcomes for anxious and depressed patients with a physical illness is a clinical priority. However, as healthcare resources become increasingly scarce, researchers face a double headed challenge; developing more effective interventions that are less expensive to deliver. In this presentation I will discuss how Metacognitive Therapy (MCT) a transdiagnostic intervention, may offer a solution. As MCT targets and modifies a core set of metacognitive beliefs and processes, it can readily be used to alleviate emotional distress across a wide range of physical health conditions. The distinctive features and core components of MCT when treating emotional distress in physical health conditions will be illustrated.

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Master Clinician Presentations

Master Clinician 1: The Attention Training Technique: Do's and Don'ts



**Dr. Costas Papageorgiou,
Priory Hospital Altrincham, UK**

The Attention Training Technique (ATT; Wells, 1990) is one of the earliest forms, and an integral part of, metacognitive therapy. ATT aims to directly modify the control of attention. In a number of studies, ATT has been associated with clinically significant improvements when delivered alone to individuals with panic and social phobia (Wells, 1990; Wells, White & Carter, 1997), health anxiety (Cavanagh & Franklin, 2000; Papageorgiou & Wells, 1998), depression (Papageorgiou & Wells, 2000; Siegle, Ghinassi & Thase, 2007), and psychosis (Valmaggia, Bouman & Schuurman, 2007), but also as part of a full metacognitive treatment package (Dammen, Papageorgiou & Wells, 2014; Papageorgiou & Wells, 2015; Wells, Fisher, Myers, Wheatley, Patel & Brewin, 2009, 2012). Reports from both therapists and patients indicate that sometimes specific setbacks are experienced during the delivery and practice of ATT. In this presentation, common difficulties encountered in the administration and homework practice of ATT will be discussed along with the strategies that have been found to be particularly helpful in preventing these and maximising ATT effectiveness.

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Master Clinician 2: Think you're crazy, think again or should that be think less?



Professor Tony Morrison & Dr. Sophie Parker
University of Manchester, UK
Greater Manchester West NHS Mental Health Foundation, UK

Recent models of psychosis implicate metacognitive beliefs and processes in the development and maintenance of psychological distress. A metacognitive approach to understanding psychosis has been suggested by researchers. What does this mean for clinicians who are working with people with psychosis? This keynote will outline a case example of psychosis from both a cognitive and a metacognitive model. Discussion will be given to the different formulations of a problem derived from these models and their associated interventions. Using this case example, the keynote will consider these approaches highlighting key differences and the potential implications.

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Symposium Abstracts

Symposia

Symposium 1: Metacognitive Theory and Therapy for Obsessive Compulsive Disorder

Convenor: Samuel G. Myers

1. The Importance of Metacognition in Understanding and Treating Obsessive-Compulsive Disorder: A Review.

Stian Solem¹

Norwegian University of Science and Technology, Norway¹

The aim of the study was to review studies addressing metacognition in Obsessive-Compulsive Disorder. We hypothesized that metacognition would show a consistent relationship with OCD and that metacognition scores separated OCD samples from normal controls. Studies published in international journals using metacognitive measures (MCQ, TFI, BARI, SSQ) based on Wells' theory of emotional disorders (not including TCQ) were included. Studies had to report correlation/regression coefficients or group comparisons. A total of 6083 subjects from 27 different studies were included. Twenty-one studies used the MCQ and found consistent relationships with OCD. Negative beliefs and need to control thoughts showed the strongest correlation with OCD symptoms. Metacognitions separated OCD samples from normal controls. Six studies used OCD specific measures of metacognitions, showing that thought fusion beliefs, beliefs about rituals and stop signals are also consistently related to OCD. The reviewed studies indicate that metacognition is a firmly established as important in explaining symptoms of OCD.

2. An Empirical Test of the Metacognitive Model of Obsessive Compulsive Disorder in a Large Clinical Sample.

Samuel Myers¹, Torun Grøtte², Svein Haseth³, Ismail Guzey², Bjarne Hansen⁴, Patrick Vogel¹, Stian Solem²

The Israel Center for the Treatment of Psychotrauma, Israel¹, Norwegian University of Science and Technology, Norway², St. Olav University Hospital, Norway³, University of Bergen, Norway⁴

The metacognitive model of Obsessive Compulsive Disorder (Wells, 1997) stresses the role of three metacognitive domains: thought fusion beliefs, beliefs about rituals, and stop signals. The aim of the study was to test the hypothesised role of the above metacognitions. 307 OCD patients completed questionnaires measuring obsessive-compulsive symptoms, worry, and non-metacognitive and metacognitive beliefs linked to OCD. Correlations and regressions were carried out with the data. With worry and non-metacognitive beliefs controlled, each of the metacognitive domains when entered in their hypothesised order of activation, incrementally predicted two different obsessive-compulsive symptom measures. Non-metacognitive beliefs did not emerge as predictors in the final equations. The results support the metacognitive model. They extend previous

findings by the use of a large clinical sample.

3. Improving Treatment Outcomes for Obsessive Compulsive Disorder: The Potential of Group Metacognitive Therapy.
Peter Fisher¹ & Adrian Wells²

University of Liverpool, UK¹ & University of Manchester, UK²

The gold standard intervention for Obsessive Compulsive Disorder produces recovery in only 50-60% of patients that complete treatment. Furthermore, almost 75% of treated patients are left with distressing symptoms. More effective interventions are clearly required. We investigated if brief group MCT can produce clinically significant improvement in obsessive compulsive symptoms. In an open trial with six months follow-up, the potential efficacy of brief group MCT was tested across 19 patients in five small groups. Group MCT was delivered by a single therapist and involved up to eight 2-hour sessions. Group MCT was acceptable and feasible to deliver as 17/19 patients completed treatment. Almost all patients (89%) met standardized criteria for recovery and 65% were classified as asymptomatic. Data from this open trial suggests that group MCT for OCD could prove to be efficacious and a cost effective psychological treatment.

Symposium 2: Metacognition, Anger and Borderline Personality Pathology

1. Metacognitions As Predictor of Anger: A Prospective Study
Alessia Offredi¹, Gabriele Caselli^{1,2,3}, Francesca Martino^{1,4}, Davide Varalli⁵, Giovanni Ruggiero^{1,2}, Sandra Sassaroli^{1,2}, Marcantonio Spada³

Studi Cognitivi, Italy¹, Sigmund Freud University, Italy², London South Bank University, UK³, University of Bologna, Italy⁴, University of Pavia⁵

The mutual relationship between anger and rumination can lead to negative reactions and consequences involving different aspects of health and wellbeing. Metacognitive theory and therapy conceptualized this perseverative relationship as driven by a set of metacognitive beliefs, information individuals hold about their own cognition and about coping strategies that impact on it. The present study aimed at testing the prospective predictive impact of metacognitive beliefs on anger, as mediators between rumination and emotion, in a community sample. A total of 76 participants were recruited and engaged in a 2-week anger, rumination and metacognitions monitoring protocol. A cross-lagged longitudinal design was employed to test if metacognitions had an impact on anger, over and above the impact of rumination. Results showed that metacognitions prospectively contribute to predicting subsequent anger independently from rumination, and that they mediate the relationship between triggering episodes and anger. Findings provide support for the potential value for applying metacognitive theory and therapy to

anger-related problems.

2. Anger, Rumination, And Aggressive Behaviour in Borderline Personality Disorders
Francesca Martino^{1,2}, Gabriele Caselli^{1,3,4}, Domenico Berardi², Francesca Fiore¹, Erika Marino⁵, Marco Menchetti², Elena Prunetti⁵, Giovanni Ruggiero^{1,3}, Anna Sasdelli², Edward Selby⁶, Sandra Sassaroli^{1,3}

Studi Cognitivi, Italy¹, Univeristy of Bologna, Italy², Sigmund Freud University, Italy³, London South Bank University, UK⁴, Private Hospital Villa Margherita, Italy⁵, Rutgers University, USA⁶

Emotional instability and dyscontrolled behaviours are central features in borderline personality disorder (BPD). Recently, some cognitive dysfunctional mechanisms, such as anger rumination, have been found to increase negative emotions and promote dyscontrolled behaviours. Even though rumination has consistently been linked to BPD traits in non-clinical samples, its relationship with problematic behaviour has yet to be established in a clinical population. The purpose of the study was to explore the relationships between emotional dysregulation, anger rumination and aggression proneness in a clinical sample of patients with BPD. Enrolled patients with personality disorders (93 with BPD) completed a comprehensive assessment for personality disorder symptoms, anger rumination, emotional dysregulation and aggression proneness. Anger rumination was found to significantly predict aggression proneness, over and above emotional dysregulation. Furthermore, both BPD diagnosis and anger rumination were significant predictors of aggression proneness. Metacognitions also mediated the effect of both triggering episodes and rumination on anger. Future research should examine whether clinical techniques aimed at reducing rumination are helpful for reducing aggressive and other dyscontrolled behaviours in treating patients with BPD.

3. The Role of Metacognition and Beliefs About Emotions in Predicting Borderline Symptoms

Simona Girui¹, Renata Bedini¹, Alessandra Brugnoli¹, Chiara Manfredi^{1,2,3}, Alice Mannarino¹, Giovanni Ruggiero^{1,2}, Sandra Sassaroli^{1,2}

Studi Cognitivi, Italy¹, Sigmund Freud University, Italy², University of Pavia, Italy³

Previous literature has investigated the role of emotions in PD symptoms. Moreover, several authors have explored the role of fear of emotions. More recently, authors have introduced the term “meta-emotion” in order to explain and better understand some avoiding processes related to emotions, as well as emotional knowledge and acceptance. The present study aims to explore the construct of meta-emotion and beliefs about emotions in a sample of Borderline patients, in order to better understand how the emotional reaction to one’s own emotions, as well as specific metacognitive beliefs about

emotions can predict BPD symptoms over and above difficulties in emotion regulation. A sample of BPD inpatients has completed a batch of questionnaires assessing meta-emotions, beliefs about emotions, anger, anger rumination and difficulties in emotional regulation. These variables have been analysed through correlational and regression analyses. Results will be presented and discussed. A better understanding of the role of both meta-emotions and metacognitive beliefs can suggest an important focus in psychotherapy practice for those patients who present difficulties in emotion regulation and anger reactions.

Symposium 3: From Ruminative Processes to Metacognition

Convenor: Sandra Sassaroli

1. Validation of the Anger Rumination Scale (ARS) in an Italian Sample

Marco Baldetti^{1,2}, Francesca Fiore^{1,3}, Claudio Bartolozzi^{2,4}, Gabriele Caselli^{1,3,5}, Carmello La Mela^{1,2}, Sandra Sassaroli^{1,3}

Studi Cognitivi, Italy¹, Scuola Cognitiva, Italy², Sigmund Freud University, Italy³, University of Florence, Italy⁴, London South Bank University, UK⁵

The Anger Rumination Scale was constructed to measure angry mood, anger experiences, and the causes and the consequences of anger episodes. The study aimed to explore the Italian version of the Anger Rumination Scale (ARS). ARS, STAXI-II (State-Trait Anger Expression Inventory- II) and the MCSDS (Marlowe-Krone Social Desirability Scale) were administered to 776 voluntary participants (235 males and 541 females). Exploratory Factor Analysis (EFA) and Confirmatory Factor Analysis (CFA) were conducted to explore the factorial structure of the ARS. Reliability analysis of the 19 items yielded an internal consistency coefficient $\alpha=0.94$. Convergent and discriminant validity showed a positive correlation between the ARS and some of the STAXI-II subscales, consistent with the interpretation that anger rumination is a maladaptive emotion regulation strategy. The adequacy of the single factor model was confirmed by the CFA. This results apparently is in contrast with the four factor structure of the original scale, but is in line with a hypothesis of Sukodolsky surmising anger rumination as a unidimensional construct.

2. Irrational And Metacognitive Beliefs As Mediators Between Dysfunctional Beliefs (Schemas) And Anxiety

Giovanni Ruggiero^{1,2}, Andrea Bassanini^{1,2}, Maria Chiara Benzi^{1,2}, Elisabetta Caletti^{1,2}, Antonio Di Tucci^{1,2}, Francesca Fiore^{1,2}, Elena Moioli^{1,2}, Sara Marsero^{1,2}, Marco Telesca^{1,2}, Elena Ponzio^{1,2}, Walter Sapuppo^{1,2}, Sara Zizak^{1,2}, Sandra Sassaroli^{1,2}

Studi Cognitivi, Italy¹, Sigmund Freud University, Italy²

Cognitive Behavioural Therapy (CBT), Rational Emotive Behavior Therapy (REBT) and Metacognitive Therapy (MCT) conceptualize anxiety in different ways. CBT focuses on the content self-beliefs, MCT on regulatory metacognitive beliefs, while REBT is partially regulatory and content related. The study aimed to test a model in which MCT and REBT concepts played a mediating role while CBT-related self-beliefs had the place of the independent variable. The model, if confirmed, approximates the different psychopathological factors in the CBT, REBT and MCT models. 149 non clinical subjects completed 4 self-report questionnaires: GAD-Q-IV for generalized anxiety disorder (GAD); negative orientation to the problems questionnaire (NPOQ) for CBT, the Attitudes and Beliefs Scale (ABS) for REBT and the MCQ-30 for MCT. A moderation model was tested using regression analyses. Regression analyses confirmed the mediating role of ABS and MCQ in the relation between NPOQ and GAD ($B = .23$; $CI = .007$ to $.33$). The relationship between belief (schema content) and GAD symptoms appears to be statistically dependent on (mediated by) metacognitions and self-regulation.

3. Worry As An Adaptive Strategy in Healthy Controls but Not in Pathological Worriers

Cristina Ottaviani¹, Rostia Borlimi^{2,3}, Gianni Brighetti^{2,3}, Gabriele Caselli^{3,4,5}, Ettore Favaretto⁶, Irene Giardini⁴, Camilla Marzocchi⁴, Valeria Nucifore², Daniela Rebecchi⁴, Giovanni Ruggiero^{3,7}, Sandra Sassaroli^{3,4}

IRCCS Santa Lucia Foundation, Italy¹, University of Bologna, Italy², Sigmund Freud University, Italy³, Studi Cognitivi, Italy⁴, London South Bank University, UK⁵, Azienda Sanitaria di Bolzano, Italy⁶, Scuola Cognitiva, Italy⁷

The cognitive avoidance model of worry assumes that worry has the adaptive function to keep under control physiological arousal in anxiety. The Metacognitive model assumes that this hypothesis is not applicable to pathological worriers. A fear induction paradigm disconfirms that worry is adaptive in pathological worriers. 31 pathological worriers and 36 healthy controls were exposed to a fear induction paradigm (white noise) during three conditions: worry, distraction, and reappraisal. Skin conductance (SCR) and heart rate variability (HRV) were measured as indices of physiological arousal. Worriers showed increased sympathetic and decreased parasympathetic activation during the worry condition compared to non-worriers. There were no differences between groups for the distraction and reappraisal conditions. SCRs to the white noises during worry were higher

in worriers versus controls throughout the entire worry period. Results support the cognitive avoidance model in healthy controls, suggesting that worry is no longer a functional attitude when it becomes the default/automatic and pathological response.

Symposium 4: MCT for Depression: Effects on Depression Types, Long-Term Outcome, and Neuropsychology

Convenor: Costas Papageorgiou

1. Impact of metacognitive therapy on cognitive dysfunction in depression

Jennifer Jordan^{1,2}, Samantha Groves³, Richard Porter¹, Christopher Frampton¹, Janet Carter⁴, Virginia McIntosh², Kumari Fernando³, Roger Mulder⁴, Cameron Lacey⁴, & Peter Joyce⁴

University of Otago, New Zealand¹, Canterbury District Health Board, New Zealand², Groves University of Otago, New Zealand³, & University of Canterbury, New Zealand⁴

Only half of those receiving cognitive behavioural therapy (CBT) for depression achieve remission, and relapse is common. Metacognitive therapy (MCT) aims to improve outcomes by targeting dysfunctional cognitive and metacognitive processes underlying attentional biases and perseverative thinking patterns common in depression. We hypothesized that MCT would produce greater change in neuropsychological functioning than CBT. 48 participants referred for outpatient treatment of depression were randomised to 12 weeks of MCT (n=23) or CBT (n=25). Mood severity and neuropsychological functioning were assessed at pre-treatment, 4 weeks and at end treatment (12 weeks). ANCOVA's, co-varying for baseline performance and depression; correlations and effect sizes. At end treatment, independent of change in depression, MCT was superior to CBT in improved performance on the Groton Maze Learning Test (spatial working memory and attention): MCT, Mean -7.7 , SD 10.9 ; CBT Mean 0 , SD 14.9 , $df=1,30$ $F= 5.04$, $p= 0.03$, $d= 0.77$. The emphasis in MCT on attention training and flexible control of thinking may have a beneficial effect on neuropsychological functioning, consistent with the purported mechanism of action.

2. A 2-year follow-up study of group MCT for depression

Toril Dammen¹, Costas Papageorgiou², & Adrian Wells^{3,4}

University of Oslo, Norway¹, Priory Hospital, UK², University of Manchester, UK³, & Norwegian University of Science and Technology, Norway⁴

Studies of individual and group MCT have demonstrated the effectiveness of MCT for depression, however there are no studies on its efficacy beyond 1-year follow-up. We aimed to examine the long-term stability of group MCT effects in the treatment of depression. Ten patients treated in an open trial of group MCT for depression participated in the study. All of the patients met diagnostic criteria and were followed up for 6 months, 1 and 2 years. The primary outcome measure was severity of depression and secondary outcome measures assessed anxiety, rumination, and metacognitive beliefs. Recovery rates and changes in comorbid Axis I and Axis II diagnoses were also assessed.

Large clinically significant improvements across all measures at post-treatment were maintained at 1-year and 2-years follow-up. Based on objectively defined recovery criteria, 70% of the patients were classified as recovered at 1-year and 80% remained recovered at 2-year follow-up. Group MCT for depression appears to have sustained efficacy after 1 and 2 years, which is beyond what has been found for CBT.

3. Metacognitive Therapy in the Treatment of Current and Treatment-Refractory Major Depression

Lotta Winter¹, Julia Gottschalk¹, Janina Nielsen¹, Adrian Wells², Ulrich Schweiger³, Kai Kahl¹

Hannover Medical School (MHH), Germany¹, University of Manchester, UK², & University of Lübeck, Germany³

Distinguishing between specific types of depression impacts on treatment decisions. In our study we found first evidence that these specifications might not be needed when applying MCT. We investigated if MCT works in treatment refractory as well as non-refractory depression. In this randomized two-armed study 30 depressed patients received outpatient treatment with MCT. 15 of them had not responded to earlier treatment. A standardized diagnostic interview (SKID-1) was applied to verify the diagnosis and comorbidity. Depression severity was assessed using 21-item Hamilton Depression Scale and the BDI-II. Metacognitive processes were evaluated using the PBRS, NBRS and the MCQ-30. All data was administered at pre-, post-treatment and at 6 months follow-up. Strong effect sizes could be found in both groups on all outcome parameters. Both groups responded equally to MCT, with comparable responder and remitter rates. No group differences were observed concerning age, gender or comorbidity. The main finding of our study is that MCT can be applied to acute depression, and to patients with treatment-refractory (chronic) depression. Follow-up data showed that treatment effects remained stable. Therefore, MCT can be considered an effective treatment for any type of depression.

Symposium 5: The Effectiveness of Metacognitive Therapy and Processes of Change.

Convenor: Lora Capobianco

1. Metacognitive Therapy versus Cognitive Behaviour Therapy for Depression: A Randomised Clinical Trial

Pia Callesen^{1,2} & Adrian Wells¹

University of Manchester, UK¹, CEKTOS, Denmark²

Depression is considered the second leading cause of disability effecting approximately 121 million people around the world. Cognitive behaviour therapy (CBT) is an evidence-based treatment for depression; however, only approximately 50% of patients respond and only a third remain recovered at follow-up. Preliminary studies show that meta-

cognitive therapy (MCT) might optimize effectiveness. This RCT intends to compare CBT vs. MCT for Major Depressive Disorder. The main research question was: What is the relative effectiveness of MCT versus CBT in the treatment of is RCT evaluated and compared efficacy of CBT and MCT in the treatment of patients with major depressive disorder. 161 depressed Danish outpatients were randomly assigned to up to 24 weekly sessions of either CBT or MCT. Data-analysis consisted of a mixed-model analysis of variance and analysis of co-variance to assess relative treatment effects. Groups were stratified for sex and level of depression. Primary outcome measures consisted of Hamilton Depression Inventory and Beck's Depression Inventory-II (BDI-II). Follow-up was conducted at 6-10 months. Preliminary analysis revealed that MCT was significantly more effective than CBT on BDI-II, BAI and several other measures. In addition, significantly more patients in the MCT condition were recovered compared with patients in the CBT condition. This study adds further evidence indicating the effectiveness of MCT. It supports the superiority of MCT over CBT in the treatment of depression and implies that the field may benefit from a paradigm change in the understanding and treating of depression.

2. Metacognitive Therapy in Transdiagnostic Groups

Carsten Juul¹, Pia Callesen^{1,2}, Lora Capobianco², & Sisse Find Nielsen¹

CEKTOS, Denmark¹, University of Manchester, UK^{1,2}

Metacognitive therapy (MCT) is developed as a transdiagnostic model and is therefore considered suitable for mixed diagnostic group treatments with patients suffering from stress, anxiety, depression, OCD and PTSD. The aim was to evaluate group Metacognitive Therapy in a transdiagnostic group. 130 Danish outpatients with a range of psychological illnesses participated in 6 weeks of 2-hour group MCT. The primary measures (CAS-1 & HADS) were administered pre, mid, and post treatment. Participants were followed up at 6 months post treatment with the primary outcomes measures. Paired t-tests were used to analyse results and effect sizes were calculated using Cohen's d. There were significant differences at pre, mid, and post on the HADS anxiety and depression subscales. Significant differences were also reported for positive and negative metacognitions. Large effect sizes were found from pre to post on all measures. Follow up data and reliable change scores will be presented at the conference. Group Metacognitive therapy appears to be a very suitable and cost-effective treatment for mixed groups of people with psychological problems.

3. Modelling the causal relationship between change in psychological processes and symptom improvement in Metacognitive Therapy
Lora Capobianco¹, Pia Callesen^{1,2}, Carsten Juul², Sisse Find Nielsen², & Adrian Wells¹

University of Manchester, UK¹, CEKTOS, Denmark²

Metacognitive theory proposes that an individual's metacognitions lead to the activation of maladaptive thinking styles in response to negative thoughts and emotions. Metacognitive therapy (MCT) is an effective treatment that aims to modify maladaptive cognitive processes and provide individuals with flexible and alternative ways of relating to mental events. However, little is known about the predictors of change during treatment. We investigated if changes in symptoms precede changes in thinking style and metacognition or if changes in these factors precede changes in symptoms. 130 Danish outpatients with a range of psychological illnesses participated in 6 weeks of group metacognitive therapy (MCT). The HADS and CAS-I were administered pre, mid and post treatment. Structural equation modelling was applied to compare the autoregressive model with the two competing models, the CAS-I predicting outcomes on the HADS vs the HADS predicting outcomes on the CAS-I. The changes in processes as measured by the CAS-I better predicted changes in symptoms as measured by the HADS. There was a significant difference in model fit between the autoregressive model and the model in which the changes in the CAS-I preceded changes in symptoms on the HADS, $\Delta\chi^2=5.703$, $df=2$, $p=0.05$. The results are consistent with the metacognitive model. Changes in metacognition precedes and leads to changes in symptoms. The results add further evidence that therapy focusing on altering the way individuals regulate responses to mental events leads to therapeutic change.

Symposium 6: Metacognitions and the Cognitive Attentional Syndrome in Addictive Behaviours

Convenor: Marcantonio M. Spada

1. The Metacognitions about Smoking Questionnaire
A.V. Nikčević¹, Gabriele Caselli^{2,3}, Adrian Wells⁴ and Marcantonio M. Spada³

Kingston University, UK¹, Studi Cognitivi, Italy², London South Bank University, UK³ & University of Manchester, UK⁴

Recent research has suggested that metacognitions may play a role in smoking. We investigated what the psychometric properties of the Metacognitions about Smoking Questionnaire are and if it can predict behaviour. Three samples of smokers ($n=222$, $n=143$, $n=25$) were employed to test the structure and psychometric properties of the Metacognitions about Smoking Questionnaire (MSQ) and examine its capacity to predict smoking behaviour. Exploratory and confirmatory factor analyses supported a four-factor solution comprising of positive metacognitions about cognitive regulation, positive metacognitions about emotional regulation, negative metacognitions about uncontrollability, and negative metacognitions about cognitive interference. Internal consistency, predictive and divergent validity, and temporal stability were found to be

acceptable. Our findings also showed that metacognitions factors correlated positively with daily cigarette use and levels of nicotine dependence, and contributed to the prediction of these outcomes over and above smoking outcome expectancies. The implications of these findings in terms of the conceptualization of smoking behavior and its treatment are discussed.

2. Profiling Metacognition in Gambling Disorder

Marcantonio M. Spada¹, Bruce. A. Fernie², Lucia Giustina³, Silvia Rolandi⁴ and Gabriele Caselli^{1,5}

London South Bank University, London, UK¹, King's College London, UK², Servizio Tossicodipendenze, AUSL, Italy³, Università di Pavia, Italy⁴ & Studi Cognitivi, Italy⁵

Research has indicated that negative beliefs about thoughts concerning uncontrollability and danger and beliefs about the need to control thoughts predict gambling behaviour. However the inter-relationship between metacognition and gambling within the framework of the S-REF model requires further exploration. We investigated if specific facets of metacognition and self-processing are related to gambling behaviour. Using metacognitive profiling (Wells, 2000) we explored: (1) the presence of metacognitive beliefs about gambling; (2) the goal of gambling, and its start and stop signals; and (3) the perceived impact of gambling on self-consciousness. Ten individuals with a diagnosis of gambling disorder participated in the study. All participants endorsed both positive and negative metacognitive beliefs about gambling. A primary goal of gambling was to improve cognitive-emotional state. All participants reported that they did not know when this goal was achieved. Start signals for gambling included the ideas and feelings that gambling could solve problems and sensations regarding the right time to win. The stop signal for gambling, for all participants, was running out of money. All participants also reported a perceived reduction in self-consciousness during a gambling episode. These data provide further support for the S-REF model as a framework for evaluating gambling behavior. Avenues for future research and implications for clinical practice are discussed.

3. A Test of a Metacognitive Model of Desire Thinking and Craving

Gabriele Caselli^{1,2} and Marcantonio M. Spada²

Studi Cognitivi, Italy¹ & London South Bank University, London, UK²

We present and test a metacognitive model of desire thinking and craving, based on the work of Spada, Caselli and Wells (2012, 2013). We tested a model in which positive metacognitions activate both visual and verbal components of desire thinking leading to an escalation in craving through the activation of negative metacognitions. The relationships among variables were examined by testing the fit of path models in four clinical samples (total N=493) and a community sample (N=494) presenting with different addictive behaviors. Findings indicated a good model fits in both clinical and community samples with a variation in model structure observed in the community

sample. These findings provide further support for the application of metacognitive theory to understanding desire thinking and craving in addictive behaviors

Symposium 7 : The Effectiveness of MCT on Anxiety and Depression: The Trondheim Randomized Controlled Trials

Convenor: Odin Hjemdal

1. Randomized Controlled Trial of Cognitive Behaviour Therapy, Metacognitive Therapy and Wait list of Patients with Generalised Anxiety Disorder (GAD): A Two- Year Follow Up Study.

Hans Nordahl¹, Roger Hagen¹, Leif Edward Ottsen Kennair¹, Odin Hjemdal¹, Stian Solem¹, Bjarne Hansen², Svein Haseeth³, Thomas Borkovec⁴, & Adrian Wells⁵

Norwegian University of Science and Technology, Norway¹, University of Bergen, Norway², St. Olavs Hospital, Norway³, Penn State University, USA⁴, & University of Manchester, UK⁵

The present study compared CBT and MCT in GAD patients. The study aimed to compare the effects of cognitive behavioural therapy and metacognitive therapy in patients with severe generalized anxiety disorder. GAD patients were block randomized in groups of 10 Eighty patients with a diagnosis of generalized anxiety disorder were randomized into three treatment conditions. CBT (N=30), MCT (N=30) or a wait-list control (N=20). Patients in the wait-list control were randomly allocated to either CBT or MCT after a 12 week waiting period. Six trained therapists delivered both treatments under supervision of the originators of CBT for GAD (Borkovec) and MCT (Wells). The results and implications will be presented in the symposium.

2. A Randomized Controlled Trial of Metacognitive Therapy and Eye Movement Desensitization and Reprocessing for Posttraumatic Stress Disorder: A Study of Effectiveness, Mediators and Moderators.

Hans Nordahl¹, Joar Halvorsen², Bjørn Aasen², Odin Hjemdal¹, & Adrian Wells³

University of Science and Technology, Trondheim, Norway¹, St. Olavs Hospital, Trondheim, Norway², University of Manchester, UK³

The clinical trial compared two treatments for PTSD: MCT and EMDR and aimed to examine the effects of these treatments for PTSD. Seventy patients referred to the Ostmarka University Hospital in Trondheim were randomly allocated to EMDR or MCT, additionally an treatment-as-usual (TAU) outpatient group were treated in parallel for comparison (N=90). Patients received 12 sessions of treatment and were compared at post treatment, 6 month, and 12 months follow up. Results and implications for treatment will be presented in the symposium.

3. Metacognitive Therapy for Depression: A randomized Controlled Trial.
Roger Hagen¹, Odin Hjemdal¹, Stain Solem¹, Leif Edward Ottesen Kennair¹, Hans Nordahl¹, & Adrian Wells²

Norwegian University of Science and Technology, Norway¹, University of Manchester, UK²

The study aimed to examine the effects of metacognitive therapy in patients with major depressive disorder. Forty patients diagnosed with major depressive disorder were randomized into two treatment conditions: MCT (N=20) or a wait-list control (N=20). Patients enrolled in the MCT condition were given 10 sessions of MCT, while the wait list control waited 10 weeks before receiving MCT. Four trained therapists delivered the treatment under the supervision of the originators of MCT (Wells). The results indicate that MCT is a highly effective treatment and randomized controlled trials comparing MCT to other treatments are warranted. The implications of the trial will be discussed in the symposium.

Symposium 8: Metacognition in Psychosis: Theory and Treatment

Convener: Sophie Parker

1. Metacognitive Theory and Therapy for Psychosis: An Overview
Anthony Morrison¹

University of Manchester, UK¹

Recent models of emotional disorders and psychosis implicate metacognitive beliefs and processes in the development and maintenance of psychological distress. A metacognitive approach to understanding psychosis will be outlined, and a series of studies examining metacognition in people with psychosis and those at high-risk of developing psychosis will be described. Patients with psychotic diagnoses and those at high risk of developing psychosis score higher on metacognitive belief dimensions than non-patients. Patients with psychosis appear to score similarly to patients with anxiety disorders on such measures. Predictions derived from a metacognitive model of psychosis and the S-REF model have been confirmed in large samples of people with psychosis and those at high-risk. An open trial evaluating Metacognitive Therapy for psychosis will also be presented and the approach illustrated with case examples. The implications of these studies for clinical practice will be considered.

2. The Beliefs about Paranoia Scale: Validation of a Metacognitive Approach to Conceptualizing Paranoia in People Experiencing Psychosis
Elizabeth Murphy¹, Melissa Pyle^{1,2}, Anthony Gumley³, David Kingdon⁴, Matthias Schwannauer⁵, Douglas Turkington⁶, & Anthony Morrison^{1,2}

Greater Manchester West NHS Trust¹, University of Manchester, UK², University of Glasgow, UK³, University of Southampton⁴, University of Edinburgh, UK⁵, & Newcastle University, UK⁶

A Metacognitive approach to the conceptualization of paranoia as a strategy for managing interpersonal threat has gained some support. We hypothesised that positive and negative beliefs about paranoia would predict the severity of suspiciousness, and that the co-occurrence of positive and negative beliefs would predict increased suspiciousness. 335 patients meeting criteria for a schizophrenia spectrum disorder completed the Beliefs about Paranoia Scale (BaPS), the Positive and Negative Syndromes Scale (PANSS) and the Psychotic Symptom Rating Scales (PSYRATS) in a cross-sectional design. Three subscales were measured by the BaPS (negative beliefs about paranoia, paranoia as a survival strategy, and normalizing beliefs). Ordinal regression showed that beliefs about paranoia as a survival strategy and negative beliefs about paranoia both predicted severity of suspiciousness. Furthermore, this was the first study to show that the co-occurrence of survival beliefs and negative beliefs predicted increased levels of suspiciousness. All hypotheses were confirmed, suggesting that a metacognitive approach has utility for the conceptualization of clinical paranoia. Clinical implications suggest a role for metacognitive therapy for clinical paranoia.

3. An Investigation of Attention Training Technique in Psychosis
Sophie Parker^{1,2}, Adrian Wells², Heather Law¹, Measha Bright¹, Eilish Burke², Lucy Carter¹, Lee Mulligan¹, Jasper Palmier-Claus¹, Rachel Sellers¹, & Elisabeth Zabel²

Greater Manchester West NHS Trust¹, University of Manchester, UK²

Attention training (ATT) has been successfully used in a number of difficulties with benefits as a stand-alone strategy. Additionally, studies suggest that attention training is promising in the treatment of auditory and visual hallucinations in psychosis along with other psychotic symptoms. A two arm randomised controlled pilot trial comparing attention training (ATT) plus treatment as usual (TAU) vs. TAU alone for psychosis was conducted to inform a definitive trial. 29 patients with psychosis were recruited and randomised between ATT plus TAU (n=15) versus TAU alone (n=14). Participants in the ATT condition were offered a maximum of 8 ATT sessions and all participants were offered follow-up assessments at 8 and 12 week follow-up periods. Recruitment rates were 73% of the target and retention rates were high in both the ATT plus TAU condition

(8 week follow-up = 79%; 12 week follow-up = 71%) and TAU alone condition (8 week follow-up = 87%; 12 week follow-up = 80%). Significant differences were found between the groups in favour of ATT. This pilot study demonstrated the acceptability and feasibility of Attention Training Technique plus treatment as usual for people with psychosis. Significant differences are suggestive that ATT is an effective brief intervention in the treatment of psychosis.

Symposium 9: Adapting Metacognitive Therapy for the Cardiac Rehabilitation Pathway: The PATHWAY Trial

Convenor: Rebecca McPhillips

1. “It’s kind of like, life changing for me”: A Qualitative Investigation of Cardiac Patients’ Experiences of Group-Metacognitive Therapy as Part of the PATHWAY Trial.
Rebecca McPhillips¹, Peter Salmon², Adrian Wells³, & Peter Fisher²

Manchester Mental Health and Social Care Trust, UK¹, University of Liverpool, UK², & University of Manchester, UK³

Thirty seven percent of cardiac rehabilitation (CR) patients experience anxiety and/or depression. PATHWAY is a RCT comparing Group-Metacognitive Therapy (Group-MCT) plus usual CR to usual CR, aiming to alleviate distress. In order to explore CR patients’ psychological needs and how Group-MCT addresses these needs interviews were conducted with patients in the Group-MCT plus usual care condition before and during Group-MCT, and with patients in the usual care condition. Before Group-MCT the psychological needs patients described concern hope, support, and normalization of their experiences, and they believed that these needs can, and usually are, met by other patients and accessible CR practitioners. Patients attempted to cope with distress by distracting and reassuring themselves. Patients who had received Group-MCT identified worry as the cause of their distress, and described postponing some worries and directing their attention in positive ways to alleviate distress. Patients also believed that CR is an appropriate context to receive Group-MCT. We conclude by considering to what extent Group-MCT addresses patients’ needs and discuss the implications these findings have for integrating Group-MCT into CR.

2. Are Metacognitive Beliefs Transdiagnostic: A Comparison of Cancer and Cardiac Patients Experiencing Anxiety and Depression
Rebecca Anderson¹, Peter Fisher², Hannah Gaffney¹, Helen Morley¹, & Adrian Wells³

Manchester Mental Health and Social Care Trust, UK¹, University of Liverpool, UK², & University of Manchester, UK³

The MCQ30 has been used to assess metacognitive beliefs and processes central to the Metacognitive model of emotional disorder. Studies have begun to explore the utility of this model for understanding emotional distress in physical health conditions. The NIHR funded PATHWAYS project aims to evaluate MCT in cardiac patients. As part of this we compared metacognitions across cardiac patients, cancer patients and non-patient controls

to test for relationships between metacognitive beliefs and distress in each patient sample. A sample of 50 patients referred to the cardiac rehabilitation programme completed the Metacognitions Questionnaire-30 (MCQ-30) and were compared with data from cancer patients. Analyses were conducted to determine similarities and differences in metacognitions and their relationship with psychological distress. Identifying and comparing the associations between metacognitive factors and emotional distress in cancer and cardiac patients will aid the development of a comprehensive understanding of the underlying common and/or specific processes of emotional distress in patients with physical health conditions.

3. Key considerations in the development, implementation and evaluation of a metacognitive therapy intervention for anxiety and depression in the cardiac rehabilitation pathway: The PATHWAY trial.

Hannah Gaffney¹, Rebecca Anderson¹, Helen Morley¹, Gemma Shields², Peter Fisher³, Peter Salmon³, Linda Davies², David Reeves², & Adrian Wells²

Manchester Mental Health and Social Care Trust, UK¹, University of Manchester, UK², & University of Liverpool, UK³

Thirty seven percent of cardiac rehabilitation (CR) patients experience clinically significant levels of anxiety and/or depression. Access to drug and psychological treatments for this population is inadequate and available treatments have limited effects. Improving psychological outcomes for patients accessing CR is a key priority. Metacognitive Therapy (MCT) is a transdiagnostic psychological treatment that has proven to be effective in both mental and physical health populations and can be adapted to the needs of CR patients. The PATHWAY study is a NIHR funded multi-site, longitudinal patient-level randomized controlled trial which aims to develop, integrate and evaluate the acceptability, clinical and cost-effectiveness of a Group-MCT intervention in reducing anxiety and/or depression in CR patients compared to usual care alone. The key considerations in the development and implementation of the Group-MCT intervention within CR services will be presented.

Symposium 10: Metacognitive Therapy and Theory in Physical Health Conditions

Convenor: Peter Fisher

1. The Influence of Metacognitive Beliefs on Positive and Negative Affect in Parents of Children with Cancer

Enrico Toffalini¹, Cesare Cornoldi¹

University of Padova¹

There is increasing interest in the application of Metacognitive theory and therapy in cancer patients. However, less is known about the role of metacognitive beliefs in distressed carers or relatives of patients with cancer. This study investigates how different metacognitive beliefs influence positive and negative affect in parents of children with cancer. Three groups of parents; 1) Parents of children being treated for cancer; 2) parents of children hospitalized for non-life-threatening illnesses, and 3) parents of healthy children completed measures of metacognitive beliefs, memory sensitivity, and positive and negative affect (PANAS). Parents of children with cancer and parents of other hospitalized children reported more negative and less positive affect than parents of healthy children. Metacognitive beliefs predicted subjective well-being more strongly in parents of children with cancer (77% of the variance) than in all other parents (up to 33% of the variance). Metacognitive aspects may have a critical impact on subjective well-being of parents of children with cancer. Assessment and treatment of metacognitive beliefs should be considered when providing psychological support to these parents.

2. The Association of Metacognitive Beliefs with Symptoms of Anxiety and Depression in Type 1 and Type 2 Diabetes Mellitus

Rebecca Purewal¹, & Peter Fisher¹

University of Liverpool, UK¹

The Common Sense Self-Regulation Model specifies that illness perceptions play a key role in emotional distress in diabetes. However, the Metacognitive model predicts that metacognitive beliefs, rather than illness perceptions determine emotional distress. Therefore, this study explored for the first time the relative contribution of illness perceptions and metacognitive beliefs to anxiety and depression. We hypothesized that metacognitive beliefs would explain additional variance in anxiety and depression over and above that explained by negative illness representations. 614 adults with Type 1 (n=335) or Type 2 (n=279) diabetes took part in a cross-sectional study and completed self-report questionnaires measuring anxiety, depression, illness representations and metacognitive beliefs. Metacognitive beliefs explained additional variance in anxiety and depression symptoms after controlling for age, gender and diabetes illness representations. Negative beliefs about worry made the largest independent contribution of all predictors in both Type 1 and Type 2 diabetes. The S-REF model appears to have

clinical utility in understanding emotional distress in both Type 1 and Type 2 diabetes and MCT may be a viable treatment option.

3. Metacognitions as Predictors of Treatment Outcomes in Chronic Fatigue Syndrome
Ana Nikčević¹, Bruce Fernie², Adrian Wells³, & Marcantonio Spada⁴

Kingston University, UK¹, Kings College London, UK², University of Manchester, UK³, & London South Bank University, UK⁴

Beliefs reflecting cognitive confidence and beliefs about the need to control thoughts predict symptom severity in Chronic Fatigue Syndrome (CFS). Studies have reported that Cognitive Behavioural Therapy (CBT) and Graded Exercise Therapy (GET) are effective treatments for CFS. We investigated if changes in metacognitive beliefs predict fatigue severity and physical functioning after controlling for negative affect in patients receiving CBT and GET for CFS. 171 CFS patients undertaking either CBT (n=116) or GET (n=55) completed a variety of self-report questionnaires including metacognitive beliefs at pre- and post-treatment and follow-up. CBT and GET were equally effective at decreasing fatigue, anxiety, and depression, and at increasing physical functioning. Changes in metacognitions had a significant effect on fatigue severity independently of changes in other covariates and across treatment modalities. Metacognitive Therapy might be an effective treatment of CFS through re-structuring metacognitions, modifying attentional control and interrupting rumination and worry.

4. Metacognitive Therapy for emotional Distress in Cancer Survivors: A Case Series
Peter Fisher¹, Peter Salmon¹, & Angela Byrne¹

University of Liverpool¹

Around 25% of cancer survivors require treatment for clinical levels of emotional distress. However, meta-analyses of well controlled studies of psychological interventions indicate that these only achieve small to medium effect sizes. A research priority is to develop and evaluate psychological interventions with the aim of enhancing treatment efficacy. This study evaluated the potential of metacognitive therapy to alleviate emotional distress in cancer survivors. We were interested in investigating if Metacognitive therapy (MCT) leads to clinically significant reductions in distress in cancer survivors. An AB design with 3 and six months follow-up was used to evaluate the potential efficacy of brief MCT in four cancer survivors. Each participant completed a baseline period followed by six, 1-hour sessions of MCT. MCT was associated with large and clinically significant improvements in anxiety, depression, fear of cancer recurrence, worry and metacognitive beliefs. MCT is a promising transdiagnostic approach to treating different forms of emotional distress in cancer survivors. Further evaluation of this brief treatment is clearly indicated.

5. The Role of Metacognitions in Parkinson's Disease
Bruce Fernie¹, Richard Brown¹, & Marcantonio Spada²

Kings College London, UK¹ & London South Bank University, UK²

Motor fluctuations, characterized by a sudden increase in symptom intensity (referred to as an 'off-period'), are common side effects associated with the longer-term use of dopaminergic medication in the management of Parkinson's disease (PD). This study explored if metacognitive beliefs and processes were associated with cognitive and attentional responses to motor fluctuations. Ten individuals with PD who experienced motor fluctuations were interviewed using an adapted metacognitive profiling (Wells, 2000) schedule. Participants were asked about their metacognitions, and the cognitive processes and attentional strategies activated in response to a distressing off-period. Worry and rumination about symptoms, as well as symptom focus, were the two main responses to motor fluctuations that were identified. Positive or negative metacognitions pertaining to either or both of these domains were elicited from all participants. Metacognitions may play a role in determining or maintaining off-period distress in PD.

6. The Metacognitions about Symptoms Control Scale
Marcantonio Spada¹, Bruce Fernie², & Ana Nikčević³

London South Bank University, UK¹, Kings College London, UK², & Kingston University, UK³

We present the development and preliminary validation of a self-report instrument designed to measure metacognitions pertaining to symptoms control in the form of: (1) symptoms focusing; and (2) symptoms conceptual thinking in chronic health conditions. One hundred and twenty four patients presenting with Chronic Fatigue Syndrome (CFS) participated in the study to test the structure and psychometric properties of the Metacognitions about Symptoms Control Scale (MaSCS). A principal components factor analysis indicated that a two-factor solution best fitted the data. The factors were labelled positive and negative metacognitions about symptoms control. Further analyses revealed that both factors had good internal consistency. Correlation analyses established preliminary concurrent validity, indicating that both positive and negative metacognitions about symptoms control were significantly associated with levels of fatigue in CFS. Regression analysis revealed that positive and negative metacognitions about symptoms control significantly predicted fatigue severity when controlling for anxiety and depression. The MaSCS may help with future examination of metacognitions in CFS and health conditions, as well as aiding in clinical assessment and case formulation.

7. Integrating Group-Metacognitive Therapy Into Cardiac Rehabilitation Pathways: Practitioner Perspectives

Rebecca McPhillips¹, Peter Salmon², Peter Fisher² & Adrian Wells³

Manchester Mental Health and Social Care Trust, UK¹, University of Liverpool², & University of Manchester, UK³

UK clinical guidelines advocate psychological assessment and support for distressed cardiac rehabilitation (CR) patients. The PATHWAY trial aims to integrate Group-Metacognitive Therapy (Group-MCT) into CR pathways to alleviate CR patient distress. In order to explore CR practitioners' experiences of training in, and the delivery of, Group-MCT, interviews were conducted with CR practitioners trained in Group-MCT before, during and after training. Before training in Group-MCT, practitioners explained that they used multiple techniques when supporting patients psychologically (e.g. low-level CBT, motivational interviewing), and they understood psychological support as following an implicit dose-response model. During Group-MCT training, practitioners reported several dilemmas, including: the perceived difficulty of engaging with patients while retaining fidelity to the Group-MCT model; and the potential (in)compatibilities of Group-MCT with other techniques. We conclude by considering whether and how the dilemmas reported can, and should, be resolved. The implications that these findings have for training CR practitioners in Group-MCT and for integrating Group-MCT into CR are also discussed.

Symposium 11: Metacognitions in Children and Adolescents: Theory and Treatment.

Convenor: Michael Simons

1. A Pilot Investigation of MCT versus CBT for Children with Generalised Anxiety Disorder

Barbara Hoff Esbjørn¹, Nicoline Normann¹, Monika Walczak¹, & Marie Louise Reinholdt-Dunne¹

University of Copenhagen, Denmark¹

Childhood anxiety disorders are most commonly treated with CBT. However, a meta-analysis indicates that only 59% are free of all anxiety diagnoses following treatment. One possible way to optimize these effects may be to treat children who suffer from primary generalized anxiety disorder (GAD) with metacognitive therapy adapted for children (MCT-C). The purpose of this project was to develop a group MCT-C which was hypothesised to produce greater changes than case-formulation based individual CBT immediately following treatment and 6 months afterwards. In a non-randomized active control study, 67 children aged 7-13 with a primary diagnosis of GAD were allocated to either CBT or MCT. Families were assessed with questionnaires measuring levels of anxiety, worry, metacognitions, and the diagnostic interview ADIS-C/P at pretreatment, posttreatment and at 6 months follow-up. Diagnostic status and effect sizes for changes in anxiety, worry and metacognitions at all time points will be presented and compared between groups. Preliminary findings of the MCT-C treatment for GAD will be discussed, including cost-effectiveness, treatment dropouts and implications for future research.

2. Moderating Effects of Attention Control on Generalized Anxiety Disorder in Children: Metacognitive Therapy vs. Cognitive Behavioral Therapy

Marie Louise Reinholdt-Dunne¹, Andreas Blicher Skanborg¹, Nicoline Normann¹, & Barbara Hoff Esbjørn¹

University of Copenhagen, Denmark¹

Attention control plays a key role in the development and maintenance of anxiety because individuals with poorer attention control may have greater difficulty regulating emotional responses, relative to those with better attention control (e.g., Rueda et al., 2004). The present study aimed to investigate effects of Metacognitive Therapy (MCT) vs. Cognitive Behavioral Therapy (CBT) on attention control in children diagnosed with Generalized Anxiety Disorder. Children (7-13 years) were assessed pre and post treatment and also at 6-months follow-up. Attention control, which is the ability to inhibit processing of task-irrelevant information, was assessed using the Attention Network Task. Anxiety was diagnosed using the Anxiety Disorders Interview Schedule. Pilot data on attention control abilities before and after MCT and CBT from 44 children will be

presented. Possible implications of results include an enhanced understanding of attention control and anxiety disorders in children and how this is targeted in MCT vs. CBT. Research findings will be discussed in relation to current metacognitive, cognitive, and developmental models of anxiety in children.

3. Testing a Transdiagnostic Metacognitive Model of Emotional Disorders in Youths
Michael Simons¹ & Andrea Zahn²

RWTH Aachen University, Germany¹, University of Bonn, Germany²

The S-REF model emphasizes the vital importance of metacognitions for the development of emotional disorders. However, there's little evidence so far that this model is also relevant for emotional disorders in youths. The study aims at examining if the metacognitive model is applicable to youths with an emotional disorder, i.e. anxiety disorder, depression, PTSD, and OCD. Structural equation models (SEM) were applied to measures of anxiety, depression, where applicable OCD or posttraumatic stress, repetitive negative thinking (RNT; i.e. worry and rumination) and metacognitions (MCQ-A) in a clinical sample of 197 youths suffering from mood or anxiety disorders, OCD or PTSD. Four models were tested that differed in the outcome variable representing disorder-specific symptoms. The metacognitive models for emotional disorders revealed poor model fit. The fit improved after excluding the construct positive metacognitive beliefs as a predictor for RNT from all structural models. Negative metacognitive beliefs and RNT are highly associated with emotional disorders in youths. However, there is preliminary evidence that positive metacognitive beliefs might not play a major causal role in the metacognitive model for youths.

Open Paper Submission Abstracts

Metacognition Open Papers

Metacognition is a Causal Moderator of Health Anxiety: A Prospective Study.

Robin Bailey^{1,2}, & Adrian Wells¹

University of Manchester, UK¹ & University of Central Lancashire, UK²

Psychological theories have identified a range of variables contributing to health anxiety, including, dysfunctional illness beliefs, catastrophic misinterpretation, somatosensory amplification and neuroticism. More recently, metacognitive beliefs have been proposed as important in health anxiety. This study aimed to test the potential causal role of metacognitive beliefs in health anxiety. A prospective design was employed and participants (n=105) completed a battery of questionnaire at two time points (6 months apart). Results demonstrated that cognitive, personality and metacognitive variables were bi-variate prospective correlates of health anxiety. Hierarchical regression analysis revealed that only metacognitive beliefs emerged as independent and significant prospective predictors of health anxiety. Moderation analysis demonstrated that metacognitive beliefs prospectively moderated the relationship between catastrophic misinterpretation and health anxiety. The results confirm that metacognition is a predictor of health anxiety and it is more substantive than misinterpretations of symptoms, somatosensory amplification, neuroticism, and illness beliefs. Any importance of misinterpretations appears dependent on metacognition. These results may have major implications for current cognitive models and for the treatment of health anxiety

The Effect of Thought Importance on Stress Responses: A Test of Metacognitive Theory

Lora Capobianco¹, Anthony Morrison¹, & Adrian Wells¹

University of Manchester, UK¹

Negative metacognitive beliefs are central determinants of distress in the metacognitive model of psychological vulnerability to stress. 78 undergraduate students were assigned to either an experimental (metacognitive belief manipulation) or control (no metacognitive belief manipulation) condition. All participants underwent a fake EEG manipulation, where they were told that the EEG would detect negative thoughts. The experimental subjects were informed that if they had a negative thought they may be exposed to a burst of loud noise, while the control condition was told that they may be exposed to a burst of loud noise at random irrespective of the type of thought they had. Results showed that on physiological measures there were no significant differences between groups. However, on psychological measures the experimental condition experienced greater levels of negative affect and lower levels of positive affect in response to stress and recovery from stress in comparison to the control condition. Results support the metacognitive model.

A prospective study of metacognitive and cognitive predictors of depressive symptoms

Odin Hjemdal¹, Roger Hagen¹, & Stian Solem¹

Norwegian University of Science and Technology, Norway¹

This study explores cognitive and metacognitive predictors of depressive symptoms in a population of healthy university students over an eight months period. The research investigated if metacognitive measures would explain additional variance of depressive symptoms over measurements of cognitive content. 229 participants completed questionnaires assessing depressive symptoms, level of dysfunctional attitudes, rumination, and positive and negative beliefs about rumination. In order to rule out the possibility that previous associations in the literature may be a conceptual overlap metacognitive beliefs were entered after dysfunctional attitudes and rumination were controlled. In a hierarchical linear regression analysis initial depressive symptoms predict depressive symptoms at follow-up. When not controlling for initial depressive symptoms, dysfunctional attitudes (DAS), rumination (RRS), and Negative Beliefs about Rumination Scale (NBRS) predicted the level of depressive symptoms. NBRS predicted an additional 4% of the variance. The results indicated that the negative metabeliefs prospectively explains additional variance to explaining depressive symptoms over and above cognitive content.

Mental Health Open Papers

Obligated to be worried: A metacognitive therapy intervention for breast cancer survivors

Simone Cheli^{1,2}, Lucia Caligiani¹, Francesco Velicogna³

Psycho-oncology Unit, Florence Healthcare District, Italy¹, University of Florence, Italy²,
Institute of Constructivist Psychology, Italy³

Metacognitive Therapy (MCT) could be very effective in treating disorders and symptoms that are very common in cancer patients: worry, anxiety and depression. At the same time, little is known about the application of MCT on cancer patients. The aim of this study is to pilot-test the effectiveness of a MCT intervention tailored for breast cancer patients. We enrolled in an open trial with pre and post assessment 43 female breast cancer survivors who received 8 weekly sessions of MCT. Measures of depressive and anxious symptoms, and quality of life (QoL) were completed at the two stages of assessment. The intervention includes two main strategies: (i) MCT; (ii) psycho-education about the impact of cancer on distress, fatigue, sexuality and relationship. Results showed that depressive and anxious symptoms reduced significantly ($p < .001$). No differences were found in QoL. A tailored MCT is an acceptable and powerful treatment for breast cancer survivors. Further studies are needed in order to overcome the main limitations of the present study (small sample size; no control group).

MCT vs Diagnosis-specific CBT for complex anxiety disorders: A randomized controlled trial.
Sverre Johnson^{1,2}, Asle Hoffart^{1,2}, Bruce Wampold^{2,3}, Hans Nordahl²

University of Oslo, Norway¹, Modum Bad Psychiatric Center, Norway², University of Wisconsin-Madison, USA³, Norwegian University of Science and Technology, Norway⁴

Few studies have investigated the generic MCT-model. A small study comparing a generic version of MCT and CBT indicated that MCT had a significantly better effect at post-treatment (Nordahl, 2009). The research question was, “what is the relative effectiveness of MCT and the best documented and wide spread form of CBT for complex anxiety disorder patients?” Patients fulfilling the DSM IV criteria for SAD, PDA and PTSD, and who had not responded to previous treatment were randomized to MCT or CBT (N=90). Intention to treat analysis (ANCOVAs controlling for the pre-treatment scores) revealed significant difference between MCT and CBT from pre to post on BAI, $F(1, 71) = 5.11$, $p < 0.05$, $d = 0.55$, the SCL-90, $F(1, 67) = 5.17$, $p < 0.05$, $d = 0.55$, and the BDI, $F(1, 73) = 18.22$, $p < 0.05$, $d = 0.59$. The results indicate that MCT is better suited than diagnosis-specific CBT for treating complex anxiety disorder patients, that have not responded to previous treatment.

Metacognitive Therapy Applications in Social Phobia: An Exploratory Study of the Individual and Combined Effects of the Attention Training Technique and Situational Attentional Refocusing

Patrick Vogel¹, Roger Hagen¹, Odin Hjemdal¹, Stian Solem¹, Maud C. B. Smeby¹, Eivind Strand¹, Peter Fisher², Hans Nordahl¹, & Adrian Wells^{1,3}

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Individuals with social phobia have difficulty disengaging from self-processing in social situations. Interventions to enhance attentional control have yielded mixed findings. Metacognitive therapy interventions for enhancing attentional control will produce significant reductions in symptoms in 24 outpatients meeting the social phobia diagnosis. In a cross-over design, 11 patients received 4 weekly sessions of the Attention Training Technique (ATT). They were then given 4 sessions of 5 minute exercises of social exposure and instructed to employ Situational Attention Refocusing (SAR). Thirteen other patients received the opposite sequence of treatments. Both interventions produced significant reductions on measures of social anxiety and in general anxiety at mid-treatment. The addition of the second intervention produced further reductions at post-treatment. Eleven of the total sample of patients (46%) no longer met DSM criteria for social phobia. A significant order effect was also found for patients receiving SAR interventions before ATT. They had lower social anxiety ratings on interview measures at mid-treatment and fewer dropouts. Metacognitive techniques aimed at modifying attentional control can produce clinically significant reductions in social phobia symptoms.

MCT of Emetophobia – A Small Case Series of Three Adolescent Girls

Michael Simons¹

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Emetophobia is a specific phobia of vomiting. Based on very limited data, CBT in the form of exposure therapy is widely recommended. In contrast to CBT, MCT sees emetophobia less as a disorder of disgust and more of excessive worrying. Since there are no metacognitive manuals for the treatment of emetophobia, we examined the applicability of MCT to this phobia. Three cases of emetophobic female adolescents were treated with MCT. Data of anxiety, depression, and metacognition were collected before and after treatment. All patients recovered and showed marked reduction in clinical and metacognition measures. Treatment was rather short with 8 - 11 sessions and well accepted by the patients. Without exposing patients to vomiting, MCT was successful in all three cases and might be a promising treatment of emetophobia.

The Beliefs about Self-Discrepancy Monitoring Scale: Development and Psychometric Properties

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Recent research has shown the importance of metacognitive beliefs in sustaining and activating cognitive processes that can in turn enhance psychological suffering. On the other hand, literature has stressed the role of self-discrepancy and its monitoring in lowering mood. The goal of this research project was to develop the first self-report instrument of metacognitive beliefs about the use of self-discrepancy monitoring even before positive situations. We conducted two studies with non-clinical samples (N = 210, N = 300) to construct the Beliefs about Self-Discrepancy Monitoring Scale (BSDMS) and test its structure and psychometric properties. A third study was added to test the predictive validity of BSDMS in a sample of depressed inpatients (N = 100). Explorative and confirmatory factor analysis supported a four-factor solution. Internal consistency and predictive and divergent validity were also examined in a community sample and predictive validity was confirmed even in a sample of depressed inpatients. The BSDMS was shown to possess good psychometric properties, as well as divergent and predictive validity within the populations that were tested.

Desire thinking: A Risk Factor for Binge Eating?

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Recent research has suggested that 'desire thinking' may be involved in the escalation of addictive and impulsive behaviours. Desire thinking appears to be a transdiagnostic process, with subjective reports indicating that this experience is qualitatively similar across a range of targets. The current study investigated the role of desire thinking in predicting binge eating independently of Body Mass Index, negative affect and irrational food beliefs. A sample of binge eaters (n=77) and a sample of non-binge eaters (n=185) completed the following self-report instruments: Hospital Anxiety and Depression Scale, Irrational Food Beliefs Scale, Desire Thinking Questionnaire, and Binge Eating Scale. Mann-Whitney U tests revealed that all variable scores were significantly higher for binge eaters than non-binge eaters. A hierarchical regression analysis, on the combined sample, indicated that verbal perseveration predicted levels of binge eating independently of Body Mass Index, negative affect and irrational food beliefs. These results highlight the possible role of desire thinking as a risk factor for binge eating and focusing this cognitive process may increase the efficacy of therapy.

Addiction Open Papers

Adverse experiences, emotion regulation and problem drinking in young women: the role of metacognitions about alcohol use

Malgorzata Dragan¹

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For young women, emerging adulthood is a period of life which can be associated with a heightened risk of excessive alcohol use as a means of emotional regulation. Our goal was to explore the relationship between childhood adversities, emotional dysregulation, positive metacognitions about alcohol use and problem drinking in young women. A sample of 502 females aged 18-25 completed a battery of self-report questionnaires aimed at measuring childhood adversities, emotional dysregulation, problem drinking and positive metacognitions about alcohol use. Structural equation modelling was used to test a model in which childhood adversities predicted emotional dysregulation, which in turn predicted problem drinking through positive metacognitions. Findings supported the hypothesised model with positive metacognitions found to entirely mediate the relationship between emotional dysregulation and problem drinking. Results are in line with previous findings suggesting important role of childhood adversities in the development of emotional self-regulation and of positive metacognitions in the activation of alcohol use.

Detached mindfulness versus cue-exposure in alcohol use disorder: A preliminary study of effects on distress and urge to use alcohol

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Studi Cognitivi, Italy¹, Sigmund Freud University, Vienna², London South Bank University, UK³ & University of Manchester, UK⁴

Metacognitive therapy is designed to impact directly on cognitive monitoring and control processes such that individuals can develop alternative ways of experiencing and regulating thoughts. One technique used for this purpose is ‘detached mindfulness’ which promotes a decentred perspective to thoughts and decouples repetitive thinking and coping from their occurrence. This study set out to test the effects of detached mindfulness against a brief cue-exposure control condition. Eight patients diagnosed with alcohol use disorder in an abstinence regime were exposed to detached mindfulness versus cue-exposure in a counterbalanced repeated-measures design. Findings showed that detached mindfulness led to a significantly greater decrease in distress and urge to use alcohol compared to cue-exposure. Significantly greater decreases in meta-appraisal and beliefs about alcohol-related thoughts were also observed in detached mindfulness. The clinical implications for the treatment of alcohol use disorder in a metacognitive perspective are discussed.

Desire Thinking Mediates the Relationship Between Emotional Intolerance and Problem Drinking

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The use of alcohol as a strategy to regulate emotional distress has been widely considered as a core risk factor for problem drinking. Recent research has suggested that using alcohol to self-regulate may be sustained by emotional intolerance (the perceived inability to tolerate emotional distress) and desire thinking (a voluntary cognitive process involving verbal and imaginal elaboration of a desired target). The goal of this study was to explore the role of emotional intolerance and desire thinking in predicting problem drinking. A sample of problem drinkers (n=50), and social drinkers (n=56) completed self-report instruments of emotional intolerance, desire thinking and problem drinking. Analyses revealed that the verbal perseveration factor of desire thinking was the only significant predictor of classification as a problem drinker. In addition both factors of desire thinking were found to predict problem drinking independently of emotional intolerance. These findings suggest that desire thinking may be a risk factor across the transition from social to problem drinking and that treatment may benefit from targeting specifically this cognitive process together with meta-emotional appraisal.

Unhelpful metacognitive beliefs in early psychosis are associated with affective symptoms and childhood social adjustment

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Unhelpful metacognitive beliefs are elevated in individuals with schizophrenia and linked to worse long-term outcome, but no studies have focused on early psychosis. We examined differences in levels of unhelpful metacognitive beliefs between early psychosis and controls, and whether demographic and clinical characteristics predicted levels of metacognitive beliefs in early psychosis. Patients (N=92) were included within two years of first treatment for a psychotic disorder. Assessment included premorbid adjustment, psychotic symptoms, anxiety/depression, and MCQ-30. Controls (N=97) completed MCQ-30. Predictors of metacognitive beliefs were explored with linear regressions. Patients scored significantly higher than controls on all MCQ-subscales, except positive beliefs about worry. The regression model explained 14-38% of the variance on each MCQ-subscale. Affective symptoms and childhood social adjustment explained a significant amount of variance on most subscales. Duration of untreated psychosis contributed to more unhelpful beliefs about cognitive confidence. Negative symptoms were linked to lower levels of cognitive self-consciousness. Unhelpful metacognitive beliefs differentiated patients from controls, and are closely linked to affective symptoms. The independent influence of childhood social adjustment supports a developmental perspective.

Metacognition, Negative Symptoms and Functioning in First Episode Psychosis.

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Copenhagen University, Denmark¹, Aarhus University, Denmark²

Negative symptoms have a significant impact on functioning in schizophrenia where deficits in metacognition have been proposed as a potential factor in the development and maintenance of negative symptoms. This study examined the relationship between negative symptoms, metacognition and functioning and investigated if metacognitive beliefs mediated the relationship between negative symptoms and functioning in schizophrenia. This study tested for relationships between course of illness and levels of specific metacognitions in schizophrenia spectrum disorders. A large cohort of people with first episode psychosis (n=227) were evaluated in terms of psychopathology, metacognitive beliefs and functioning. Correlational analysis and hierarchical regression analysis were used to identify the relationship between variables. Negative symptoms were significantly correlated to functioning and metacognitive beliefs. Several metacognitive beliefs were shown to be partial mediators between negative symptoms and functioning when controlling for baseline psychotic symptoms. Metacognitive beliefs about the need to control thoughts were the strongest mediators for affective flattening and anhedonia. A strong relationship was found between negative symptoms and functioning in first episode

psychosis and this relationship was partially mediated by a number of metacognitive beliefs. The clinical and theoretical implications of these results will be examined.

Innovation For It's Own Sake Has Little Value: Protecting Your Intellectual Assets

Jane Garnett¹

Manchester Mental Health and Social Care Trust¹

Improving treatment outcomes for anxious and depressed patients has become a clinical priority. There are increasing numbers of examples of metacognitive therapy demonstrating benefits to patients. Innovative interventions need to improve patient's lives, but they also need to reduce healthcare costs. Healthcare systems are not asking has an invention been patented but they are asking "are you saving us money?" Innovation for it's own sake has little value. The adoption of new interventions in healthcare should increase the quality of care and be less expensive to deliver. We look at the prevalent models for adoption of new innovative interventions (innovation / evaluation / adoption / diffusion) and identify barriers to adoption and uptake in healthcare. The law of intellectual property provides an incentive for inventors to produce works for the benefit of the public and to be compensated for their efforts. We will demonstrate how protecting intellectual property has been used to create value. We conclude by considering: What is the value proposition for metacognitive therapy? What is the minimum clinical performance that would be valuable? What is the value of the improvement and how is that value demonstrated?

Poster Presentations

Development and Initial Validation of a Measure of Metacognitive Beliefs in Health Anxiety: The MCQ-HA

Robin Bailey^{1,2}, & Adrian Wells¹

University of Manchester, UK¹, & University of Central Lancashire²

The Role of Metacognition in Adolescents' Drinking Behaviors

Daniela Di Blasi^{1,2}, & Loredana Benedetto¹

University of Messina, Italy¹ & Tolman Institute, Italy²

Cognitive Attentional Syndrome and Metacognitions in Male Sexual Dysfunctions

Simona Giuri¹, Gabriele Caselli^{1,2,3}, Chiara Manfredi^{1,2,4}, Daniela Rebecchi^{1,5}, & Antonio Granata⁵

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Metacognitive Therapy For Work-Related Stress – A Case Replication Series

MaikkenLykke Christiansen¹, & Pia Callesen¹

CEKTOS, Denmark¹

Desire Thinking As A Mediator Of The Relationship Between Novelty Seeking And Craving

Chiara Manfredi^{1,2,3}, Gabriele Caselli^{1,2,4}, Annalisa Ferraris³, Francesca Vinciullo⁴, & Marcantonio Spada⁴

Studi Cognitivi, Italy¹, Sigmund Freud University, Italy², University of Pavia, Italy³, London South Bank University⁴

Alexithymia in Borderline Personality Disorder and Emotion Regulation Strategies.

Marika Ferri^{1,2}, Maria Cristina Barnabei², Valerio Castellucci², Maria Paola Costantini², Lucia Epifani², Manuela Scarpantoni², Simona Tripaldi^{1,2} & Valentina Spina²

Studi Cognitivi, Italy¹ & Associazione Cognitivismo Clinico, Italy²

FKBP5 Polymorphisms and Positive Metacognitions About Alcohol

Wojciech Dragan¹, Malgorzata Dragan¹, & Wojciech Domozych¹

University of Warsaw, Poland¹

Single Dose of the Attention Training Technique Increases Resting Alpha and Beta Oscillation Power in Frontoparietal Brain Networks

Mark Knowles¹, Caroline Lee-Carnall¹, & Adrian Wells¹

University of Manchester, UK¹

Worry and Rumination: Do They Prolong Physiological or Affective Recovery From Stress?

Lora Capobianco¹, Julie Morris¹, & Adrian Wells¹

University of Manchester, UK¹

A Metacognitive Therapy Intervention for Family Caregivers of Cancer Patients. A Case Study

Simone Cheli^{1,2}, & Lucia Caligiani¹

Psycho-oncology Unit, Florence Healthcare District, Italy¹, University of Florence, Italy²

Schizophrenia and Metacognition: An Investigation Of Course of Illness And Metacognitive Beliefs Within a First Episode Psychosis.

Stephen Austin¹, Ole Mors², Merete Nordentoft¹, Carsten Hjorthøj¹, Rikke Gry Secher¹, Roger Hagen³, Marcantonio Spada⁴, & Adrian Wells⁵

Copenhagen University, Denmark¹, Aarhus University, Denmark², Norwegian University of Science and Technology, Norway³ London South Bank University, UK⁴, & University of Manchester, UK⁵

Detached Mindfulness and Physical Illness

Tina Bihal¹

CEKTOS, Denmark¹

Low Beliefs in Obsessive-Compulsive Disorder: Relationship with Metacognition and Treatment Outcome

Torun Grøtte¹, Stian Solem¹, & Patrick A. Vogel¹

Norwegian University of Science and Technology, Norway¹

Group MCT For Generalized Anxiety Disorder: A Pilot Study

Svein Haseth¹, Grethe Baardsen¹, Torun Grøtte², Stian Solem², Peter Fisher³

St. Olavs Hospital, Norway¹, Norwegian University of Science and Technology, Norway², & University of Liverpool, UK³

Desire Thinking As A Prospective Predictor of Binge Drinking

Martino F¹⁻², Caselli G¹⁻², Ceci G², Felicetti F², Mezzaluna C², Rampioni M², Romanelli P², Troiani L², Sassaroli S², Spada MM¹.

London South Bank University, UK¹, & Studi Cognitivi, Italy²

A Metacognitive Approach in Mental Health Prevention

Korn O¹, Frieling, A², Hauptmeier M², Steinhoff F²

University of Luebeck, Germany¹, & Addisca gGmbH, Germany²

Rumination, worry and anger rumination in psychopathology: are they the same process independent from negative emotions?

Fadda E¹, Gulmini M¹, Fiore F¹

Studi Cognitivi, Italy¹



MCT Masterclass 2017 [Manchester/Oslo]

The MCT Masterclass will start a new program in 2017. MCT Master-class provides state of the art training for therapists and clinical specialists to develop a high level of competency in MCT leading to the award of Diploma (Level 1). This training program is arranged by the Metacognitive Therapy Institute in Manchester and Trondheim. Dr. Adrian Wells and Dr. Hans M Nordahl are responsible for the program. In addition, our affiliates of MCT-I in the UK also provide supervision and management of training. All supervisors are experienced clinical psychologists and have been trained in MCT and work as clinicians and supervisors in health and academic settings.

WORKSHOPS

MCT training will run in 2017 and 2018, with workshops being held in Manchester, UK (6 workshops), and in Oslo, Norway (2 workshops). The workshops will cover the application of MCT for a variety of psychological disorders, including chronic depression, OCD, Social phobia, GAD, personality disorders, psychosis, PTSD and more.

SUPERVISION/LOGS

The supervision process is aided by a supervision log implemented via email. Workshops will be held four times a year, and will be a mix of theoretical presentation, demonstrations and practise (role-play).

STUDY PARTNER

All participants are assigned a study partner, who acts as a buddy. Your buddy will be another participant completing the MCT Masterclass training, and the two of you will work as a team encouraging and supporting each other's personal and professional growth.

COSTS

The fee for participation is (GBP 4.950) for the whole program. This includes the workshops, supervision, equipment, handouts and materials provided at the venues. The fee can be paid in two or more instalments. Expenses such as travel and accommodation and some lunches and beverages' must be covered by the participant. Any special preferences should be addressed to our organizer.

ETHICAL CODE

All participants are required to pay close attention to the ethical codes of conduct during their training. Information about patients used in the training should be handled strictly confidential, so no names or identity is disclosed.

INFORMATION

You may wish to make your own travel and accommodation arrangements. Our organiser can provide you information about suitable hotels and access to venues etc. More information will be provided on commencement of the training. The MCT Masterclass is an international training program so the official language for the teaching and supervision is English. For more information contact: Dr. Hans M Nordahl; e-mail: hmor-n@online.no See also www.mct-institute.com

HOW AND WHEN TO APPLY

Karen Larsen will be responsible for the secretarial administration and you should enclose your CV (max 3 pages) with description of your clinical experience and contact address. The application should be addressed by e-mail to:

Karen Larsen: karen.larsen@travel.no. Applications should be received by 1. February 2017 by e-mail.