First International Conference of Metacognitive Therapy

Programme and Abstracts

Manchester 12-13 May 2011

Pre-congress workshops 11 May 2011

First International Conference of Metacognitive Therapy

Manchester Town Hall: 11-13 May 2011

Conference Organising Committee:

Adrian Wells, Manchester
Hans Nordahl, Trondheim
Karin Carter, Manchester
Karen Larsen, Trondheim
Vivian Aasen, Trondheim
Lene Marie Osterman, Trondheim

Scientific Committee:

Adrian Wells, co-chair, Manchester
Hans Nordahl, co-chair, Trondheim
Karin Carter, Manchester
Peter Fisher, Manchester
Costas Papageorgiou, Liverpool
Marcantonio Spada, London

Dear Delegates,

A very warm welcome to Manchester and the first International Conference of Metacognitive Therapy. This is a truly international event with delegates and presenters from countries including: Great Britain, Ireland, Norway, Denmark, Sweden, United States, Australia, Italy, New Zealand, Germany, Spain, and Nigeria.

The venue for this event is the magnificent Manchester Town Hall and its Gothic architecture. The scientific program covers a broad range of psychological disorders and processes. We have 10 Keynote addresses by prominent contributors in the area. As well as a state-of-the-art scientific programme there is a social event to provide an opportunity to meet other delegates and presenters in a relaxed and informal setting.

We hope that you will take full advantage of the scientific and social programme and help us to make this inaugural conference a professionally valuable, memorable and enjoyable experience.

Adrian Wells
Hans M. Nordahl

In association with the MCT Institute: www.mct-institute.com

GENERAL INFORMATION

Registration

All delegates must register. The conference registration desk is located at the Town Hall, at the entrance to the Great Hall. Registration will be open at the following times:

Wednesday 11th May, 08.00-13.00   Pre-Congress Workshops

Thursday 12th May, 08.00-15.00   Conference
Friday 13th May, 08.00-14.00   Conference

Exhibition Area

The book exhibition will be held throughout the conference and will be located in the Great Hall or the landing area outside. The exhibitors are Wiley, Routledge and Checkware.

Security

Please do not leave valuables in the workshop rooms or the conference hall during the refreshment and lunch breaks.

Refreshments

Tea and coffee are provided free of charge to all delegates in the morning and afternoon. Serving points will be in the reception rooms opposite the Great Hall.

Lunch is not provided, but areas for purchasing snacks and meals are available within the Town Hall and there are restaurants and bars in the area surrounding Albert Square.

A buffet and live music has been arranged for Thursday 12th and will take place in the Great Hall. There is no additional fee for this. Please join us at 7.00pm for a complimentary glass of wine, music and food. There will be a bar open throughout the night for purchase of beverages. The entertainment will continue until late.

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: Din konferanse AS Schultz, 2-4 N-7013 Trondheim, Norway. Email: post@dinkonferanse.no
Tel: + 47 73 80 20 80

MCT Conference: Overview

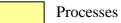## Pre-congress skills-based half-day workshops (11 May):

Leader	9.00-12.30	2.00-5.30
Adrian Wells	**GAD**	**PTSD**
Costas Papageorgiou	**Depression**	**Depression (repeat)**
Hans Nordahl	**Borderline PD**	**Borderline PD (repeat)**
Peter Fisher	**OCD**	**OCD (repeat)**
Tea/coffee	10.30-11.00	3.30-4.00

Conference:

Time	Day 1: 12 May	Day 2: 13 May
9.00	**Keynote 1**: Adrian Wells GAD & Trauma	**Keynote 6**: C. Papageorgiou Depression
9.40	**Symposium 1**: Medical conditions	**Symposium 5**: Social Phobia
10.20	Tea & coffee	Tea & coffee
11.00	**Keynote 2**: Tom Borkovec Worry	**Keynote 7**: Robert Leahy Emotional schemas
11.40	**Symposium 2**: Child-Adolescent	**Symposium 6**: Addictions
12.20	Lunch	Lunch
2.00	**Keynote 3**: Gerald Matthews S-REF & emotion	**Keynote 8**: Graham Davey Stop rules & Obsessions
2.40	**Symposium 3**: Eating Disorders	**Symposium 7**: PTSD
3.20	Tea & coffee	Tea & coffee
3.50	**Keynote 4**: Hans Nordahl Borderline personality	**Keynote 9**: Tony Morrison Psychosis
4.30	**Symposium 4**: OCD	**Keynote 10**: Peter Fisher MCT as progress?
5.10	**Keynote 5**: D. Turkington Schizophrenia	Closing address
7.15	Buffet and Live Music	

Treatment & outcomes   Processes

Specific Disorders (see also treatment)   Populations

Pre-Congress Workshops

Metacognitive Therapy for Chronic Worry and Generalized Anxiety Disorder
Adrian Wells, University of Manchester, UK

Metacognitive Therapy for Depression
Costas Papageorgiou, Priory Hospital, Altrincham, UK

The ERIS Protocol: MCT for Borderline Personality
Hans M Nordahl, NTNU, Trondheim, Norway

Metacognitive Therapy in the Treatment of Obsessive Compulsive Disorder
Peter L. Fisher, University of Liverpool, UK

Treating PTSD with Metacognitive Therapy
Adrian Wells, University of Manchester, UK

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 change. 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 workshop that can be used as proof of continuing professional development.

Symposia

Symposium 1:
Broadening the application of metacognitive theory and therapy to physical health populations

Convenor & Chair: Peter Fisher, University of Liverpool

1. **Metacognitions and negative emotions as predictors of severity of symptoms in chronic fatigue syndrome**
   M. Spada, London South Bank University,
   L Maher-Edwards, Fatigue Service, Royal Free Hospital,
   B. Fernie, Fatigue Service, Royal Free Hospital
   G. Murphy, Fatigue Service, Royal Free Hospital
   A.Wells, University of Manchester
   A. Nikccevic, Kingston University

2. **An examination of metacognitive beliefs and emotional distress in recently diagnosed cancer patients**
   S. Cook, University of Liverpool
   P. Salmon, University of Liverpool
   P. Fisher, University of Liverpool

3. **A preliminary study of metacognitive therapy for anxiety and depression after a cardiac event**
   G. Paszek, University of Manchester
   A. Wells, University of Manchester

Symposium 2:
Metacognitive therapy for children and adolescents

Convenor & Chair: Michael Simons, Aachen University

1. **The association between metacognitive beliefs and treatment outcome in anxiety-disordered adolescents**
   D.M. Ellis, Macquarie University, Sydney
   J. L. Hudson, Macquarie University, Sydney

2. **Comparing individual cognitive therapy and group based CBT with attentional placebo in adolescents with social phobia: A randomized controlled trial of junior high school students**.
   J.M Ingul, Department of Child and Adolescent Psychiatry, Levanger Hospital
   T. Aune, Department of Psychology NTNU, Trondheim
   H.M. Nordahl, Department of Psychology NTNU, Trondheim

3. **PTSD in youth – a case series of metacognitive therapy**
   M. Simons, Aachen University

Symposium 3:
Eating Disorders

Convenor & Chair: Gillian Todd, University of East Anglia & University of Cambridge

1. **Metacognition in Anorexia Nervosa**
   R.A. Woolrich, Oxford & Bucks Eating Disorder service, Aylesbury
   M. Cooper, University of Oxford
   H.M. Turner, University of Oxford

2. **An examination of metacognitions and Intolerance of Uncertainty in relation to eating attitudes**
   A. Konstantellou, Institute of Psychiatry, London
   M. Reynolds, Brunel University

3. **Predictors of eating disorder symptoms in 16 to 19 year old school girls: A 12-month prospective cohort study**

   G. Todd - University of East Anglia & University of Cambridge
   M. Cooper, University of Oxford
   T. Croudace, University of Cambridge
   I. Goodyer, University of Cambridge
   A. Wells, University of Manchester

Symposium 4:
Changing Metacognitive Processes in Obsessive Compulsive Disorder

Convenor & Chair: Peter Fisher, University of Liverpool

1. **Changes in thought fusion-beliefs and beliefs about rituals following treatment of OCD**
   S.Solem, Norwegian University of Science and Technology,
   B.Hansen, Norwegian University of Science and Technology
   K.Hagen, Norwegian University of Science and Technology
   P.A.Vogel, Norwegian University of Science and Technology
   P. Fisher, University of Liverpool, UK

2. **Metacognition and Memory in obsessive compulsive disorder**
   C. Exner, University of Marburg
   J. Kikul, University of Marburg
   W. Rief, University of Marburg

3. **3. All subtypes welcome: An open trial of group metacognitive therapy for OCD**
   P. Fisher, University of Liverpool
   A. Wells, University of Manchester

Symposium 5:
Metacognition in the Treatment of Social Phobia

Convenor & Chair: H. M. Nordahl, NTNU Trondheim

1. **A Randomised, placebo-controlled trial comparing the effects of Metacognitively enhanced cognitive therapy (mCT), paroxetine and both mCT and paroxetine in generalized social phobia.**
   H.M Nordahl, Dept. of Psychology, NTNU;
   A.Wells, University of Manchester
   P. A. Vogel, Dept. of Psychology, NTNU
   G. Morken, INU, NTNU
   T.C Stiles, Dept. of Psychology, NTNU

2. **Changes in meta-cognitions as predictors of outcome in cognitive therapy for social phobia. Results from a randomized controlled trial**
   T.C. Stiles, Dept of Psychology, NTNU
   P.A.Vogel, Dept of Psychology, NTNU
   G. Morken, INM, NTNU
   A.Wells, University of Manchester
   H.M. Nordahl, Dept of Psychology, NTNU

2. **Detached mindfulness versus though challenging in high socially anxious individuals: A comparison**
   S. Gkika, University of Manchester
   A. Wells, University of Manchester

Symposium 6:
Metacognitive Processes in Addictive Behaviours.

Convenor & Chair: M.M. Spada, London South Bank University

1. **The relative contributions of metacognitive beliefs and expectancies to drinking behaviour**
   M.M. Spada, London South Bank Univeristy
   G.B. Moneto, London Metropolitan University
   A. Wells, University of Manchester

2. **Metacognitions as a predictor of drinking status and level of alcohol use following CBT in problem drinkers: A prospective study.**
   M.M. Spada, London South Bank University
   G. Caselli, London South Bank University
   A. Wells, University of Manchester

3. **The role of metacognitive processes in desire thinking.**
   G.Caselli, London South Bank University & Studi Cognitivi, Modena, Italy
   M. M. Spada, London South Bank University

4. **Development and validation of the Smoking Metacognitions Questionnaire**
   A.V. Nikcevic, Kingston University
   M.M. Spada, London South Bank University

Symposium 7:
Post Traumatic Stress

Convenor & Chair: A.Wells, University of Manchester

1. **Metacognition, memory disorganization and rumination in posttraumatic stress symptoms**
   H. Bennett, Bolton NHS Trust
   A. Wells, University of Manchester

2. **Effects of Attention Training on intrusive thoughts and attention flexibility following life stress: An experimental study**
   Y. Nassif, University of Manchester
   A. Wells, University of Manchester

3. **Metacognitive therapy versus exposure therapy in the treatment of PTSD: A randomized controlled trial**
   D. Proctor, University of Queensland
   D. Walton, University of Manchester
   K. Lovell, University of Manchester
   A.Wells, University of Manchester

Abstracts

Keynote 1
Adrian Wells, University of Manchester, UK

Metacognitive Therapy: The Treatment of Traumatic Stress

Metacognitive theory and therapy has developed over 25 years and was expressed as a generic self-regulatory framework, the S-REF model (Wells & Matthews, 1994). This has become grounding for disorder specific approaches, many of which are covered in this conference. In this keynote the metacognitive model of PTSD will be presented and the stages of treatment described. It asserts that the process of emotional recovery after trauma is modulated by the individual's style of thinking. The focus is on removing specific factors that prevent cognition from returning to the normal 'safe-mode' of processing. Metacognitive knowledge and strategies are central in the down-regulation or maintenance of threat-related processing and these are targeted in treatment. An advantage of this approach is that it does not rely on imaginal reliving, recounting of traumatic memories or challenging of thoughts about the trauma. Evidence from uncontrolled and controlled trials of the effects of MCT will be reviewed. The data shows that the treatment is effective producing large and stable effects and high recovery rates in approximately 8 sessions.

Reference

Wells, A. (2008). *Metacognitive Therapy for Anxiety and Depression*. New York: Guilford Press.

Keynote 2
Tom Borkovec, Arizona, USA

The Nature, Functions, and Consequences of Worry: A Thirty Year Odyssey

Experimental research on worry traces its origins to a college bar in Pennsylvania in 1980. From over a year of weekly meetings, shared introspective accounts of personal worry experience from a (sometimes slightly inebriated) research team laid the foundation for three decades of investigation on worry and Generalized Anxiety Disorder at Penn State University. My presentation will summarize the historical progression of the thinking and the empirical results that occurred over this period, concentrating on what they had to say about the nature, functions, and consequences of worry and ending with a description of several of the insightful discoveries that began to emerge from the laboratories of other clinical scientists.

Keynote 3
Gerald Matthews, University of Cincinnati, USA

Executive Processes and the Emotions: New Prospects for the S-REF Model

The S-REF model of emotional dysfunction (Wells & Matthews, 1994) identifies

maladaptive executive processing as a source of impairment in attention and performance. Such executive processing may be initiated as a part of efforts to cope with the demands of performance tasks. I will review recent studies that have investigated the role of coping in performance of attentional tasks. Data suggest that affective states and coping are reciprocally related, and that avoidance coping may be linked to attentional impairment. Findings also point towards the importance of cognitive fatigue and loss of task engagement in performance decrements. These findings can be loosely accommodated within resource models of performance. However, a stronger theoretical account may require a more detailed specification of executive processes, and I will discuss future research directions of this kind.

Keynote 4
Hans M Nordahl, Norwegian University of Science and Technology

Can Metacognitive Therapy be used to treat Borderline Personality Disorder?

The author presents the ERIS protocol, which is the treatment program of Metacognitive therapy for borderline personality disorder. In the ERIS protocol there are three problem domains that must be targeted in treatment. First, the patient's vulnerability for deprivation and abandonment in interpersonal settings. Second, the self-regulatory problems causing emotional and behavioural instability and poor impulse control. Third the maladaptive coping styles of self-harming behaviours, withdrawal/attacking behaviour and sustained worry and rumination related to issues of control and abandonment. My presentation will provide an outline of the ERIS protocol. Characteristics of the treatment are that it has a brief format (10-12 months); it aims to increase emotional self-regulation and modify metacognitions; and integrate community health services as part of the treatment. The author presents a case series and an open trial of treatment for borderline personality disorder using this approach. The ERIS protocol seems to be a very promising treatment based on these first studies. However, the long-term effects, exceeding 12 months have yet to be investigated.

Keynote 5
Douglas Turkington, University of Newcastle, UK
with Sara Tai, University of Manchester, UK

CBT for patients with psychosis who refuse antipsychotic medication: Does the use of metacognitive techniques improve outcome?

In a pilot study of CBT for schizophrenia spectrum disorder therapists were able to deliver classical CBT for psychosis from the Kingdon and Turkington (2005) manual or to use an enriched form of CBT based on the Morrison manual (2002)with metacognitive strategies. These techniques were developed by Wells (2009) for the treatment of anxiety and depression but had never been piloted in psychosis. In particular worry postponement, detached mindfulness and attention training were used in the Manchester site but not in the Newcastle/ Durham site. The use of metacognitive strategies in medication free psychotic patients is fully described using case vignettes and a site analysis will show whether metacognitive techniques add benefit in terms of retention in therapy, symptomatic outcome, social recovery or

achieving a good clinical outcome as defined by a 25% improvement in the PANSS total score at end of therapy. The most useful metacognitive technique with psychotic patients will be identified.

Keynote 6
Costas Papageorgiou, Priory Hospital Altrincham, UK

Evidence for a Metacognitive Model and Treatment of Depressive Rumination

Persistent, recyclic, negative thinking, in the form of rumination, is a salient cognitive feature of dysphoria and major depressive disorder. Empirical evidence has shown that rumination is linked to the development, maintenance, and recurrence of depression. Knowledge of the mechanisms associated with the initiation and perpetuation of rumination in depression can assist us in enhancing further our understanding of depression, and importantly, maximising the effectiveness of current psychological interventions. Wells and Matthews' (1994) Self-Regulatory Executive Function (S-REF) theory of psychological disorders suggests that vulnerability to, and maintenance of, disorders is associated with metacognitions that lead to monitoring of threat, self-focused attention, and activation of repetitive, negative thinking styles, such as rumination and worry, as coping strategies. Grounded on this theory, Papageorgiou and Wells (2003, 2004) tested a clinical metacognitive model of rumination and depression. In this model, positive metacognitive beliefs about rumination are likely to motivate individuals to engage in sustained rumination. Once rumination is activated, individuals may appraise this process as both uncontrollable and harmful and likely to lead to negative interpersonal and social consequences. The activation of negative metacognitive beliefs about rumination contributes to the experience of depression. In this keynote address, cross-sectional and prospective studies supporting the role of metacognition in depressive rumination will be presented together with data supporting the effectiveness of metacognitive therapy for rumination and depression (Wells, 2008; Wells & Papageorgiou, 2004).

References

Papageorgiou, C. & Wells, A. (2003). An empirical test of a clinical metacognitive model of rumination and depression. *Cognitive Therapy and Research, 27*, 261-273.
Papageorgiou, C. & Wells, A. (2004). *Depressive rumination: Nature, theory and treatment. Chichester*, UK: Wiley.
Wells, A. (2008). *Metacognitive therapy for anxiety and depression*. New York, NY: Guilford.
Wells, A. & Matthews, G. (1994). *Attention and emotion: A clinical perspective*. Hove, UK: Erlbaum.
Wells, A. & Papageorgiou, C. (2004). Metacognitive therapy for depressive rumination. In C. Papageorgiou & A. Wells (Eds.), *Depressive rumination: Nature, theory and treatment. Chichester*, UK: Wiley.

Keynote 7
Robert L. Leahy, Weill-Cornell University Medical College, USA

Emotional Schemas and Implicit Theory of Emotion: Overcoming Fear of Feeling

Emotional regulation is a central feature of each of the anxiety and mood disorders and for several personality disorders. In addition, cognitive-behavioral therapy often encourages behavioral experiments, such as exposure and behavioral activation, in which emotions are intensified and need to be tolerated. Emotional schemas refer to the beliefs, evaluations, and strategies that individuals employ regarding their own emotions and those of others. These schemas reflect implicit theories of emotion and regulation of emotion which have relevance for experiential avoidance, guilt over emotions, self-labeling, affective forecasting and problematic strategies of emotion regulation. We will review data from a variety of studies illustrating how emotional schemas are related to meta-cognitive factors of worry, experiential avoidance, dispositional mindfulness, personality disorders, relationship adjustment and other variables. In addition, we will review how theories about the emotions of others may impact relationship dysfunction and impede therapeutic progress.

Keynote 8
Graham Davey , University of Sussex, UK

Stop Rules for Worrying and Checking: A Metacognitive Factor in Perseverative Psychopathologies

Both checking and worrying are open-ended tasks and this is no more apparent than in disorders such as OCD and GAD when these activities become perseverative and form cardinal features of the diagnostic criteria. However, research over the past 10 years has highlighted the fact that individuals engaging in checking and worrying do deploy implicit stop rules for these activities, and the kinds of stop rules they deploy will influence their perseveration at the task. This paper reviews research on stop rules for checking and worrying, describes the different types of stop rules that individuals with anxiety-based disorders may deploy, explains how these stop rules may interact with the individuals current mood to generate perseveration at the activity, discusses the factors that influence the type of stop rule deployed, and examines how stop rule use can become linked to metacognitive beliefs.

Keynote 9
Anthony P. Morrison, University of Manchester, UK

Metacognitive Theory and Therapy for Psychosis

Recent models of emotional disorders and psychosis implicate metacognitive beliefs 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: negative metacognitive beliefs are positively associated with several dimensions of symptomatology, particularly distress, and positive metacognitive beliefs appear to be particularly implicated in the frequency of psychotic experiences. Case series data and 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 theory and clinical practice will be considered.

Keynote 10
Peter Fisher, University of Liverpool, UK

Metacognitive Therapy: A Move in the Right Direction?

Across most anxiety and depressive disorders, the majority of patients completing psychological treatment continue to experience distressing levels of symptoms. Despite the demonstrable need for improved treatments, the focus of treatment outcome research has recently shifted towards dissemination and away from the development of innovative and novel interventions.   This presentation will begin by highlighting some of the limitations of existing psychological treatments for emotional distress. I will then examine whether metacognitive therapy represents a promising development for the treatment of anxiety and depression in the context of both adult mental health and physical health populations.

Symposia Abstracts

Broadening the application of metacognitive theory and therapy to physical health populations

Convenor & Chair: Peter Fisher, University of Liverpool

1. Metacognitions and negative emotions as predictors of symptom Severity in Chronic Fatigue Syndrome

M. Spada, London South Bank University,
L Maher-Edwards, Fatigue Service, Royal Free Hospital,
B. Fernie, Fatigue Service, Royal Free Hospital
G. Murphy, Fatigue Service, Royal Free Hospital
A.Wells, University of Manchester
A. Nikccevic, Kingston University

Chronic Fatigue Syndrome (CFS) describes a condition that is primarily characterized by fatigue and flu-like symptoms which are not alleviated by rest. This study investigated the relationship among metacognitions, negative emotions and symptom severity in CFS. A total of 96 patients, who had received a diagnosis of CFS according to the Oxford Criteria, completed a battery of self-report measures that consisted of the Depression, Anxiety and Stress Scale (DASS), the Metacognitions Questionnaire 30 (MCQ-30), the Chalder Fatigue Questionnaire (CFQ), and the RAND Short Form 36 Physical Functioning (SF-36 PF). Correlation analyses showed that negative emotions and metacognitions were positively correlated with measures of symptom severity and that metacognitions were a better predictor of symptom severity than anxiety and depression. Hierarchical regression analyses indicated that: (1) lack of cognitive confidence predicted both mental and physical factors of the CFQ and physical functioning independently of negative emotions; and (2) beliefs about the need to control thoughts predicted the mental factor of the CFQ independently of negative emotions and lack of cognitive confidence. The data support the potential application of the metacognitive model of psychological disorder to understanding CFS.

2. An examination of metacognitive beliefs and emotional distress in recently diagnosed cancer patients

S. Cook, University of Liverpool
P. Fisher, University of Liverpool
G.Dunn, University of Manchester
P. Salmon, University of Liverpool

Emotional distress after cancer diagnosis is normal and for most people will naturally diminish over time. However, a significant minority of cancer patients experience persistent distress for which they need professional help. Before we can begin to find ways to prevent such persistent distress we need to identify the causal psychological mechanisms involved. A prospective study has been designed to test the prediction

that metacognitive beliefs and processes predict persistent emotional distress after cancer. This paper reports a cross-sectional component of the study. A total of 187 participants were assessed within 3 months of diagnosis before the start of acute medical treatment for primary breast or prostate cancer. They completed a battery of self-report questionnaires, including the Hospital Anxiety and Depression Scale (HADS) , the Impact of Events Scale (IES), the Metacognitions Questionnaire (MCQ 30), the Penn State Worry Questionnaire (PSWQ) and the Illness Perceptions Questionnaire (IPQ-R;). A preliminary analysis indicates that metacognitive beliefs and processes are positively correlated with current anxiety and trauma and that they contribute to the variance in emotional distress over and above illness perceptions and worry. These findings provide promising first evidence that the metacognitive model can be usefully applied in cancer.

3. **A preliminary study of metacognitive therapy for anxiety and depression after a cardiac event**.

G. Paszek, University of Manchester
A. Wells, University of Manchester

Psychological distress in cardiac patients is associated with increased morbidity and mortality. Depression and anxiety in cardiac patients seem to respond only modestly to existing cognitive behavioural treatments (CBT); and interpersonal psychotherapy (IPT) has been found to be no more effective than standard clinical management. Since many antidepressants are contraindicated in cardiac patients, psychotherapy is becoming the preferred option. Subsequently there is demand for an evidence-based, well specified, transdiagnostic psychotherapy treatment. This study investigated the feasibility and potential efficacy of metacognitive therapy (MCT; Wells, 2009) to treat psychological distress in cardiac patients. An A-B multiple natural baseline case series design (n = 6) with 6 month follow-up assessments was implemented. Treatment was delivered in 6 sessions of up to 1 hour each. To account for the heterogeneous psychological presentation of patients, and to allow the study to be replicated, a generic metacognitive model was used to guide therapy. Treatment was associated with significant reductions in time spent ruminating and threat monitoring; increased attentional control and flexibility, and modified metacognitive beliefs about worry. A formal recovery criterion was used to define change in symptoms. Corresponding to symptoms of anxiety and depression, at post-treatment 83% and 67% were classified as recovered, respectively. The small number of cases limits generalisation of findings to the larger population of patients, but the study highlights the potential efficacy of MCT and the importance of continued evaluation.

Symposium 2

Metacognitive Therapy in Children and Adolescents

Convenor and Chair: Michael Simons, Aarchen University

1. **Comparing individual cognitive therapy and group based CBT with attentional placebo in adolescence with social phobia: A randomized controlled trial of junior high school students**.

J.M. Ingul, Levanger Hospital Norway , Department of Psychology NTNU
T. Aune, Department of Psychology NTNU, Trondheim Norway
H.M. Nordahl, Department of Psychology NTNU, Trondheim, Norway

We conducted a randomized controlled trial of adolescents (13-17) with social phobia. Three different interventions were compared: A group cognitive behavioural therapy (N=20), individual cognitive therapy (N=21), and attentional placebo (N=16).

Method: We did a pre-post comparative study with 1 year follow up. Clinical interviews, self report and treatment diaries were used in the assessment of the patients. The group cognitive behavioural therapy was based on Beidel (SET-C) and Kendall (Coping CAT) emphasizing psychoeducation, exposure, skills training, and role play. The individual cognitive therapy manual was based on the Clark and Wells model with additional Metacognitive therapy techniques. The treatment manual included attentional training and refocusing, videofeedback behavioural experiments, and elimination of worry and rumination. The attentional placebo had elements such as social activity, social interaction, and social support as the main components. The amount of exposure to therapists was equal in all three conditions.

Results: The individual cognitive therapy did significantly better than both the group therapy and the attentional placebo both at post treatment and one year follow up. The results will be presented and discussed at the conference.

2. **The association between metacognitive beliefs and treatment outcome in anxiety-disordered adolescents**

Danielle M. Ellis, Dept of Psychology, Macquarie University, Sydney
Jennifer L. Hudson, Dept of Psychology, Macquarie University, Sydney

Previous research supports the use of the metacognitive model of Generalized Anxiety Disorder (GAD) in understanding worry in adolescent populations (Bacow, Pincus, Ehrenreich, & Brody, 2009; Cartwright-Hatton et al., 2004). Cognitive-behavioural treatment (CBT) is an efficacious treatment for child and adolescent anxiety disorders, although a percentage of anxious youth continue to meet criteria for their disorder following CBT. Research in adults suggests treatments that modify positive and negative metacognitive beliefs about worry reduce levels of worry and anxiety. This research explored the association between metacognitive beliefs about worry and treatment outcome in a sample of anxious and anxious/depressed adolescents aged between 12 and 17 years who participated in CBT. Results indicated that metacognition was associated with severity of diagnosis and emotional symptoms at pre- and post-treatment. There were significant reductions in worry and anxiety from pre- to post-treatment, but no reductions in metacognition or depression.

Nonetheless, pre-treatment metacognition, and change in metacognition during treatment, predicted treatment outcome, even when controlling for pre-treatment impairment. These results suggest that treatments for adolescent worry and anxiety may be improved through modifying metacognitive beliefs about worry.

3. PTSD in youths – A case series of metacognitive therapy

M. Simons, Department of Child & Adolescent Psychiatry and Psychotherapy, RWTH Aachen University

There is growing evidence that metacognitive therapy (MCT) works well in adult post traumatic stress disorder (PTSD). We adopted the metacognitive treatment manual for PTSD (Wells 2009) for juvenile outpatients with PTSD.

Method: Patients of our outpatient trauma clinic were consecutively treated with MCT after affirming the PTSD diagnosis with a structured interview. They suffered from chronic PTSD, e.g., after sexual abuse. MCT was usually conducted on a weekly basis and consisted of psychoeducation, case formulation, detached mindfulness, worry/rumination postponement, refocusing, and relapse prevention. Treatment was monitored with questionnaires before every session, treatment lenght wasn't predetermined but depended on the course of symptoms.

Results: MCT proved to be highly efficacious in rather short time. Often after about 5 sessions patients were symptom free so that they only needed booster sessions some months after treatment.

Discussion: To our knowledge these are the first young patients treated with MCT for PTSD. Only minor changes were necessary to adopt the original manual (conceptualised for adult patients) to children and adolescents. We strongly recommend to use and to further study the efficacy of MCT for that condition.

Symposium 3

Metacognition and Eating Disorders

Convenor and Chair: Gillian Todd, University of East Anglia

1. An examination of metacognitions and intolerance of uncertainty in relation to eating attitudes.

Anna Konstantellou, Institute of Psychiatry Kings College London
Martina Reynolds

The present study investigates metacognitions and intolerance of uncertainty in relation to eating attitudes. It was hypothesised that individuals with problematic eating attitudes (PEA) will score high on metacognitions and intolerance of uncertainty when compared to individuals with normal eating attitudes (NEA). Intolerance of uncertainty and metacognitions will further be positively associated. A non-clinical sample of 116 UK-based university students completed the Eating Attitudes Test (EAT-26), Metacognitions Questionnaire (MCQ-30) and Intolerance of Uncertainty Scale (IUS). Twenty-seven participants formed the (PEA) group and 89

the (NEA). Results overall supported the hypotheses, participants with PEA scored significantly higher on three of the five metacognition factors, total metacognition score and intolerance of uncertainty compared to participants with NEA. Positive correlations were also found between intolerance of uncertainty and metacognitions. Findings further point towards examining intolerance of uncertainty and metacognitions in the field of eating disorders. Changing metacognitions and targeting high levels of intolerance of uncertainty could contribute to better treatment outcome for individuals with eating disorders.

2. Metacognition in anorexia nervosa

Presenter: Myra Cooper, University of Oxford
Authors: Dr Rachel Woolrich, Dr Hannah Turner & Dr Myra Cooper

The current study aimed to examine metacognition in relation to thoughts about eating/weight/shape in participants with anorexia nervosa (AN), dieting and non-dieting women. A particular focus was whether there were group differences in the content of metacognitive appraisals or the use, function and success of metacognitive control strategies. Participants were 15 women with AN, 17 normal dieters and 18 non dieters. A semi structured interview was used to collect the data. It was adapted from previous interviews with patients with eating disorders and incorporated metacognitive profiling questions. In addition a list of possible metacognitive control strategies was provided. Open ended comments were analysed via content analysis and good inter-rater reliability was achieved. Using categories derived from previous metacognitive profiling work explicit metacognitions and a range of metacognitive control strategies were present in all three groups of women. However, there were group differences in the amount and function of metacognitive activity. Trends in the qualitative data also suggested that participants with AN believed that their thoughts were abnormal and uncontrollable. Those with AN used six specific metacognitive strategies more often than participants in either of the control groups and were less successful at using thought re-appraisal and attending to body and others. Half of participants with AN reported using these strategies to deliberately make themselves feel worse. It is suggested that metacognitive activity may play a role in the maintenance of AN, particularly in reinforcing negative self-evaluations, and thus may have a role in both the development of theory and clinical practice with this group.

3. Cognitive and metacognitive predictors of eating disorder symptoms: A prospective cohort study

Gillian Todd, University of East Anglia
Myra Cooper, University of Oxford
Tim Croudance, University of Cambridge
Ian Goodyer, University of Cambridge
Adrian Wells, University of Manchester

The study aimed to test the cognitive and metacognitive predictors of eating disorder symptoms prospectively in a cohort of 16 to 19 year old schoolgirls. The first objective was to establish if eating disorder beliefs measured by the Eating Disorder

Belief Questionnaire (EDBQ; Cooper et al 1997) predicted the development of eating disorder symptoms measured by the EAT26 which served as the dependant variable. The second objective was to examine if there was a prospective relationship between metacognitive beliefs measured by the Metacognitions Questionnaire - short version (MCQ: 30; Wells & Cartwright-Hatton, 2004) and the development of eating disorder symptoms. A community sample of 393 women were recruited through schools in the city of Cambridge UK.   Of these n=331 completed the measures at T1 and n=206 at T2, 12 months later. The mean age at T1 was 16.5 years (SD 0.561), and the mean BMI was 21.7 (SD 3.11). Participants were asked to provide demographic information, complete self-report measures of depression, anxiety and social support. Hierarchical multiple regression analyses were computed to establish the contribution of cognitive factors measured at T1 in the prediction of eating disorder symptoms at T2 over and above eating disorder symptoms at T1. There was no prospective relationship between eating disorder beliefs measured by the EDBQ and the development of eating disorder symptoms over 12 months. However metacognitive beliefs measured by the MCQ30 made a unique contribution to the development of eating disorder symptoms. The findings suggest that the cognitive model might need to be revised to include metacognitive dimensions of beliefs.

Symposium 4

Changing Metacognitive Processes in Obsessive Compulsive Disorder

Convenor & Chair: Peter Fisher, University of Liverpool

1. Changes in thought fusion-beliefs and beliefs about rituals following treatment of OCD

S.Solem, Norwegian University of Science and Technology
B.Hansen, Norwegian University of Science and Technology
K.Hagen, Norwegian University of Science and Technology
P.A.Vogel, Norwegian University of Science and Technology
P. Fisher, University of Liverpool, UK

Metacognitive beliefs such as positive and negative beliefs about worry, low cognitive confidence, the need to control thoughts, and cognitive self-consciousness are central in psychological disorders. Changes in these metacognitive beliefs are also related to treatment outcome in people with OCD completing exposure and response prevention. Two domains of metacognitive beliefs are specifically implicated in the model and treatment of OCD: thought fusion beliefs and beliefs about rituals. Cross-sectional studies have demonstrated that these two beliefs are central in explaining obsessive-compulsive symptoms. The current study set out to investigate the role of fusion beliefs and beliefs about rituals in people with OCD completing cognitive behavioural treatment (N = 79). Post-treatment levels of metacognitive beliefs predicted overall level of obsessive-compulsive complaints after controlling for depressed mood, threat, and cognitive beliefs such as responsibility and perfectionism. In addition, metacognitive beliefs were significant predictors of all subtypes of OCD except for hoarding. Taken together these findings suggest that

metacognitions are important in explaining obsessive-compulsive symptoms and that recovery is associated with improvement in metacognitive knowledge and strategies.

2. Metacognition and memory in obsessive compulsive disorder

C. Exner, University of Marburg
J. Kikul, University of Marburg
W. Rief, University of Marburg

Memory deficits in patients with obsessive-compulsive disorder (OCD) have been frequently reported but are not sufficiently accounted for by cognitive appraisal-belief models of OCD. Previous research has documented high trait cognitive self-consciousness (CSC) in OCD. Two studies will be presented that aimed at identifying meta-cognitive mechanisms that might be able to explain memory deficits in OCD. In the first study episodic verbal memory performance was assessed in 23 participants with OCD (DSM-IV criteria) and 22 matched controls. Cognitive self-consciousness (CSC) was assessed with a self-report measure derived from the Meta-Cognitions Questionnaire (MCQ). Compared to controls, OCD participants showed reduced immediate and delayed recall of complex verbal material and increased self reported levels of CSC. Multiple regression analyses indicated that group differences in story recall were significantly mediated by self-reported trait CSC. The second study examined whether experimentally heightened situational CSC affects visual memory performance in OCD. OCD participants (n=36) and matched healthy controls completed a complex figure test under three experimental conditions. In the OCD sample both the CSC and in a dual-task condition reduced memory performance compared to a standard condition, whereas in controls only the dual task condition led to reduced performance. Results indicate that heightening CSC in OCD has a deteriorating effect on memory encoding that parallels the effect of a secondary task. Results point to the deteriorating effects of a thought-focused cognitive style on effortful encoding processes in OCD. High CSC and its effects on cognitive performance might be amenable to meta-cognitive treatment approaches

3. All subtypes welcome: An open trial of group metacognitive therapy for OCD

P. Fisher, University of Liverpool
A. Wells, University of Manchester

In this paper, we report initial outcome data on the potential effectiveness of metacognitive therapy for OCD (Wells, 1997, 2009), when delivered in a small group format. Group MCT for OCD does not require a broad range of idiosyncratic formulations based on varying combinations of cognitive beliefs/appraisals or a variety of exposure hierarchies as metacognitive beliefs about intrusions and rituals are comparable across subtypes. The focus is on altering the patient's relationship with their thoughts as opposed to challenging the actual content of the thought. Treatment was delivered by a single therapist and involved six 2 hour sessions conducted over 9 weeks. The results of the study showed that all patients achieved large symptomatic gains at post-treatment, which were maintained through to six months follow-up. These encouraging data suggest that group MCT for OCD could prove to be efficacious and cost effective psychological treatment.

Metacognition in the Treatment of Social Phobia

Convenor and Chair: Hans, M. Nordahl, NTNU, Trondheim, Norway

1. **Metacognitive focused cognitive therapy for social phobia: A randomised, placebo-controlled trial comparing the effects of metacognitively oriented cognitive therapy(mCT), paroxetine and both mCT and paroxetine in generalized social phobia.**

Hans M Nordahl, Dept of Psychology, NTNU
Patrick A. Vogel, NTNU
Tore C Stiles, NTNU
Berit Nordstrand, St. Olavs Hospital
Gunnar Morken, NTNU
Pål Sandvik, MD, St.Olavs Hospital
Adrian Wells, University of Manchester

A sample of 86 patients with DSM-IV generalized social phobia diagnosis were included. Patients were randomly assigned to metacognitive focused Cognitive therapy (mCT), SSRI, a combination of mCT plus SSRI, or a pill-placebo control condition. They were assessed at pre-treatment, post-treatment and 1-year follow-up. All patients had 12 weeks of treatment in the acute phase, which includes 12 sessions of individual treatment, and the drug groups had in addition 12 weeks of drug treatment in the maintenance phase. The placebo group ran for 24 weeks with clinical management. The mCT was based on the Clark & Wells' model (1995), but was modified to include more metacognitive techniques focused on mental control and less on reality testing thoughts and beliefs. Measures were based on all three main sources; self-report inventories, clinical assessments by independent raters and psycho-physiological assessments. Our primary aim was to evaluate the effectiveness of mCT, paroxetine and their combination, and to investigate the patterns of change and the mechanisms of action involved during treatment. The main results were that the combination of SSRI and mCT was not as effective as mCT alone, but more effective than SSRI plus clinical management. All treatments were more effective than the pill placebo condition. Moreover, an additional diagnosis of Avoidant personality disorder seemed to increase the need for sessions in mCT but responded well to treatment. Paroxetine was not effective for patients with an additional personality disorder.

2. **Changes in meta-cognitions as predictors of outcome from cognitive therapy for social phobia: Results from a randomized controlled trial.**

Tore C. Stiles, Dept. of Psychology, NTNU, Trondheim
Adrian Wells, University of Manchester
Patrick A. Vogel, NTNU, Trondheim
Hans M. Nordahl, NTNU Trondheim

The main aim of the study was to test a specific hypothesis derived from the meta-

cognitive model developed by Adrian Wells predicting that changes in meta-cognitions during treatment are associated with levels of symptom improvement at treatment termination. 86 patients participating in a randomized controlled trial for social phobia with four treatment conditions were included in the present study. The four treatment conditions were: cognitive therapy alone, cognitive therapy with paroxetine, paroxetine combined with clinical management and a pill placebo condition with clinical management. Symptom improvement was assessed by using scores from the Fear of Negative Evaluation(FNE) and LSAS (Liebowitz) assessed at pretest and posttest. Changes in meta-cognitions from pretest to posttest, as measured by subscales of The Meta-Cognitions Questionnaire (MCQ-30), were used as a predictor of symptom improvement. Hierarchical regression analyses were applied with FNE-scores at posttest as the dependent measure. FNE-prescores were entered in the first step. Changes on each of the subscales on the MCQ-30 from pretest to posttest were entered in the second step in separate analyses. Several control analyses examining potential confounding effects were also performed. Changes in meta-cognitions during treatment were associated with symptom improvement following treatment as measured by the FNE. To what extent changes in meta-cognitions are a general or a treatment specific predictor will be discussed. The study also has some methodological limitations that will be considered.

3. Detached mindfulness versus thought challenging in high socially anxious individuals: A comparison

Styliani Gkika, University of Manchester
Adrian Wells, University of Manchester

The Self-Regulatory Executive Function (SREF) model (Wells and Matthews 1994) suggests that detached mindfulness, a way of developing meta-awareness and of interrupting conceptual processing, can reduce symptoms of emotional disorders. This study examines this suggestion in a sample of high socially anxious individuals. Twelve participants practised detached mindfulness and thought challenging in a cross-over repeated measures design. It was expected that both techniques would lead to improvements but that detached mindfulness would be superior overall. Results showed that both techniques reduced the outcome variables, but detached mindfulness showed greater change than thought challenging in worry ($Z = -2.79$, $p = .003$), belief levels ($Z = -2.04$, $p = .04$), and the observer perspective ($Z = -2.22$, $p = .03$). Moreover, thought challenging seemed to increase worry, anxiety and belief levels when delivered after detached mindfulness. Results are discussed in terms of the potential incorporation of detached mindfulness in the treatment of social phobia. Further studies are needed to explore its potential applications as a stand-alone technique or within the framework of meta-cognitive therapy. Moreover, the study suggests that it may be counter-productive to combine some techniques in some sequences.

Metacognitive Factors in Addictive Behaviours

Convenor and Chair: Marcantonio M. Spada, London South Bank University

1. Metacognitions as a predictor of drinking status and level of alcohol use following CBT in problem drinkers: A prospective study

Marcantonio M. Spada, London South Bank University
Gabriele Caselli, North East London, NHS Foundation Trust
Adrian Wells, University of Manchester

Dimensions of metacognition have been found to be associated with alcohol use and problem drinking in a variety of cross-sectional studies (Spada & Wells, 2009). This study aimed to investigate the role of negative emotions and metacognitions in predicting problem drinkers' drinking status (absence or presence of drinking) and level of weekly alcohol use at 3, 6 and 12 months after a brief course of cognitive behaviour therapy. A total of 70 problem drinkers with a DSM-IV diagnosis of alcohol abuse participated in the study. At baseline, prior to the first session of a brief course of cognitive behaviour therapy, a battery of instruments were administered to measure background drinking behaviour and history, negative emotions and metacognitions. Drinking status and level of weekly alcohol use were then recorded at 3, 6 and 12 months. Beliefs about need to control thoughts were found to predict: (1) drinking status at 3 and 6 months; and (2) level of weekly alcohol use at 3, 6 and 12 months. The contribution of these beliefs was independent of negative emotions and initial level of weekly alcohol use. The findings support the role of metacognitions in problem drinking. Given that metacognitions are a possible risk factor for drinking status and level of weekly alcohol use it is suggested that treatment for problem drinking could target this variable.

2. The relative contribution of metacognitive beliefs and expectancies to drinking behaviour

Marcantonio M. Spada, London South Bank University
Giovanni B. Moneta, London Metropolitan University
Adrian Wells, University of Manchester

Alcohol expectancies refer to the anticipated effects of alcohol use by an individual. Metacognitive beliefs about alcohol use are a specific form of alcohol expectancy relating to the beliefs individuals hold about the effects of alcohol on cognition and emotion. A community sample of 355 individuals completed measures of alcohol expectancies, metacognitive beliefs about alcohol use, and drinking behaviour. Correlation analyses indicated that alcohol expectancies and metacognitive beliefs about alcohol use were positively correlated with drinking behaviour. Structural regression modelling revealed that three of the four facets of metacognitive beliefs about alcohol use were an independent contributor to drinking behaviour, and that, when controlling for such beliefs, only Negative Social Performance alcohol

expectancies explained additional variance in drinking behaviour. These results add to the argument that there is a value in differentiating between metacognitive beliefs about alcohol use and alcohol expectancies in predicting drinking behaviour.

3. The role of metacognitive processes in desire thinking

Gabriele Caselli, London South Bank University & CPSR, Milano
Marcantonio M. Spada, London South Bank University & NE London NHS Trust

Desire thinking is defined as a voluntary thinking process orienting to prefigure images, information and memories about positive target-related experience. Recent research has highlighted the role of desire thinking in the maintenance of addictive, eating and impulse control disorders. Currently little is known about metacognitions in desire thinking. The aim of the present study was to investigate: (1) the presence and content of desire thinking during a desire experience; (2) the presence of metacognitive beliefs in desire thinking; (3) the goal of desire thinking; (4) attentional focus during desire thinking; and (5) the impact of desire thinking on craving. Twenty four individuals with a diagnosis of either alcohol abuse, bulimia nervosa, pathological gambling or smoking dependence were assessed using a semi-structured interview. Findings indicated that participants engaged in desire thinking and endorsed both positive and negative metacognitive beliefs about this process. The goal of desire thinking was to regulate internal states. Participants also reported that during a desire experience their attentional focus was continuously shifting between internal state and external context and that engaging in desire thinking increased craving. These findings provide preliminary evidence that metacognitions play a role in desire thinking.

4. Metacognitions about smoking: A preliminary investigation

A.V. Nikčević, Kingston University, UK
Marcantonio M. Spada, London South Bank University &NE London NHS Trust

Preliminary research has indicated that metacognitions are involved in smoking. Guided by the Self-Regulatory Executive Function (S-REF; Wells & Matthews, 1994) theory, the current study aimed to investigate metacognitive aspects of the smoking experience. Twelve individuals (6 men, 6 women) self-identified as regular smokers and scoring a positive value on the Fagerström Test of Nicotine Dependence (FTND; Heatherton, Kozlowski, Frecker & Fagerström, 1991) were assessed using a semi-structured interview to establish: (1) whether they held positive and/or negative metacognitive beliefs about smoking; (2) what was their main goal in smoking, and how they knew if they had achieved their goal; (3) how they directed their focus of attention when smoking; and (4) what they perceived the advantages and disadvantages of these attentional strategies to be. Results indicated that participants endorsed both positive and negative metacognitive beliefs about smoking and that the goal of smoking was to regulate negative emotion and/or to enhance cognitive functioning. Participants reported that they either relied on an internal signal, such as improvement in the emotional/cognitive state, or on a physical sign, in the form of a finished cigarette, to determine if they had achieved their goal. During an episode of

smoking, half of the participants reported focusing their attention internally on thoughts and feelings or the sensation of smoking. The remainder of participants reported either an exclusively external focus of attention (e.g. the environment) or a varied focus of attention. Most participants were able to identify advantages to their attentional strategies, whilst two reported perceived disadvantages. On the basis of the above findings, the Metacognitions Questionnaire about Smoking (MQS) was developed. Results from preliminary analyses are also discussed.

<u>**Symposium 7**</u>

Post Traumatic Stress

Convenor and Chair: Adrian Wells, University of Manchester, UK

1. **An experimental study of the effects of ATT on symptom reduction in a sub-clinical traumatized sample**

Yasmine Nassif, University of Manchester
Adrian Wells, University of Manchester

The aim of this study was to test the effect of a metacognitive treatment technique, Attention Training Technique (ATT), on specific PTSD symptoms in a student population that was exposed to stress. Additionally, the study explored which dimensions of detached mindfulness were associated with symptom improvement, using the Detached Mindfulness Questionnaire (DMQ). It was hypothesized that participants who received metacognitive training by ATT would report fewer intrusions than a control group, when each group were exposed to reminders of their trauma and when controlling for exposure time. It was also hypothesized that participants in the ATT would report a greater positive change in Attention Flexibility measured by the DMQ. Results showed that when exposed to reminders of their trauma people who received at least 3 sessions of ATT reported (3.4x) fewer intrusions than a control group. Moreover, there were significant group differences in Attention Flexibility, with higher scores reported in the group that received ATT $(F(38,1)=5.19, p<.05, \text{partial eta}^2 =.12)$, confirming the hypotheses. Clinical implications of this study may suggest the usefulness of ATT in the treatment of PTSD and milder stress symptoms, and the importance of integrating elements of detached mindfulness, namely techniques that foster Attention Flexibility, in order to stop dysfunctional coping processes involved in the CAS. These results are in line with the metacognitive theory of emotional disorders proposed by Wells.

2. **Metacognition, memory disorganisation and rumination in posttraumatic stress symptoms**.

Hazel Bennett, Bolton NHS Trust
Adrian Wells, University of Manchester

Many theoretical models of PTSD propose that disorganisation of the trauma memory contributes to the maintenance of symptoms. The evidence for the role of memory

disorganisation in maintaining PTSD is inconclusive. The metacognitive model of PTSD proposes that rather than the trauma memory itself, it is the individual's beliefs about the trauma memory that are important. This paper examined the relative contribution of memory disorganisation and 'meta-memory' in the prediction of posttraumatic stress symptoms. Beliefs about trauma memory, but not memory disorganisation within the trauma narrative, predicted a significant proportion of the variance in posttraumatic stress symptoms. Consistent with the metacognitive model of PTSD, the use of rumination was found to mediate the relationship between beliefs about memory and PTSD symptoms. The findings have implications for the treatment of PTSD.

3. A randomized controlled trial of Metacognitive Therapy versus Exposure Therapy for adult PTSD

Dawn Proctor, Institute of Health and Biomedical Innovation, QUT, Brisbane
Deborah Walton, University of Manchester
Karina Lovell, University of Manchester
Adrian Wells, University of Manchester

Metacognitive Therapy (MCT) was compared with exposure therapy (E) and a wait-list control in patients with chronic PTSD. Following randomization participants were tested at pre-treatment, at mid therapy (4 sessions) and after 8 sessions/weeks (post-treatment). Both active treatments resulted in significantly lower PTSD symptoms, anxiety and depression compared with the control condition. MCT was superior to E at post treatment on measures of PTSD symptoms and on a measure of physiological arousal (heart-rate) under exposure to trauma reminders. In addition MCT produced effects more rapidly than E with differences observed at mid-treatment. Recovery rates showed that following MCT 90% were recovered whilst 70% of the E group were recovered as indexed by the IES. Clinical gains were largely maintained at follow-up by which time the E group had caught up. In conclusion both treatments were effective but MCT may have an advantage on some indices and exerts an effect more rapidly without the need for exposure or reliving.

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MCT Master-Class 2012-2013

You are invited to join the MCT Master-class training program. MCT Master-class aims to provide state of the art training for experienced CBT clinicians or specialists to develop a high level of competency in MCT. This training program is arranged by the Metacognitive Therapy Institute in Manchester and Dr. Adrian Wells and Dr. Hans M Nordahl are responsible for the program. The Master-class is considered to be the minimal training required to develop core competency in MCT and gain accreditation by the MCT institute. Successful completion leads to the level 1 diploma. MCT Institute aims to regulate MCT and maintain acceptable minimal standards of practice in the interests of client wellbeing, research and development.

The training will run in 2012 and 2013 (over 2-years) and will be held in Manchester, UK (6 workshops) and in Oslo, Norway (2 workshops). There is individual supervision of cases on a regular basis with a nominated supervisor who is an expert in MCT. The supervision process is implemented by a supervision log administered via email. Workshops will be held four times a year and further group supervision is provided at these events.

The program consists of the following 2-day workshops:

  I.   MCT: Theory and Foundation Treatment Skills (presented by A.Wells and H.M. Nordahl)
  II.   MCT for GAD (A. Wells)
  III. MCT for Social phobia and Avoidant Personality Disorder (A. Wells & H.M.Nordahl)
  IV. MCT for PTSD and trauma (A. Wells & H.M.Nordahl)
  V.   MCT for OCD (P.Fisher)
  VI. MCT for Chronic depression (A. Wells)
  VII. MCT for Borderline PD (H. M. Nordahl)
  VIII. MCT for Psychosis (T. Morrison)

Each participant in training is allocated a study partner, who acts as a buddy. Your buddy is one of the other colleagues in training at the MCT Master-class, and the two of you will work as a team encouraging and supporting each other's personal and professional growth. On the first gathering you will meet your selected training buddy. All participants must attend at least 6 workshops in order to get the course accepted. In addition every participant must submit a tape of an MCT session at the mid-point of training for feedback and evaluation. It is a course requirement that participants submit a minimum of 10 completed supervision logs that have been implemented by email before they can have the course accepted.

The fee for participation is GBP 4.850 for the whole program. This includes the workshops, supervision, equipment, handouts and materials provided at the venues. Expenses such as travel and accommodation and some lunches and beverages' must be covered by the participant.

The best way to access more information is through the web site: www.mct-institute.com
You can apply to the MCT Master-class by submitting your CV by 1st January 2012. Applications should be submitted to Mrs Lene Finnerud, post@kognitiv.no

 For more information Contact: Dr Hans M. Nordahl, E-mail: hmor-n@online.no