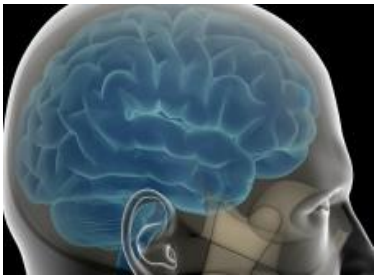
MANCHESTER



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Second International Conference of Metacognitive Therapy

Programme and Abstracts

Conference 25th-26th April 2013

Pre-Congress Workshops 24th April 2013

Venue: Manchester Town Hall

Sponsored by:

MCT INSTITUTE

Contents

Second International Conference of Metacognitive Therapy

Manchester Town Hall: 24th-26th April 2013

Conference Organising Committee:
Prof. Adrian Wells, Manchester
Prof. Hans M. Nordahl, Trondheim
Dr. Karin Carter, Manchester
Dr. Kirsten McNicol, Manchester

Scientific Committee:
Prof. Adrian Wells (Co-Chair), Manchester
Prof. Hans Nordahl (Co-Chair), Manchester
Dr. Yasmine Nassif (Secretary), London
Dr. Karin Carter, Manchester
Prof. Graham Davey, Sussex
Dr. Peter Fisher, Liverpool
Dr. Costas Papageorgiou, Altrincham

Dear Delegates,

A very warm welcome to Manchester and the second International Conference of Metacognitive Therapy. This conference aims to build on the success of the first conference held in 2011. We have chosen Manchester a second time for the venue based on feedback and recommendations made by delegates attending the last event. Once again this is a truly international event with delegates from countries including United Kingdom, Norway, Denmark, Poland, Sweden, United Arab Emirates, United States, Turkey, Australia, Italy, New Zealand, Germany, Faroe Islands, Ireland, China and Switzerland.

The scientific programme covers a broad range of psychological disorders and processes. There are keynote addresses and the addition of master-clinician presentations and poster sessions alongside the symposia and open-papers to maximise exposure to new research, developments and skills. We also have a roundtable discussion with leaders in state-of-the-art therapy modalities who will debate the distinctive features and futures of treatment.

In our role as co-chairs of the scientific and organising committees we have been very impressed by the large number of submissions to the conference and we would like to thank all members of the scientific committee who have acted as reviewers of submissions to the scientific programme. We believe the result represents a diverse and rich mixture of data and practice principles across disorders that is a window to the latest scientific and conceptual developments in the field.

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.

Adrian Wells
Hans M. Nordahl

GENERAL INFORMATION

Registration

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

Wednesday 24th April, 08.00-13.00	Pre-Congress Workshops
Thursday 25th April, 08.00-15.00	Conference
Friday 26th April, 08.00-14.00	Conference

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 (10.20am) on Thursday 25th April. Delegates are free to view the posters at any time during the conference. Authors should attend their posters and be available for discussion during the refreshment breaks.

Exhibition Area

The book exhibition will be held throughout the conference. 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, coffee and biscuits 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. Fresh drinking water is available at the back of the conference hall.

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

Conference Reception and Party

A wine reception, buffet and live music have been arranged for Thursday 25th April and will take place in the Great Hall. If you have pre-booked your attendance you will find a ticket in your conference folder. If you have not and you would like to attend you can purchase a ticket from the conference registration desk. To reduce the cost this event has been subsidised by the MCT institute. Please join us at 7.15pm for a glass of wine, followed by a buffet and live music. The buffet includes vegetarian and

non-vegetarian foods. 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: Dr Kirsten McNicol, MCT-Institute Ltd. Email: kirstenmcnicol@hotmail.com. Tel: + 44 7949 783305.

MCT Conference: Overview

Pre-congress skills-based half-day workshops (24th April):

Leader	9.00-12.30	2.00-5.30
Adrian Wells	GAD & Worry	PTSD & Trauma
Costas Papageorgiou	Depression	Depression (repeat)
Hans Nordahl	Borderline PD	Borderline PD (repeat)
Peter Fisher	OCD	Treating Distress in Cancer Patients
Tea/coffee	**10.30-11.00**	**3.30-4.00**

Conference (25th & 26th April):

Keynote Addresses	**Master Clinician**	**Open Papers**
Symposia	**Roundtable Discussion**	**Posters**

Time	Day 1: 25 April	Day 2: 26 April
9:00	**Keynote 1** **Adrian Wells** Attention Training and Detached Mindfulness: Changing Perspectives using Metacognitive Control	**Master Clinician Presentation** **Rob Zettle** Acceptance and Commitment Therapy
9:40	**Symposium 1** Metacognitive Theory and Therapy in Children and Adolescents	**Symposium 3** MCT for Depression: Individual and Group Treatment Outcomes
10:20	Tea & coffee *(poster session)*	Tea & coffee *(poster session)*
11:00	**Keynote 2** **Steven Hollon** CBT in the Treatment and Prevention of Depression	**Roundtable Discussion** MCT, ACT & CBT: Distinctive Features & Futures? (Fisher, Hollon, Leahy, Wells, Zettle)
11:40	**Open Papers** • Rumination and avoidance (Thomas) • Social Phobia and ATT (Vogel) • A RCT of MCT for Depression (Jordan)	**Symposium 4** Metacognitive Factors and Treatment Applied to People with Psychosis
12:20	Lunch	Lunch
2:00	**Master Clinician Presentation** **Costas Papageorgiou** Delivering Effective Meta Cognitive Therapy for Depression in Groups	**Master Clinician Presentation** **Robert Leahy** Emotional Schema Therapy
2:40	**Open papers** • Metacognition & Family Distress in	**Open papers** • Metacognition & health anxiety (Bailey)

	Psychosis (Jansen) • Temperament & Metacognition (Dragan) • MCT for health anxiety (Bailey)	• ATT & Trauma Symptoms (Callinan) • Metacognition, GABA & Panic (Zurowski)
3:20	Tea & coffee *(poster session)*	Tea & coffee *(poster session)*
3:50	**Master Clinician Presentation** **Hans M Nordahl** Principles and Effects of MCT in Borderline Personality Disorder: The ERIS Protocol	**Keynote 4** **Peter Fisher** Translating Metacognitive Theory and Therapy to Emotional Distress in Cancer Patients
4:30	**Symposium 2** OCD: Metacognitive Modification and Symptom Change	**Symposium 5** Predictors of Treatment Outcome: Therapist Competence and Client Metacognition
5:10	**Keynote 3** **Graham Davey** Mood and Perseverative Thinking	**Keynote 5** **Marcantonio Spada** A Triphasic Metacognitive Formulation of Problem Drinking --- **Closing Address**
7:15	Buffet, Live Music & Late Bar	

Pre-Congress Workshops 24th 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 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.

How to Treat Chronic Uncontrollable Worry with MCT: Application to Generalized Anxiety Disorder (GAD) and Beyond

 Adrian Wells, University of Manchester, UK

Difficult to control worrying is a predominant feature of GAD but according to the metacognitive model it is also a feature of many disorders. Metacognitive therapy is a

proven and highly effective treatment for GAD. This workshop presents the metacognitive formulation of worry in the treatment of GAD. Participants will learn how to use the GAD model as a basis of case formulation and how to use specific MCT techniques to modify thought-control strategies and underlying metacognitive beliefs in order to bring worry under effective control. The workshop will show how the basic principles of MCT can be applied to worry in other disorders including health-anxiety and social anxiety disorder.

Workshops participants will learn:

1. The metacognitive model of worry and GAD
2. How to formulate GAD using a disorder-specific model
3. Techniques for developing adaptive mental control
4. Techniques for modifying metacognitive beliefs
5. The application of treatment to other high-worry populations

Reference:

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

Metacognitive Therapy for Depression


Costas Papageorgiou, The Priory Hospital, Altrincham, UK

Preliminary empirical evidence supports the implementation of metacognitive therapy (MCT) for depression in individual (Wells et al., 2009, 2012) and group (Dammen, Papageorgiou & Wells, 2013; Papageorgiou & Wells, 2013) formats to maximise therapeutic effectiveness and prevent the relapse and recurrence of this common and disabling problem. MCT for depression aims to remove the metacognitive causes of rumination, which is a core process implicated in the maintenance and recurrence of depression. The overall objective of this skills-based clinical workshop is to outline the components of metacognitive therapy for rumination and depression (Wells, 2009; Wells & Papageorgiou, 2004) and include the following areas: 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. At the end of the workshop, participants are expected to gain up-to-date knowledge of the link between rumination and depression, understand the metacognitive model and therapy of depressive rumination, and become familiar with the assessment, conceptualisation, and treatment of rumination in depression. A

combination of lecture, discussion, experiential, role-plays, and case presentations will be used to facilitate the workshop.

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Treatment of Patients with Borderline Personality Disorders: The ERIS Protocol

Hans M. Nordahl, Norwegian University of Science and Technology, Norway

The presentation will introduce the treatment principles and techniques used in the ERIS protocol for treatment of patients suffering with borderline personality disorder. The ERIS protocol consists of individual and systemic interventions targeting various domains of problems. The ERIS protocol has a brief and intermittent format targeting the patient's self-regulatory problems and maladaptive strategies. The individual intervention focuses on three domains:

1. The patient's vulnerability for deprivation and abandonment in interpersonal settings.
2. The self-regulatory problems causing emotional and behavioural instability and poor impulse control.
3. The maladaptive coping styles such as self-harming behaviours, withdrawal/attacking behaviours and sustained worry and rumination related to issues of control and abandonment.

The systemic interventions integrate community health services and the social network in the treatment. Techniques that are designed to deal with the metacognitions and angry ruminations are very powerful in the treatment of borderline personality disorder and illustrations and useful MCT techniques will be demonstrated and practiced in role plays. The workshop includes case conceptualisation; socialisation techniques; techniques and strategies for dealing with self-harming behaviours, anger and emotional instability, rumination and worry; modifying old strategies and implementing alternative strategies; reducing vulnerability and relapse prevention.

Reference: Literature will be provided at the workshop

Metacognitive Therapy for Obsessive Compulsive Disorder


Peter Fisher, University of Liverpool, UK

Metacognitive Therapy (MCT) is based on an information processing model of psychopathology (Wells & Matthews, 1994). At the heart of the model is a specific thinking style, called the cognitive attentional syndrome (CAS). The CAS is characterised by high levels of worry/rumination, unhelpful attentional strategies and counterproductive coping strategies. Each component of the CAS is guided by metacognitive beliefs and knowledge. In this workshop, the metacognitive model and treatment of OCD will be described in detail.

Participants will have the opportunity to develop assessment and case formulation skills as well as a range of metacognitively focused treatment strategies for each disorder subtype. 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 to facilitate the development of MCT skills for OCD

References:

Books

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

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

Journal Articles:

Fisher, P.L. (2009). Obsessive Compulsive Disorder: A comparison of CBT and the metacognitive approach. International Journal of Cognitive Therapy 2(2).

Fisher, P. L., & Wells, A. (2008). Metacognitive therapy for obsessive compulsive disorder: A case series. Journal of Behavior Therapy and Experimental Psychiatry, 39(2), 117-132.

Treating Post-Traumatic Stress Disorder (PTSD) with Metacognitive Therapy


Adrian Wells, University of Manchester, UK

One of the major advantages of the metacognitive therapy approach to trauma is that it delivers effects quickly and it avoids the need for repeated or prolonged reliving and reviewing of the trauma narrative. In this workshop the metacognitive model of traumatic stress reactions will be presented and participants will learn how to use it to formulate and to guide the intervention. Participants will be guided through the stages of the treatment and will learn the most effective techniques for correcting the thinking styles that block adaptation. The workshop will focus on how to modify the underlying metacognitions that control patient fixation on threat in the aftermath of trauma.

Workshops participants will learn:

1. The metacognitive model of PTSD
2. How to formulate PTSD using the disorder-specific model
3. Techniques for removing maladaptive thinking styles
4. Techniques for modifying metacognitive beliefs
5. Strategies of relapse prevention

Reference:

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

Metacognitive Therapy for Emotional Distress in Cancer


Peter Fisher, University of Liverpool, UK

Emotional distress in the form of anxiety, depression, and post-traumatic stress is common in cancer patients. In this workshop, the application of metacognitive therapy (MCT) to alleviating emotional distress in cancer patients will be illustrated. MCT is derived from a trans-diagnostic model of metacognitive processes in psychopathology. This model asserts that emotional disorders are maintained by the cognitive-attentional syndrome (CAS) which involves three processes: (i) perseverative thinking (worry and rumination); (ii) attentional strategies (monitoring

for signs of potential threat); and (iii) counterproductive coping strategies (e.g. thought suppression and avoidance). In cancer patients, multiple factors may temporarily activate the CAS, e.g. uncertainty over diagnosis to fears of recurrence. For most patients, resulting worry and rumination are transient but, in depressed or anxious individuals, sustained rumination (e.g. about the diagnosis) or worry (e.g. about what will happen in future) occurs. The S-REF model specifies how such perseverative thinking is activated and maintained by metacognitive beliefs. Similarly, the S-REF model explains how threat monitoring (e.g. scanning for symptoms or for negative thoughts) is also driven by metacognitive beliefs. Each aspect of the CAS and the supporting metacognitive beliefs require modification to successfully alleviate emotional distress.

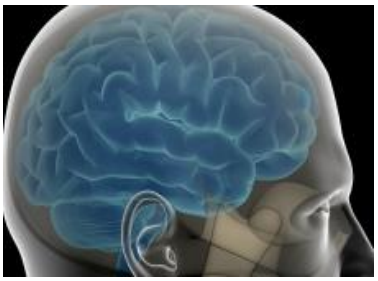
This workshop will illustrate how MCT can be used to treat anxiety, depression and trauma related symptoms in cancer patients and how MCT represents a distinct therapeutic approach. Participants will learn how to use the generic metacognitive formulation of psychopathology with cancer patients. Socialisation strategies, and verbal and behavioural reattribution methods to modify metacognitive beliefs and processes will be demonstrated.

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., & Wells, A. (2009). Metacognitive Therapy: Distinctive Features. Hove: Routledge.

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



Symposia

Symposium 1:
Metacognitive Theory and Therapy in Children and Adolescents

Convenors: Samuel Myers, University of Manchester & Charlotte Wilson, Trinity College, Dublin, Republic of Ireland
Chair: Samuel Myers, University of Manchester, UK

1. **The Metacognitions Questionnaire and its derivatives in children and adolescents: A systematic review and meta-analysis**

   Samuel Myers, University of Manchester
   Adrian Wells, University of Manchester

2. **Developmental differences in meta-cognitive beliefs about worry**

   Charlotte Wilson, Trinity College, Dublin, Republic of Ireland

3. **A pre-pilot study of metacognitive therapy for children with Generalized Anxiety Disorder**

   Nicole Lønfeldt, University of Copenhagen, Denmark
   Barbara Hoff Esbjørn, University of Copenhagen, Denmark
   Sara Kerstine Nielsen, University of Copenhagen, Denmark
   Maja Tyle, University of Copenhagen, Denmark
   Nicoline Normann, University of Copenhagen, Denmark

4. **Metacognitive beliefs in adolescents with sub-threshold psychotic symptoms**

   Patrick Welsh, Durham University, UK & Tees, Esk and Wear Valleys NHS Foundation Trust
   Sam Cartwright-Hatton, University of Sussex, UK
   Adrian Wells, University of Manchester, UK
   Libby Snow, University of Sussex, UK
   Paul A. Tiffin, Durham University, UK

Symposium 2:
Obsessive Compulsive Disorder: Metacognitive Modification and Symptom Change

Convenor & Chair: Peter Fisher, University of Liverpool, UK

1. **An experimental manipulation of metacognition: A test of the metacognitive model of obsessive-compulsive symptoms**

   Samuel Myers, University of Manchester, UK
   Adrian Wells, University of Manchester, UK

2. **MCT for OCD adapted to children under 10 years of age – a case series**

   Michael Simons, RWTH Aachen University, Germany

3. **An open trial of group metacognitive therapy for OCD**

   Peter Fisher, University of Liverpool, UK
   Adrian Wells, University of Manchester, UK

Symposium 3:
Metacognitive Therapy for Depression: Individual and Group Treatment Outcomes

Convenor and Chair: Costas Papageorgiou, The Priory Hospital, Altrincham, UK

1. **MCT for depression: Nature and preliminary outcomes in chronic and treatment resistant cases**

   Adrian Wells, University of Manchester, UK

2. **An open trial of the effectiveness of group MCT for patients with depression**

   Toril Dammen, University of Oslo, Norway

3. **An evaluation of group MCT for antidepressant and CBT resistant depression**

   Costas Papageorgiou, The Priory Hospital, Altrincham, UK

Symposium 4:
Understanding Metacognitive Factors and the Application of Metacognitive Therapy for People with Psychosis.

Convener & Chair: Sophie Parker, Greater Manchester West Mental Health NHS Foundation Trust, UK

1. **Schizophrenia and metacognition: An investigation of course of illness and metacognitive beliefs and processes within a first episode psychosis cohort, 10 years after diagnosis.**

   Stephen F. Austin, Aarhus University, Denmark
   Ole Mors, Aarhus University, Denmark
   Roger Hagen, Norwegian University of Science & Technology, Norway
   Morten Hesse, Aarhus University, Denmark
   Adrian Wells, University of Manchester, UK
   Marcantonio Spada, London South Bank University, UK
   Rikke G. Secher, University of Copenhagen, Denmark
   Carsten Hjorthøj, University of Copenhagen, Denmark
   Merete Nordentoft, University of Copenhagen, Denmark

2. **Metacognitive therapy in people with a schizophrenia spectrum diagnosis and medication resistant symptoms: A feasibility study**

   Nicola Chapman, Greater Manchester West NHS Mental Health Foundation Trust, UK
   Sophie K. Parker, Greater Manchester West NHS Mental Health Foundation Trust, UK
   Anthony P. Morrison, University of Manchester, UK & Greater Manchester West NHS Mental Health Foundation Trust, UK
   Melissa Wardle, Greater Manchester West NHS Mental Health Foundation Trust, UK
   Paul French, Greater Manchester West NHS Mental Health Foundation Trust, UK
   Adrian Wells, University of Manchester, UK & Norwegian University of Science & Technology, Norway

3. **Treating worry in paranoia**

   Katherine Pugh, Oxford University, UK
   Daniel Freeman, Oxford University, UK
   David Kingdon, University of Southampton, UK
   Helen Startup, University of Manchester, UK
   Graham Dunn, University of Manchester, UK
   Emma Cernis, Oxford University, UK
   Jacinta Cordwell, University of Southampton, UK
   Gail Wingham, University of Southampton, UK

Symposium 5:
Predictors of Treatment Outcome: Therapist Competence and Client Metacognition

Convenor: Adrian Wells, University of Manchester, UK
Chair: Hans M. Nordahl, Norwegian University of Science and Technology, Norway

1. **Basic therapy skills as a predictor of treatment outcome in MCT for social phobia**

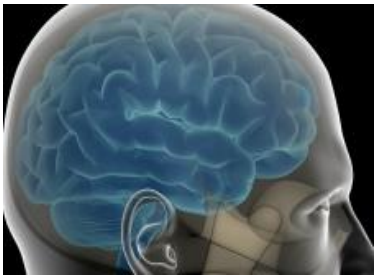
   Truls Ryum, Norwegian University of Science and Technology, Norway
   Patrick A. Vogel, Norwegian University of Science and Technology, Norway
   Roger Hagen, Norwegian University of Science and Technology, Norway
   Odin Hjemdal, Norwegian University of Science and Technology, Norway
   Adrian Wells, University of Manchester, UK & Norwegian University of Science and Technology, Norway
   Hans M. Nordahl, Norwegian University of Science and Technology, Norway

2. **Metacognitions as predictors of outcome in a randomized controlled treatment trial of GAD and their relationship with resilience**

   Odin Hjemdal, Norwegian University of Science and Technology, Norway
   Roger Hagen, Norwegian University of Science and Technology, Norway
   Leif E. O. Kennair, Norwegian University of Science and Technology, Norway
   Stian Solem, Norwegian University of Science and Technology, Norway
   Adrian Wells, University of Manchester, UK & Norwegian University of Science and Technology, Norway
   Hans Nordahl, Norwegian University of Science and Technology, Norway

3. **Metacognition in generalized anxiety disorder, social phobia, and obsessive-compulsive disorder and relationship with treatment outcome**

   Stian Solem, Norwegian University of Science and Technology, Norway
   Kristen Hagen, Norwegian University of Science and Technology, Norway
   Bjarne Hansen, Norwegian University of Science and Technology, Norway
   Patrick A. Vogel, Norwegian University of Science and Technology, Norway
   Roger Hagen, Norwegian University of Science and Technology, Norway
   Odin Hjemdal, Norwegian University of Science and Technology, Norway
   Adrian Wells, University of Manchester, UK & Norwegian University of Science & Technology, Norway
   Leif E. O. Kennair, Norwegian University of Science and Technology, Norway
   Hans M. Nordahl, Norwegian University of Science and Technology, Norway



Abstracts

Keynote Addresses

Keynote 1:
Attention Training and Detached mindfulness: Changing Perspectives using Metacognitive Control

Adrian Wells, University of Manchester, UK

The perspective we occupy in relation to our own thoughts doesn't change as often as it could. Modern day psychotherapy has helped to cement a singular perspective on cognition as exemplified by the principle: 'the power of positive thinking'. Keeping patients and therapists preoccupied with mental content, the importance of thoughts and their relationship with reality. Metacognitive therapy (MCT) is based on a different model of the mind as it relates to self-regulatory processing and psychological disorder. It stresses the need to change the perspective taken in relation to thoughts and the need to reduce the over-importance given to them. Metacognitive therapy is based on the principle that in order to change mental suffering we need a more profound change of mind - a change in how we directly experience and regulate our own minds and what we believe about them. One way this is achieved in MCT is through the process of metacognitive control. This keynote illustrates metacognitive control using attention training and detached mindfulness and how they relate to the practise and goals of treatment for psychological disorders. Data from studies of specific metacognitive control strategies and implications for their effective use in treatment will be considered.

Background Reading:

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

Wells, A. (2007). The attention training technique: Theory, effects and a metacognitive hypothesis on auditory hallucinations. Cognitive and Behavioral Practice, 14, 134-138.

Wells, A. (2005). Detached mindfulness in cognitive therapy: A metacognitive analysis and ten techniques. Journal of Rational-Emotive & Cognitive-Behavior Therapy, 23, 337-355

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Keynote 2:
Cognitive Behavior Therapy in the Treatment and Prevention of Depressions


Steven Hollon, Vanderbilt University, USA

The cognitive and behavioral therapies (CBT) are to be preferred to antidepressant medications as the first-line treatment for most patients with nonpsychotic unipolar depression. Placebo-controlled trials indicate that CBT can be as efficacious as medications when adequately implemented and patients who respond to CBT are about half as likely as patients who respond to medication to relapse following treatment termination. Given this enduring effect, CBT is likely to prove more cost-efficient than medication over time. Severity appears to be an important moderator of specificity of response to medications, which do not separate from pill-placebo among patients with less severe depressions. This means that at least half the patients with major depression derive no pharmacological benefit from taking medications and none of the enduring effect that they get from CBT. Patients who can best perform specific skills learned in CBT are least likely to relapse following treatment termination and insight into the causal role of cognition precedes sudden gains in treatment that predicts freedom from subsequent relapse. Adding CBT to medications enhances response for patients with more severe or less chronic depressions and the incidence of severe adverse events and risk for suicide both appear to be reduced for patients treated with CBT relative to medication alone. There are even indications that CBT can prevent episode onset in at-risk adolescents. These findings suggest that CBT is to be preferred to medication as the first-line treatment for most patients with major depression.

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Keynote 3:
Stop Rules: Mood and Perseverative Thinking


Graham C. L. Davey, University of Sussex, UK

Worrying, checking and depressive rumination are all open-ended activities that appear to be controlled by implicit stop rules deployed by the individual. When worrying, checking and depressive rumination become pathological, the stop rules used are derived from metacognitive beliefs that the individual has developed about the usefulness of these activities. I will describe some studies across all of these psychopathologies that show how stop rules are linked to metacognitive beliefs and how these stop rules interact with current mood to determine perseveration and make the experiences of worrying, checking and ruminating seem uncontrollable.

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Keynote 4:
Translating Metacognitive Theory and Therapy to Emotional Distress in Cancer Patients


Peter Fisher, University of Liverpool, UK

Survival rates in cancer continue to improve, with now over 2 million adult cancer survivors in the UK, projected to increase to 4 million by 2030. Around 25% of survivors require treatment for clinical levels of emotional distress. Unfortunately, current psychological and pharmacological treatments are of comparable, but modest efficacy. Cancer patients prefer psychological treatments, but few have access to specialist psychological services. These factors equate to a pressing need to develop a more effective and efficient psychological intervention for cancer survivors.
In this keynote address, I will illustrate how metacognitive therapy (MCT), a highly promising psychological approach for emotional disorders, can be adapted to the needs of cancer patients. Recent research into psychological treatment in mental health has demonstrated the value of this theory-driven approach, whereby treatment targets the fundamental psychological processes responsible for emotional disorder. Therefore, by drawing on recent developments in metacognitive therapy and theory, it is possible to provide an intervention that is generalisable to cancer patients because it targets the processes underpinning their emotional distress. A series of studies will be presented which demonstrate the role of metacognitive processes and beliefs in emotional distress (anxiety, depression, posttraumatic stress symptoms) in young

adult survivors of cancer, and in breast and prostate cancer patients. An open trial evaluating metacognitive therapy for emotional distress in young adult survivors of cancer will also be presented and a case example used to demonstrate how MCT is applied in cancer patients.

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Keynote 5:
A Triphasic Metacognitive Formulation of Problem Drinking

Marcantonio M. Spada, London South Bank University, UK & North East London NHS Foundation Trust, UK

Drawing on metacognitive theory of psychological disorder it has been suggested that advances in the treatment of problem drinking may be gained from the development of formulations grounded on mental self-regulation principles. The basic premise of this approach is that alcohol is used as a metacognitive control strategy which becomes poorly regulated because of the activation of the Cognitive Attentional Syndrome (CAS) and impairments in metacognition caused by the chemical effects of alcohol. It is further proposed that these processes and associated metacognitive factors operate over a triphasic time-course in explaining drinking-related behaviours. The focus of this keynote talk will be on introducing this novel triphasic metacognitive formulation of problem drinking and its implications for treatment together with a summary of the evidence consistent with this approach.

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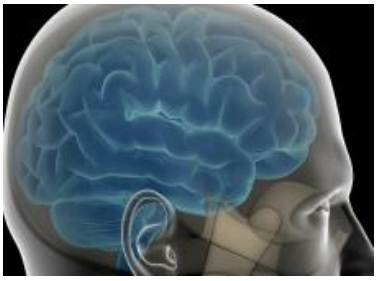

Master Clinician Presentations

Master Clinician 1:
Delivering Effective MCT for Depression in Groups


Costas Papageorgiou, The Priory Hospital, Altrincham, UK

To date, metacognitive therapy (MCT) for depression has been evaluated and practiced in an individual treatment format. However, from a conceptual perspective, MCT lends itself to be particularly applicable within a group approach not only because of its potential financial savings, a criterion often used in delivering group therapy, but also in view of its clinical effectiveness. In fact, it is argued that a group MCT modality can offer unique therapeutic opportunities, which may not always be readily available during individual treatment. In this presentation, evidence supporting the implementation of group MCT for depression will be described along with the strategies that have been found to be particularly effective in maximizing its delivery. These strategies will range from the basic structure of group MCT to the different components and techniques of this intervention within this therapeutic format. In addition, technique- versus process-driven factors will be discussed with reference to pre-group, in-group, and post-group stages of group MCT for depression. Conference delegates will be able to gain knowledge of the evidence and practice of MCT for depression in groups, become familiar with strategies used in optimizing its implementation, and avoid common pitfalls.

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Master Clinician 2:
Principles and Effects of Metacognitive Therapy in Patients with Borderline Personality Disorders: The ERIS Protocol


Hans M. Nordahl, Norwegian University of Science and Technology, Norway

The principles and techniques of the ERIS protocol, a metacognitive approach to borderline personality and the results of an open trial on patients will be presented. ERIS protocol describes individual and systemic interventions. The individual intervention focuses on three domains: 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 in the form of self-harming behaviours, withdrawal/attacking behaviour and sustained worry and rumination related to issues of control and abandonment. The systemic interventions integrate community health services and the social network in treatment. On an individual level techniques are aimed at modifying specific metacognitive beliefs, attentional flexibility, and angry and negative-self-focused ruminations. Cases will be used as illustrations and MCT techniques will be demonstrated. The ERIS protocol seems to be a promising program for patients with moderate and severe BPD. The results of the open trial indicate that this treatment can be brief and acceptable to patients.

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Master Clinician 3:
Acceptance and Commitment Therapy and the Unmotivated Client


Robert Zettle, Wichita State University, USA

Dealing with unmotivated, disengaged, and apathetic clients is a frequent clinical challenge in providing cognitive-behavioral therapies across a wide array of presenting complaints, particularly in working with clients who struggle with depression. The approach that acceptance and commitment therapy (ACT) takes in responding to “uncaring clients” will be discussed and illustrated. Specific techniques and strategies within ACT that are more unique and specific to the approach such as the identification and clarification of values and related activities, defusion at multiple levels of verbal constructions, and acceptance of sorrow will be emphasized.

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Master Clinician 4:
Emotional Schema Therapy


Robert L. Leahy, American Institute for Cognitive Therapy, USA

Emotional Schema Therapy is a meta-experiential cognitive model of individual "theory of emotions". Emotional schemas reflect the following dimensions of belief about emotions in self and others: durability, danger, need for control, complexity/contradiction, legitimacy, guilt, consensus with others, need for rationality, and expressiveness. In addition, these beliefs have implications for emotion regulation strategies, such as seeking support, avoidance, suppression, rumination, worry, blaming, acceptance, problem-solving and self-numbing. In this Master Class I will present an Emotional Schema Model that can be used in conceptualizing a tendency of some patients to maintain a superficial presentation in CBT. Using a case example of the treatment of a patient with borderline personality, I will describe how the therapist can confront the strategy of superficiality, distinguish between "back-stage" and "front-stage" selves, collaborate in conceptualizing its function for experiential avoidance and fear of emotion, and reverse the process so that deeper and more meaningful therapy can occur.

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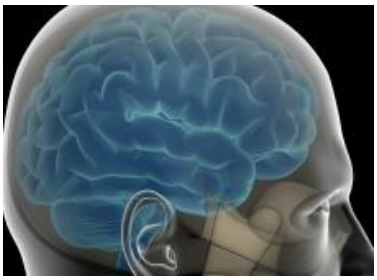


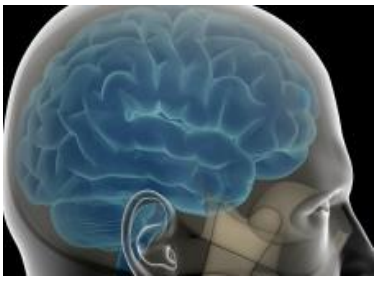
Roundtable Discussion

MCT, ACT, BA & CBT: Distinctive Features & Futures

Chair: *Peter Fisher, University of Liverpool, UK*
Speakers: *Steven Hollon, Vanderbilt University, USA*
Robert Leahy, American Institute for Cognitive Therapy, USA
Adrian Wells, University of Manchester, UK
Robert Zettle, Wichita State University, USA

Debate abounds as to the clinical and theoretical differences between leading psychological approaches to treating emotional disorders. This panel discussion

brings together experts on Acceptance and Commitment Therapy, Behavioural Activation, Cognitive Behaviour Therapy and Metacognitive Therapy with the aim of clarifying the distinctive features of the four treatments. The speakers will; i) describe the core psychological constructs which underpin and guide each treatment, ii) explain how the goals of each treatment are communicated to patients and iii) describe the unique techniques of each treatment. There will be the opportunity for audience members to pose questions during the panel discussion.



Symposia

Symposium 1:
Metacognitive Theory and Therapy in Children and Adolescents

Convenors: Samuel Myers, University of Manchester & Charlotte Wilson, Trinity College, Dublin, Republic of Ireland
Chair: Samuel Myers, University of Manchester, UK

Psychological models and treatments for psychological disorders in young populations have lagged behind developments in adults (see Field, Cartwright-Hatton, Reynolds, & Creswell, 2008). One possible solution to this problem is to apply recent adult models and treatments to children and adolescents. The Metacognitive Theory of psychopathology has a considerable evidence base in adult populations and there are a number of studies that suggest Metacognitive Therapy in adults may lead to significantly improved outcomes (see Wells, 2012 for a review). There has been a recent increase in studies examining the applicability of Metacognitive theory and therapy to young populations. This symposium brings together four presentations on this issue. Samuel Myers, in the first presentation, describes a systematic review and meta-analysis of studies that used the Metacognitions Questionnaire (MCQ-65; Cartwright-Hatton & Wells, 1997) or derivatives in children and adolescents. In the second presentation, Charlotte Wilson brings data from several studies to examine whether the meta-cognitive model of problematic worry could be applicable to both older and younger children. Nicole Lønfeldt in the third presentation reports on a preliminary study into the efficacy of group Metacognitive Therapy for GAD in children. In the final presentation, Patrick Welsh describes a study that compares metacognitions in adolescents at risk of psychosis, with controls. Overall, the results are supportive of the applicability of Metacognitive theory and therapy to young populations. However, they highlight the need for further research in several areas.

1. The Metacognitions Questionnaire and its derivatives in children and adolescents: A systematic review and meta-analysis

Samuel Myers, University of Manchester
Adrian Wells, University of Manchester

Background: A large number of studies with adult populations have used the Metacognitions Questionnaire (MCQ-65; Cartwright-Hatton & Wells, 1997) and its derivatives to test the relationships between metacognition and psychological disorders and symptoms proposed in the Self-Regulatory Executive Function Model (S-REF; Wells and Matthews, 1994). Results have supported the model and recent research has examined whether findings are applicable to children and adolescents. To explore this, a systematic review of studies that had used the MCQ or derivatives in young people (aged 18 or less) was carried out.
Method: Sixteen studies, with a combined total of 2206 participants, were identified and their findings examined. Meta-analyses were carried out to examine across-study findings on the relationship between the subscales and total-score of the MCQ and emotional symptom measures.
Results: Consistent with results in the adult literature the meta-analyses showed effect sizes ranging from medium to large. However, the review highlighted a number of areas in need of further research such as the psychometric properties of MCQ measures when used in this population.
Conclusions: Findings suggest that the S-REF model may be applicable to younger populations. Metacognitions may be an important area for research and psychological treatments of children and adolescents.

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2. Developmental differences in meta-cognitive beliefs about worry

Charlotte Wilson, Trinity College, Dublin, Republic of Ireland

Background: The metacognitive model of worry in adults has significant empirical support. However, much less is known about its validity in younger populations. There are compelling reasons for proposing that there might be differences in younger populations; metacognitive abilities in relation to cognitive processes such as memory only begin to be reliable from 7 years of age and increase over the following years.
Method: This presentation reports on five individual studies of children and adolescents; three studies qualitatively explored beliefs about worry, and three studies explored relationships with trait worry using questionnaire measures of metacognitions.
Results: Children as young as 6 could report positive and negative beliefs about worry, and the qualitative data suggested minimal differences. For example, children reported largely simple beliefs (e.g. worry gives me headaches), whereas adolescents reported more complex beliefs (e.g. worry stops bad things happening). Quantitative data also suggested minimal differences; trait worry was predicted by negative beliefs and cognitive monitoring in children, and by positive and negative beliefs in adolescents.
Conclusion: The meta-cognitive model of worry is likely to be as valid in younger populations as it is in older populations.

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3. A pre-pilot study of metacognitive therapy for children with Generalized Anxiety Disorder

Nicole Lønfeldt, University of Copenhagen, Denmark
Barbara Hoff Esbjørn, University of Copenhagen, Denmark
Sara Kerstine Nielsen, University of Copenhagen, Denmark
Maja Tyle, University of Copenhagen, Denmark
Nicoline Normann, University of Copenhagen, Denmark

Background: In collaboration with Professor Adrian Wells the Copenhagen Child Anxiety Project is developing a manual for Metacognitive Therapy (MCT) for children with GAD. Based on this work, the current study takes a preliminary look at the effect of a GAD-targeted treatment for children.
Method: MCT for adults was adapted for the use of children. Eight children, aged 11-12, attended 10 group therapy sessions and two family sessions with their parents. Additionally, parents attended two group sessions of psycho-education. Treatment was provided by a university research clinic in Denmark. Number of completers and feedback from parents and children were used to evaluate treatment acceptability. Diagnostic status, worry, and metacognitions related to worry were assessed before and after treatment for four children to gain preliminary insight into the efficacy of this treatment. The remaining four participants are pending post-treatment assessment.
Results: All families completed treatment. Feedback from parents was generally positive, whereas feedback from the children was more ambiguous. Suggested changes for the manual, based on participant feedback, will be discussed. Three children lost their GAD diagnosis; two reported less worry, and four endorsed fewer metacognitions
Conclusion: Preliminary evaluation of MCT for children justifies further development of the manual and pilot studies.

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4. Metacognitive beliefs in adolescents with sub-threshold psychotic symptoms

Patrick Welsh, Durham University, UK & Tees, Esk and Wear Valleys NHS Foundation Trust
Sam Cartwright-Hatton, University of Sussex, UK
Adrian Wells, University of Manchester, UK
Libby Snow, University of Sussex, UK
Paul A. Tiffin, Durham University, UK

Background: The Self-Regulatory Executive Function (S-REF) model suggests that metacognitive beliefs play a role in all forms of psychological disorder, including psychosis. However, our understanding of these beliefs and their relationship with symptoms in adolescents with an At-Risk Mental State for psychosis (ARMS) is limited.

Method: The Metacognitive Questionnaire-short form (MCQ-30) was administered to 31 adolescents (aged between 12-18 years) with an identified ARMS. Scores were subsequently compared to a control group of 76 adolescents drawn from a community population.
Results: As predicted ARMS patients scored significantly higher on metacognition subscales, with *Negative beliefs* (F =42.97, p=0.001), *Cognitive Confidence* (F=17.11, p=0.001) and *Need for control* (F =22.48, p=0.001) subscales of the MCQ-30 distinguishing them from the comparison group.
Conclusions: The finding that metacognitive beliefs are significantly elevated in comparison to a community sample of adolescents is in keeping with previous adult orientated research. Possible implications for clinical practice are discussed as well as the limitations of this study.

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Symposium 2:
Obsessive Compulsive Disorder: Metacognitive Modification and Symptom Change

Convenor & Chair: Peter Fisher, University of Liverpool, UK

Nearly 20 years ago, a prototypical model of obsessive compulsive disorder (OCD) was proposed based on the Self Regulatory Executive Function (S-REF) theory (Wells and Matthews, 1994). Subsequently, there have been a considerable number of investigations into the clinical and theoretical merits of the model including cohort, experimental and initial treatment studies. The studies have provided consistent empirical support for both the validity of the metacognitive model theory and the potential of metacognitive therapy in treating OCD. This symposium comprises three research papers which make further contributions to the burgeoning evidence base underpinning the metacognitive theory and therapy of OCD. The first paper presents an experimental manipulation which highlights the association between metacognitive beliefs and OCD symptoms. In the second paper, the adaptation of MCT for OCD in younger children is described and the final paper illustrates the potential efficacy of group MCT for adult OCD patients.

1. An experimental manipulation of metacognition: A test of the metacognitive model of obsessive-compulsive symptoms

Samuel Myers, University of Manchester, UK
Adrian Wells, University of Manchester, UK

Background: The metacognitive model of obsessive-compulsive symptoms (Wells, 1997) assigns a necessary causal role to metacognitive beliefs. The current study tested the model by evaluating the effects of experimentally manipulating such beliefs**.**
Method: A 2 X 2 factorial design was used. Thirty-two students with high and 32 students with low obsessional symptoms were subject to an experimental (metacognitive belief induction) or control (no metacognitive belief induction) condition. All participants underwent fake EEG recordings and were informed that the

EEG could sense hypothalamus activity caused by having thoughts related to drinking. Only participants in the experimental condition were told that if such thoughts were detected they may be exposed to an aversive noise.
Results: There was a significant interaction between level of obsessional symptoms and belief induction. In the high obsession group, participants in the experimental condition had significantly more intrusions about drinking, time spent thinking about these intrusions and discomfort from them, than controls. There were also significant main effects on some measures with higher scores in the experimental condition irrespective of levels of obsessional symptoms.
Conclusions: Results support the metacognitive model suggesting that specific metacognitive beliefs may be central concepts in understanding and treating OCD.

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2. MCT for OCD adapted to children under 10 years of age – a case series

Michael Simons, RWTH Aachen University, Germany

Background: Children under 10 years of age have been underrepresented relative to older children in existing OCD treatment trials. The treatment of choice so far is family-based CBT consisting of exposure and response prevention and parent training. In an earlier study, we used a hybrid of metacognitive and cognitive interventions in older children with OCD. The present case series utilized a purely metacognitive treatment for younger children combined with a new role play technique which helped to make the rather abstract concept of metacognition more concrete.
Method: Four children aged 7 to 9 years were consecutively treated with MCT. Diagnosis was confirmed with a structured clinical interview, in 3 cases the Children's Yale-Brown Obsessive Compulsive Scale (CY-BOCS) was obtained before and after treatment. The children suffered from aggressive, sexual, and "not-just-right" obsessions. MCT was usually conducted on a weekly basis and consisted of a shortened case formulation, socializing, detached mindfulness, and thought fusion experiments. Further, narrative role plays were conducted in which the children learned to disregard the obsessions' content and to answer them metacognively in the sense of detached mindfulness.
Results: MCT proved to be highly efficacious in rather short time. Within 4 to 12 sessions full remission of OCD symptoms was obtained.
Conclusions: The preliminary results show that a developmentally adapted metacognitive treatment could be effective in treating young children with OCD. Further studies are needed to prove these results and to examine if even younger (preschool) children could benefit from MCT.

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3. An open trial of group metacognitive therapy for OCD

Peter Fisher, University of Liverpool, UK
Adrian Wells, University of Manchester, UK

Background: OCD remains a difficult disorder to treat effectively with the majority of patients continuing to experience distressing symptoms following psychological and/or pharmacological treatment. There is evidently a need to develop more effective interventions and this study examines the potential efficacy of metacognitive therapy delivered in a small group format.
Method: An open trial with six months follow up was employed Nineteen (19) patients were recruited and treated in a small group format. Treatment was delivered Treatment was delivered by a single therapist and involved six to eight 2 hour sessions conducted over a maximum of 12 weeks. 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
Results: An intention to treat analysis (2 patients terminated therapy early) indicated that group MCT resulted in large pre to post treatment gains (ITT effect size on self-report Y-BOCS =2.42) which were largely maintained through to six month follow-up. Comparable magnitude of effect was observed on depressive and anxiety symptoms and metacognitive processes.
Conclusion: Group MCT for OCD could prove to be efficacious and cost effective psychological treatment.

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Symposium 3:
Metacognitive Therapy for Depression: Individual and Group Treatment Outcomes

Convenor and Chair: Costas Papageorgiou, The Priory Hospital, Altrincham, UK

Although cognitive-behaviour therapy is one of the most effective psychological treatments for depression, a significant proportion of patients either do not fully remit or they relapse and experience recurrences following this intervention. So, how can treatment effectiveness be maximized? A large number of empirical studies suggest that interventions should target core processes implicated in the maintenance and relapse/recurrence of depression. A key process shown to be implicated in the maintenance and relapse/recurrence of depression is rumination (Papageorgiou & Wells, 2004). Therefore, in order to maximize therapeutic effectiveness, metacognitive therapy (MCT) for depression (Wells, 2009; Wells & Papageorgiou, 2004) aims to remove the causes of rumination in depression. This symposium brings together some of the most recent attempts to evaluate the effectiveness of MCT for depression in individual and group treatment formats. The symposium will consist of three research presentations. In the first presentation, Adrian Wells will outline the components of MCT for depression and report evidence supporting its

implementation in individual treatment formats of patients with recurrent and persistent depression. Next, Toril Dammen will report a study investigating the effectiveness of group MCT for depression in a specialist psychiatric clinic in Norway. In the final presentation, Costas Papageorgiou will report the outcome of a preliminary evaluation of group MCT for depression in both antidepressant and CBT resistant depression in a hospital setting. Together, these studies attest to the growing evidence supporting the implementation of MCT for depression in individual and group formats.

1. MCT for depression: Nature and preliminary outcomes in chronic and treatment resistant cases

Adrian Wells, University of Manchester, UK

Background: MCT targets rumination, metacognition and mental control as the central factors in the treatment of depression. The basic principles and components of treatment will be described and data from two initial outcome studies presented.
Methods: The first study used an AB multiple baseline replication across 4 patients with recurrent and persistent MDD. The second study consisted of an open-trial of 12 patients presenting with treatment resistant depression. Across these studies patients received 5-8 sessions of MCT and were followed up for 6 or 12 months.
Results: Treatment was associated with substantial improvements in depression and anxiety symptoms and changes were evident in rumination and metacognition. High levels of objectively defined recovery rates were observed and they were maintained over follow-up. Using the Frank et al criterion (BDI $\leq$ 8 plus no longer meeting diagnostic criteria), 60% of the formerly treatment-resistant cases were recovered at post-treatment and 12m follow-up with a further 30% improved.
Conclusion: MCT appears to be an acceptable treatment that is well tolerated. The treatment could be delivered in a small number of sessions and was associated with high recovery rates and changes in underlying factors considered causal in the metacognitive model.

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2. An open trial of the effectiveness of group MCT for patients with depression

Toril Dammen, University of Oslo, Norway

Background: Initial data support the implementation of individual MCT for the treatment of depression. Given the transdiagnostic nature of MCT, we hypothesized that MCT would be a clinically effective intervention when delivered within a group format. In this presentation, an open trial of the effectiveness of group MCT for depression will be described.
Methods: The participants were eleven patients who had been consecutively referred by their family physician to a specialist psychiatric practice. Following assessment and screening, all of the patients were monitored in a baseline period before attending 2-hour weekly treatment sessions of group MCT for ten weeks. The primary symptom outcome measure was severity of depression whilst secondary outcome measures included levels of anxiety, rumination, and metacognitive beliefs. We also assessed

the clinical significance of treatment outcomes and number of comorbid Axis I and Axis II diagnoses.
Results: Large clinically significant improvements across all measures were detected at post-treatment and these were maintained at follow up. Based on objectively defined recovery rates all patients were classifed as recovered at post-treatment and 91% at 6 months follow up. The intervention also led to significant reductions in comorbid diagnoses.
Conclusion: These preliminary data contribute to the growing evidence supporting the use of MCT in the treatment of depression and it extends its clinical application to group formats as a potential cost-effective intervention.

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3. An evaluation of group MCT for antidepressant and CBT resistant depression

Costas Papageorgiou, The Priory Hospital, Altrincham, UK

Background: A common approach to managing resistance to antidepressants involves combining these treatments with CBT. Despite this, a large proportion of patients remain symptomatic or experience a relapse/recurrence of depression. This form of severe treatment-resistance is associated with significant distress, disability and impairments. This presentation will describe a preliminary evaluation of the clinical and cost effectiveness of group MCT for patients who had not responded to both antidepressants and CBT.
Methods: Ten patients with severe treatment-resistant depression were consecutively referred to the group MCT evaluation. Following a baseline period, patients attended 2-hour weekly treatment sessions for 12 consecutive weeks and were followed up at 3 and 6 months. Our primary outcome measure was rates of recovery as defined by Frank et al (1991). Levels of depression, anxiety, rumination and metacognitive beliefs were assessed at pre-treatment, post-treatment and follow-up.
Results: Following a stable baseline period, the group MCT led to significant improvements across all measures. These gains were maintained at follow-up. Analyses of rates of recovery revealed that 70% of patients were classified as recovered at both post-treatment and 6 months follow-up. In addition, there were reductions of comorbid diagnoses following the intervention.
Conclusion: These preliminary results support the implementation of group MCT for severe treatment-resistance depression as a clinical and cost effective intervention. The results also highlight the potentially enhanced effect of delivering MCT for depression in a group format.

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Symposium 4:
Understanding Metacognitive Factors and the Application of Metacognitive Therapy for People with Psychosis.

Convener & Chair: Sophie Parker, Greater Manchester West Mental Health NHS Foundation Trust, UK

This symposium aims to explore the role of metacognitive factors in people with psychosis and the possible applicability of MCT for people with psychosis. 3 presentations will be given outlining metacognitive factors involved in the course of psychosis over a 10 year follow-up period, the application of metacognitive therapy in a group of people with psychosis in a feasibility study and the application of a large RCT targeting worry as a key mechanism of change for people with paranoia. Presentations will be given by Stephen Austin (Aarhus University, Denmark), Nicola Chapman (Greater Manchester West Mental Health NHS Foundation Trust, UK) and Katherine Pugh (Oxford University, UK).

1. Schizophrenia and metacognition: An investigation of course of illness and metacognitive beliefs and processes within a first episode psychosis cohort, 10 years after diagnosis.

Stephen F. Austin, Aarhus University, Denmark
Ole Mors, Aarhus University, Denmark
Roger Hagen, Norwegian University of Science & Technology, Norway
Morten Hesse, Aarhus University, Denmark
Adrian Wells, University of Manchester, UK
Marcantonio Spada, London South Bank University, UK
Rikke G. Secher, University of Copenhagen, Denmark
Carsten Hjorthøj, University of Copenhagen, Denmark
Merete Nordentoft, University of Copenhagen, Denmark

Background: Metacognitive beliefs guide cognitive and behavioural responses to cognitive experiences. The Self Regulatory Executive Function model (S-REF) implicates maladaptive metacognitive beliefs and processes in the predisposition and/or maintenance of positive psychotic symptoms. This study examined the relationship between course of illness and levels of specific metacognitions in schizophrenia spectrum disorders.
Method: A total of 578 people with first episode psychosis recruited from the OPUS trial (1988-2000) were invited to participate in the study. Information about course of illness (remitted, episodic or continually psychotic) and current metacognitive beliefs was collected.
Results: Participants (n=367) revealed significant correlations between delusions and hallucinations and all types of maladaptive metacognitions. Levels of maladaptive metacognition varied as a function of course of illness. Metacognitive beliefs explained 12% of the variance displayed in course of illness in a multinomial regression analysis. Need to control thoughts metacognitive beliefs (RR 1.14, 95%C.I 1.05-1.24, $p<0.001$) predicted continually psychotic symptoms.
Conclusions: Elevations in metacognitive beliefs were associated with the severity and duration of psychotic symptoms, consistent with the S-REF model. If these

associations are shown to be causal, clinical interventions that modify metacognitive beliefs may also impact on positive symptoms and course of illness within schizophrenia.

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2. Metacognitive therapy in people with a schizophrenia spectrum diagnosis and medication resistant symptoms: A feasibility study

Nicola Chapman, Greater Manchester West NHS Mental Health Foundation Trust, UK
Sophie K. Parker, Greater Manchester West NHS Mental Health Foundation Trust, UK
Anthony P. Morrison, University of Manchester, UK & Greater Manchester West NHS Mental Health Foundation Trust, UK
Melissa Wardle, Greater Manchester West NHS Mental Health Foundation Trust, UK
Paul French, Greater Manchester West NHS Mental Health Foundation Trust, UK
Adrian Wells, University of Manchester, UK & Norwegian University of Science & Technology, Norway

Background: CBT for psychosis has been shown to be effective when delivered in combination with antipsychotic medication, but there are recent suggestions that it is less efficacious than initial meta-analyses have concluded. Metacognitive therapy (MCT) has led to positive results in other disorders, but has yet to be evaluated in people with schizophrenia spectrum diagnoses. This study evaluates the feasibility of MCT for people with psychosis.
Method: 10 participants received up to 12 sessions of MCT in an open trial. Outcomes included psychiatric symptoms measured using the PANSS, at baseline, 9 months (end of treatment) and at 12 months (follow-up), as well as dimensions of hallucinations and delusions, emotional dysfunction, self-rated recovery and social functioning. We also assessed hypothesised mechanisms of change such as metacognitive beliefs.
Results: Significant beneficial effects on several outcomes were seen at end-of-treatment and follow-up and effect sizes were moderate to large. 50% and 40% of participants achieved at least a 25% reduction in PANSS total scores by end of therapy and follow-up, respectively. Several of the hypothesised mechanisms significantly changed over treatment and follow-up periods, and reductions in negative metacognitive beliefs were related to improvements on outcome measures.
Conclusions: This study provides preliminary evidence that MCT is a feasible treatment for people with psychosis, and effectiveness data is encouraging. It also shows that hypothesised mechanisms of change were altered and that such changes are associated with outcomes.

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3. Treating worry in paranoia

Katherine Pugh, Oxford University, UK
Daniel Freeman, Oxford University, UK
David Kingdon, University of Southampton, UK
Helen Startup, University of Manchester, UK
Graham Dunn, University of Manchester, UK
Emma Cernis, Oxford University, UK
Jacinta Cordwell, University of Southampton, UK
Gail Wingham, University of Southampton, UK

Background: Persecutory delusions are the most distressing type of delusion. They are the most likely to be acted upon, are associated with suicide, and are a predictor of admission to psychiatric hospital. Existing treatments are only partially effective. A way to improve treatment is to target the key mechanisms causing delusions to persist. Recent research has identified worry as a key factor in maintaining persecutory delusions. In a pilot study, a brief cognitive-behavioural intervention targeting worry in patients with psychosis led to large reductions in both worry and persecutory delusions. This has led to a larger and more rigorous evaluation of the intervention (Freeman et al., 2012).
Method: 150 participants currently experiencing persecutory delusions will be recruited to the Worry Intervention Trial (WIT). 75 will be randomised to treatment as usual and 75 will be randomised to the six session cognitive-behavioural intervention focused on reducing worry. Recruitment to the trial is half way complete.
Results/Discussion: In this talk the rationale for the treatment will be explained and the components of the intervention will be described, including normalising the experience of worry, assessing and reviewing metacognitive beliefs about worry, the use of worry periods and emotional expression. The results of the trial will be known in 2014.

Freeman, D., Dunn, G., Startup, H. & Kingdon, D. (2012). The effects of reducing worry in patients with persecutory delusions: study protocol for a randomized controlled trial. *Trials*, 13, 223.

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Symposium 5:
Predictors of Treatment Outcome: Therapist Competence and Client Metacognition

Convenor: Adrian Wells, University of Manchester, UK
Chair: Hans M. Nordahl, Norwegian University of Science and Technology, Norway

This symposium brings together three papers examining the correlates of treatment outcome across a range of disorders. The relationship between therapist competency and outcome in social phobia treatment, and data on the client metacognitive predictors of outcomes across generalized anxiety, social phobia, and OCD will be presented. The results address the importance of therapist skill level and changes in metacognitive factors as determinants of effective treatment.

1. Basic therapy skills as a predictor of treatment outcome in MCT for social phobia

Truls Ryum, Norwegian University of Science and Technology, Norway
Patrick A. Vogel, Norwegian University of Science and Technology, Norway
Roger Hagen, Norwegian University of Science and Technology, Norway
Odin Hjemdal, Norwegian University of Science and Technology, Norway
Adrian Wells, University of Manchester, UK & Norwegian University of Science and Technology, Norway
Hans M. Nordahl, Norwegian University of Science and Technology, Norway

Background: There is increasing evidence that therapist-effects explain a relatively large proportion of the variance related to outcome in clinical trials. However, little is known concerning therapist qualities that may help explain these effects. The present study examined therapists' basic therapy skills as a predictor of treatment outcome in a randomized controlled trial of mCT for social phobia.
Method: Ninety six patients were included in a randomized controlled trial for social phobia. The treatment arms consisted of mCT, anti-depressant+mCT, anti-depressant, and placebo. Two independent raters viewed and rated a representative sample of early treatment session from the mCT condition according to basic therapy skills, which in turn was used to predict treatment outcome.
Results: The results demonstrated that therapist competency in basic therapy skills predicted treatment outcome.
Conclusions: These results demonstrate that further research on the influence of therapist competence may help improve our understanding of how mCT works. Such knowledge may in turn help improve treatment manuals as well as enhance therapist competence throughout clinical training.

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2. Metacognitions as predictors of outcome in a randomized controlled treatment trial of GAD and their relationship with resilience

Odin Hjemdal, Norwegian University of Science and Technology, Norway
Roger Hagen, Norwegian University of Science and Technology, Norway
Leif E. O. Kennair, Norwegian University of Science and Technology, Norway
Stian Solem, Norwegian University of Science and Technology, Norway
Adrian Wells, University of Manchester, UK & Norwegian University of Science and Technology, Norway
Hans Nordahl, Norwegian University of Science and Technology, Norway

Background: This study aimed to explore if metacognitions predicted changes in GAD symptoms during the course of treatment and if there is a relation between metacognition and resilience.
Method/Results: 60 patients were included in a randomized controlled treatment trial of GAD. The patients were randomized to three conditions, waiting list, CBT and MCT. Metacognitions were measured with the MCQ-30 (Wells & Cartwright-Hatton, 2004) and symptom outcomes were assessed as changes in measures of worry: PSWQ, anxiety: STAI, BAI, and mood: BDI. In addition the relation between

metacognitions and resilience was investigated to explore if change in resilience was related to treatment effect, and if change in resilience was correlated with metacognitive change. The data are currently undergoing analysis.
Conclusions: It is important to understand if and how metacognitions predict changes in GAD symptoms, and to explore if measurements of metacognition and resilience are related to each other.

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3. Metacognition in generalized anxiety disorder, social phobia, and obsessive-compulsive disorder and relationship with treatment outcome

Stian Solem, Norwegian University of Science and Technology, Norway
Kristen Hagen, Norwegian University of Science and Technology, Norway
Bjarne Hansen, Norwegian University of Science and Technology, Norway
Patrick A. Vogel, Norwegian University of Science and Technology, Norway
Roger Hagen, Norwegian University of Science and Technology, Norway
Odin Hjemdal, Norwegian University of Science and Technology, Norway
Adrian Wells, University of Manchester, UK & Norwegian University of Science & Technology, Norway
Leif E. O. Kennair, Norwegian University of Science and Technology, Norway
Hans M. Nordahl, Norwegian University of Science and Technology, Norway

Background: Metacognitive profiles can be described using the five subscales of the Metacognition Questionnaire (MCQ). These profiles describe different levels of beliefs about the need to control thoughts, uncontrollability of thoughts, cognitive confidence, positive beliefs about worry, and cognitive self-consciousness. These metacognitive beliefs may be central to different anxiety disorders and recovery could be related to changes in these beliefs. The first aim of the study was to compare these metacognitive profiles in patients with generalized anxiety disorder (GAD), social phobia (SP), obsessive-compulsive disorder (OCD), and a normal control sample. The second aim of the study was to describe how changes in metacognitive beliefs were related to treatment outcome.
Method: Data was collected from three different treatment trials conducted by the Trondheim group for GAD, SP, and OCD. Pre-treatment profiles on MCQ were used for sample comparisons. Regression analyses were used to investigate how changes in metacognition were related to post-treatment levels of symptoms for the three patient groups.
Results: The main results will be presented at the conference.
Conclusion: The analyses are ongoing and the results will be important in clarifying the role of metacognition in treating anxiety disorders.

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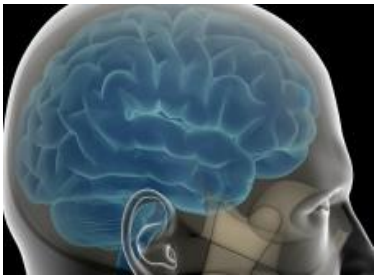

Open Papers

Does metacognition make a unique contribution to hypochondriacal symptoms in addition to neuroticism, illness cognition and somatosensory amplification?

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Background: Somatosensory amplification (Barsky, 1992), illness cognition (Salkovskis & Warwick, 1986) and neuroticism (Noyes 1999) have all been linked to hypochondriasis. Preliminary studies have also shown that metacognitive beliefs appear to be positively associated and predictive of this disorder (Bouman & Meijar, 1999). This study investigated whether metacognition has an important role in hypochondriacal symptoms, and can demonstrate predictive power over and above other established correlates associated with these symptoms.
Method: An analogue sample (N=351) completed a questionnaire battery consisting of Cognitions about Body and Health Questionnaire (CABAH), Somatosensory Amplification Scale (SSAS), Neuroticism scale of the Eysenck Personality Questionnaire-Revised: Short Form (EPQ–R–N) and the Metacognitions Questionnaire 30 (MCQ-30).
Results: Analyses demonstrated metacognition correlated significantly and positively with hypochondriacal symptoms. Hierarchical regression analyses indicated that three metacognitive dimensions: negative beliefs about the uncontrollability of thoughts and danger, cognitive confidence and beliefs about the need for control accounted for substantial variance over and above the control variables. Further analysis revealed that controlling for metacognition also had a large effect on the strength of the relationship between cognition and hypochondriacal symptoms.
Conclusion: This study indicates that metacognition may have an important and substantive relationship with hypochondriacal symptoms.

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Metacognitive therapy for health anxiety: A case series

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Background: Hypochondriasis is a debilitating and chronic condition. The most effective psychological treatments for hypochondriasis are cognitive and behavioural therapies. However, the degree of improvement across these treatments is variable, often with low recovery and high dropout rates. The aim of this study was to provide

a preliminary clinical investigation into the effectiveness of metacognitive therapy (MCT) for hypochondriasis.
Method: An A-B single case series methodology (N=4) with a six month follow up was implemented. A generic MCT treatment plan adapted for hypochondriasis was used to guide therapy and patients received a mean of 8 treatment sessions.
Results: MCT was associated with reductions in hypochondriacal symptoms and metacognition with all patients demonstrating clinically significant improvements in all measures after the treatment phase and at follow-up. Based upon a formal recovery criterion (Jacobson & Truax 1991), all patients also met recovered status at the end of therapy and follow up.
Conclusion: Overall, this case series provides preliminary evidence that a specific MCT treatment protocol may be an efficient and effective approach for treating hypochondriasis, and warrants future randomised and controlled evaluations.

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Attention training and traumatic stress symptoms: A controlled evaluation

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Background: Attention training technique (ATT) is a specific technique used in metacognitive therapy to modify metacognition and the control of attention. It aims to reduce self-focused attention, increase attention flexibility and change metacognitive strategies so that the person may discontinue preservative cognitive styles and threat monitoring behaviours.
Method: The present study investigated the impact of ATT on specific stress symptoms in a sample of 60 university students following exposure to a stressful life event. Participants were randomly assigned to either an ATT group (n = 29) or a control group (n = 31). An emotional attention set-shifting task was included as an objective measure of attention.
Results: ATT significantly reduced intrusions and improved negative affect in individuals who had experienced a stressful life event. The technique also reduced self-focused attention and increased attention flexibility on subjective and objective measures.
Conclusion: The results suggest that ATT can be beneficial in reducing traumatic stress symptoms and the results add to studies suggesting positive effects of the technique across a range of disorders.

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Temperament, metacognition and anxiety

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Background: Research confirms the independent roles both of temperament and of metacognition in the constitution of vulnerability to psychopathology; however the relationship between these two constructs is rarely studied. It is postulated that some temperamental traits may play an important role in the development of dysfunctional

metacognition, and that metacognition may have the status of mediator within the relationship between temperament and anxiety.
Method: Two studies were conducted (a student sample, *n*=315, and a clinical sample, *n*=216), concerning the regulative theory of temperament. It was hypothesized that metacognition and temperamental effects on anxiety are independent, and that temperamental effects are channeled, at least partially, by metacognition.
Results: In these two studies, emotional reactivity and briskness correlated significantly with both state anxiety and metacognitions (emotional reactivity correlated positively, briskness negatively).These traits were predictors of state anxiety. Metacognition predicted state anxiety, and the relationships were independent of temperamental traits. Moreover, effects were observed of the partial and full mediation of metacognition.
Conclusions: The findings suggest that two temperamental traits in particular (emotional reactivity and briskness) are associated with metacognitions implicated in psychopathology, and that these traits may have effects, both direct and metacognitively mediated, on anxiety.

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Metacognitive beliefs and emotional overinvolvement in caregivers of first-episode psychosis

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Background: Caregivers of persons with psychosis often report high degrees of distress. Distress has been linked to caregivers' level of emotional overinvolvement (EOI), which is found to be a reliable psychosocial predictor of relapse in patients with psychosis. However, little is known about the psychological factors involved. This study examines whether maladaptive metacognitive beliefs relate to the level of EOI.
Method: We interviewed 44 relatives of persons with first-episode psychosis and used the Metacognitions Questionnaire (MCQ-30) and Family Questionnaire (FQ-EOI subscale). To control for current emotional distress we used General Health Questionnaire (GHQ-30).
Results: Pearson correlations showed associations between maladaptive metacognitive beliefs (MCQ-30) and EOI (0.463, $p<.01$). When GHQ-30 and MCQ-

30 were entered in a multiple regression with EOI as independent variable, MCQ-30 contributed significantly to the variance ($p<.05$).
Conclusion: Data seem to support our hypotheses that maladaptive metacognitive beliefs are related to the caregivers' level of emotional overinvolvement. Working with these beliefs might reduce emotional overinvolvement, which has been related to relapse/symptom exacerbation in the patient. Further studies should consider implementing metacognitive-focused interventions in family work.

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Metacognitive therapy for depression

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Background: Despite consistently demonstrated efficacy, only around half of those receiving cognitive behavioural therapy (CBT) for depression achieve remission and relapse is common. Metacognitive therapy (MCT) was compared with CBT in outpatients with depression to examine whether MCT would achieve more rapid and effective reduction in depressive symptoms.
Method: 48 referred participants were randomised to 12 weeks of MCT or CBT. Key outcomes were reduction in depressive symptoms from baseline to weeks 4 and 12 on the independent-clinician-rated Quick Inventory of Depressive Symptoms$_{16}$. Intention to treat and completer analyses are reported.
Results: Both therapies produced clinically significant change in depressive symptoms, with moderate to large effect sizes obtained for both therapies. Benchmarked against similar samples, the CBT results are satisfactory however our effect sizes for MCT are lower than Wells (2012). No differences were detected between therapies in outcome or in change within the first four weeks of therapy. Therapists attended workshops, followed treatment manuals and were closely supervised but not by trained MCT therapists as the study was conducted independently of the developers of MCT.
Conclusion: In this pilot study, MCT was an effective treatment for outpatients with depression and as effective as the current gold standard CBT. It was not faster acting when measured over the first four weeks of treatment.

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Depressive rumination as a form of cognitive avoidance: A task based exploration

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Background: Previous research suggests rumination in response to depressive mood is associated with cognitive and behavioural avoidance. Such studies generally propose rumination is associated with avoiding threatening thoughts, a function similar to that ascribed to worry in some models of generalized anxiety disorder. However, most research to date exploring the idea of depressive rumination as a form of cognitive avoidance has been cross-sectional, and relied solely on self-report measures of cognitive avoidance.
Aim: The present study explores a task-based behavioural index of cognitive avoidance, and assesses the degree to which performance on this task is associated with depressive rumination
Design: This is a cross sectional study of 140 students studying at Zayed University in the Emirate of Abu Dhabi in the United Arab Emirates.
Method: All participants completed Nolen-Hoeksema's ruminative response scale (RRS) and also completed a computerized image-rating task. Images were from the international affective picture set (IAPS): 20 positive, neutral and negative affective images, all equally balanced for arousal. Participants worked alone, and were encouraged to take as long as they liked to rate each image in terms of affective valence. Unbeknownst to participants the time they spent on valence rating each image was recorded in milliseconds.
Results: RRS total scores, and more notably, scores on the RRS's brooding sub scale, were negatively correlated with response latencies for negative images. Participants with higher rumination scores spent shorter durations looking at and rating negative images; there were no such association with positive or neutral images. These effects persisted even after controlling for depressive symptoms.
Conclusion: This study provides further support for the idea that rumination may be a mechanism associated with cognitive avoidance. This view has important implications for the refinement of cognitive therapeutic techniques in the context of depressive illness.

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The effects of attention training and situational attentional refocusing on symptoms of social phobia

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Background: Individuals with social phobia have difficulty disengaging from anxiety-related sensations in social situations. Metacognitive interventions for increasing attentional control were administered to a convenience sample of 12 outpatients meeting Social Phobia diagnoses.
Method: In a cross-over design, half were offered 4 weekly sessions with Attention Training Technique (ATT) delivered by a standard CD of everyday sounds. Home practice and social activity were monitored. Patients were reevaluated and then given 4 more weekly sessions involving social exposure situations based on patient hierarchies and instructed to employ Situational Attention Refocusing (SAR). Home practice of hierarchy items was monitored. The other patients received the opposite sequence of treatments.
Results: At post treatment, seven of 12 (58%) patients completing both treatments no longer met criteria for social phobia in clinical interviews. Both ATT and SAR produced significant reductions on most measures at mid-treatment, but SAR patients were significantly lower than ATT patients on interview ratings of social phobia. Adding SAR produced no further significant gains for ATT-first patients, but adding ATT resulted in further significant gains to SAR-first patients on social cognitions.
Conclusions: These results show that interventions aimed at increasing attentional control can lead to clinically useful changes in social phobia symptoms.

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Cortical levels of GABA in patients with panic disorder are associated with the strength of metacognitive beliefs

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Background: Non-invasive spectroscopic measurement of cortical levels of gamma-Aminobutyric acid (GABA) may indicate integrity of inhibitory circuits, crucial for perceptual, motor and cognitive functions.
Method: Since GABAergic deficiency is well conceptualized in panic disorder (PD), we tested whether cortical GABA (major inhibitory neurotransmitter), Glutamate (major excitatory neurotransmitter) levels predict (i) symptom severity in PD upon

standard psychometric measures (PAS, HAM-A, BAI) (ii) strength of metacognitive beliefs upon metacognitions questionnaire (MCQ-30) in n=23 Patients with PD, with or without agoraphobia.
Results: Significant correlations between individual GABA levels and psychometric measures were observed for metacognitions only, specifically for two subscales: 'positive beliefs about worry' (POS) and 'need for control' (NC). In contrast, correlations with symptom severity of PD (and depression) were moderate, at best. Lower GABA levels preferentially predict elevated positive beliefs towards worry and the need for control of thoughts in PD.
Conclusions: POS and NC might represent rather invariable belief domains in PD ('metacognitive phenotype'), possibly showing a stronger link to neurobiological measures than individually and state-dependently variable expression of symptoms. Subsequently, in a subgroup of patients with PD we will test whether metacognitions predict symptom change in the course of CBT with ERP, again in relation to neurobiological parameters.

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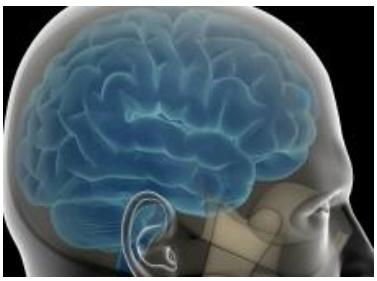

Posters

Incorporating ACT in traditional group CBT for OCD: Challenges and possibilities

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In our clinical practice we have applied ACT in traditional CBT group therapy for OCD outpatients in Psychiatric Center Copenhagen. Our experience is based on our work with 10 groups, each consisting of 6-8 patients and with duration of 14 group sessions and 2 individual sessions. Quantitative data of treatment effect will be presented, and these results will be related to existing literature on the topic. Based on our findings, we will conduct a further hermeneutic, narrative discussion of our experiences with incorporating ACT into traditional CBT. We will discuss the similarities and differences between ACT and CBT concepts as creating possibilities as well as difficulties in incorporating ACT in CBT. In this discussion we will focus on the use of ACT techniques when working with rumination and worry, as they are central features in OCD. We will elaborate on aspects of ACT which are related to preventing rumination and worry: Incorporating mindfulness in CBT. Training attention regulation during exposure and behavioural experiments. Stressing personal

goals and values throughout therapy. Training acceptance as opposed to cognitive restructuring of distressing thoughts, and focusing on willingness to allow emotional pain, as opposed to focusing on motivation for "feeling better" in traditional CBT.

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The Metacognitions about Desire Thinking Questionnaire: Development and psychometric properties

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Background: Recent research has suggested that specific metacognitions, that is information individuals hold about their own cognition and about coping strategies which impact on it, may play a role in the activation and escalation of desire thinking. Desire thinking is the voluntary dwelling on positive thoughts about the nature and effects of consuming alcohol. The goal of this research project was to develop the first self-report instrument of metacognitions about desire thinking.
Method: In Study 1 we constructed the Metacognitions about Desire Thinking Questionnaire (MDTQ) and conducted a preliminary factor analysis which identified three factors: (1) positive metacognitions about desire thinking; (2) negative metacognitions about desire thinking; and (3) negative metacognitions about desire-related thoughts. Items were derived from data collected in an earlier semi-structured interview study (Caselli & Spada, 2010). In Study 2 we performed a confirmatory factor analysis which provided support for this three factor solution, with all factors achieving adequate internal consistency. Divergent and predictive validity was also established through correlation and regression analyses. In Study 3 the temporal stability of the MDTQ was examined and confirmed. Finally, in Study 4, the predictive validity of the MDTQ in a sample of alcohol abusers was investigated.
Results: The MDTQ was shown to possess good psychometric properties, as well as divergent and predictive validity.
Conclusions: This self-report instrument may aid future research into desire thinking and craving, as well as facilitate assessment and case formulation within the context of addictive, eating and impulse control disorders.

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The impact of meta-cognitive beliefs on state anxiety in high socially anxious individuals: Interactions with anticipatory processing and distraction

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Background/Research aim: A cognitive model of social phobia proposed that socially anxious individuals engage in a worry-like process termed anticipatory processing. This process has been associated with increased state anxiety. According to a meta-cognitive model, meta-cognitive beliefs should play a role in the maintenance of such process. The present study investigated whether meta-cognitive

beliefs interact with anticipatory processing and distraction to influence state anxiety before and after a speech.
Method: Eighty socially anxious individuals completed a battery of questionnaires followed by a threat induction (speech). Then, half engaged in a 10-minute anticipatory processing period and half in a distraction task. Subsequently, participants prepared and delivered a 3-minute speech. State anxiety was assessed before the manipulation, and before and after the speech.
Results: Results showed that beliefs about the uncontrollability of anticipatory processing were associated with greater decrease in anxiety from pre to post-speech. In the AP condition, these beliefs were associated with increased anxiety before the speech. In the distraction condition, positive meta-cognitive beliefs were associated with maintained anxiety after the speech.
Conclusions: The results suggest that meta-cognitive beliefs and AP play a role in the anxiety experienced in social situations and the results are discussed in terms of treatment.

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Metacognitive therapy for posttraumatic stress disorder: A case series

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Background: Although empirically supported psychological treatments for posttraumatic stress disorder (PTSD) exist, especially exposure-based interventions, there is still a need for the development of alternative treatment options as a substantial number of patients do not respond to existing treatments, have residual symptoms after treatment or drop-out of treatment prematurely. The present poster presents results from the first 6 cases allocated to MCT in an RCT of PTSD.
Method: Patients referred to the outpatient speciality clinic for treatment of PTSD, St. Olavs University Hospital, and meeting the inclusion criteria, were randomized to receive either metacognitive therapy or eye movement desensitization and reprocessing (EMDR). For the present poster initial data from patients randomized to metacognitive therapy will be presented. Patients were assessed with ADIS-IV, SCID-II and a number of self-report measures at pre-treatment and post-treatment.
Results: The present poster reports results from the 6 first patients consecutively randomized to receive metacognitive therapy as part of the randomized controlled trial. A limitation of the present study is the lack of multiple baseline assessments at pre-treatment.
Conclusions: This is the first independent case series, to our knowledge, of metacognitive therapy for PTSD, and can give preliminary indications whether treatment effects previously achieved/attained can be replicated by an independent party.

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Change in metacognitions in patients receiving in-patient treatment for obsessive-compulsive disorder

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Background: Metacognitions have been proposed as important beliefs in development and maintenance of obsessive-compulsive disorder (OCD; Wells, 1997). Metacognitive measures were administered to a convenience sample of 108 in-patients meeting OCD-diagnoses. The following hypotheses were tested: (1) OCD-severity is significantly reduced during treatment. (2) Metacognitions are significantly reduced during treatment. (3) There is a significant difference in post-treatment metacognition score between patients who meet the standard recovery criteria on the Y-BOCS-SR (Fisher & Wells, 2005) and the patients who do not.
Method: The sample consisted of 108 OCD-patients, who completed an in-patient cognitive-behavioral treatment (CBT) with duration of three weeks. Psychometric measures were completed at admission and discharge of treatment, including the Yale-Brown Obsessive Compulsive Scale-Self-Report (Y-BOCS-SR), Obsessive Compulsive Inventory –Revised (OCI-R), and Obsessive Compulsive Disorder – Scale (OCD-S).
Results: All three hypotheses were confirmed. At post-treatment, 69.4 % of the patients met Fisher and Wells' (2005) standardized recovery criteria on the Y-BOCS-SR. There was a statistical reduction in metacognitive beliefs. The difference between the recovered and non-recovered patients was also statistical significant ($p < .01$).
Conclusions: These results provide further support for the metacognitive model of OCD.

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Metacognitive therapy for Body Dysmorphic Disorder (BDD)

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Background: This poster presents the results of a pilot study of a subsample of patients referred for OCD inpatient treatment. There were two patients who qualify for the diagnosis of BDD which is characterized by compulsive behaviour related to their physical appearance. The patients engage in a number of grooming activities and in some cases also the use of plastic surgery in response to intrusive thoughts concerning their appearance. The present pilot study investigates the effects of metacognitive therapy in altering metacognitions and reducing symptoms in patients with BDD.
Method: The methodology is comprised of an intrasubject design and single case quantitative analysis of two patients receiving metacognitive therapy over a course of 3 weeks.

Results: The reduction in symptoms of BDD, as measured by BDD-YBOCS, from pre to post treatment is 71 percent and 100 percent for the two patients. The reduction in metacognitive beliefs, as measures by MCQ-30, is 53 and 45 percent.
Conclusion: The results from the pilot study indicate that metacognitive therapy can be an effective therapeutic approach in the treatment of patients with BDD. The treatment also appears to result in altered metacognitions in patients with BDD.

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A study of cognitive, metacognitive and resilience predictors of depressive symptoms

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Background: This is a two phased study that explores cognitive and metacognitive along with resilience variables as predictors of depressive symptoms in healthy university students in a cross-sectional and a prospective perspective.
Method: The cross-sectional study included 617, and the prospective study 243 non-patients. Participants completed questionnaires at two time points over an eight month period.
Results: Hierarchical linear regression analysis indicated that dysfunctional attitudes (DAS; Weissman & Beck, 1978), rumination (RRS; Nolen-Hoeksema & Morrow, 1991), negative beliefs about rumination (NBRS; Papageorgiou & Wells, 2001a) and levels of resilience (RSA; Hjemdal et al., 2001) predicted the level of depressive symptoms. The results further indicated that negative metacognitive beliefs and resilience prospectively explained variance in depressive symptoms when controlling for the cognitive predictors.
Conclusions: The results add to the literature demonstrating that metacognition explains unique variance in depression symptoms independently of cognition and that there is a contribution of resilience. The nature of these constructs is discussed.

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Are metacognitions associated with physical symptom reporting, health preoccupation, distress and illness behaviours?

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Background: Excessive physical symptom reporting is a major clinical problem, associated with distress, disability and increased healthcare utilisation. Maladaptive metacognitions have been shown to predict health anxiety, but have not been examined directly in relation to symptom reporting.
Aims: The study evaluated the hypothesis that metacognitive beliefs are significantly associated with physical symptom reporting in general practice patients. A secondary

aim was to provide a preliminary evaluation of a new metacognitive measure; the metacognitive health questionnaire (MCHQ).
Method: Spearman's rank correlations between meta-beliefs and strategies, physical symptom reporting, health anxiety, catastrophic misinterpretation, health preoccupation and health distress were evaluated in a cross-sectional study of general practice patients.
Results: Clinically significant levels of physical symptoms were reported by the study sample. Negative metacognitive beliefs about worry and metacognitive beliefs about the need to control thoughts on the MCQ-30 were significantly associated with levels of physical symptom reporting. Positive and negative meta-beliefs on the MCHQ were significantly associated with health preoccupation, health-related distress, body-focussed attention, illness behaviours and thought-control strategies on the same instrument.
Conclusion: This study provides preliminary support for the hypothesis that metacognitive beliefs are associated with physical symptom reporting, and health-related preoccupation and distress.

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Metacognitive therapy in recurrent and persistent depression: A case replication series of a new treatment in Denmark

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Background: Metacognitive therapy (MCT) for depression is derived from Wells & Mathews' (1994) self-regulatory model, in which the Cognitive-Attentional Syndrome (CAS) is the cause of psychological disorders. MCT for depression focuses on identifying patients' CAS and helpsive strategies, such as rumination, by challenging positive and negative metacognitive beliefs and eliminating dysfunctional behaviour such as avoidance.
Method: In this trial, MCT was delivered to 4 recurrent depressed Danes and treatment was evaluated in 5-11 sessions of up to one hour each. An A-B design with follow-ups at 3 and 6 months was conducted using self-report ratings such as Becks Depression Inventory II (BDI-II) and Major depressive Disorder Scale (MDD-S).
Results/Conclusion: The results of the trial showed clinically significant improvements in depressive symptoms, rumination and metacognitive beliefs and the effects were still present at follow-up for all patients. The small number of patients limits generalizability, however, the results indicated promising potential for a shorter and more effective treatment of depression compared to other treatments.

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Metacognitive beliefs and thought control strategies in early psychosis

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Background: Metacognitive beliefs and strategies are probably of major importance in establishing and maintaining symptoms in severe mental disorders. To our knowledge no studies have explored metacognition in early psychosis. In the present study we examine the relationship between metacognitive beliefs (MCQ-30), thought control strategies (TCQ) and positive symptoms.
Method: So far 27 patients from the ongoing TOP study of early psychosis have been included. All patients were assessed on SCID, PANSS and GAF, and completed the MCQ-30 and TCQ.
Results: We found significant relationships between all MCQ-30 subscales and the TCQ-Punishment subscale. MCQ subscales 1-4 were significantly correlated with TCQ-Worry. MCQ subscales 2, 4 and 5 were negatively related to TCQ-Social control. PANSS-P1 was negatively related to TCQ-Distraction. PANSS-P3 was related to MCQ-4 and TCQ-Punishment. PANSS-P5 was negatively related to TCQ-Worry. No MCQ-30 or TCQ subscales were significantly related to depression (CDSS). **Conclusion:** The present study shows a close relationship between MCQ and three of the TCQ subscales, indicating that metacognitive beliefs are associated with similar thought control strategies. Hallucinatory experiences are related to general negative beliefs about thoughts and punishment as a self-regulative strategy. Further results with a larger sample will be presented at the conference.

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Positive beliefs about rumination: Causal factor or epiphenomena?

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Background: Given the role of rumination in predicting the onset of new depressive episodes, it is important to learn why people engage in rumination. The metacognitive model assumes positive beliefs about rumination (PBR) initiate rumination. However, the model is predominantly supported by studies cross-sectional in nature or studies including metacognitive beliefs not specific to rumination and depression. Furthermore, the metacognitive model predicts an indirect effect of PBR on depressive symptoms via rumination. Yet this indirect effect has not been tested through a prospective study.
Research question: The current study aimed to test PBR as a prospective predictor of rumination and to investigate the indirect effect of positive beliefs about rumination on depressive symptoms via rumination.

Method: We conducted a longitudinal design with a two month retest interval. Participants were 60 university students. A hierarchical regression was run with T2 rumination as dependent variable and T1 rumination and T1 PBR as predictors.
Results: Results revealed a significant effect of PBR, even after controlling for T1 rumination. In the second analysis multiple regression and Sobel test confirmed an indirect effect of PBR on depressive symptoms via rumination. These results support the metacognitive model.

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Psychometric properties of the Positive and Negative Beliefs about Rumination Scales in a non-clinical Turkish sample

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Background: Positive Beliefs about Rumination Scale (PBRS; Papageorgiou & Wells, 2001) and Negative Beliefs about Rumination Scale (NBRS; Papageorgiou, Wells & Meina, 2008) are widely used assessment devices in metacognition research on depressive disorders. The aim of the present study was to examine the psychometric properties of the PBRS and NBRS in a Turkish non-clinical sample.
Method: Four-hundred and forty seven subjects comprised of 328 (73.4 %) students and 119 (26.6 %) non-students participated in the study. Other instruments administered together with PBRS and NBRS were Ruminative Response Scale (RRS), Meta-Cognitions Questionnaire-30 (MCQ-30), Penn State Worry Questionnaire (PSWQ), the trait-anxiety subscale of the State-Trait Anxiety Inventory (STAI-T), Beck Depression Inventory (BDI), and Beck Anxiety Inventory (BAI).
Results: Reliability analyses showed that the Turkish versions of the PBRS and NBRS had adequate internal consistency and test-retest reliability coefficients. Considering the concurrent validity, both PBRS and NBRS were found to be significantly and positively correlated with rumination, metacognition, pathological worry, trait anxiety, and anxiety and depression symptoms. With regard to the criterion validity the high rumination group significantly differed from the low rumination group in both negative and positive beliefs about rumination.
Conclusion: The findings of the present study indicated that the PBRS and NBRS had adequate psychometric properties in a Turkish non-clinical sample.

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MCT Master-Class 2014

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 clinical 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 2014 and 2015 (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.

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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)
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VI. MCT for Chronic depression (A. Wells)
VII. MCT for Borderline PD (H. M. Nordahl)
VIII. MCT for Psychosis (A. Morrison)

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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. Expenses such as travel and accommodation and some lunches and beverages' must be covered by the participant.

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