

Preface

Cognitions count. By now it is well established that thoughts have a strong impact on emotional and psychological well-being. But consider the following: You had thousands of thoughts yesterday. Some were pleasant and some were less so. Where did all those thoughts go?

Thoughts appear and disappear. A central premise of the approach described in this book is that psychological disorder is the extent to which some thoughts are extended and recycled and some are simply let go. This is a process of selection and control of thinking styles, which depends on metacognition. It is also a matter of how we relate to our own inner experiences.

In cognitive-behavioral theories the content of thought has been given great importance as determining the presence of disorder. But how we think about an event, or how we think about a constellation of conversations, ourselves, and the world around us, is the more profound effect. In fact, how we respond to thoughts can, and all too frequently does, lead to emotional suffering.

Over the past 40 years the cognitive-behavioral model has provided a robust understanding of the impact of cognition on psychological well-being, and led to techniques for treating anxiety, mood, and other disorders. Like this model, metacognitive therapy (MCT) assumes that psychological disorder results from biased thinking; however, it provides a different account of its nature and causes. Earlier approaches have said surprisingly little about the issue of what gives rise to unhelpful thinking patterns. It is incomplete to attribute such patterns to the presence of underlying beliefs about the self and world, such as “I’m vulnerable”

or “I’m a failure.” A negative belief, such as “I’m a failure,” can be the impetus for a range of responses, such as the deployment of strategies for becoming a success that might include learning from mistakes, working harder, developing new skills, or dismissing the belief as simply a thought that is irrelevant.

Negative beliefs do not necessarily lead to disturbed thinking patterns and prolonged emotional suffering. Metacognitive theory proposes that disturbances in thinking and emotion emerge from metacognitions that are separate from these other thoughts and beliefs emphasized in cognitive-behavioral therapy (CBT).

There is something significant about the pattern of thinking seen in psychological disorder. It has a repetitive, recyclic, brooding quality that is difficult to bring under control. Earlier theories have tended to say little or nothing of such qualities and instead have preferred to focus on the content of thoughts. Earlier approaches have focused on specific irrational beliefs or shorthand negative automatic thoughts, but this is only a small feature of cognition and might be of limited importance. For instance, most patients report long chains of uncontrollable cognitive activity that hardly fits the description of automatic thoughts. It is control of mental processes and selection of some ideas for sustained thinking that is at the heart of emotional suffering. Rather than identifying emotional problems with automatic thoughts, MCT views troublesome internal states as closely related to unhelpful processes of worry, rumination, and strategies of mental control.

At the beginning of my journey leading to MCT, which has taken over 20 years, it seemed that what might be needed to advance the field was an account of the factors that control thinking and cause distressing thoughts to be enriched and extended. I believed that this would depend on extending the concept of metacognition and its assessment and using this to formulate the control of attention and mental processes in psychological disorder.

Metacognition refers to the internal cognitive factors that control, monitor, and appraise thinking. It can be subdivided into metacognitive knowledge (e.g., “I must worry in order to cope”), experiences (e.g., a feeling of knowing), and strategies (e.g., ways of controlling thoughts and protecting beliefs).*

*I should like to point out that there are important issues of cognitive architecture, the relative effects of levels of control of attention, and cognitive resource issues that are taken account of in the theory and are described elsewhere (Wells & Matthews, 1994, 1996). The metacognitive model assimilates theory and research in these important areas and offers an explanation of bias and attention effects on task performance. However, this will be of peripheral interest to most practitioners of MCT, and it is therefore not considered in detail in this book.

A central idea is that metacognitive factors are crucial in determining the unhelpful thinking styles seen in psychological disorder that give rise to the persistence of negative emotions. In its “hard” form, the metacognitive theory suggests that the irrational beliefs or schemas emphasized by Albert Ellis and Aaron T. Beck in their respective cognitive theories—or at least, their persistence and influence—are the products of metacognitions.

Metacognitions direct attention, determine the style of thinking, and direct coping responses in a way that repeatedly gives rise to dysfunctional knowledge. This is a dynamic view of beliefs as created by more stable metacognitions. This view implies that metacognitions, and not their consequences, should be modified in treatment.

In a “soft” form the theory suggests that metacognitive beliefs exist alongside other stored beliefs about the self and world, but as separate entities that are responsible for controlling cognition and making use of other more general beliefs and knowledge. In this form treatment might retain a component of challenging traditional beliefs, but it must also deal with the coexistent metacognitions.

In both its hard and soft forms, the metacognitive approach has profound implications for treatment. It guides us toward strategies that enable patients to develop new relationships with their thoughts and beliefs. Rather than questioning the validity of thoughts and beliefs as in traditional CBT, it directs the therapist toward changing the metacognitions that give rise to maladaptive styles of difficult-to-control repetitive negative thinking. For example, the metacognitive approach to treating trauma assumes that metacognitive beliefs and control strategies that disrupt in-built self-regulation are the reasons symptoms do not naturally subside. The tendency to worry or ruminate, lock attention onto threat, and cope by avoiding thoughts interferes with a normal adaptation process and leads to sustained thinking about danger and a persistence of symptoms.

It follows from this that treatment should consist of removing worry and rumination, abandoning attentional strategies of threat monitoring, and helping individuals to experience intrusive thoughts without avoiding or reacting to them with unhelpful suppression, or with ruminative or extended thinking strategies. This treatment differs from standard CBT in that it does not involve challenging thoughts or beliefs about trauma, or prolonged and repeated exposure to trauma memories. Instead, it consists of relating to thoughts in a different way, banning resistance or elaborate conceptual analysis, and suspending maladaptive thinking styles of worry, rumination, and inflexible threat monitoring. In MCT, beliefs *are* challenged—but the focus is on the person’s beliefs about cognition itself.

In treating depression, MCT targets the process of rumination rather

than the content of a range of negative automatic thoughts. Treatment consists of the attention training technique to interrupt repetitive styles of negative thought and regain flexible control over thinking styles. This is coupled with challenging negative metacognitive beliefs about the uncontrollability of depressive thinking, and challenging positive beliefs about the need to ruminate as a means of coping and finding answers to sadness.

Inevitably, each person who approaches this book will have his or her own goals in reading it, and his or her own style of processing the material contained within. The book is a detailed treatment manual and is replete with therapy techniques grounded in theory. The reader will find interview schedules for developing case formulations, treatment plans, and measures to assist in assessment. Many of the ideas will be new, and it is likely to require experience in applying them to fully appreciate the nature of MCT. I have tried to omit as much technical terminology as possible, I hope without losing the scientific and conceptual integrity of the MCT approach.

ADDENDUM FOR THE PAPERBACK EDITION (2011)

Since the first printing of this book metacognitive therapy research has continued to make important discoveries. Metacognitive beliefs about memory are associated with trauma symptoms more strongly than features of memory (Bennett & Wells, 2010). Positive outcomes in CBT for obsessive-compulsive disorder and alcohol addiction are associated with metacognitive beliefs (Solem, Haland, Vogel, Hansen, & Wells, 2009; Spada, Caselli, & Wells, 2009). The mechanism of change in psychotherapy, irrespective of modality, could depend on metacognitive factors. In addition, applications of the metacognitive model are widening into areas of chronic fatigue syndrome and health and emotional susceptibility to life stress (Maher-Edwards, Fernie, Murphy, Wells, & Spada, in press; Yilmaz, Gencoz, & Wells, in press). Trials demonstrating potential superiority of MCT over other treatments have been published (Wells et al., 2010; Nordahl, 2009) with several large-scale controlled trials underway. My hope is that this book will continue to stimulate research of this kind as we aim for a better understanding of the causes of mental suffering and their treatment.

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