Metacognitive Therapy for Anxiety and Depression

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About the Author

Adrian Wells, PhD, is Professor of Clinical and Experimental Psychopathology at the University of Manchester, United Kingdom, and Professor II in Clinical Psychology at the Norwegian University of Science and Technology, Trondheim, Norway. He is internationally known for his contributions to understanding psychopathological mechanisms and advancing cognitive-behavioral therapy, particularly for anxiety disorders. The originator of metacognitive therapy, Dr. Wells has published over 130 scientific papers, chapters, and books. He is Associate Editor of the journals *Behavioural and Cognitive Psychotherapy* and *Cognitive Behaviour Therapy*, and is a Founding Fellow of the Academy of Cognitive Therapy.

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).[*]

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.

[*] 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.

Acknowledgments

The journey culminating in the work presented in this book began more than 20 years ago. I have worked with many people during that time, both colleagues and students. My doctoral research addressed self-attentional processes in anxiety. My supervisor was D. Roy Davies, an important influence and mentor. Later I was fortunate to be joined by Gerald Matthews in coauthoring the book *Attention and Emotion: A Clinical Perspective*, which provided the early theoretical grounding for MCT. I worked with Aaron T. Beck in Philadelphia, where I received training in cognitive therapy. In the early to mid-1990s I collaborated with David M. Clark and colleagues at Oxford, where we developed a cognitive model and treatment of social phobia drawing on my earlier metacognition work. At that time I was developing both cognitive therapy and MCT in parallel. This is evident in my book *Cognitive Therapy of Anxiety Disorders: A Practice Manual and Conceptual Guide*.

After moving to the University of Manchester I continued to develop and evaluate MCT and authored the first book devoted completely to MCT, *Emotional Disorders and Metacognition: Innovative Cognitive Therapy.* I was not courageous enough to lose "cognitive therapy" completely from the title of that work, as MCT was proving to be controversial. However, many colleagues are involved in MCT today. I am particularly grateful to my academic colleagues in Trondheim—Hans Nordahl, Tore Styles, and Patrick Vogel—who are undertaking MCT research. I am also grateful to Chris Brewin for our recent collaborations on a project funded by the Medical Research Council involving MCT for depression.

One of my PhD students, Costas Papageorgiou, has been a long-standing collaborator; our work on depression can be found in our edited book, *Depressive Rumination: Nature, Theory and Treatment*. My secretary, Joyce Russell, has been a great support throughout. Sundeep Sembi was involved in the early evaluation of MCT for posttraumatic stress disorder, Peter Fisher has been involved in the early evaluation of MCT for obsessive–compulsive disorder, and Marcantonio Spada worked on addictions. Karin Carter played an important role in early work on attention training and research on GAD and made helpful suggestions on how to improve the manuscript. I am very grateful to each of these people and to the many others with whom I have worked over the years.

ADRIAN WELLS

Contents

CHAPTER 1

Theory and Nature of Metacognitive Therapy

Thoughts don't matter but your response to them does.

Everyone has negative thoughts and everyone believes their negative thoughts sometimes. But not everyone develops sustained anxiety, depression, or emotional suffering. An important question is: What is it that controls thoughts and determines whether one can dismiss them or whether one sinks into prolonged and deeper distress?

This book offers an answer to this question. It proposes that metacognitions are responsible for healthy and unhealthy control of the mind. Furthermore, it is based on the principle that it is not merely *what* a person thinks but *how* he or she thinks that determines emotions and the control one has over them.

Thinking can be likened to the activity of a large orchestra involving many players and instruments. To produce an acceptable overture there must be a music score and a conductor. Metacognition is the score and the conductor behind thinking. Metacognition is cognition applied to cognition. It monitors, controls, and appraises the products and process of awareness.

For most of us, emotional discomfort is transitory because we learn ways of flexibly dealing with the negative ideas (i.e., thoughts and beliefs) that our minds construct. The metacognitive approach is based on the idea that people become trapped in emotional disturbance because their metacognitions cause a particular pattern of responding to inner experiences that maintains emotion and strengthens negative ideas. The pattern in question is called the cognitive attentional syndrome (CAS) which consists of worry, rumination, fixated attention, and unhelpful self-regulatory strategies or coping behaviors.

A hint of this toxic pattern can be seen in the response of a recent patient. I asked this person, "What is the main thing you have learned during metacognitive therapy for your depression?" She replied, "The problem isn't really that I have negative thoughts about myself, it's how I've been reacting to them. I've discovered that I've been pouring coal on the fire. I just didn't see that process before." This patient discovered that her responses to negative thoughts had inadvertently developed into an unhelpful thinking style that reinforced her negative self-view. We will return to the nature of this process later in this chapter.

Metacognitive therapy (MCT) is based on the principle that metacognition is vitally important in understanding how cognition operates and how it generates the conscious experiences that we have of ourselves and the world around us.

Metacognition shapes what we pay attention to and the factors that enter consciousness. It also shapes appraisals and influences the types of strategies that we use to regulate thoughts and feelings. The argument developed and illustrated throughout this book proposes metacognition as a crucial influence on what we believe and think and as the basis of normal and abnormal emotional and conscious experiences.

A basic premise of traditional cognitive-behavioral therapy (CBT), such as Beck's schema theory (e.g., Beck, 1967, 1976) and Ellis's rational-emotive behavior therapy (REBT; Ellis, 1962; Ellis & Harper, 1961) is that disturbances or biases in thinking cause psychological disorder. Both of these approaches give a central role to dysfunctional beliefs. MCT is in agreement with this view as a general principle, making it a type of cognitive therapy. Where it differs from previous approaches is in identifying a particular style of thinking and types of beliefs not emphasized by these other theories as the cause of disorder. The style of thinking emphasized is not about cognitive distortions such as absolutistic standards or black-and-white thinking. The style of interest in MCT is the CAS, which is marked by engaging in excessive amounts of sustained verbal thinking and dwelling in the form of worry and rumination. This is accompanied by a specific attentional bias in which attention is locked onto threat. The beliefs of importance in MCT are not the ordinary cognitions of CBT and REBT concerning the world and the social and physical self, but are beliefs about thinking (metacognitive beliefs).

The traditional CBT approach to psychological disorder asserts that it is not events themselves that cause psychological problems but the way those events are interpreted. CBT deals with the meanings that people give to their experiences. It assumes that the problem rests with erroneous and distorted views of the self and the world. It deals with changing this thought content and the person's belief in the validity of that content. In contrast, MCT deals with the way that people think and it assumes the problem rests with inflexible and recurrent styles of thinking in response to negative thoughts, feelings, and beliefs. It focuses on removing unhelpful processing styles. It proposes that any challenges to cognitive themes (content) occur exclusively at the metacognitive level. For instance, if we consider the case of a depressed patient who believes "I'm worthless," the CBT therapist tackles the problem by asking, "What is your evidence?" In contrast, the MCT therapist asks, "What is the point in evaluating your worth?"

In both the CBT and the MCT approaches, the content of beliefs and thoughts determines the type of disorder experienced. Thoughts about danger give rise to anxiety; thoughts about loss and self-devaluation give rise to sadness. MCT posits that this content does not cause disorder because most people have these thoughts and for most the emotion is transitory. Emotional disorder is a problem of being trapped in a state of distress. It is chronic or recurrent. Emotional disorder is caused by the metacognitions that give rise to thinking styles that lock the individual into prolonged and recurrent states of negative self-relevant processing. In essence, MCT is about the factors that lead to sustained thinking and misdirected coping.

In CBT erroneous interpretations of events that cause psychological disorder are assumed to emanate from beliefs, but the beliefs emphasized are in the ordinary cognitive domain. These are beliefs such as "The world is dangerous" and "I'm

inadequate." In MCT these beliefs can be seen as the products of metacognitions that give rise to patterns of attention and thinking that repeatedly generate or lock onto these ideas. The implication is that metacognition and patterns of thinking should be modified in treatment because these are the cause of stable negative beliefs or "ordinary cognitions." The beliefs or schemas of CBT are not seen by the MCT practitioner as stable entities that should be erased but instead are seen as the products of thinking processes.

It is clear from the foregoing introduction that MCT introduces an important distinction between cognition and metacognition, with therapeutic work focused primarily on the latter domain. There is no clear differentiation between cognition and metacognition in earlier cognitive therapies. This is exemplified in an extract taken from Beck's influential writing: "Through interviewing this depressed mother, I discovered that her thinking was controlled by erroneous ideas about herself and her world. Despite contrary evidence, she believed she had been a failure as a mother" (Beck, 1976, p. 16).

Here, it is apparent that depressive thinking is attributed to the presence of negative beliefs about being a "failure." Beck assumes that the patient's thinking is controlled by her erroneous ideas about being a failure. However, it does not invariably follow that believing that one is a failure will control one's thinking. If we take all of the individuals who believe this, will they all become depressed? According to cognitive theory they should, but this is unlikely to be true. MCT views this situation differently. It assumes that most people will have thoughts or beliefs about being a failure, but that individuals will respond to these thoughts in different ways depending on their metacognitions. So it is metacognitive knowledge or beliefs that control subsequent thinking, not the ordinary cognitions that do so.

Let's look at this in more detail. Most people will believe that they are a "failure" at some time in their lives, but for some this belief is followed by renewed efforts to succeed, while for others it is followed by chains of negative thoughts consisting of brooding on personal failings and weaknesses. What is needed is a mechanism that accounts for the existence of these different cognitive and emotional response patterns. I have proposed that the mechanism is metacognition, that aspect of cognition that controls the way a person thinks and behaves in response to a thought, belief, or feeling.

In the case of the depressed mother Beck describes, we might assume that her thinking is controlled by metacognitive beliefs, perhaps something resembling the following: "If I think about my failings and analyze why they occurred, I will be a better mother." Unfortunately, the thinking process of rumination that results from this metacognitive belief is unlikely to lead to satisfactory answers, and the patient will persist in thinking about being a failure.

In the remainder of this chapter, I describe in greater depth the basic principles of MCT theory and treatment. A basic implication of metacognition as a central driver of psychological disorder is that treatment should not invest effort in interrogating and reality testing the person's individual thoughts and beliefs but should focus on changing *how* a person responds to these ideas. The focus of intervention shifts to cognitive processes and the metacognitions giving rise to them and away from evaluating the evidence for and against the cognitive products (e.g., "I'm a failure").

The only exception occurs when the products themselves are metacognitions, as in the form of worry about worry (e.g., “Worrying will harm me”).

Having built an argument for metacognition so far in this chapter, now I will explore this construct in greater detail before presenting the complete metacognitive model of disorder.

THE NATURE OF METACOGNITION

The study of metacognition emerged in the area of developmental psychology and subsequently in the psychology of memory, ageing, and neuropsychology (Brown, 1978; Flavell, 1979; Metcalfe & Shimamura, 1994). Only recently has metacognition been examined as a fundamental basis for most or all psychological disturbances (Wells & Matthews, 1994; Wells, 1995, 2000).

Metacognition describes a range of interrelated factors comprised of any knowledge or cognitive process that is involved in the interpretation, monitoring, or control of cognition. It can be usefully divided into knowledge, experiences, and strategies (e.g., Flavell, 1979; Nelson, Stuart, Howard, & Crawley, 1999; Wells, 1995).

Knowledge and Beliefs

"Metacognitive knowledge" refers to the beliefs and theories that people have about their own thinking. For example, this knowledge consists of the beliefs that are held about particular types of thoughts as well as beliefs about the efficiency of one's memory or powers of concentration. An individual may believe that some thoughts are harmful. A religious person may believe that experiencing certain thoughts is sinful and will lead to punishment. These are examples of metacognitive beliefs about the importance of thoughts. Holding such beliefs has implications for how a person responds to his or her thoughts and how he or she orchestrates his or her thinking.

According to the metacognitive theory of psychological disorder, there are two types of metacognitive knowledge (Wells & Matthews, 1994; Wells, 2000): (1) explicit (declarative) beliefs and (2) implicit (procedural) beliefs.

Explicit knowledge is that which can be verbally expressed. Examples include "Worrying can cause a heart attack"; "Having bad thoughts means I'm mentally defective"; and "If I focus on danger I'll avoid harm."

Implicit knowledge is not directly verbally penetrable. It can be thought of as the rules or programs that guide thinking, such as the factors controlling the allocation of attention, memory search, and use of heuristics in forming judgments. The plan or program for processing can be indirectly inferred from assessment strategies such as metacognitive profiling (Wells & Matthews, 1994). Implicit or procedural knowledge represent the "thinking skills" that individuals have.

In addition to these two types of metacognitive knowledge, there are two broad-content domains in MCT. Individual disorders show some content-specificity within these domains. The broad domains are positive and negative metacognitive beliefs. *Positive metacognitive beliefs* are concerned with the benefits or advantages of engaging in cognitive activities that constitute the CAS. Examples of positive metacognitive beliefs include "It is useful to focus attention on threat," and "Worrying about the future means I can avoid danger."

Negative metacognitive beliefs are beliefs concerning the uncontrollability, meaning, importance, and dangerousness of thoughts and cognitive experiences. Examples of such beliefs include "I have no control over my thoughts"; "I could damage my mind by worrying"; "If I have violent thoughts I will act on them against my will"; and "Being unable to remember names is a sign of a brain tumor."

In MCT metacognitive beliefs are a key influence on the way individuals respond to negative thoughts, beliefs, symptoms, and emotions. They are a driving force behind the toxic thinking style that leads to prolonged emotional suffering.