Dr Pia Callesen is conducting a large trial of a new psychological intervention that in smaller trials has been shown to permanently cure major depression within a short timeframe.

Meta-cognitive Therapy (MCT) versus Cognitive Behaviour Therapy (CBT) for Depression: A Randomised Clinical Trial (MetaDep) – in Denmark of an innovative therapeutic approach for treating emotional disorders, such as generalised anxiety and depression. MCT techniques were recently developed by Dr Adrian Wells, Professor of Clinical and Experimental Psychopathology at Manchester University in the UK. MCT is based on his extensive work on metacognition – thinking about awareness – and emotion over recent decades. It builds upon the self-regulatory executive function model (S-REF model) that he and Dr Gerald Matthews developed, which proposes that cognitive attentional syndrome (CAS) contributes to the development and maintenance of psychological disorders and increases the probability of relapse.

**MCT PRINCIPLES**

In MCT patients, CAS – consisting of worry, rumination and threat monitoring – is identified and reduced. Patients are taught that thoughts and feelings are transitory and only prolonged if the person engages in repetitive thinking processes. Trigger thoughts are typically ‘What if…?’-type questions in worry and ‘Why…?’-type questions in rumination: “Emotional trigger thoughts will not last for long, unless you spend energy on them and so fuel them,” explains Callesen. “A metaphor for trigger thoughts is that they behave like fish hooks – if you bite on them, you will feel worse for a longer time than if you leave them alone and do nothing.”

The technique taught to patients for managing trigger thoughts and avoiding the distress they engender, thus establishing an effective coping mechanism, is detached mindfulness (DM): “Through DM, the patient rediscovers control and that they can stop rumination, which then overcomes depression and low self-esteem,” Callesen elaborates. “DM is the awareness of the automatic and non-volitional ebb and flow of internal events, like thoughts, beliefs and feelings.” Crucially, only six to eight MCT sessions are normally required – half that of CBT.

Could you outline your research into the novel metacognitive therapy (MCT) method for treating depression?

My present study is designed to overcome the limitations of earlier studies (small sample size, no comparison conditions, no blinding, inadequate randomisation), comparing MCT and cognitive behavioural therapy (CBT) in a large randomised clinical trial for major depressive disorder.

**What is the basis of MCT?**

MCT is based on Drs Adrian Wells and Gerald Matthews’ 1994 research on attention and emotion. They developed the metacognitive model of emotional disorders, in which a particular style of repetitive toxic thinking called cognitive-attentional syndrome (CAS) contributes to development, maintenance and relapse of psychological disorders. CAS consists of rumination, worry, dysfunctional attention strategies and behaviour, and is maintained by the individual’s metacognitive beliefs about their thinking, such as ‘I have no control over my worries’. The therapy directly challenges metacognitive beliefs that maintain CAS, by strengthening the patients’ mental awareness, flexibility and control over their rumination.

How does MCT differ from CBT?

MCT exclusively focuses on metacognitive beliefs, whereas CBT focuses on the content of thoughts. For example, negative thoughts about self and the future, such as ‘I’m a failure’, ‘I shall never get my life back’. CBT poses questions that challenge the content of such thinking, eg. ‘What is the evidence/counterevidence that you are a failure?’

But in MCT, thoughts are not important for a person’s wellbeing and therefore their restructuring is not necessary. MCT will only ask metacognitive questions concerning CAS, like ‘How much time do you spend ruminating about being a failure?’ and ‘Can you control your rumination?’

Can you discuss the methodology of your trial?

Outpatients at CEKTOS, a Danish national health service clinic specialised in supervision of and training in CBT, are evaluated by an

**METADEP**

**Thoughts don’t matter**

**Beyond the blues**

The largest ever trial of an innovative new approach – metacognitive therapy – designed to overcome the dysfunctional thinking and beliefs that maintain anxiety and depression is underway in Denmark. In smaller trials, the therapy has been shown to permanently cure depression in most cases.

In depression, negative mood, low self-esteem, fatigue and lack of appetite for life are sustained by tortuous rumination on destructive experiences and thoughts. The illness is often accompanied by co-morbid psychological conditions such as anxiety and compulsive behaviours. Antidepressant drugs and psychological therapy are the usual means of treatment.

Among the psychotherapeutic techniques available, cognitive behavioural therapy (CBT) is considered a highly effective method of equipping a depressed person with coping strategies and thinking skills. It is also quick, typically taking 16 sessions. Yet, despite its impressive record of helping many patients overcome depression, it has recently been established that at least 60 per cent will relapse into depression within 18 months of ending treatment.

Funding her research herself, Dr Pia Callesen of CEKTOS is currently carrying out a trial –
Prior to MetaDep, Callesen conducted a case study of the MCT technique on four depressed individuals in Denmark. The patients were given eight to 11 sessions of MCT and all four were cured after treatment. Follow-up assessments six months later showed no relapses into depression. Other case studies of similarly small sample sizes have revealed that in about 80 per cent of cases the effects of MCT are lasting.

TRIAL APPROACH

For Callesen’s trial, 128 outpatients of a CBT clinic have been randomised to receive either CBT or MCT over 24 weekly sessions. Structured clinical evaluations are carried out before therapy commences; co-morbid conditions, such as anxiety, are assessed by self-report scales such as the Beck Anxiety Inventory.

The patients assigned to MCT begin therapy by thinking about a recent depressive episode, identifying the trigger thought that initiated the rumination process and describing how this affected their emotional wellbeing. This produces the metacognitive case formulation – their personal example of CAS. The patient’s negative and positive metacognitions are then identified and challenged. Following this, attention training – ATT – is introduced, with the patient encouraged to practice ATT for 10 minutes every day: "This enhances their metacognitive awareness, flexibility and control," explains Callesen. In between sessions, this homework is an important part of their treatment, which culminates with planning for the future, including strategies for avoiding relapse.

As smaller trials have shown excellent results from MCT, Callesen is confident that MetaDep will reveal the approach to be at least as effective as CBT, but with fewer sessions required.