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Christina Andreou, Ryan P. Balzan, Lena Jelinek, Steffen Moritz

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Letter to the Editor: Metacognitive training *and* metacognitive therapy. A reply to Lora Capobianco and Adrian Wells

Christina Andreou[1], Ryan P. Balzan, Lena Jelinek[1] and Steffen Moritz[1*]

Author Note:

Christina, Andreou, M.D., University Medical Center Hamburg-Eppendorf, Department of Psychiatry and Psychotherapy, Hamburg, Germany

[1]University Medical Center Hamburg-Eppendorf, Department of Psychiatry and Psychotherapy, Hamburg, Germany

[2]School of Psychology, Flinders University, Australia

Corresponding author: Steffen Moritz, moritz@uke.de; FAX: ++49 (0)40 741057566

To the Editor: It is indeed unfortunate that our metacognitive treatment programs use a similar name as the psychotherapy developed by Adrian Wells. Nevertheless, we believe that our use of the term 'metacognitive' is justified.

The term 'metacognition' is somewhat over-inclusive. Coined by Flavell (1979) it is usually understood as "thinking about one's thinking". Yet, subsequent research used the term in various ways (Koriat, 2002). For example, metacognition has been closely tied to confidence/doubt (Koriat & Levy-Sadot, 1999). In neuropsychology, a discrepancy between subjective and objective performance is termed a deficit in metacognition. At times, Flavell's definition of metacognitive knowledge is quite close to the concept of social cognition further blurring the boundaries (p. 906).

The idea for metacognitive *training* for psychosis originated in the early 2000s based on research indicating 'cognitive biases' in people with psychosis (Garety & Freeman, 1999), such as jumping to conclusions (JTC), incorrigibility and overconfidence (note that these are not "thought contents" as Capobianco and Wells write, but rather overarching distortions in the processing of information; see Pohl, 2004). Importantly, awareness of these biases is poor in many patients. The primary goal of our approach was to 'straighten' these cognitive biases (not to be confused with emotional biases proposed by Aaron Beck) and raise metacognitive awareness in a gentle, non-confrontational manner (e.g., through playful exercises that generate surprising outcomes [i.e., metacognitive experience] and through education regarding cognitive biases [i.e., metacognitive knowledge]). A recurring theme in MCT for psychosis is that patients should check whether their confidence in a given judgment is justified (metacognitive strategy, cf. Koriat, 2002) and to "sow the seeds of doubt".

Importantly, MCT exercises on cognitive biases use delusion-neutral material. Although the ultimate goal is to improve delusions, this is achieved indirectly, as the main emphasis of the intervention remains on the modification at a meta-level of processing (e.g., confidence in judgements). We therefore reject the claim that our program "is clearly a cognitive behavioral approach that deals with the content of negative thoughts."

Over the years, we incorporated compatible elements from CBT, while the focus remained on metacognition. Why did we do this? Initially, we had the perhaps naive hope that our MCT would run alongside other psychotherapeutic programs on wards. However, as the literature shows, psychotherapy for psychosis is rarely provided. In order to address this problem within our low-threshold program, the newest versions of MCT and MCT+ include modules with a CBT orientation, dealing with issues deemed by patients to be a priority in treatment, namely

self-esteem and stigma. We have devised a number of MCT interventions for other disorders, which are clearly rooted in the setup and presentation mode of MCT for psychosis. These disorder-specific versions were developed as hybrids to amalgamate a cognitive and a metacognitive perspective, as we do not view working on a cognitive or metacognitive level as mutually exclusive.

Wells' work dates back to the 1990s - however, to the best of our knowledge, the term 'metacognitive therapy' was introduced much later. When we became aware of its existence, MCT for psychosis was already available and used in many different languages (currently 33 languages). Therefore, changing its name would have created new confusion; however, we used slightly different names or acronyms (e.g., myMCT) to distinguish the two approaches.

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The authors are the developers of metacognitive training (MCT)