

Attention-Focused and Attention-Related Interventions in Metacognitive Therapy

 Sedat Batmaz

Department of Psychology, Social Sciences University of Ankara, Ankara, Türkiye

ABSTRACT

In metacognitive therapy (MCT), attention is targeted not to produce temporary calm or distraction but because the cognitive attentional syndrome (CAS) is maintained by maladaptive attentional habits such as self-focused attention, threat monitoring, checking, and the repeated return to internal cues. This clinically oriented narrative review examines the principal attention-focused and attention-related interventions used in MCT from a strictly metacognitively consistent perspective. It distinguishes between techniques that act directly on attentional deployment, including the attention training technique, situational attentional refocusing, external attention practice, and therapist-guided *in vivo* attentional reallocation, and techniques that modify attention more indirectly by altering metacognitive engagement, including detached mindfulness, worry postponement, rumination postponement, anti-monitoring behavioral experiments, and response delay. A further distinction between core-level techniques and implementation-level variants is introduced to preserve conceptual clarity while retaining clinical flexibility. The review also summarizes the rationale, mechanisms, clinical markers, targets, therapist language, common delivery errors, and evidence base for these procedures. Overall, the literature suggests that attention modification in MCT is clinically meaningful when delivered within a coherent metacognitive formulation and aimed at weakening the CAS rather than managing symptoms moment by moment.

Keywords: Metacognitive therapy, attention training technique, detached mindfulness, cognitive attentional syndrome, threat monitoring.

ÖZ

Metakognitif Terapide Dikkat Odaklı ve Dikkatle İlgili Müdahaleler

Metakognitif terapide (MKT) dikkat, geçici bir rahatlama ya da dikkat dağıtma sağlamak amacıyla değil, bilişsel dikkat sendromunun (BDS) kendine odaklı dikkat, tehdit izleme, kontrol etme ve içsel ipuçlarına yinelenen geri dönüş gibi işlevsel olmayan dikkat alışkanlıklarıyla sürdürülmesi nedeniyle hedef alınır. Klinik odaklı bu anlatsal derleme, MKT’de kullanılan başlıca dikkat odaklı ve dikkatle ilişkili müdahaleleri, üstbilişsel modele sıkı biçimde bağlı bir perspektiften incelemektedir. Bu kapsamda, dikkat yerleşimini doğrudan etkileyen teknikler, dikkat eğitimi tekniği, durumsal dikkati yeniden odaklama, dışı odaklı dikkat uygulamaları ve terapist eşliğinde seans içinde dikkat yeniden yönlendirme ile dikkati daha dolaylı biçimde, üstbilişsel katılımı değiştirerek etkileyen teknikler, mesafeli farkındalık, endişelenmeyi erteleme, ruminasyonu erteleme, izlemeyi azaltmaya yönelik davranışsal deneyler ve tepkiyi geciktirme birbirinden ayrılmaktadır. Kavramsal netliği koruyup klinik esnekliği de sürdürebilmek amacıyla, çekirdek düzey tekniklerle uygulama düzeyi varyantlar arasında ek bir ayırım daha önerilmektedir. Derleme ayrıca bu müdahalelerin kuramsal gerekçelerini, etki mekanizmalarını, klinik belirteçlerini, hedef süreçlerini, terapist dilini, sık görülen uygulama hatalarını ve mevcut kanıt temelini özetlemektedir. Genel olarak alanyazın, MKT’de dikkatin değiştirilmesine yönelik müdahalelerin, ancak tutarlı bir üstbilişsel kavramsallaştırma içinde ve belirtileri anlık olarak yönetmekten çok BDS’yi zayıflatmayı hedefleyecek biçimde uygulandığında klinik açıdan anlamlı olduğunu düşündürmektedir.

Anahtar Kelimeler: Bilişsel dikkat sendromu, dikkat eğitimi tekniği, mesafeli farkındalık, metakognitif terapi, tehdit izleme.



Cite this article as:

Batmaz S. Attention-Focused and Attention-Related Interventions in Metacognitive Therapy. J Cogn Behav Psychother Res 2026;15(3):172-182.

Address for correspondence:

Sedat Batmaz.
Ankara Sosyal Bilimler
Üniversitesi, Psikoloji Bölümü,
Ankara, Türkiye
Phone: +90 312 596 44 44
E-mail:
sedat.batmaz@asbu.edu.tr

Submitted: 17.04.2026

Revised: 02.06.2026

Accepted: 10.06.2026

Available Online: 19.08.2026

JCBPR, Available online at
<http://www.jcbpr.org/>



This work is licensed under
a Creative Commons
Attribution-NonCommercial
4.0 International License.

INTRODUCTION

In metacognitive therapy (MCT), attention is not modified because the therapist wants the patient to be calmer, distracted, or temporarily less distressed. This interpretation would be too limited and clinically unstable. Attention is targeted because the cognitive attentional syndrome (CAS) depends on a specific style of allocation: self-absorption, threat monitoring, checking, and repeated return to internal cues. If that style is left intact, symptom relief tends to be unstable because the patient keeps reactivating the same maintenance loop. Wells' treatment model is explicit on this point. The aim is to reduce the CAS and modify the metacognitive control system that governs it (Wells, 2009, 2019). In session, this means helping the patient discover that attention can be deployed more flexibly, that monitoring is not the safeguard it appears to be, and that inner events do not need continuous management.

DISTINGUISHING METACOGNITIVE INTERVENTION TYPES

A practical distinction is useful when considering metacognitive interventions. Some MCT procedures are directly attention-focused: they train the selection, shifting, division, or redirection of attention. Others are attention-related: they reduce maladaptive engagement with thoughts and cues by altering metacognitive responses. These categories work together in a good therapy. An experienced MCT therapist rarely treats attention as a standalone faculty. The target is the patient's whole style of mental responding. However, it still matters to know whether one is training attentional control itself, reducing self-monitoring *in vivo*, or changing the rules that tell the patient to monitor in the first place. This distinction becomes especially important once we move from the attention training technique (ATT) to detached mindfulness (DM), postponement, and anti-monitoring experiments.

Direct Attention-Focused Techniques

A useful distinction begins with the question of what is being changed first. In some MCT procedures, the immediate target is attentional deployment itself: where does attention go, how long does it stay there, and can it be shifted voluntarily? ATT belongs here most clearly. So do situational attentional refocusing (SAR) and other forms of deliberate external reallocation used when the patient would otherwise collapse into self- or threat monitoring. These are direct attention-focused techniques because their first therapeutic move is not to analyze thoughts, dispute content, or process emotion. It alters how attention is being allocated in the moment. This is important in the metacognitive treatment model because the CAS is fed by a characteristic attentional style.

Direct techniques, therefore, work on one of the system's most visible operating components: self-absorption, threat monitoring, attentional fixation, and inflexible return to internal cues. Metacognitive theoretical writing is consistent on this point, and the small ATT and SAR literature in social anxiety also reflects it. These procedures are designed to modify attentional control and situational allocation rather than to restructure propositional content (Wells, 2009; Vogel et al., 2016; Jahn et al., 2023).

In practice, experienced MCT therapists know that these techniques can look deceptively simple from the outside. However, they are not. ATT is not "paying attention to sounds" in any generic sense. SAR is not an ordinary distraction. Their therapeutic value lies in the specific shift they produce: from reflexive, threat-led, self-referential allocation to flexible, top-down attentional control. When performed well, the patient does not merely feel temporarily better. They learn something far more important, i.e., that attention is less captive, less fused with alarm, and more trainable than the CAS led them to believe. Therefore, these procedures are central rather than decorative in MCT. Recent experimental work on ATT has continued to frame the technique in precisely these terms, i.e., as a method for enhancing attentional flexibility and control (Knowles et al., 2016; Haukaas et al., 2018; Jahn et al., 2023).

Attention-Related Metacognitive Interventions

Other interventions influence attention just as powerfully, but they do so by a different route. Their immediate target is not attentional placement itself. It is the patient's mode of engagement with internal events and the metacognitive rules that govern that engagement. DM is the clearest example. Wells' 2005 paper defined DM as a metacognitive state in which thoughts are noticed without extended conceptual processing, suppression, evaluation, or response (Wells, 2005). This definition is important because it prevents the usual drift into broader mindfulness vocabularies that do not belong to the metacognitive model. In MCT, DM is not primarily a relaxation exercise, an acceptance ritual, or a contemplative stance borrowed from elsewhere. It is a strategic change in cognitive handling that prevents trigger thoughts from recruiting further CAS activity. The immediate clinical gain is not "feeling more calm" in the abstract. It is, specifically, less engagement, less elaboration, and, thus, less attentional capture by thought.

The same logic applies to postponement procedures and anti-monitoring experiments. Worry postponement is not direct attentional retraining in the ATT sense. Instead, it weakens the rule that threat-related cognition must be entered immediately. Anti-monitoring experiments do not begin by

teaching attention switching. They begin by testing the belief that continuous checking, self-observation, or surveillance is necessary for safety, certainty, or control. Once those beliefs start to loosen, attention often changes with them. The patient no longer needs to keep returning to the body, the self-image, the thought stream, or the emotional state with the same urgency. These are, hence, best described as attention-related metacognitive interventions (Wells, 2009; Krzikalla et al., 2024; Atmaca et al., 2024). They reduce maladaptive attentional engagement indirectly, i.e., by changing the person's relationship to thinking and to the urge to monitor. That distinction is entirely compatible with the metacognitive model and is clinically useful because it helps the therapist avoid delivering every intervention as if it were just another attention drill.

Core-Level and Implementation-Level Techniques

A second distinction is needed for the intervention section to remain conceptually clean. Not all MCT techniques occupy the same level of theoretical and clinical status. Some are best understood as core-level techniques. These are conceptually central procedures with clear transdiagnostic relevance and a sufficiently distinct therapeutic rationale to justify their use as primary interventions in their own right. In this review, ATT, SAR, external attention practice, DM, worry postponement, rumination postponement, anti-monitoring behavioral experiments, response delay, and therapist-guided *in vivo* attentional reallocation are treated in this way. They each target a meaningful part of the CAS or a major metacognitive rule governing attentional engagement, and they can be formulated as principal intervention choices rather than as mere clinical add-ons (Wells, 2009, 2019).

Alongside these, however, there is a second group of procedures that are clinically useful but better understood as implementation-level techniques. These are narrower delivery variants, contextual adaptations, or between-session extensions of the core procedures rather than fully independent techniques with equivalent theoretical status. Monitoring reduction homework, dropping self-observation, reducing body monitoring, reducing emotional state monitoring, and anti-review work are good examples. They are not unimportant. On the contrary, they are often the place where change becomes portable and durable in everyday life. But conceptually, they usually derive their logic from one or more core-level procedures rather than standing alone as distinct metacognitive methods. Treating them as implementation-level techniques allows the review to preserve both fidelity and clinical richness. In this way, the conceptual architecture remains clear, while practical refinements still have a legitimate place in the treatment model (Wells, 2009).

Why These Distinctions Matter Conceptually and Clinically

These distinctions are important because confusion here quickly leads to technical drift. If ATT, DM, postponement, anti-monitoring work, and a range of narrower practical tactics are all loosely described as “attention strategies,” the model loses precision. One begins to miss the fact that different procedures are correcting different parts of the CAS and that they do so at different levels of intervention. Direct, attention-focused techniques mainly challenge inflexible allocation and the felt inability to redirect attention. Indirect, attention-related techniques mainly challenge the metacognitive imperative to engage, monitor, analyze, or secure certainty (Wells, 2009, 2019; Pukstad et al., 2025). Core-level techniques provide the main therapeutic architecture. Implementation-level techniques sharpen, extend, or operationalize that architecture in specific situations, symptom constellations, or homework contexts. In good therapy, these levels converge on similar outcomes, e.g., less self-focused processing, less threat monitoring, and less perseveration, but they do not get there in the same way. A therapist who ignores these distinctions will often misapply the intervention. A patient who needs to discover that attention can be moved voluntarily may not benefit from a vaguely delivered DM instruction. A patient who is covertly treating ATT as a safety behavior may need belief-focused anti-monitoring work more than repetition of the drill. A patient who understands the rationale in session may still need implementation-level procedures, such as monitoring reduction homework, to prevent the same surveillance habits from reappearing between sessions. This is one of those places where experienced MCT practice becomes recognizably different from generic cognitive behavioral therapy language. The procedure must be matched not only to the active metacognitive problem but also to the level at which that problem is best addressed.

There is also a research reason to keep these distinctions clear. When outcomes are reported for MCT components, the field benefits from knowing whether change followed a direct modification of attentional control, a reduction in self-monitoring during live situations, a shift in metacognitive engagement with thoughts, or the successful application of a narrower implementation-level variant in daily life. The exploratory study of ATT and SAR in social anxiety, for example, is informative precisely because it treats those interventions as identifiable procedures rather than as an undifferentiated package (Vogel et al., 2016). DM studies are more interpretable when they preserve the original construct instead of blending it with broader mindfulness terminology (Wells, 2005; Bolzenkötter et al., 2024; Atmaca et al., 2024). The

same principle applies to implementation-level strategies. They become more meaningful when linked clearly to the core technique they are extending. As the empirical literature grows, conceptual cleanliness will matter more, not less. A review on attention in MCT should, therefore, insist on these distinctions, i.e., some interventions train attention directly, others alter the metacognitive conditions under which attention becomes trapped, and still others represent structured implementations of those core procedures in narrower clinical forms. That is not a minor taxonomic preference. It is part of preserving the logic, fidelity, and technical precision of the model.

These distinctions provide the framework for the intervention section that follows. The techniques reviewed in the next section are organized primarily around their clinical and metacognitive function rather than around disorder categories. The emphasis is on how each procedure modifies attentional deployment, attentional engagement, or the metacognitive rules that keep the CAS active. For that reason, the review begins with the core-level techniques that form the main therapeutic architecture of attention modification in MCT and then situates narrower implementation-level variants in relation to those core procedures. This structure is intended to preserve both conceptual clarity and clinical usefulness while remaining fully consistent with the metacognitive model (Wells, 2009, 2019).

This distinction also helps position MCT more clearly in relation to other cognitive-behavioral traditions. Although attention may be addressed in several therapeutic approaches, attention modification in MCT is not primarily conceptualized as distraction, symptom management, reassurance reduction, or a broad mindfulness exercise. Its rationale is more specific, i.e., to weaken the CAS by altering maladaptive attentional deployment, metacognitive engagement, and the beliefs that make monitoring seem necessary.

The present paper is intended as a clinically oriented narrative and conceptual review rather than a systematic review. The literature discussed was selected to clarify the rationale, technical distinctions, and clinically relevant use of attention-focused and attention-related interventions within the metacognitive model. Accordingly, no formal PRISMA-style search strategy, study-selection flowchart, or structured quality appraisal was undertaken, and the evidence is synthesized selectively in the service of conceptual and clinical clarification.

SPECIFIC METACOGNITIVE ATTENTION MODIFICATION TECHNIQUES

The interventions are summarized across two companion tables to make the distinctions easier to use. Table 1 focuses

on status, definition, rationale, and mechanism of action. Table 2, then, turns to how the techniques are actually recognized and used in clinical work by summarizing their structure or components, the clinical markers that indicate a good fit, and their principal therapeutic targets. Together, the two tables are intended to serve as a compact map of the attention-focused and attention-related intervention repertoire in MCT (Wells, 2009, 2019).

Taken together, Table 1 shows that attention modification in MCT is not a single technique category but a structured set of interventions that differ in terms of immediate target, therapeutic status, and mechanism. This distinction is clinically useful because it helps prevent overly broad descriptions of all attention-related work as if it were functionally identical. It also clarifies that some procedures act directly on attentional deployment, whereas others act more indirectly by changing metacognitive engagement or the rules that sustain monitoring.

Table 2 translates these distinctions into clinical use by showing how the technique structure, best-fit markers, and therapeutic targets align. In this way, the table is intended less as a rigid treatment algorithm than as a formulation aid for identifying the type of attentional-metacognitive problem that is most active in the individual case.

In addition to the information summarized in these tables, a further clinical question remains: when should one intervention be preferred over another? In routine practice, this decision is rarely made on the basis of the diagnosis alone. Instead, it is guided by the immediate configuration of the CAS: (i) what is the patient monitoring? (ii) how is attention being used? (iii) is the main difficulty capture, engagement, urgency, or procedural checking? and (iv) is the intervention likely to work best as a first move or only after other metacognitive groundwork has been laid? The next table summarizes the main clinical decision markers that can help the therapist choose among the ten interventions reviewed here (Wells, 2009, 2019; Pukstad et al., 2025).

As may be inferred from Supplementary Table 1 (available at <https://osf.io/pybcj/>), selection of an intervention in MCT is not based on diagnosis alone. The therapist listens for the active CAS pattern and chooses the intervention that best matches the patient's immediate attentional-metacognitive problem. In practice, the key distinction is often this: does the patient need help moving attention, help dropping engagement, help weakening urgency, or help testing the belief that monitoring is necessary?

Table 1. Attention-focused and attention-related interventions in MCT: status, definition, rationale, and mechanism of action

Intervention	Status	Definition	Rationale	Mechanism of action
Attention training technique	Core-level; attention-focused	A direct attention-focused MCT procedure that trains selective attention, switching, and divided attention under voluntary control.	Used when attention is experienced as dominated by threat, symptoms, self-focus, or intrusive internal material.	Strengthens top-down attentional flexibility and reduces fixation and the perceived uncontrollability of attention.
Situational attentional refocusing	Core-level; attention-focused	In vivo reallocation of attention from self-monitoring or threat monitoring to external, task-relevant cues during live situations.	Used when attention collapses inward under situational load, especially in evaluative or interpersonal contexts.	Weakens self-focused processing and restores situational participation by leaving the observer position.
External attention practice	Core-level; attention-focused	A structured practice of sustained outward allocation of attention while refraining from internal surveillance.	Used when the patient remains covertly absorbed in monitoring the body, self, or emotions during activity.	Reduces the dominance of internal surveillance and increases engagement with the external environment.
Detached mindfulness	Core-level; attention-related	A metacognitive mode in which thoughts and inner events are noticed without extended conceptual processing, suppression, evaluation, or response.	Used when the main difficulty is not where attention goes but rather the tendency to engage with thoughts and feelings once they appear.	Reduces elaborative engagement and prevents trigger cognitions from recruiting further CAS activity.
Worry postponement	Core-level; attention-related	A structured delay of engagement with worry until a predetermined later period.	Used to challenge the belief that worry must be entered immediately.	Weakens the trigger-engagement link and modifies beliefs about urgency and uncontrollability.
Rumination postponement	Core-level; attention-related	A structured delay of engagement with depressive or self-referential analytical thinking.	Used to weaken the belief that low mood or self-relevant pain must be analyzed immediately.	Interrupts the move from an affective trigger to conceptual self-processing.
Anti-monitoring behavioral experiments	Core-level; attention-related	Prediction-based behavioral experiments designed to test beliefs that monitoring is necessary, useful, or protective.	Used when the patient explicitly or implicitly believes that monitoring prevents danger, humiliation, deterioration, or loss of control.	Provides experiential disconfirmation of metacognitive rules sustaining monitoring.
Response delay and reduction of checking urges	Core-level; attention-related	A brief interruption procedure in which checking is delayed rather than enacted immediately.	Used when checking has become rapid, procedural, and almost reflexive.	Creates space between the trigger and the checking response, weakening urgency and procedural momentum.
Therapist-guided <i>in vivo</i> attentional reallocation	Core-level; attention-focused	Real-time therapist coaching of attentional deployment during live CAS activation in a session or task.	Used when patients misjudge where their attention is actually going or when covert monitoring persists despite verbal understanding.	Corrects subtle self-monitoring, sharpens attentional deployment, and prevents hidden drift into CAS-consistent processing.
Monitoring reduction and implementation-level variants	Implementation-level; mixed attention-focused and attention-related	A grouped category of narrower delivery strategies that operationalize the core principles of anti-monitoring, refocusing, disengagement, and between-session consolidation.	Included to capture clinically useful variants that do not require full standalone status as independent techniques.	Applies core MCT principles in focused, situational, or homework-based forms.

Definitions, rationales, and mechanisms are synthesized from the metacognitive treatment model and the technique-specific literature on ATT, detached mindfulness, postponement, anti-monitoring work, and related procedures. Status combines two distinctions introduced in Section 1, i.e., whether the procedure is treated as a core-level or implementation-level intervention and whether it operates primarily as an attention-focused or attention-related technique. These labels are intended to preserve conceptual clarity rather than to imply rigid boundaries. In practice, some procedures may influence both attentional deployment and metacognitive engagement, but they are classified here according to their most immediate therapeutic function within the metacognitive model (Wells, 2005, 2009, 2019; Knowles et al., 2016; Vogel et al., 2016; Haukaas et al., 2018; Krzikalla et al., 2024; Bolzenkötter et al., 2024; Atmaca et al., 2024).

Table 2. Attention-focused and attention-related interventions in MCT: structure, best-fit markers, and clinical targets

Intervention	Technique structure/components	Best-fit clinical markers	Clinical targets
Attention training technique	Selective attention, rapid switching, divided attention, and repeated practice of deliberate attentional allocation.	<i>"My mind gets stuck there"; "I can't pull my attention away";</i> strong attentional capture and shifting difficulty.	Self-focused attention, threat monitoring, attentional fixation, disengagement difficulty, and beliefs about attentional uncontrollability.
Situational attentional refocusing	Identify the trigger situation, specify the attentional error, select an external anchor, practice <i>in vivo</i> , and review attentional placement and functioning.	<i>"As soon as I'm with people, I go inside myself";</i> strong performance monitoring in live situations.	Self-focused attention, performance monitoring, audience scanning, and situational internal checking.
External attention practice	Identify the internal surveillance pattern, choose external anchors, sustain outward allocation, detect covert relapse, and repeat across settings.	<i>"I was there but was really inside my head";</i> covert body/self-monitoring during tasks.	Internal surveillance, body monitoring, self-observation, and emotional state checking during activity.
Detached mindfulness	Identify the trigger cognition, clarify noticing versus engaging, practice non-response, generalize across triggers, and review engagement rather than symptom reduction.	<i>"Once the thought comes, I have to deal with it";</i> repetitive engagement with inner events.	Conceptual elaboration, repetitive engagement, cognitive monitoring, emotional state analysis, and mental checking.
Worry postponement	Identify onset markers, label worry, defer engagement, return to the present task, and review urgency and predicted consequences.	<i>"If I don't think about this now, I'll miss something";</i> immediate future-oriented threat thinking.	Urgency-driven worry engagement, beliefs about immediate responsibility, and the uncontrollability of worry.
Rumination postponement	Detect early rumination markers, label rumination, postpone engagement, return to activity, and review assumptions about usefulness and necessity.	<i>"As soon as I feel low I start working out why";</i> repetitive self-review or post-event rumination.	Depressive dwelling, self-focused review, mood monitoring, and beliefs about the necessity of analysis.
Anti-monitoring behavioral experiments	Identify the exact form of monitoring, the elicit belief, make a prediction, reduce or drop monitoring, and review effects on safety, uncertainty, and distress.	<i>"If I stop checking, I'll miss something serious"; "If I don't monitor, I'll lose control."</i>	Body monitoring, self-monitoring, cognitive monitoring, emotional surveillance, and certainty-driven checking.
Response delay and reduction of checking urges	Identify the checking sequence, detect the earliest actionable point, delay the response, reallocate attention, and review the urge and prediction.	<i>"It happens before I even think";</i> fast pulse checking, mental review, and reassurance-linked scanning.	Checking urges, procedural monitoring habits, certainty-seeking return to threat material, and beliefs that delay is dangerous.
Therapist-guided <i>in vivo</i> attentional reallocation	Elicit the live process, identify covert monitoring, coach the attentional shift in real time, refine the target, and review actual attentional behavior.	The patient reports "using the technique" but still monitors covertly; persistent subtle self-observation in session.	Covert self-monitoring, subtle situational threat monitoring, poor technique implementation, and real-time drift into the CAS.
Monitoring reduction and implementation-level variants	May include monitoring reduction homework, dropping self-observation tasks, reducing body monitoring, reducing emotional state monitoring, and anti-review work.	Patients with recurrent everyday surveillance habits or narrow, context-bound monitoring patterns that need a practical extension of core work.	Routine surveillance habits, between-session reactivation of the CAS, narrow monitoring variants, post-event review, and relapse-style checking.

The descriptions of technique structure/components are intended as concise procedural summaries rather than as full treatment protocols. Best-fit clinical markers refer to the kinds of patient statements, process indicators, and CAS patterns that typically signal a good intervention fit in routine MCT practice. Clinical targets refer to the dominant attentional and metacognitive processes that each procedure is designed to modify. Technique structure/components, best-fit clinical markers, and clinical targets are derived from the metacognitive treatment model and clinical and component studies examining attentional control, SAR, DM, postponement, and related metacognitive procedures (Wells, 2005, 2009; Vogel et al., 2016; Haukaas et al., 2018; Jahn et al., 2023; Krzikalla et al., 2024; Atmaca et al., 2024).

ILLUSTRATIVE THERAPIST LANGUAGE FOR METACOGNITIVE ATTENTION MODIFICATION TECHNIQUES

The next step is to demonstrate how these interventions sound in clinical use. This is important because even technically correct procedures can lose their metacognitive character when poorly translated into therapist language. In MCT, fidelity is preserved not only by the choice of intervention but also by the way the rationale, task, and therapeutic target are communicated in the session. The goal is never simply to calm the patient, distract them, or help them cope in a broad sense. The goal is always to modify attentional deployment, attentional engagement, or the metacognitive rules that keep the CAS active (Wells, 2009, 2019).

Therefore, the table below presents illustrative therapist scripts for the ten interventions retained in the treatment architecture. These scripts are not intended to be full protocols or fixed verbal formulas. They are brief examples of how the therapist can preserve the logic of the metacognitive model while speaking in language that is concrete, clinically usable, and process-focused (Wells, 2005, 2009).

Table 3 illustrates that therapist language is not merely a stylistic matter. The same intervention can preserve or lose its metacognitive character depending on how the rationale and task are framed in the session. In this sense, therapist wording functions as part of the intervention itself rather than as a neutral delivery method.

COMMON THERAPIST ERRORS IN DELIVERING METACOGNITIVE ATTENTION MODIFICATION TECHNIQUES

Although illustrative scripts are useful because they show how MCT interventions sound when they are delivered well, the reverse question is clinically just as important: how do these same interventions drift off the model? In practice, attention-focused work often fails not because the chosen technique is wrong but because the therapist's wording, rationale, or in-session emphasis quietly shifts the intervention away from the metacognitive model and toward reassurance, symptom control, content discussion, or generic coping advice. The next table, hence, summarizes common therapist errors across the ten intervention categories reviewed. Its purpose is not merely corrective. It is to help preserve technical fidelity by showing where even experienced clinicians can begin to drift when working with attention modification in MCT (Wells, 2005, 2009, 2019).

In MCT, therapist error usually appears when the intervention drifts away from the metacognitive rationale and becomes symptom control, reassurance, content debate, or generic

coping advice. In many cases, a useful safeguard is to keep returning to the following four questions: (i) what is the patient monitoring? (ii) what belief authorizes that monitoring? (iii) what aspect of the CAS is active right now? and (iv) which intervention best targets that exact process? (Wells, 2005, 2009, 2019).

Taken together, the scripts in Table 3 and the errors summarized in Supplementary Table 2 (available at <https://osf.io/pybcj/>) make a broader point about attention modification in MCT. Technical success depends not only on which intervention is chosen but also on whether the intervention is delivered in a way that preserves its metacognitive function. The same procedure can either weaken the CAS or be absorbed back into it, depending on how it is framed and practiced, e.g., ATT can become symptom control, DM can become suppression, postponement can become avoidance, and monitoring reduction can become another form of covert checking unless the therapist keeps returning to the above-listed core questions. In that sense, therapist language is not a cosmetic part of treatment delivery. On the contrary, it is one of the places where fidelity to the metacognitive model is either preserved or lost (Wells, 2005, 2009, 2019).

EVIDENCE BASE FOR ATTENTION-FOCUSED INTERVENTIONS IN METACOGNITIVE THERAPY

The available literature suggests that attention-focused and attention-related work in MCT is clinically relevant across multiple disorders and delivery formats, although the strength and specificity of the evidence vary by technique and study type (Knowles et al., 2016; Normann & Morina, 2018; Rochat et al., 2018; Andersson et al., 2025). The most direct support comes from component and experimental studies examining ATT, DM, postponement, and related procedures, whereas the broader clinical literature provides stronger evidence for full MCT treatment packages (Haukaas et al., 2018; Jahn et al., 2023; Bolzenkötter et al., 2024; Atmaca et al., 2024; Krzikalla et al., 2024). For clarity, the evidence discussed below is divided into two broad levels: (i) studies examining specific attention-focused or attention-related components, and (ii) studies evaluating full MCT treatment protocols in which such procedures are embedded within a broader metacognitive intervention package.

The broader MCT outcome literature strengthens this picture at the level of full treatment packages. These comparator studies are useful for positioning MCT within the broader literature on cognitive behavioral therapy, but they should not be interpreted as direct evidence for the isolated causal contribution of any single-component technique discussed in the present review. Randomized and comparative trials across anxiety, depression, obsessive-compulsive disorder, health

Table 3. Illustrative therapist scripts for core-level and implementation-level attention modification techniques in MCT

Intervention	Clinical aim	Illustrative therapist script
Attention training technique	Strengthen flexible top-down attentional control and reduce the sense that attention is trapped by threat or internal events	<i>“For the next few minutes, I do not want you to try to relax or get rid of anything. The task is different. I want you to discover that attention can be placed where you choose, moved when you choose, and broadened when you choose. If your mind pulls back to the symptom, the worry, or the feeling, that is not a problem. Simply bring it back to the sound I ask you to focus on. We are training control, not chasing comfort.”</i>
Situational attentional refocusing	Shift attention in vivo from self-monitoring or threat monitoring to external, task-relevant cues	<i>“As you speak, notice what usually happens: part of your attention goes inward and starts checking how you are coming across. This time, I want you to leave yourself alone. Put your attention on the other person’s words, their meaning, the flow of the conversation, and the next practical thing happening in the room. Your job is not to monitor yourself well. Your job is to participate.”</i>
External attention practice	Reduce internal surveillance and restore engagement with the environment	<i>“Right now, you are still half inside yourself, checking. Let us move fully outward. What do you see in the room? What is the other person actually saying? What details are present outside you that you normally miss when you start supervising your body or your performance? Stay with the environment without first solving the feeling inside.”</i>
Detached mindfulness	Help the patient notice thoughts and internal events without entering into extended processing or control attempts	<i>“Let the thought be there, but do not go in after it. Do not answer it, analyze it, test it, or try to stop it. Notice that it has appeared, and let it remain just as a mental event. We are not trying to make it disappear. We are dropping the habit of engaging with it.”</i>
Worry postponement	Weaken the rule that threat-related thinking must be entered immediately	<i>“When the urge to worry arrives, I want you to respond differently from usual. Instead of starting the process now, note that the worry has shown up and postpone it until the planned time. This is not avoidance. It is a test of the belief that you must engage immediately. We are finding out whether the thought really needs your attention now.”</i>
Rumination postponement	Interrupt immediate self-focused analytical processing and depressive dwelling	<i>“The moment you notice yourself starting to go over why you feel like this, what it means, or what it says about you, pause. You do not need to solve the mood right then. Label it as rumination, leave it for the set period, and return to what you are doing. The question is not whether the topic feels important. The question is whether engaging now helps or traps you.”</i>
Anti-monitoring behavioral experiments	Test beliefs that monitoring is necessary for safety, control, or adequate functioning	<i>“You believe that if you stop checking, something important will be missed. Let us test that directly. For the next few minutes, I want you not to monitor your body / your thoughts / your performance in the usual way, and we will see what actually happens. We are not debating the belief in theory. We are putting it under observation.”</i>
Response delay and reduction of checking urges	Create space between the trigger and the checking response and weaken the urgency of procedural monitoring	<i>“When the urge to check appears, do not satisfy it straight away. Delay it. Stay with the urge without obeying it. Watch what the mind predicts, and notice what happens if you do nothing for a moment. This helps us see that checking is not inevitable and that urgency is not the same as necessity.”</i>
Therapist-guided in vivo attentional reallocation	Correct covert self-monitoring and sharpen real-time attentional deployment during live CAS activation	<i>“You are still checking yourself right now. I can hear it in the way you keep reporting what you think you look like from the outside. Let us reset. Drop the internal commentary. Put your attention back on my words, the actual exchange between us, and what is happening here rather than inside the observer position.”</i>
Monitoring reduction and implementation-level variants	Translate core intervention principles into narrower daily-life variants, homework-based forms, and context-specific anti-monitoring practices	<i>“This week, I want you to spot the small monitoring routines that keep the problem alive: checking your body, reviewing the conversation afterward, measuring your mood, or watching yourself while you speak. The task is not to replace one checking strategy with another. The task is to stand down. Notice the urge, drop the monitoring, and return to the situation rather than supervising it.”</i>

These scripts are illustrative and should be adapted to the patient’s formulation, developmental level, and current CAS pattern. In MCT, therapist language remains process-focused: the target is not thought content, emotional catharsis, or reassurance, but the patient’s style of attentional deployment and the metacognitive beliefs that sustain it. The rationale of the scripts is derived from the metacognitive treatment model and the technique-specific literature on ATT, SAR, DM, postponement, and related interventions (Wells, 2005, 2009, 2019; Vogel et al., 2016; Haukaas et al., 2018; Krzikalla et al., 2024; Bolzenkötter et al., 2024; Atmaca et al., 2024).

anxiety, post-traumatic stress disorder, and related conditions indicate that MCT is effective and often highly competitive with established psychological treatments (Normann & Morina, 2018; Callesen et al., 2020; Wells et al., 2015; Nordahl et al., 2018; Brown et al., 2022; Bailey et al., 2024; Exner et al., 2024). Such studies are highly relevant to the clinical credibility of the metacognitive model as a whole, but they do not by themselves isolate the proportion of the outcome attributable to any one attention-focused or attention-related element. Although these trials do not always experimentally isolate attention-focused components, they are still relevant because attention modification is built into the treatment logic of MCT rather than added as a peripheral tool. By implication, the clinical message here is important: ATT, SAR, DM, postponement, and anti-monitoring work are best understood not as isolated tricks but as parts of a coherent metacognitive system designed to reduce the CAS (Wells, 2009, 2019; Normann & Morina, 2018; Erdoğan-Yıldırım, 2025; Myers & Solem, 2026). These findings support the plausibility and clinical relevance of the component procedures reviewed here, but they should not be interpreted as definitive evidence for the independent causal contribution of each technique within full MCT.

The mechanisms literature is also beginning to converge in a way that is highly consistent with the metacognitive model. Recent work suggests that changes in metacognitive beliefs, CAS activity, and perceived attentional control are associated with symptom improvement, and newer studies in younger samples point in the same direction (Pukstad et al., 2025; Thingbak et al., 2024). This does not yet settle the causal question in a definitive way, but it does support the central MCT claim that attention-focused interventions work most meaningfully when they weaken both maladaptive attentional habits and the beliefs that keep those habits in place. Evidence from group, self-help, home-based, medical, and remote formats further suggests that these procedures are portable, even if the strongest support still comes from full MCT protocols rather than highly dismantled single-technique applications (Wells et al., 2021, 2022, 2023; Dammen et al., 2023; Tunheim et al., 2025).

At the same time, this literature remains heterogeneous and should be interpreted with appropriate caution. It includes analog and clinical samples, component studies and full treatment protocols, varied delivery formats, mixed age groups, and studies conducted across differing clinical contexts. In addition, the strongest support still comes from full MCT treatment packages rather than dismantling designs focused on individual techniques. Therefore, component-level findings are best viewed as promising and theoretically consistent rather than as definitive evidence of independent causal effects.

A broader grouped literature map, including selected studies on efficacy, delivery formats, mechanisms, and technique-focused evidence, is provided in the appendix available at <https://osf.io/pybcj/> for readers seeking a more detailed overview.

CONCLUSION

Ultimately, in MCT, the task of the patient is not to accumulate techniques but to alter their relationship with attention. In clinical practice, the decisive shift often occurs when the patient begins not only to feel less anxious or less preoccupied but also to recognize where attention is going, why it is being deployed there, and which metacognitive rule is driving that pattern in the moment. That is the point at which therapy moves from surface management to genuine change. ATT, SAR, DM, postponement, and anti-monitoring work are not simply useful tools. When delivered well, these interventions reorganize the patient's overall response to internal events. The therapist's role is, therefore, not to soothe, reassure, or help the patient manage symptoms more efficiently but to make the CAS visible and interruptible, i.e., to help the patient step out of monitoring, self-observation, analytical absorption, and threat-led attention and into a more flexible style of self-regulation. Clinical experience repeatedly suggests that meaningful change begins when the patient discovers, in lived practice rather than in theory alone, that constant monitoring is not protection, that the mind does not need to be managed moment by moment, and that attention can be guided by choice rather than by threat. This may represent an important point of clinical change in MCT.

Conflict of Interest: The author declares that there is no conflict of interest.

Financial Disclosure: No funding was received for the preparation, writing, or publication of this study.

Use of AI for Writing Assistance: ChatGPT (OpenAI) was used during manuscript preparation to assist with language editing, structural refinement, and journal-specific presentation. All AI-assisted output was critically reviewed and revised by the author, who takes full responsibility for the accuracy, interpretation, and final content of the manuscript.

Peer-review: Externally peer-reviewed.

REFERENCES

- Andersson, E., Aspvall, K., Schettini, G., Kraepelien, M., Särholm, J., Wergeland, G. J., & Öst, L. G. (2025). Efficacy of metacognitive interventions for psychiatric disorders: a systematic review and meta-analysis. *Cognitive Behaviour Therapy*, 54(2), 276-302. [CrossRef]
- Atmaca, M., Tabara, M. F., & Gürok, M. G. (2024). Effects of detached mindfulness on patients with obsessive-compulsive disorder. *Alpha Psychiatry*, 25(1), 88-93. [CrossRef]

- Bailey, R., Muir, S., Wells, A., & Capobianco, L. (2024). Feasibility and preliminary efficacy of metacognitive therapy for health anxiety: A pilot randomized controlled trial. *Journal of Contextual Behavioral Science*, 34, 100781. [\[CrossRef\]](#)
- Bolzenkötter, T., Bürkner, P.-C., Zetsche, U., & Schulze, L. (2024). Assessing the immediate effects of detached mindfulness on repetitive negative thinking and affect in daily life: A randomized controlled trial. *Mindfulness*, 15, 1136–1148. [\[CrossRef\]](#)
- Brown, R. L., Wood, A., Carter, J. D., & Kannis-Dymand, L. (2022). The metacognitive model of post-traumatic stress disorder and metacognitive therapy for post-traumatic stress disorder: A systematic review. *Clinical Psychology & Psychotherapy*, 29(1), 131–146. [\[CrossRef\]](#)
- Callesen, P., Reeves, D., Heal, C., & Wells, A. (2020). Metacognitive therapy versus cognitive behaviour therapy in adults with major depression: A parallel single-blind randomised trial. *Scientific Reports*, 10, 7878. [\[CrossRef\]](#)
- Dammen, T., Tunheim, K., Munkhaugen, J., Klungsøyr, O., & Papageorgiou, C. (2023). Attention training technique delivered in groups as treatment for anxiety and depression in patients with coronary heart disease: Study protocol for a waiting-list randomized controlled trial. *Frontiers in Psychology*, 14, 1226539. [\[CrossRef\]](#)
- Erdoğan-Yıldırım, Z. (2025). Üstbilişsel terapi stratejisi olarak dikkat eğitimi tekniğinin etkililiği: Sistemati bir gözden geçirme. *Türk Psikoloji Dergisi*, 40(96), 105–126. [\[CrossRef\]](#)
- Exner, C., Melchior, K., Stangier, U., Roessner, V., & Voderholzer, U. (2024). Metacognitive therapy versus exposure and response prevention for obsessive-compulsive disorder: A non-inferiority randomized controlled trial. *Behaviour Research and Therapy*, 184, 104746. [\[CrossRef\]](#)
- Haukaas, R. B., Gjerde, I. B., Varting, G., Hallan, H. E., & Solem, S. (2018). A randomized controlled trial comparing the Attention Training Technique and mindful self-compassion for students with symptoms of depression and anxiety. *Frontiers in Psychology*, 9, 827. [\[CrossRef\]](#)
- Jahn, N., Sinke, C., Kayali, Ö., Krug, S., Leichter, E., Peschel, S., Müller, T., Burak, A., Krüger, T. H. C., Kahl, K. G., & Heitland, I. (2023). Neural correlates of the Attention Training Technique as used in metacognitive therapy: A randomized sham-controlled fMRI study in healthy volunteers. *Frontiers in Psychology*, 14, 1084022. [\[CrossRef\]](#)
- Knowles, M. M., Foden, P., El-Deredy, W., & Wells, A. (2016). A systematic review of efficacy of the attention training technique in clinical and nonclinical samples. *Journal of Clinical Psychology*, 72(10), 999–1025. [\[CrossRef\]](#)
- Krzikalla, C., Buhlmann, U., Schug, J., Kopei, I., Gerlach, A. L., Doebler, P., Morina, N., & Andor, T. (2024). Worry postponement from the metacognitive perspective: A randomized waitlist-controlled trial. *Clinical Psychology in Europe*, 6(2), e12741. [\[CrossRef\]](#)
- Myers, S. G., & Solem, S. (2026). Detached mindfulness as a stand-alone intervention: A systematic review and meta-analysis. *Frontiers in Psychiatry*, 17, 1771705. [\[CrossRef\]](#)
- Nordahl, H. M., Wells, A., Olsson, M. C., Bjerkeset, O., & Hansen, B. (2018). Metacognitive therapy for social anxiety disorder: An A-B replication series across social anxiety subtypes. *Frontiers in Psychology*, 9, 540. [\[CrossRef\]](#)
- Normann, N., & Morina, N. (2018). The efficacy of metacognitive therapy: A systematic review and meta-analysis. *Frontiers in Psychology*, 9, 2211. [\[CrossRef\]](#)
- Pukstad, E., Halvorsen, J. Ø., Jensen, M. R., Solhaug, S., & Nordahl, H. (2025). Do metacognitive beliefs satisfy criteria as mechanisms of change in treatment? A systematic review and evidence synthesis. *Clinical Psychology Review*, 122, 102654. [\[CrossRef\]](#)
- Rochat, L., Manolov, R., & Billieux, J. (2018). Efficacy of metacognitive therapy in improving mental health: A meta-analysis of single-case studies. *Journal of Clinical Psychology*, 74(6), 896–915. [\[CrossRef\]](#)
- Thingbak, A., Wells, A., & O'Toole, M. S. (2024). Group metacognitive therapy for children and adolescents with anxiety and depression: A preliminary trial and test of proposed mechanisms. *Journal of Anxiety Disorders*, 107, 102926. [\[CrossRef\]](#)
- Tunheim, K., Papageorgiou, C., Lie, H. C., Munkhaugen, J., & Dammen, T. (2025). Experiences of the attention training technique delivered in groups as treatment for anxiety and depression in patients with coronary heart disease: A qualitative study. *BMC Psychiatry*, 25, 573. [\[CrossRef\]](#)
- Vogel, P. A., Hagen, R., Hjemdal, O., Solem, S., Smeby, M. C. B., Strand, E. R., Fisher, P. T., Nordahl, H. M., & Wells, A. (2016). Metacognitive therapy applications in social anxiety disorder: An exploratory study of the individual and combined effects of the Attention Training Technique and situational attentional refocusing. *Journal of Experimental Psychopathology*, 7(2), 260–273. [\[CrossRef\]](#)
- Wells, A. (2005). Detached mindfulness in cognitive therapy: A metacognitive analysis and ten techniques. *Journal of Rational-Emotive and Cognitive-Behavior Therapy*, 23(4), 337–355. [\[CrossRef\]](#)
- Wells, A. (2009). Metacognitive therapy for anxiety and depression. Guilford Press.
- Wells, A. (2019). Breaking the cybernetic code: Understanding and treating the human metacognitive control system to enhance mental health. *Frontiers in Psychology*, 10, 2621. [\[CrossRef\]](#)

- Wells, A., Reeves, D., Heal, C., Davies, L., Fisher, P., Doherty, P., Davies, L., Heagerty, A., & Capobianco, L. (2022). Metacognitive therapy self-help for anxiety-depression: Single-blind randomized feasibility trial in cardiovascular disease. *Health Psychology, 41*(5), 366-377. [\[CrossRef\]](#)
- Wells, A., Reeves, D., Heal, C., Fisher, P., Doherty, P., Davies, L., Heagerty, A., & Capobianco, L. (2023). Metacognitive therapy home-based self-help for anxiety and depression in cardiovascular disease: A randomized controlled trial. *PLOS Medicine, 20*(6), e1004161. [\[CrossRef\]](#)
- Wells, A., Reeves, D., Capobianco, L., Heal, C., Davies, L., Heagerty, A., Doherty, P., & Fisher, P. (2021). Improving the effectiveness of psychological interventions for depression and anxiety in cardiac rehabilitation: PATHWAY: A single-blind, parallel, randomized, controlled trial of group metacognitive therapy. *Circulation, 144*(1), 23-33. [\[CrossRef\]](#)
- Wells, A., Walton, D., Lovell, K., & Proctor, D. (2015). Metacognitive therapy versus prolonged exposure in adults with chronic post-traumatic stress disorder: A parallel randomized controlled trial. *Cognitive Therapy and Research, 39*(1), 70-80. [\[CrossRef\]](#)