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A qualitative evaluation of the effects of Metacognitive Reflection and Insight Therapy: 'Living more consciously'

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Objectives. Extensive research showed that one of the major difficulties that people with schizophrenia spectrum disorders are struggling with involves their ability to reflect on their own and others' mental activities, also defined as metacognition. Several new psychotherapies have been developed to assist patients (re)gain metacognitive capacity, including Metacognitive Reflection and Insight Therapy (MERIT). The current study investigated the client's subjective experience of psychotherapy, to determine whether service users found MERIT effective and whether these gains align with quantitative findings, which processes they considered responsible for these benefits, in which ways participants found MERIT similar or different from other interventions, and whether they experienced non-desirable factors and outcomes.

Design. All participants who had participated in a randomized controlled trial investigating the efficacy of MERIT were offered a structured post-therapy interview by an independent assessor. Fourteen out of 18 (77%) participants, all of whom had completed therapy, responded.

Results. Most participants (10/14) indicated that they had experienced the therapy as beneficial to their recovery, and in general contributed to their understanding of their own thinking, which maps closely onto the quantitative findings reported elsewhere. They mainly attributed these changes to their own active role in therapy, the intervention letting them vent and self-express, and forming an alliance with the therapist.

Conclusions. Participants reports of change map closely onto the quantitative findings from the randomized controlled trial. Findings are discussed in the frameworks of the

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metacognitive model of psychosis and the integrative intersubjective model of psychotherapy for psychosis emphasizing the role of the clients as active agent of change.

Practitioner points

- The use of a systematic, qualitative interview at the conclusion of therapy may yield important information regarding process and outcome.
- Analysis of the interview revealed that clients' perceptions regarding change within themselves closely maps onto quantitative findings.
- MERIT may not be the appropriate intervention for all clients; some may prefer a more solution-oriented approach such as CBTp or Metacognition-Oriented Social Skills training.
- Self-expressing with a trained clinician may be therapeutic in itself.

Extensive research showed that one of the major difficulties people with schizophrenia spectrum disorders are struggling with is a diminished ability to reflect on their own and others' mental activities (see recent meta-analysis; Arnon-Ribenfeld, Hasson-Ohayon, Lavidor, Atzil-Slonim, & Lysaker, 2017). These difficulties are broadly conceptualized as deficits in metacognition (Dimaggio & Lysaker, 2010; Moritz & Lysaker, 2018; Schwartz & Perfect, 2002; Semerari, Carcione, Dimaggio, Nicolò, & Procacci, 2007), which includes a range of abilities that enable one to perform an ongoing construction of integrative and holistic representations of the self and other. Making sense of one's place in the world and to be able to understand one's own reactions to psychological difficulties may help to achieve a greater sense of agency and support subjective recovery (Lysaker *et al.*, 2015).

To assist clients in (re)gaining metacognitive capacity, several integrative psychotherapy approaches have been developed (Dimaggio & Lysaker, 2010; Hamm, Hasson-Ohayon, Kukla, & Lysaker, 2013; Inchausti *et al.*, 2017; Moritz *et al.*, 2011; Morrison *et al.*, 2014; Ottavi *et al.*, 2014; Salvatore, Lysaker, *et al.*, 2012). The current study focuses on one of these new approaches: Metacognition Reflection and Insight Therapy (MERIT; Lysaker, Buck, *et al.*, 2014; Lysaker & Klion, 2017).

MERIT can be regarded as an integrative approach aimed at reducing metacognitive deficits that interfere with recovery from severe mental illness. The MERIT protocol is not a session-by-session manual, but is rather centred around eight core elements which therapists are intended to attempt to introduce each session. These elements are as follows: (1) Attending to the client's agenda; (2) Introduction of the therapist's thoughts in ongoing dialogue; (3) Narrative focus, that is, tuning to reflection on self and others within the flow of life; (4) recognition of the psychological difficulties which clients experience; (5) Reflection upon interpersonal process; (6) reflection on changes within the sessions; (7) Optimal stimulation of reflections about self and others; and (8) Optimal stimulation of metacognitive mastery, which refers to the ability to use information about oneself and others to responds to stressors.

Importantly, the approach is largely based on a hierarchical model of metacognition as specified by an adaptation of the Metacognition Assessment Scale (MAS; Semerari *et al.*, 2003) for use with psychotic disorders, the MAS-A (Lysaker *et al.*, 2005; Lysaker, Vohs, *et al.*, 2014). The model considers metacognition to consist of four semi-independent domains and divides each of these domains (Self-Reflectivity, Understanding the Other's Mind, Decentration and Mastery) up into a hierarchy ranging from basic functions with a more discrete character (e.g., noticing a thought) to more complex, integrative activities (noticing how one's thinking has changed over the course of their lives). This allows for the therapist to continuously monitor the client's metacognitive functioning and ask

questions or offer reflections either at the current level or slightly above it, to stimulate the client to develop an increasing ability to use metacognitive knowledge when responding to psychological and social challenges (Lysaker & Dimaggio, 2014). Practically speaking, the therapist takes a warm, positive attitude (Rogers, 1951). Unlike such client-centred approaches, however, the therapist utilizes this attitude to create an atmosphere of joint reflection on the patient's agenda, goals, and challenges. First, the therapist tries to determine what the patient's goal is in coming to the session today and elicit narrative episodes relevant to this goal. The therapist then attempts to stimulate the patient to perform metacognitive activities by joint reflection through questions. The focus of therapy is not to uncover the 'truth' of experiences, but rather the therapist functions as a 'cognitive prosthetic' in helping the client think about his or her life (Lysaker, Buck, & Ringer, 2007).

Accumulating evidence exists regarding the effectiveness of MERIT and similar therapies. Case studies showed increased metacognitive abilities and improvement in functioning (Arnon-Ribenfeld *et al.*, 2017; Bargenquast, Schweitzer, & Drake, 2015; Buck & George, 2016; Buck & Lysaker, 2009; Hasson-Ohayon, Arnon-Ribenfeld, Hamm, & Lysaker, 2017; Hillis *et al.*, 2015; Lysaker *et al.*, 2015; Schweitzer, Greben, & Bargenquast, 2017), even in patients with severe disorganization (de Jong, van Donkersgoed, Pijnenborg, & Lysaker, 2016; Hamm & Firmin, 2016), negative symptoms (van Donkersgoed, de Jong, & Pijnenborg, 2016), and impaired insight (Leonhardt *et al.*, 2016). One open trial and a pilot study have reported positive outcomes (Bargenquast & Schweitzer, 2013; de Jong, van Donkersgoed, Aleman, *et al.*, 2016), in particular on Self-Reflectivity. Following aforementioned pilot study, a randomized controlled trial (Van Donkersgoed *et al.*, 2014) was conducted, where significant gains in metacognitive Self-Reflectivity and mastery were observed at follow-up, though not immediately post-therapy (de Jong *et al.*, 2018).

While these studies and reports provide preliminary evidence for the benefits of MERIT with regard to mostly objective outcomes, little is known about the subjective experience of clients who take part in it. Learning about the subjective experience of interventions aimed at improving recovery is of great import as objective and subjective forms of recovery are considered complementary rather than incompatible (Silverstein & Bellack, 2008). Furthermore, integrative psychotherapies such as MERIT are characterized by a relatively high number of sessions (40, in the RCT) compared to approaches such as cognitive behavioral therapy, with case reports frequently spanning multiple years, requiring a significant investment of time and energy from patients. Understanding client's experiences of the therapy may help to improve adherence.

Accordingly, it was argued that assessment of interventions aimed at enhancing recovery should include both objective (e.g., symptoms, functional outcome) and subjective measurements of outcome of the client experience, that is, narrative accounts of clients (Hasson-Ohayon, Roe, Yanos, & Lysaker, 2016). With this in mind, the current study reports a qualitative assessment of the subjective effectiveness and client experience of MERIT. With the quantitative findings of the trial published elsewhere (de Jong *et al.*, 2018), the current study aims to provide the subjective experience angle.

The current research questions are as follows: (1) Did the participants perceive MERIT as helpful to them? (2) If they did, in which domains did they find it effective, and does this experience align with quantitative findings of MERIT that were reported elsewhere? (3) Which process did they consider responsible for the perceived benefits? (4) Did the participants perceive MERIT as different or similar to previous

interventions they took part in and how? and (5) Do participants experience non-desirable factors and outcome following their participation in MERIT?

Method

Participants

All participants took part in a randomized controlled trial (de Jong *et al.*, 2018; Van Donkersgoed *et al.*, 2014) investigating the efficacy of 40 sessions of MERIT versus treatment as usual. In brief, participants had to be aged 18 or older and in a post-acute phase as indicated by an average score lower than 4 on the positive symptoms scale of the Positive and Negative Syndrome Scale (Kay, Fiszbein, & Opler, 1987) and no change in medication for 30 days. Thirty-five participants begun treatment, with 18 finishing treatment. Half the dropout was the result of therapist attrition (n = 5) or took place before the first session (n = 4). Additionally, several participants (n = 4) dropped out, citing 'too busy with work' or 'doing too well' (n = 3). It is unknown whether these are attributable to positive effects of MERIT or social desirability.

All participants (dropout or not) were contacted by research assistants for the post-therapy interview. All who decided to participate in the interview had completed therapy (n = 14), comprising the final sample of the current study. Participant's mean age was 46 (SD = 11.01), consisted of slightly more males than females (8:6), and had a diagnosis of schizophrenia (n = 9) or schizoaffective disorder (n = 5). All participants were receiving a standard dose of antipsychotic medication, and no other psychological treatment during the course of the study.

Materials

Metacognitive Reflection and Insight Therapy

Metacognitive Reflection and Insight Therapy (MERIT; based on Lysaker *et al.*, 2011) is a manual-based individual psychotherapy developed to assist persons with a psychotic disorder to (re)develop metacognitive capacity. Central to the manual are eight elements which the therapist attempts to introduce each session, with a focus on reflection rather than teaching skills or correcting beliefs. Generally, therapists attempt to elicit a personal narrative from the client, which they use as a basis to stimulate metacognitive activity through questions or reflections tailored to the current metacognitive level of the client on the four domains of Self-Reflectivity, Understanding the Other's Mind, Decentration, and Mastery.

The Narrative Evaluation of Intervention Interview

The Narrative Evaluation of Intervention Interview (NEII; Hasson-Ohayon, Roe, & Kravetz, 2006) was conducted via telephone by six master's students of clinical psychology following the conclusion of therapy in order to assess the subjective experience of process and outcome of MERIT. Research assistants were not aware of the manner of analysis would be used and were instructed to summarize the participant answers into a digital form. The NEII consists of 16 open-ended questions formulated to elicit spontaneous reports of the participants' experiences of the intervention and do not explicitly refer to any expected specific outcome or change. Participants are encouraged to respond to questions in an unrestricted, unstructured, and comprehensive manner

allowing for unexpected findings. The instrument has previously demonstrated its utility and reliability in several studies (Hasson-Ohayon *et al.*, 2006; Levy-Frank, Hasson-Ohayon, Kravetz, & Roe, 2012; Roe, Hasson-Ohayon, Derhi, Yanos, & Lysaker, 2010).

Qualitative analysis

As with previous use of the NEII (Levy-Frank *et al.*, 2012), the grounded theory analytic approach (Strauss & Corbin, 1990) was used to evaluate responses. Accordingly, two judges (first and second authors) read the interviews and decided on coding themes. Independent coding was done both to ordinal categories (i.e., level of perceived change) and to themed categories (i.e., domains of change).

To answer research question one, scores between 1 (participant did not notice any change due to therapy) and 5 (participant noticed a great deal of change) were assigned to each interview. Research questions two and three were answered in three steps: First, raters reviewed all interviews to identify themes and domains of change. Second, raters assigned a binary rating (yes/no) on four different domains:

(1) Self & Coping: Participant noticed changes in their general experience of themselves or the way they cope with difficulties.
(2) Interpersonal: Participant indicates having improved relationships with other people
(3) Cognition and Reflection: Participant indicates noticing their thinking has changed (e.g., 'I started living more consciously')
(4) Affective: Participant notices feeling different (e.g., 'she gave me a method to deal with my emotions and anger')

Or, for research question 3, the therapist factors of Alliance, Concrete Real-Life problems, or the client factors of Venting/Self-expression, Adherence/Active role, or Putting into practice what was learned during therapy.

Answers to the questions surrounding research questions four and five, pertaining similarities and differences between MERIT and other therapies, and non-desirable outcomes were very straightforward. Participants either explicitly answered the questions, following a few clear themes, or indicated 'No'. For these research questions, all interview answers are discussed.

Results

Subjective degree and domains of change

Interrater reliabilities are found in Table 1. Excellent interrater reliability was obtained on the index of *degree of change,* with an intraclass correlation coefficient (absolute agreement) of .93. On the domains of change, one rater had to repeat ratings due to an initial miscommunication. Interrater reliability of scores on the domains ranged from perfect (Self & Coping, $\kappa = 1$) to fair (Cognition and Reflection, $\kappa = .46$; Affective, $\kappa = .36$). Disagreements were resolved through discussion, to obtain a final consensus score (Figure 1).

Pertaining research question one, 43% ($n = 6$) of participants indicated having noticed clear changes: 'I definitely benefited from the intervention' or 'Special. It was so useful. . .', with one remarking his spouse had also noticed change. Of the remaining participants, 29% ($n = 4$) either demonstrated a neutral stance with indications towards having noticed

Table 1. Interrater reliability per domain of interest

Domain	κ
Self	1
Interpersonal	.71
Cognitive	.46
Affective	.36
Degree of change (ICC, 2-way mixed, absolute)	.93
TF: Alliance	.30
TF: Concrete RL problems	.70
CF: Venting & self-expression	.32
CF: Putting into practice	.57

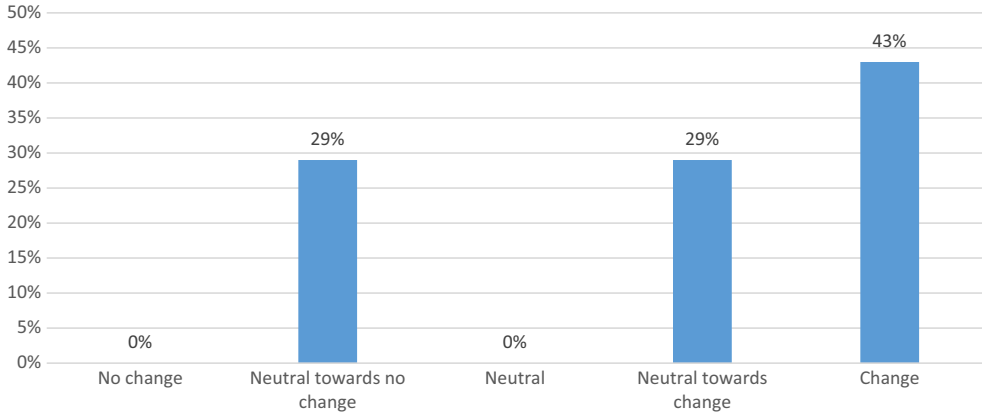

Figure 1. Degree of change (% observed). [Colour figure can be viewed at wileyonlinelibrary.com]

change ('Well, I got a bit calmer. I also got more confidence. That's it, really'.) or indicated they had benefited a lot but did not detail what change, precisely ('No, I just really needed these conversations, I don't know'). Another 29% ($n = 4$) demonstrated a neutral stance leaning towards not having noticed change, generally through contradictory statements such as first remarking: 'I don't think anything changed during the intervention. What do you mean with the intervention?' but then noting they would recommend the intervention to others ('The therapy is recommendable, but other people will be startled by how many appointments I've had for the therapy').

In regards to the domains in which change had been reported (if any), most participants (86%, $n = 12$) indicated having noticed a difference in how they conceive of themselves or how they cope with difficulties, with remarks such as: 'I've started to look differently at myself, more positively' or enthusiastically answering: 'that's a beautiful question, [the therapy] really did a lot for me. That I'm also allowed to be happy with who I am myself and that I don't have to change. And that I can better deal with problems, psychological problems'. Much fewer (43%, $n = 6$) also reported differences in how they perceive or relate to others, remarking, for instance: 'When I started I couldn't put to words what I experienced when I was being bothered at home or at my girlfriends. When I finally could put that to words, well. . .'. Participants generally indicated (64%, $n = 9$) that the changes they noticed were in the Cognition and Reflection domain, either in how they

think: 'I'm a little less critical of myself, I've started to think more positively. Those are important things, yes' or indicating better *awareness* of how they think. One fewer (57%, $n = 8$) remarked on changes in how they feel: 'MERIT made [me] deal with the fear for people and fear of failure. To let them come up, and put those aside that [I] can't deal with' or 'I got calmer and the fears were pushed back and became less. And I got more self-confident' (Figure 2).

Perceived factors contributing to change

As per research question 3, interviews were scored on different therapy processes which participants considered responsible for any changes (Figure 3). At the outset, it is important to note that in one interview, the participant did discuss the alliance with the therapist, concrete real-life problems and the exploratory nature. However, these responses were markedly ambivalent with a negative tendency, and were therefore not scored as present in that interview, to avoid the interpretation of their answers as positive-valenced.

Alliance

Almost all (79%, $n = 11$) participants spoke highly of the alliance with their therapist, with phrases like: 'the therapist respected [me]', 'made me feel understood' or discussing how 'he has learned a lot from the therapist' and associates this with the good bond that was built up. Often, the alliance was referred to more implicitly: 'The therapist made me feel at ease and that I am allowed to be at ease and that I'm allowed to be who I am'.

One participant remarked how the length of the intervention had assisted the alliance: '[the therapist] was always well prepared for what I wanted to say and guided me through [his/her] study and stuck to [his/her] position, in the beginning I didn't understand [him/her], and then I would think at home that [he/she] talks well about me, but I don't always come across in such a good light to [him/her], we talked about it afterwards'.

Several participants mentioned the degree to which the therapist came to understand them in such a way, remarking: 'Yes, [therapist] could listen well to what I said, and could

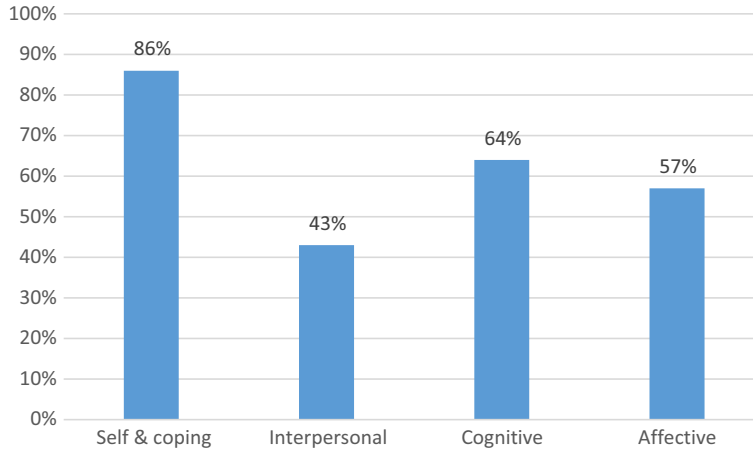

Figure 2. Domains of change (% observed). [Colour figure can be viewed at wileyonlinelibrary.com]

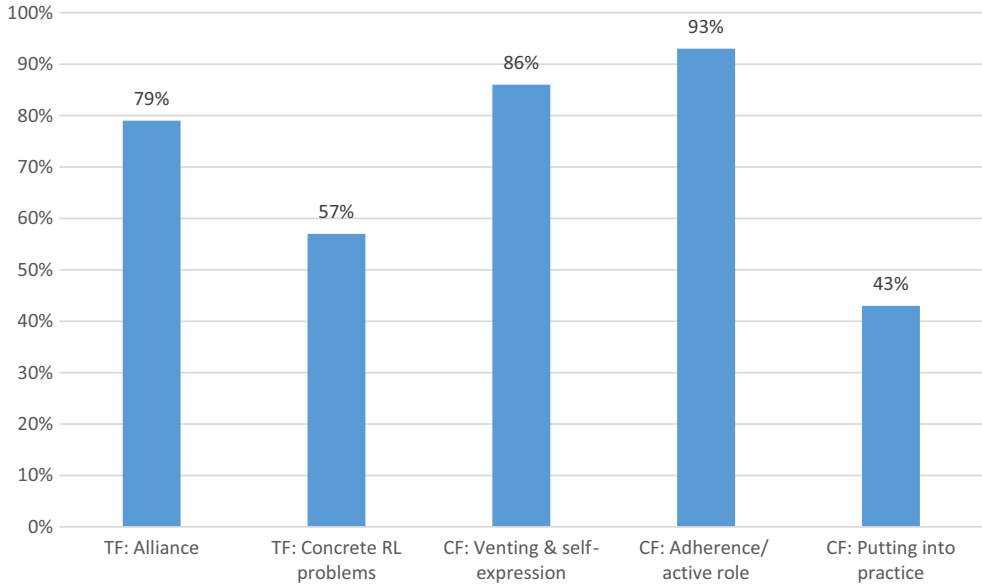

Figure 3. Processes of change (% observed). *Note.* CF = client factors; TF = therapy or therapist factors. [Colour figure can be viewed at wileyonlinelibrary.com]

word it better than when I said it myself, so that was unique' or 'the therapist always knew how to figure out what was going on. He did this by asking questions and by talking through situations from the last week'.

One participant felt more critical towards the therapist, saying that 'the psychologist was tired sometimes, almost fell asleep', which is not coded to avoid the implication of it being a positive remark. Interestingly, this participant did note that the conversations were pleasant, and that they would recommend the therapy to others. Two participants indicated that the alliance was severely disrupted during moments when the therapist would display skepticism towards their experiences: 'That I wasn't always fundamentally believed when strange things happened. The therapist would say that it was impossible, such as receiving messages via the radio. And I would try to explain, but there would be no understanding'. This sense of misunderstanding was alleviated, in such moments, through feeling listened to: 'There was good listening. I could tell from the questions that were asked. Not always easy, but questions were well thought out. I appreciated that'.

Concrete real-life problems and 'venting'

Around half (57%, $n = 8$) of participants remarked on the real-life problems which are a focus in MERIT as per element four. One participant indicated: 'She got me to the point where she gave me a method to deal with my emotions and anger', another spoke more broadly, saying therapy 'helped close the book on things'. Several participants mentioned how the therapist helped them get a clearer picture of their struggles: 'To clearly represent things well. If I had a day that wasn't going well, or something, then [therapist] could give it also a positive spin and say you can also look at it like this. Take the positive from it, from remarks I made'.

Related to this, almost all (86%, $n = 12$) participants mentioned how one of the most important parts of therapy was simply being allowed to express themselves and their issues ('venting'), to 'be open about what was bothering me'. Several participants remarked in some form that being able to simply tell their story was a large step, for instance: 'The therapist made me feel at ease and that I am allowed to be at ease and that I'm allowed to be who I am. That made it possible for me to tell my story, because at first I couldn't tell my story. It did take me a while before I started to trust others'.

Others noted how discussing what they had experienced was part of their healing process; one participant, when asked about negative effects from the therapy, explained: 'It was undesirable for me that I had to tell my story and that I had to go through it, you could say. That was undesirable, but I did have to go through it or otherwise I wouldn't be able to process it, you could say, and get above it. It was useful'. One participant felt that 'the presence of the therapist and that [I] could talk, that's what helped'.

Such venting appears related to therapeutic alliance and a more general sense of *being seen*: 'I felt more supported and understood. I was treated more like a person, I was being taken seriously. Not just 'here's your medication and manage with that', which was the case for a very long time. And with only medication you can't process things. So I was very happy that now I could have conversations, and could express myself. It helped me deal with certain things and to process them'. Intriguingly, two participants who were very critical of the therapy still recommended the therapy for just this reason: 'Yes. If the past is bothering you, then you can let go of a lot in it, you can vent', and 'It's a different way of having a conversation, which [I] found pleasant. Especially because it was a relief for [me] to be able to vent [my] story'.

Active role

Almost all (93%, $n = 13$) participants commented on the active role that was requested of them in therapy, indicating, for instance, that MERIT was 'more intensive' in response to the question what made MERIT different from other therapies. There were marked differences in what was perceived as difficult. For some patients, it proved challenging to come to session ('I loyally went to therapy and did my best to follow the advice') or to provide topics to discuss ('I found it difficult that it was 40 times, so often and so long, you didn't know which topic to talk about'). Others felt that the topics themselves were challenging and required work from them: 'all components were necessary. . .I just didn't necessarily get very happy from [doing] it' and another noting: 'Yes, I had to think really well. Then she'd ask something and then I'd have to think a lot. That was difficult. That took effort, yes. Yes, difficult to think well about the words to put to my thoughts'.

One theme that emerged was closely related to the therapeutic alliance and the difficulties paranoia poses in forging that trust: 'Tried to trust him. Yes. . . just come. Sounds really simple.' or commenting on their role being: 'Well, I was very open to him'. Some participants related this theme to being able to vent, noting that it was 'the presence of the therapist and that [I] could talk, that's what helped' or 'I dared to put a lot of myself into it, I dared to say how it was, what was going on inside me'.

Fewer participants (43%, $N = 6$) reported putting things that were discussed in therapy into practice. Oftentimes, these comments pertained to metacognitive mastery, or the ability to detect and deal with intrapsychic stressors: 'When I'm busy, for instance, that you have to stay calm and think it through, and look to see if it's because of the new house or the situation in your life? And that helped me forward quite well. The sessions helped me a lot' or 'Furthermore you learn during the intervention to stand up for yourself,

that you're a human being too and not everything has to be connected to your vulnerability'. Other comments were related to staying calm in dealing with others: 'It's better for [me] to take it easy, also by not talking to others too much, because [I am] very paranoid. [my] paranoia did shrink, because [I don't do] so much'.

Some remarks demonstrated the integrative nature of MERIT rather than a core element of MERIT in itself. Some participants noted that their therapist had given them exercises from common CBT practice (recording situations, automatic thoughts, and alternative interpretations) or that their therapist 'gave me a little test to take with me, also. That helped, when I would feel bad I could apply that little test'. When participants indicated a specific practical application of therapy outside of the sessions, it was generally regarding the way they related to other people in their lives: '[the therapist] gave me handholds. He handed me, on a silver plate, how I work in regards to other people, with respect to fears and such, and yeah, that sort of thing'.

Differences MERIT – Other therapies

As per research question 4, we wanted to analyse whether participants perceived MERIT as different or similar to previous interventions they took part in, and in what ways. In-depth answers were rather sparse, and as such, will all be briefly discussed. Six participants heavily emphasized how it was the individual nature (rather than group therapy) they found most important, with statements such as: 'Yes, yes it's 1-on-1, right. There's too little staff on that. Yes, when your head is full, then sometimes you really need that, man. A man or a woman who gives you a little attention'.

Four participants indicated how important the length of therapy had been to them and their recovery. One participant felt the opposite, noting how the therapy had been 'too long'.

Six participants noted how intensive or difficult therapy had been, which felt different from previous therapies. Once more, one participant felt the opposite, noting how he had assumed he was in the control condition. One more participant noted: 'I expected more from the therapy. I missed advice because when you see those psychologists on TV they always come with advice. I had the impression I had to figure everything out myself'.

With respect to research question 5, none of the participants noted any *undesired* side effects. Participants did, however, frequently mention needing time after therapy to recover: 'that I would have to recover a little, afterwards. I was, yes, that I thought, yes, that was heavy. I could put that aside, later, but afterwards, when I would be biking home, then it would occupy my mind, yes' or 'tiredness after the sessions'.

Discussion

Based on extensive research showing metacognitive deficits act as a significant barrier for the recovery of persons with schizophrenia (Brüne, Dimaggio, Lysaker, & Brune, 2011; Buck & Lysaker, 2009; Dimaggio & Lysaker, 2010; Holm-Hadulla & Koutsoukou-Argyraki, 2016), therapeutic approaches were developed to enhance metacognition (Dimaggio & Lysaker, 2010; Hamm *et al.*, 2013; Salvatore, Lysaker, *et al.*, 2012; Salvatore, Russo, Russo, Popolo, & Dimaggio, 2012). Evidence has been starting to accumulate with regard to the effectiveness of such interventions. Specifically, regarding MERIT, studies have shown that the therapy is generally accepted by patients and may lead to improvements in Self-

Reflectivity and metacognitive mastery (de Jong *et al.*, 2018). The current study adds to this literature by reporting qualitative findings on the subjective experience of MERIT.

Findings of the current study show that participants found the intervention contributing mainly in the Cognition and Reflection domain and mentioned an increased understanding of themselves. They identify the contributing factors as their own adherence/active role, the ability for them to 'vent and self-express', and forming an alliance with the therapist. In addition, most participants remarked on the benefits of a 1-on-1 setting versus a group setting.

On a more critical note, some participants indicated that they had wished for the therapy to provide more concrete handholds or tips on how to deal with daily issues. These findings are discussed below in the frameworks of the metacognitive model of psychosis and integrative model of psychotherapy.

Subjective reports of degree and domains of change

Pertaining research questions one and two, all participants indicated having experienced positive change of some kind, with a total of 71% being neutral-positive to positive in terms of recovery. This finding adds to the broad general literature on the potential benefits of psychotherapies for persons with psychosis (Hamm *et al.*, 2013) and to the particular literature on metacognitive or mentalization based psychotherapies (Dimaggio & Lysaker, 2010, 2015; Inchausti *et al.*, 2017; Lysaker *et al.*, 2013; Salvatore, Lysaker, *et al.*, 2012). Of course, our sample comprised only of participants who had completed the therapy, and as such this finding must be understood with nuance.

Of particular note is the fact that therapist adherence was emphasized heavily through both bi-weekly supervision sessions and a therapist adherence scale. However, several participants made remarks which can be attributed to the integrative nature of MERIT, such as referring to 'little tests to take home'. This is in line with theoretical accounts (Brent, 2009; Hamm *et al.*, 2013; Hasson-Ohayon, 2012; Weijers *et al.*, 2016), which suggest that integrative psychotherapies that are flexible in combining elements from different approaches and are focused on reflective process are important in enhancing recovery. For instance, some participants indicated that MERIT lacked clear handholds to utilize in everyday life. It is possible the therapy manual may be improved by adding a specific section for such participants, where the therapist can bring in elements from either cognitive behavioral therapy or social skills training, preferably with a metacognitive basis. For instance, a trial of Metacognition-Oriented Social Skills Training (MOST) reported significant improvements on outcome and low dropout but, more crucially, high patient-rated 'utility' scores (Inchausti *et al.*, 2017). Future study should determine whether patients who are finding MERIT to lack concrete handholds are better served by switching their intervention to MOST entirely, or whether only certain elements from MOST should be introduced.

Notably, the perceived domains of change reported by the participants indicated an improvement in reflection regarding the self but not in reflection of others. This is in accord with the quantitative analysis of the larger trial (de Jong *et al.*, 2018) that showed significant improvements on Self-Reflectivity and metacognitive Mastery at follow-up when compared to the control group, but not on Understanding the Other's Mind.

These data align remarkably with similar studies, where gains are generally found on Self-Reflectivity or Mastery, but not awareness of Other (Bargenquast & Schweitzer, 2013; Bargenquast *et al.*, 2015; Lysaker *et al.*, 2015; Schweitzer *et al.*, 2017). One possible explanation may be found in case reports detailing a very long course of treatment

(32 months; Lysaker *et al.*, 2007, 5 years; Buck & George, 2016) where the first changes in understanding the Other are found only after 16 months of psychotherapy. With disturbances in self-experience frequently considered central to schizophrenia (Andresen, Oades, & Caputi, 2003; Hasson-Ohayon, Goldzweig, Lavi-Rotenberg, Luther, & Lysaker, 2018; Hasson-Ohayon *et al.*, 2014; Hasson-Ohayon, Mashiach-Eizenberg, Lysaker, & Roe, 2016; Kukla, Lysaker, & Salyers, 2013; Luther *et al.*, 2016), it is possible that increases in Self-Reflectivity are the first stage of improvement, as it allows one to develop motives for change and take responsibility over the process of changing (Hasson-Ohayon *et al.*, 2017).

In addition, also in accord with the larger trial main quantitative results, the current study showed cognitive changes and much fewer self-reported affective changes, possibly due to high baseline reflective ability. Most participants already could identify emotions, thus most therapeutic focus was on cognitive processes. This explanation is supported by the fact that the Interviewees who indicated having noticed affective changes indeed had baseline scores on the MAS-A reflecting struggling with emotion recognition, and over the course of therapy acquired the next level of metacognition (understanding that one's thoughts are subjective and fallible). Most participant remarks on affective change appeared more related to coping with negative emotions such as fear than acquiring a deeper understanding, and therefore likely reflect increases in metacognitive mastery rather than Self-Reflectivity.

Perceived factors contributing to change in MERIT

With research question three, we sought to investigate which factors are generally considered responsible for positive changes. Three factors emerged in almost all interviews: 'Venting & Self-Expression', 'Adherence, or active role', and the forming of 'Alliance'. These related factors highlight the importance of ownership over the recovery process, as all three factors were mentioned in relation to the patients doing something: coming to therapy, talking, and forming a relationship. Thus, participants reported that their active role was the moving force behind change. Previous studies using the NEII to assess interventions' process and outcome also showed participant's view of their role as an important factor in the process (Levy-Frank *et al.*, 2012; Roe *et al.*, 2010), suggesting that when asked specifically to reflect on participation in an intervention, participants explore their personal role.

While it is tempting to consider 'venting' or 'self-expression' as a factor indicating that the therapy was not functional and/or did not require a professionally-trained (and expensive) psychologist, its value in the context of recovery from schizophrenia should be recognized. Schizophrenia has frequently been conceptualized as a disturbance of the self by clinicians, researchers, and patients themselves (Buck *et al.*, 2013; Kean, 2009; Lysaker & Hermans, 2007; Stanghellini & Lysaker, 2007), and challenges in self-expression and coherent narrative are documented (Hasson-Ohayon *et al.*, 2014). Participant responses to the NEII indicated that the ability to express oneself to a qualified professional, and to be taken seriously, are considered by patients to have had the most beneficial effects on them. The process of self-expression is assumed to help participants enhance a coherent narrative derived by self-reflective processes (Hasson-Ohayon *et al.*, 2017).

Self-expression took place in a warm and positive interpersonal context. The MERIT principles, or therapeutic stances such as a client-centred or humanist approach, appear to provide a useful framework to deal with possible challenges to the alliance. They do

not, however, inoculate against these threats: patients noted how they had felt a rupture in instances when the therapist expressed disbelief in their experiences. Given how a positive alliance has been found beneficial to therapy success in psychosis, but how a negative alliance is associated with *detrimental* effects to the client (Goldsmith, Lewis, Dunn, & Bentall, 2015), it is clear that delusional thought must be dealt with carefully. Metacognitively, it may be important for therapists to remain aware that to know that one's thoughts are fallible/changeable is a relatively advanced metacognitive capacity. The dyad must be able to respectfully agree to disagree, but in order to do so, both must be able to understand that there is no one true view of reality (Hasson-Ohayon *et al.*, 2017).

Along these lines, participants indicated they preferred the individual format of psychotherapy to group therapy. It may be wise to take the current trend of ever-shortening interventions with caution, as it seems that participants need time to form a relationship of trust with a therapist, which does not come easily, particularly to those with paranoia. Shorter interventions may not have given these participants the chance to develop the trust in their therapist to open up in such a way, nor given the dyad time to develop sufficient understanding of the client's difficulties to even begin discussing difficult issues. This fits with outcome data of more than 10,000 patients with various forms of psychopathology suggesting clinical improvements to occur in 50% of cases after 21 sessions, and 75% of all cases to find meaningful improvement after 40 sessions or more (Lambert, Hansen, & Finch, 2001). In cognitive behavioral therapy for psychosis (CBTp) specifically, the authors recommend 25 sessions as an optimal dose (Lincoln, Jung, Wiesjahn, & Schlier, 2016).

Negative side effects

In the current study, most clients indicated no negative side effects, other than that the therapy was demanding, with evident heterogeneity: For some, simply showing up to therapy sessions was difficult, while others struggled with finding topics to discuss, and some others commented on the work that was required of them in *thinking* or putting words to their difficulties. The effort of participants seems to provide a sense of ownership over their process of recovery, which some expressed in vague terms ('I took the handholds') while others were specific, explaining that sometimes, topics were 'not pleasant, but necessary' in order to enhance recovery.

Conclusions

The way participants responded to the interview should be discussed in the light of its therapeutic potential. The clients interviewed demonstrated seeing themselves as *service users* and had no qualms about being critical or demonstrating that they expected good care from their professionals. They provided rich answers and commented on the questions being interesting, nice, or important (e.g., 'what a beautiful question!'). It seems that the interview in itself was oriented towards self-reflection which is in accordance with the principles of MERIT. Accordingly, adding qualitative assessment to the examinations of different therapeutic intervention is recommended not only for gathering rich and comprehensive data (Hasson-Ohayon *et al.*, 2006) but also for its therapeutic benefits. There may even be an effect of empowerment, allowing service users to think with the interviewer about their experience of therapy, and to know that their personal feedback and participation in the study is taken seriously and serves to improve mental health care.

There are several limitations to this study. Although all patients, including dropout, were offered an interview, only therapy completers chose to participate in the interview and no control group was present. This led to a relatively modest sample, with a high likelihood of a positive bias and no basis for comparison. Furthermore, the answers to the interview were reported in summarized format by research assistants, and much may have therefore been 'lost in translation'.

In conclusion, MERIT appears to be well-received by participants who complete the intervention. Participants mainly report positive changes in how they view themselves and can conceptualize their difficulties, mainly attributing these changes to the therapeutic alliance, the ability to express themselves or 'vent', and to take an active role in their treatment. Long-term, individual psychotherapies like MERIT have an important place in psychosocial interventions for psychosis, alongside more specific symptom-specific shorter interventions and group interventions. Utilizing a metacognitive framework appears beneficial to outcome and metacognitive functioning in general. However, the specific choice of intervention should be based on the client's wishes and expectations from therapy: some may wish a more solution-oriented approach such as cognitive behavioral therapy or Metacognition – Oriented Social Skills Training (Ottavi *et al.*, 2014), while for others a narrative approach such as MERIT may be best suited. Further study utilizing a systematic interview to collect patient experiences of psychosocial interventions is highly recommended, as they offer unique data.

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