Metacognition in psychotic disorders

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CHAPTER 4

Metacognitive reflection and insight therapy (MERIT) with a patient with severe symptoms of disorganization

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ABSTRACT

One recent development within the realm of psychotherapeutic interventions for schizophrenia has been a shift in focus from symptom management to consideration of metacognition, or the processes by which people synthesize information about themselves and others in an integrated manner. One such approach, metacognitive reflection and insight therapy (MERIT) offers a description of 8 therapeutic activities that should occur in each session, resulting in the stimulation and growth of metacognitive capacity. In this report, we present a description of 12 sessions with a patient suffering from schizophrenia manifesting significantly disorganized symptoms. Each MERIT element is described along with observed clinical and metacognitive gains. As illustrated in this report, these procedures helped the patient move from a state of having no complex ideas about himself or others, to one in which he could begin to develop integrated and realistic ideas about himself and others and use that capacity to think about life challenges.

INTRODUCTION

In her first person account of schizophrenia, Kean (2009) made the following notes: "The clinical symptoms come and go, but this nothingness of the self is permanently there. Not a single drug or therapy has ever helped with such nothingness. By nothingness, I mean a sense of emptiness, a painful void of existence that only I can feel" (p. 1034). Consistent with this, integrative forms of psychotherapy for schizophrenia increasingly focus less on symptom reduction and more on aspects of self-experience (Hamm, Hasson-Ohayon, Kukla, & Lysaker, 2013).

One specific form of integrative psychotherapy emphasizes subjective experience and focuses on metacognition–the ability to form integrative representations of self and others (Lysaker, Glynn, Wilkniss, & Silverstein, 2010). Metacognition is a psychological function encompassing a spectrum of mental activities that involve thinking about thinking. It refers to psychological functions ranging from discrete acts in which people recognize specific thoughts and feelings to more synthetic acts in which an array of intentions, thoughts, feelings, and connections between events are integrated into larger complex representations (Semerari *et al.*, 2003).

In particular, it has been proposed that loss of metacognitive capacity may underpin many of the most distressing subjective elements of schizophrenia (Lysaker *et al.*, 2015). It may, for example, leave people without the larger sense of themselves as unique beings in the world, a quality needed to discern meaning in past and current events and make decisions about how to respond to life challenges. As reviewed in Lysaker *et al.* (2015), multiple studies have demonstrated the presence of relatively greater levels of metacognitive deficits among people with

schizophrenia relative to others with different medical and psychiatric challenges and linked those deficits with a range of functional impairments.

Building on these findings, case studies (Hillis *et al.*, 2015; Lysaker, Buck, & Ringer, 2007; Salvatore, Russo, Russo, Popolo, & Dimaggio, 2012), a pilot study (Bargenquast & Schweitzer, 2014), and one qualitative study (Lysaker *et al.*, in press) have reported that metacognitive therapy can be delivered and accepted by people with schizophrenia and that it may be linked with positive effects. A more recent development has been to manualize this work. This procedure, metacognitive reflective insight therapy (MERIT; van Donkersgoed *et al.*, 2014), seeks to promote synthetic metacognitive capacity and requires a focus on reflection itself, as opposed to correcting beliefs or teaching skills.

MERIT specifies eight interrelated processes that should occur within every session. The first six elements include a focus on the patient's agenda, the sharing of therapists' thoughts without disrupting dialogue, eliciting a narrative episode, defining a psychological problem, discussing interpersonal processes in session, and discussing progress. Each is intended to offer an opportunity to promote increasingly complex reflection of different phenomena, specifically patients' experience of their needs and wishes, their reactions to the presence of the therapist's mind, their sense of themselves in the midst of historical events, their challenges, and their awareness of the therapeutic relationship and of the session itself. The last two elements of MERIT call for interventions that are consonant with patients' metacognitive abilities and stimulate reflective activities about the self and others and thoughts about how best to understand and respond to psychological and social challenges.

Of note, MERIT is considered to be an integrative form of psychotherapy guided by a theoretical understanding of the

metacognitive processes that underpin any disability and recovery from schizophrenia. Thus, it can entail the use of cognitive behavioral, humanistic, or psychodynamic techniques; however, these are used or interlaced in accord with their relevance for promoting the synthesis of an integrated sense of the self and others.

In this report, we will describe the application of each of the elements of MERIT in the case of a man with prolonged schizophrenia with significantly disorganized symptoms. Although MERIT is intended to be a potentially long-term treatment, the therapy in this case was offered as part of a pilot trial of the feasibility of MERIT (de Jong *et al.*, 2015) as a specific 12-session treatment. In contrast to previous reports of long-term therapies, it offers a unique opportunity to assess what kinds of outcomes may occur in the short term.

CASE ILLUSTRATION

Abraham is a never-married male in his early 50s with prolonged schizophrenia. He reports being bullied in school but did graduate from high school. In his late teens, Abraham was drafted into the army and there he was diagnosed as suffering from a psychotic episode; consequently, he withdrew from service. Since leaving, he has never worked steadily for any period of time. Both of his parents are living and play an active role in Abraham's life. He is currently living alone, with the support of a community healthcare worker. At the time of entry into psychotherapy, he was receiving a standard dose of an atypical antipsychotic medication.

Clinically, at the time of entry into psychotherapy, Abraham presented with severe positive and disorganized symptoms. For example, he believed he had been conducting secret experiments and was going to be awarded a Nobel prize. There was considerable evidence of conceptual disorganization, including utterances containing loose associations to

Bible figures and musical styles. Moreover, he appeared relatively unable to think about his life with any temporal continuity. In the following excerpt, Abraham attempts to talk about the story of his life:

> **A:** *When I was born, my family was very poor. They couldn't help that. That was the economy then. They were in expenditure control–I don't know what that is, exactly. I was very young then. My father was alright but he opened a savings account with two guilders fifty. When I was born, they received a [inaudible]. That is normal when you are born. They were happy, then, that it was a boy. On my birth photo I don't look too happy. It could be I was cold. It could be that I . . . had my umbilical cord cut and that I felt that then. When you get older you don't feel that pain anymore.*

Regarding self-reflection–the first metacognitive capacity MERIT is based on–at the outset of psychotherapy, Abraham appeared generally aware that he experienced different forms of cognitive operations (thoughts, beliefs, dreams, desires) but appeared to lack a fully nuanced sense of his own emotions: "I became more sensitive. Less thinkable than then. I have a problem with frowns in my forehead, that is all old thinking work." As to the second capacity, understanding the other's mind, Abraham was unable to recognize the affective states of others, and struggled to describe the mental states of others–for example, explaining how others are "low-frequency sensitive" versus his own "high-frequency sensitivity."

As to mastery, the ability to conceptualize psychological problems and find adequate coping strategies, Abraham was unable to formulate a coherent psychological problem: "It's because I was intelligent and those dendrites were too close together . . . . When that short-circuits it's like an electric chair, but that is only three hours and then it is gone."

ELEMENT 1:

THE PREEMINENT ROLE OF THE AGENDA OF THE PATIENT

The first element of MERIT requires the therapist to remain aware that the patient has entered the session with a purpose or agenda and reflect with the patient about that agenda. In this sense, the agenda refers to the hopes and wishes of the patient and these can involve items that are initially unknown, contradictory, and/or changing. Attention to the agenda is said to stimulate metacognitive activity, as it continuously trains patients' attention to what they hope and want and helps to frame that experience as a subject for reflection. To discern the true agenda(s) of the patient, the therapist must pay attention to patient utterances from the first moment, distinguishing casual comments from others with deeper meaning embedded within them.

In the initial sessions, it was frequently difficult to ascertain Abraham's agenda, though there were clues in the form of props brought to the session. For example, in the first session he brought a painting to the session: "[I wanted to bring] something from my house that is positive. With respect to use of color, uh . . . holly branch or whatever it may be. But to be honest, I'm a little worried about my neighbors. My neighbor has soon or already had a birthday. I don't know what is wrong with them–one moment the car is there, then not, and would they have the flu . . . all variants are possible."

Trying to understand the agenda, the therapist explored whether Abraham was worried about something. Abraham responded that "there are old people that die from flu," explaining that he saw on the news that a man died when his car hit the water and that "that man has a family. They all have a family." In response, the therapist formed the idea that perhaps Abraham's agenda concerned worries about his parents passing away. Abraham confirmed that this bothers him sometimes and connected the death one day to his being at "a breaking point".

Continuing to try to track Abraham's agenda, the therapist found themes around health, life, and death.

As therapy progressed, Abraham began to open each session with an utterance or action that seemed to contain an increasingly clearer idea of his agenda. For example, in the fourth session, he immediately stated that he had an unpleasant birthday. He received a gift that he broke the same evening. His father made a joke about World War II, which he found offensive, and he did not feel taken seriously. Although Abraham was not able, on his own, to say what he was seeking in the session, together with the therapist it was discovered that he had come to session to deal with the distress of his feeling that he was not taken seriously by others, couldn't communicate his thoughts, and was unsure what the behavior of others meant. In the eighth session, Abraham continued to wish to be understood, freely revealing fears and concerns mostly related to loss as they occurred to him.

Session 12 was marked by Abraham appearing better kept and shaven and with his hair trimmed. When the therapist asked about this, he remarked, "You have to remain calm in these wild, uh, wild times with all sorts of excesses." The therapist asked, "You have to remain calm in these wild times?" He replied in a manner indicating he had a clear purpose today: "Yes. With all sorts of mental or physical excesses. Physically, I mean more that people all worry so much about their appearance, wondering, 'Am I attractive enough for another, physically?' But it's also about the mind and ability to think." This led to the therapist and Abraham agreeing that he wanted others to see him as a person.

Considered as a whole, attention to his agenda allowed Abraham to voice his wishes and needs, recognize that he had wishes and needs, and develop a deeper and richer sense of what those were.

ELEMENT 2:

THE INTRODUCTION OF THE THERAPIST'S MIND

Central to MERIT is the understanding that metacognition occurs in an intersubjective space or context. Intersubjectivity refers to shared meanings constructed by people in their interactions with each other; furthermore, it is assumed that understandings of the self and others are formed in the context of real or imagined interactions with other people (Stern, 1985). As such, it is important that the therapist insert his or her own mind—that is, share thoughts or observations with the client—as a means to facilitate dialogue, promote the client's awareness of the therapist's mind, and communicate to the client that the therapist is making a genuine effort to understand. This element not only positions the therapist's mind so that intersubjectivity is possible but also promotes reflection about intersubjectivity itself. Thus, as the first element allows reflection upon a patient's wishes and desires, the second allows reflection about the experience of the presence of another mind.

In the beginning, to meet this element, the therapist frequently asked for clarification, remarking that he couldn't follow Abraham's thoughts. As mentioned above, it became clear that one of Abraham's agendas was purely to have someone attempt to understand him. The therapist thus had to introduce, carefully and respectfully, his experience of being confused, expressing interest in understanding, thereby meeting that agenda. At other times, the therapist shared his thoughts about the matters he could understand, for example, feelings of frustration when borrowed items are not returned. Such utterances–along with reflections such as "But you thought [person] a little cruel at that moment?" and self-disclosures such as "I have been frustrated with my mother at times, as well"–were accepted by Abraham and established that the therapist was a thinking person who could reflect with Abraham about the issues he brought up.

Abraham did not, however, always welcome the thoughts of his therapist, no matter how benign. They were often experienced as interrupting his personal meaning making. This led to discussion about how disorganizing it was when the therapist had an idea that Abraham did not share. This trend continued until the end of the 12 sessions; however, it should be noted that the goal of this element is not problem solving, but reflection upon the patient's experience of the presence of the therapist's mind. Evidence of this can be found in the following exchange:

T: *Intimacy is very difficult.*

A: *Yes. But that's enough about that. We've spoken for half an hour. I want to get out of this seat, get some feeling back.*

By the end of the trial, there was a shared reflection that the therapist had changed roles, moving from someone who passively accepted Abraham's thoughts to one who was entrusted to experience, and at times influence, those thoughts. As such, Abraham developed a beginning awareness of his experience of the therapist and developed the ability to see how that changed over time.

ELEMENT 3:
THE NARRATIVE EPISODE

To promote reflection upon the client's actual experiences, the third element of MERIT is a focus on personal narratives. These narratives may pertain to any moment of the client's life, as long as he or she is the main actor in the story told. Whereas the first element promotes reflection about wishes or desires in the moment and the second

promotes reflection upon the presence of the therapist's mind, the third offers an opportunity to reflect upon personal experiences in detail.

Here, disorganized thought posed a consistent difficulty: The flow of Abraham's thoughts was such that details were difficult to connect in any coherent or temporal manner. Furthermore, his thoughts were frequently of an abstract manner and did not offer narrative episodes from his own life. He appeared frankly unable to readily offer narratives on his own. This required careful consideration of his utterances to find events that he (the therapist) could think about:

A: *A few days ago. It's close by, but also already a week ago or something. I heard on the radio, and I thought . . . oh . . . and sometimes also music that I–that played at funerals–that I thought . . . oh . . . Where I was present at times, but I also keep distance because I have to know my boundaries in that. Suicide is serious.*

T: *Is that what you'd like to discuss?*

A: *I've had suicide in my social environment, yes. And that was the first one. The first experience with a human being's death.*

T: *Do you want to talk about death or suicide?*

A: *I also want to discuss life.*

T: *So you don't want to die?*

A: *Who doesn't? Nobody. But every person has his breaking point.*

Although Abraham's thoughts began to appear less disorganized as therapy progressed in the first four sessions, his narrative episodes continued to lack sufficient detail and were occasionally fictional. There was a sense that Abraham was not always aware that when he referred to a singular event, the therapist did not already know the full story. The therapist addressed this issue in the third session to see if it was possible to produce a narrative that could be the basis for joint understanding, and Abraham seemed to understand:

A: *We go from topic to topic, all little bits and piece . . . . It's not like a puzzle you put together or anything.*

T: *It's difficult for you as well, to . . . in this moment . . . .*

A: *Get a clear overview*

In the fourth through eighth sessions Abraham appeared to take more initiative to produce narrative, which, though still brief and abstract could be reflected upon:

T: *What kind of feeling does that give you?*

A: *Awkward. When I like people that are threatened. I've had it once myself at the supermarket. I was buying some tobacco–and what else was I buying?–and suddenly a young man acted very aggressive towards me. Verbally aggressive, like, "I'm going to beat you to a pulp." I–I was perplexed. I didn't know what to do.*

Abraham seemed, in such situations, to be more comfortable discussing abstract (e.g., "Why does someone respond like that?") rather than concrete situations. In such situations, the therapist attempted to relate the concern about events Abraham had told him about in past sessions, which underlay the same abstract concern, and offering these pieces back to Abraham. An example of this can be found in a poignant moment from a later session when Abraham and the therapist jointly reconstructed the events in which Abraham was flooded with a feeling of terror while in a group of people and he was ultimately hospitalized. He thus appeared increasingly able to think about himself as a being who existed within a complex web of life events.

ELEMENT 4:

THE PSYCHOLOGICAL PROBLEM

The fourth element requires the joint elucidation of a specific psychological problem that the patient is experiencing in his or her life. Here, the aim is mutual reflection upon the patient as a being experiencing a common human dilemma (e.g., fear for one's safety or a sense of rejection). Again, the disorganized nature of Abraham's thoughts made it difficult to see him as grappling with a difficulty and the therapist was aware of the danger of manufacturing a problem as he might construct a percept on the basis of a Rorschach ink blot. This required the therapist to continuously wonder what Abraham was confronting and then carefully see if Abraham agreed:

T: *Yes, because you seem to think a lot about persons who die in very unpleasant ways . . . and a factor I see returning frequently is that it was almost never their fault or a mistake they made.*

A: *And die without it being their fault.*

T: *And then I think, Is Abraham worrying all the time?*

A: *Well, not at the moment. I just got my [depot medication], right? That puts you more into reality, too.*

T: *So it's a nice time, after you receive the medication?*

A: *It's a bit of a relief.*

T: *Because normally it's too busy in your head.*

A: *Oh, it can become too much for any person . . . .*

Paralleling growth in the ability to generate narratives, Abraham began to notice that he indeed confronted things as a unique being. He was thus increasingly able to see himself as a person who existed within historical events, and someone who not only has needs and wants but also confronts recognizable psychological and social obstacles. His psychological problems became more nuanced accordingly.

A: *It's been a while since I played cards.*

T: *So you miss the contact with other people, a little?*

A: *What's a king without a queen, and what's a man without a woman?*

T: *Yes. So maybe that's why you look so charming today?*

A: *Yes. Maybe I'm looking for a little lady*

ELEMENT 5:

REFLECTING ON INTERPERSONAL PROCESSES WITHIN THE SESSION

The fifth element of MERIT involves reflecting on the interpersonal processes inherent in the session. Here the goal is to stimulate increasingly complex reflections about the kind of relationship that exists between the patient and therapist, which is the basis for any developing shared understanding. In the case of Abraham, there was little space to reflect on these processes during the first three sessions. Abraham didn't appear to relate to the therapist as a unique person. The therapist instead appeared as a generic other who was there to listen to him, perhaps in the manner of the audience of a radio show who could sometimes ask questions. By the fourth session, the therapist was able to stimulate some reflection about the relationship as involving their mutual confusion:

T: *You're going fast today, Abraham.*

A: *Am I going too fast?*

T: *Yes. I find it hard to follow you.*

A: *I'm on the fence myself, as well . . . Oh, I'm going too fast. Sorry.*

In session nine, Abraham seemed more cognizant of the therapist and the therapist carefully attempted to stimulate joint thought about their relationship:

T: *Hey, what I'm noticing . . . and that's happened a few times, during our conversations. Then you say something which could be a joke, or could not be a joke–I don't know at such moments. Then you laugh, yourself, then I laugh along . . . but then it seems to frustrate you that I laugh along. You respond, saying something like, "Yes, you laugh about that, but . . . ."*

A: *Yes! yes! yes!*

T: *That confuses me.*

A: *Yes, sorry, sorry.*

T: *No, that's fine, don't worry about it. But I was wondering if you'd noticed that.*

A: *Yes, no . . . I just smile because I want to say something friendly.*

T: *Ah, I see. As in, you don't mean anything wrong . . . .*

A: *No, not hilarious or cynical or anything.*

ELEMENT 6:

REFLECTION ON PROGRESS WITHIN THE SESSION

The sixth element of MERIT seeks to stimulate joint reflection about how sessions are progressing and whether the results are positive and/or as expected. In contrast to the fifth element, the idea here is not to reflect upon the therapeutic relationship, but on how the session is affecting the patient. Just as Abraham struggled to reflect on how he

related to the therapist, he also seemed to struggle to think about how the session had progressed. At best, he appeared able to note that it was helpful but he was unable to say much about how the session went other than comments such as, "It was impressive." Though frequently asked how the session had gone or was going, Abraham seemed unable to truly master a sense of being able to form his own ideas about the session and provided little feedback to the therapist.

Certainly, the therapy changed how Abraham thought about himself. It would have been helpful, in hindsight, for the therapist to have offered exactly that reflection or to have commented on how difficult it was for Abraham to think about the therapeutic relationship, to better stimulate his abilities to think about himself and others. What follows is a brief exchange that could have served as a basis for such a reflection:

T: *So, Abraham . . . is it possible for you to let me come close then? Or . . . ?*

A: *Well, we haven't known each other very long.*

ELEMENT 7:

STIMULATING SELF-REFLECTIVITY AND UNDERSTANDING THE OTHER'S MIND

The seventh element of MERIT requires the therapist to reflect with patients about themselves and others at levels that do not exceed patients' capacities. In other words, if patients struggle to form complex integrated sense of themselves as being in the world, or if therapists do not reflect about patients' agenda, experience of the therapist, or narrative episodes at levels that patients are capable of comprehending, then those reflections will not stimulate the development of

metacognitive capacity. To operationalize the levels of metacognitive functioning a patient is capable of comprehending, MERIT therapists employ the Metacognitive Assessment Scale-Abbreviated (MAS-A). More detailed information about the MAS-A including psychometrics and scale descriptions are described in detail elsewhere (Lysaker *et al.*, 2014).

After Abraham's struggles to track even his own mental activities, the therapist accordingly offered an open space in which Abraham could express what was happening in his mind, no matter the degree of disorganization, and then sought to merely reflect with Abraham that he (Abraham) was having was having those mental experiences:

A: *I felt free then, there. Really. And that second trip, that was in a different year . . . then my sister joined. Then there was unrest in the country. It really wasn't pleasant there then. First trip, fine, really.*

T: *Do you maybe mean a little bit that your parents were a little on your case?*

A: *They're bothered with my dinner times. That what I mentioned earlier, with my structure. I've had that, and it was so strict in the [closed ward] that I got dazed.*

T: *In truth you'd want to be a little bit more free.*

A: *Yes, who doesn't? I'm kind of a freedom-loving person.*

Similarly, Abraham struggled to form more than elemental ideas about the mental activities of others. For instance, although he thought others had ideas and intentions— "He noticed I was over-stressed"— these statements were lacking detail or even plausibility. The therapist's task then was to simply offer Abraham opportunities to notice he was thinking about others.

However, as sessions progressed, Abraham began to create more integrated ideas about himself and others, not only noticing his own mental activities but also forming more integrated ideas about others, with the therapist himself offering more complex reflections to match the growth in Abraham's metacognitive capacity:

T: *Could you describe to me how someone feels when they are sad?*

A: *Some express it in a group . . . discuss it with a group . . . and others lock themselves off, build sort of a witches' circle with candles around themselves and, uh . . . . starts crying.*

T: *Emotions. You don't describe those often. About that situation in the supermarket, right?*

A: *Yes.*

T: *I asked, "Were you afraid?" and you said, "No."*

A: *No, wait. That was different. I felt unpleasant and wanted to get out of the store.*

T: *But then . . . I kept asking questions, and you said you felt unpleasant, that you couldn't help, then you felt insecure, you wanted to leave, you stayed quiet, you even referred to fleeing behavior. And then I thought that sounds like fear.*

A: *Yes. How would you feel if someone suddenly gets aggressive with you?*

T: *I would feel exactly like that. That's why I asked, "Were you afraid?"–because I thought I'd be half scared to death.*

A: *Well, uh, I thought . . . I'll keep quiet because you don't know what he'll do.*

ELEMENT 8:

STIMULATING MASTERY

The eighth element of MERIT calls for the therapist to stimulate mastery– the ability to use metacognitive information about the self, others, and one's place in the world, to identify and cope with inter- and intrapersonal psychological difficulties. As in the case of element seven,the therapist seeks to stimulate mastery at a level consonant with the patient's current capacity. Also, as in element seven, the MAS-A is used to conceptualize and guide the therapist to offer interventions. Returning to Abraham, early in therapy with little sense of himself or others as unique beings, he struggled to even frame a challenge that could call for mastery:

A: *Yes, but maybe they're a bit troubled by the neighborhood–could be. Look, I'm, uh . . . high-frequency sensitive. She is low-frequency sensitive. That's also difficult.*

T: *What do you mean by that?*

A: *With sounds and such. She can't handle a motorcycle that's standing there, but I can handle that. But screeching of those girls in the neighborhood–maybe she sleeps through that–and that's what bothers me in turn. That I'm working on something and that I then hear that screeching of those girls and then I'm out of my concentration.*

As noted above, as sessions progressed Abraham began to notice discrete problems and the therapist intervened by merely noticing this and an absence of response on Abraham's part to these problems. This led Abraham to realize he was responding to difficulties, which made it possible to consider the use of metacognitive knowledge:

A: *Yeah, look, it can have an influence. But the reverend used to say, "Don't let what is on television bother you," but . . . you can't close your eyes for everything.*

T: *You can . . . you can worry heavily, I know.*

A: *Yes . . . very.*

T: *When you worry, you don't just worry, you really really worry. [Abraham makes a noise of agreement.] What do you do to get rid of it?*

A: *Games, maybe. Yes. That's the only solution.*

T: *I can see on you that it doesn't work well.*

A: *It does work well, but then . . . [sighs] . . . people say, "Damn it, why don't you go have fun at [winter games location] again?" I say, "Yeah" . . . but my health is failing me more this year, because last year I was more mobile in that period.*

This led to frank discussions of how hard it was to cope with distress and challenge:

T: *It went from bad to worse. Before, you worried and then you could leave and go do things. But now your health doesn't allow that anymore.*

A: *Yes. And physically too.*

T: *And that's causing you to sit home more. You can't get rid of it anymore.*

A: *Yes. And it's hard to find distractions on your own.*

In this case report we have described interventions that were offered over an abbreviated period of 12 sessions for a pilot study of the feasibility of MERIT. Across these few sessions, Abraham began to become more aware of and able to notice his own mental activities. He further was able to distinguish cognitive operations. Although he began to spontaneously acknowledge that he felt distinct emotions, he struggled to form a nuanced lasting sense of the different emotions he experienced. At some moments, but not others, he demonstrated the ability to see his mental states as phenomena that were subjective and that changed over time in ways that were comprehensible. Regarding the thoughts of others, he was able to discern that others have their subjective experiences, though he similarly had difficulties understanding the emotional experience of others.

Some of the most striking changes concerned the emergence of clear psychological and social struggles that Abraham was facing. Whereas early in therapy the world around him appeared as something

metaphorically akin to a leaf storm, he was able to share his experiences of a range of painful dilemmas in a moving and genuine manner, assuming some sense of agency in terms of deciding how he might respond to them.

Outside of metacognition, Abraham appeared to create in the short time a more coherent account of his life, one with some temporal connections and populated by others to whom he could potentially relate. He continued to experience positive symptoms, though these occupied less and less of each session. He similarly continued to experience significant levels of conceptual disorganization, though expressions of disordered thought also slowly began to occur less frequently.

Regarding countertransference, early on the therapist struggled with doubts that Abraham could make sense of his own life and form the kinds of complex representations needed to take control in some sense of his own recovery. This was replaced with moments of wonder when Abraham was able to directly express painful emotions that the therapist could relate to, just as he could to the dilemmas of people who have never experienced psychosis. Of note, the therapist in this case had a history of comprehensive training in cognitive behavior therapy and a background in existential thought. His integrative use of MERIT may differ from how others will likely deploy this work.

Finally, regarding prognosis, Abraham sadly did not accept an offer of further therapy at the end of the trial, appearing demoralized that therapy was ending and noting he had taken a high dose of his medication, possibly in order to cope. It is unknown to what extent the gains observed over the 12 weeks have persisted, though case work previously has suggested that longer periods of intervention are needed for lasting gains (Lysaker, *et al.,* 2007).

CLINICAL PRACTICES AND SUMMARY

Concerning the implications of this methodology for clinical work with people with a psychotic disorder, the therapist made several observations. First, and most salient, was the absence of a specific problem Abraham sought to resolve: He entered therapy in the context of a scientific study into the efficacy of this methodology. The recruitment text specified that the therapy would involve thinking about the patient's life together with a therapist. Once rapport was established, mutual reflections could begin to occur. Although disorganization was a great obstacle, it surprised the therapist to find that with sufficient focus on simply listening and attempting to understand Abraham, puzzle pieces of his life started to come together. In searching for patterns, often together with Abraham, problems and therapy goals began to emerge. It appeared to the therapist that it would have been impossible to aid Abraham in finding these patterns if he (the therapist) did not spend considerable time and energy trying to understand the man underneath the problems.

As Abraham's life story emerged, so did traumatic memories, which Abraham was hesitant to delve into. It was difficult for the therapist to maintain a balance between being open to discussing these traumatic events and simultaneously allowing Abraham full agency in the choice of whether or not to speak about them. Abraham appeared concerned about the therapist's well-being at being confronted with such traumatic details, and in hindsight the therapist has often wondered if he perhaps erred on the side of caution and unintentionally came across as reluctant to discuss trauma. Not all pain that emerged, however, stemmed from these traumatic experiences. There were also common human dilemmas such as social isolation and the lack of intimate contact, which is consistent with other work that finds that with reflection comes a great deal of pain (Leonhardt *et al.*, in press).

Although allowing Abraham the agency to determine which matters to reflect on in therapy, the therapist began to notice a pattern in which Abraham would frequently become more lucid before disorganizing once more, usually at times when the topics turned to matters that caused him psychological pain. Abraham himself commented on this, noting that children flee into fairytales and that he himself fled into psychosis. Such deep observations, infrequent as they were, surprised the therapist greatly; he is left with a sense that these insights would not have occurred if a more structured or "by the protocol" approach to therapy had occurred. It deserves mention that such insights from Abraham also served to strengthen the therapist's resolve and belief in the treatment; when faced with Abraham's heavy disorganization, the therapist struggled with moments of hopelessness and demoralization, wondering if sense making could occur at all.

LIMITATIONS

There are limitations to this case illustration. At best, it describes what happened initially and quickly when MERIT was used to treat a patient with prolonged schizophrenia. It is not clear how these principles apply to first episode patients or to patients who are further in their recovery. It was also delivered in an outpatient setting and is unclear how well these observations apply to people living in institutional settings. More work is needed with formal assessments of metacognition and psychopathology over time in both case studies and controlled trials of this treatment. Future studies might continue to explore the interplay of different forms of metacognition assessed in this work as well as the links between metacognitive gain and the emergence of pain that accompanies more complex reflections.

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