

MERIT

Metacognitive Reflection and Insight Therapy

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Introduction

| *What is MERIT?*

Eugen Bleuler was a Swiss psychiatrist who coined the term schizophrenia in the first decade of the 20th century¹. He pointed out that this was a disorder that first and foremost interrupted the lives of people. Persons who used to work, relate to others and function in their communities had become unable to do so any longer.

Bleuler believed that schizophrenia did not interrupt the lives of people because of specific symptoms like hallucinations or delusions, or because of gross loss of cognitive ability; rather, he believed that life is interrupted in schizophrenia because of a disruption *in the ability to form the complex ideas* about the self and others that are needed to guide one's own behavior in an organized and meaningful way.

MERIT - Metacognitive Reflection and Insight Therapy - is a form of individual psychotherapy based upon research methods that have: i) detected the kinds of difficulties Bleuler described in persons in both early and later phases of illness; and ii) found that those difficulties were tied to problems with daily functioning, beyond the effects of symptoms alone. Designed for people with schizophrenia and other psychotic disorders, and in line with Bleuler's original insights, MERIT's core assumption is that that persons with these disturbances struggle largely due to their difficulties in forming complex ideas about themselves and others, the process that we all use to structure our lives.

In other words, life is disrupted in schizophrenia not only because of symptoms but also because of difficulties in understanding the *meaning* of things. MERIT seeks to help clients with these conditions to become better able to recognize what is happening in their own minds, and in the minds of others. In turn, this enables them to become better able to both understand and respond to life challenges in an increasingly flexible, adaptive, and healthier fashion. MERIT does try to address symptoms but it also addresses the processes needed to understand and respond to symptoms.

MERIT differs from other types of psychotherapy for individuals with psychosis because it takes an integrative approach to helping clients to think about their thinking and to form more complex

ideas of themselves and others. To recover from serious mental illness, clients need to make sense of what their condition is, of the challenges it brings, and what it is they can do to gain or regain quality of life. Metacognition is needed to make sense of what has unfolded in in the course of a life, and how different events - positive and negative - fit together.

MERIT helps clients recognize and think about the range of personal experiences - memories, hopes, dreams, emotions, beliefs, and the experience of mental illness itself - and supports the effort to integrate them into more complex ideas about themselves and others. One of the goals of the MERIT approach is for clients to recognize that they have many aspects of self (i.e., self as brother, musician, soccer enthusiast, amateur chef, husband, son, etc.) and to integrate them into more complex understandings of who one is as a human being.

MERIT helps clients derive that knowledge by stimulating self-exploration in a safe and supportive therapeutic alliance, and then to they decide how they want to use that knowledge.

Thus, MERIT is concerned with helping clients to form more adaptive ways of thinking about themselves so that self-experience comes to feel richer, more coherent, and understandable.

What is Metacognition?

Metacognition is a key concept underlying MERIT. It derives from some of the earliest conceptualizations of schizophrenia¹ and its importance in understanding this disorder continues to be supported by contemporary research.^{2,3} In simplest terms, a “metacognition” is a *thought-about-a-thought*. Growing out of research in education and human cognition⁴⁻⁶, metacognition is best described as the spectrum of mental activities in which people *think about their own mental activities*.

On the one side of the continuum are *discrete* metacognitive acts; on the other are *synthetic* processes which integrate these discrete experiences into larger ideas. Thus, metacognition⁶⁻⁹ is not simply a thought about a specific fact but rather the ability to *form* ideas about oneself, others, and the world as complex entities that may have many and perhaps even contradictory facets.

Knowing and thinking about one’s self and others is not the same thing as accurately detecting the presence of different things. Here, it is useful to differentiate between *discrete* and *synthetic* metacognitive processes. Discrete metacognitive judgments often can be said to be either correct or not. For instance, one could be correct in assessing how many errors someone else has made or more or less correct that another person is angry. However, there are many ways that synthetic processes might be used to integrate discrete information into larger ideas about oneself or others which are largely a matter of opinion or perspective⁸.

Individuals differ in complexity and integrative capacity in their understandings of self and others. For example, one person’s view of himself could integrate more facets than his

neighbor's. A more integrative self-understanding could, for instance, offer a coherent account of how one's aspirations, beliefs, and feelings fit together and a life story that is experienced as flowing coherently across the lifetime. Additionally, more integrated ideas about oneself should also be expected to evolve over time as a person encounters new experiences.

On the other hand, a less integrative self-understanding might result in a life story that seems like a series of unconnected episodes or it might not even seem like a real life story at all. It is this kind of non-integrative social cognitive system that we see in disorders such as schizophrenia and other forms of psychosis.

Why is Metacognition Important?

Metacognition is essential for human adaptation. Our understandings of self and others allow us to distinguish appearance from reality, recognize that events can be misperceived or misremembered, acknowledge that others can see things differently from different perspectives, and know that people (including oneself) can view events differently at different times. Metacognition, then, is the basis for our being able to adjust our ideas in response to the flow of daily life and make adaptive decisions when needed.

Metacognition allows us to construct the meaning needed for deciding a course of action and also influence whether we persist with a given understanding or course of action. One's self-conceptualization might supply a reason not to quit a job after being disillusioned by some aspects of it (e.g., it is important that I provide for my family). A metacognitive therapeutic stance also allows that there are reasons *why* to pursue certain courses of action above and beyond whether or not we know *how* to pursue them.

Metacognition and Mental Illness

Metacognitive capacity can diminish in persons with severe mental illness for a range of reasons. The literature has suggested that possible antecedents of such deficits include change in neurocognitive function, atrophy due to social withdrawal, deficient attachments to others both in the present and early in life, and past traumatic experiences. The distracting and consuming nature of florid psychotic symptoms and the loss of social roles and functionality doubtlessly impact metacognition as well.

How one understands oneself also plays a critical role in how one copes with a life-altering illness. Serious mental illnesses such as schizophrenia have disabling symptoms and associated features. Sources of impairment include hallucinations, delusions, disorganized thoughts, negative symptoms (i.e., blunted affect, withdrawal), and decreased abilities to focus attention, store and retrieve memories, and flexibly think about unexpected changes in the environment. Serious mental illnesses also pose a number of social challenges including the need to cope with stigma against people with these disorders.

Like anyone facing a major medical or social challenge, persons with serious mental illness have to make sense of those challenges and decide what to do about them. The metacognitive process is what makes it possible to *make sense of mental illness*, what effects it has had in a particular life, what is hoped for by contrasting options, what has to be mourned, and what is to be done. As a result, the ideas persons with mental illness form about themselves in facing these challenges play a decisive role in determining the course of recovery.

Measuring Metacognition

While many methods exist for assessing more discrete metacognitive and/or social cognitive abilities¹⁰⁻¹², these procedures measure the accuracy of perceptions or judgments made in a laboratory setting and do not necessarily tap into the capacity to develop larger and integrated ideas about oneself and others.

As a result, we sought to develop a method to assess the capacity to form complex representations of self and others and to use that knowledge to guide one's life. The approach we arrived at was to first obtain a sample of how persons think about themselves and others and then assess the complexity of that thinking.

By use of a structured interview, individuals are first asked about their life history and struggles with emotional challenges (the *Indiana Psychiatric Illness Interview; IPII*¹³). What is said in the interview is considered to be a sample of clients' thinking about their and others' mental states. Because the narrative spontaneously elicits an account of emotionally charged life events, it can also provide a sample of how persons think about deeply personal matters and can be quite different from responses to laboratory tasks (e.g., guessing the emotions of strangers in photographs).

In order to assess the complexity of metacognitive acts within the narrative, we developed the *Metacognitive Assessment Scale-Abbreviated (MAS-A)*¹⁴, a rating scale methodology adapted with permission from the *Metacognition Assessment Scale*⁹. The MAS-A is comprised of four subscales -- Self-Reflectivity (S), Understanding the Mind of the Other (O), Decentration (D), and Mastery (M) -- and provides a reliable¹⁴⁻¹⁶ and objective measure of metacognition. MAS-A scores correlate with independent assessments of awareness of illness,^{14,17,18} cognitive insight,¹⁹ complexity of social schema,²⁰ self-reported coping preference,²¹ and accuracy of appraisal of memory,²² and work performance.²³

Evidence for Metacognitive Deficits

Research has found evidence of stable deficits in the capacity for synthetic metacognition in persons with serious mental illness. For example, assessments of metacognition using the Metacognitive Assessment Scale Abbreviated (MAS-A) indicate that many with schizophrenia experience decrements in the ability to form integrated and complex ideas about themselves

and others^{14,15}. Additionally, MAS-A scores of persons with first episode and prolonged schizophrenia are significantly lower than samples of individuals with prolonged non-psychiatric medical conditions, substance abuse disorders²⁴⁻²⁶; and PTSD²⁷.

Decreased capacity for metacognition is also associated with greater problems carrying out *goal-directed behavior*. For instance, multiple studies have reported lower levels of metacognition tended to predict more severe negative symptoms, such as a lack of emotion or drive, symptoms which are some of the most disabling of all the symptoms of mental illness.^{15, 16,18,28,29} One study has found that lower MAS-A scores predicted heightened levels of *negative symptoms* in the future, even after controlling for initial levels of negative symptoms¹⁶.

Similarly, other research has found that lower levels of metacognition predict *decreased intrinsic motivation*, the tendency to perform tasks because they are interesting or fulfilling in the future^{30,31}. Additionally, lower levels of metacognition have been associated with *anhedonia*, the failure to find life engagement to be pleasurable even when not experiencing depressed mood.³²

Behaviorally, poorer MAS-A scores are correlated with lower levels of *functional competence*³³, feelings of that one's *life is dominated by symptoms* and a diminished sense that one can *seek social support* as they move towards recovery³⁴, having a poorer *therapeutic alliance* with mental health professionals,³⁵ and having less ability to *reject stigma* against mental illness.³⁶

Lower levels of metacognition have also been found to predict *impulsive violence* in forensic patients,^{37,38} and *job placement success*.³⁹ Another study, based upon structural equation modelling, has found evidence that deficits in memory and attention impair the quality of *social relationships*, in part because of their impact on metacognition.⁴⁰

In other words, symptoms of mental illness do not tell the whole story about whether people with mental illness can live the kind of life they want to be able to live. Rather, there is significant evidence suggesting that problems in metacognition can significantly interfere with person's abilities to function in daily life above and beyond the symptoms associated with their condition.

Summary

The intent of MERIT is to help clients to create a functional narrative of themselves as a person living in the world, one which connects the past to the present and incorporates their specific and very personal experiences of illness and its psychological and social challenges. This approach embodies the expectation that clients can re-enter society as contributing individuals, form positive relationships and self-regard over time, and manage the inevitable disappointments, symptoms, and indignities of aging, relationship rejections, and other unavoidable challenges confronted in any lifetime.

MERIT Psychotherapy

Background

In developing MERIT, we had two basic goals. First, we wanted to describe a set of core elements or therapeutic activities that should be present. The elements are principles to be deployed and are based on an overarching theoretical conceptualization that views metacognitive disturbance as a core feature of schizophrenia.

As a result, we did not articulate a set of activities to be done in a specific order. Rather, we sought to identify core elements and processes that are essential to MERIT, which, while related, can be considered independently. Second, we wanted to outline the therapeutic activities that should occur if metacognitive process is the focus of the treatment session, regardless of the specific type or phase of psychotherapy. In this spirit, we encourage therapists who are working within a wide range of treatment models to consider using them.

MERIT began with a series of dialogues in 2009 between Paul Lysaker and several other scholars, most notably Giancarlo Dimaggio, Giampaolo Salvatore, Kelly Buck, Andrew Gumley, and Suzanne Harder. Developing concepts without benefit of institutional sponsorship or support, these clinicians focused on their individual experiences in conducting and supervising psychotherapy in many settings, through the lens provided by the literature on metacognitive dysfunction in psychosis.

The results of these discussions provoked iterative drafts of a treatment protocol by Paul Lysaker, describing the core principles, which were then reviewed with multiple colleagues, both within the original group and involving others later, including Ilanit Hasson-Ohayon, Jay Hamm, Bethany Leonhardt, Jen Vohs, Marina Kukla and Benjamin Buck.

The term MERIT itself was first proposed by Steven de Jong in conversations with Rozanne van Donkersgoed and Marieke Pijnenborg, after the therapy manual was fully drafted. De Jong then translated the therapy manual into Dutch in order to carry out a randomized trial of this therapy to complete the requirements for his doctoral dissertation in the Netherlands.

Overview of Clinical Practice

MERIT is a set of guiding principles for individual psychotherapy for persons with serious mental illness. It is a protocol but its implementation is framed within the context of the therapeutic alliance. MERIT needs to be deployed in a genuine, respectful relationship and it is expected that therapists will incorporate their clinical experience and stylistic preferences into the delivery of the protocol.

Within the framework and steps in the MERIT protocol, *technical eclecticism* is accepted. For example, there are many ways that a therapist can respond when a client “unpacks” a command hallucination in treatment, with the specific response depending on the current state of therapeutic progress, context, timing, and the therapist’s training and preferences.

We believe the relatively less structured qualities of MERIT to be essential because they are genuine and reflect the improvisational quality of daily life. This allows the therapy to be both an *in vivo* conversational space for clients to consider their own thinking in relation to the therapist but also an *in vitro* situation; that is, a experimental, accepting, non-censorious place of rehearsal, refuge, and safety. Guided by MERIT principles, skilled therapists can readily weave micro-level exercises and therapeutic responses into treatment.

While MERIT is flexible in terms of its delivery and technique, its focus remains on improving metacognition, based on the assumption that this will drive improvements in other areas of function. This concept informs the MERIT protocol; adhering to this principle at the macro-level allows for stylistic variation and natural improvisation at the more molecular level while maintaining a therapeutic focus.

It is assumed that the therapeutic dyad will be dealing with the most severe symptomatology of psychosis. Content such as command hallucinations, paranoid delusions, ideas of influence and reference, or psychosexual obsessions may seem outré or discomfiting to the inexperienced practitioner, especially if they are related to him or her. It is essential, then, that the therapist be comfortable talking about *anything* because this is what MERIT advocates. MERIT sees symptoms as potential gateways to the core concerns of the person. By exploring them, symptoms often respond with decreased intensity.

To practice MERIT, one should be an experienced and licensed mental health professional and familiar with the latest research on severe mental illness and recovery. Ideally, one should become formally trained in MERIT and receive clinical supervision from a MERIT supervisor. Of course, the therapist should be fully versed in the ethical principles of his or her discipline and practice only within areas of competency.

Eight Core Elements

MERIT psychotherapy for schizophrenia consists of eight core elements. There should be synergy between the elements as they amplify one another.

1. AGENDA - The first element concerns the preeminence of the *client’s* agenda. Therapists must seek to understand the wishes, hopes, desires, plans, and purposes that clients bring with them to each session. The client should have the primary say in how this content is approached and in what order. However, clients may have multiple agendas, agendas may change, and some clients may not yet be ready to even set an agenda. This requires therapist attunement and suspending any predetermined plans

while also being aware of the need to provide some high level structure. Further, once agendas have been identified, the client and therapist should discuss whether they are a good subject for reflection, and if they are, they should explore them together.

2. **THERAPIST TRANSPARENCY** - Therapists must attend to their own thoughts about the client's mental states and share these in a way that promotes a dialogue and does not override the client's agendas. This calls for not just accurate inferences about the client but also sharing thoughts about the client's mental processes in a way that is sensitive to issues in the context of the moment, the therapeutic alliance, and the client's cultural and historical background.
3. **NARRATIVE ANALYSIS** - The third element is the elicitation of narrative episodes. Narrative episodes involve the client relating a sequence of events about specific people and places, which have occurred for either clear or unclear reasons, have antecedent and consequent events, and have relevance for the client.

MERIT explicitly focuses on narratives, or personal stories. As a rule, we often ask for stories before we want abstractions or general ideas about events. Eliciting narrative episodes often requires therapist action and should be pursued with the goal of understanding what events actually happened. These narratives should be understood by therapists as the process through which persons make sense of their immediate experience - in the light (or shadows) of past experience.

People experience, remember, relate, and anticipate in life *via* psychological core constructs, typically represented as stories or easily incorporated into narratives. The creation and consideration of narrative episodes is a ubiquitous human activity that we all use to lay out ideas about ourselves. Through narration, not only can these understandings be shared with others but also adapted and revised in the face of continued participation in the world.

4. **PROBLEM DEFINITION**- The fourth element involves defining and agreeing upon a psychological problem facing the client. This element concerns pinpointing and discussing a discrete psychological problem with which they are struggling.

While the problem may be either intrapersonal or interpersonal, what is at stake is some relevant goal, need, wish, desire or concern that is perceived and experienced as unmet or frustrated. It needs to be part of the client's genuine experience, not supplied by the therapist or others and something the client is coerced to accept. Rather, through attending to the patient's agenda and the therapist's reflecting upon it, a narrative episode will emerge, and a discrete psychological problem can be identified.

5. **DYADIC REFLECTION** - The fifth element holds that sessions should contain a discussion of the interpersonal processes occurring within the session *between the therapist and client*, especially those which support or limit metacognitive activities. Considering how the client is experiencing the therapist and their relationship is an opportunity to understand the context within which thinking-about-thinking is being generated. Done consistently, this is a powerful but safe vehicle for stimulation of metacognitive activity because many clients have few, if any, chances to talk calmly, acceptingly and compassionately about “us.”
6. **CLIENT ASSESSMENT** - The sixth element simply calls for discussing with clients whether they feel they are achieving their goals in treatment. Here, clients are invited to assess the therapy and its impact on them. This may include eliciting reflections about specific outcomes, progress over the session, relating the session to other life events, or management of subjective feelings of distress or confusion. The overarching intent is to stimulate metacognition and reflection about the mutual project. We view clients as purposive agents whose experiences with therapy are taken seriously and who have every right to evaluate whether they are getting what they want or need from it.
7. **SPECIFIC REFLECTION (ABOUT SELF AND OTHERS)** - The seventh element calls for therapists to stimulate patients to think about their own thinking, either about themselves or others.

The assumption is that *metacognitive capacity will increase with exercise*, either in a single session or across multiple sessions. Since clients are expected to become able to perform increasingly more and more complex metacognitive acts, therapists will need to intervene differently over time.

A person can have a variable level of functioning across the different spheres of metacognition and may have very different profiles of metacognitive strengths and weaknesses. One way to assess this is with the MAS-A (see *Measuring Metacognition* section above), particularly with the Self-Reflectivity (S) and Awareness of Mind of Other (O) scales.

Scores on these dimensions provide a guide to intervention because they assess the most complex kind of metacognitive act which the client can complete and points to type of intervention that might be offered. The therapist should tailor interventions to meet the client where they are in terms of metacognitive ability, and provide scaffolding to help them reach the next highest level of metacognition.

For instance, for a client who is only able to notice she has thoughts in her mind but not able to distinguish different thoughts from each other, the therapist should seek to help her do what she is capable of, that is, notice as carefully as possible what is happening in her mind. Once those clients are able to distinguish different thoughts, MERIT calls

therapists to stimulate them to form ideas which are slight more complex and contain different kinds of affects.

It is thought that stimulating persons to think about themselves at a level of complexity which is beyond them is only likely to be frustrating and to reinforce feeling of helplessness and dependency. Meeting clients at their own level is believed to provide clients with the kinds of practice that helps to build their ability to think in more and more complex ways about themselves and others

8. **STIMULATING MASTERY** - The eighth and final element is the client's level of mastery, the ability to use knowledge of oneself and others in order to respond to social or psychological problems. This can be assessed with the MAS-A Mastery (M) scale. Like Self-Reflectivity (S) and Awareness of the Mind of Other (O).

It is expected that clients will differ from one another in terms of the most complex form of Mastery which they can perform and that interventions should occur that stimulate persons to think about how they are responding to challenges at, but not beyond, their maximal level.

For example, a client unable to define a plausible challenge should be assisted to do so before ways of coping with the challenge are addressed. As in the seventh element, it is expected that Mastery scores will change over time with therapists adjusting their interventions accordingly.

Principles for Therapists

There are six principles that it is important for therapists to follow when carrying out MERIT.

1. Acceptance on the therapist's part that psychotic experiences can be understood and that people with the most severe forms of mental illness are capable of understanding their own thoughts, feelings, intentions, and psychological challenges. We assume that clients can be accountable, active agents in their own recovery and are so from the start of treatment. The victories are theirs, too, since they are responsible. As a fundamental ethical position, MERIT seeks at all costs to avoid taking an infantilizing or paternalistic stance towards clients.
2. Understanding of a client's representations, or *constructs*, requires that therapists consider the narrative of the client's *actual* life experiences, and not just the therapist's abstractions or conclusions *about* those experiences. Fonagy and colleagues⁴¹ highlight how a focus on episodic memory is "the most productive material to use in elaborating the patient's self-understanding and understanding of others" (p 104).

Vignettes from the client's real life – past, present, future - provide the content for MERIT therapeutic interaction. Of course, fantasy is real, too, as events in one's imagination are mental events and must be considered. Accounts of commonplace events can be explored, organized, and critiqued. In MERIT, such dialogue nurtures metacognition

3. Attending to the client's current metacognitive capacity is important in targeting interventions and monitoring progress. Different areas can be identified for remediation. Interventions can be refined and forward progress and setbacks can be assessed and directly shared with clients in a truly transparent and collaborative manner.

Therapists should consider using the abbreviated *Metacognition Assessment Scale (MAS-A)* for this. Since the MAS-A S and O scores present hierarchies of metacognitive acts, they can be used to determine where within the hierarchy the patient functions. Once clients achieve a higher metacognitive level, the therapist should then begin intervening at that level. Similarly, if a setback is experienced and client's function deteriorates, the therapist should target interventions at these lower levels.

Using the MAS-A can prevent therapists "from making unwarranted assumptions about the patient's processing capacities" ⁴⁴ (p 104). Sensitive to change, the MAS-A can also be to monitor MERIT-based treatment goals.

4. Therapists must be aware that thinking about the self and others after a period of psychosis may be very painful for some clients. This emergence from psychosis may leave them acutely aware of potentially humiliating and discouraging feelings and memories. Treatment must offer a supportive and rational atmosphere that allows for patients to feel safe when experiencing and discussing their psychological pain.

Feelings that were not previously apparent to the client, including episodes involving loss and trauma, may become quite salient. We are clear about the resources available to help clients in times of distress or regression and encourage them to play a lead role in determining which ones to access. Throughout this, it is important to differentiate between support and infantilization.

5. Therapists must be aware of and sensitive to the many varieties of *stigma* against persons with mental disorders. Stigma includes frank assertions that persons with mental illness are more prone to be violent and incompetent but can also take the form of seemingly benign verbalizations in which less-than-adult expectations are made of clients.

We advocate dealing with the "real world" and helping clients know, expect, and tolerate the slings and arrows of fortune that we all must tolerate. At the same time, we acknowledge they may experience episodic fragility and help them acquire positive experiences of self-regard and self-confidence in dealing with such challenges.

6. Therapists must understand that there are two potential mechanisms of change in MERIT.

First, as patients think and talk about themselves and others in MERIT, they may become more capable of performing those very kinds of metacognitive acts. Just as practicing most things results in improved performance over time, so it likely is with the ability to think-about-thinking.

The therapist is participating in a dialogue to enable clients to experience their own subjectivity *as well as* that of the therapist; in this way, the client is prompted to *construct a representation of the other's mind*. George Kelly⁴² called this a "role relationship." This can then be extended to others in the client's life - past, present, and future. Thus, MERIT helps metacognitive capacity to grow through practicing acts of metacognition in treatment.

Second, as patients master emotions, they may also be able to bear the increased emotional pain and the symptom escalation that may accompany this greater awareness. In this way, they begin to form more complex representations of themselves and others. As a result, they may become better able to move from the experience of themselves as a fragmented set of unconnected experiences to an experience of a more differentiated and integrated being.

With a more flexible, nuanced sense of who they are and what has happened in their lives, they may be able to *tolerate personal invalidation and threats to self-esteem without experiencing the kinds of psychological collapse that culminates in regression and symptom exacerbation*. MERIT thus hopes at its apex to facilitate the creation of greater resilience and the development of new levels or types of competencies.

How is MERIT Unique?

MERIT aspires to be more than another acronym in the world therapies which seem essentially similar other than their initials. In the spirit of the Hegelian theory of history, MERIT aspires to represent a synthesis of psychodynamic, humanistic, existential, and cognitive behavior therapies. It hopes to foster the development of significant advances in theory and practice which neither dismisses nor seeks to return to the past but move forward from it.

MERIT interventions are neither aimed at the discovery of a static "self" that was heretofore hidden in consciousness, nor the development of a new or specific set of beliefs about oneself. Rather, MERIT focuses on helping clients to synthesize a fragmented set of memories and personal experiences into complex representations of self and others and use those learnings to choose and pursue more efficacious life choices and actions and move toward psychological

reconstruction and responsibility. While skill building and a more discrete approach to intervention may help many with schizophrenia know *how* to do certain things, MERIT seeks to address the processes needed to know *why* to do them.

MERIT does rely on the construct of metacognition which itself overlaps with many other terms including mentalization, theory of mind, social cognition, emotional intelligence, and cognitive insight, to name a few. While these ideas share common ground, *metacognition* diverges from the other constructs in several ways which warrant its use as the focus of the MERIT therapy program.

For example, metacognition differs from social cognition⁴³ because of its concern with synthetic processes and the means by which a number of facets, including sometimes contradictory elements of oneself, are integrated with one another in order for a person to form conceptualizations about the self that are often required to respond adaptively to the flow of daily life. Metacognition further differs from mentalization⁴³ as the latter considers disruptions of metacognitive processes happen in the context of disturbed attachment, an assumption that metacognitive research does not share.

Limitations of MERIT

Obviously, there are limitations to our knowledge. We have described a set of procedures which have yet to be fully tested in a wide range of settings. As a result, it is unknown which types of patients and under what circumstances they might be best applied. For instance, these procedures may be less useful for *acutely* ill patients, in the so-called decompensation phase of severe mental illness.

While we have not addressed the length of treatment, the described procedures involve considerable time investments and a high degree of therapist competence. To date, client populations primarily have been urban and seeking treatment in medical school-affiliated settings. MERIT therapists largely have been clinical psychologists, clinical nurse specialists, and psychology trainees and interns.

The work is intensive, and, while metacognitive breakthroughs or developments can and do occur rapidly in some cases, it typically requires an extended period to develop and recover metacognitive processes. Further, the “testing” and tightening of the enhanced metacognitive abilities (e.g., reflection, empathic reading of others, multiple perspectives on reality, mastery of self-in-situ) against in-session and daily life contexts and outcomes, generally entails a longitudinal recovery-time expectation.

As a result, it may be that MERIT will be less helpful in settings where there are fewer resources and skilled therapists

Research Evidence for MERIT

Evidence that the MERIT procedures are effective in improving metacognitive functioning has been reported in case studies and open trials.⁴⁵⁻⁵⁰ In work currently in preparation, we also have found that clients treated with MERIT vs. standard supportive therapy showed evidence of significant changes in the in the depth of internal experience and an increased sense of ability to manage their own recovery.⁵¹ A full scale and a second more modest randomized controlled trial are now underway exploring the effectiveness of MERIT for persons with schizophrenia.⁵⁰

Multi-site and international collaborators are under recruitment by MERIT Institute, P.C., for ongoing research into MERIT therapy. Our main focus is on schizophrenia-spectrum and other psychotic disorders. Interested practitioners and clients can utilize the website to access training, research, and clinical services offered by MERIT Institute, P.C.

Our goal with MERIT is to generate scientific research demonstrating its efficacy, such that MERIT may be classified as an empirically validated treatment package for schizophrenic clients, thus become a solid clinical option for practitioners.

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