Elements That Enhance Therapeutic Alliance and Short-Term Outcomes in Metacognitive Reflection and Insight Therapy: A Session-by-Session Assessment

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CITATION
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**Objective:** Preliminary evidence has found metacognitive capacity is associated with therapeutic alliance and with other outcomes in psychotherapy among persons with schizophrenia. The current study explored: (a) before to after changes in clients’ metacognition capacity following Metacognitive Reflection and Insight Therapy (MERIT) and (b) whether the use of specific therapeutic elements of MERIT were followed by higher ratings of therapeutic alliance at the end of each session as well as with short-term outcome as measured prior to the next session, in a session-by-session intensive data collection. **Method:** Two hundred twenty-one sessions of 10 completers with schizophrenia who took part in an ongoing MERIT trial were analyzed. Measures of therapeutic alliance (short version of the Working Alliance Inventory), general outcome (Outcome Rating Scale), and metacognition (Metacognition Assessment Scale–Abbreviated) were used. **Results:** Findings showed significant change in 2 domains of metacognition, self-reflectivity and mastery, following therapy. In addition, the presence of 2 specific MERIT elements, the introduction of the therapist’s mind and reflecting on the progress in therapy within a given session, were related to better outcomes in the following week. Finally, reflecting on the progress was also followed by higher therapeutic alliance. **Conclusions:** Metacognitively oriented therapy may positively affect both therapeutic alliance and short-term outcome. Specifically discussing the therapist’s and client’s experiences of what is occurring in therapy may positively affect short-term outcome and could be applicable to other psychotherapy approaches.

**Impact and Implications**

Findings showed significant change in clients’ metacognitive capacity for self-reflectivity and mastery following therapy. In addition, specific therapeutic elements of Metacognitive Reflection and Insight Therapy, that is, discussion of the therapist’s and client’s experiences of what is occurring in therapy, were followed by either higher rating of therapeutic alliance at the end of the sessions or better outcome in next-session assessment, thus indicating the importance of metacognitively oriented therapy.

**Keywords:** metacognition, therapeutic alliance, outcome, schizophrenia, MERIT

**Editor’s Note.** David Roe served as the action editor for this article. —SGR
Metacognitive Reflection and Insight Therapy (MERIT; Lysaker & Klion, 2017) is an integrative form of individual psychotherapy that seeks to enhance metacognitive capacity for adults with serious mental illness. It was developed on the basis of research documenting the presence of deficits in metacognition among persons with schizophrenia and the association of those deficits with poorer functional and psychological outcomes (see meta-analysis of Arnon-Ribenfeld, Hasson-Ohayon, Lavidor, Atzil-Slonim, & Lysaker, 2017). MERIT conceptualizes metacognition as involving the integration of information so that a cohesive sense of self and others may be available within the flow of life. The metacognitive abilities of individuals are assumed to vary in terms of their degree of integration. With lesser metacognitive capacities experience is believed to be more fragmented, whereas with more intact metacognitive activities, experience is believed to be more complex and coherent. Evidence from several open and randomized trials and separate qualitative analyses, as well as case studies, offers evidence that MERIT is acceptable to clients and linked with more positive outcomes (cf. Arnon-Ribenfeld et al., 2018; de Jong, van Donkersgoed, Pijnenborg, & Lysaker, 2016; de Jong et al., 2019; Hills et al., 2015; Leonhardt et al., 2016; Van Donkersgoed, de Jong, & Pijnenborg, 2016; Lysaker, Gagen, Moritz, & Schweitzer, 2018; Vohs et al., 2018). The current study aims to broaden this evidence by examining both changes in metacognition following MERIT and the interplay between therapist’s intervening using MERIT elements and therapeutic alliance.

MERIT is defined by the implementation of eight therapeutic elements within each session. Presented in Table 1 (Lysaker et al., 2017), these include content, process, and superordinate elements that are posited to interact synergistically and allow clients the opportunity to practice and become better able to form more integrated senses of themselves and others and use that knowledge to better understand and manage the challenges they face in life. MERIT understands metacognition as a set of fundamentally intersubjective acts (Hasson-Ohayon, Kravetz, & Lysaker, 2017; Lysaker et al. 2017). It hence pays special attention to the therapeutic relationship and therapeutic alliance. In particular, thinking is presumed to take place between the therapist and client and, as such, the therapeutic alliance is considered as the environment in which reflection occurs and is supported.

Broadly, therapeutic alliance refers to the quality and strength of the affective bond between therapist and client, agreement upon the goals for therapy, and a consensus on how to attain those goals (Bordin, 1979). Consistent with studies among other patient populations (Fisher, Atzil-Slonim, Bar-Kalifa, Rafaeli, & Peri, 2016; Horvath, Del Re, Flückiger, & Symonds, 2011; Zilcha-Mano, Dinger, McCarthy, & Barber, 2014), recent studies have found that therapeutic alliance is an essential aspect of psychotherapy for persons diagnosed with schizophrenia (Davis & Lysaker, 2007; Davis, Eicher, & Lysaker, 2011). In psychotherapy with persons diagnosed with schizophrenia, the development of a positive therapeutic alliance has been suggested as directly leading to change (Davis et al., 2007; Goldsmith, Lewis, Dunn, & Bentall, 2015; Lecomte, Laferrière-Simard, & Leclerc, 2012; Svensson &ansson, 1999), with the strength of the therapeutic alliance linked to better adherence to therapy, reduced symptomatology, and improved quality of life as well as high satisfaction and maintenance of contact with mental health treatment (Frank & Gunderson, 1990; Solomon, Draine, & Delaney, 1995; Lacro, Dunn, Dolder, Leckband, & Jeste, 2002; Davis et al., 2007; Davis et al., 2011; Lysaker, Davis, Buck, Outcalt, & Ringer, 2011; Shattock, Berry, Degnan, & Edge, 2018). In addition, poor therapeutic alliance has been found to have negative and detrimental effects (Goldsmith et al., 2015).

Establishing therapeutic alliance with persons with schizophrenia, regardless of the treatment modality, often involves several challenges. For instance, symptoms severity, impairments in interpersonal functioning, client’s anxiety and misunderstandings, and history of interpersonal trauma, as well as confusion regarding interpersonal boundaries, may all act as barriers for developing therapeutic alliance (Lysaker & Gumley, 2010; Weiden & Havens, 1994; Shattock et al., 2018). A broader intersubjective approach has suggested that therapeutic alliance may also be challenged when clients and therapists have different narratives regarding the client’s problems, ideas about each other’s roles in psychotherapy, and underlying beliefs about psychotherapy (Hasson-Ohayon et al., 2017). According to this model, clients’ metacognitive deficits, that is, deficits in their ability to form holistic and integrative senses of self and others (Lysaker & Hasson-Ohayon, 2014; Lysaker & Dimaggio, 2014), may result in challenges to reach mutual recognition and agreement about therapy goals and roles. In line with this model, Davis et al. (2011) have found that a greater capacity for mastery, an aspect of metacognition, was associated with the development of stronger and more positive therapeutic alliance over time in a vocationally oriented psychotherapy for

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<td>Element 8</td>
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persons with schizophrenia. In other words, overcoming challenges to therapeutic alliance seem to require the enhancement of metacognition as a means to reflect on the ongoing intersubjective dialogue (Hasson-Ohayon et al., 2017).

Given MERIT, as described above, consists of interventions that are concerned with metacognitive capacity, the forging of a shared sense of clients’ needs and history, as well as intersubjective experience (Hasson-Ohayon et al., 2017), it may represent an approach to overcoming the challenges to establishing a positive therapeutic alliance. Nevertheless, whereas evidence for MERIT’s effectiveness is accumulating, no studies to date have directly examined the effects on therapeutic alliance by either MERIT as a whole or by any of its specific elements. To explore these issues, the current study sought to: (a) determine whether clients receiving MERIT experience a positive change in metacognitive capacity and (2) using session-by-session intensive data to determine whether the delivery of different MERIT elements were significantly associated with the emergence of better therapeutic alliance over time. We also sought to determine whether the delivery of different MERIT elements was significantly associated with improvement in short-term outcomes. A better understanding of these issues could aid in further establishing MERIT effectiveness and in the development of a more systematic account of how therapist’s interventions might enhance therapeutic alliance and outcome, and subsequently maximize the benefits of therapy.

Method

Study Design and Participants

Clients were 10 adults enrolled in an ongoing integrated design of a randomized controlled trial of MERIT and session-by-session assessment at a community clinic at the Bar-Ilan University (Clinicaltrials.gov ID NCT03427580). The mean treatment length was 23 sessions (SD = 2.06, range = 19–26), and approximately 95.0% of these sessions were available for statistical analyses, resulting in N sessions = 221. The clients were older than 18 years old (Mean age = 36.4 years, SD = 10.1, age range = 24–55 years), and the majority were male (80%). Clients had a mean of 12.7 years of education (SD 1.25), eight clients were single or divorced and two clients were married or in a permanent relationship. The clients had a mean of 1.8 lifetime psychiatric hospitalizations (SD = 1.23). All clients had a diagnosis of schizophrenia spectrum disorders according to previous medical data (three clients had diagnosis of schizoaffective disorder and five clients had diagnosis of schizophrenia) as well as according to the Mini International Neuropsychiatric Interview (Sheehan et al., 1998) that was conducted as part of the intake procedure. According to the Positive and Negative Syndrome Scale that was conducted prior to the treatment, clients’ average level of positive symptoms was 12 (SD = 2.79), clients’ average level of negative symptoms was 13.4 (SD = 4.55), and client’s average level of general symptoms was 26.1 (SD = 4.46). One client was hospitalized while in treatment, and the nine others were not hospitalized for at least the 6 months preceding the treatment. Seven clients were randomized to the treatment group and received MERIT immediately after intake, and three clients were randomized to the delayed treatment control group and received MERIT after a 6-month wait. All clients received psychiatric treatment for medication at outpatient clinics during the treatment. In addition, most clients received rehabilitative services in the community, such as vocational rehabilitation. However, clients did not participate in any other psychological therapies in parallel with MERIT or during the 6-month wait period.

Measures: Tool for Rating Therapist Interventions (Coding System)

MERIT Therapist Adherence Scale (MERIT-TAS; Lysaker et al., 2017). The MERIT-TAS is an eight-item therapist self-report scale. The items are based on the eight therapeutic elements of the MERIT protocol, described previously, and therapists are required to rate the extent to which each element was present during each session on a scale from 0 (absent) to 3 (optimal). For the purposes of this study, the MERIT-TAS was used to assess how adherence to each element impacts process measures (both therapeutic alliance and functioning, as rated by the clients).

Pre-Post Measures

Indiana Psychiatric Illness Interview (IPII; Lysaker, Clements, Plasceak-Hallberg, Knipscheer, & Wright, 2002). The IPII is a semistructured interview developed to assess how individuals understand their experience with mental illness. The interview consists of five open-ended questions concerning the life story and illness history of the client, allowing for metacognition to naturally arise while the client talks about his or her life narrative. In the current study, the IPII was administered by a clinical psychologist during the intake procedure, and again at the end of the therapy. Responses were audiotaped and transcribed, and later the levels of client’s metacognition were rated using the Metacognition Assessment Scale–Abbreviated (MAS-A).

Metacognition Assessment Scale–Abbreviated (MAS-A; Lysaker et al., 2017; 2005, 2010; 2019). The MAS-A is an adaptation of the Metacognition Assessment Scale, which was originally designed to study the frequency of certain metacognitive acts within psychotherapy transcripts of patients with personality disorders (Semerari et al., 2003). The MAS-A specifically transformed the original items of the MAS into four ordinal scales. These scales include self-reflectivity, which assesses the extent to which a person has formed an integrated versus a fragmented sense of self; awareness of others, which assesses the extent to which a person has formed an integrated versus fragmented sense of other people; decentration, which measures the extent to which a person has an integrated or fragmented sense of their own position and the positions of other people within the larger community; and mastery, which assesses the extent to which a person can use metacognitive knowledge to respond to psychosocial challenges. The MAS-A further reconceptualized metacognition as a series of increasingly hierarchical processes in which information is being integrated in an increasingly complex fashion. It is assumed for scales self-reflectivity, awareness of others, and decentration that once a given level is not attained, no higher levels can be meaningfully achieved because each level requires the successful function of the levels beneath it. For the mastery scale, it is assumed that each level similarly reflects a more complex metacognitive act. Thus, for all scales higher scores indicate a relatively more integrated set of experiences of the person in the world. Interrater
were used in the current study). Evaluation at the end of their treatment (their prepost therapy data collection). Six-month wait, prior to the beginning of their therapy, and another assessment at the end of the therapy. Three of 10 clients had second assessment at the end of the treatment. All clients underwent assessment prior to their initiation of treatment, and three clients were randomized to delayed treatment control group and received MERIT immediately after intake, while clients in the treatment group and received MERIT after a 6-month wait. All included clients underwent assessment prior to their initiation of treatment, that is, three of 10 clients had second assessment at the end of the 6-month wait, prior to the beginning of their therapy, and another assessment at the end of their treatment (their prepost therapy data were used in the current study).

Process Measures

Working Alliance Inventory (WAI-SR; Hatcher & Gillaspy, 2006). The WAI-SR is a short version of the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989), which is widely used to track session-by-session (SBS) changes in the strength of alliance between client and therapist. The WAI-SR is a 12-item scale, with three subscales: agreement on tasks, agreement on goals, and quality of the therapeutic bond. The WAI has been used extensively as a measure of the therapeutic alliance, and its validity has been established both with evidence of high correlations with other measures of the alliance and as a predictor of treatment outcome (Horvath & Symonds, 1991). Internal consistency has been found to be high for both total WAI scores and for the three subscales, with alpha coefficients ranging from .85 to .96 (Horvath et al., 1989; Tichener & Hill, 1989). In the current study, clients rated the WAI-SR following each session, and only clients’ ratings were used.

Outcome Rating Scale (ORS; Miller, Duncan, Brown, Sparks, & Claud, 2003). The ORS is a four-item SBS measure developed as a short-form alternative to the Outcome Questionnaire-45 (Lambert et al., 1996). The ORS is designed for tracking client progress in every session. The scale assesses change in three domains of client functioning that are widely considered as valid indicators of progress in treatment and successful outcome: individual functioning, interpersonal relationships, and social role performance. The ORS scale yields four separate scores between 0 and 10, which were summed into one score ranging from 0 to 40, with higher scores indicating better functioning. In the current study, the client rated the ORS prior to each session regarding their functioning within the week preceding the session, and the general score was used. As in previous studies (Chen, Atzil-Slonim, Bar-Kalifa, Hasson-Ohayon, & Refaeli, 2018), the ORS was considered as an indicator for the client progress during the treatment.

Procedure

Approval for the study was obtained from the ethics committee of the Department of Psychology at Bar-Ilan University. All clients provided written informed consent. Clients were told that they could choose to terminate their participation in the study at any time and were also told that their anonymity would be preserved. The clinician conducting the intake was not the same as the one who actually provided the treatment. After intake, the clients were randomized to either the treatment group or delayed treatment control group. In the current study, seven clients were randomized to treatment group and received MERIT immediately after intake, and three clients were randomized to delayed treatment control group and received MERIT after a 6-month wait. All included clients underwent assessment prior to their initiation of treatment, that is, three of 10 clients had second assessment at the end of the 6-month wait, prior to the beginning of their therapy, and another assessment at the end of their treatment (their prepost therapy data were used in the current study).

Pre- and posttreatment questionnaires were administered to clients as part of the intake procedure, and again at the end of therapy; session questionnaires were completed in each session by both clients and therapists electronically using computers located in the clinic rooms. For the purpose of the current study, measures of therapeutic alliance, general outcome and metacognition were used.

The clients were treated by five therapists (four women and one man). All therapists were master’s or doctoral students in the clinical program at the Bar-Ilan University Department of Psychology and were clinical psychology interns with at least 3 years of experience.

The Psychotherapy

MERIT consisted of weekly sessions over a period of 6 months (19–26 sessions), with a duration of 50 min for each session. Clients did not participate in other psychological treatment during the course of the study. Relying on MERIT protocol and its eight therapeutic elements (Lysaker & Klion, 2017), the therapy included three phases. The first phase focused on creating therapeutic alliance and trust as well as exploring the client’s agenda, the second phase focused on working on the client’s goals and challenges, and the last phase focused on processing completion of therapy, generalization of achievements, and relapse prevention tailored to the specific client.

Therapists took part in a structured training in MERIT prior to the trials and participated in 1 hour of group supervision on a weekly basis. All therapy sessions were audiotaped. Supervision was offered weekly by a senior psychologist (last author of current study, Ilanit Hasson-Ohayon).

Analytic Strategy

To assess pre-to-post differences in the MAS-A subscales’ scores, a set of paired t-tests was conducted. In addition, effect size calculations (Cohen’s d) were performed.

Regarding SBS changes, the evaluation was done based on the fact that the data set had a hierarchical structure (sessions nested within clients); as a result, individual observations were not independent of one another. For this reason, to test the study’s hypotheses regarding the associations between session-level therapist’s interventions according to MERIT therapeutic elements and session-level client’s alliance/functioning, we used multilevel modeling (Hox, 2013). Specifically, a two-level multilevel modeling was used, partitioning the total variability in the outcome variable on session s of client c into two components: within-client variability at Level 1 and between-client variability at Level 2. The predictors (i.e., the elements) were person-mean centered, which allowed us to examine the associations at the within-client level (i.e., whether in a particular session in which a certain intervention was higher than the average, the alliance level was higher).

Results

Pre-to-Post Evaluation

Table 2 presents the means and standard deviations for each of the MAS-A subscales at two assessments points (i.e., beginning of
treatment, end of treatment). The data are based on the metacognitive capabilities of nine clients (one client did not arrive to the final assessment session). As can be seen in Table 2, findings of paired t tests showed a significant increase in the clients’ capacity for self-reflectivity and mastery. However, no significant changes have been observed in the scale regarding the other’s mind or in the decentration scale.

**SBS Evaluation**

The mixed multilevel equation, in which therapeutic alliance was the outcome, and the intercept was considered to be random, was:

\[
\text{Alliance}_{ic} = (\gamma_{00} + u_{0c}) + (\gamma_{10} \times \text{Intervention}_{1ct}) + (\gamma_{20} \times \text{Intervention}_{2ct}) + (\gamma_{30} \times \text{Intervention}_{3ct}) + (\gamma_{40} \times \text{Intervention}_{4ct}) + (\gamma_{50} \times \text{Intervention}_{5ct}) + (\gamma_{60} \times \text{Intervention}_{6ct}) + (\gamma_{70} \times \text{Intervention}_{7ct}) + (\gamma_{80} \times \text{Intervention}_{8ct}) + e_{ic};
\]

where the therapeutic alliance level in session \(t \) of client \(c \) is predicted by the sample's intercept (i.e., fixed effect; \( \gamma_{00} \)), the clients’ deviation from the sample’s intercept (i.e., random effect; \( u_{0c} \)), this session’s eight interventions (i.e., \( \gamma_{10}, \gamma_{20}, \gamma_{30}, \gamma_{40}, \gamma_{50}, \gamma_{60}, \gamma_{70}, \gamma_{80} \)), and by a Level 1 residual \( e_{ic} \); quantifying this session’s deviation from all the previous effects). An autoregressive structure was imposed on the Level 1 residuals. The model predicting outcome was identical, although the predicted outcome was the clients’ ORS, \( \gamma_{tc} \), that is, the reports of clients’ general score of ORS at the beginning of session while + 1.

The results of the fixed-effects part of these models are presented in Table 3. As the table shows, Element 6, reflecting on the progress, predicted significantly higher levels of therapeutic alliance as the end of the session as well as marginally higher levels of clients’ outcome at the beginning of the following session. In addition, element 2, introducing the therapist’s mind, predicted significantly higher levels of clients’ outcome at the beginning of the following session. However, this element was not significantly associated with the client’s therapeutic alliance.

**The MERIT Elements—Frequent SBS Usage**

To ensure that some elements were not more frequently used than another and therefore have significant associations with therapeutic alliance and with short-term outcome, the average usage of each one of the elements was calculated: the average use of element 1 was 3.05, the average use of element 2 was 2.61, the average use of element 3 was 2.44, the average use of element 4 was 2.84, the average use of element 5 was 2.41, the average use of element 6 was 2.4, the average use of element 7 was 2.86, and the average use of element 8 was 2.44.

**Discussion**

The current study sought to further explore the effects of MERIT on metacognition and to evaluate whether specific therapeutic elements of the MERIT protocol (of the recommended eight) have stronger connection with therapeutic alliance and short-term outcome. Consistent with previous findings (de Jong et al., 2016), pre-to-post assessment of metacognitive capacity revealed that clients in the current study showed improvement in both self-reflectivity and mastery. Examining multiple time points over a 6-month course of MERIT therapy showed that applying the sixth element, that is, reflecting on the progress in therapy, was followed by higher therapeutic alliance at the end of the session.

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### Table 2

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<tr>
<th>Changes in Metacognition From Before to After Treatment</th>
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<td>Variables</td>
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<tr>
<td>Metacognition: self</td>
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<td>Metacognition: other</td>
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<td>Metacognition: decentration</td>
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<td>Metacognition: mastery</td>
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### Table 3

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<th>MERIT Elements, TA, and Outcome Rating</th>
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<td>Variables</td>
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*Note.* MERIT = Metacognitive Reflection and Insight Therapy; TA = therapeutic alliance; Est. = estimated.
and with better outcome in the following week as reflected by the general score of three areas of functioning: individual/symptomatic functioning, interpersonal relationships, and social role performance. In addition, the application of the second element, that is, the introduction of the therapist’s mind, was also related to better outcome in the following week.

In terms of the clinical meaning of improvements in the metacognitive capacity for self-reflectivity, findings suggested that clients initially were able to notice discrete cognitive and emotional experiences and by the end of treatment had developed the ability to recognize that their representations of the self were subjective and fallible and could change over time (Lysaker et al., 2005, 2019). Concerning metacognitive mastery, in parallel, clients began with at most the ability to grossly avoid others and life demands when facing distress and by the end of treatment were able to seek out and to respond to psychosocial and psychiatric challenges in a more flexible and adaptive manner.

Concerning the relationship of MERIT elements with short-term outcome, one way to understand the specific links between the second (the introduction of the therapist’s mind) and sixth (reflecting on the progress in therapy) elements with outcome is to posit that these elements, more than the other elements, promoted intersubjectivity. The intersubjective approach regards both client and therapist as two subjects interacting in an intersubjective space, creating a new joint meaning that is not available to each by his or her own (Hasson-Ohayon et al., 2017). Similarly, the second element, which refers to the insertion of the therapist’s mind, view the therapist as a subjective participant in the dialogue. Fulfillment of this element will establish the therapist as a person with distinct thoughts, promote the client’s awareness of the therapist’s mind, and allow dialogue as well as mutual reflection about the experience of the presence of another mind (Lysaker et al., 2017). This element can also be seen as immediate therapist self-disclosure, in the here and now, which was argued to enhance metacognition and therapy outcome (Hasson-Ohayon, 2012). The therapist’s self-disclosure, as defined by Knox and Hill (2003), is verbal statements that reveal something personal about the therapist. Regarding the efficacy of it in psychotherapy in general, studies have yielded contradictory findings, indicating that therapist self-disclosure can have both beneficial and detrimental effects on the therapeutic alliance, depending on the frequency and timing (Audet, 2004; Audet & Everall, 2003; Geller, 2003; Henretty & Levitt, 2010). Although the present study did not find significant association between this element and the client’s therapeutic alliance, in line with previous studies regarding intersubjectivity, sessions that were characterized by higher levels of this element were followed by better client’s outcome in the following week.

Similar to the intersubjective nature of the second element, the sixth element, that is, reflecting on the progress in therapy, refers to joint discussion and consideration regarding what has taken place in therapy. It calls for mutual reflection about client’s experience regarding the treatment as well as mutual reflection about specific goals, outcomes, or unexpected things. The purpose of this element is not simply to gather information but to stimulate deeper reflection of the client as an active agent with wishes and intentions and specifically with an ability to direct his own recovery process according to those thoughts. It is important to note that in contrast with the fifth element, that is, reflecting on the therapeutic relationship, this element does not refer to how patients experience their therapist but how they experience their therapy. In other words, it is assumed that a positive appraisal of the therapy progress is not always accompanied by a positive appraisal of the therapist and vice versa (Lysaker, Dimaggio, & Brüne, 2014; Lysaker et al., 2017). In line with previous studies regarding intersubjectivity, sessions that were characterized by higher levels of this element were followed by higher client’s ratings of therapeutic alliance as well as with better client’s outcome in the following week.

The findings regarding the sixth element, that is, reflecting on the progress in therapy, are also consistent with the literature of shared decision making (SDM). SDM is a health communication approach in which the client and the therapist think together on treatment goals. SDM highlights the importance of client-centered care in which the active role of the client is central as well as the importance of collaborative and interactive conversations between clients and therapists, two equally involved parties, regarding the ongoing therapy (Coulter, 2017; Dixon, Holoshitz, & Nossel, 2016). Implementing SDM in mental health care demonstrated higher treatment engagement in addition to an increase in the client’s involvement and satisfaction (Loh et al., 2007; Beitinger, Kissling, & Hamann, 2014; Hamann, Holzhüter, Stecher, & Heres, 2017; Dixon et al., 2016; Matthias, Fukui, & Salyers, 2017). In addition, previous studies have found a positive effect of SDM on the therapeutic alliance in other populations (Bieber et al., 2008). In line with these findings, the applications of element 6 is consistent with SDM because they both emphasize the need for a mutual dialogue between equal participants to enhance therapeutic alliance and outcome. Considering the SBS findings with the pre-post ones highlights the intertwining between intersubjectivity and metacognition (Hasson-Ohayon et al., 2017) because therapeutic alliance and reflection seem to affect each other.

Of note, other elements of MERIT were not found to predict improvement in therapeutic alliance or outcome. It might be that their effects happened later in time, or it also might be that most of the other elements, such as defining the psychological problem or eliciting narrative episodes, serve as guidelines for the therapist to think about the session but are not as commonly manifest in the session, as are the introduction of the therapist’s mind and reflecting on the progress in therapy (second and sixth elements). Thus, talking about the changes in therapy with the insertion of therapist’s mind may be more closely related temporally to immediate improvement in therapeutic alliance and outcome than elements that are not explicitly present in the therapeutic exchange. For example, the therapist sharing his experience of tension and ambivalence regarding unspoken topics in the therapy by saying, “I feel that we both avoiding talking about . . .” might open up greater possibilities for strengthening an affective bond. Similarly, in the sixth element, when a therapist invites mutual exploration regarding the progress of therapy by saying, for example, “I am wondering if you are getting what you want from recent sessions and generally,” it may open the possibility of strengthening agreement upon the goals for therapy. The emphasis on mutual exploration of these two elements are in line with the pre-to-post findings of the current study, showing improvement in self-reflectivity and mastery because that might intuitively be expected to increase a person’s subjective sense of being an agent in the world.

The current study has several limitations. First, the sample was relatively small. Power in multilevel models is complicated be-
cause it depends on both the number of Level 1 and Level 2 units as well as the variance/covariance matrix of the random effects (Hox, 1995; West, Ryu, Kwok, & Cham, 2011). We note here that our data are probably insufficiently powered, and thus, the results should be interpreted with caution before being replicated. Second, the majority of participants in our sample were males, which limits the generalization of the findings. Third, the study assessed adherence to MERIT elements only from the therapists’ perspective; thus, differences in the therapists’ own subjective experiences might affect accuracy. Therefore, future studies should explore adherence to MERIT protocol also from perspectives of objective observers. Fourth, the study assesses the process measure only from the clients’ perspective. Adding external ratings, such as those of the therapists or objective observers’ ratings, might develop a fuller picture regarding the elements that foster good therapeutic alliance and outcome. Fifth, because metacognition scores were pre-post based and therapeutic alliance and therapist interventions were session by session based, we could not examine the association between metacognition and therapeutic alliance over time. Sixth, there is a possibility that the elements may affect outcomes in ways that we could not detect in the current study. Lastly, the scale of client outcome was not specific to schizophrenia and might not capture unique aspects of coping with the disorder.

With these limitations in mind, it is reasonable to speculate that metacognitively oriented therapy may positively affect both therapeutic alliance and short-term outcome. Specifically, ongoing dialogue regarding how the client experiences the sessions, as well as therapist’s disclosure of his or her thoughts and feelings that are related to the ongoing process of therapy, are important since both allow for the increasing sense of subjectivity of the client, expressed by enhanced self-reflectivity and mastery. Future studies should further explore the benefits of additional elements on other mediators of outcome in addition to the use of a larger sample size and outcome measure that are specific to schizophrenia.

References


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