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ORIGINAL PAPER

Metacognitive Reflection and Insight Therapy (MERIT) Delivered Virtually During the COVID-19 Pandemic: An Illustration of Two Cases

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Abstract

Alternative platform offerings for psychotherapy have become a necessity in the age of the novel coronavirus (COVID-19) pandemic. The current study describes the virtual adaptation of Metacognitive Reflection and Insight Therapy (MERIT) for people with psychosis. MERIT is a recovery-oriented psychotherapy that has shown promise in increasing metacognition and allowing individuals to make meaning of their psychiatric challenges and direct their own recovery efforts. MERIT delivery requires the assumption that metacognitive reflection is an intersubjective act where individuals make meaning with others instead of in isolation. As such, considering the current COVID-19 pandemic, research is needed to understand how intersubjectivity and the therapeutic alliance may differ in a virtual environment rather than in-person. The present study addresses this question by illustrating two case examples of MERIT's adaptation to a virtual delivery telehealth format. Moreover, this study expands on Lysaker and colleagues' (2020) investigation of virtual adaptations of MERIT by exploring how MERIT is adapted in a virtual environment, how intersubjectivity changes in a virtual environment, and, what opportunities virtual platforms allow for metacognitive reflection. Overall, we found that MERIT can be successfully delivered in a virtual telehealth platform. We discuss opportunities and considerations for MERIT and other psychotherapy virtual delivery.

Keywords Metacognition · Intersubjectivity · Virtual mental health interventions · Telehealth · Psychosis · Schizophrenia

Mental health treatment therapists have been faced with the challenge of effective psychotherapy delivery among the uncertainty of the novel coronavirus (COVID-19) pandemic (Lynch et al., 2020; Miu et al., 2020). The need for safe alternatives to in-person care has led therapists to offer virtual telehealth therapy options to patients with psychosis and other serious mental illnesses (SMI) to avoid the spread of COVID-19 infection (O'Keeffe et al., 2021; Xiang et al., 2020). Virtual interventions (telephone or video) for individuals with SMI are feasible and acceptable, according to systematic reviews (Tremain et al., 2020). Still, these findings are nascent. Less is known about the delivery of specific mental health interventions using a virtual platform, particularly those that heavily target intersubjective processes, such as the therapeutic alliance (e.g., via changes in communication methods). The current study addresses possible changes in psychotherapy delivery, specifically Metacognitive Reflection and Insight Therapy (MERIT; Lysaker & Klion 2017; Lysaker et al., 2020a), utilizing a virtual platform.

Individuals with psychosis live with unusual perceptual experiences that can make living in the world traumatic and confusing (Longden & Read, 2016). These experiences can cause individuals to feel alienated from their loved ones and society (Firmin et al., 2021). To help us understand ourselves, others, and our challenges in a flexible and evolving way, metacognitive capacity involves a set of cognitive processes that individuals with serious mental illness tend to have difficulty with (Lysaker & Dimaggio, 2014). To

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address these issues, MERIT is a recovery-oriented psychotherapy that focuses on building metacognitive capacity to help individuals form evolving, integrated ideas of themselves, their challenges, other people, and the world; metacognitive knowledge is then used to adaptively respond to life's dilemmas (Lysaker & Klion, 2017; Lysaker et al., 2020a). MERIT is an emerging, evidence based treatment supported by published randomized controlled trials (de Jong et al., 2019; Vohs et al., 2018) and a range of case reports (e.g., Buck & George 2016; Kukla et al., 2016; Huling et al., 2021; Leonhardt et al., 2018) documenting evidence of improvements in metacognition, insight, and many recovery outcomes, such as interpersonal functioning, vocational achievement, intrinsic motivation, and the capacity for self-compassion.

The integrative model of metacognition is inherently intersubjective (Lysaker & Klion, 2017; Lysaker et al., 2020a), as meaning making involves a number of interpersonal considerations (e.g., the effect of this meaning on other people, and whether they share this meaning themselves; Lysaker at al., 2020a). Importantly, the therapeutic relationship, the quality of a relationship between therapist and patient (Dixon et al., 2016; Leibovich et al., 2020), is directly discussed in MERIT to enhance intersubjectivity by gaining an understanding of the relationship and what it means within the session. It is established that therapeutic alliance relates to metacognitive capacity (Hasson-Ohayon et al., 2016, 2020) and contributes to engagement and positive outcomes in therapy for people with psychosis (Bourke et al., 2021). More research is needed to explore whether the MERIT psychotherapy delivery platform (i.e., virtual vs. in-person) impacts intersubjectivity and the therapeutic relationship.

Primarily, MERIT was delivered in-person until the sudden emergence of the COVID-19 pandemic. Promising initial research has shown that MERIT delivered in a virtual platform is feasible and effective for improving metacognition (Lysaker et al., 2020b). As patients formed ideas of themselves in relation to others and the world within the altered social landscape of the pandemic (e.g., of social distancing and quarantining), therapists' observations of metacognition within virtual interventions became especially relevant. The current study aims to expand Lysaker and colleagues' (2020b) initial investigation to explore how a virtual platform affects the formation of the therapeutic relationship, intersubjective exchanges, and potential changes in metacognitive capacity. We address these aims by describing two case examples of virtual teletherapy utilizing MERIT with individuals with psychosis.

Method

Participants

Participants were recruited from an urban Midwest Veterans Affairs (VA) hospital in the United States. Inclusion criteria were as follows: (1) 18–65 years of age; (2) Diagnosis of schizophrenia, schizophreniform disorder, schizoaffective disorder, bipolar disorder, or major depression with psychotic features, as confirmed by Structured Clinical Interview for DSM-V (SCID; American Psychological Association, 2013); (3) Moderately impaired level of insight as measured by a 4 or higher on the Positive and Negative Syndrome Scale (PANSS; Kay et al., 1987) insight item; (4) No history of significant neurological illness or head trauma; (5) IQ of 70 or higher based on medical history; (6) No current alcohol or drug dependence (excluding nicotine or caffeine) based on the SCID interview; (7) Subjects who are not considered a high risk for suicidal acts (i.e., active suicidal ideation or suicide attempt within the past 90 days as determined by clinical interview). The current study includes two participants who engaged in MERIT therapy from 2019 to 2021 during the course of the study. Their names and other identifying information have been altered to protect their confidentiality. All participants completed informed consent documents prior to start of study procedures including permission to use session audio recordings and de-identified study data in future research. The protocol was approved by local institutional review boards. Participants were paid $10 for each therapy session and assessment they attended. While enrolled in this study, participants were enrolled in the VA's Psychosocial Rehabilitation and Recovery Center (PRRC), which offers outpatient services such as medication management, individual therapy, and group therapy.

Psychotherapy Approach

The current study utilized Metacognitive Reflection and Insight Therapy (MERIT), a recovery-oriented psychotherapy that aims to improve metacognitive processes (Lysaker & Klion, 2017). Therapy was delivered by a postdoctoral level psychotherapist with one year of formal MERIT training. Therapy delivery occurred with a combination of in-person and virtual delivery (described in more detail below).

Metacognitive capacity is conceptualized and measured in four domains: self reflectivity, understanding of the other, decentration, and mastery (Lysaker et al., 2005; Semerari et al., 2003). Self-reflectivity is an individual's ability to understand the self in a complex and integrated manner. Basic self-reflectivity begins with one's ability to recognize thoughts and emotions, progressing to the ability to recognize mistakes in thinking, and most complexly be able

to recognize cognitive, emotional, and behavioral patterns across time. Understanding others is an individual's ability to comprehend another person in an increasingly complex and integrated manner. Basic levels of understanding others includes the ability to recognize other's thoughts and emotions, progressing to the ability to make reasonable inferences about other people, and most complexly, the ability to recognize psychological patterns across another person's life, including the other's thoughts and emotions. Decentration is a person's ability to understand others that may not relate to themselves, and from multiple perspectives within the context of a person's community. Mastery is a person's ability to respond to psychological challenges using metacognitive ability. Basic levels of mastery begin with identifying a psychological challenge, progressing to more passive responses such as following another person's direction, to more active responses such as seeking support and most complexly, the ability to use higher levels of metacognitive knowledge, that is integrated and complex ideas about self and others, to respond to psychological challenges. MERIT aims to help individuals understand these experiences, develop a sense of agency, and gain a more cohesive sense of self in order to live a more meaningful life and better understand and manage challenges (Lysaker & Klion, 2017; Lysaker et al., 2020a).

MERIT consists of eight elements that are utilized by therapists to enhance metacognition (Lysaker et al., 2020a). These elements are intended to guide therapists in each session of using MERIT with patients for maximal metacognitive gains. The elements are divided into three groups: content, process, and superordinate. The first group of four content elements includes the subject matter within sessions (e.g., wishes, desires, and reactions) and are utilized for the therapist and individual's discussion and reflection. Element One clarifies the individual's agenda, for example, what the individual is hoping for in the session, or what are their intentions. The next element, Element Two, involves the therapist sharing their own thoughts with the individual about the patient's thoughts, emotions, or behaviors. Element Three asks therapists to elicit patient narratives to illustrate the individual's own experience that make up the flow of their life. Element Four involves the therapist and patient to jointly identify a plausible psychological problem the person is facing.

MERIT process elements pertain to the development of context within the session. These begin with Element Five, where both individuals discuss the therapeutic relationship directly, in other words, the interpersonal environment in which joint reflection-making occurs. Next, Element Six focuses on progress in sessions; this element asks therapist and patient to reflect on the effects of therapy on the individual's internal experience, for example, cognitive and emotional processes.

Finally, the MERIT superordinate elements require the therapist to offer therapeutic approaches that meet (and not exceed) the individual at their current metacognitive level. Thus, Element Seven requests that the therapist provoke intersubjective thought of both self and others at the patient's current metacognitive level. For example, at more basic levels a therapist might reflect, "You had a thought that. . ", or, "You recognized the anger you felt in your body". At more complex levels, a therapist might reflect, "You realized the paranoid thought you had caused you to feel angry inside. This is a pattern you've noticed before and it has caused problems in your relationships". Element Eight, the final element, asks the therapist to discuss the application of metacognitive ability (i.e., Mastery) at the appropriate metacognitive level. In this element, therapist and patient will first identify and describe a psychological problem. Growth in this area starts with behavioral strategies such as seeking support from others or engaging in helpful behavioral coping. As metacognition grows, individuals will be able to more skillfully use internal processes to address difficulties, starting with changing how they think about their problems and, more complexly, be able to understand patterns in their life and decide how to address them.

Results

Case Description 1: Steven

The client in this case will be referred to as Steven. He began MERIT in-person and after approximately 10 sessions switched to phone therapy due to newly initiated hospital COVID-19 safety protocols. After several telephone sessions, he transitioned to video sessions, the primary modality for the remainder of his sessions. He engaged in 43 therapy sessions until he completed his study participation.

Steven was a Caucasian man in his mid-40s who grew up in a Midwest city. Diagnostically, he met criteria for schizophrenia, reporting experiences of psychosis, disorganization and negative symptoms. He was taking psychiatric medication prescribed by his doctor during the course of the study. He presented with narcissistic traits, including the need for admiration, lack of empathy, and relationship difficulties. He was raised by a mother and father, and had two sisters. He was currently married with no children, living near his mother and sister. He reported being bullied as a child and feeling like he never fit in. As he got older, he reported romantic interests in women, but few close friends. He completed graduate school followed by various jobs of brief duration, many of which he found unfulfilling. In these

jobs, he reported several instances of interpersonal conflicts with coworkers and supervisors. He expressed feeling unable to understand why these incidents occurred, and his role in them.

Course of Treatment 1: Steven

Early in therapy, Steven focused on processing his unusual experiences (e.g., disorganized speech, bizarre beliefs, and strange perceptual experiences) with therapist and understanding his diagnosis. He stated that he wanted to learn "coping mechanisms" and "distinguish between [mental] states". In his first session, he divulged various personal thoughts without the hesitation that is typical of initial therapy sessions. To address Steven's possible agenda (i.e., Element One) for the desire to be seen as a "good patient", the therapist shared her own thoughts (i.e., Element Two) by reflecting, "You want to make sure I know you're taking your mental health diagnosis seriously." Steven intermittently made evasive, vaguely sexual comments about the therapist's appearance and on the fifth session, Steven made a direct, sexually inappropriate and provocative comment towards his therapist in an attempt to push the therapist away. Later, Steven was preoccupied with determining if his therapist liked him and, at times, apologized repeatedly for the incident. Steven and his therapist discussed this incident openly in multiple sessions and, over time, repaired the rupture. His agenda was to test the relationship to see if the therapist could withstand his unpredictable behaviors. Steven continued to attempt to determine if the therapist liked him and he assumed the role of "educator" to impress the therapist and appear as an intelligent person. To elicit Steven's reflection about this agenda (i.e., Elements One and Two), therapist used such reflections as, "I sense that you're trying to impress me with your knowledge."

When the pandemic caused the switch from in-person to telephone sessions, conversations were focused on COVID-19 and allowed an opportunity to discuss the therapeutic relationship and facilitated joint reflection (i.e., Element Five), as the interpersonal environment now more closely matched the shared experience of the pandemic. The patient and his therapist shared concern in tandem for each other and for family members who were at heightened risk for serious consequences of contracting the illness; This afforded the opportunity for Steven to consider the therapist's world affected by the pandemic (i.e., decentration). When therapy transitioned from telephone to video sessions, the other's physical home environment entered the conversation and facilitated shared reflection and discussion of life narratives (i.e., Element Three). For example, both therapist and patient had cats that appeared and created an emerging, genuine shared interest. Further, the presence of family artwork in both homes facilitated conversations about shared values. In this way, Steven began sharing life narratives about art growing up and his relationship with family members who influenced him to value art.

Later on, sessions focused on Steven's own thoughts, psychological problems (Element Four), and wishes he had for his life, allowing more space for therapist reflections at Steven's current metacognitive levels and metacognitive growth (i.e., Elements Seven and Eight). For example, he wondered which of his thoughts aligned with reality, and which were inaccurate. Furthermore, Steven became increasingly interested in the therapist's own ideas by explicitly asking what she thought, and he sought support regarding his challenges in an increasingly intersubjective way (e.g., rather than presenting in a monologic fashion). Moreover, he speculated about others' intentions and reappraised his judgments about family members. Lastly, Steven spoke of his passion for writing and a desire to increase productivity. In essense, he increasingly reflected on his life, what went wrong, and how things may improve. At the end of therapy, both client and therapist shared their positive experience of the relationship (Element Six).

Case Formulation 1: Steven

Steven presented with confusion regarding his behavior, internal experiences, and interpersonal exchanges. At baseline, metacognitively, Steven was able to identify his own thoughts, but unable to fully understand and respond to his emotions. His life narratives were fragmented, chaotic, and lacking autonomy, which was difficult to comprehend for both the patient and his therapist. He was able to recognize others' thoughts, however he struggled to understand others' feelings or intentions, and described confusing, sometimes bizarre interactions. He was sometimes able to recognize that he is not the center of the world, but was unable to fully comprehend others as having separate, valid ideas. He addressed psychological challenges through gross avoidance (e.g., complete avoidance of venturing out in the world).

Steven felt like an outcast throughout his life. He built some relationships as he aged, but they continued to be confusing and, at times, problematic. Discouraging and, at times, rejecting relationships led to a sense of defeat and an inability to "fit in" with his peers. Steven repeatedly acted out aggressively to cope with his lack of autonomy and to regain control in his life. After several interpersonal failures, and in an act of self preservation, he decided that staying home was safer and, subsequently, thought that *the world is unsafe*.

The therapist was a threatening presence for Steven at the beginning of therapy. Steven felt small in the world and his

therapist, whom he perceived as a successful person, may have served as a reminder of his professional failures. Steven interfered with the therapeutic relationship in several ways that further separated each person (e.g., by making a sexually aggressive comment, or by attempting to appear intelligent by placing himself as the educator and therapist as student). When Steven and his therapist began telephone sessions, the switch ameliorated the physical threat of the therapist's presence by allowing both individuals to experience the uncertainty and fear of COVID-19 together. Overall, this change facilitated interpersonal reflection between the therapist and patient.

Intersubjectivity improved via the shared experience of fear and isolation within the collective trauma of the pandemic, along with eliminating the perceived threat of the therapist's physical presence. Moreover, once video sessions began, the patient and his therapist were able to relate to each other using the physical environment as a cue for conversation. This strengthening of the therapeutic alliance allowed for the patient to more freely wonder about himself in a nonjudgmental environment. While reflecting on the relationship within therapy, further reflection occurred when discussing relationships outside of therapy. Steven and his therapist were able to jointly reflect that his troubling interpersonal interactions were at least in part resulting from his own problematic behaviors (i.e., he played a role in his consequences). That is, his descriptions early in therapy were largely about events happening to him, without him actively playing a role in them. As his metacognition grew, he was able to better understand his sense of self. He more clearly realized that he plays an active role in his life, and began to consider that he has some degree of control (i.e., increased autonomy). Over time, Steven was able to describe nuanced emotions for both himself and others, question his own thoughts, and recognize how different mental activities influence one another (e.g., thoughts and feelings). Steven was able to better understand confusing interpersonal interactions and better judge others' intentions and agendas. He was able to start to address psychological problems by changing how he thinks about them, or himself.

Case Description 2: George

The client in this case will be referred to as George. He completed 14 MERIT sessions with a combination of in-person and telephone sessions. He declined to meet via video, and engaged in therapy via telephone in the beginning, and after five sessions transitioned to in-person for the majority of sessions. This was George's first experience with therapy.

George was an African American man in his mid-20s who grew up in the suburbs of a Midwest city. Diagnostically, he met criteria for schizophrenia, describing psychosis, disorganization, and negative symptoms. He was not taking psychiatric medications during the course of the study. George was raised by a mother and father in the suburban Midwest. He had one full sister and four other half- or stepsiblings. He was not married, with one child. He had a high school level education. He said he was never very close to his family, yet wishes they were closer. He described wanting love and support from his mother that he felt he never received. He served in the Army for about 3 years. He reported repeated conflicts with superiors in the military that led to disciplinary action. Since then, he worked multiple jobs that ended abruptly due to conflict or absenteeism.

Course of Treatment 2: George

Beginning sessions focused on George's exploration of self and goals, such as his identity as a worker, spirituality, and sense of his interpersonal difficulties. George wanted the therapist to know of his accomplishments moreso than failures (Element One). George began by describing current happenings in his life without much focus on internal processes; the therapist remained interested in George's mental activities to encourage thinking about his own thoughts by offering such reflections as, "You were thinking. . ", or, "I wonder what is going through your mind now," (Element Seven). While George continued to attend telephone sessions, he focused on current events and external barriers, such as lack of daily structure (e.g., unemployed status) and legal challenges. He did not describe life narratives in detail (Element Three). After five sessions of teletherapy, George requested to meet in person due to lack of privacy in his home and preference to communicate in-person. At this point, COVID-19 protocols and safety guidelnes allowed therapist to accommodate his request.

In the first session of in-person therapy, George shared more past narratives about his family difficulties (Element Three) and his internal reactions and emotions (e.g., anxiety; Element Seven). Beginning in the second in-person session, George began to discuss psychotic experiences such as bizarre behavior and unusual beliefs. In these in-person sessions, he wondered if a spiritual influence affected his psychosis. He admitted that psychotic experiences were difficult to discuss and he avoided discussing such experiences with anyone. Relatedly, therapist and George discussed his difficulty trusting others with knowing about his experiences, and not feeling understood by others (Element Four). The therapist then offered reflections such as, "I wonder how you feel with me knowing this information," (Element Two). Pointedly, he would only discuss psychotic experiences with the therapist during in-person appointments, which appeared to be a safer space for George's own self-reflectivity and identification of psychological problems. He

increasingly was able to reflect about more complex emotions (e.g., anger, fear, and anxiety) and, further, he admitted to smoking marijuana daily to ease his anxiety. Therapist and George discussed the possibility of using active behavioral strategies to cope with anxiety and how it would be different than using marijuana (Element Eight). As the therapeutic relationship improved, George and therapist were able to openly discuss George's increased trust with therapist and how it felt for him to share personal information (Element Five) and how he felt after sharing thoughts each session (Element Six).

After several in-person sessions, George transitioned back to telephone sessions. During this time, George was insecurely housed, missed probation meetings, and struggled to keep steady employment. At this time, George did not schedule therapy sessions in advance and engaged on an as-needed basis. These telephone sessions contained more narratives and personal information than previous telephone sessions, however communication lacked visual cues that aided intersubjectivity for George. However, George became difficult to reach by the therapist and after two telephone sessions, he disengaged from therapy.

Case Formulation 2: George

George presented to therapy with vague descriptions of distress and confusion in his life and a desire to explore self identity, expressing that he would like to find "answers to questions" about himself. Metacognitively, he was able to distinguish basic thoughts and some emotions. He was confused by others and their thoughts, and had difficulty connecting with people. His short-lived jobs mirrored his transient relationships. He was the center of his own world and had difficulty understanding any other person's ideas or experiences, separate from his own. He dealt with challenges with gross avoidance and was unable to describe plausible psychological challenges in his life. It appeared important for George to appear as an interesting person without having significant challenges or mental illness. He felt insignificant in the world and not valued by others. He presented as a person who is unsure of himself, purposeless and lost in the world.

When beginning therapy, he was guarded with his therapist and did not share detailed thoughts, problems, or narratives. Sharing personal or unusual experiences over the telephone was too risky for George, without the ability to judge the therapist's nonverbal reactions or a private space in his home. Intersubjectivity and joint reflection was thus limited while therapy was conducted over the telephone. When therapy transitioned to in-person, intersubjectivity increased because George and his therapist were able to communicate more effectively by judging each other's reactions (e.g., nonverbal responses such as nodding and facial expressions). George increasingly shared narratives about himself, his family, and other relationships to understand past autobiographical events better and start to form an integrated idea of himself and his interpersonal exchanges.

Although George preferred in-person therapy, the option of telephone sessions appeared to be a useful alternative to in-person sessions when George's life became more chaotic. Notably, as George had gained trust with the therapist through in-person sessions, he was more willing to openly share in telephone sessions. Throughout therapy, he increasingly gained insight into his psychological problems, psychotic experiences, and wishes for his life. He became more open to discussing his own perceived difficulties, such as guardedness, difficulty connecting with others, and lack of purpose in his life. Though George's therapy was relatively short, he made several notable metacognitive gains. Through joint reflection, he was able to increasingly understand his own and others' emotions and describe psychological problems he was currently facing. Through thinking about others, he was able to recognize that he is not the center of the world and that others have goals and ideas that are unrelated to him. After trust was formed within the therapeutic alliance, George started to value the therapist's ideas and sought support through weekly sessions. However, it is notable that George abruptly ended therapy, and this may have been a manifestation of George's history of transient relationships.

Discussion

The current study describes two individuals who engaged in MERIT virtually during the COVID-19 pandemic. Through detailed case examples, our work extends previous findings demonstrating that MERIT is feasible in a virtual telehealth environment (Lysaker et al., 2020b). Specifically, MERIT was successfully delivered using telephone and video sessions, which afforded both unique benefits, opportunities and challenges, particularly regarding intersubjective processes. Furthermore, these cases extend work that telehealth is a feasible and important option for people with psychosis (Donahue et al., 2021) in that both clients were able to engage in telehealth despite being of different racial and educational backgrounds, illustrating the importance for therapists to withhold assumption about patients' preference or ability to use teletherapy (e.g., due to stigma; Tremain et al., 2020). In both cases presented, the option of virtual therapy was convenient and well-utilized, and avoided the postponement of ongoing services in the case of Steven or the initiation of services in the case of George. In the case of Steven, teletherapy was the preference for both therapist and

client and afforded the opportunity to continue treatment in an emerging pandemic. Although George developed emerging trust with his therapist after meeting her in person (i.e., when COVID-19 protocols allowed for distanced, masked, in-person meetings), and preferred in-person therapy, the virtual platform offered George flexibility while scheduling MERIT sessions amid his chaotic home life.

Compared with traditional in-person therapy, the virtual environment afforded different opportunities for intersubjectivity and rapport-building that allowed for metacognitive gains in this new environment. Despite the aspects of intersubjectivity that were conserved (e.g., vocal tone, and facial expression in video sessions) or gained (e.g., decreased threat of other's physical presence, and visual cues of shared interest in video sessions) using telehealth, virtual MERIT required some adaptations in communication. For example, the flow of conversation changes with both telephone (e.g., without visual cues to judge the other's reactions) and video (e.g., without cues of body language). In our study, virtual MERIT appeared differently with each of our patients. For Steven, beginning therapy in-person was challenging, and virtual therapy afforded new, beneficial opportunities to connect with the therapist. Given Steven's history of interpersonal challenges, in-person interpersonal exchanges were threatening and overwhelming, possibly made worse due to gender differences in communication (Bedi, 2014) and a rupture early in treatment. Seemingly, telephone therapy facilitated connection without the interference of the other's physical presence, afforded a less-threatening, safe exchange, and contributed to the rupture-and-repair, important for positive outcomes and greater retention in treatment (Safran et al., 2011; Eubanks et al., 2018). In addition, video sessions realized new rapport-building opportunities encouraging an equal stance for joint reflection in which therapist and client existed in their personal physical spaces, buttressed by shared interests and common human experiences related to the pandemic. This virtual environment afforded the opportunity for the therapist to build rapport through genuineness and authenticity, an important element of the therapeutic alliance (Faith et al., 2022; Schnellbacher & Leijssen 2009). In the case of George, he declined video sessions, so therapy began over the telephone. Offering therapy virtually allowed for an initial therapeutic exchange to begin while George was motivated for treatment, without delay, and later afforded the opportunity to continue treatment when George's life became more chaotic. Thus, the option of telephone sessions was helpful for George given its convenience.

Adaptation of MERIT was met with some challenges. First, although teletherapy offers convenience for some, other patients may not have their own private space. In our case, George did not have a private space to speak freely regarding his difficulties. It is possible this communication barrier hindered the therapeutic alliance at the beginning of therapy, as communicating emotional discomforts builds the therapist-client relationship (Hasson-Ohayon et al., 2021). When therapy was on the telephone, George and therapist were unable to judge each other's facial expressions, body language, and other visual cues over the telephone, which typically adds to communication enhancement (e.g., by "leaning in" to the screen, or expressing empathy through body posture and facial expressions; Simpson et al., 2020). Nonverbal cues can build metacognitive processes by reflecting markers of internal states and emotions emerging in the therapeutic exchange (Dimaggio & Lysaker, 2018). Although telehealth offers a useful alternative to in-person care, perhaps digital platforms cannot satisfactorily replace in-person care for some patients (Lynch et al., 2021), especially for those that value nonverbal cues such as facial expressions and tone of voice (Valentine et al., 2020). Further, it is possible that some patients need the full visual information from in-person interactions for effective communication. For example, the Interpersonal Synchrony (IS) Model of Psychotherapy (Koole & Tschacher, 2016) posits that the most basic form of synchrony in psychotherapy is movement synchrony (e.g., whole body movements), which facilitates basic communication and the therapeutic alliance. In the case of George, the switch to in-person therapy allowed for a detectable improvement in intersubjectivity (e.g., sharing more of his life narratives, and offering reflections about himself); perhaps George needed basic levels of movement synchrony so he could judge the other person's reactions fully in order to communicate effectively.

In summary, the current study provides two detailed case descriptions of successful engagement of MERIT teletherapy. We found that the virtual environment afforded different opportunities for successful engagement as well as barriers and solutions useful for future research and considerations in psychotherapy. These findings have notable implications for metacognitive based therapies, as well as other therapies that emphasize intersubjective processes.

Declarations

Conflict of interest We have no conflicts of interest to disclose.

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