Metacognitive- and Cognitive behavioral therapy

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Abstract

Background: Cognitive behavioral therapy (CBT) has become known as the "gold standard" treatment. Metacognitive therapy (MCT), on the other hand, is a newer therapeutic approach that has recently acquired popularity. **Objective:** Because there is a gap in the literature, this study looks into how clients in a Danish context experience therapy based on MCT and CBT. Furthermore, in Denmark, there is just one qualitative study that compares the two therapy approaches and solely focuses on the helpful factors. As a result, this study's contribution is extremely valuable because it also focuses on hindering factors in therapy. **Method:** We conducted a qualitative study using hermeneutic phenomenological research method to analyze 6 participants' experiences with MCT and CBT. To do this we used a semi-structured interview. The collected data was examined using Interpretative Phenomenological Analysis (IPA). **Findings:** Our main findings from the analysis consisted of five themes 1) Understanding of own mental issues, 2) Method & Tools, 3) The relationship between client and psychologist 4) Group therapy vs. Individual therapy and 5) View on therapy. The themes reflected the participants' positive and negative experiences with MCT and CBT and the challenges and positive changes they encountered. **Conclusion:** The majority of CBT clients' reported that the information about maintaining patterns; the cognitive model, psychoeducation and reconstructing negative automatic thinking was helpful. The majority of the MCT clients' reported an improvement in their mental well-being. They specifically pointed towards betterment in metacognitions, rumination & worry. Our findings show that the majority of the participants who experienced CBT and MCT preferred MCT. However, our findings also show discontentment among the CBT and MCT clients, which reflected their dissatisfaction with the specific therapy methods.

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1. Introduction

Many people with mental illnesses find strength and recovery by participating in individual or group therapy. As the number of people suffering from mental illnesses rises, so will the demand for treatment. There is no single therapy form that works for everyone; instead, individuals can select the therapy form or combination of therapy approaches that work best for them. Although medication and psychotherapy are helpful for many patients, they might not help everyone and many patients can relapse and suffer from mental disorders. Moreover, it can be inferred that RCT (Randomized controlled trial studies) frequently overlook patients' subjective experiences. Understanding the effects of psychotherapy is critical for both research and clinical practice, so professionals can improve and adapt to the clients' needs. However, while the outcome is primarily assessed using quantitative pre-post outcome questionnaires, it is unclear what this means for patients in their daily lives. Thus there is room for improvement in psychotherapy to help clients. To do so, it is critical to understand how patients perceive therapy and what they consider as helpful or unhelpful. Clients are generally hesitant to voice unfavorable thoughts about their psychologist (Blanchard & Farber, 2016), thus they may choose to change their behavior toward them in a socially acceptable way so psychologists might be unaware of what they can improve on. Clients may be more likely to reveal their actual impressions in a confidential report than to express their negative views during sessions. When it comes to therapist ratings, research has shown that client-rated alliance has a higher predictive validity in cognitive behavioral therapy (CBT) than therapist measures (e.g. Hoffart et al., 2012; Luong et al., 2022). According to CBT, how we think and behave influences our emotional well-being. In specific situations, these cognitive distortions and beliefs cause people to have negative thoughts. CBT aims to challenge and change negative thoughts and beliefs, assisting clients in replacing them with realistic thoughts (Beck & Beck, 2011). On the other hand, metacognitive therapy (MCT) was created as a different way of responding to thoughts to lessen the severity of symptoms. MCT is a newer therapeutic approach

compared to the golden standard treatment: CBT. Both CBT and MCT focus on cognition (thoughts), however, MCT and CBT are based on two distinct theories. According to MCT theory, mental illness is caused by engaging with thoughts through rumination and worry, and that worry and rumination are controlled by metacognitive beliefs. In recent years MCT has increased in popularity in Denmark, with lots of news articles surrounding its effectiveness. (Navn & Grundtvig, 2019).

Thus this research paper seeks to examine the clients' subjective experiences with CBT and MCT with a focus on helpful and unhelpful factors. Our statement of intent and the reason behind it will be presented in our literature review.

1.2 Reading guide

Due to the scope of the thesis, we chose to divide the assignment into chapters. There will therefore be a brief presentation of this in the following section, as well as a brief description of what the reader can expect:

Chapter 1) Chapter 1 contains the introduction to the assignment with a short description of the subject field. Additionally, there will be a clarification of the relevant concepts in our thesis.

Chapter 2) In this chapter there will be a literature review where we will explain our search process, the literature in metacognitive therapy (MCT) and cognitive behavioral therapy (CBT) and the relevant gaps that culminated in a statement of intent.

Chapter 3) This chapter is called *theories* where there will be an account for CBT and MCT, which consists of the historical background for therapies' occurrence as well as the typical method and tools applied by the specific form. Furthermore, to account for the common factors and specific factors in the therapeutic relationship, The Contextual Model has been chosen. Moreover, Rogers's theory on

client-centered therapy is also included because it puts emphasis on the real relationship and elaborates on the concept of empathy in therapy. Furthermore, Bandura's theory about self-efficacy and Julian Rotter's theory about the locus of control has been chosen since it can perhaps help to understand how an individual's belief system can affect their therapeutic experience.

Chapter 4) This chapter is called *Method and Design* where there is an in-depth introduction to the method used in the thesis, namely the hermeneutic-phenomenological approach. This chapter will also describe the design, concrete execution of the study, ethical considerations and quality assessment of the study.

Chapter 5) with the title "Analysis" consists of an analysis of the 6 transcriptions with Interpretive Phenomenological Analysis as the analysis method used. The results will here be unfolded based on the chronological order of 5 themes that arose in connection with the analysis processes. These are: 1) *Understanding of own mental health issues, 2) CBT & MCT methods & tools, 3) the relationship between the psychologist and the client, 4) group therapy vs. individual therapy* and *5) view on therapy.* Each theme has different sub-categories that are related to the overall theme.

Chapter 6) The discussion will shed light on the study's themes and the theories will be used to understand the participants' statements. Additionally, this chapter examines the findings in the context of the field's literature. The section is divided into five sub-discussions. Additionally, the methodical and theoretical limitations are also discussed. Moreover, clinical implications and the ethical reflections will be considered and the chapter will end with a conclusion on the discussion. Furthermore, our studies' results can contribute to improvements in future research.

Chapter 7) Conclusion is the last and summary section of this thesis, where there is a conclusion on the findings as well as nuances that can be discussed in our findings.

1.3 Clarifications of concept

This section aims to clarify the important concepts; Client, psychotherapy & psychologist.

1.3.1 Client

The patient–client dilemma is about determining who should receive psychological services or intervention (i.e., the nomenclature used for the recipient). Psychiatrists, many clinical psychologists, and some other mental health providers use the medical model's traditional language and refer to people seeking their services as patients. Counseling psychologists, some clinical psychologists, social workers, and counselors prefer to refer to the person seeking their services as a client rather than a patient, which is associated with illness and dysfunction. We therefore choose to select the definition clients for our participants due to our personal preferences where we view clients as equal rather than psychologists treating them as patients. (“Patient-client issue,” 2022).

1.3.2 Psychotherapy & Psychologist

Psychotherapy is a psychological treatment provided by a trained professional which entails assessments, diagnosis and treatment of dysfunctional emotional reactions, ways of thinking, and behavior patterns through forms of dialogue and interaction. It can be provided for individuals, couples, families or a group of individuals. There are many different types of psychotherapy, but they all fall into one of four groups: psychodynamic psychotherapy, cognitive behavioral therapy, humanistic therapy, and integrative psychotherapy. Psychotherapist and psychologist can be used interchangeably since psychotherapy can be given by different professions, however

this thesis will only focus on psychotherapy given by psychologists in Denmark, who holds a master's degree in psychology, which is a 5-year university education. ("Psychotherapy," 2022).

The following section investigates what the literature has to say about Metacognitive- and Cognitive Behavioral Therapy.

2. Literature review

The following section contains a literature review of metacognitive- and cognitive behavioral therapy. The purpose of this literature review is to create an overview of existing research in the field. We are interested in investigating how clients experience metacognitive- and cognitive behavioral therapy. In the following, the work process in the literature review will be described; including the preparation of suitability criteria, the search process, screening and inclusion of studies. Subsequently, characteristics of the included studies are presented in a table, after which a synthesis is designed based on their results. Finally, it will result in the choice of the study's research questions.

2.1 Search and Suitability Criteria

The search for this literature review was performed in the database PsycInfo. As the literature review does not include the thesis' primary examination, but is used as a basis for knowledge of the subject field, only one database has been searched. This may have precluded other relevant research in the field. However, PsychInfo has been chosen on the basis since it is the largest database within psychological research, and therefore it is assumed that the literature review covers relevant

research in the subject field. The following inclusion and exclusion criteria were established:

The studies should be from Western countries since our participants are born in Denmark. Studies outside these continents were not included due to cultural differences that might impact the results. Studies concerning the effect or experience of metacognitive- and cognitive behavioral therapy as well as studies focusing on the therapeutic alliances are included. In addition, criteria are set; the participants' should be over the age of 18 and the disorders should mainly be anxiety and depression. This is to ensure that the studies we select can be used for our participants that have similar disorders and experiences. Furthermore, we only include primary studies and studies published in Danish and English. In addition, only studies that are "Peer-Reviewed" are included. This is to ensure that the included studies meet scientific standards.

A search was made in the database PsycInfo on 28/04/2022. The search string was built on the basis of the inclusion and exclusion criteria shown in table 1. Based on this, we designed a list of relevant keywords, after which significant index terms were identified. We set a criterion that the included words from the search string should appear in the abstract. This criterion was established as the studies were not considered relevant if words from the search string were not included in the abstract. The following keywords were included in the search string: "*Metacognitive therapy*" AND "*Depression*" OR "*Metacognitive therapy*" AND *"Anxiety"* OR "*Cognitive behavioral therapy*" AND "*Depression*" OR *"Cognitive behavioral therapy"* AND *"Anxiety*" OR "*Metacognitive therapy*" AND "*Therapeutic alliance*" OR "*Cognitive behavioral therapy*" AND "*Therapeutic alliance*". We chose 3 types of methodology: Meta-analysis, quantitative- and qualitative studies.

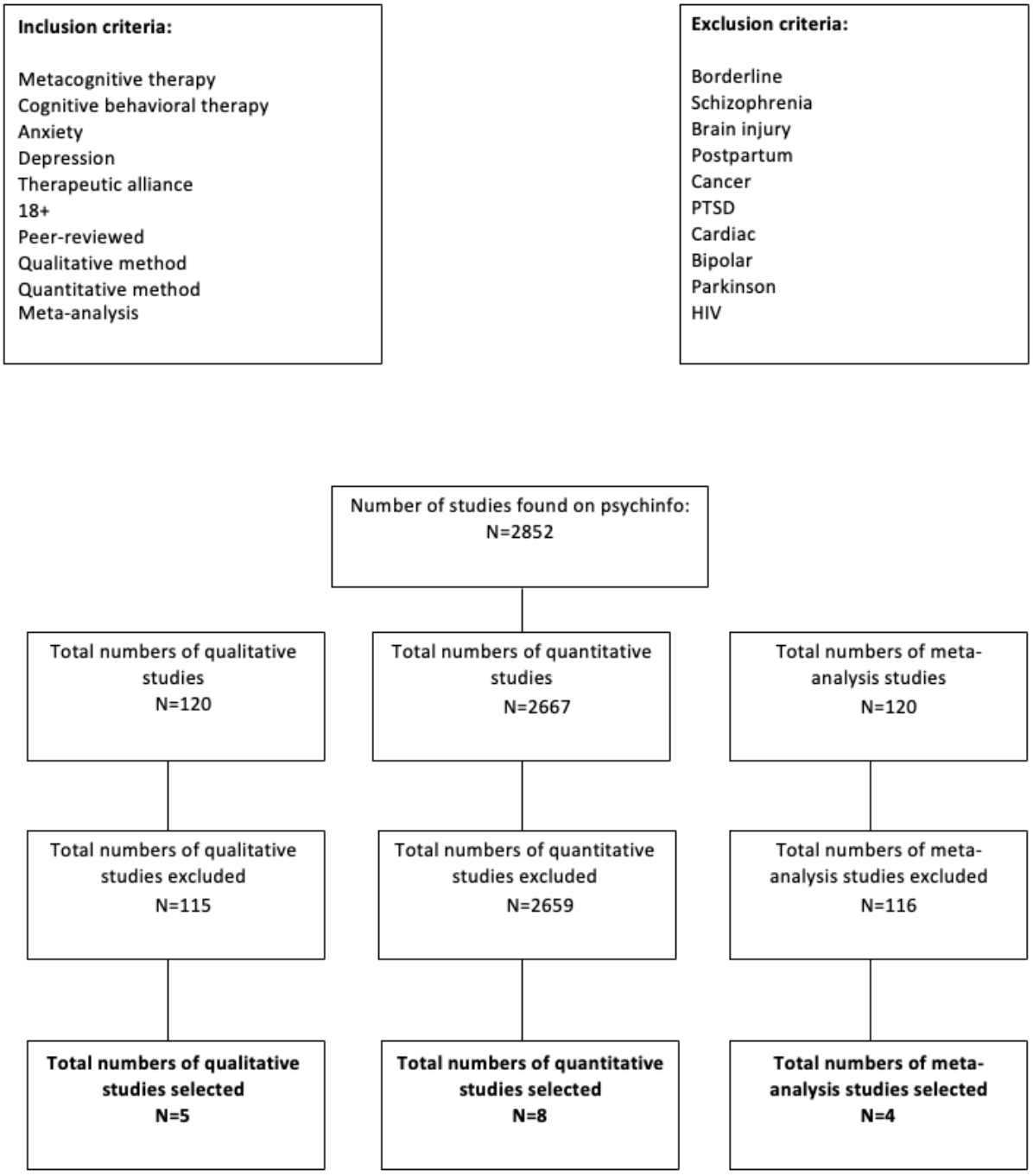
This research paper is interested in examining the individual's life-experiences through semi-structured interviews thus we decided to search for studies conducted

with qualitative methodology. However, due to the lack of qualitative studies on metacognitive therapy, we decided to include quantitative studies. Moreover, in the beginning of our search process we wanted to investigate what the quantitative studies of cognitive behavioral therapy and metacognitive therapy entailed inorder to examine what quantitative studies couldn't account for. To do so we chose the methodology meta-analysis since there have been numerous studies that look into cognitive behavioral therapy and we wanted to read about multiple studies across the same subject area in a comprehensive way. By choosing meta-analysis we could look into important conclusions, gaps and trends that could influence our own research question.

2.2 Results

The above search provided a total of 2852 hits. This was followed by a screening process based on the inclusion and exclusion criteria. The first part of the screening process consisted of screening the relevance of the studies based on their title and abstract. The second part consisted of the screening process consisting of full-text screening of the remaining studies based on their focus, geography, disorders, method and age-group. We thus ended up with a total of 17 studies which can be seen in the figure down below.

2.2.1 Table 1 over the selected articles



Furthermore the results of the studies are summarized in an overall synthesis in table 2 down below.

2.2.2 Tabel 2

Author	Country	Purpose	Sample	Method	Results
Andrew C Butler, Jason E Chapman, Evan M Forman, Aaron T Beck (2006).	Western countries	The purpose of this study is to review the outcomes of CBT and find out how effective is CBT, for which disorders and in comparison to what, and how long does the effect last.	9995 subjects in 332 studies. These meta-analyses included 562 comparisons covering 16 disorders.	16 meta-analyses were reviewed and effect-sizes were compared.	CT is extremely effective for adult unipolar depression, adolescent unipolar depression, generalized anxiety disorder, panic disorder with or without agoraphobia, social phobia, post-traumatic stress disorder (PTSD), and childhood depressive and anxiety disorders.
Bandelow, B., Reitt, M., Röver, C., Michaelis, S., Görlich,	Western countries	Compared the effectiveness of pharmacological, psychological, and combined treatments for the three major anxiety	234 randomized studies where there were 37 333 patients.	Meta-analysis. Pre–post and treated versus control effect sizes (ES) were	Individual CBT outperformed waiting lists, psychological placebos, and

Y., & Wedekind, D. (2015)		disorders (panic disorder, GAD, and social phobia).		calculated.	pill placebos.
Cujipers, Cristea, Karyotaki, Reijnders, Huibers (2016).	Western countries	How effective are cognitive behavior therapies for major depression and anxiety disorders.	The 144 trials included a total of 184 comparisons between CBT and a control condition (63 comparisons for MDD, 31 for GAD, 42 for PAD, and 48 for SAD). A total of 11,030 patients were enrolled.	Meta-analysis. Aimed to establish the most up−to−date and accurate estimate of the effects of CBT in the treatment of MDD, GAD, PAD and SAD by comparing ES.	Overall effects for all four disorders were large, ranging from g=0.75 for MDD to g=0.80 for GAD, g=0.81 for PAD, and g=0.88 for SAD.
Carter et al. (2021)	New Zealand/ Australia	To investigate patients' status on depression, anxiety and social functioning after two-years post CBT- and MCT treatment.	31 patients with a diagnosis of major depressive disorder.	Measured with QIDS (Depression), SCL-90 (Anxiety) , PSWQ (worry), DAS (Dysfunctional attitudes), RSQ (Rumination), GI (General impression).	Both CBT and MCT produced positive change over time. No significant improvement was found in the outcomes of CBT and MCT.

Callesen, Reeves, Heal & Wells (2020)	Denmark	To examine the clinical efficacy of MCT compared to CBT in patients with major depressive disorder.	174 patients were referred by a general practitioner to the clinic.	Measured at pre- and post treatment with HDRS and BDI-II and secondary measures for anxiety.	No differences were found on HDRS. Significant difference was found on BDI-II favoring MCT. During follow-up 74% MCT clients' and 52% CBT clients' met criteria for recovery.
Christensen et al. (2021)	Denmark	Investigate group cohesion in CBT for anxiety and depression.	23 patients from four different psychiatric outpatient clinics.	Qualitative analysis	The findings revealed that, regardless of treatment style, group cohesion and other group-related processes were seen as major, if not the most important, aspects in group therapy.

Dammen, Papageorgiou & Wells (2014)	Norway	To investigate the effects and feasibility of group MCT for depression.	11 participants referred by general practitioners that met the DSM-IV criteria for major depressive disorder.	The participants were tracked at the start and at the completion of a 10-week group MCT treatment that lasted 90 minutes per week. The measurement consisted of: Severity of depression, anxiety, rumination and metacognitive beliefs.	Significant clinical improvement across all measures.
De Smet, Meganck, Van Nieuwenhove, Truijens, Desmet M (2019)	Belgium	This study looks into the phenomenon of non-improvement in psychotherapy by combining quantitative pre-post outcome scores that show no reliable change in depression symptoms with a	19 patients	Qualitative + quantitative analysis.	Reasons for Non-improvement: Being stuck between knowing and doing. Reasons for positive changes:

		qualitative investigation of patients' perspectives.			(mental stability, personal strength, and insight) were stimulated by therapy.
Hoffmann & Smiths (2008)	Western countries	The present study meta-analytically reviewed the efficacy of CBT versus placebo for adult anxiety disorders.	27 studies were selected leading to 1,496 patients.	Meta-analysis. Measured the efficacy of CBT by *hedge's g* in randomized placebo-contr olled trials.	For all anxiety disorders studied, results showed that CBT produced significantly more benefits than placebo + social anxiety disorder had the third best response rate.
Hagen et al. (2017)	Norway	investigates the efficacy of MCT for depression.	39 patients with depression were randomly assigned a wait-list (WL) period or MCT for 10 sessions.	Structured clinical interviews (SCID-I, SCID-II and theHRSD-17) at pre- and post treatment.	Large controlled effect sizes were observed depressive and anxious symptoms. 70-80% were recovered

				Self-report (BDI & BAI).	whereas 5% in the WL were recovered.
Haseth et al. (2019)	Norway	The purpose was to assess the feasibility and effectiveness of group MCT for GAD in a community mental health setting.	23 patients with GAD participated.	Self-reported symptoms measured at pre- and post treatment and 3 months follow-up with Penn State Worry Questionnaire, the Generalized Anxiety Disorder-7, and the Patient Health Questionnaire -9	A significant reduction in worry, anxiety, depression, metacognitive beliefs, and maladaptive coping. 65.3% were recovered at post-treatment , whereas 30.4% were improved and. At follow-up recovery was increased to 78.3%.

Jordan et al. (2014)	New Zealand / Australia	A planned randomized controlled trial that compares MCT and CBT, to investigate the relative speed and efficacy of MCT in patients with depression.	48 patients with a DSM-IV diagnosis of major depressive disorder were randomly assigned 12 weeks of MCT & CBT.	Measured with QIDS & MADRS.	Both CBT and MCT were equally effective.
Løvgren, Røssberg, Engebretsen & Ulberg, (2020).	Norway	Investigate the factors that aided and patients' experiences of improvement in time-limited psychodynamic therapy for depression.	10 adult patients who received up to 28 sessions of manualized psychodynamic psychotherapy.	The post-therapy interviews addressed the participants' experiences from therapy.	Four helpful dimensions: "Therapist activities" comprised supporting and acknowledging, advising and offering tips for everyday life, questioning and pressuring.

Malkomsen Røssberg, Dammen, Wilberg, . Ulberg & Evensen (2021)	Norway	Wanted to investigate which metaphors patients with major depressive disorder (MDD) use to explain their experience in therapy and their recovery from depression.	22 patients from two public psychiatric outpatient clinics from Oslo.	Qualitative analysis.	Metaphors used:surface and depth, being open or closed, tools, chemistry, and other metaphorical ideas.
Nilsson, T., Svensson, M., Sandell, R., & Clinton, D. (2006)	Sweden	Individuals who had experienced CBT or psychodynamic therapy were interviewed about their experiences in psychotherapy.	32 patients from from a Swedish psychiatric outpatient clinic	Qualitative analysis.	Clear differences in the types or qualities of outcomes described, as well as some common experiences shared by the two groups of patients.
Nordahl HM (2009)	Norway.	In a clinic setting, to investigate the efficacy of brief MCT in a treatment-resistant population.	28 heterogeneous patients. Divided into two groups; CBT and MCT.	Participants were measured using BDI, BAI, AnTI at pre- and post treatment.	There was a difference in CBT and MCT on levels of anxiety and meta-worry (favoring MCT).

Straarup, N. S., & Poulsen, S. (2015).	Denmark	To examine clients' experience with CBT and MCT with a focus on the helpful elements.	6 clients that met the criteria for DSM-IV for major depressive disorder.	Qualitative analysis.	Themes: 1) A good therapeutic relationship 2) Understanding of depression, 3) Insight Into maintenance patterns. 4) Changing maintenance patterns. 5) Change

Through our two tables it becomes evident that we chose 4 meta-analyses, 8 quantitative and 5 qualitative studies. Since MCT is a newer therapy method, the CBT literature has a stronger presence than MCT. First, there will be an account of the meta-analysis that investigates CBT and its effectiveness. Since most of our participants received group therapy, a CBT group therapy study has also been included. Afterwards, qualitative studies that compare CBT to PDT have been used to find emerging themes and topics that are relevant for our search process. Furthermore, quantitative studies that compare CBT and MCT are included. Later, we found one qualitative analysis in Denmark that compares MCT with CBT Straarup & Poulsen (2015). Gaps in the literature were identified and led to the statement of intent of this thesis.

2.3 CBT

CBT is arguably one of the most well-researched psychosocial treatments, with the number of studies focusing on CBT continuing to grow. Research has established cognitive-behavioral therapy (CBT) as an effective treatment for anxiety disorders (Butler, Chapman, Forman & Beck, 2006; Bandelow et al., 2015; Cuijpers et al., 2016). Butler et al. (2006) identified 16 meta-analyses of CBT, and Bandelow et al. (2015) identified 269 meta-analytic studies focusing on CBT. To date, several hundred meta-analyses of CBT report its effectiveness for both depressive (Cuijpers et al., 2013) and anxiety disorders (Hofmann & Smits, 2008). The randomized placebo-controlled trial is the gold-standard design in clinical outcome research. This strategy has been utilized as the principal test of the direct effects of the treatment on outcomes in clinical research. The major goal of Hoffmann & Smith's study in 2008 was to compare the acute efficacy of CBT to placebo in adult patients. Unlike previous meta-analyses of CBT for anxiety disorders, they focused on randomized placebo-controlled trials of DSM-III-R or DSM-IV anxiety disorders that directly evaluated CBT treatment efficacy in a placebo condition. To answer these questions, they screened 1,165 studies and identified 27 randomized placebo-controlled trials totalling 1,496 patients. As reflected by medium to large effect sizes for measures of anxiety disorder severity, CBT yields significantly greater benefits than placebo treatments.

However, it has become obvious in recent years that the effects of CBT and other psychotherapies have been overestimated. There is a lot of indirect evidence of publication bias, based on the over-publishing of small studies with big effect sizes. Furthermore, the majority of meta-analyses only included trials up to 2008, and numerous more studies have been completed since then. Because newer trials are often of higher quality than older ones, the current best estimate of the impact size of CBT after accounting for these newer studies is unknown (Cujipers et al., 2016).

Cujipers et al. (2016) investigate an alternative estimate of the effects of cognitive behavior therapy (CBT) in the treatment of major depression (MDD), generalized

anxiety disorder (GAD), panic disorder (PAD), and social anxiety disorder (SAD), accounting for publication bias, trial quality, and the impact of waiting list control groups on outcomes. The effect size reflecting the difference between the two groups at post-test (Hedges' g) was determined for each comparison between a psychotherapy and a control condition. In order to calculate effect sizes, they used measures examining depressive symptoms, such as the Beck Depression Inventory and the Hamilton Rating Scale for Depression, or anxiety symptoms, such as the Beck Anxiety Inventory. Effect sizes of 0.8 are considered high, while those of 0.5 are considered moderate, and those of 0.2 are considered small. Effect sizes were calculated by subtracting the psychotherapy group's average score from the control group's average score (at post-test) and dividing the result by the pooled standard deviation. They concluded that CBT is effective in the treatment of MDD, GAD, PAD, and SAD; that the effects are large when the control condition is a waiting list, but small to moderate when the control condition is care-as-usual or pill placebo; and that these effects are still uncertain and should be considered with caution due to the small number of high-quality trials. The degree to which a therapist delivers an intervention may be objectively examined after it is stated in a treatment manual and different treatments can be discriminated along crucial dimensions in comparative efficacy and effectiveness trials. On the other hand, treatment integrity involves more than what a therapist does (i.e., protocol adherence), but also how a therapist does it (i.e., therapist competence and skills) (Boswell et al., 2013). Consequently, it is important to assess the quality of therapy forms through qualitative methods. Therefore a study about CBT group therapy is also included.

2.3.1 CBT - Group therapy

A study by Christensen et al. (2021) investigated patients' experiences of group cohesiveness in diagnosis-specific versus transdiagnostic CBT groups in using a qualitative comparison paradigm. The current study included 23 patients from four psychiatric outpatient clinics in Denmark. After the treatment, the patients were

interviewed in semi-structured interviews. Major depressive disorder, panic disorder, agoraphobia, or social anxiety disorder were the most common primary diagnoses among the participants. It was decided to do a comparative theme analysis. The transition from differences to similarities, the function of group cohesion in group CBT, and factors that aid and inhibit group cohesion were discovered to be three themes. In both diagnosis-specific and transdiagnostic CBT groups, group cohesion formed and was regarded as extremely important.

The findings revealed that, regardless of treatment style, group cohesion and other group-related processes were seen as major, if not the most important, aspects in group therapy. Patients tended to notice how they differed from other group members at first, but quickly began to see past the distinctions and recognize the commonalities that brought them together; as a result, this process built the groundwork for group cohesion. Normalization, anti-stigmatization, mirroring, support, encouragement, and understanding were some of the group-related processes that were used to build cohesion. The experience of belonging to the group, as well as the feeling of being mutually supportive and supported by the group, resulted in increased motivation to attend treatment and complete homework assignments, as well as a greater willingness to contribute to the group. Nonetheless, the group appears to be experienced as a healing constituency on its own by the patients in the current study, despite the fact that it is not recognized as an independent healing constituency in the CBT literature but rather as a factor that may help optimize specific processes and outcomes (Christensen et al, 2021).

Since metacognitive therapy is a newer therapeutic method there are not many comparative qualitative analyses of CBT and MCT. Therefore studies that compare cognitive behavioral therapy (CBT) with psychodynamic therapy (PDT) have been chosen.

2.3.2 Qualitative studies that compare CBT to PDT

There are several qualitative studies that investigate client's experiences of psychotherapy (Nilsson, Svensson, Sandell & Clinton, 2006; Malkomsen et al, 2021; De Smet et al., 2019; Løvgren et al, 2020). In this section there will be given an in depth review of the studies that compare cognitive behavioral therapy with psychodynamic therapy (Nillson, Svensson, Sandell & Clinton (2006); Malkomsen et al, 2021):

Nillson, Svensson, Sandell & Clinton (2006) wanted to qualitatively compare two theoretically distinct forms of psychotherapy: psychodynamic therapy (PDT) and cognitive behavioral therapy (CBT). Patients from a Swedish psychiatric outpatient clinic who had either received PDT or CBT were interviewed. 14 patients had previously been in CBT, whereas 17 had taken part in PDT. Length of CBT varied from 2 to 48 months and PDT varied from 18 to 120 months. All therapies were conducted with once-weekly sessions. The interviews covered six specific domains, with equal emphasis on the part of the interviewer: nature of change, course of change, therapist's methods, therapist and the therapeutic relationship, external influences on change, and patient's own contribution to change. The study's key findings are that there are clear differences in the types or qualities of outcomes described, as well as some common experiences shared by the two groups of patients. Despite the fact that both satisfied patients continued to improve after termination, the majority of CBT patients were directly satisfied with their abilities to apply specific techniques to specific problems, whereas the PDT patients described themselves as more self-reflective and with a broader range of personality-related changes. With one PDT patient mentioning that she was more ambivalent about therapy in general. The CBT method was focused and disciplined and the therapist was an active and directive partner in a collaboration. The progressive confrontation of certain fears was commonly described as the gradual mechanism of change. The PDT method involved open-ended, sometimes painful self-exploration, with the therapist serving as more of a witness at a safe distance, providing linkages and

summaries. As a result, the CBT patient's version of the change that had occurred was more explicit than the PDT patient. The interpretation is that CBT is less open-ended and more explicit, tangible, and concentrated in its goals and procedures, as evidenced by the patient's experiences. Both groups' perspectives on what contributed to change included the "common factors" (Hubble et al., 1999 cited by Nillson, Svensson, Sandell & Clinton, 2006), such as both partners' involvement and motivation, as well as a strong therapeutic alliance. The descriptions of obstacles that hindered the unsatisfied patients' therapeutic activity often reflected their discontent with the specific therapy approach. For instance the PDT patient wanted a more direct and active approach as seen with CBT whereas the CBT patient wanted a more in depth approach as seen with PDT.

Similarly another study by Malkomsen et al (2021) compared PDT and CBT patients qualitatively but focused on which metaphors patients used to describe their experience of being in therapy and their improvement from depression. 22 patients who received either psychodynamic therapy (PDT) or cognitive behavioral therapy (CBT) from two public psychiatric outpatient clinics in Oslo were interviewed with semi-structured qualitative interviews after ending therapy. They organized the metaphors into three different categories concerning 1) the therapeutic process 2) the therapeutic relationship 3) the experience of improvement from depression. The main metaphors they discovered in the therapeutic process were: 1) metaphors of surface and depth 2) metaphors of tools 3) metaphors of sorting and organizing 4) metaphors of cleaning and emptying.

The results were following:

1) Metaphors of surface and depth

Several PDT clients felt that they got to understand themselves on a deeper level and that the therapist recreated some of their relational challenges. Some patients (CBT) who indicated general dissatisfaction with their therapy believed that it "didn't go deep enough" or merely "scratched the surface". This is also supported by a qualitative comparison of CBT and PDT by Nilsson et al. (2006). They found that

the statement “getting to the root of things” was used by 73% of the satisfied PDT-patients, while none of the satisfied CBT patients used this metaphor. De Smet et al (2019) found the same thing in a qualitative study of depressive patients receiving CBT and PDT, where they discovered that many patients believed CBT was too shallow. However, not all CBT patients felt the need to talk about their past and were satisfied with not talking about it since they felt that there was no point in talking about a past you can’t change. Another patient who had tried both PDT and CBT stated the CBT raised her up faster than the psychodynamic one, but she dropped down very quickly and experienced the same difficulties. Both helped her but since the client had depression, she felt that psychodynamic therapy went deeper.

2) Metaphors of tools

Most of the patients from both therapy groups expected to get some tools from therapy (Malkomsen et al, 2021). One CBT client characterized a tool as concrete advice on what to do and how to accomplish it, such as scheduling worry time to reduce the time spent worrying during the day. Another patient (PDT) described a tool as follows: "It's what we've worked with, accepting myself and asking the why-question, like she (the therapist) did, but asking it myself." The authors discovered that the patients in both groups had the same expectations of therapy and described it using the same metaphor: to get a mental tool to solve their problems. Many patients appear to be unsure of what constitutes a mental tool; all they know is that they want one.

3) Metaphors of sorting and organizing

Some patients saw treatment as a way to organize and sort their ideas. "It's like a jigsaw puzzle," one patient (PDT) said. When you begin (therapy) you just have a couple of pieces and some corners, and you start by putting down the edges. It's almost as though you subconsciously keep putting the pieces together after a while. Some CBT clients used the metaphorical concept of a ball of threads to indicate how the therapist helped them "untangle" their own thoughts. "If she (the therapist)

replied, 'OK, what makes you say that?' then I could start unwinding and say, 'because this and that,'" one CBT patient explained.

4) Metaphors of cleaning and emptying

Several patients felt that therapy gave them room to express their distress. When speaking about therapy, one patient (CBT) used this metaphor: "It felt good just to ventilate my thoughts with someone." I used to look forward to... just being able to breathe."

The therapeutic relationship: openness, chemistry and temperature

The most significant metaphors for the therapeutic relationship appear to be openness, chemistry, and warmth. One patient (PDT) feels that chemistry in therapy is determined by how "similar" the patient and therapist are in terms of values. According to another (CBT), "excellent chemistry" is more an issue of "mutual respect.". Furthermore, being able to open up to the therapist was also emphasized by many clients.

Improvement from depression: disease, opponent, stuck and darkness

A few individuals described their recovery from depression as "something loosened inside" or "something clicked inside.” Furthermore, the majority of patients used metaphors to express the benefits of taking medicine (antidepressants, SSRI). "I started noticing that things were easier, it was like someone had oiled my equipment," one patient (PDT) stated, while another (PDT) felt the medicine "took the edge off."

Overall, Malkomsen et. al (2021) have discovered a number of metaphors that patients use to describe their experiences in therapy such as surface and depth, being open or closed, tools, chemistry, and other metaphorical ideas.

Since psychodynamic therapy is one of the oldest forms of therapy, we wanted to investigate a newer form of therapy that could be compared to CBT.

2.4 MCT

Metacognitive therapy is developed as an alternative way of responding to thoughts in order to reduce symptoms severity. The majority of the literature on MCT is conducted on patients with different forms of anxiety, depression, OCD and PTSD. In 2019 Haseth et al. sought to examine metacognitive therapy as an alternative to CBT for patients with GAD. They have studied the efficacy of group metacognitive therapy on 23 clients with generalized anxiety disorder in Norway. Since CBT is currently the evidence-based treatment for GAD and according to the standardized Jacobson criteria it was found that after 6-months 50-60% of patients were recovered, thus, the authors sought to examine an alternative approach which is metacognitive therapy. The 23 clients completed 10 sessions and were assessed by trained raters using the Anxiety Disorder Interview Schedule-IV. Self-reported symptoms were assessed using the Penn State Worry Questionnaire-9 at pre- and post-treatment. They found a significant reduction in worry, anxiety, depression, metacognitive beliefs, and maladaptive coping. At the end of the treatment it was found that 65.3% were recovered according to the standardized Jacobson criteria, however, it was found that during a 3-month follow-up the recovery rate had increased to 78.3%. Additionally, these results suggest that group therapy with a metacognitive approach could be just as efficient as individual therapy. Similar results can be found throughout the metacognitive therapy literature which will be introduced in the following.

Another example is Dammen, Papageorgiou & Wells (2014) who examined the effects associated with group MCT for depression in 11 patients who were referred by general practitioners to a specialist psychiatric practice in Norway. The patients all met the criteria for major depressive disorder according to DSM-IV and were monitored in a baseline period before attending 10 weeks of group MCT. The patients were assessed on their severity of depression as well as their levels of anxiety, rumination and metacognitive beliefs. Recovery rates and changes in comorbid Axis I were also measured. They found clinical significant improvements across all of the measures at the end of the 10-weeks. All patients were classified as

recovered at post-treatment and 91% during a 6-month follow-up. Hagen et al. (2017) examined the efficacy of MCT for depression in 39 patients diagnosed with depression. The patients were divided into two different groups, one group receiving MCT for 10 sessions or a 10-week wait list period. The authors found that the participants that received MCT reported a significant improvement compared to the waitlist group. Large controlled effect sizes were found for depressive and anxious symptoms. During a 6-month follow-up it was found that 70-80% in the MCT group were recovered, whereas it was only 5% for the waitlisted group. Hence, it can be concluded that MCT is a promising treatment for depression. However, it is still questionable how effective MCT is compared to CBT.

2.5 MCT and CBT

Callesen, Reeves, Heal & Wells (2020) assessed the clinical efficacy of Metacognitive therapy (MCT) and compared it to cognitive behavioral therapy (CBT), in adults with major depressive disorder in a mental health clinic care in Næstved, Denmark. Between January 2011 and June 2015, patients were recruited through referrals from general practitioners to the clinic. Patients were assessed by an experienced clinical psychologist utilizing the structured clinical interview for DSM-IV-TR who met the diagnostic criteria for Major depressive disorder (MDD). Each treatment was delivered by the same two therapists, both of whom were clinical psychologists and CBT therapists with a minimum of 10 years of experience. A total of 174 persons aged 18 and above who met the DSM IV criteria for major depressive disorder were eligible to participate and gave their consent. 85 people were randomly assigned to MCT while 89 were assigned to CBT. Patients were offered up to 24 sessions of CBT or MCT. Sessions lasted 60 minutes and were provided face to face. At pre- and post-treatment, as well as at longer-term follow-up (6 months post-treatment), a variety of outcome and psychological process assessments were gathered. The researchers used the Hamilton Depression Rating Scale (HDRS) and Beck's Depression Inventory (BDI-II) to assess the severity of depression symptoms (pre-treatment) and the effectiveness of the treatments (post-treatment). Treatment was terminated when a patient received a BDI II score of 11 and had reduced by 10

points from pre-treatment. Furthermore, the client's expectations of the therapy and the working alliance was also assessed. Process measures consisted of the Metacognitions Questionnaire 30 (MSQ-30), negative beliefs about rumination scale (NBR), positive beliefs about rumination scale (PBRS), dysfunctional attitudes scale (DAS) and Young's schema questionnaire- short version (YSQ-SF). The overall aim for CBT is to challenge and identify negative automatic thoughts and core beliefs that reduce the opportunity for mastery and pleasure in life. These thoughts were identified and challenged, where homework assignments were used throughout. According to advocates of MCT, depression is maintained by difficulties to control repetitive thinking supported by unhelpful metacognitive beliefs (Callesen, Reeves, Heal & Wells, 2020). Treatment aims to improve cognitive-attentional control and modify such metacognitions. The clients were introduced to attention training technique (ATT) to enhance the sense of flexibility and control over thinking. The findings from this study show that MCT was superior to CBT at post treatment and follow-up on the primary outcome of depression symptoms as measured using the BDI-II, but treatments did not differ significantly on the HDRS.

In another research by Nordahl HM (2009) similar results were found. The author conducted a quantitative study to assess the effectiveness of brief metacognitive therapy versus cognitive-behavioral therapy for 30 heterogeneous treatment resistant patients in a clinic setting. The findings of the study was that there were improvements in depression, anxiety and worry in both CBT and MCT. However, the patients that received MCT showed significantly greater levels of improvement in anxiety and worry compared to the patients that received CBT. However, other studies that compare MCT and CBT found that both therapy methods produce similar effects. Jordan et al. (2014) examined the relative speed and efficacy of MCT in a group of 48 participants aged 18-65. The patients were diagnosed with major depressive disorder. The participants were randomly assigned into 12 weeks of either MCT or CBT. The participants were assessed during pretreatment which consisted of demographic information and a diagnostic assessment. During week 4 and week 12 the efficacy and speed of the therapy sessions were assessed with the 16-item Quick

Inventory of Depressive Symptomatology. The results of the study was that MCT and CBT were effective in producing clinically significant changes in depressive symptoms. Moreover, both therapy methods were similar in their outcome in both the clinician-rated and self-reported measures. In research from Carter et al. (2021) A two-year follow-up was conducted on the study by Jordan et al. (2014) where 31 out of the 48 participants took part. The similar assessments used at pretreatment were used in the follow-up and a general Impression (GI) five-item scale developed for the study was used to assess overall functioning. They found no significant differences in outcome between CBT and MCT. The authors found significant improvement for all outcome variables, the biggest change over time being for depression and anxiety, more specifically metacognitions, rumination, dysfunctional attitudes and worry. Overall conclusion is that both therapy methods produced long-term positive change. Moreover, in a qualitative study from Straarup & Poulsen (2015) six clients were interviewed about their experiences with MCT and CBT with a focus on helpful elements. Overall clients in both therapy methods expressed that they gained an insight into the cause of their depression and modification of negative maintenance patterns as helpful. Additionally, they found the positive and informal relationship with the therapist as helpful. However, the understanding of the cause of the depression and treatment for it varied. Clients in CBT focused on their negative experiences as the cause of present maintenance patterns and the treatment for it would be to change the negative thought patterns. However, clients in MCT thought that rumination was their key problem and in order to treat this problem they had to decide to not engage in negative thinking. Moreover, the two groups differed in what they reported as their main benefits of therapy. Clients in CBT reported personal strength and self-confidence as their main gain. Clients in MCT described improved ways of coping with thoughts or problems. Lastly, the authors found that the clients put a lot of emphasis on the technical factors, which doesn't align with previous qualitative studies that examined various therapeutic methods, since great emphasis has been put on common therapeutic factors more than specific factors.

2.6 Common therapeutic factors Vs. Specific factors

2.6.1 Clients' perspective

A study by Luong, Drummond & Norton (2022) aimed to examine and compare the predictive validity of client and observer ratings of alliance and cohesion. Of particular interest was exploring whether there was an additional benefit in assessing the process from a third-party perspective, after accounting for client ratings. Regarding the first hypothesis that both client and observer ratings of alliance would uniquely explain outcomes, only client-rated agreement was found to predict symptom improvement. Client-rated agreement has consistently been found to relate to CBT outcomes and the current study adds to that data (Hagen et al., 2017) by showing that this factor predicts outcomes even after controlling for observer-rated alliance. This shows that a client's perception of agreement about how and why therapy is carried out influences change during treatment. Early agreement on introductory interventions like psychoeducation, as well as later agreement on more advanced strategies like exposure, appear to be significant in improving treatment response Client commitment and adherence to therapy and its tasks may be encouraged by more agreement with the rationale and techniques of treatment, enhancing its ameliorative effects. At any time throughout therapy, however, therapist judgments of agreement and bond were not linked to post-treatment outcomes. After controlling for client-rated alliance, client-reported group cohesion was not related with any additional variance in result. Overall, the findings emphasize the necessity of putting the client's impression of the client–therapist connection first in CBT for anxiety disorders, as well as separating the impacts of component, rater, and time in future process–outcome investigations. Consequently, therapists should be aware that their perceptions of the alliance may differ from their client's experience and should therefore regularly seek feedback from their clients about the relationship. Clients are generally hesitant to voice unfavorable thoughts about their therapist (Blanchard & Farber, 2015), thus they may choose to change their behavior toward them in a socially acceptable way. Clients may be more likely

to reveal their actual impressions in a confidential report than to express their negative views during sessions. When it comes to therapist ratings, research has shown that client-rated alliance has a higher predictive validity in CBT than therapist measures (e.g. Hoffart et al., 2012; Luong et al., 2022). Overall, these findings imply that future studies should prioritize and use client ratings of the alliance until the predictive validity of observer (and therapist) measures is defined. Therefore, our focus in our thesis would be the client's experience of cognitive therapy and metacognitive therapy.

2.7 Identified Gaps in the literature

The following section will present the identified shortcomings in the literature followed by an argument for the choice of our research focus in the current study.

The purpose of this literature review was to gain an overall idea of the existing research concerning clients' experience with metacognitive therapy and cognitive therapy. This culminated in 17 articles, where there is a lack of qualitative studies that compare clients' experiences with MCT and CBT. To our knowledge there is only one qualitative study in Denmark that compares MCT with CBT. In addition to this, the qualitative study only focuses on helpful factors, important hindering factors for clients' in therapy might be overlooked. Moreover, the qualitative analysis that compares CBT and MCT was only conducted by one researcher. To increase the quality of the research it is important to have a minimum of 2 researchers. This thesis tries to make up for that limitation by having 2 researchers that are involved in the verification of the results. Furthermore, the majority of quantitative studies on metacognitive therapy have been conducted by affiliated metacognitive psychologists, which can create biases that could have affected their results. Moreover, the majority of the literature lacks a high ecological validity since researchers purposely divide two groups into either CBT or MCT whereas we have tried to eliminate that by interviewing participants that have had experienced the

therapy forms without anyone's influence. However, it is important to mention that there are advantages and disadvantages to both methods. Furthermore, no qualitative studies have had participants that have experienced both CBT and MCT whereas the majority of our participants have experienced both. To our knowledge this is the first qualitative study that has participants that have experienced both CBT and MCT.

Based on the review of the existing research, our empirical study will focus on clients' experience with receiving MCT and CBT. We will examine this through a hermeneutic phenomenological perspective. The research question of the study therefore reads as follows:

2.8 Statement of intent

How do clients in a Danish context experience therapy based on metacognitive therapy (MCT) and cognitive behavioral therapy (CBT)?

To answer this statement of intent, it is important to have an understanding of MCT and CBT's historical and theoretical background. Furthermore, The Contextual Model has been chosen to account for both common and specific factors in the therapeutic relationship. Furthermore, Rogers' client-centered therapy theory is included because it emphasizes the real relationship and expands on the concept of empathy in therapy. Furthermore, Bandura's self-efficacy theory and Julian Rotter's locus of control theory have been chosen because they may help to understand how an individual's belief system affects their therapeutic experience. All these relevant theories will be elaborated down below.

3. Theories

To examine the participants experience of CBT and MCT, we have chosen following theoretical standpoints: Cognitive behavioral therapy, metacognitive therapy, The Contextual Model of psychotherapy by Wampold & Imel, Carl Rogers client-centered therapy, Bandura's theory of self-efficacy and Julian Rotter's theory about locus of control.

An account for CBT and MCT is relevant in order to gain an understanding of our participants' experience with therapy and whether it aligns with the specific methods and tools used in the specific therapeutic approach. Moreover, The Contextual model of psychotherapy is accounted for since it is an alternative understanding of therapy to CBT and MCT. The model explains how there are common factors across different therapies that account for the outcome of therapy. Additionally, previous qualitative studies suggest that common therapeutic factors are more important than specific factors, for that reason we find that it is important to incorporate this theory in our research paper (Wampold & Imel, 2015). Rogers theory on client-centered therapy has been selected as it goes into depth with some of the common factors mentioned in The Contextual Model such as the relationship between the client and therapist. Julian Rotters' theory about locus of control has been chosen since there are some studies on locus of control which help to explain why people with certain locus of control (external or internal) can have different therapy outcomes. This theoretical standpoint has been chosen since it can perhaps explain some of our participants' expectations of therapy and their opinions about their experience. We could look into whether our participants use external or internal forces for reasoning their view on therapy and whether they believe they benefited from it. Furthermore, Bandura's theory of self-efficacy has been selected since it can be expected that individuals with a higher self-efficacy perhaps will have positive therapeutic outcomes than people with a lower self-efficacy. Individual beliefs about their competence could have an effect on their ability to do well in therapy. Even though we didn't measure

our participants' self-efficacy or locus of control quantitatively, we can still make assumptions about what we think our participants could have based on their experience and qualitative statements.

There will now be an account for the thesis' two theoretical approaches: CBT and MCT.

3.1 Cognitive Behavioral Therapy (CBT)

First there will be an introduction to Aaron Beck's key findings and afterwards there will be an account for the core concepts of CBT such as the cognitive model, schemas (core beliefs), automatic thoughts, cognitive restructuring, exposure and avoidant/safety behaviors. Furthermore, to have an understanding of how a typical therapy session could look like in CBT, the structure and important procedures and techniques of CBT is also explained.

3.1.2 CBT - Background

Aaron Beck established the foundations for cognitive theory in his 1970 article (Beck, 1970) and distinguished it from psychoanalysis by focusing treatment on current difficulties rather than unearthing hidden traumas from the past, and by studying accessible rather than unconscious psychological experiences. Beck and colleagues conducted the first trial of this novel type of depression treatment in the mid-1970s (Rush, Beck, Kovacs, & Hollon, 1977; Rush, Hollon, Beck, & Kovacs, 1978). They compared the efficacy of CBT versus antidepressant medication where CBT was found to have better results, especially at the follow-up assessment. These findings caused attention in the fields of psychiatry and psychology, first because they presented a credible research trial that called into question the "gold standard" of depression medications and second, because they provided a manualized treatment that could be evaluated and disseminated in theory.

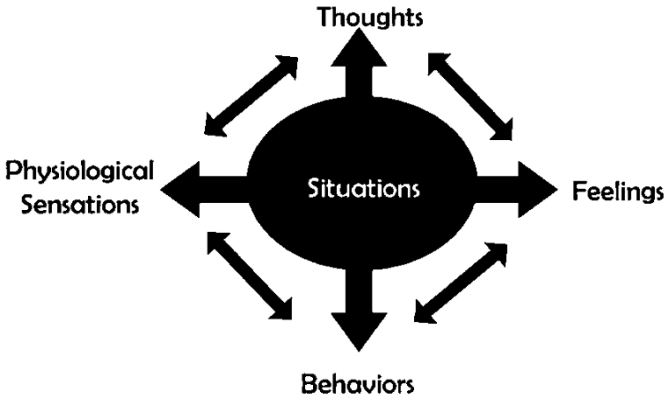
Other problems, such as anxiety, personality disorders, substance abuse, and suicidality, were treated using CBT. He produced a comprehensive psychopathology theory that served as the foundation for treatment as well as ways for assessing the validity of his theories as well as the usefulness and effectiveness of the therapy. He would start with clinical observations for each new disease, noting typical maladaptive beliefs connected with the disorder. To assess these ideas, he frequently constructed scales and instruments (Beck & Fleming, 2021). He did then devise a strategy to address the dysfunctional beliefs and their accompanying maladaptive behavioral patterns. A randomized controlled trial would be used to validate the therapy, after which it would be published in the literature for others to examine, practice, and refine it (Beck, 2019).

We are aware that there are different types of cognitive behavioral therapy for different psychological disorders, however a general sense of CBT's concepts that this thesis finds relevant is accounted for.

3.1.3 CBT - Concepts

3.1.3.1 The cognitive model

The core concept of cognitive behavioral therapy might be stated through the model listed below, which shows how thoughts, feelings, bodily sensations and behaviors affect each other in all situations. Our thoughts have an impact on our feelings, therefore changing our thoughts can change our feelings, which then will affect our behaviors and physiological sensations. We need to learn a few basic ideas to comprehend how to create improvements in these four areas. All of these sectors are interconnected and have an impact on one another. If we change one of these four areas, it affects the others.



An example of this can be seen with a patient who has social phobia. The individual describes a situation at a shop, where he had to ask the cashier where an item was. The feeling involves anxiety and the thoughts could be that the he thinks 'I am stupid' and 'that I am weak'. Body sensations include palpitations, sweaty palms and trembling hands. His behavior is that he avoids asking the cashier and uses excessive amounts of time to find the product.

3.1.3.2 Avoidance and safety behavior

Special catastrophic thoughts can increase anxiety by turning something neutral and harmless into something dangerous. Light palpitations can, for example, trigger catastrophic thoughts of cardiac arrest where for instance staying in a shop can be associated with catastrophic thoughts of falling over, not being able to breathe, etc. It is important to convey that the bodily symptoms are unpleasant but harmless, and that it is the thoughts (catastrophic thoughts) that aggravate the feeling of anxiety and the characteristic forms of anxiety behavior: avoidance and safety behaviors. In avoidance behavior, the person is absent from or leaves a dreaded situation. In the case of safety behavior, the person takes an action that in an inappropriate way provides security, e.g. by constantly checking his/her pulse. When this is the case the therapist typically helps the client find alternative thoughts that do not trigger or

aggravate the anxiety. Restructuring helps the patient to build thoughts that are soothing and realistic in the specific situation, and to practice mobilizing these in the face of catastrophic thoughts (Clark & Beck, 2011).

3.1.3.3 Exposure

Another technique that can be employed is exposure which means that the patient systematically exposes himself to situations that cause anxiety and remains in these situations until the anxiety has subsided. Exposure thus targets the patient's avoidance behavior toward certain situations that he perceives as dangerous. During the exposure, the patient focuses on his disaster thoughts and restructures these. It is the thoughts of disaster that the patient must fight against. Exposure initially involves a not insignificant discomfort that the patient should be prepared for and accept. With repeated exposure, a habituation takes place, just as the catastrophic thoughts about the situation are dispelled, and the anxiety decreases in intensity.

Based on this model the clients work with their therapist on analyzing current problem situations in their life. The purpose of the analysis is for the client to identify inappropriate (negative) thoughts and actions in certain situations. Based on this, they then work towards the thoughts so they become more realistic and helpful (alternative thoughts), and that their actions become more appropriate. When their thoughts and actions become more appropriate their mental and physical discomfort (symptoms) will eventually decline. This happens automatically because thoughts, actions, feelings and bodily sensations are always closely connected - as seen in the model (Clark & Beck, 2011).

3.1.3.4 Automatic thoughts

According to cognitive therapy, there are thoughts that emerge in the fringe of awareness and are an immediate interpretation of any given scenario. Automatic

thoughts are distinct from the normal flow of thoughts experienced during introspective thinking or free association. They're often believed to be plausible, and their accuracy is assumed. Unless they have been educated to monitor and identify automatic thoughts, most people are unaware of their presence (Beck, 2019).

3.1.3.5 Schemas

Schemas, also known as core beliefs or cognitive structures in CBT, does not try to replace negative beliefs with positive ones; rather, it aims to assist people in shifting their cognitive evaluations from unhealthy and maladaptive to evidence-based and adaptable ones. Our core beliefs are the concepts we develop over time about others, the world, and ourselves. These beliefs can be both positive and negative, and they are commonly accepted as absolute facts regardless of their content. Negative core beliefs are frequently overgeneralizations of partial truths, but they can also be a reflection of the exact opposite of the actual truth. Although automatic thoughts represent a person's perspective on a circumstance, basic beliefs are more universal principles that exist regardless of the situation. Schemas are deeper since they form the root of incorrect automatic thoughts (Beck, 2019). Schemas are relatively enduring internal cognitive structures of stored generic or prototypical features of stimuli, ideas, or experiences that are used to organize new information in a meaningful way, thereby determining how phenomena are perceived and conceptualized. Once a basic belief is formed, it can affect the production of other related beliefs, which are then included into the persistent cognitive framework or schema if they endure. These cognitive structures affect an individual's thinking style and nurture the cognitive mistakes seen in psychopathology. Early in a person's development, schemas serve as "filters" through which current information and experience are processed. Personal experiences shape these ideas, which are generated through identification with significant others and perceptions of other people's views toward them.

Different levels of cognition exist within the cognitive system, ranging from surface-level concepts to "deeper" cognitive schemas. Individuals' perceptions of self and others, objectives, expectations, and memories are all stored in cognitive schemas, which are ordered frameworks of recorded information (Clark & Beck, 2011). These elements are well-organized within the cognitive structure and influence incoming stimuli screening, coding, categorization, and interpretation, as well as retrieval of stored knowledge. Schemas are adaptive in the sense that they allow for efficient information processing; nonetheless, they can contribute to psychopathology when they become negatively biased, maladaptive, rigid, and self-perpetuating. Schemas, such as "I am unlovable," are activated by situations that are comparable to the early experiences that engendered the schema's formation, even if they are latent or inactive at the moment. Individual conditional beliefs are associated with dysfunctional core beliefs, leading to assumptions like "If I don't have a loving wife, I'm nothing" and regulations like "A man cannot exist without a wife." The activation of these schemas impairs the ability to assess events objectively, and reasoning suffers as a result. As dysfunctional schemas are activated, systematic cognitive distortions (e.g., catastrophizing, emotive reasoning, and selective abstraction) arise. Patients may engage in compensatory methods as a hesitant coping strategy to avoid confronting their core and underlying beliefs. Although these cognitive and behavioral methods temporarily reduce their emotional distress, compensatory strategies may perpetuate and worsen dysfunctional beliefs in the long run. Seeking help from a therapist can make the client aware of the automatic thoughts and schemas that might prevent the individual from developing to their fullest potential. The table down below show how a typical CBT session might look like (Clark & Beck, 2011)

3.1.4 CBT therapy session

TABLE 1.1. **Structure of a Typical Cognitive Therapy Session**

Session item	Description
1. Weekly review and anxiety check	Each session begins with the client providing a brief report on any anxiety-relevant experiences during the week as well as a rating of the frequency and intensity of anxiety episodes. (5–10 minutes)
2. Set session agenda	The therapist and client together set an agenda of issues for the therapy session. (5 minutes)
3. Evaluate previous session action plan	The results or outcome of the last session action plan are discussed and evaluated. What has the client learned from doing this between-sessions task? How can this be incorporated into a strategy for reducing anxiety? (10 minutes)
4. Primary session topic(s)	The main part of the session focuses on identifying, evaluating, and modifying specific problematic thoughts, beliefs, and behaviors that maintain anxiety. (20 minutes)
5. Develop action plan	An action plan is developed that the client does as homework between sessions. The action plan is based on the outcome of the "primary session topic." (10 minutes)
6. Session summary and feedback	The client provides a summary of the main points of the session and feedback on what she found most and least helpful. (5 minutes)

Clark & Beck (2011)

Although cognitive therapists range in how precisely they follow this session format, most will have the aspects from the picture that will be present during most anxiety therapy sessions. This therapeutic style, combined with the characteristics of a good therapeutic relationship (trust, confidence in the therapist's understanding, demonstrated concern and empathy, ease of self-disclosure, assurance of confidentiality), creates the best therapeutic environment for fear and anxiety treatment.

Exploration (determining one's idiosyncratic meaning system and maladaptive beliefs), examination (reviewing the evidence for and against a particular belief and considering alternative interpretations or explanations), and experimentation (testing one's beliefs) are all processes that cognitive therapy uses to help people consider the accuracy and usefulness of their thoughts. Early in therapy, this method is utilized to target more proximal and surface-level cognitions (e.g., automatic thoughts, dysfunctional attitudes), and later sessions are used to improve deeper cognitive structures and core beliefs.

Training the patient to notice his unique cognitions or "automatic thoughts" is one of the most important cognitive strategies (Beck, 1963). These cognitions are referred to as "internalized statements" or "self-statements" which are "things you tell yourself."

Automatic thoughts are extremely fast and can often contain a complex thought compressed into a very short time, even a split second. These perceptions are felt as if they are automatic; that is, they appear to emerge as if by reflex rather than reasoning or decision. They also have an involuntary quality about them. A person who is excessively nervous, sad, or paranoid, for example, may have negative automatic thoughts all of the time, despite his best efforts to avoid them. Furthermore, the patient's cognitions tend to be entirely believable (Beck, 1970).

Patients essentially learn how to become scientific investigators of their own thinking, treating their views as hypotheses rather than facts and putting them to the test. When a belief is framed as a hypothesis, it allows patients to evaluate its validity, consider alternate explanations, and acquire enough distance from a thinking to allow for more objective analysis. Patients learn to change their thinking to be more consistent with the evidence. When your thoughts and evidence are in sync, you'll be able to make better decisions.

Using collaborative empiricism, guided discovery, and Socratic dialogue, cognitive therapists assist patients in moving through the process of investigation, examination, and experimentation, which will be elaborated below.

3.1.4.1 Techniques and procedures in CBT

According to Beck, the first and most critical step in completing the therapeutic attempt is to build a healthy working relationship with the patient, a therapeutic practice known as collaborative empiricism. Patient and therapist collaborate as a team of scientists to assess the patient's beliefs, test them to see if they are correct,

and adjust them based on reality. Second, the therapist uses Socratic questioning to lead the patient through a conscious questioning process that allows them to gain insight into their erroneous thinking, a process known as guided discovery**.** Throughout the treatment, clients are taught to: 1) monitor and identify automatic thoughts; 2) recognize the relationships between cognition, affect, and behavior; 3) test the validity of automatic thoughts and core beliefs; 4) correct biased conceptualizations by replacing distorted thoughts with more realistic cognitions; and 5) identify and alter beliefs, as needed.

The first stage of treatment focuses on raising the patients' awareness of automatic thoughts, with subsequent work focusing on core and underlying beliefs. Treatment may begin with detecting and challenging automatic thinking, which can be accomplished in a variety of ways. By simply asking, "What is going through your mind?" or any variant of this question, the therapist can help patients examine their automatic thoughts, especially when there is a perceived emotional arousal during the session. "What is the evidence for your conclusion?" "Are you omitting contradictory evidence?" "Does your conclusion follow logically from the observations you've made?" "Are there alternative explanations that may be more accurate in explaining this particular episode?" "Are there alternative explanations that may be more accurate in explaining this particular episode?" When asked to think about anything. When encouraged to consider alternate explanations, patients may recognize that their earlier explanations were based on incorrect inferences, leading them to consider various interpretations of events and therefore attaching diverse interpretations to events.

The majority of people are unaware that negative automatic thoughts precede unpleasant feelings and behavioral inhibitions, and that the emotions are consistent with the automatic thoughts' substance. Patients can learn to catalog their thoughts and specify what kind of thoughts occurred shortly before an emotion, a behavior or physiologic reaction to raise their awareness of these thoughts.

Cognitive rehearsal is an imaginative approach that allows patients to experience their feared events by imagining that they are happening right now. Patients are advised to "live through" the fearful event in imagery at the office or as a between-session project in order to develop the appropriate coping skills for successfully overcoming it. Patients can also use visualization to practice problem solving and assertiveness training as needed to overcome their challenges (Beck, 2019).

The use of homework is one of the distinctive features of CBT for depression (Beck, 1963). In general, cognitive therapists feel that what happens in between sessions is more significant than what happens within the session. There are a variety of "coping statements" that clients might employ to help them stay calm in an anxious circumstance.

The first is cognitive restructuring, in which people question their excessive threat assessments by observing evidence in the exposure setting that the risk isn't as large as they think it is and that anxiety gradually fades. Furthermore, relaxation training, such as gradual muscle relaxation, controlled breathing, or meditation, is a second anxiety management strategy. These coping reactions could then be employed to lessen anxiety during exposure. Third, paradoxical intention is used, in which a person is told to exaggerate her anxious response in a fear situation. Exaggerating people's fears typically emphasizes the ridiculousness and improbability of the concern, which has the paradoxical effect of forcing a reevaluation of the real threat and vulnerability associated with the circumstance (Clark & Beck, 2011).

Overall, it can be concluded that cognitive behavioral therapy is a well-documented therapeutic approach that has been shown to be credible in treating various mental disorders. By using the cognitive model, the client can get an insight into their situation and see how thoughts, feelings, behaviors, and physiological sensations are interrelated and changing one of the components can affect other factors. Moreover, a typical therapy session would consist of a typical CBT therapeutic style combined

with good therapeutic relationships through collaborative empiricism, socratic dialogue and guided discovery. Furthermore, since the client is the investigator of their own thinking, homework is also an essential part of CBT. Techniques such as exposure and cognitive restructuring can help the client to identify their core beliefs and automatic thoughts.

Adrian Wells sought to find an alternative therapeutic approach since he claimed there was a limitation in the clinical and psychopathology literature. This led to the development of MCT.

3.2 Metacognitive Therapy (MCT)

The following section will present the theoretical understanding behind MCT. Moreover, the concepts of CAS, metacognitive knowledge, experiences and strategies will be accounted for. The metacognitive model and the S-REF model will be presented. Additionally, important elements in metacognitive therapy procedure are given. Finally, MCT is compared with CBT. Moreover, our research paper is mainly focused on clients that experience anxiety and clients that experience lack of control of their thoughts. It is important to understand the metacognitive approach to these types of psychological disorders, so the majority of the examples will be on this.

3.2.1 The MCT background

Metacognition has been studied in developmental psychology, memory psychology, aging psychology, and neuropsychology. However, it has only recently been examined as a fundamental basis for the majority, if not all, psychological disorders. During his doctoral studies in the mid-1980s, Adrian Wells, the founder of MCT, began testing mechanisms and underlying concepts of what would later become the

metacognitive model. Wells was fascinated by information processing theory and the role of self-attention in anxiety (Wells, 1985). Wells and Matthews (1994) found that the use of cognitive science principles in clinical psychology and psychopathology literature was limited, and that existing models did not account for top-down influences on the biases and negativity evident in psychological illnesses. They set out to change that, and after conducting a rigorous review of the literature, they produced the Self-Regulatory Executive Function model, which was later modified by Wells and used as the cornerstone for metacognitive treatment.

MCT is not merely what a person thinks, but how the individual thinks that determines emotions and the control one has over them. According to Wells (2009) it is important to understand how cognition operates and how it generates the conscious experiences that we have of ourselves and the world around us. Metacognition shapes what we pay attention to and the factors that enter consciousness. It also shapes appraisals and influences the type of strategies that we use to regulate thoughts and feelings. MCT is based on the approach that people become trapped in emotional disturbance because their metacognitions cause a particular pattern of responding to inner experiences that maintains emotion and strengthens negative ideas. The pattern in question is called the cognitive attentional syndrome (CAS) (Callesen, 2017).

3.2.2 MCT - Concept

Metacognition refers to a group of interconnected components that include any knowledge or cognitive process that is involved in the interpretation, control of cognition or monitoring; it can be separated into three categories: knowledge, experiences and strategies.

3.2.2.1 Metacognitive knowledge (beliefs)

Knowledge refers to people's beliefs and theories regarding their own thinking, which is split into two categories: Explicit knowledge is knowledge that is expressed verbally and implicit knowledge is knowledge that is not expressed verbally. These

are the rules or programs that direct one's thoughts and represent the individual's thinking skills. Additionally, MCT is concerned with metacognitive beliefs which determine how the individual responds to negative thoughts, beliefs, symptoms and emotions. MCT differentiates between positive metacognitive beliefs which refer to the individual's perceived advantage or reward of participating in cognitive activities, such as "It is useful to focus attention on threat" or "worrying about the future means I can avoid danger" (Wells, 2009, p. 5). And negative metacognitive beliefs which refers to the individuals' lack of control over their thoughts and the experience of danger connected to one's thoughts and cognitive experiences.

3.2.2.2 Metacognitive experiences

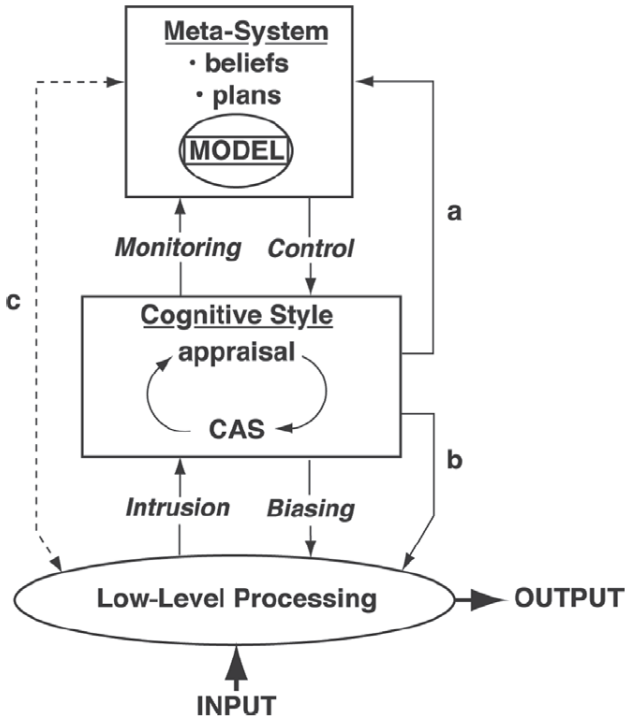
Metacognitive experiences are separated into two ways of experiencing: the object mode and the metacognitive mode. The object mode is concerned with thoughts that can be experienced as separate events from the world and the self. The individual relates to these thoughts from a distance. The metacognitive mode refers to relating to inner experiences in a different way regardless of the accuracy.

3.2.2.3 Metacognitive strategies

The metacognitive strategies are used to manage and change one's thoughts in order to maintain emotional and cognitive self-control. Examples of this can be found in clients when they experience psychological disturbances. For instance, when a client's subjective experience is that they feel out of control, a strategy to manage that might be to control the nature of thinking such as efforts to suppress certain thoughts, analyze experiences to find a solution. The issue with these strategies according to MCT is that they maintain the psychological disorder. The type of strategy used depends on the individual's metacognitive knowledge (beliefs), thus it is important to understand that strategies, experiences and metacognitive knowledge (beliefs) all function together in psychological disorder. "In the metacognitive theory of psychological disorder, maladaption in knowledge, experiences, and strategies

combine to give rise to an unhelpful pattern of thinking that leads to psychological disturbance.“ (Wells, 2009, p. 7).

3.2.3 Metacognitive therapy model



(Wells, 2009).

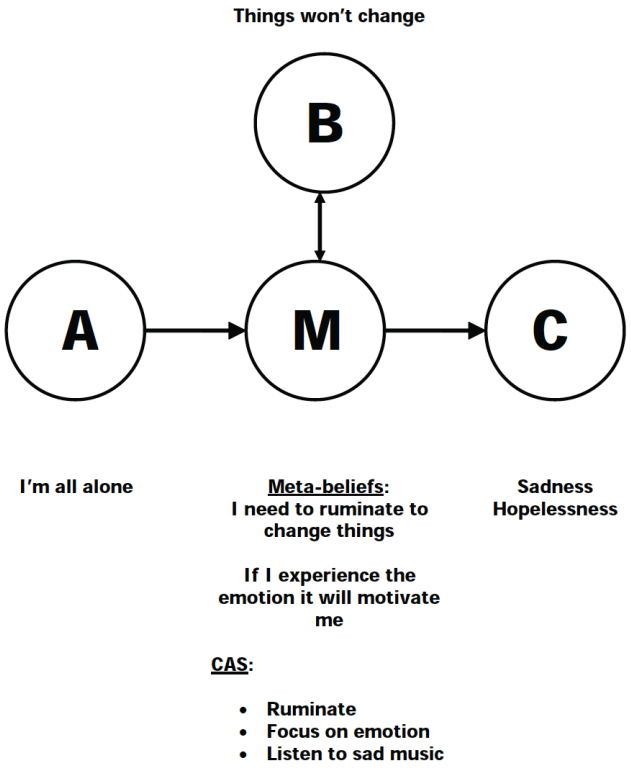
MCT is based on the metacognitive model of psychological disorders, which is made up of the theoretical model self-regulatory executive function (S-REF) model, which accounts for several factors that maintain psychological disorders (Wells, 2000;Wells, 2009). In the S-REF model the cognitive processes of the individual are divided into 3 interactive levels. The low-level processing consists of automatic and reflexive processing works outside of consciousness, however, it can become conscious. The other level is referred to as cognitive style which consists of a conscious processing of thoughts and behavior. Last level that is described is the meta-system which is understood as the collection of knowledge or beliefs that are

metacognitive in nature and preserved in long-term memory. Although the meta-system is separated from the other two, it is simultaneously dispersed through the different levels of processing. The meta-system represents the individual's current ordinary cognitive functioning and directs it toward an active plan (Wells, 2013).

3.2.4 CAS

CAS, short for cognitive attentional syndrome, is part of the S-REF model, which can contribute to development and maintenance of psychological disorder (Wells, 2013; Callesen, 2017). CAS can be found in psychological disorders and is made up of a preservative thinking style that takes the form of worry or rumination. It is also characterized by "threat monitoring," which is defined as a concentrated attention on threat-related stimuli. Moreover, CAS is defined as unhelpful metacognitive strategies and coping behaviors that are counterproductive. The CAS is a result of inaccurate metacognitive knowledge/beliefs controlling and interpreting thinking and feeling states. The CAS increases the negative emotional experience through specified pathways. For instance, worrying and ruminating on a regular basis strengthens the habit of these responses to the point where the individual loses awareness of them and enables them to continue unchanged. This in turn contributes to the sense of no control of these mental processes. Worry and rumination can obstruct the other cognitive processes in S-REF.

3.2.5 A-M-C Model



(Wells, 2009)

The consequence of CAS as mentioned earlier is that it leads to psychological disturbances. One way of understanding this is the A-M-C model, which reformulated the standard A-B-C model by including metacognitive beliefs. A in this model depicts the inner experience of a negative thought or ordinary belief which is the trigger. The M signifies the metacognitive beliefs and the CAS, and B is influenced and used by the metacognitive processes and refers to the ordinary beliefs and lastly C which refers to the consequence/outcome. Moreover, it is important to address how metacognitive therapy is conducted in practice which the following section will account for.

3.2.6 Metacognitive therapy tools

There are four crucial skills that have to be present in the MCT therapy. First skill is the therapist's ability to identify and shift between what is metacognition and what is ordinary cognition. This entails the therapist advising the client to take a step back and consider the thought and belief and recognize it as a symptom that does not need a conceptual or analytical response. The second skill is the ability to identify CAS. The therapist must examine beyond the content and validate the clients' statements in order to be successful in identifying CAS. The third skill is to use MCT-focused Socratic dialogue; this differs from CBT, since the MCT therapist is not interested in exploring the content of thoughts and directly modifying them. In MCT questioning is used to detect and stop the CAS. When it comes to ideas or assumptions, the Socratic dialogue focuses on identifying and changing beliefs about thoughts and emotions (metacognitions), rather than self- and world-related thinking. The fourth skill involves learning to implement MCT-Based exposure, which is used to change beliefs and to strengthen a different and more adaptive processing, some of these examples will be elaborated in the following section.

3.2.6.1 Challenging dysfunctional metacognitive beliefs

As mentioned earlier the CAS develops and maintains the mental illness. So the MCT therapist focus is on changing this fact, for instance, a positive metacognitive belief could be "If I worry I will be prepared" this is where a MCT therapist would be focused on reframing such as "Is it possible to be prepared without worrying?". (Wells, 2000; Wells, 2009). Additionally, an example of negative metacognitive beliefs "I have no control over my worrying/ruminating", where the therapist again would focus on why the client should even seek control?

3.2.6.2 Attention Training Technique (ATT)

Wells (1990) created Attention Training Technique (ATT) for use in metacognitive therapy. ATT is based on the theoretical understanding behind MCT. As stated earlier CAS contributes to the cause and maintenance of psychological disorder, where ATT disrupts the CAS and assists the individual in increasing their awareness of attentional control (Wells, 2009; Callesen, 2017).

In practice, this strategy entails actively listening and concentrating attention in the presence of several sounds of varying volume and spatial locations. When using this technique it is divided into 3 parts. The first part refers to selective attention where the client has to focus on single sounds and spatial location while still being selective and minimizing distraction. The second part focuses on quick switching of attention between various sounds and spatial locations.The third part consists of dividing attention and trying to pay attention to concurrent sounds and spatial locations. It is important that the client follows the exercise regardless of what they may feel in their body or mind that should not be given any attention. The purpose of this is not to suppress one's thoughts, however, it is to know that they can be there without having to give them attention.

Moreover, it is suggested in MCT to lessen the amount of time spent thinking on and analyzing thoughts and feelings when practicing ATT.

3.2.6.3 Detached mindfulness

Detached Mindfulness relates to the way we relate to our cognitions such as one's thoughts. It is a technique that can teach us to develop a flexible control over our attention and thinking. The two concepts of detached and mindful are combined and result in that you refrain from any reaction in response to a thought, feeling or a condition and you separate the conscious experience of yourself from the thought. The individual is aware of their thoughts but also aware that they are more than their thoughts. The purpose of this is that the individual has a realization that their negative beliefs exist outside of one self and does not define the individual.

Overall, the metacognitive model offers a different perspective on mental illnesses. Mental diseases are caused and sustained, according to the metacognitive model S-REF, by a type of thinking known as CAS, which is characterized by rumination, concern, threat monitoring, and so on. Positive and negative metacognitive beliefs maintain the CAS, which is an ineffective coping method. MCT emphasizes paying attention to negative beliefs rather than the significance of meaning behind it. The goal of MCT is to change the relationship that clients have with their thoughts (Wells, 2009; Callesen, 2017).

Overall, the metacognitive model offers a different perspective on mental illnesses. Mental diseases are caused and sustained, according to the metacognitive model S-REF, by a type of thinking known as CAS, which is characterized by rumination, concern, threat monitoring, and so on. Positive and negative metacognitive beliefs maintain the CAS, which is an ineffective coping method. MCT emphasizes paying attention to negative beliefs rather than the significance of meaning behind it. The goal of MCT is to change the relationship that clients have with their thoughts.

Since some of our participants have experienced both MCT and CBT we find it relevant to give an account for the key difference between the two therapeutic approaches.

3.2.7 How does MCT differ from CBT

Overall, it can be concluded that MCT aligns with the basic premise of CBT which is that disturbances or biases in thinking cause psychological disorders. However, it is different from earlier approaches because MCT identifies a particular style of thinking and types of beliefs as the cause of disorder. In other approaches the styles of thinking that has been emphasized is cognitive distortions such as absolustistic standards or black-white thinking, however in MCT the style of thinking that is

interesting is CAS which is characterized by worry and rumination and is accompanied by a specific attentional bias (Wells, 2009).

The focus is no longer on beliefs regarding the world, the social or physical self but beliefs about thinking (metacognitive beliefs). The events themselves do not cause the difficulties in CBT; rather, it is how we interpret the events that causes the problem, therefore the emphasis is on the meaning. The solution in CBT is modifying the thought content and the individual's confidence in the content's validity. The issue in MCT is the person's thinking style which are rigid and recurrent styles of thinking in response to negative thoughts, feelings, and beliefs. Removing unhelpful processing styles is one way to find a solution. The solution can be found by removing unhelpful processing styles. For instance, if a client states: "I am worthless," the solution in CBT would be to look for evidence of this belief, whereas in MCT, you would look to see if evaluating your worth is really necessary. According to MCT, this content does not cause disorder because most people have these thoughts and the emotions are temporary for most people. The cause for emotional disorder in MCT is being stuck in a state of distress. It is chronic or recurrent. Emotional disorder is caused by the metacognitions that give rise to thinking styles that lock the individual into prolonged and recurrent states of negative self-relevant processing. In essence, MCT is about the factors that lead to sustained thinking and misguided coping (Wells, 2009).

In MCT, CBT beliefs or schemas are considered as the results of thought processes. As a result, there is a substantial difference between cognition and metacognition. Metacognition is defined as "thinking about thinking," and it allows us to execute a task successfully by planning, monitoring, assessing, and comprehending. This indicates that, while cognitive processes enable people to function normally, metacognition takes it a step further by allowing people to become more aware of their own cognitive processes.

To put it another way, in CBT, a person's negative thoughts might be a cause of depression. While proponents of MCT argue that people will have negative ideas about failure, it is how we respond to these emotions that determines whether or not we become depressed.

Overall, CBT is content-focused, with the therapist focusing mostly on the content of an individual's thinking. MCT is concerned with processes, and it usually focuses on content in the metacognitive domain. The acts involved in applying that knowledge and gaining new information are referred to as the processes. We can't work on knowledge directly with MCT, such as the belief "I am worthless," but we can work on the processes that locate and use knowledge.

We have now elaborated the specific factors related to the techniques and interventions that distinguish MCT and CBT.

Now The Contextual Model of psychotherapy will be described since it explains the common factors that are present across various psychotherapeutic approaches.

3.3 Common therapeutic factors

3.3.1 Historical background

Saul Rosenzweig (1936) observed a similarity in the effects of various psychological treatments regardless of their approach. He proposed the idea behind common factors, which are the factors that are common for different therapeutic approaches that include hope, expectation, relationship with the therapist, belief and corrective

experience account for a lot of the benefits of psychotherapy. Rosenzweig described this with the metaphor "At last the Dodo bird said, 'Everybody has won and all must have prizes'" (Wampold & Imel, 2015, p. 33), thus the benefit of psychotherapy is described as the Dodo bird effect.

3.3.2 A theoretical understanding of common factors

Since then, multiple researchers have investigated what the common factors consist of, which has resulted in numerous theoretical presentations of the common factors over the years. However, our research paper will focus on a contextual model for psychotherapy conducted by Bruce E. Wampold and Zac E. Imel (2015) because it is a meta-model unlike CBT and MCT, which means that it doesn't focus on a specific treatment, but rather seeks to explain how all psychotherapies produce their benefits. The contextual model is based on research on psychotherapy and social science theory. The model describes factors that should be incorporated in therapy. It is explained through 3 pathways.

3.3.2.1 The Contextual model of Psychotherapy

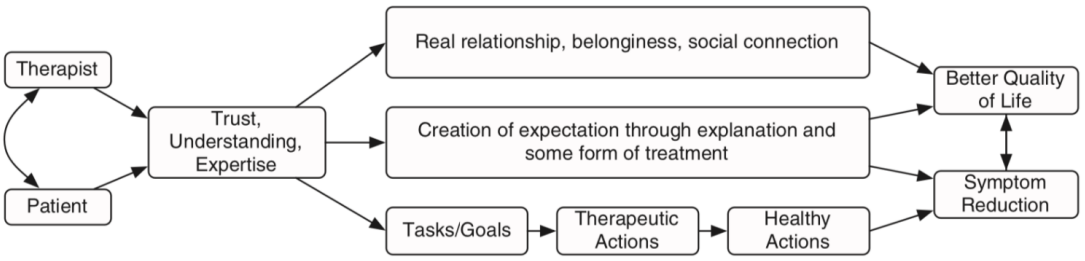


Figure 2.2 Contextual Model.

3.3.2.1.2 The Initial Therapeutic Bond

This refers to the establishment of an initial bond between therapist and client prior to the first therapy session. According to Ed Bordin (1979) this is crucial before psychotherapy can be started, since a deeper level of trust and attachment is needed in this sort of relationship. This initial stage the client first meets the therapist and forms a quick judgment such as whether they can trust the therapist, the therapist's dress code and the decor of the therapy room. Moreover, According to Wampold & Imel (2015) the client comes into therapy with their own sets of attitudes, expectations, prior experiences, motivation for change and knowledge about the specific therapist etc. However, they claim that in general humans have a positive orientation towards healing, but only when it is consistent with their own cultural understanding of healing.

3.3.2.1.3 First pathway: The Real Relationship

The concept of the real relationship is described as two humans having genuine, authentic, open, honest intimate emotional relationships. The Contextual Model puts forward that to a certain degree the real relationship will be therapeutic in and of itself. For this process to succeed it is crucial that this relationship depends on empathy. This is defined as a complicated process which an individual can be affected by and share the emotional state of another and understand what caused this emotional state by relating with the other person: This is crucial for collaboration, goal sharing and the regulation of social interaction. Research concludes that empathy is a strong predictor for psychotherapy outcome. Thus this model suggests that the stronger the real relationship, the better the outcome of therapy regardless of the orientation of the therapist.

3.3.2.1.4 Second pathway: Expectations

When the client seeks help it is to find a solution which they believe can benefit their situation, thus they usually have a positive expectation of the therapy and it is the

therapist's job to instill hopefulness in the client. According to the Contextual Model, patients come to therapy with an explanation for their distress, formed from their own psychological beliefs, which is influenced by their cultural conceptualization of mental illness. The theoretical background of the therapy is not important, rather what is important is that the individual client believes the explanation given to them about their mental disorder and that they received therapy matches that explanation. The client's belief that this will help them overcome their struggles if they engage and successfully complete the therapy sessions which create further expectations and will result in a positive outcome. This sense of belief in one's own capacity has been further elaborated in the section about Bandura self-efficacy. Moreover, great emphasis has been put on the therapeutic alliance which involves agreement between client and therapist on the goals and tasks, which is a strong predictor of outcome regardless of theoretical background.

3.3.2.1.5 Third pathway: Specific Ingredients

The third pathway refers to when the client participates in the therapeutic actions of the treatment, which refers to the 'specific' ingredients of the treatment. According to Barlow (2004) there are commonalities between different psychotherapy approaches, however, it is the specific psychological procedures that target the mental disorder which is what makes the therapy effective. The Contextual Model does put great emphasis on the specific ingredients, however, it is seen as something that encourages the client to participate in health-promoting activity rather than it being something that is the remedy for a deficit. This health-promoting activity can be found in all psychotherapies, regardless of the theoretical background. For instance, in many disorders the client has a dysfunctional view of the world, in CBT the solution to this is to change the dysfunctional thoughts which results in adaptive cognitions. However, it is suggested that most therapies do address this issue but use different terms for it. Overall, each therapy promotes the well-being of their client and reduction in symptoms. When a client sees improvement in one domain, for

instance, it is likely that when the client gets better in behavior therapy that they also feel better about themselves. For instance, if a client that had difficulties with alcohol abuse reduces their alcohol usage, they will likely see improvement in their interpersonal relationships as well.

Overall, The Contextual Model posits that there are three pathways that account for change in psychotherapy: the real relationship, expectations and specific ingredients. Moreover, common factors' popularity was at its peak during the period of humanistic treatments, with which they were best linked since humanistic approaches put emphasis on common factors such as the client-psychologist relationship. We decided to include Rogers theory on client-centered therapy because it puts emphasis on the real relationship and elaborates on the concept of empathy in therapy.

3.4 Client-Centered Therapy

According to Rogers, reality varies from person to person, and humans are guided more by their internal experience than by exterior reality. Humans are motivated toward self-actualization, according to Rogers, and they are born with the ability to reach their full potential. Rogers believes that everyone has organismic valuing systems which is an innate guide that leads to self-trust and finally results in self-actualization. In some circumstances, self-actualization may be unachievable since children rely on parental figures for survival and have a need for unconditional positive regard, which includes unconditional acceptance, respect, and love without conditions of worth. If the youngster is met with conditional positive attention, this will result in these conditions being introjected the child. This can consequently cause inconsistency between the real and ideal self which can lead to anxiety, despair, and defensiveness in relationships. People employ defenses to reduce the inconsistency between their experiences and their sense of self, making them feel less anxious and depressed. A supportive relationship is usually required to overcome defenses and allow the person to return to trusting the organismic value

process. A helping connection allows an individual's self-actualizing proclivity to overcome the restrictions that were internalized in the context of worth. According to Rogerian theory most clients profit greatly from being listened to, understood, and accepted. Congruence, unconditional positive regard, and empathy are ways that the helper can use in the therapeutic partnership.

Rogers (1975) discovered that empathy is the most potent aspect in therapy for bringing about change and learning. According to Rogers, empathy has many aspects: “It means entering the private perceptual world of the other and becoming thoroughly at home in it” (Rogers, 1975, p. 3) and it involves being sensitive to the other person. It requires seeing things through their eyes and refraining from passing judgment. It involves not exposing feelings that the person is fully ignorant of since doing so would be too risky. It involves giving the person a fresh perspective on his or her environment. Rogers defines empathy as a nonjudgmental approach in which the therapist's own beliefs and ideals are put on hold.

Rogers proposed six change conditions: 1) There must be a therapeutic relationship or emotional connection. 2) The client must be in an incongruent state in order to be motivated to participate in the helping process. 3) The helper must be congruent. The helper must be approachable and sincere. 4) The client must be treated with unconditional positive regard by the helper. The helper should empathize with the client, but not pass judgment on whether or not the client should feel specific emotions. 5) The helper, as previously indicated, must have empathy for the client. 6) The client must sense the helper's consistency, unconditional positive respect, and empathy. If the client does not encounter the facilitating circumstances, they do not exist for all intents and purposes. (Rogers, 1975; Hill, 2014)

Overall, Rogers claims that a facilitative attitude, such as empathy, congruency, and positive regard are the most beneficial components of the helping process. According to Rogers, if helpers accept clients, clients will accept themselves, allowing them to feel their true emotions while acknowledging that these feelings are their own. As the

organismic valuing process is unblocked, people become more open to their experiences.

Rogers's theory of Client-centered therapy has been presented. Now Julian Rotter's theory of locus of control and Bandura's theory on self-efficacy will be accounted for, since it might influence the client's view of therapy and perhaps outcome. We are well aware of the fact that Rotter and Bandura have a vast amount of theoretical concepts, but we will only utilize the relevant concepts that we think could be useful in understanding our participants.

3.5 Locus of control and self-efficacy: Rotter and Bandura

Locus of control orientation is described in the context of Rotter's (1954) social learning theory. The extent to which individuals attribute outcomes to their own actions is hypothesized to be related to their own experiences and reinforcement history (i.e., a more externalized or more internalized orientation) Therefore, beliefs, expectations and attitudes associated with an individual's locus of control orientation are thought to develop, be reinforced, and strengthen as a result of interactions with others, the environment, and individual differences (e.g., cognitive development, feelings of alienation or powerlessness, need for autonomy or active mastery of the environment, and need for achievement; Rotter, 1966). Locus of control refers to the degree of which an individual attributes what happened to him/herself as being in or out of the realm of personal control. A person who sees him or herself as being in control of important life conditions is said to hold an internal locus of control (Rotter & Mulry, 1965). An individual who has an external locus of control perceives that they have no power over their behavior and blames their situation on external factors.

According to Julian Rotter, it is a combination of the cognitive aspects of the personality along with the behavior that is crucial to human personality and decisions. The study, where Rotter divides subjects into 2 teams shows that externals take longer to solve a competency oriented task than internals (Rotter & Mulry, 1965). Locus of control is one of the few personality variables which has been related to therapy outcomes (Baker, 1979). For instance some studies show that clients with internal locus of control have better therapy outcomes (Balch & Ross, 1975) while another study shows that externals do better than internals in therapy (Abramowitz et al, 1974). Being external or internal perhaps could influence whether the client feels that they have had a pleasant experience in their sessions and could have had an impact on their view on their symptoms and whether they feel that therapy has helped them. The degree to which the therapist structures and directs the process of therapy seems to be an important mediating factor in the locus of control-therapy outcome relationship. There have already been studies on some variables in relation to locus of control. For example, client diagnosis and severity of symptoms have been studied with locus of control. Lefcourt (1976) found out that internals may have better therapy outcomes because they are perhaps healthier to begin with. Butterfield (1964) found that internals express frustration in a more constructive way than externals. This tendency might carry over into therapy and internals may work more constructively in therapy. Phares (1976) found that "externals" can be more defensive than people with internal locus of control. This adds more information as openness and non defensiveness are thought to be important determinants of therapy success.

According to Albert Bandura's social learning theory, environmental and cognitive factors interact to influence human learning and behavior. In this connection, one can also combine Albert Bandura's theory about self efficacy to explain why an individual’s belief about their competence can perhaps have an effect on their ability to do well in therapy. Self-efficacy refers to a person's specific set of beliefs that determine how well one can carry out a plan of action in hypothetical situations (Bandura, 1977). To put it simply, self-efficacy is a person's belief in their own

ability to succeed in a given situation. According to Bandura, the amount of self-efficacy a person has will have a significant impact on the individual's behavior and can affect the course of life (Bandura, 2007). Individuals can improve their sense of self-efficacy by learning how to manage anxiety and improve mood in stressful situations. Having a high efficacy consists in the fact that we believe that we have the competence to possess or exercise effective behavior, which is a significant cognitive and motivating prerequisite for our opportunities.It is not just exposure to stimulation that matters, but the actor's action in influencing the environment.

Over the years, much has been written about self-efficacy and outcome expectation (Brown et al, 2014). Outcome-expectancy is the degree to which one believes a specific outcome will occur, whereas self-efficacy is the degree of certainty that one can successfully execute the behavior required to produce an outcome. In terms of treatment, outcome-expectancy is the belief that a specific treatment will reduce symptom levels or improve functioning, whereas self-efficacy is one's assessment of one's ability to participate in and complete treatment. While these are clearly related concepts, they are distinguished because individuals may believe they are capable of completing treatment but do not believe the treatment will be effective in reducing their distress, and vice versa. Both outcome-expectancy and self-efficacy are thought to boost task motivation and intention. Several studies have found that initial outcome expectations, which are usually measured at the end of the first therapy session, predict treatment outcome (Brown et al, 2014). This is true for a variety of psychosocial treatment modalities, including cognitive behavioral therapy (CBT). Due to these findings we will be curious to know how our informants expectations of the therapy method was and whether this could have affected their experience of the therapy method.

It can be concluded that Bandura's theory can be used to explain why an individual's belief about their competence can perhaps have an effect on their ability to do well in therapy and Rotter's theory can be used to explain whether being an internal or external can affect the clients way of explaining their experience.

3.6 Conclusion

Overall, the theories have given us an understanding of possible association that can be made with the clients' experiences with MCT and CBT. This knowledge will be useful in our further discussion later. More specifically, CBT allows the client to gain insight into their situation and they can see how thoughts, feelings, behaviors, and physiological sensations are interconnected and how changing one component can affect other factors. A typical therapy session would also include a typical CBT therapeutic style combined with good therapeutic relationships developed through collaborative empiricism, Socratic dialogue, and guided discovery. Furthermore, homework is also an important component of CBT. Exposure and cognitive restructuring techniques can assist the client in identifying their core beliefs and automatic thoughts. On the other hand, the metacognitive approach provides an alternative approach to mental diseases. According to the metacognitive model S-REF, mental disorders are caused and sustained by a style of thinking known as CAS, which is characterized by rumination, concern, threat monitoring, and so on. The CAS, which is an inefficient coping mechanism, is maintained by positive and negative metacognitive beliefs. MCT focuses on negative beliefs rather than the significance of the meaning underlying them. The purpose of MCT is to help clients modify their relationship with their thoughts. Moreover, The Contextual Model proposes that in psychotherapy, three pathways account for change: the real relationship, expectations and specific ingredients. Furthermore, Rogers believes that the most beneficial components of the helping process are empathy, congruence and unconditional positive regard. According to Rogers, if helpers accept clients, clients will accept themselves, allowing them to experience their true emotions while acknowledging that these emotions are their own. People become more open to their experiences as the organismic valuing process is unblocked. Lastly, it can be concluded that Bandura's theory can be used to explain why an individual's belief in their competence may have an effect on their ability to do well in therapy, as well as

whether being internal or external influences their way of explaining their experience.

These theories will later be used to understand our participants' experience. The theory behind our method is also relevant to account for and would be elaborated down below.

4. Method and design

Now we'll look at the method and the relevant reflections in this regard. We sought to gain an understanding of How clients in a Danish context experience therapy based on metacognitive therapy (MCT) and cognitive behavioral therapy (CBT). We tried to understand this experience from their lifeworld. Consequently, we decided to apply a hermeneutic-phenomenological theoretical approach. As a result, there will be an explanation of philosophy of science, followed by a presentation of the interview form. Thus, there will be a quality assurance of our method with a focus on the concepts of reliability, validity and generalizability. The actual interview process with the participants will also be reviewed and the chapter will be concluded with a presentation of the phenomenological interpretive analysis method (IPA).

4.1 Hermeneutic phenomenology

The hermeneutic phenomenological perspective combines the two perspectives from hermeneutics and phenomenology to form a coherent understanding of the individual. To comprehend hermeneutic phenomenology, it is necessary to understand the background for both phenomenology and hermeneutics.

Phenomenology was founded in the early twentieth century by Edmund Husserl as a theoretical and philosophical discipline and it was later expanded into a more existential direction by thinkers such as Martin Heidegger (Langdridge,

2007;Brinkmann & Tanggaard, 2020). The study of phenomenology is concerned with how a phenomenon manifests and appears in the real world. The lifeworld is the world as it is lived and experienced by the people (Langdrige, 2007). For Husserl, intentionality is an essential component of consciousness, referring to the fact that we as humans are not only conscious, but also constantly direct our attention toward something definite. Phenomenological reduction is another key concept in transcendental phenomenology. This means that the individual sets its preconceptions aside to describe the phenomenon precisely; this concept is also known as epochê (Langdrige, 2007). However, Heidegger criticized Husserl's transcendental phenomenology, arguing that the subject and self cannot be abstracted from their context, but must be understood in the existential-phenomenological way by virtue of their relationship to the world. Thus, we cannot put brackets around our natural attitude, but we can clarify and challenge it. As a result, Heidegger contributed to the advancement of phenomenology in a more interpretive hermeneutic direction.

Hermeneutics is a philosophy discipline that dates back to the 17th and 18th centuries (Rønn, 2011). “The existential phenomenologists follow Heidegger, Sartre and Merleau-Ponty and believe that you should try to achieve epoché but that you can never truly bracket off all your presuppositions and achieve a ‘God’s eye view’.” (Langdridge, 2007, p. 18). Human beings, rather than simply being described, should be understood in relation to the historical and cultural contexts in which they exist. Hans Georg-Gadamer (1900-2002) advocated for the hermeneutic turn in phenomenology, believing that the researcher could not unconditionally consider or describe the reality in which he or she is immersed. To put it another way, he believed that humans will always have prejudices and preconceptions, and that only by challenging them can we learn new things and gain new insights into the world we live in (Rønn, 2011). This is also known as the hermeneutic circle (Willig, 2013) which refers to the cyclical movement between assumption and interpretation when interpreting a phenomenon. Consequently, in order to facilitate the acquisition of scientific knowledge, the researcher should interpret human phenomena rather than

simply reporting them, as transcendental or descriptive, which phenomenology would usually suggest (Langridge, 2007; Willig, 2013).

Now that we've covered phenomenology and hermeneutics, let's look at hermeneutic phenomenology. To comprehend unique lifeworld experiences, we must investigate and approach them using hermeneutic tools (Langridge, 2007; Brinkmann & Tanggaard, 2020). The world of existence, on the other hand, is always built within a social, cultural, and historical framework that serves as the starting point for the development of individual opinions. From a hermeneutic-phenomenological perspective, the phenomenological researcher will try to put his prior knowledge and assumptions in brackets in the meeting with the other human being, but does not believe that a 'pure' description of an experienced phenomenon can be created, because description always involves some form of interpretation (Willig, 2013; Brinkmann, 2012). As a consequence, the study evolves into a dynamic process in which the researcher's assumptions become a necessary precondition for creating meaning.

As a result, we acknowledge that we play an active role in the overall research process, and that our own beliefs and perspectives are a necessary precondition for interpreting our informants' experiences from their perspective.

4.2 The qualitative interview

Furthermore, we chose a hermeneutic-phenomenological method since this is how information about people's experiences of a phenomenon is produced. This method can thus help us understand more about how Danish clients' experience CBT and MCT. In this study, we chose the semi-structured interview as our starting point, which will be discussed in more detail in the next part.

4.2.1 The semi-structured interview

The semi-structured interview is commonly used to investigate and learn about an individual's attitudes, life situations, and experiences (Kvale & Brinkman, 2015, p. 49). This allows the participant to provide an in-depth response that is focused on the selected phenomenon. The semi-structured interview has an interview guide, which is specifically designed to gather as much information as possible about the phenomenon (Langridge, 2007, p. 65). Before the interview, the researchers must have theoretical knowledge of the subject field examined to ask relevant questions and listen openly to the informant's narrative. We, therefore, made sure that we researched enough about MCT and CBT in the existing literature and found the gaps that were relevant to our statement of intent. A combination of inductive and deductive reasoning is used in our analytical approach (Kvale & Brinkman, 2015). Initially, we were theory-driven, where existing research and theory provided a nuanced understanding of MCT and CBT. This served as the foundation for structuring and thematizing the interview guide. On the other hand, because research on the clients' MCT and CBT experiences of therapy in Denmark is limited, we took an inductive approach and we were open and inductive to the stories of our participants. This enabled us to incorporate new relevant concepts and change our theoretical perspective, which we then applied to the analysis. We alternated between theory and empiricism to achieve a nuanced study.

4.3 Interview guide

The interview guide contains an overview of topics, question formulations and structuring theoretical concepts and themes as well as an introduction and conclusion with formalities (APP7). We conducted two interview guides, one for MCT and one for CBT. A combination of both the interview guides were used if the participants had received MCT and CBT and some comparative questions were also added in

cursive. Furthermore, we ended the interview by asking how it felt to be interviewed in order to give the informants a sense of empowerment.

Through our literature review, we were guided by themes that could be relevant to address in our interview. These were themes like expectations, reasons for seeking therapy, first experience with a psychologist, specific ingredients, client-psychologist relationship, turning point, tools received and own development & change. Thematically, the questions relate to the interview's "what", to the theoretical perceptions of the research topic and the subsequent analysis of the interview. Moreover, we structured our interview guide in a chronological approach where we went from asking questions about their expectations to therapy in general to ending the interview with lessons learned from therapy and what advice they would give to other clients. By doing so we made sure that the interview ended in a reflective and positive manner. The questions were easy to understand, short and free of academic language. However, if the interviewee answered some of the questions we had already prepared, we made sure to keep the conversation flowing naturally by following up with the answers we received. This made the conversation more dynamic and natural. Furthermore, we tried to avoid questions like "why..." because we as researchers wanted to interpret and investigate why the interviewee experiences and behaves in a certain way. The goal was thus to obtain detailed descriptions of the participants' experiences and to follow up on their responses by clarifying their understanding of the statements through interpreting questions (Kvale & Brinkman, 2015). Before proceeding to the actual themes in our interview, we began our interview with an introductory question: Can you tell us a little bit about yourself? By doing so, we ensured that informants could structure and select what they felt was important to tell and that the interview began on a less serious note. We made sure that we had specified questions in case the informant didn’t interpret that question the same way as we did. We found that using a variety of question types helped to ensure that appropriate information was gathered while also keeping the interviewee's interest (Kvale & Brinkman, 2015). Furthermore, our statement of intent requires a certain awareness of ethics.

4.4 Ethical considerations

It's crucial to talk about the ethical difficulties that could occur for the participants since they shared their personal stories in the interviews which makes them vulnerable. Some of the ethical considerations that have to be taken into account are informed consent, confidentiality, disclosure and potential consequences of participation (Kvale & Brinkmann, 2015). Prior to the interview the participants were briefed on the research's objective and types of questions they may expect to be asked, this way they can say no to certain questions if they feel it interferes or triggers their personal boundary and they can feel more prepared to sensitive topics. Additionally, we gave a brief introduction of ourselves so that the participants feel comfortable knowing who we are. Furthermore, participants received informed consent forms prior to the interviews (APP8). This will include the participants' confidentiality and anonymity, which was guaranteed by using pseudonyms and modifying personal information that could reveal their identity. It was also emphasized that their involvement is entirely voluntary and that they can withdraw their statements at any time. Furthermore, because of the nature of interviews, the interview situation can become quite sensitive and intimate, leading to participants' placing their trust in us researchers. In addition to this, it can resemble therapy as a result of this (Kvale et al. 2015). For this reason we were conscious and reflecting on our role as a researcher, in which we must balance between professionalism and being personal (Kvale et al. 2015). Following the interview, it is critical to minimize the potential consequences of participation in this personal interview. We had a debriefing to minimize it. The first debriefing occurs towards the end of the first interview, the participant is asked whether they have questions or comments they would like to share. The second debriefing occurs after the interview is conducted, where the participants share their experience about being interviewed. Additionally, if the participants are interested more information can be provided about the project. Finally, the participants will have the option to view a summary of our results that pertains to them individually. When we wanted to recruit our participants several considerations were made, which will be elaborated down below.

4.5 Recruitment and participants

The sample size in phenomenological studies is frequently limited because IPA is a time-consuming and complex analysis method. The importance in selecting participants is that the sample is purposeful and somewhat homogenous. The emphasis is on understanding and interpreting the informants' experiences. The demographic, age, and gender characteristics of the informants should not differ greatly due to the homogeneous form. The participants were screened prior to the interview based on these characteristics. We had 7 participants, however, one participant was screened out due to her receiving CBT from a nurse and to ensure the homogeneity of their experiences we wanted all the therapy sessions to be conducted by a psychologist.

When contacting the participants, we were aware of the fact that they had to be able to reflect on their experiences. In addition to this, we wanted to make sure that the participants were in the right space in their life to be interviewed. Thus we decided to contact different clinics that offered MCT or CBT and asked if they had any clients that they believed would be able to share their experience with therapy. By doing so, the psychologist would determine whether or not their previous clients were capable of conducting an interview with us. They wouldn't have to reveal any names, the psychologist would contact the clients and ask if they wanted to be interviewed. As a result, no one will feel obligated to be interviewed, and only those who truly want to participate will take part. Our contact information was provided to the participants which they used to contact us.

We contacted over 30 psychologists in Denmark that provided CBT and MCT. In addition to this we shared our project-poster (APP9) on different groups on facebook. However, only 2 psychologists came back to us with possible candidates for our interview. Many psychologists stated that they were time-limited or that it was going against ethics. So our participants primarily came from different facebook groups. Therefore our criteria for our informants was not as strict, but following criteria were

taken into consideration. We recruited 6 participants in total where 4 of our participants had received both MCT and CBT (Lasse, Tina, Sara, Sofie) while 2 of our participants had either received MCT(Lea) or CBT(Meera).

4.5.1 Criteria

4.5.1.1 Experience of CBT or MCT

The main criteria is that the informant should have had an experience with CBT or MCT. They must have completed the therapy before interviewing them. They must be able to reflect on their experience.

4.5.1.2 Gender

We did not set any criteria for gender in our research paper since our main focus was on the therapeutic approaches.

4.5.1.3 Age

We aimed for participants that were mature enough to comprehend and reflect upon our questions. In addition to this, due to ethical concerns, we did not want to select participants who were under 18. We limited the age group to 25-40, with the majority of the clients' being between 25-35. Due to a lack of available informants and time constraints, we chose this age range.

4.5.1.4 Demographic:

Denmark.

This leads to the following selection criteria:

1) Should have had an experience with therapy in CBT or MCT 2) The therapy must be completed prior to the interview. 3) Gender: all, 4): Age: 25-40 years, 5) Demographic: Denmark

As mentioned before 6 participants were selected after considering ethical factors and the aforementioned criteria. After selection and interviewing the participants we selected some transcription rules for our interviews, which will be elaborated down below.

4.6 Transcription and transcription rules

Typically, phenomenological psychology projects employ a simple level of transcription (Langridge, 2007, p. 73). Frequently, the emphasis is on producing a transcript that provides the analyst with a verbatim account of the interview. Because transcription is a step removed from the interaction during the interview, the researcher should stay as close to the statements as possible (Langridge, 2007, p. 74). As a result, the transcripts of the interviews in this study focused on the informant's spoken words rather than reformulations, linguistic errors, and appreciative statements from the interviewer such as "ahhh", "hmmm". These were only included if they were necessary for understanding the individual informant's statements. It is important to note that a significant amount of information will inevitably be lost during this phase because body language and voice cannot be instantly translated into written language. However, rather than discourse analysis, where a very detailed and precise transcription appears to be important, the starting point for phenomenological studies will be meaning condensation with a focus on general themes. We established some transcription rules to ensure that we as researchers transcripted in the same manner:

- Interviewer 1, I1 and interviewer 2 as I2 and interview person as Ip.
- Pauses more than 5 seconds is labeled (Pause)

- Smiles, laughter, and other emotions or gestures that may capture the mood are indicated in parentheses and italics, and the person expressing themselves is identified., e.g: (laughs)
- To ensure clarity, we included the person being discussed in brackets such as in "I was talking to him (psychologist)."

Furthermore, it is relevant to take some elements into consideration when assessing the quality of our study.

4.7 Quality assessment of this study

The section that follows tries to explain the thesis's internal validity, reliability and analytical generalizability.

There is no clear agreement among researchers about how to evaluate the quality of qualitative studies. As a result, it must be acknowledged that qualitative researchers disagree on the extent to which validity, reliability, and generalizability should be considered in qualitative research, as well as how they should be obtained (Willig, 2013).

4.7.1 Validity

The term validity refers to whether a study investigates what it is supposed to investigate (Kvale & Brinkmann, 2015). Qualitative methodologies address validity concerns in different ways. Qualitative data collection techniques seek to ensure that participants are free to ask and, if necessary, correct the researcher's inferences about the meanings under investigation (Willig, 2013). We accomplished this by asking clarifying questions to ensure the meanings in the interviews are understood in the same way as the client views it. Some qualitative researchers receive participant feedback on the findings of their studies (participant validation). The argument goes that if the study and its findings make sense to participants, it must have some validity. To ensure this, we as researchers presented our findings to our participants

before handing in our thesis. Secondly, to ensure ecological validity we made sure that the location of the interview was selected by the participants to make it as natural as possible and as close to real-life setting. All the participants preferred the interview to be online so they could stay at home and answer their questions. Finally, we used reflexivity, where we constantly evaluated our roles as researchers. For instance, we made sure to write our own preconceptions down before interviewing our participants. One of our preconceptions was that our MCT participants would have a positive experience of their therapeutic experience since they were all joined in a facebook-group for MCT. Another example of one of the biases that we have reflected on is that we have a personal belief that therapy should be specified for the individual client. That the client decides what is important to discuss in therapy. We have strived to bracket off our own biases and meet the participants with a neutral stance, even though we know that it isn't fully possible.

4.7.2 Reliability

According to Kvale and Brinkmann (2015), reliability "relates to the consistency and credibility of research results". When it comes to qualitative research, the concept of reliability is inevitably linked to the study's transparency. We attempted to achieve a high level of transparency in this thesis by including selection criteria for our literature search, disclosing our interview guide and recruitment processes, so that the experience can be replicated by others (APP1-9). This improves the credibility and consistency of the research findings.

In the interview situation, the researchers can use leading questions to both verify their own interpretations and conduct an ongoing reliability check on the informant's answers (Kvale & Brinkmann, 2015). This could be done by asking interpreting questions such as: I1: "What I hear you say is that through your conversations you could challenge your thoughts, partly through assessing how realistic they were, but also that with exposure". Ip: "Yes. That's how it was"(APP4, p. 5, l. 29). The interviewee is here given the opportunity to either accept or reject the interviewer's

interpretation, which is based on the informant's lifeworld perspective as much as possible (Kvale & Brinkmann, 2015).

Although it is not possible to generalize qualitative studies, we can still use the knowledge gained to gain a new perspective on our statement of intent.

4.7.3 Generalization

This study aimed to examine clients in Denmark's experience with MCT and CBT, which is why there was focus on an analytical generalization. Whether the findings of a study can be used to predict what will happen in other similar situations is called analytical generalization. To establish the analytical generalization, we try to come up with detailed contextual descriptions as possible as well as transparency and explicitness throughout the research process for instance by being transparent and open about our interview guide and transcriptions (Kvale & Brinkmann, 2015). Hereby, in the hopes that this will increase the likelihood that others will be able to conduct research from similar premises and thus determine whether the research results apply in other situations. Despite the fact that each of our participants has had a unique experience with MCT and CBT, we discovered some similarities in their experiences, which supports an analytical generalization.

Our analysis will look upon these similarities between the informants and how we will conduct our analysis is described in the following section below.

4.8 Interpretive Phenomenological Analysis (IPA)

IPA was chosen to analyze our interviews, which is a method used for analyzing how people experience and perceive a given phenomenon. In the 1990s Jonathan Smith invented IPA, but later refined the method with Mike Osborn. The progress puts focus on the method's hermeneutic-phenomenological background so that there is reduced focus on description, and a greater focus on interpretation through the use of

double hermeneutics (Langridge, 2007). Consequently, IPA is a version of the phenomenological method, where the analysis aims to investigate the informant's world, but acknowledges that this is the researcher's interpretation of the participant's experience (Willig, 2013). The interpretation of the participant's statements is heavily influenced by the researcher's assumptions, attitude and thoughts. These, however, are not seen as biases that must be avoided, but rather as a crucial condition for the meaning-creating activity of interpretation (Willig, 2013). Consequently, research becomes a dynamic process in which the researcher seeks to understand and identify the individual informant's world of life through interpretive activity to create meaning. It is important to emphasize that IPA is an interpretation method that should be accustomed to the specific subject and researcher. Because the technique is time-consuming and labor-intensive, it is only recommended for small samples. When analyzing interviews, it is best to spend some time with each transcript before moving on to the next. The idiographic method is employed, with specific examples serving as the starting point, followed by interpretation. The transcript is read and re-read from beginning to end in the first stage of the analysis process so that the researcher becomes as familiar with the content as possible. This is important because each reading has the potential to provide new insights (Landgridge, 2007). Comments are then made in the left margin. This stage's goal is to provide associations, interpretations or summaries that will help the researcher figure out what's going on in the transcript. This stage may be repeated several times to increase the likelihood that the researcher has understood the meaning of the transcriptions (Langridge, 2007). Emerging themes are noted in the right-hand margin in the second stage. Initial notes are transformed into more meaningful statements indicating a deeper level of meaning in specific text sections. More psychological terminology can be used by the researcher, and more theoretical connections are likely to emerge (Willig, 2013). The terms are not final at this point and will most likely change during the next phase when they are examined together (Langridge, 2007). We decided to make it a single page with two columns, one for each student, so that the topics and references are listed next to each other.

Themes are listed separately on a document in their original chronological order in the third stage. Common links between themes are discovered and then reorganized analytically or theoretically. Some themes will naturally group together, while others will necessitate further investigation. Some will appear to be minor themes, while others will appear to be more prominent. As the analyst works to reorder and restructure the topics, he or she will need to return to check the emerging analysis. We divided developing themes into two columns so we could see which ones were deleted and which ones became sub-themes.

The fourth stage involves the researcher creating a table of themes in a logical order. Themes are given proper names, and each theme is linked to the original text via specific citations (given through page and line numbers). Some themes may be removed if they do not connect with the superordinate themes or do not contribute significantly to the analysis.

Once these stages for one transcription are completed, the researcher moves on to the next transcription. The researcher can either begin with stage 1 or use the tables of themes generated from the first case's analysis to guide the analysis of the subsequent case. We've decided to start at the beginning. Moving from case to case requires flexibility because themes that are only applicable to one case and not the other will be dropped. As a result, the process is circular and iterative, with data revisited on a regular basis to assess meaning and validate interpretation. The overarching goal of these steps is to generate a final table of themes, which will be presented in the following chapter.

5. Analysis

Based on our IPA, we derived five overarching themes: 1) Understanding of own mental issues, 2) Method & Tools, 3) The relationship between the psychologist and the client 4) Group therapy vs. Individual therapy 5) View on therapy. Each theme is divided into different sub-themes, which will be elaborated upon in the following sections.

5.1 Understanding of own mental issues

The first main theme is related to understanding one's mental issues. This theme is divided into five sub-themes. The themes are; Rumination - Letting go of one's thoughts, being passive, metaphors & images and maintaining patterns. Clients in both MCT and CBT expressed that they gained a better understanding of the cause of their mental issues, however, their reasons are very different.

5.1.1 MCT

5.1.1.1 Rumination - Letting go of one's thoughts

The majority of clients who received metacognitive therapy said they realized ruminating and worrying were the triggers for their mental issues. For instance, Sara stated that she had always believed that thinking a lot and analyzing events and situations was a good thing, however, shortly before receiving MCT she expressed how her brain had become her enemy (APP3, p. 17, l. 95). Through MCT therapy, she recognized that this act could be a trigger for her symptoms, as stated in the following:

> *" [...] but yes definitely a feeling that I was just completely beside myself because I constantly let negative thought spirals just take over everything I*

did all the time and I was like it is clear why my doctor thought I had become depressed [...]" (APP3, p. 18, l. 98).

Tina also described that she believed she could solve mental issues by thinking and analyzing

" [...] the belief that such problems should be solved mentally. So if only I was good at analyzing things, then I should probably get through them. So it was about separating it into different pieces that were what was important, so there I had chosen the strategy of thinking a lot […]" (APP1, p.3, l. 24).

However, much like Sara, she realized through therapy that this strategy was prolonging her mental issues:

"It is a process where you just realize that it does not actually help one, even though I could clearly feel it." (APP1, p. 3, l. 24)

Moreover, Lasse also mentions that he experienced a sense of relief when he realized that thoughts are just thoughts:

"*Yes, so there were quite a few things and something I also have carried on with me. It was sometimes liberating to know that thoughts are thoughts and sometimes they show up too, other times they are gone. You get so many thoughts in one day that it is impossible to register all yours. I actually think it was nice because I felt [...] in cognitive therapy, where you had to make these schedules for the thoughts and put them in the system. I think you did very little of that in metacognitive and I was really happy about that ... and because I think there were too many different inputs and thoughts and sometimes I felt that it was a bit impossible to register them all. So the fact that I was told that the thoughts come and go and run a bit on their own I*

think it was really very very good so very nice. Then you did not feel tired in the same way." (APP4, p.11, l. 67).

5.1.1.2 Being Passive

Sofie sought therapy for her panic attacks and found it difficult to let go of her thoughts during the attacks since she found that it was undermining her natural instincts *(APP2, p.15-16 , l. 118).*

"[...] In relation to the panic attack I could not understand and still can not understand how I should use it. When my body just kind of panics. I can see afterwards that I should not put too much importance on going and pondering on it, 'oh no I am now on my way down the slippery rope'. I think that made really good sense. But when I am in the situation and I get that sinking feeling and or that it hurts somewhere and such to just let it be it is completely counterintuitive to go against one's instincts and then be like my body is in panic so (pause) I also feel like maybe you are undermining [....] your symptoms, you do not listen to yourself, that I just wanted to be like that. Yes, no, I must not feel that I must not feel it. I might also have had a hard time figuring that out, well, when you have to postpone some thoughts to pondering time, like how does one say that the thoughts are welcome or like not pushing them away. [....] Because it's more about being passive in the mind [...]and having a relaxed relationship with them (thoughts) [...]" (APP2, p.15-16, l. 118).

She felt that she was being passive, which she found difficult *(APP2, p.16, l. 120).* Similarly, when Lea asked what advice she would give to someone going through comparable problems to her, Lea said:

"So I've been going through this since 2016. Something has to happen actively, move, or do something drastic because I can not ponder myself out of it and I can not metacognitive myself out of it. It is important to separate a situation that you have to

do something about or is it a superstructure that creates your problems. You probably have to distinguish them. It's like if you get beaten by your husband, then it does not help that you do not ponder over it you have to do something" (APP5, p.10, l. 53).

Lea states that she needed to take action to fix her dilemma. However, while both individuals saw the benefits of not ruminating in daily tasks, they did not find it helpful for the main mental issues for which they sought therapy. This could be interpreted as MCT not being a sufficient basis for understanding the two participants' mental issues.

5.1.1.3 Metaphors & Imagery

The majority of MCT clients utilized metaphors and imagery to help them understand their mental issues.

Sara states the following:

> *" […] Then there was also one thing that you had to think about e.g. running sushi where there are all the different pieces. All the different pieces or all the different plates are different thoughts you can have about yourself or your life or your specific problem, and then you have to practice and just let them run. Such an exercise I also think was fun because [...] I can recognize it because it then connects to sushi. In any case, I think I have grabbed them because a lot of my problem is that I feel that all my thoughts are piling up and it becomes a huge mess in my head." (APP3, p.22, l. 118).*

Likewise, Tina explains how picturing a tiger helped her understand how she should relate to her thoughts:

"So I remember one of the first times where there was such an example of imagining that there was a tiger. [...] you have to have that picture of you standing and looking at a tiger, it also moves around, but you do not have to follow it [...] but you are just aware that it moves without having to go to it. I was kind of surprised that it actually worked very well. It was also kinda the same approach you should have to your thoughts, the fact that they can move without you having to stare at them and go to them and relate to them. I can remember that fairly specifically. [...]" (APP1, p.7, l. 57).

Because the majority of the clients employed metaphors and imagery to express the mental issues they may have internalized the MCT language. Moreover, the following section will touch upon CBT clients' understanding of their mental issues.

5.1.2 CBT

5.1.2.1 Maintaining patterns

Understanding the maintaining patterns and causes of their mental issues is beneficial to the majority of CBT clients. Sara, for example, believes that the educational information provided in CBT was the most beneficial, as illustrated by the following:

" [...] One (psychologist) who always taught psychoeducation, which gives an understanding of the brain, I thought it was really good, really nice. He could say well say okay has this happened in your childhood, then your reptilian brain has told you to be careful. It makes sense that you take care of it now. That kind of thing I could really use. [...] " (APP3, p.6, l.23).

This informative information about the cause of her mental issues was useful. Similarly, Tina points to the maintaining factors which maintain her in this vicious circle.

"Probably more maintaining factors, yes. Probably more like, well then this happens neurologically and then there are thoughts, feelings and behaviors and the brain and it made good sense for me I can remember. That the individual strengthened a more rational brain and what to say." (APP2, p.4, l. 28).

Additionally, Lasse also emphasizes unrealistic thoughts:

"I would say that my anxiety about illness diminished significantly. Because I kind of wanted to feel like I could think more realistically about my thoughts. There was like something in my mind that was completely up in an unrealistic field that might not be so yes (pause) it might not be like that in reality, for example about how one could get infected and different things, so cognitive therapy helped me in the way that I got a more realistic relationship with my thoughts around that it does not happen because (pause). He talked with me on a level where I understood [...] then I was afraid of needles at that time, which made me also afraid of getting HIV, so he said a few milliliters of blood or something it does not mean you can get HIV, where I thought well he is probably right and then I got such (pause) realistic relationship to my thoughts and that way. It's not as bad as my head would tell me. (APP4, p.5-6, l. 34)."

Lasse believed that his thoughts were realistic for him prior to CBT therapy; it wasn't an issue of if something would happen, but when it would happen and how he could avoid it. He developed a deeper grasp of his illness anxiety through CBT, and he realized that these were unrealistic thoughts that he needed to work on.

Likewise, Meera points to *the cognitive diamond* as a way to understand her mental issues:

> *"I remember that we, for example, used the cognitive diamond, well, thoughts, feelings and actions or something like that. I also think it for example puts things in perspective for me. For example, I told him that I did not like to be alone or alone in my company and during the corona [...] I also think that one of the things he made me realize, for example, is also that there is nothing wrong with it. [...] There he made me fill in the cognitive diamond, where I realized that there is nothing to be scared of. [...]". (APP6, p.4, l. 30).*

Meera puts great emphasis on her relationship with the psychologist, however, it is also evident that the exercises used have helped her with a better understanding of herself.

Although Sofie mentions that she understands that her anxiety is not rational, her brain doesn't understand it.

> *"Because this is about thinking rationally about it, I already feel I did or have done it [...]. It's kind of hard to answer anxiety back by being rational because you know anxiety is irrational, but it's like yes but my brain does not understand it or something". (APP2, p.5, l. 32).*

Sofie expressed that she felt she was missing an explanation for her anxiety:

> *"Should we never talk about why we have anxiety? Should we just treat our symptoms." (APP2, p.4, l. 24).*

It could be interpreted that she was referring to a personal understanding of what caused her specific anxiety. *(APP2, p.8, l. 53; APP2, p.9, l. 9).*

Overall, it could be concluded that in both MCT and CBT that the clients gain a better understanding of their mental issues. However, their insights vary depending on the form of therapy they received. Clients in MCT report rumination, metaphors, and letting go of one's thoughts. Clients in CBT report informative information about

their issues as beneficial and challenging their unrealistic thoughts. However, clients in both MCT and CBT also reported some difficulties. In MCT it was difficult for some of the participants to follow through without ruminating or worrying, and some explained that they felt like they were being passive. On the other hand, a participant in CBT expressed difficulties with internalizing that her thoughts were unrealistic. Moreover, another theme that can be derived from our interviews is CBT & MCT - Methods & Tools, which will be elaborated down below.

5.2 CBT & MCT - Methods & Tools

This section is about the methods and tools our participants had experienced in both CBT and MCT. This section is divided into 3 subthemes: Thought record and exposure, cognitive model, *CAS* and lastly detached mindfulness.

5.2.1 CBT tools

5.2.1.1 Thought record and exposure

5 out of 6 participants have had experience with CBT. One common theme among the participants is how action-based CBT is and the tools they received.

Sofie, Lasse and Meera received home assignments and cognitive tools they could use for their situations. Sofie felt that exposure exercises and home assignments were useful for her:

> *"For example, with us doing some exposure while we were there with them, but it was also these homework assignments, it was probably what benefitted me the most."(APP2, p. 5, l. 32).*

Lasse also mentions a lot of tools he was given when he received CBT. Tools such as exposure, alternative thoughts and working with automatic thoughts and realistic thinking were prominent in his CBT sessions:

> *"It was cognitive, it is this realistic way of thinking, so he used a lot of this "is this realistic or what is the probability that this would happen?" [..] Then we also had this with exposure where there were some things I was afraid of, such as I had a hard time with needles. I tried to be exposed to it, and I was afraid of how you overcame this fear. Here I remember we talked a bit about bacteria and some different things and he had learned when he was training as a psychologist that he was taught to lick his shoes because there was so much exposure to bacteria. It was a lot of this that you had to try to (pause) and do such small exercises for yourself where you kind of exposed your fear to it."(APP4, p. 3-4, l. 24-25).*

When Lasse was asked about what he felt helped in CBT, he mentions the following:

> *"Having these thoughts on a piece of paper and then talking about them with him, I remember it helped me a lot back then because then we kind of got to talk about whether this is realistic or not realistic. That was the kind of exercise I did with this. I remember using it a lot back then. But at the same time, I also did (pause) what he was talking about with bacteria and something like that, I also tried to challenge myself on some of the things I was very afraid of [..]. For example, if I was scared of needles, then I remember my friends would sit and play with a compass at some point and they would think of poking a little with this compass and such. Then instead of throwing it out, I actually kept it. I do not know why I did it, but it's probably because I thought that (pause) it does not hurt that I still have it so it's like a little exercise for myself" (APP4, p. 3-4, l. 26).*

This quote shows how Lasse tries to break things down into smaller chunks, so they become more manageable and easier to manage, which is typical for an exposure exercise. Lasse is afraid of needles but saving the compass is a way for him to slowly expose himself to his fear. Similarly, Sofie also states that exposure was beneficial for her anxiety:

> *"[...] But yes, I really think that exposure was quite rewarding because it was at least something where I pressured my anxiety so I could feel it and felt there was something to work with. For example, to be told that now you must breathe through a straw or now you must turn around a lot, so you get dizzy or hyperventilate on purpose and feel pressure on my chest, so you got used to feeling those unpleasant things and see that there was nothing dangerous about it. I was afraid to lock the door to the bathroom and take a shower because what if I fell down. To be challenged and then see what happens. So these experiments, I think it was also rewarding [...]." (APP2, p. 4, l. 30).*

It is evident that Sofie has anxiety problems but some of the tools she got in CBT were exposure and challenging herself, which seems to have helped her challenge her fears.

Lea, who received MCT also mentioned some of the same examples about hyperventilating, but struggled to find it meaningful:

> *"It's not because you do not trust the psychologist you are facing, but it can be tiny things, I think when I had 2 sessions with her she used a lot of time saying I should sit and hyperventilate on purpose because she was going to show me that it was not dangerous to hyperventilate. I thought yes yes it is good and I thought about it. I understand it now and well you do not need to explain it to me, well then I just know that it is not dangerous to hyperventilate, it is not dangerous to cry let us now move on (APP5, p. 8-9, l. 43)."*

It can be interpreted that it depends on the purpose and whether tools such as hyperventilating on purpose are advantageous for the client. However, it is questionable why Lea's psychologist uses reality testing (typically done in CBT) in a MCT session. Combining CBT and MCT treatment approaches is likely to be troublesome because they send contradictory messages about how clients should relate to and control their thoughts. Perhaps this shows that the boundaries can sometimes be blurred since some psychologists might use an eclectic approach making it harder to define the method.

Even though Sofie, in the beginning, states that exposure was rewarding she later contradicts herself a bit:

> *"One can say that it is a bit two-sided because.. Exposure worked well at some points, but at other points, I also had a feeling that well if I sit here and turn around on a chair, then I know I'm dizzy because I turn around on a chair or breathing through a straw, then I do not get as much oxygen to the brain, it blackens a little, then I know this is the reason. But if it happens out of the blue then I might have a hard time connecting it like that [...]. Now I know I contradict myself a bit, but it's just when I get to think a little more about it, so yes, it was with slightly different situations that things worked."(APP2, p. 5, l. 34).*

It is understandable that some exposure exercises work better than others and that the exercises can appear to be common sense at times, making them more difficult to use while you are experiencing panic attacks, for example.

Sara also mentions that she felt that the CBT exercises were a bit condescending and felt it was like talking to a child. Here she comes with an example of exposure exercises for another client in group therapy who was afraid of buying toilet papers:

"The cognitive is very much about having to practice what you think is difficult. Then there was such a thing as going over and buying a toilet roll, where you have to hold it in your hand instead of putting it down in the bag. I can see the point of it, but there are times when those exercises get a little condescending. It was not the way they do it, but there is something in my brain or the way I work, it was completely off-putting for me. Those exercises and now you have to do it that way. It became very educational and it's insanely good for some, but not because someone is dumber than me, but it's really about how you process things yourself. As I said, I can see meaning in the exercises and if I did, I'm not dismissive of it working either, but there is something in the whole approach that did not appeal to how I just got over things" (APP3, p. 5, l. 21).

CBT exercises may not be effective for everyone. Sara claims that it might be as simple as doing small exercises such as holding the toilet paper, which makes her wonder if it's the same as talking to a child. The whole approach didn't appeal to her, but it might work for others as she states.

5.2.1.2 Cognitive model

Meera who also received CBT tells how her psychologist used the cognitive model/diamond to put things into perspective for her:

"I remember that we, for example, used the cognitive diamond, well, thoughts, feelings and actions or something like that. I also think it for example put things in perspective for me. For example, then I told him I did not like being alone or alone in my company and during the corona pandemic so my roomies were often at home with their parents. I also think that one of the things he made me realize, for example, is also that there is nothing wrong with it. Not because I felt there was anything wrong with it. I felt so lonely, but not like that if it makes sense. There he made me fill in the

cognitive diamond, where I realized that there is nothing to fear. You just have to find something to do by yourself. I listened a lot to podcasts" (APP6, p. 4, l. 30).

This quote shows that the cognitive model can be useful in making sense of your thoughts, feelings and actions. Due to the pandemic, Meera felt a bit lonely, but by giving her the model she realized that she could do something actively to change her thoughts and feelings since they all are interrelated. It can be interpreted that listening to podcasts made Meera less lonely in the corona pandemic.

5.2.2 MCT - tools

5.2.2.1 CAS

Furthermore, all of the participants who received MCT were introduced to *CAS* and rumination. Lasse states the following:

"She just showed that this is CAS and this is excessive worrying. They had a standardized method for it all and you can solve through these methods and increase your awareness" (APP4, p. 14, l. 77).

Sofie, however, felt it was difficult for her to understand that her anxiety could only be explained by *CAS:*

"Then I might also have had a hard time because it was only due to CAS that I had panic disorder, especially when medication had had such a good effect on me, how could that be?" (APP2, p. 15, l. 116).

From Lasse and Sofie's statements, it becomes clear that MCT has a very standardized way of explaining the cause of disorders. For instance, if you work on *CAS* you can help treat your disorder. However for Sofie only seeing it as *CAS* being the problem for your disorder didn't make sense to her since medication also helped immensely with her anxiety.

5.2.2.2 Audio files, metaphoric language and visualization

Some of the tools that most of our participants who received MCT got were audio files, use of metaphoric language and visualization. Many of the participants received the same tools, where Tina for instance stated the following:

> *"We then had specific tasks from time to time, where we had to practice with the various tools. There is this method among other things that we must listen to an audio file with some different sounds, where you must change your focus between them" (APP1, p. 2, l. 2).*

Lasse also states similar experiences:

> *"Then we had these audio exercises, where we had to focus on a certain sound. You tried to make your mind aware that you can direct the focus somewhere else, even though the mind seems full of thoughts. There is a thought that knocks on the door or you can just direct your focus to something else[…]. Well, we are working on this window exercise, where you had to look out the window and then you had to focus on what you had written with a felt-tip pen and then alternatively focus on what was around (APP4, p. 11, l. 69)."*

Through these citations it becomes evident that the participants were introduced to attention training techniques (ATT) and visualization exercises or detached

mindfulness which perhaps helped the clients to understand thoughts and their attention in a new light, resulting in a greater capacity to detach themselves from unhelpful thoughts and a better ability to control their attention focus. On the other hand, Lea also noted that she acquired some nice tools through the use of pictures and metaphors, but it was not revolutionary for her:

> *"There were lots of nice tools, there were lots of nice pictures and nice imagery on a beach ball that you try to press down under the water. The more you push the beach ball down under the water the more it pops up. It must then be metaphors that if one tries to suppress the negative thoughts then they pop up and become more persistent. The psychologist talked a lot about this, but you must not imagine a pink elephant and the only thing you can imagine is a pink elephant. These are old pictures, and they are not new to me. I'm very interested in psychology, and I think it's very exciting, but it was not so ground-breaking that if you try to suppress something then at some point you get some problems with it" (APP5, p. 3, l. 10).*

This quote shows that the psychologist tried to use metaphor examples such as the pink elephant to emphasize the MCT approach, however it didn't work for Lea. Sofie also felt that the most giving technique for her was to be aware of how much she ruminates, but the tools with sounds didn't help her at all (APP2, p. 15, l. 115).

Even though Lasse was very fond of the techniques and tools he received from MCT, there were still some tools he was less fond of:

> "Yes, or it was a bit unrealistic sometimes, they talked a lot about this with having to worry for a limited amount of time like half an hour or an hour[…]. I can follow the way of thinking in that and I also try it a bit, but it is a difficult exercise no matter what, so I think it is difficult for many people." (APP4, p. 12, l. 74).

There are differentiated opinions on whether the tools received in CBT and MCT were helpful. Some felt that CBT exposure exercises and cognitive model were helpful, whereas others felt it was not helpful when they were in the actual situation. Lasse for instance felt that writing down thoughts could be draining, whereas Sara felt that exposure exercises were condescending. Furthermore, many could see the benefits of MCT and be aware of how much time they used worrying, however, putting the work into action was difficult for many.

5.2.2.3 Detached mindfulness

Some of the participants were introduced to detached mindfulness or talked about mindfulness in their MCT sessions. Many people debate whether mindfulness and MCT are separate entities or can be combined. Lasse compares MCT with mindfulness:

"The exercises were about making us aware of how our mind works, i.e how our thoughts work. We just have to close them if we get in a bad mood, just like with mindfulness, where you get peace of mind if you feel it going away. We had to do it for our minds and to make us aware of how our mind works and body works." (APP4, p. 12, l. 71).

Some of the techniques used in MCT are called detached mindfulness. In the next quote, it is evident that it can be confusing to differentiate between detached mindfulness and pure mindfulness. Sofie states the following:

> *"Yes, it was especially mindfulness that was debated a bit on the team. There I thought for a while, why? Why use time on it? That it should be something very special for itself. I think it works well in interaction with mindfulness. I think the 2 things play tremendously well together. So one has open*

mindfulness or if one is detached mindfully in metacognitive therapy." (APP2, p. 15, l. 114).

It can be interpreted that both Lasse and Sofie felt that mindfulness is helpful, but how they feel it helps and their definition of it could be different. Sara, on the other hand, didn't like the mindfulness practices she was introduced to in her sessions:

"When they had to be presented to us for some mindfulness there I could also just feel, it was not for me at all. It amazes me that they did not also put more emphasis on it, but mindfulness does not have to be about clearing your mind. This is something I have a hard time with and it is terrible if you are told that it is important to be able to empty your mind. If you can not do it yourself then you feel very wrong, but I think I have instead found that I can achieve a form of mindfulness when I do something, for example, something creative or something where I do something active, especially with my hands and where I can concentrate, but not where I watch a movie or something […]. It can also be going for a walk in the woods, but I remember that they introduced mindfulness as this huge thing and there I can remember that there I was enormously disappointed that it did not work for me with lying and relaxing and emptying your mind of thought. That I cannot do." (APP3, p. 2, l. 9).

Sara's statements show that for her mindfulness can be many things such as going for a walk or doing something creative where you don't actively use your mind or think much. For Lasse and Sofie mindfulness was also introduced in their sessions for Lasse it was perhaps detached mindfulness and for Sofie, it made sense to combine both.

Overall it can be concluded that all of the participants got some tools from both CBT and MCT. Whether they were useful and happy with them is debatable. Sara was overall disappointed with the tools she received in her CBT sessions and Lea with MCT. Lasse wasn't totally against CBT methods. He liked the exposure exercises but

felt that registering thoughts all the time could be draining and therefore MCT was more beneficial for him. However, he didn't use all the tools he received in MCT since some could be harder to use in practice. Meera was pleased with her CBT sessions, but this could also be explained by the relationship that was between her and her psychologist, which will be elaborated down below.

5.3 The relationship between the psychologist and the client

The third main theme is related to the relationship between the psychologist and the client. This theme is divided into four sub-themes. The themes are; Humor & chemistry, age, skill and distant & professional.

5.3.1 Humor & Chemistry

The majority of the clients when asked about their relationship with their psychologist, regardless of therapeutic approach, mention humor or being able to joke with their therapist.

> Sofie mentions that her relationship with the two psychologists was based on familiarity and humor (APP2, p.4, l. 24).

Lasse states that he shares similar humor with his psychologist and felt that they got along well with one another.

> *"Yes. The feeling that one felt that he was struggling in some way. He turned out like that. If I shared with him some things then he knew a little bit of my*

humor and I knew a little bit of his humor and such. I felt like we were on good standings with each other". (APP4, p.3, l. 22).

Meera mentions that her therapist is funny and that he laughs at her jokes (*APP6, p.3, l. 22-24)*. Additionally, it could be argued that Meera puts a stronger emphasis on the relationship between her and the psychologist than the specific tools and methods used in the session.

Based on this it could be interpreted that humor is an essential factor in building a good relationship between psychologist and client. Additionally, two of the participants emphasize the importance of having chemistry with their therapist. Lea states it in the following quote:

"[...] I do not know if it is something you classically run into that if there is no chemistry between the client and the psychologist then it can be difficult to (pause) Well it is a declaration of trust when you sit and give out your soul in that way [...]". (APP5, p.8, l. 43).

It could be argued that many of the participants believe that humor and chemistry are important elements in a good and trusting client-psychologist relationship.

5.3.2 Age

4 out of 6 clients mentioned the psychologists' age regardless of therapeutic orientation. Sofie and Tina mentioned that their first impression of their psychologist was that he/she was very young, making them skeptical as to whether he/she had enough experience to help them, which is evident in the following:

"Now, it's not because there's anything wrong with being a recent graduate, but I kind of thought he was pretty young. It turns out that it did not matter. He had to teach us a method and he could easily do that. That's probably my

first thought, he probably knows if he has enough experience of talking to people so that we can learn it right or something like that. But it has become so really quickly disproved since. Otherwise, I do not think I thought so much about it, other than that I could feel that he was in control of it". (APP1, p.6, l. 48).

However, Meera on the other hand mentioned it in the context of the client being more relatable:

"He was also young which I also felt made it maybe a little more relatable." (APP6, p.3, l. 22).

Lastly, Sara mentions that her therapist was old and had a very old fashioned set-up in her room *(APP3, p.4, l. 19)*. This was part of the reason why she canceled her therapy session with this specific psychologist.

5.3.3 Skill

All of the clients in MCT pointed out that their psychologist was skilled and good at their job.

Lea states the following:

"She was really good. Well, very sympathetic and very compassionate but at the same time also very professional and driven for this 12-man team, and she ran it very well. I think she was good at taking care of people and taking individual considerations into account ". (APP5, p.8, l. 41).

Similarly, Sara states the following:

"She (pause) actually was a very ordinary psychologist. I do not know what to say. I think she was talented. It was not like she stood out in any way, she

was actually very […] she tries and gets everyone involved she put a lot of effort into us to define (pause) so she did not come up with the answers herself." (APP3, p.19, l. 106).

The majority of the clients emphasize their psychologist's abilities. This leads us to the following section, where most of the clients describe their psychologist as distant and professional.

5.3.4 Distant & professional

Another sub-theme that became apparent for the clients was that many of the clients expressed they felt the relationship with their psychologist was distant and professional.

Tina states the following

"I would say it was not a very close relationship, that is because I did not talk to him on a personal level at any point. Yes, I do not know what to call it, it was very professional, so such a teacher-student relationship" (APP1, p.6, l. 50).

Similarly to Tina, Sofie points out that her relationship did not become close to the psychologist, however, she argues that this is due to it being a group therapy *(APP2, p.13, l. 104).*

According to Lasse's observations, the distance is because, in MCT, you do not address your specific problems but instead focus on overthinking, therefore the psychologist was unaware of the specific problems that were going on in the client's life.

"It is much more distant than it is in cognitive therapy. It's because you do not relate to people's problems, but you think that everything is overthinking,

so we did not tell the psychologist about our problems. We got some tools right away and the relationship was more distant. She gave some practical exercises, but she did not know what we were missing. It was not so individual; you have to do such and such to move forward in your life. It was a very very overall consideration in the metacognitive." (APP4, p.10, l. 65).

It could be interpreted that the focus is on the specific methods more than on building a relationship between the client and psychologist.

Moreover, Sara states that it was distant because the therapy sessions were manualized:

"She then had an organized course she had to go through. [...] it was maybe a little bit impersonal if you can say it that way, but it may also be just because when you know it is from such a known organization, one has a feeling that everyone is going through the same process and why should they not go through it. It's not because it's a problem but I just think she had a course and of course, she also focused on our problems so I think she did the job really well. They could run the course for everyone. So yeah I do not know what to say. So I think she was good and she was really nice and you were comfortable in her company and yes I think she solved the task." (APP3, p.19, l. 106).

Due to this distance between the psychologist and client, some of the clients expressed that they did not build a relationship built on trust. This becomes evident in the following when Lasse follows up his comments about the psychologist:

"But no I did not feel that I had a relationship of trust with her in that way." (APP4, p.14, l.79).

However, it could be argued that those describing the psychologist as distanced, cold etc. could be due to the differences between group & individual therapy which will be elaborated in the following text.

5.4 Group therapy vs. Individual therapy

The main theme of group therapy vs. individual therapy touches upon the clients' experience with the two types of therapy. This theme is divided into the following sub-themes: Teacher-student relationship, manualized vs. flexible and the others in the group.

5.4.1 Teacher-student relationship

All of the clients in MCT received group therapy, two of them describe it as a teacher-student relationship.

> *" [...] Yes, I do not know what you call it, it was very professional, so such a teacher-student relationship [...]" (APP1, p.6, l.50).*

Another participant describes the client-psychologist relationship as what could be considered a student-teacher relationship when addressing her thoughts on group therapy:

> *"[...] So I think maybe both in this and the other group therapy it does not become as close. The relationship with the psychologist becomes much closer, I think, when it's one to one independent of whether they have been (pause) when I think back on the psychologist I had CBT with or the psychologist I have psychodynamic with now, it becomes much closer, when it is individual than when it is in the group. [...] I had a nice relationship, it becomes more like a teacher-student relationship when it's a group[…] " (APP2, p.13, l. 104).*

Moreover, another difference between group- and individual therapy is how flexible the therapy sessions are.

5.4.2 Manaulized vs. Flexible

Both clients in CBT and MCT expressed concerns with group therapy being too manualized. One of the participants (Sofie) explains it:

> *"It was one psychologist, yes. And then I kind of found out that I was going into 2 other psychologists and I had gotten much better with medication I remember. I might feel that the 2 psychologists I was with were a bit more rigid [.....] So I really liked her, the first psychologist that had screened me. The psychologists that had to do the treatment were more manualized and a bit box-like and I felt that they were more rigid." (APP2, p.2, l. 14).*

Moreover, Sofie mentions that in individual therapy she experienced that she had the flexibility to bring up issues that were important to her. This point is also true for Meera who only received individual therapy.

> *"But it was me who dictated things very much. From the initial talk, he had made some keywords or suggestions for things he thought were relevant to talk about. When I came into the session he asked do you want to talk about this today or if there was something else you would rather talk about [...] I had a lot to say about what I felt". (APP6, p.10, l. 92).*

Furthermore, the inflexibility in MCT could be seen as a result of the strategy in MCT, which requires you to use it alone without mixing it with other methods. However, Sofie prefers a method that is adapted to her needs. This is clear in Sofie's subsequent reflection.

"Yes, that was also what I was thinking. Now I had a group which was very method-based and now I needed exactly that which was individually adapted to me and which was very method flexible, where I then found her as I could see had been around different things and was a specialist in psychotherapy. But she was schooled psychodynamically, which of course includes flexibility. She is very flexible, yes, so that's what I'm going into now." (APP2, p.9, l. 65).

However, the participants also reported some pros to engage in group therapy which will be elaborated on in the following section.

5.4.3 The others in the group

Many of the clients pointed out that there were some benefits to being in group therapy. Such as the ability to learn from one another, one participant mentions the following:

"[...] Yes I probably remember in particular that I felt we were together about it in that group. Together we should get better [...] we should lift each other. [...]"(APP2, p.6, l. 40).

Sara, on the other hand, felt very different from the other members of her group and hence did not have the same sense of relating to them.

"As I said before, I stood out a little bit in that the others were a little anxious about people in general and especially large numbers of people and getting out to places. I was quite the opposite. I liked walking around the city with a lot of people or being among a lot of people."(APP3, p.5-6, l. 23).

Similarly to Sara, Lea also experienced being the odd one out in her group therapy.

"[...] At the same time, I could see that most of the participants on the team were very nice people, it must be said that they were enormously committed and people paid many thousands of crones to sit there. I could feel that they faced some other challenges than the ones I faced […] " (APP5, p.3, l. 12).

Despite feeling different from the other members of the group, Sara and Lea were both pleased about group therapy and felt a sense of belonging and community.

"I was really happy with the group therapy because there was a cohesion with the others on the team and because we were not so many and because people told us why they were there so people exposed themselves and there was some community". (APP5, pp. 3-4, l. 14).

Moreover, clients in CBT and MCT had mixed feelings regarding group therapy focusing on individual problems. Tina, for example, expressed her delight that they concentrated on how to manage their thoughts rather than the specific issues that each person faced because how to manage thoughts was relevant to everyone.

"In group therapy, it is probably what I prefer, otherwise you spend 90% of the time on something you may not be able to use yourself. Yes, I actually think it was very nice that there was a focus on action." (APP1, p.6, l. 46).

In general, clients in CBT and MCT indicated benefits and drawbacks to group- and individual therapy. A benefit of group therapy is that you feel like you belong and can learn from your fellow participants, however, a disadvantage is that it is quite structured and you don't have the same close relationship with the psychologist as you would in individual therapy. Moreover, another theme that emerged from our interviews is "view on therapy" which will be covered in the following section.

5.5 View on therapy

All our 6 participants had an opinion on the received therapy given to them. Sara, Lasse, Tina & Sofie who had experienced both MCT and CBT felt that MCT had changed their way of thinking. However, Sofie didn't prefer one therapy form over the other. Meera had only received CBT and Lea had received MCT and other therapy forms earlier. This section is divided into three subthemes: Expectations, improvement & development and lastly change.

5.5.1 Expectations

Lea's first experience with therapy didn't go so well which she suggested is due to expectation of her psychologist could help her change her personality:

> *"Maybe it was also because I went into it with the expectation that I would like to change my personality. I was very shy and very introverted. It was my last year of high school at the time and I did not say anything in class. I wanted to make myself more not extroverted but outgoing and the psychologist could not fix that funny enough (laughs). […] So I actually went from there a little disappointed" (APP5, p. 1, l. 4).*

It is evident that Lea expected her psychologist to change her as a person and her laughing also shows that she perhaps knows that this is not what the psychologist could help her with.

Sofie had positive expectations of her first experience with CBT:

> *"Yes, but my expectations were that I was excited about whether it was something that could help me. I thought it was exciting to try a pure form of therapy and that it should be evidence-based. Yes, I had high expectations*

that it would be good […] that when it is something they offer in psychiatry then it must be a good offer and specialized" (APP2, p. 1, l. 8).

Sofie states that she expected her therapy to be good since it was offered in psychiatry, and was tailored toward her problems. It also seems like she has expectations about the therapy method since she states it should be evidence-based.

Sara also shares a similar experience. She had always a belief in authorities. Before she received MCT, she had a lot of experience receiving therapy in the public sector and has had good experiences:

"I have always believed that what I had been suggested was probably going to be good. I have a huge belief in authority so if there is a doctor who says this is good, then I believe in it and I will do it [..]. So when my parents said now we go to the doctor and when the doctor said now we refer you to a psychologist, then I just followed along" (APP3, p. 3, l. 13).

Meera, on the other hand, states that going to therapy can be stigmatized and that she had prior beliefs that you should have a specific issue to go to therapy. However, later she felt that if she thinks it could help her then she just decided to do it:

"Before, for example, I had the belief that if you were going to therapy then there should be something wrong (pause) or not that there should be something wrong, but I feel there should be an episode or something […]. I do not think I have had anything against it before but now I think if it could help me then I should just have done it. I feel that it can sometimes be a bit stigmatized, just therapy in general, but I do not feel that I had the belief that it was bad. I just think I thought that if it helps me then I should do it of course. I think I have often considered doing it too, but I have just not gotten myself into it before" (APP6, p. 1, l. 8).

Tina also had positive expectations for both MCT and CBT.

> *"Yes, I have had a great deal of openness to the fact that if you need to talk about some things, then it can be nice that there is someone from the outside you can turn to with things." (APP1, p. 1, l. 6).*

In general, it can be interpreted that the majority of the participants had positive expectations of therapy and therefore were receptive to receiving it, however, some felt it was a bit stigmatized and one expected therapy to change her personality. With MCT, Tina had heard about it through her friends and had also read about it and felt that it sounded reasonable for her overthinking problems (APP1, p. 2, l. 12).

Lasse on the other hand didn't have any expectations for CBT since he had not tried it before. However, after receiving CBT and had tried that he wanted to try something else:

> *"My view was quite positive at the time. Because I remember I read an article where it states the percentage of people who come out of this anxiety disorder or* stress *disorder. Then I also read books about it and thought it was good. 2 years after reading the book, I began to get problems with my anxiety again and I had no doubt that I should try MCT. Now I had tried the cognitive quite a few times and to use all these papers and written down so much, I was not so happy about it. So, this is what I was going to try." (APP4, p. 10, l. 63).*

While Lasse was sold on the way the MCT clinic stated how many people they got out of their disorder, Sofie felt that it sounded like an advertisement:

> *"I did not have such high expectations to start with, so I could see, well but it is something new so I became a little skeptical. It sounded a bit American, the way they try to sell another product "here it can heal everyone". Something was striking in the wording where I thought it sounded a bit like a sales ad.*

But, I thought, I'll give it a shot anyway. I thought if nothing else then yes, it's exciting to hear something and learn something new I think." (APP2, p. 11, l. 85).

Overall, most of the participants had an open mind and positive expectations of the therapy they were going to receive. Some had their early experiences as a teen with their parents going to the doctors with them while others took initiative on their own and contacted a psychologist. Some were a bit skeptical but no one went there with negative expectations. Throughout the process, many felt they improved and developed, which leads to the next sub-theme.

5.5.2 Improvement and development

Sara had received both MCT and CBT, but feels that MCT had helped more with her thinking:

"I think I actively use it when I feel very bad, so I remember quicker and think in these ways. The thing about refocusing and just thinking about what I'm doing right now in my head, it's very much about just getting myself caught up in it (APP3, p. l. 134)".

Here it becomes evident that Sara becomes more aware of her thoughts and stops herself when she catches herself overthinking.

When Lasse was asked whether he would reach out to his psychologist again following was stated:x4

"Yes, I will, but then it will probably be metacognitive that I will use. I think I've gone away from cognitive. It will be metacognitive and where I might think there is something that needs to be refreshed if I am stuck in some old habits. I can experience these random worries and people can also see it in

me sometimes. But I think I act differently in terms of acting more and not as stuck and bedridden as I was when I received cognitive or before" (APP4, p. 18, l. 99).

Lasse, Tina and Sara actively use MCT when they are challenged with their thoughts and they know how to handle it better now. Tina compares it to taking a driving license, where you need to practice it to learn it thoroughly (APP1, p. 4, l. 29). Similarly, Sara also feels MCT has helped but says that it is a constant process:

"It is still very hard and it may take several years before I get to the end of it because once you get used to it and the psychologist also said we have just spent many years doing it one way now we are suddenly going to do it another way. It is of course very difficult" (APP4, p. 13, l. 75).

Even though MCT has helped with their thought processes it is not always an easy process and it requires a whole new way of adaptation.

Lea didn't have a positive experience with MCT, but still feels she has improved in some aspects:

"It's hard to say, I'll probably become more aware of it at least and I also experience that I at least stop and think shut up you are really thinking right now. That I'm not that good at breaking it, that's another thing. In any case, I have become more aware that this is what is going on and what is stressing me. So a step in the right direction, but it could also be that I will move on at some point" (APP5, p. 6, l. 28).

Sofie who had experienced both MCT and CBT also felt that MCT gave an insight into her thoughts.

> *"Well, it has given me a different way of thinking about thoughts. So yes, I think it has been very interesting and educational and given me another way of having an awareness of my thoughts, well I can stop pondering and say no, however, I cannot prevent panic attacks and that makes it more difficult. But I can choose how long I want to spend pondering and ruminating over something… that is possible for me" (APP2, p. 17, l. 132).*

Even though MCT hasn't helped immensely with Sofie's panic attacks she has become more aware of her thoughts. Furthermore, she doesn't feel that one form of therapy is better than the other. She states the following:

> *"[...] Know that there are other ways of doing things and some things help for someone, but one should not feel like a failed person because one form of therapy does not exactly benefit one. One must know that then there is something else that can help you. One should not think that metacognitive therapy is the end station, that if this does not help then you might as well give up. And it doesn't have to be evidence-based for it to work for the individual, because all people are very different and very complex beings. That is my advice and there is something to be gained from all forms of therapy [...]" (APP2, p. 19, l. 140).*

Sofie's point of statement emphasizes that even though she has tried many different forms of therapy one is necessarily not better than the other and she changed her opinion on whether the therapy should be evidence-based. She states that you should be wary of a method that says that it can fix everything. She is one of the participants who feels that MCT has made her more aware of her thoughts, but it hasn't been the therapy form that has helped her the most in its pure form. Talking about her childhood and getting to the root of the problems and having a psychologist who can adapt to her needs without sticking with only one therapy form has helped her.

Meera, who had only experienced CBT stated the following:

> *"I feel like you see things a little more objectively through a third person's point of view […]. But in general, it's a good way to look at things objectively and get some tools that I might not even think about. Not because I feel like it's the inventing wheel or out of this world no, but it's not something you wouldn't think about, yes" (APP6, p. 6, l. 58).*

For Meera, therapy helped her to see things differently and it is not the same as asking a friend for advice since you look at it more objectively (APP2, p. 6, l. 58).

However, Sara who also had received CBT has a different opinion:

> *"It was okay, but I felt I did not get that much out of it where I thought that now I have had a life-changing situation. It was probably not the best therapy session I received. I'm glad I did it and it has helped on some things as I said, but since then I have not reflected on it other than that I always thought that cognitive therapy was probably not the right one for me. It's not something I would seek out again because I did not have the experience that it helped me so much" (APP3, p. 28, l. 155).*

Sara's experience shows us that CBT didn't work for her.

Lea who received MCT wasn't pleased with her experience either:

> *"It probably worked for a lot of people, it worked for her (the psychologist), but it just did not work for me and I do not understand how to use those tools. I do not understand what it is that happens from the point the psychologist says you should stop thinking about your thoughts, you should stop going into it. I do not understand the concept, not to go into your thoughts. The more they repeated it the more I thought, I do not understand" (APP5, p. 6, l. 26).*

It is evident that even though MCT worked for many, it didn't have the same effect on Lea and Sofie as it did on Tina, Sara and Lasse. They became more aware of their thoughts and overthinking, but it couldn't be a method that would always fit their problem at hand.

Overall it is evident that a lot of our participants have developed their way of thinking some more than others. This can also be related to change, which will be the next sub-theme that will be elaborated on:

5.5.3 Change

Several of our participants experienced some change after they received therapy. Some felt that they became more aware of their thoughts, while others had a more positive outlook on things. Some also began to change their actions:

Meera states the following:

> *"After this process, I have taken time with the doctor, for example, so I do not know if it is a reflection. But I went to the doctor to see if I could be diagnosed with ADHD [..] The doctor didn't feel that I had it, but I think it pushed me to do things that I might have always intended to do [...] something I might not have just done if it were not for this" (APP6, p. 9, l. 83).*

Meera had always thought or imagined about taking action, but after she had gone to a psychologist, she became more action orientated.

Tina states the following:

"For example, if I was thinking negatively about someone at work or something like that, then maybe I could ponder why I felt that way about that person and what I could do about it. What is said about me and it goes a lot into something like that. Now I am probably more like that thought is there, but then I just think of something else" (APP1, p. 5, l. 33).

Tina has also changed after receiving therapy where there is a clear distinction between how she used to think and how she thinks now. Similarly, Lasse also feels that MCT helps him on his off days too:

"It is nice that you have some exercises where you do not have to use your thoughts every time but that you just learn that thoughts are something that is there for a short time. If there are some days you are completely down then say that if I just do this little thing then I have done a little. Then you act and then the thought may go away and then you can have even more and do even more. Metacognitive therapy has given me the greatest thoughts afterwards and given me the most benefit" (APP4, p. 18, l. 97).

Sara also sees a change in her way of thinking:

"I can feel that it is healthy for me and change the way I go to my problems and before I was digging and attacking myself into this problem, where I am now trying to teach myself to think okay, what do I get out of digging that hole. I want to try to go past the hole" (APP3, p. 23, l. 120).

Meera also states that after receiving therapy one of the key points she learned was that she needs to be happy in whatever she is doing. Furthermore, Meera adds that her general thought process has become more positive after receiving CBT (APP6, p. 5, l. 46).

However, not all participants felt they had changed for the better after therapy. Lea didn't feel that she changed for the better after therapy and felt disappointed:

> *"I went in with an expectation that yes maybe I actually went into it with the same expectation as I did 20 years ago [...] that I should be a better person or more relaxed person. So when you do not come out of such a process differently, I think that was what disappointed me" (APP5, p. 2, l. 8).*

The majority of participants felt they had changed after they had received therapy. However, Lea stands out a little since she doesn't feel that she has experienced a huge change.

5.6 Analysis conclusion

Overall, it can be concluded that the majority of the participants had positive expectations of the therapy they were going to receive. However, one participant felt that the psychologist couldn't change her personality. Furthermore, many developed their thought processes through the therapy they received. One felt that they became more positive after receiving CBT whereas another participant from MCT felt they were better at shifting their focus on other thoughts. Lea however didn't feel she experienced any change after receiving MCT and Lasse felt that MCT worked better than CBT. However with MCT, many agree that it is a constant process and never-ending learning experience since it requires a new way of adapting to your thoughts than what they are used to. Furthermore, it can be argued that clients develop a better understanding of their mental issues with MCT and CBT. Their perspectives however differ. Rumination, analogies, and letting go of one's thoughts are all reported by MCT clients. Clients in CBT report that learning more about their problems is helpful and that it challenges their unrealistic beliefs. Clients in both

MCT and CBT, however, experienced some issues. Some participants found it difficult to understand how to act on what they were taught in MCT. Others found it difficult to internalize the reasons given in CBT.

Furthermore, the methods and tools received by our participants in CBT and MCT have been beneficial for many, some more than others. In CBT tools such as exposure exercises, cognitive restructuring of thoughts and the cognitive model seem to have benefitted the majority where they learned how to challenge themselves and think and act differently. However, Lasse felt that registering thoughts all the time could be draining and some felt that exposure exercises such as hyperventilating on purpose didn't make sense. MCT has helped most of the participants to become more aware of how much time they spent on their thoughts through attention training techniques (ATT), visualization exercises, and detached mindfulness, which helped the clients comprehend their thoughts and attention in a new manner. However, not all the tools received in MCT were helpful. Many of the exercises were difficult for the participants to use in reality such as setting time aside to worry and not focusing on your problems.

Both CBT and MCT clients emphasized similar characteristics of their psychologist as essential for the client-psychologist relationship, such as humor and chemistry; the clients who showed the most positivity toward their psychologist all highlighted humor. Furthermore, clients put a high priority on their psychologist's abilities to deliver the specific therapeutic approach as well as their skills. Clients also stated that in both MCT and CBT, they felt that the psychologist was distant and that the relationship was not as close. The clients give several explanations for this, such as MCT not focusing on the individual's problem, as a result of which the bond will not be as close because the client is not vulnerable. As a result, it's possible to conclude that the MCT the clients received focuses less on the client-psychologist relationship and more on how to teach clients a skill. However, it's worth noting that the only time the client-psychologist relationship is labeled as distant is when they're working in the context of group therapy. Clients in CBT and MCT state that group- and

individual therapy have advantages and disadvantages. Group therapy has the advantage of making you feel like you belong and allowing you to learn from your peers; however, it has the downside of being very organized and not allowing you to have the same close contact with the psychologist as you would in individual therapy.

Now that the emerged themes in the interviews have been elaborated, the following sections seek to discuss these themes in relation to the selected theories and the literature in the field.

6. Discussion

In this section, there will be a discussion of the results of our analysis. The 5 themes are divided into different sub-themes. The following chronological order has been chosen: First, there will be a discussion of our participant's view on therapy which will be understood through Bandura's theory of self-efficacy and Rotter's theory about the locus of control. Moreover, there will be a discussion on the client-psychologist relationship described in our analysis in relation to the first pathway in The Contextual Model of psychotherapy and Rogers' client-centered therapy. Additionally, the second- and third pathways will be discussed in regard to the main theme: understanding of own mental issues. Furthermore, in the theme CBT & MCT - Method & Tools the discussion is focused on looking into specific tools and methods that characterize MCT and CBT. We would see whether our participants have experienced the typical standardized methods of CBT and MCT and we will try to understand their experience through Rogerian principles. Finally, we would seek to investigate whether our main findings support the existing literature about MCT and CBT. The following section will discuss the first main theme which is the client's view on therapy.

6.1 View on therapy

This section will elaborate on how our participants' view on therapy can be understood through self-efficacy and locus of control. We try to understand the 3 sub-themes; Expectations, improvement & development, and change through the two theoretical standpoints; Rotter's theory about Locus of control & Bandura's theory about self-efficacy. It is important to clarify that Rotters' Locus of control theory and Bandura's self-efficacy theory is one of the many ways to understand our clients' experience. We are well aware of the fact that the theories cannot stand alone in explaining their behavior and many other factors can affect the way our clients behave.

6.1.1 Expectations

6.1.1.1 Locus of control & Self-efficacy

Lea's first experience with therapy didn't go so well due to expectations that her psychologist could help her change her personality. This could be understood by Rotter's theory about locus of control. We could assume that Lea has an external locus of control since she blames her experience on external factors instead of taking charge of her situation. Lea perhaps expected that therapy should be ground-breaking and that her psychologist should have assisted her in making her more outgoing. Sara always had the belief that authorities were good at what they were doing and expected CBT to help her but ended up being disappointed. When Sara received CBT she was very young and wanted to take any form of help possible, however, when she received MCT she was more mature and was in a different stage in her life

(APP3, p. 15, l. 143). It can be interpreted that Sara's locus of control has changed since she has grown more. She states that her mental health issue hasn't been the same for CBT and MCT. As Lefcourt (1976) found out, internals may have better therapy outcomes because they are perhaps healthier to begin with, where it can be assumed that Sara had more of an external locus of control when she received CBT and an internal locus of control when she received MCT resulting in better therapy outcomes for MCT than CBT for Sara. Meera also didn't have highly concerning mental health issues and could be considered somewhat healthy when she received CBT. Therefore it can be interpreted that she has an internal locus of control which perhaps resulted in a positive therapy outcome (Balch & Ross, 1975; Jessness & DeRisi, 1973). Sofie also had positive expectations of CBT and had a mixed experience. She felt that medications took the root of the problem and CBT helped a little afterward. Whether Sofie is external or internal can be difficult to interpret since she doesn't necessarily state that one therapy form is better than the other or puts the blame on one therapy form. She went with the expectation that MCT could heal her problems but ended up being disappointed. However, after trying different therapy methods she later realized that one shouldn't necessarily feel like a failure if one therapy method doesn't work since she now knows how to include the things that work and omits the things that don't work. Perhaps with increased knowledge and growth Sara now has more of an internal locus of control where she has taken ownership of her situation and found out what works for her. On the other hand, the degree to which the therapist structures and directs the process of therapy can be an important mediating factor in the locus of control-therapy outcome relationship and therefore other factors in the relationship could also have affected the outcome for our participants (Baker, 1979).

6.1.1.2 Improvement & development

Lasse, Tina, and Sara actively use MCT when they are challenged with their thoughts, which they report lead to improvement and development. Furthermore, Meera also feels that her thought process has become more positive after receiving

CBT. It is not just exposure to stimulation that matters, but the actor's action in influencing the environment that affects self-efficacy. Individuals with higher self-efficacy have more confidence in their abilities and are thus more inclined to engage in beneficial habits. Even though CBT is more action-based than MCT, all our participants actively needed to do something whether it is to shift their focus to something else or rewrite their thoughts. It can therefore be interpreted that if the participants felt that the therapy they received could be beneficial for them it increased their belief in their abilities to implement the methods in their real-life situations. For the participants who received both MCT and CBT, it could be inferred that they preferred one therapy form over the other because of the belief they had on whether the therapy form made sense or not (Outcome-expectancy). If a participant felt that the therapy they received didn't make sense (Low outcome-expectancy) it didn't help with their self-efficacy since they didn't believe in it in the first place which perhaps led to poor therapy outcomes. Therefore it could be interpreted that Lea has a low self-efficacy and low outcome-expectancy since she perhaps put more responsibility on the specific therapy form to change her life than her ability to change her situation. However, on the other hand, it could also be argued that perhaps MCT didn't work for her despite her self-efficacy. Sara, Tina, and Lasse preferred MCT over CBT, which could explain that they all had a high self-efficacy since they actively use the methods in their daily life, but their outcome-expectancy differed depending on the therapy form received. It is evident that even though MCT worked for many, it didn't have the same effect on Lea and Sofie as it did on Tina, Sara, and Lasse. This could be explained by the fact that Lea and Sofie had lower outcome-expectancy compared to the rest since CBT and MCT didn't always make sense for them. They became more aware of their thoughts and overthinking, but it couldn't be the only method that would help solve the problem at hand. However, whether our participants' outcome-expectancy affected their self-efficacy or vice versa is still up for discussion and difficult to say since we didn't measure it. However, both could perhaps affect each other in some way. If Sara had a high self-efficacy, to begin with, but didn't feel like CBT fit her needs then she would still have been able to apply the tools but didn't feel the need for it since she didn't prefer

it. So it could also be interpreted that she had a high self-efficacy but a low outcome-expectancy. Moreover, the following section will elaborate on sub-theme change.

6.1.1.3 Change

It can be inferred that the majority of our participants have increased their self-efficacy after receiving therapy since many of our participants experienced change after receiving therapy. Meera's self-efficacy perhaps increased after receiving therapy since she took the initiative to make a doctor's appointment to check if she had ADHD, something she didn't do before therapy. Lasse also believes that he has the ability to tell himself that if he just makes small improvements then he is a step away from doing more, which shows that perhaps his perceived capability to perform certain behaviors has increased. However, it could be argued that this was not the case with Lea and therefore her low self-efficacy and low-outcome expectancy could have affected her behavior and perceived experience. Furthermore, a client's perception of agreement about how and why therapy is carried out influences change during treatment, and since Lea felt her issue was different from the majority in her group it was perhaps difficult for her to agree to the purpose of the exercises leading to no change for her (Luong, Drummond & Norton, 2022). Furthermore, determining whether our participants had low or high self-efficacy, to begin with, is hard to determine since we didn't measure it quantitatively. However, through their improvement and development, we can make assumptions on whether they had a low or high self-efficacy, which made them put more effort into achieving their goals and persist longer in the face of barriers.

Overall, it can be concluded that we cannot with certainty state whether our participants had high or low self-efficacy. However, based on their statements we can infer that some of our participants were perhaps more receptive to receiving therapy if they had a positive out-come expectancy leading them to have a higher

self-efficacy. On the other hand, participants could also have a high self-efficacy, but due to their low outcome-expectancy they didn't have the belief that they were able to change themselves which could lead to a decrease in their self-efficacy. It can be interpreted that Meera, Sara, Tina, and Lasse had a higher outcome-expectancy and higher self-efficacy than Lea and Sofie since they were able to apply the tools more in practice compared to Lea and Sofie. However, this doesn't necessarily mean Lea and Sofie had a low self-efficacy but they could just have had a lower outcome-expectancy. However, Sofie on the other hand found out that it isn't one therapy method that works for her but multiple so it is harder to interpret whether she had a low outcome expectancy or not. Moreover, another element that could affect our client's experience of therapy could be the relationship between the client and psychologist.

6.2 The relationship between client and psychologist

This sub-discussion will largely relate to the third theme in our analysis: The relationship between client and psychologist since it was a relevant topic for all informants. Moreover, this topic is related to common therapeutic factors, and as stated earlier, previous qualitative studies indicate that common therapeutic factors are more important than specific factors, for that reason, it's important to include this hypothesis in our discussion.

6.2.1 Common therapeutic factors and specific factors

Based on our IPA analysis of the six clients it was evident that common therapeutic factors and specific factors were present in their experiences with MCT and CBT. However, it could be argued that a greater emphasis is put on specific factors which are particularly evident for MCT clients. When describing their experiences and what they found the most beneficial it is consistent with the specific therapeutic method

that they received. For instance, a CBT participant when asked about what she found most beneficial points towards the techniques used (APP3, p.9, l. 35). MCT clients pointed towards gaining an awareness of their thoughts, and the tools and methods they could use moving forward. The findings in the current study do support the findings in the qualitative study conducted on individuals' experience with MCT & CBT by Straarup & Poulsen (2015), where clients put focus on the specific tools and methods of the therapeutic approach they received. Moreover, it is also in line with qualitative studies done on clients' experience of CBT, where it has been found that clients mentioned specific techniques of CBT more frequently. Additionally, according to the literature on CBT and MCT, it is the cognitive changes that account for the benefits of the therapy. As stated in the literature review, it is apparent that clients in CBT emphasize specific techniques as more important compared to clients in other therapeutic approaches such as psychodynamic therapy (PDT) (Nillson, Svensson, Sandell & Clinton, 2006).

6.2.1.1 First pathway from the Contextual Model of Psychotherapy

However, the findings in this study do not align with the previous qualitative studies that investigated different therapeutic approaches (Wampold & Imel, 2015). The findings in those studies were that common therapeutic factors accounted for most outcomes in therapy. This section seeks to understand the clients' experience with therapy through The Contextual Model of psychotherapy.

According to the contextual model, an initial bond between therapist and client must be built since a deeper level of trust and attachment is needed in this sort of relationship. In our analysis, we found that the majority of the clients' commented on the physical aspects of the therapy room and shared their initial judgments on the psychologist, some sharing that the age of the psychologist made an impact on whether they thought he/she could help them. Moreover, the expectations the clients shared were mostly positive which is in line with the theoretical foundation that The

Contextual Model is built on, which is that most individuals have a positive orientation towards healing.

The first pathway in this theoretical model refers to the real relationship. The model suggests the stronger the real relationship, the better the outcome of therapy and thus is an essential part of therapy. However, the findings in our study, especially with MCT clients, found that the clients described their relationship as distant and professional where each client's problems were not discussed, which is quite the opposite of the trusting and vulnerable relationship that the real relationship is referring to. This is especially evident when Lasse mentions that he has not built trust with the MCT psychologist and many of the participants described the MCT sessions as manualized and impersonal. Despite this, the majority of the MCT clients were satisfied with their session and felt that it had helped them with their issues.

6.2.1.2 Teacher-student relationship

Moreover, it could be that the reason why there is a lack of a real relationship is that it is group therapy. Many of the clients describe it as being a distant relationship and that it resembles a teacher-student relationship, where they are there to learn. This could explain why they put more emphasis on the psychologists' capabilities and skills. They do not know much about their psychologist's personal life and neither does the psychologist know about theirs making the relationship distant and cold. Perhaps, if the clients in MCT received individual therapy our findings would have shown a stronger emphasis on the client-psychologist relationship. However, much like a classroom, the alliance is built between the participants in group therapy. Despite this, it could be argued that since the clients are in group therapy they are gaining some of the benefits of the real relationship since they gain a sense of belongingness with the group and a sense of community with the others in the group. The sense of group cohesion and self-exposure among the group all contribute to common factors in a group setting. This is in line with the article by Christensen et al. (2021), where group cohesion and other group-related processes were found to be

important for CBT clients. Moreover, the interesting finding in our study is that the two participants Meera and Lasse put a stronger emphasis on the client-psychologist relationship more than the other participants who both received individual therapy, so it could be argued that whether the participants received group- or individual therapy has played a key factor in their description of the client-psychologist relationship. However, there are some common factors that 3 of the participants put a strong emphasis on, which were humor and being able to joke with their psychologist, this shows a level of comfortability with the psychologist.

6.2.1.3 Client-centered therapy

Furthermore, another perspective is that the real relationship is not as important in CBT and MCT as it is in other therapeutic orientations such as Rogers' theory on client-centered therapy. According to Rogers' it is important that therapy is conducted in a supportive environment with a close relationship between the client and the psychologist. It could be argued that for Meera she experienced more of client-centered therapy, since she for instance had a more of a directive role in the sessions. Whereas the clients in MCT the psychologist had the role of administering the therapy with a direct interaction with the clients where they were taught a skill. However, this could be due to the theoretical background behind CBT and MCT where the therapy is more goal-oriented. The findings in our analysis suggest that Rogers' six conditions for therapy were not met for clients' in group therapy. The psychologists' were described as distant and professional which is the opposite of entering into the clients' world and understanding their world. It could be argued that MCT in general is in contrast with Rogers' ideas since in MCT the concrete problems of the individual's life are not important for therapy. Moreover, in CBT Sofie shares how a psychologist questioned her seeking help and was cold toward her, thus this psychologist did not share the facilitative attitude. Sofie compares this psychologist to another psychologist whom she described as being empathetic and who wanted to see the whole of her from all perspectives. Sofie was one of the participants that were not entirely satisfied with either CBT or MCT. This could

indicate that for her it is important to have a psychologist with a facilitative attitude rather than being taught a specific method. On the other hand, another participant mentions that when she was younger she sought attachment with the psychologist, however, as a 35-year-old woman she doesn't see the need for that and was fine with the teacher-student relationship in MCT. Overall our findings suggest that Rogers' six conditions are not a must for therapy to be beneficial, but rather it depends on the individual's need.

Overall, it can be concluded that clients' put more emphasis on specific ingredients than the real relationship. This finding is supported by literature on MCT and CBT. However, there is a discrepancy in the literature, and a majority of studies support that common therapeutic factors account for the majority of the outcome in psychotherapy. Our findings have been discussed in relation to The Contextual Model which is based on those studies (Wampold & Imel, 2015). This aligns with The Contextual Model in some aspects such as the initial bond and the positive expectations that individuals have for healing. However, our findings suggest that the real relationship and Rogers' six conditions do not have to be met before the clients are satisfied with their therapy. Additionally, our findings suggest that whether clients have experienced group therapy or individual therapy influences the emphasis they put on the client-psychologist relationship.

The following section will elaborate on the clients' understanding of their mental issues where the rest of The Contextual Model will be incorporated

6.3: Second and third pathways: Understanding of own mental issues

This sub-discussion will largely relate to the first theme in our analysis: Understanding our mental issues, this was a topic that clients in both CBT and MCT

could relate to. This will be discussed with the second and third pathways in the contextual model.

The participants expressed that prior to receiving therapy they had an explanation for their mental struggles. For instance, some of the participants explain how they believed that if they analyzed their thoughts that they would be able to solve their problems. However, through MCT they gained a better understanding of the cause of their mental issues which offered a solution for their problems. This finding is in support of the second pathway in The Contextual Model which states that if the clients believe the explanation given to them about their mental issues and receive therapy that matches that explanation it will influence the clients' belief as to whether or not completing the therapy will help them overcome their issues. It is evident that the explanation given to the majority of the clients makes sense to them and they strongly believe that the specific therapeutic method will help them overcome their problems. For instance, Sara stated that she had always believed that thinking a lot and analyzing events and situations was a good thing, however, shortly before receiving MCT she expressed how her brain had become her enemy (APP3, p. 17, l. 95). Through MCT therapy, she recognized that this act could be a trigger for her symptoms. When the client is in agreement with the explanation given by the psychologists, this will in turn increase their belief in themselves to overcome their problems. This belief in one's own capacity to overcome their problem is part of the second pathway in the model and is correlated with the positive outcome of therapy.

As stated previously, our data shows that the clients put more emphasis on the specific ingredients when sharing their experiences. The last pathway in The Contextual Model takes into account the specific ingredients in the therapeutic orientation. It states that if there is an agreement between the clients' understanding of their mental issue and the explanation and solution presented by the psychologist then they will also benefit from the specific ingredient present in the therapeutic method. This could also explain why the clients' put great emphasis on methods since both CBT and MCT put a strong emphasis on methods which is evident in the

clients' descriptions of their experiences with therapy. Additionally, our study has had the opportunity to explore our clients' comparison of their experience with CBT and MCT. For instance, Sara found that the specific ingredients of CBT were too childish for her, however, she found the techniques of MCT to be very helpful. Whereas, Sofie did not find the techniques of MCT helpful. So although the specific techniques for both CBT and MCT were health-promoting, they were not always helpful for the clients. It could be argued that, the same clients that did not meet the criteria for the second pathway: The same clients that did not agree on the therapy's goals and tasks, Sofie (MCT), Lea (MCT), Sara (CBT), are the same clients' that did not find all of the specific ingredients of the therapy method health-promoting. Thus, it could be argued that our findings can be understood from the perspective of the contextual model. The following section will look into the Methods & Tools of CBT & MCT.

6.4 CBT & MCT- Method & Tools

6.4.1 Thought record, exposure & cognitive model

This section is about understanding how the methods and tools affected our participants' experience in both CBT and MCT. CBT & MCT - Method and Tools are divided into the following subthemes: 1) Thought record, exposure and cognitive model, 2) CAS and detached mindfulness 3) Audio files, metaphoric language, and visualization.

Sofie, Lasse, and Meera received home assignments and cognitive tools they could use for their own situations. Through, Lasse and Meera's statements it becomes evident that their psychologists use exploration (determining one's idiosyncratic meaning system and maladaptive beliefs), examination (reviewing the evidence for and against a particular belief and considering alternative interpretations or

explanations), and experimentation (testing one's beliefs), which is used to help them consider the accuracy and usefulness of their thoughts. Training the patient to notice his unique cognitions or "automatic thoughts" is one of the most important cognitive strategies (Beck, 1963), which the majority of the participants that received CBT experienced. However, Lasse mentions that it was hard for him to register his thoughts. It could be interpreted that when your mental state isn't at your best it could be draining to actively do the work as expected with CBT as a method. Perhaps exposure worked better for Lasse since he didn't need to find a paper and begin to think about his thoughts but had to do something actively to change his situation. This could be as simple as keeping a compass to expose himself to his fear of needles, which could explain why he felt exposure was the most beneficial aspect for him in CBT. However, whether just having a compass by you is enough exposure could be debatable. With exposure exercises, habituation should take place and whether this was the case with our participants is questionable. This could also be one of the reasons why many who received both CBT and MCT preferred MCT since they perhaps didn't challenge themselves enough with exposure to see a change. Furthermore, Lasse and his CBT psychologist seemed to have used collaborative empiricism where they collaboratively tried to find, test, and alternate Lasse's beliefs. Through Lasse's statements, it becomes evident that he had good chemistry with his psychologist and it can therefore be interpreted that Lasse's psychologist also showed empathy, congruence, and positive regard. Lasse states that he felt that CBT helped momentarily, but he preferred MCT. The relationship he had with the MCT psychologist was more distanced and whether the psychologist met Roger's criteria is questionable.

The same can be said with Meera's experience in CBT where her psychologist through a guided discovery made Meera realize that her thoughts are assumptions but not a reality. Meera realized she became more open to asking her parents questions instead of assuming their opinions on things beforehand (APP6, p. 8, l.74). It could be interpreted that when Meera was encouraged to consider alternate explanations, she recognized that her earlier explanations were based on incorrect inferences,

leading her to consider various interpretations of events and therefore attaching diverse interpretations to events. Furthermore, Meera had a positive experience with using the cognitive model and it could be interpreted that changing her actions such as listening to podcasts changed her feelings about her feeling lonely, which shows that all of these factors are interconnected and have an impact on one another.

Many of the participants' psychologists in CBT employed cognitive rehearsal where they allow the participants to experience their fear by "living through" the experience. This was done through hyperventilating with participants who had anxiety. However, this was experienced differently by our participants. Sofie felt that it was helpful, however, she also was a bit ambivalent towards it since she had to force herself to hyperventilate and when she gets panic attacks the situation is different. Lea who received MCT also felt that she knew that in this particular situation hyperventilating isn't dangerous. It can be interpreted that some of the exercises can be easy to understand when you force yourself to do them, but when you naturally get a panic attack it is harder to use them. This could also be added to Sara's point of view, who felt that the exposure exercises were condescending. Furthermore, a CBT therapeutic style, combined with the characteristics of a good therapeutic relationship (trust, confidence in the therapist's understanding, demonstrated concern and empathy, ease of self-disclosure, assurance of confidentiality), creates the best therapeutic environment for fear and anxiety treatment, which wasn't evident in Sara's CBT experience.

Furthermore, Sofie is the only CBT participant who talks about safety behavior (APP2, p.5, l.32) To this day she still uses safety behavior since she feels that it doesn't harm her to have a water bottle by her side if she goes for a walk since it gives her ease. It could be interpreted that in CBT it is not always necessary or possible to eliminate safety behavior and for Sofie, she is aware of it but doesn't mind doing it because she feels it helps her.

Furthermore, it is relevant to see whether our findings are in alignment with the literature. The majority of the participants talked about automatic thoughts, exposure, cognitive model, and alternative thoughts, however, none of the participants who received CBT talked about core beliefs. Different levels of cognition exist within the cognitive system, ranging from surface-level concepts to "deeper" cognitive schemas. It can be interpreted that many of the psychologists stayed on the surface-level concept rather than going to the “deeper” cognitive schemas, which could explain why Sofie felt that they didn’t get to the root of the problem with her anxiety. This also supports several studies that state CBT patients indicated general dissatisfaction with their therapy because they believe it "didn't go deep enough" or merely "scratched the surface”. They found that the statement “getting to the root of things” was used by 73% of the satisfied PDT- patients, while none of the satisfied CBT patients used this metaphor. (Nilsson et al., 2006; Malkomsen et al, 2021). Furthermore, findings emphasize the necessity of putting the client's impression of the client-therapist connection first in CBT for anxiety disorders (Luong, Drummond & Norton, 2022) and this could perhaps explain why Lea and Sofie felt that their CBT sessions were manualized and didn’t necessarily fit all their needs. Meera, on the other hand, did not feel that she received a specific tool in CBT that she still utilizes, but she did get to the root of the problem in her CBT session. Her psychologist was able to talk about her cultural barriers and it can be interpreted that it was through guided discovery and challenging questions that Meera was pleased with her CBT sessions. Since Socratic questioning and guided discovery don’t require the client to do something active like exposure exercises it didn’t feel like a tool for Meera. However, Meera still felt it was hard to constantly think and be reflective. It can be inferred that Meera did have some aspects of a typical CBT session, such as recognizing the relationships between cognition, affect, and behavior, testing the validity of automatic thoughts, correcting biased conceptualizations by replacing distorted thoughts with more realistic thoughts, and identifying and altering beliefs, but it wasn't as goal-oriented as a typical CBT session.

On the other hand, it could also be a specific method that the psychologist used but it was more implicit and not explicit for Meera. This could also be due to the fact that Meera's problem was more diffuse and not as concrete as disorders such as anxiety or depression. As Rogers states most clients profit greatly from being listened to, understood, and accepted. Congruence, unconditional positive regard, and empathy are ways that the helper can use in the therapeutic partnership and it can be interpreted that Meera's psychologist succeeded in doing so by having an understanding of her cultural background but also accepted her wishes in the session instead of sticking to the agenda of his method. It can be interpreted that the methods that were most beneficial for our participants who received CBT were not the actual tools such as exposure or thought registration but more the way the psychologist had a facilitative attitude. This has been further discussed in specific and common factors. The following section will discuss MCT clients' experience with CAS.

6.4.2 CAS

It is evident that our participants who received MCT increased their knowledge about metacognitive concepts such as CAS. The purpose of metacognitive therapy is to phase out CAS in response to negative thoughts. This is achieved by helping the client to get a sense of control over CAS that the client has never been without. Through the participants' statements, they worked with CAS in therapy by challenging and weakening the client's incorrect metacognitive beliefs through exercises that demonstrate that their thoughts are in fact just thoughts. Once the participant realizes this, he or she becomes able to respond to his or her negative thoughts in ways that are far more appropriate than CAS. However, it can be interpreted that for Sofie just getting control over CAS couldn't solve her panic attacks, because why did medication work for her if CAS was the only explanation for her mental disorder. This also supports a statement from a client in Malkomsen et

al (2021)’s study who felt that the medicine "took the edge off”. It can therefore be discussed whether therapy alone is helpful or if sometimes medication is also needed.

On the other hand, it can be interpreted that the participants who received MCT got a thorough knowledge of CAS. All the participants mentioned how they became more aware of their thoughts and how much time they used on ruminating and worrying. Many of our participants had positive metacognitive beliefs where Sara for instance used to think that you could ruminate yourself to answers and solutions, but later found out it didn’t benefit her (APP3, p. 23, l. 124). The same goes for the other MCT participants, many of them have realized how much time they used on CAS strategies such as rumination and worrying and how it hasn’t benefited them at all. So the tools the participants got from MCT differs from CBT in that it isn’t something you should actively do compared to an exposure exercise for instance and for this reason, it can be interpreted that many preferred MCT over CBT. Furthermore, the purpose of MCT tools is not to suppress your thoughts but to know that they can be there without having to give them attention. This was done through audio files, metaphoric language, and visualization.

6.4.3 Audio files, metaphoric language and visualization

All of the MCT participants mention the use of audio files, which shows that the participants were introduced to the Attention Training Technique (ATT). By doing so the participants became aware of their ability to shift focus and how they can listen to different sounds without having to give all the sounds attention. It can be interpreted that the purpose of these tools in MCT is for the participants to become aware of their thinking style and not as a tool to solve their problems. Perhaps that could be the reason why Lea felt that she was given some nice tools through metaphoric language and audio files but didn’t feel that it was ground-breaking. Sofie and Lea also felt that most of the MCT exercises didn’t work for them. Although they became aware of their thinking, it wasn’t something they actively could use. Malkomsen et al

(2021) discovered that the patients in both groups(PDT + CBT) had the same expectations of therapy and described it using the same metaphor: to get a mental tool to solve their problems. Similarly, it can be inferred that our participants had the same expectations, and therefore if our participants felt that they didn't feel it solved their problems they didn't find the tool useful. Lasse was pleased with the MCT tools he got but felt that many of the exercises were hard to use in practice such as setting time aside specifically to limit his worrying. It can therefore be interpreted that even though the majority of the participants liked the way MCT made them aware of their metacognitive beliefs, not every tool was helpful and was used by our participants.

Furthermore, Lasse described the MCT psychologist as being a bit strange and tough (APP4, p. 13, l. 89). According to Lasse, she stated that if the MCT tools didn't work then they could always go back to cognitive therapy, because that we know doesn't work. It can be interpreted that the psychologist is not able to show unconditional positive regard to her clients and passed a judgment on whether or not a client should feel specific emotions, which is against the Rogerian principle. However, Lasse still felt that the psychologist was good at her method and therefore it can be discussed whether Rogers claims such as having empathy, congruency, and positive regard are the most beneficial components of the helping process. even though Lasse's CBT psychologist had a facilitative attitude, Lasse didn't feel that he used all the methods. On the other hand, his MCT psychologist perhaps didn't have a facilitative attitude, but he uses her methods more and was overall pleased with her sessions. However, this could also be because of time and memory since CBT was given a long time ago and MCT was received recently for Lasse so whether CBT or MCT was more beneficial for Lasse is debatable. Sara on the other hand didn't have chemistry with her CBT psychologist and didn't feel that the method matched her needs. On the other hand, she felt that her MCT psychologist was very empathetic but professional at the same time which could be the reason why she preferred MCT over CBT. Perhaps it can be interpreted that a combination of a facilitative attitude and professionalism is needed for a good therapeutic experience. Whether tools and methods alone can create a good experience is arguable, but it didn't seem to be a

problem for Lasse that his psychologist was a bit tough. Roughly speaking, in CBT you need to actively think about your thoughts whereas in MCT you have to detach yourself from your thoughts also known as detached mindfulness.

6.4.4 Detached mindfulness

Some of the participants were introduced to mindfulness or talked about mindfulness in their MCT sessions. It is evident that many people debate whether mindfulness and MCT are separate entities or can be combined. In detached mindfulness you refrain from any reaction in response to a thought, feeling, or a condition and you separate the conscious experience of yourself from the thought. It can be interpreted that it was difficult for our participants to mindfully detach from their thoughts and for many, the awareness of detached mindfulness helped them to be aware of their thoughts. However, through Lasse and Sofie's statements, it becomes evident that mindfulness is introduced in their sessions and it can be difficult for the participants to distinguish between mindfulness and detached mindfulness. Furthermore, Lea's statements show that the tools that helped in mindfulness weren't lying down and emptying her mind but going for a walk or doing something creatively that didn't necessarily require her to use her mind. Overall it can be interpreted that even though the psychologists present detached mindfulness and mindfulness for their clients it is different how it is perceived by the client and how they use it in practice.

Overall it can be concluded that all our participants received the tools and methods that are typically seen with an MCT and CBT session. A majority of the participants who received both CBT and MCT preferred MCT which could be explained by the fact that the tools they got in MCT were less action-based than CBT. Moreover, the following section will discuss our findings in relation to the literature on the field.

6.5 MCT

This section will relate to the main MCT findings in our analysis and discuss to which extent they are supported by the literature on MCT.

The clients that experienced MCT reported an improvement in their mental issues, anxiety, and more specifically metacognitions, rumination, and worry, which corresponds to the literature on the area that found MCT as an effective therapy method and clients report significant improvements such as reduction in worry, anxiety, metacognitive beliefs, and maladaptive coping. The results in our analysis point to the fact that what helped the clients in MCT improve was the insight that rumination was their primary problem and that they could decide to not participate in negative thoughts (CAS) with the help of metaphors and imagery. They found that the tools they were taught in MCT improved their ability to deal with their mental problems.

However, there were some participants who were not satisfied with their MCT therapy, for instance, Lea found that engaging in ATT or other MCT exercises did not help her main concern, she found that it helped her in her daily life since she has a tendency to overthink. However, when it came to her main concern which was an unpleasant neighbor, it could be argued that Lea's anxious thoughts surrounding the unpleasant neighbor are justified since the neighbor has shown violent behavior towards people in the neighborhood including Lea's husband. The approach in MCT does not focus on the content of the individual's thoughts or situation. This is unlike CBT where you look at the content of the clients' problems and test if they are realistic or not by looking for evidence. However, MCT does not focus on the content of the thoughts, it attaches the same meaning and value to all thinking. This is also reflected in the clients' experience with MCT when for instance Lasse mentions that the psychologist has no idea what the person is struggling with. It could be interpreted that the theoretical idea and approach in MCT were not useful for Lea since it would not make the threat of the unpleasant neighbor go away. It

could be argued that Lea's example highlights a shortcoming in MCT. In Lea's case, something had to be changed with her situation, and looking at it from a metacognitive perspective was not sufficient. This finding suggests that MCT is not beneficial in such cases.

Moreover, in the MCT literature, there have been follow-up studies that found that there is an increase in improvement after the last therapy session (Haseth et al., 2019; Hagen et al., 2017; Carter et al.,2021). This is consistent with the findings in our study; The participants describe their improvement process as a life-long process that is continuously improving. Tina compares it to a driver's license, where you will become better the more you practice it. The clients' qualitative description of this ongoing process where their improvement doesn't stop after the last session could be an explanation for the results found in the quantitative data. Furthermore, our findings will be discussed in relation to the literature that compares MCT and CBT in the following section.

6.6 Comparison of MCT and CBT

Our clients' experience with MCT and CBT and the findings will be discussed in the following section and will be related to the overall literature.

The qualitative literature that compares MCT and CBT is limited, however, there are multiple studies that compare the two therapeutic approaches from a quantitative perspective. The overall findings in the literature suggest that MCT and CBT are equally as effective or that MCT is superior (Callesen, Reeves, Heal & Wells, 2020; Nordahl HM, 2009; Straarup and Poulsen, 2015). In our study, we had the opportunity for clients to share their comparison of the two therapy methods, and it was evident that most of them found MCT more beneficial, this is also supported by the literature on the area. However, in our findings, there are some similarities in the experiences reported in CBT and MCT such as their emphasis on understanding their mental issues and making changes in their behavior. Despite these similarities, there

were multiple differences between the experiences shared by the clients. CBT clients' mental issues are explained through how feelings, body, and emotions are all connected and contribute to their problems. Change happens in CBT mostly through the changing of maintenance behavior and cognitions, where negative beliefs are replaced with more balanced ones.

6.7 Conclusion of discussion

Overall it can be concluded that a person's self-efficacy and outcome-expectancy can affect the client's experience of MCT and CBT. Many of the participants had a high self-efficacy to begin with but those with unhealthy starting points perhaps had a lower self-efficacy leading to a lower outcome expectancy since they didn't believe they had the ability to change themselves. For those who didn't have a positive experience with MCT or CBT it could be due to their external locus of locus of control.

Moreover, clients place a greater focus on specific ingredients than on the real relationship. The literature on MCT and CBT supports this conclusion. There is, however, a disagreement in the research, with the bulk of studies indicating that common therapeutic factors account for the majority of psychotherapy outcomes. Our findings coincides with The Contextual Model in some areas, such as the initial bond and individuals' positive expectations for healing. Our results imply, however, that the real relationship and Rogers' six conditions are not required for clients to be satisfied with their therapy. Moreover it could be concluded that CBT and MCT provided the clients' with an explanation for their mental issues; this aligns with the second pathway of the contextual model. However, this explanation is not sufficient for all of the clients', which results in unsatisfied clients. Additionally, the third pathway of the model takes into account specific ingredients as health promoting, our findings showed that specific ingredients of MCT and CBT were helpful for clients'. The same clients that were in agreement with the specific therapy method's goals and

tasks (the second pathway) also benefited from the specific ingredients (third pathway). Furthermore, it may be argued that what works for particular clients is highly reliant on their unique needs, implying that while some clients need a closer relationship with their psychologist, others are content with a teacher-student relationship. Moreover, it can be concluded that all our participants received the tools and methods that are typically seen with a MCT and CBT session. In CBT the majority of the participants were able to recognize their distorted thoughts and all of them except Meera got exposure exercises. For Lasse it was exhausting to constantly think about his thoughts and therefore he preferred MCT over CBT despite his MCT psychologist being more distanced and cold than his CBT psychologist, which goes against the Rogerian principle. Furthermore, some of our participants felt that cognitive rehearsal wasn't as helpful when it needed to be employed in a real-life situation. Moreover, another participant felt that the CBT exercises were condescending. However, Meera overall had a very positive experience with her CBT sessions and puts more emphasis on her psychologist's personality than the tools and method itself. It can be interpreted that for Meera her CBT therapy session was a success due to the psychologist's implicit use of guided discovery and socratic questioning combined with a facilitative attitude. It can therefore be argued that the specific ingredients and non-specific ingredients can be hard to determine since the method that the psychologist uses could be a part of his personality making it hard to interpret whether it is specific or nonspecific ingredients that are at play. Furthermore, findings emphasize the necessity of putting the client's impression of the client–therapist connection first in CBT for anxiety disorders (Luong, Drummond & Norton, 2022) and this could perhaps explain why some of our participants felt that their CBT sessions were manualized and didn't necessarily fit all their needs making it harder for clients to get to the root of the problem. Furthermore, the majority of the participants who had experienced both CBT and MCT preferred MCT, which could be due to the fact that MCT was "easier" to use since it is more about not taking action while in CBT you need to do something actively with you thoughts or behavior to see a change. The tools given in CBT were harder to use since it requires more from the participants whereas with MCT it could be interpreted

that it requires less; when the participants become aware about the way they think things can begin to change. However, many people who preferred MCT still felt some of the tools were hard to use which shows that perhaps the tools in MCT are less important for the way the clients describe their experience as positive or negative. However, one of the participants from MCT wasn't pleased with her experience since she didn't understand how to employ the tools about CAS strategies and detached mindfulness in practice. This shows that it can be difficult to say what determines a pleasant therapeutic experience for the clients. Furthermore, an alternative interpretation of our findings is that the clients' description of their experience with CBT and MCT are simply reiterating their psychologist's explanation of their therapeutic causes of change. It might thus be argued that common therapeutic elements may have played a larger role in therapy than clients have explicitly stated, even if the clients have only partially acknowledged its importance in their interviews. Moreover, our findings showed that clients who received MCT saw improvements in their mental health, anxiety, and, more specifically, metacognitions, rumination, and worries, which is consistent with the literature on MCT. Finally, there have been quantitative follow-up studies in the MCT literature that show an increase in improvement for the clients after the last therapy session. Our findings contribute with a qualitative explanation for the results in the follow-up studies of MCT.

The following section will discuss the methodical and theoretical limitations of the research paper.

6.8 Methodical and theoretical limitations

Because of the small sample size, the data in our analysis of our 6 participants are not representative of all clients' experiences with CBT and MCT in Denmark. Furthermore, there are certain limits to our participants' homogeneity, such as the fact that two of them have only tried one therapy approach, whereas four have tried both

CBT and MCT. Furthermore, one of the participants is of a different gender than the others. All of the participants in MCT received group therapy while some of the participants who received CBT received individual therapy making it harder for us to compare their experiences and make inferences. Another limit of homogeneity is that not all participants suffer from the same sorts of mental illnesses, therefore their needs and expectations for therapy may differ. Moreover, not all the studies that have been used to understand our participants can be generalized to our findings since they use different methods, have different sample sizes and the characteristics of their participants might differ.

Furthermore, it is vital to remember that retrospective narratives are flawed sources of information since it introduces the issue of selective memory. This is especially relevant for our participants since the participants that experienced both CBT and MCT had received CBT many years prior. Their newer experiences and the current situation could influence the remembered feelings. As a result, interviewing the participant closer to their CBT and MCT sessions would have been optimal. However, this wasn't possible due to the lack of availability of participants. In addition to this, there were no criteria set for a range for when the clients' should have last received therapy except that they must have completed it before our interviews.

Another limitation in our study is that it is difficult to determine whether or not the psychologist used eclectic approaches or pure CBT or MCT. This was especially evident in the case of Meera where it could be argued that her psychologist took a more Rogerian approach where she had a more directive role. Same with Lea who had to hyperventilate during the MCT session, something that is usually done in a CBT session.

Additionally, a limitation in our study was that when a client mentioned their experience with a specific tool or method it is difficult to infer whether this a method a psychologist was using or whether it was the psychologist's personal style making

it difficult to say whether it was the specific or nonspecific ingredients that led to a positive outcome. For instance, Meera received CBT, however, her psychologist was less directive and goal-oriented making her sessions less “traditional”. This makes it harder for us to compare our clients’ experiences since some might have received a hard-core CBT session while other psychologists perhaps used an eclectic approach and fit the client’s needs more. Furthermore, Meera states that she began to be more reflective after receiving CBT and whether her experience would have changed if she also received MCT could be debatable. Furthermore, our interviews for each participant differed in length depending on how reflective and explicit examples our clients gave. Every client is different, and the average time used for our participants was around one hour and to get the whole client’s therapeutic experience in one hour can be limited. Some are more open and are more reflective in their answers than others which makes it more difficult for us to compare their qualitative experiences. Therefore, our findings don’t show the full extent of the client’s experiences with CBT and MCT. Furthermore, many of the MCT clients were from the same metacognitive clinic which would create biases. However, this could also be an advantage since our MCT clients are more homogenous.

Moreover, our theories also had their limitations. It is difficult to distinguish between efficacy and outcome expectation. Whether self-efficacy is heavily influenced by outcome expectations and vice versa is difficult to say. Furthermore, whether our participants are externals or internals is difficult to interpret since many factors could have an influence in determining what they are, and making inferences based on their therapeutic experience alone can give a false identification of their locus of control. Furthermore, we didn’t measure our participants' self-efficacy and locus of control quantitatively, leading our interpretations to be less strong.

Lastly, we could also have incorporated other theoretical perspectives which could have led to other results in our study, however by omitting that we were able to get a deeper understanding of our participants. Furthermore, as researchers, we have our own preconceptions that are likely to influence the interpretation process, which may

have formed the data in a particular way. Moreover, our theoretical perspective could have influenced our questions leading the participants to give certain answers in a specific way.

As previously stated, our focus is on analytical generalization, which evaluates whether the findings of our study are representative of what will occur in comparable situations. Our empirical research reveals similar patterns across our informants' experiences. These patterns are further validated by the current research on the area, thus it could be argued the experiences reported by our informants can be found in similar contexts with Danish clients who experience CBT and MCT, however more qualitative research in this area is needed.

We are aware that MCT takes up more space in this research paper. This is due to several reasons such as the participants who preferred MCT over CBT talked more about the helpful aspects of their MCT experience which led to MCT overshadowing their CBT experience. This could also be explained by the order in which they received their therapy since all the participants received CBT before MCT. However, this study does contribute with great clinical implications and important knowledge for future research, which will be discussed in the following section.

6.9 Clinical implications and future research

This is the first qualitative Danish study of our knowledge that has participants who have experienced both CBT and MCT. Our findings can be used for clinical implications since psychologists can always improve on their methods when giving therapy to clients. By having two therapy forms that our participants have tried psychologists can see what kind of tools and methods in the specific therapy form have worked and what is necessary for improvement. Psychologists should match the client's expectations to the therapy so the client isn't left feeling like a failure if the specific method doesn't work. The psychologist must be aware of whether or not the

clients agree with the specific therapy method's explanation for the client's mental issue and the solution that it offers to the clients' problems. It is evident that there is no one size fits all method and therefore professionals should be aware of the fact that every client has different needs and the therapy method should be adapted to the client. This is of course more difficult in group therapy and it could therefore be suggested that it could be advantageous to have individual sessions with the clients before recruiting the clients to group therapy so they have similar issues that could be worked on so nobody is left feeling alone with their problem. In addition, psychologists must uphold their ethics when helping clients.

In future research, it is recommended that the researcher considers our limitations. More qualitative studies are needed in comparing CBT and MCT where it is suggested that the participants are more homogeneous in terms of age, gender, and form of therapy received (Individual vs. group and pure methodical session vs. eclectic approach). Furthermore, a quantitative assessment of their self-efficacy, locus of control and their disorder could also make the quality and interpretations of the study stronger. Moreover, a different theoretical perspective could be incorporated into the interpretation of the findings. For instance, the client's theory of change (Duncan & Miller, 2000) is an alternative theory of understanding therapy and the client's role. This could give a new insight into understanding the clients' description of their therapy. For instance, it could be argued that many the therapists do not take into account their client's theory of change but instead, the therapist imposes their theory on the client (APP5, p.5, l.18)

Moreover, a placebo could also be incorporated to potentially gain an alternative understanding of clients' experience with therapy. Different factors influence placebo such as a strong verbal suggestion that a treatment will work. Another factor is the clients' positive expectations for therapy. Thus the placebo depends on the information available to the client (Haour, 2005).

Furthermore, the process by which a service user and clinician negotiate a shared understanding of the presenting difficulty is referred to as "socialization to the model". This could also be used to describe the processes that occur in the early stages of psychological therapy and could be used to understand the participants' experiences (Roos & Wearden, 2009).

Furthermore, another perspective that could be incorporated could be the psychologist's view on the client's experience and whether the client's and psychologists' experiences are in line with each other.

As stated earlier, psychologists must uphold their ethics. In this research process we as researchers have come across some ethical concerns which we have reflected upon in the following section.

6.10 Ethical reflections

In our interviews with the participants, we discovered some ethically concerning statements. With IPA the main focus is on finding themes that are common for all of our participants. As a result, this paper has not focused on this aspect and therefore lacks some nuance or distinctions; the following part will address some of these nuances.

Based on our findings, MCT could be criticized for failing to adapt to specific clients and for leaving clients feeling defeated when they fail to use MCT. The metacognitive clinics can be criticized for advertising MCT for solving all the clients' problems and giving the clients false expectations for what they can expect to receive. If the client doesn't feel that MCT helped then perhaps the client has done something wrong. Furthermore, another concern is that a client states that the MCT psychologist told him if MCT doesn't work then he could go back to CBT, because that we know doesn't work (APP4, p.13, l.77). This indicates a narrow-minded

perspective on therapy from a psychologist's point of view and a fixed vision of what works for the client, where the client's wishes are put to the side. Moreover, a concerning statement was shared by one of the participants that stated that she was told by her MCT psychologist that all other forms of therapy are just the client and psychologist engaging in pondering (APP2, p.19, l. 140). This particular client states that had it not been because of prior therapy this comment from the MCT psychologist could have discouraged her from continuing therapy after MCT.

7. Conclusion

This paper sought to examine the following statement of intent:

How do clients in a Danish context experience therapy based on metacognitive therapy (MCT) and cognitive behavioral therapy (CBT)?

This was examined with a hermeneutic phenomenological approach with semi-structured interviews. Our research was based on descriptions from 6 participants who received CBT and MCT. The semi-structured interviews were analyzed based on IPA. Based on our analysis we have concluded five main themes 1) Understanding of one's own mental issues, 2) Method & Tools, 3) The relationship between client and psychologist 4) Group therapy vs. Individual therapy and 5) View on therapy.

4 participants received both MCT and CBT, where the majority preferred MCT over CBT. The participant who only received CBT was pleased with her therapeutic experience and the participant who only received MCT didn't find her therapy sessions as helpful. The participants who were unsatisfied with CBT either felt that exposure exercises such as hyperventilating on purpose didn't make sense or thought

registration was exhausting. On the other hand, one participant was fully satisfied with CBT and didn't have any major concerns. The helpful aspects of CBT for this participant were seen when the psychologist was able to use guided discovery, the cognitive model, and collaborative empiricism. However, one participant was very dissatisfied with MCT and didn't understand how she could use the method, which shows that not all therapy forms can work for everyone. This could also be explained by locus of control and self-efficacy, where a participant's belief about their own competence and whether you put the blame on yourself or external forces can impact the client's therapeutic experience. However, these theories cannot stand alone in explaining their experience.

Moreover, our findings suggest that clients put a stronger emphasis on specific ingredients than on the real relationship. This could be explained in many different ways. According to the contextual model, the same clients that were in agreement with the specific therapy method's goals and tasks (the second pathway) also benefited from the specific ingredients (third pathway). And since MCT and CBT both emphasize specific ingredients it could be argued that it is reasonable that the clients also emphasize this.

Furthermore, one interpretation of our findings is that the clients' descriptions of their CBT and MCT experiences are merely repeating their psychologist's explanation of their therapeutic causes of change. It might therefore be argued that common therapeutic aspects played a larger role in therapy than clients have explicitly indicated, even if clients have only partially acknowledged their value in their interviews. Moreover, it might be argued that what works for a given client is greatly dependent on their specific needs.

In a comparison between the study's findings in relation to existing research in the field, we find both differences and similarities. There was a discrepancy in our findings and the literature on common factors since our participants found that specific ingredients were more important. Furthermore, our findings revealed that

clients who received MCT saw benefits in their mental health, anxiety, and, more specifically, metacognition, rumination, and anxieties, which is in line with the MCT literature. Finally, in the MCT literature, there have been quantitative follow-up studies that show an increase in client improvement after the last therapy session. Our findings provide a possible qualitative explanation for the outcomes of MCT follow-up studies (Dammen, Papageorgiou & Wells, 2014; Carter et al., 2021).

The majority of the participants talked about automatic thoughts, exposure, cognitive model, and alternative thoughts, however, none of the participants who received CBT talked about core beliefs, which is in line with existing literature where unsatisfied CBT clients state that they didn't get to the root of the problem and stayed at the surface-level (Nilsson et al., 2006; Malkomsen et al, 2021).

Many participants received group therapy and most gained a sense of belongingness with the group and a sense of community with the others in the group which is in line with another qualitative study that shows that group cohesion is regardless of treatment style seen as major, if not the most important, aspects in group therapy (Christensen et al, 2021). Additionally, it is difficult to interpret whether our participants received MCT and CBT in their pure form since many psychologists also use an eclectic approach. Furthermore, it is difficult to differentiate between what has been the psychologist's personal style or what was done from the specific method.

The findings from this study may be relevant to therapy practice in relation to CBT and especially MCT since this is a newer therapeutic approach. It contributes to a more nuanced understanding of what it is like to receive CBT and MCT for clients in Denmark. Additionally, our findings contribute to a gap in the literature. This study suggests future research which includes more qualitative research that compares CBT with MCT, where the participants appear to be more homogeneous in terms of age, gender, and the type of therapy received (Individual vs. group and pure methodical session vs. eclectic approach). In addition, suggestions are given on how

our findings can be used for clinical implications, ethical reflections, and how psychologists can improve on their approach.

8. Curriculum inventory

8.1 New curriculum

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