11/28/17

Dear Editor

Thank you for the detailed and helpful reviews you have provided. In response to the reviewer feedback we have made a number of changes to the ms and would like to resubmit the ms for further consideration at this time. Those changes are keys to the review responses below

Reviewer one

1. It should be clarified that recovery for patients with schizophrenia does not mean return to the previous self. An overoptimistic view runs the entire paper, which is striking especially for clinicians that work with chronic psychotic patients. I agree that there are small possibilities of full recovery of schizophrenia but this concerns few young patients after the first episode. It is a common knowledge that after the second episode (see Lieberman) full recovery is rather impossible. Maybe it is a matter of definition. If the patient feels "a full recovery" is a point. But this is different than returning to the former brain anatomy, brain functioning, and social performance. What kind of recovery do we expect from an inpatient with refractory schizophrenia after decades of hospitalization and significant reduction of brain volume? Of course we must hope and expect improvement and struggle for it. Maybe the proportion of the improvement is higher than in less impaired patients. But we must be also realistic because negative results of overestimated goals, may lead to frustration and disappointment, which in turn might lead to burn-out of health providers and patient's abandonment. Cure should be clearly differentiated from recovery

***Respectfully we suggest that the literature paints a different picture of recovery than the reviewer suggests. The literature reviewed in Silverstein and Bellack (2008) and then in the more recent paper by Leonhardt et al (2017) – which includes both longitudinal studies from Ciompi, M Blueler, Strauss and Harding but also longitudinal quantitative and qualitative assessments suggests individuals with SMI experience a range of outcomes, including symptom remission and a return to a life which is fully satisfying. This view has many current proponents including Larry Davidson, David Roe and Mike Salde and is a mainstream view. It is true that the studies of recovery have not reported assessments of brain function which return to normal limits but that was not their aim. SMI is a problem because of the life that is interrupted and thus this work has sought to explore how that interruption can clear up. In operational terms, recovery then includes establishing that both symptoms remit, and people can again find their way in life. We have tried to portray this view more carefully in the current version of this ms with more careful to a broader range of references.**

2. Page 5: Schizophrenia is Bleuler's neologismin using ancient Greek terms. However the original meaning of "phren" (φρην) was diaphragm. It was believed that the locus of emotions was the heart which is separated from the abdomen with the diaphragm and the disruption of the diaphragm resulted in the outburst of emotional symptoms. However, "phren" was also used in Greek ancient years in the terms of mind.

***We appreciate this clarification and have altered the ms to more clearly indicate the complexity of the root word and note that mind was only one meaning of the word "phren."**

3. Extra information about MAS-A would be useful. First, it is of interest that it is based on interview using open questions (e.g. IPII). Second, which are the objective criteria for scoring, when it depends on the information taken from such an interview? Does the experience of the rater plays critical role? 4. It is mentioned in page 14 that MERIT was superior to supportive therapy. How long did the patients receive therapy, which were their characteristics and which were the inclusion criteria? Are there any other studies implicating MERIT? Are there any double-blind studies? If not, this should be mentioned in the future perspectives-limitations paragraph.

***We now include a richer and more detailed description of how the MAS-A is rated. We also now note more detailed about the qualitative study and have added to the limitations comments on the need for more research.**

5. In the Summary section is mentioned that MERIT focuses on processes, purposes of the patient and inter-subjectivity. Are these parameters, however, adequate for recovery? What about content? What about psychoeducation? What about adherence to drug therapy, which is the milestone for schizophrenia treatment? Is MERIT capable of ensuring that the patient will not stop taking medication, which is a very common phenomenon (over 75% after 2 years of treatment), and inevitably results in hospitalization? Does it provide robust and timely results in insight and drug-treatment adherence, which are the milestones of recovery?

***We have added more information about how MERIT deal with issues of self-management and agency as well as the rationale for why MERIT may enhance metacognition, which then leads to enhanced self-management. Enhanced metacognition and self-management should then lead to improved community tenure as well as improved quality of life.**

6. A. It seems that MERIT may be a useful tool complementary to other psychotherapies B. It seems that some of its principles can enrich other psychotherapies. C. It is needed to define more specifically its indications as a sole psychotherapy D. It is needed to be more clear and objective therapy, which does not depend on the therapist's talent, jeopardizing its scientific quality All the above should be handled accordingly in the limitation section 7. Minor grammatical errors. Page 4, lines 5 - 8 person(s)…..their

***We have added comments to the limitation section that address: 1) issues with fidelity and adherence, 2) methods which ensure the treatment is the same from therapist to therapist, 3)as well as issues to do with integrating MERIT with other approaches. In the MERIT section itself we have also added more material to note that it is intended to compliment other rehabilitative practices. We have also addressed a range of grammatical errors.**

Reviewer two

(a) Although the authors have reviewed a variety of literature, there are several sections that need appropriate references. These are as follows: - page 7, para 1: "in this model, metacognition processes are what ..... and social challenges." - pages 12 and 13 - pages 16-19 have been poorly referenced. There are only 4 references throughout these pages.

***We have added additional references in the areas indicted by the reviewer.**

(b) Instead of the words "person" and "persons" please use "individual" or "individuals" where appropriate

***We have changed the text as suggested.**

In summary we are grateful for the time and effort both reviewer put into their comments and feel this guidance has resulted in a significantly improved paper. I look forward to learning of your reactions to these changes.

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