IX Congresso Nazionale AIPP

Mind the gap: l'intervento precoce
tra continuità evolutiva, discontinuità diagnostiche e multiculturalità.

Bari, 27-28-29 Settembre 2023
Università degli Studi di Bari "Aldo Moro"

DISCLOSURE INFORMATION

ALESSIA ZANGRILLI

Dichiaro che negli ultimi due anni non ho avuto rapporti di finanziamento con soggetti portatori di interessi commerciali in campo sanitario.

ABILITÀ METACOGNITIVE, DECISION MAKING E RELAZIONE CON IL PAZIENTE IN ACUZIE: UNO STUDIO PILOTA

Zangrilli, A., Ottavi, P., Bandinelli, PL., Caravaggi, C., Dimaggio, G., Elmo, MG., Monaco, L., Popolo, R., Santone, C., Scifoni, G., & Ducci, G.

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CENTRO TMI

3

OBIETTIVI

Osservare se il funzionamento metacognitivo del clinico misurato mediante **MAS-A** (globale e sottoscale) sia associato a:

1. migliore capacità di coinvolgere attivamente i pazienti affetti da psicosi delirante in un progetto di cura condiviso;
2. miglioramento sintomatologico;
3. migliore qualità percepita della relazione.

IN CORSO DI APPROFONDIMENTO:

Osservare se e quali associazioni siano presenti tra il **funzionamento metacognitivo** del clinico e la disponibilità dei pazienti a parlare dei propri ed altrui **pensieri**, **emozioni** e **comportamenti**, creare **collegamenti** tra questi, riconscere la prospettiva dell'altro diversificandola dalla propria.

1. The patient describes **HOW HE/SHE FEELS** and/or his/her present emotions and feelings, naming them explicitly.

2. The patient explains the **EMOTIONS UNDERLYING**/ linked to **BEHAVIORS** in the patient's current or ongoing situation.

3. The patient displays an **INTEREST IN THE CLINICIAN'S POINT OF VIEW** (asking questions, or clarifications) about therapeutic choices and about his/her symptoms or considers options or **EXPRESSES A PREFERENCE** in relation to therapeutic issues.

4. The patient provides an **EXPLANATION FOR EVENTS** that took place in the past and the effects they had, or are still having, on the patient's life.

5. The patient shows an understanding of the **EMOTIONAL CONSEQUENCES** that his/her behaviors may have **ON OTHER PEOPLE**.

6. The patient explains his/her **WISHES AND INTENTION**s that are not about treatment.

7. The patient describes others' **MOODS AND FEELINGS** and/or speaks about someone else's feelings (including psychiatrist's) and/or describes some situations in "**SOMEONE ELSE'S SHO**es".

8. The patient analyses practical problems in detail and/or attempts some **PROBLEM-SOLVING** in the present.

Left Paper

The development of the Metacognition Assessment Interview: Instrument description, factor structure and reliability in a non-clinical sample

Antonio Semerari [a,*], Michele Cucchi [b], Giancarlo Dimaggio [a], Daniele Cavadini [b], Antonino Carcione [a], Vittoria Battelli [b], Giuseppe Nicolo [a], Roberto Pedone [a,c], Tomaso Siccardi [b], Stefania D'Angerio [a], Paolo Ronchi [b], Cesare Maffei [b], Enrico Smeraldi [b]

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ARTICLE INFO

ABSTRACT

Background: Metacognition is a multi-facet psychological construct; deficits in metacognitive abilities are associated to low social functioning, low quality of life, psychopathology, and symptoms. The aim of this study was to describe and develop a valid and reliable interview for assessing metacognition.
Methods: The semi-structured interview, based on the author's theory model of the metacognition construct, is described. The Metacognition Assessment Interview (MAI) is an adaptation of the Metacognition Assessment Scale (MAS) and evaluates how the subject is interviewed used metacognition during his own real life experiences elicited by the interviewer. A user manual was developed to assist the interview and scoring procedure.
Results: Exploratory factor analysis and confirmatory factor analysis revealed preliminary evidence of a two factor-hierarchical structure, with two lower-order scales, representing the two main theoretical domains of the metacognitive function, "the Self" and "the Other", and one single higher-order scale that we labelled metacognition. Contrary to the authors' prediction the existence of the four distinct dimensions under the two domains was not confirmed. The MAI and its two domains demonstrated acceptable levels of inter-rater reliability and internal consistency.
Conclusions: The MAI appears to be a promising instrument for assessing metacognition. Future psychometric validation steps and clinical directions are discussed.

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1. Introduction

Research investigating the metacognitive construct has advanced rapidly over the past decade. Metacognition, as formulated by Semerari (Semerari et al. 2003; Carcione et al. 2008), refers to a broad set of cognitive and affective skills which allow people to identify mental states, reasoning about them, and ascribing them to themselves and others. These skills allow us to recognize the reason why a person reacts psychologically according to some regularities and constructs personal meaning over their lifespan.

Several authors refer to the same concept with different meanings. Wells (2000), for example, views metacognition as a set of beliefs about one's own mental content that helps people regulate their attentive processes and that, in some cases, could induce the maintenance of dysfunctional attentive processes such as worry. There is a terminological confusion over metacognition and this is also due to the fact that mind-reading abilities have been traditionally investigated by researchers belonging to different theoretical backgrounds and research fields, each of them with their own lexicon (Flavell, 1976; Fonagy, 1991; Baron-Cohen, 1995; Frith and Happé, 1999; Frith and Frith, 2006).

Metacognition, as considered by Semerari et al. (2003), partially overlaps with similar constructs such as theory of mind (ToM) (Baron-Cohen et al., 1985) and mentalization (Bateman and Fonagy, 2004; Allen et al., 2008), but with some differences. Compared to ToM, as described below, metacognition usually includes more complex mental functions. Additionally, metacognition also refers to emotional understanding, while ToM mainly focuses on cognitive attribution. Compared to the general definition of mentalization given by Bateman and Fonagy (2004), Semerari's concept differs since it considers mind-reading to be a general ability created by different subfunctions that interact with each other and that can be selectively impaired. Dysfunctions in metacognition are associated with low social functioning, low quality of life, psychopathology and symptoms of several psychiatric and personality disorders, and

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Right Paper

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Metacognition in schizophrenia: a practical overview of psychometric metacognition assessment tools for researchers and clinicians

Vassilis Martiadis[1]*, Enrico Pessina[2], Fabiola Raffone[1], Valeria Iniziato[3], Azzurra Martini[2] and Pasquale Scognamiglio[4]

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Metacognition refers to the cognitive ability to control, monitor and modulate cognitive processes thus guiding and orienting behavior: a continuum of mental activities that ranges from more discrete ones, such as the awareness of the accuracy of others' judgment, to more integrated activities, such as the knowledge of cognitive processes. Metacognition impairment in schizophrenia, which is considered a core feature of the illness, has become a growing research field focusing on a wide range of processes including reasoning, autobiographical memory, memory biases, cognitive beliefs and clinical insight. There is a well-established relationship between metacognition and schizophrenia symptoms severity, as well as between impaired metacognitive functioning and specific symptomatic sub-domains, such as positive symptoms, negative symptoms, or disorganization. The development of specific cognitive-derived psychotherapies for metacognitive deficits in schizophrenia has been ongoing in the last years. Although sharing a metacognitive feature, these treatments focus on different aspects: false or unhelpful beliefs for metacognitive therapy; cognitive biases for metacognitive training; schematic dysfunctional beliefs for cognitive behavioral therapy (CBT) for psychoses; metacognitive knowledge and sense of identity for MERIT; interpersonal ideas or events triggering delusional thinking for MIT-P. This article reviews the instruments designed to assess metacognitive domains and functions in individuals with schizophrenia, providing mental health professionals

BMC Psychiatry

RESEARCH ARTICLE — Open Access

How do psychiatrists address delusions in first meetings in acute care? A qualitative study

Alessia Zangrilli[1], Giuseppe Ducci[1], Pier Luca Bandinelli[1], Jemima Dooley[2], Rosemarie McCabe[2] and Stefan Priebe[2*]

Abstract

Background: Communicating about delusions can be challenging, particularly when a therapeutic relationship needs to be established in acute care. So far, no systematic research has explored how psychiatrists address patients' delusional beliefs in first meetings in acute care. The aim of this study was to describe how psychiatrists address patients' delusional experiences in acute in-patient care.

Methods: First meetings between five psychiatrists and 14 patients in acute care were audio-recorded and analysed using thematic content analysis.

Results: 296 psychiatrist statements about delusions were identified and coded. Three commonly used approaches (with a total of 6 subthemes) were identified. The most common approaches were eliciting the content (1 subtheme: eliciting content and evidence) and understanding the impact (3 subthemes: identifying emotions, exploring links with dysfunctional behaviour and discussing reasons for hospital admission) while questioning the validity of the beliefs (2 subthemes: challenging content and exploring alternative explanations) was less common. The last approach sometimes put patients in a defensive position.

Conclusions: Psychiatrists commonly use three approaches to address patients' delusions in the first meeting in acute in-patient care. Questioning the patients' beliefs can lead to disagreement which might hinder establishing a positive therapeutic relationship. Future research should explore the impact of such an approach on outcomes and specify to what extent questioning the validity of delusional beliefs is appropriate in the first meeting.

Keywords: Delusions, Acute care, Communication, Therapeutic relationships

Background

Delusions occur in patients with psychotic disorders and are frequently presented in acute situations such as hospital admissions. When patients communicate about delusions, psychiatrists have the challenging task to respond and address the experiences of patients. They need to address beliefs that they regard as false and are aware that merely arguing about the validity of the delusional content is unlikely to lead to immediate agreement. The beliefs can be seen as so far from the "norm" that they become "non-understandable" for the psychiatrist [1]. McCabe and Priebe [2] describe a commonly held view that psychiatrists should not discuss patient delusions in order to avoid inadvertently colluding with the patient's beliefs.

A previous study using conversation analysis explored psychiatrist-patient communication about psychotic symptoms in regular out-patient consultations [3]. The findings showed that patients actively attempted to talk about the content of their delusional beliefs, while psychiatrists tended to avoid these discussions because of ensuing disagreement. The difficulties hindered engagement and led the authors to conclude that addressing delusional beliefs may be central to improving clinical communication with this patient group [2]. In psychological treatments, such as cognitive behavioural therapy, techniques have been developed to address delusions [4,5], and most research in this area has been conducted in outpatient and psychotherapy settings [3,6,7].

When psychiatrists first meet with a patient in acute in-patient care, the task of addressing delusions is even more difficult as there is no previous history with the patient and delusions are likely to be stronger than in outpatient

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ELSEVIER

Metacognitive profiles in schizophrenia and bipolar disorder: Comparisons with healthy controls and correlations with negative symptoms

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ARTICLE INFO

ABSTRACT

While deficits in metacognition, or the ability to notice and reflect upon mental states has been observed in schizophrenia and linked with poorer concurrent and future function, it is unknown whether these deficits are unique to schizophrenia. Accordingly, this study assessed metacognition using the Metacognitive Assessment Scale–Abbreviated (MAS-A) and the Metacognitions Questionnaire– 30 (MCQ-30) among 26 adults with schizophrenia, 23 with bipolar disorder and 23 healthy controls. Symptom levels of the psychiatric groups were assessed with the Brief Psychiatric Rating Scale. ANCOVA controlling for age and education revealed that the schizophrenia group had lower scores on the MAS-A total and its subscales compared to the bipolar group and healthy controls. The bipolar disorder group also had lower MAS-A scores than the healthy control group. No group differences were found for the MCQ-30. Examination of symptom correlates revealed MAS-A scores were most commonly related to negative symptoms in both clinical groups. The total score and need for control subscale of MCQ-30 was related to total symptomatology and positive symptoms in patients with bipolar disorder. Correlations between the two measures of metacognition revealed that higher MAS-A scores were significantly related to lower scores on the Need to Control Thoughts MCQ-30 subscale.

1. Introduction

The ability to think about mental states has been referred to as metacognition (Flavell, 1979). As research on metacognition has expanded, the construct has come to encompass a spectrum of activities which range from noticing discrete thoughts, wishes and feelings, being aware of attentional biases and ultimately integrating these phenomena into a more complex sense of oneself and others which is needed to negotiate psychosocial challenges (Semerari et al., 2003; Lysaker et al., 2013). Recently, metacognitive deficits have been seen as playing an important role in outcome in schizophrenia. Metacognitive deficits have been observed in schizophrenia in all phases of the disorder (Lysaker et al., 2014; Vohs et al., 2014; Hasson-Ohayon et al., 2015; Masse and Lecomte, 2015; MacBeth et al., 2016;) and are linked to poorer outcomes. For example, deficits in the ability to form and use complex representations of self and others has been found to predict poorer levels of daily functioning (Snethen et al., 2014;

Bo et al., 2015), anhedonia in the absence of depression (Buck et al., 2014), lesser levels of subjective recovery (Kukla et al., 2014), prospective assessments of psychosocial functioning (Lysaker et al., 2010), intrinsic motivation (Luther et al., 2016), and negative symptoms (McLeod et al., 2014; Lysaker et al., 2015a). From another perspective (Wells, 2000), dysfunctional metacognitive beliefs have also been reported in schizophrenia. These include negative appraisals about the benefit of becoming involved in cognitive activities and heightened anticipation of the uncontrollability, and danger of thoughts (Sellers et al., 2016) and have been associated with positive symptoms (Baker and Morrison, 1998; Morrison et al., 2011), especially hallucinations (Varese et al., 2011; Hill et al., 2012; Austin et al., 2015).

While these studies regarding metacognition have offered promising insights into understanding the unique challenges of schizophrenia, less is known about how unique these deficits are to schizophrenia as opposed to being a general feature of serious mental illness. For example, it is unclear whether persons with schizophrenia have similar versus

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ORIGINAL ARTICLE

Categorizing what patients with psychosis say in clinical interactions: the development of a framework informed by theory of mind, metacognition and cognitive behavioral theory

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ABSTRACT

Background: Many patients with psychosis are socially isolated and struggle to maintain or establish satisfying social relationships. This has been explained as resulting from a reduced ability to understand one's own mind, others' minds, and how these interact. This understanding of one's own and others' minds is the foundation of many different theories and models from developmental to cognitive psychiatry. Increasing this ability is the goal of many therapeutic approaches and may facilitate establishing a positive therapeutic relationship. Although much interest has focused on what clinicians say in clinical encounters, few scales exist to categorize the content of patients' communication.

Aim: Theoretically founded in literature on metacognition, theory of mind and cognitive theory, the aim of this study was to create a framework to capture and quantify how patients with psychosis talk about their own and others' thoughts, feelings and behaviors in clinical interactions.

Method: A two-stage iterative process of analysis, refinement and reliability testing was undertaken. In the first stage, thematic analysis, using a combined inductive and deductive approach, was carried out on 14 Italian transcripts of real clinical encounters in acute setting. An initial framework was developed from Italian transcripts, refined, translated and then applied to a sample of 15 English transcripts of real clinical encounters. The framework was further refined, finalized and concordance between independent raters was calculated.

Results: A framework comprised of 8 categories was developed to categorize verbal displays in which patients recognize and communicate their own emotions, mental states, desires and plans, relevant narratives of their own life and experiences as expressed in routine clinical interactions. Good reliability was obtained in both English (k = 0.87) and Italian transcripts (k = 0.90).

Conclusion: Patients' thoughts about their thoughts, feelings and behaviors, and others' can be reliably assessed in routine clinical encounters using this newly developed framework. Future research should broaden the scope of this research to explore how the questions asked by psychiatrists may influence how patients talk about their thoughts, feelings and actions, and if/how they are correlated with the therapeutic relationship and clinical outcomes.

Background

Previous research (Federico et al., 2013; McCabe et al., 2002; McCabe & Priebe, 2008; McCabe et al., 2016; Sperber & Wilson, 2002) has observed that psychiatrist communication can impact on patients' outcomes. The way in which a psychiatrist communicates influences the therapeutic relationship that is established with the patient. The quality of the therapeutic relationship, in turn influences the benefit of therapy, regardless of the form of intervention (Priebe et al., 2020; Priebe & McCabe, 2006; Shattock et al., 2018; Wampold, 2015). The association between the quality of the relationship and patient outcomes (such as reduced symptoms, better engagement and improved satisfaction with life) have been explained using different theories and

constructs (Browne et al., 2019; Nienhuis et al., 2018; Okorafor, 2016; Owens et al., 2013; Priebe & Mccabe, 2008). Many of these theories are founded on, or closely related to Theory of Mind research, in that they all place people's ability to understand their own minds as separate to other people's minds as important. These constructs include metacognition, social cognition, emotional intelligence and mentalization (Corcoran, 2001; Davis et al., 2011; Lysaker & Klion, 2018). Although different in some respects, and typically measured using different tools, all of these approaches underline the importance of understanding one's own and others' minds to establish, maintain and negotiate relationships (Davis et al., 2011; Lysaker et al., 2013; Sperber & Wilson, 2002). This ability has been called mentalization and can be defined as the capacity to think about, or "read"

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METODO

RECLUTAMENTO E PROCEDURA

- 4 clinici del SPDC
- 7 pazienti per ogni clinico
- 28 incontri audioregistrati e trascritti.

METODO

ASSESSMENT PAZIENTI

- **Mini-Mental State Examination** (MMSE, Folstein et al., 1975)
- **BPRS IN e OUT** (Overall, Gorham, 1962)
- **STAR P** self-reported (McGuire-Snieckus et al., 2007)
- **Criteri di inclusione per i pazienti:** ospedalizzazione in SPDC, criteri ICD-10 per Disturbi Psicotici (F20-F29) o Disturbi dell'Umore (F30-F39), **presenza di delirio**, 18-65 anni, lingua italiana, capacità di fornire consenso informato scritto.
- **Criteri di esclusione per i pazienti:** compromissione organica o cognitiva, intossicazione da sostanze psicotrope.

METODO

ASSESSMENT CLINICI

- **Intervista IPII** (Lysaker et al., 2002, adattata), audioregistrata e trascritta, codificata tramite MAS-A

- **MAS-A** (Lysaker, Buck, 2010), per osservare il funzionamento metacognitivo dei clinici declinato nelle 4 sottofunzioni

- **Option Scale** (Elwyn et al., 2005), per valutare i comportamenti osservati dei clinici volti a coinvolgere i pazienti nel decision making

- **Scala Star C**, self-reported (McGuire-Snieckus et al., 2007), per valutare la percezione dei clinici sulla qualità della relazione.

Codice registrazione   data

Legga le seguenti affermazioni e indichi, accanto a ciascuna, quanto essa descriva la relazione che ha con il suo paziente, utilizzando i punteggi indicati nelle colonne laterali. Grazie!

	Versione per lo specialista (STAR C)	mai	raramente	qualche volta	spesso	sempre
1	Vado d'accordo con il mio paziente	0	1	2	3	4
2	Io ed il mio paziente abbiamo un buon rapporto	0	1	2	3	4
3	Ascolto il mio paziente	0	1	2	3	4
4	Sento che il mio paziente mi rifiuti come specialista	0	1	2	3	4
5	Penso che io ed il mio paziente abbiamo una buona relazione	0	1	2	3	4
6	Mi sento inferiore al mio paziente	0	1	2	3	4
7	Io ed il mio paziente condividiamo le stesse aspettative di progresso nel trattamento	0	1	2	3	4
8	Sento di essere supportivo per il mio paziente	0	1	2	3	4
9	E' difficile per me empatizzare con i problemi del mio paziente	0	1	2	3	4
10	Io ed il mio paziente siamo aperti l'uno verso l'altro	0	1	2	3	4
11	Sono capace di assumere la prospettiva del mio paziente quando lavoriamo insieme	0	1	2	3	4
12	Io ed il mio paziente abbiamo una relazione di fiducia	0	1	2	3	4

codice registrazione

Legga le seguenti affermazioni e indichi, accanto a ciascuna, quanto essa descriva la relazione che ha con lo specialista che ha incontrato oggi, utilizzando i punteggi indicati nelle colonne laterali. Grazie!

	Versione per il paziente (STAR P)	mai	raramente	qualche volta	spesso	sempre
1	Il mio dottore parla con me dei miei obiettivi e pensieri sul trattamento	0	1	2	3	4
2	Io ed il mio dottore siamo aperti l'uno verso l'altro	0	1	2	3	4
3	Io ed il mio dottore abbiamo una relazione di fiducia	0	1	2	3	4
4	Penso che il mio dottore riesca a far emergere la verità da me	0	1	2	3	4
5	Io ed il mio dottore abbiamo una relazione onesta	0	1	2	3	4
6	Io ed il mio dottore lavoriamo su obiettivi reciprocamente condivisi	0	1	2	3	4
7	Il mio dottore è severo con me quando parlo di cose che sono importanti per me e la mia situazione	0	1	2	3	4
8	Io ed il mio dottore condividiamo la comprensione del tipo di cambiamento che sarebbe buono per me	0	1	2	3	4
9	Il mio dottore è impaziente con me	0	1	2	3	4
10	Io sembra di piacere al mio dottore, a prescindere da quello che dico o faccio	0	1	2	3	4
11	Io ed il mio dottore siamo d'accordo su quali siano le cose importanti su cui lavorare	0	1	2	3	4
12	Penso che il mio dottore capisca cosa la mia esperienza abbia significato per me	0	1	2	3	4

OPTION Observing patient involvement © March 2009

Date of Rating: .... DD MM YY   Practitioner: .... Age Sex

Rater Name: ....   Patient: .... Age Sex

Clinician Code: ....   Consultation Type: ☐ New ☐ Review ☐ Composite

Consultation Number: ....

Consultation Duration: .... (minutes: seconds)   Another Person In The Room? ☐ Yes ☐ No Who? ....

Description of Index Problem:

1. The clinician <u>draws attention</u> to an identified problem as one that requires a decision making process.
0 = No attempt to draw attention to a need for a decision making process *(there is no clarity about problems, or at least no clarity about the decisions to be taken about the problem or problems identified)*.
1 = Very brief or perfunctory attempts to draw attention to the need to embark on a decision making process.
2 = Baseline skill level: Clinician draws attention to a problem that requires a decision making process.
3 = Clinician puts emphasis on the decision making process required.
4 = The skill is exhibited to a high standard *(e.g. supplementary explanations and evidence of patient recognizing the need to engage in the process of decision making)*.

2. The clinician states that there is more than one way to deal with the identified problem ('*equipoise*').
0 = The clinician does not state that there is more than one way of managing problems.
1 = Perfunctory attempt to convey the existence of more than one option.
2 = Baseline skill level: Clinician conveys the sense that the options are valid and need to be considered in more depth.
3 = Explains 'equipoise' in more detail and that options have pros and cons that need to be considered.
4 = The clinician also explains 'why' choices are available *(e.g. there is genuine professional uncertainly as to the 'best' way of managing the problem – clinical equipoise);* the skill is exhibited to a high standard.

3. The clinician <u>assesses patient's preferred approach</u> to receiving information to assist decision making (e.g. *discussion in consultations, read printed material, assess graphical data, use videotapes or other media*).
0 = The behaviour is not observed.
1 = A minimal attempt is made to exhibit the behaviour.
2 = Baseline skill level: Clinician asks for patient's preferred method of receiving information.
3 = Doing this behaviour well *(e.g. states that there are many ways in which information can be conveyed; provides reading for outside of consultation)*.
4 = Gives many examples of the types of information formats and media available for the patient, and then provides an opportunity for the patient to select their preferred method or methods.

4. The clinician <u>lists 'options'</u>, which can include the choice of 'no action'.
0 = The behaviour is not observed *(listing options is different from providing details about each option)*.
1 = Minimal or perfunctory attempt is made to list options.
2 = Baseline skill level: Clinician lists options as distinct possibilities that are available *(e.g. using 'either / or' phrasing to describe the existence of options)*.
3 = Careful listing of all possible options, including the choice of taking no action, or deferring the decision.
4 = Clinician exhibited this behaviour to a high standard.

5. The clinician <u>explains the pros and cons</u> of options to the patient *(taking 'no action' is an option)*.
0 = No explanation.
1 = The clinician fails to provide information about more than one option *(according to the extent that each option is described)*.
2 = Baseline skill level: The clinician provides details about the pros and cons of the options.
3 = The behaviour is exhibited to a good standard.
4 = The skill is exhibited to a high standard *(e.g. by description of options followed with discussion)*.

6. The clinician explores the patient's <u>expectations *(or ideas)*</u> about how the problem(s) are to be managed.
0 = No attempt to ascertain patient's views about their expectations.
1 = Unskilled or perfunctory attempts to uncover patient's ideas or expectations about management.
2 = Baseline skill level: The clinician explicitly asks the patient what they expected *(thought)* about the actions required to manage the problem(s). Skilled clinicians are able to explore these expectations and ideas *(using open ended questions, suggesting a range of common expectations, using pauses, being alert to verbal and physical cues and so on)*.
3 = This behaviour is exhibited and leads to supplementary questions to clarify expectations or ideas *(e.g. exploration of expectations takes place)*. The behaviour is performed to a good standard.
4 = The behaviour is achieved to high standards and patient's views are discussed and addressed.

STRUMENTI

SOMMINISTRAZIONE IPII ADATTATA

Narrazione generale Libera

Periodo di crisi/narrazione delle difficoltà

Cosa è sbagliato vs cosa non è sbagliato

Livello di influenza del periodo di crisi identificato

Il futuro, speranza e soddisfazioni

STRUMENTI

TRASCRIZIONE E
CODIFICA DELLA MAS-A
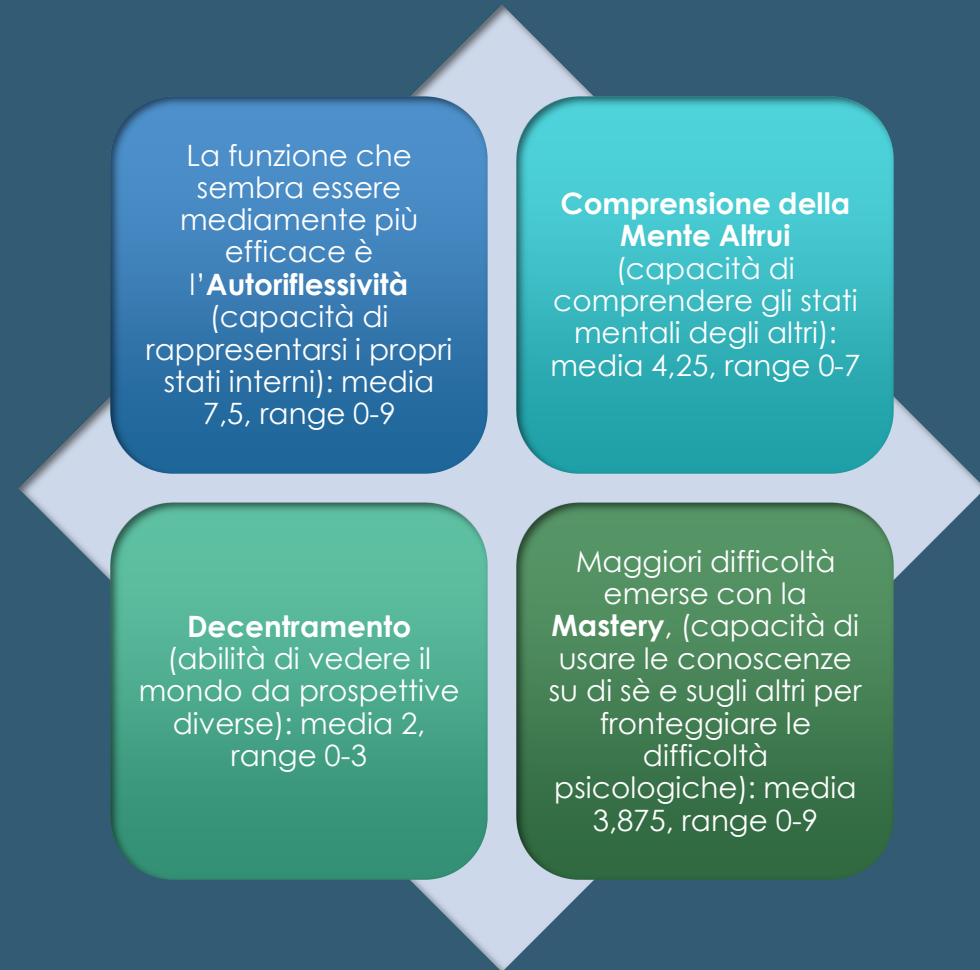
Analisi
delle 4
sottoscale
della
MAS-A:

Autoriflessività

Comprensione della Mente Altrui

Decentramento

Mastery

ANALISI

SIGLATURA MAS-A

La funzione che sembra essere mediamente più efficace è l'**Autoriflessività** (capacità di rappresentarsi i propri stati interni): media 7,5, range 0-9

Comprensione della Mente Altrui (capacità di comprendere gli stati mentali degli altri): media 4,25, range 0-7

Decentramento (abilità di vedere il mondo da prospettive diverse): media 2, range 0-3

Maggiori difficoltà emerse con la **Mastery**, (capacità di usare le conoscenze su di sè e sugli altri per fronteggiare le difficoltà psicologiche): media 3,875, range 0-9

ANALISI

DESCRITTIVA UNIVARIATA

1. Punteggi più alti alla **MAS-A** sembrano essere associati ad una maggiore disponibilità e capacità di coinvolgere il pz nel processo decisionale condiviso:

   - La sottoscala **Decentramento** correla positivamente con più alti punteggi **Option Scale** (r=0,422; p=0.025)
   - La sottoscala **Mastery** correla positivamente con più alti punteggi **Option Scale** (r=0,400; p=0.035)

2. La sottoscala **Autoriflessività** correla positivamente con più alti punteggi di qualità percepita della relazione da parte dello specialista, misurata mediante **STAR C** (r=0,420; p=0.026)

3. Non si osservano associazioni significative tra **MAS-A** (o sottoscale) e **miglioramento sintomatologico.**

INOLTRE…

1. **Autoriflessività** e **Comprensione Mente Altrui** sembrano associati alla presenza delll'item **2** (il pz fa collegamenti tra emozioni e comportamenti), **3** (mostra interesse per il punto di vista dello specialista, pone domande, considera opzioni diverse), **5** (mostra di comprendere le conseguenze emozionali dei propri comportamenti sugli altri) e **6** (esprime desideri ed intenzioni)

3. La media dei punteggi della sottoscala **Decentramento** sembra essere associata alla presenza di **tutti gli Item** (tranne il 7)

4. La media dei punteggi della sottoscala **Mastery** sembra essere associata alla presenza di **tutti gli Item** del frame

5. l'Item **2** sembra essere associato a punteggi **BPRS OUT** più bassi

6. Si osservano correlazioni lineari, ancorchè deboli, tra il **punteggio totale al frame** e tutte le **sottoscale MAS-A**

7. Si osserva una debole correlazione positiva tra il **punteggio totale** al frame e la **Star P**

CONCLUSIONI 1

COMPLIANCE

Un miglioramento della funzione metacognitiva del clinico è associata ad una maggiore disponibilità di **coinvolgimento attivo** del paziente nelle scelte di cura.

CONCLUSIONI 2

RELAZIONE

Il miglioramento delle capacità metacognitive dei clinici si associa ad una migliore **percezione della qualità della relazione** con il paziente.

CONCLUSIONI 3

OUTCOME
SINTOMATOLOGICO

Non si è osservata significative correlazione lineare tra il funzionamento metacognitivo del clinico e la **diminuzione del livello di sintomatologia** del paziente in uscita.

POTENZIALITÀ, LIMITI ED IPOTESI FUTURE

COMPLIANCE

Un miglioramento della funzione metacognitive del clinico può avere implicazioni positive per l'aderenza al trattamento grazie alla **maggiore capacità di coinvolgere** il paziente nell'individuazione di ipotesi di cura soddisfacenti. Ulteriori studi potrebbero osservare e valutare come questi fattori influenzano l'aderenza al trattamento e altri esiti centrati sul paziente.

POTENZIALITÀ, LIMITI ED IPOTESI FUTURE

RELAZIONE E MOTIVAZIONE INTRINSECA

Il miglioramento delle capacità metacognitive dei professionisti sanitari può aumentare la loro **motivazione intrinseca e la visione ottimistica sulla cura**, contribuendo alla soddisfazione professionale. Ciò è in linea con la ricerca che collega motivazione, ottimismo terapeutico e outcome clinico(Janus et al., 2007, Nantha, 2013).

POTENZIALITÀ, LIMITI ED IPOTESI FUTURE

THEORY OF MIND

Il funzionamento metacognitivo del clinico si associa alla presenza di specifici contenuti verbali ispirati alla ToM nel paziente...

POTENZIALITÀ, LIMITI ED IPOTESI FUTURE

OUTCOME CLINICI

La mancanza di una significativa correlazione lineare tra funzionamento metacognitivo del clinico e miglioramento dei sintomi del pz dovrebbe essere interpretata con cautela, considerando le **dimensioni ridotte** del campione e l'eventuale influenza di **variabili** non analizzate. Auspicabile ulteriore ricerca.

RIFERIMENTI BIBLIOGRAFICI

- Janus, K., Amelung, V. E., Gaitanides, M., & Schwartz, F. W. (2007). German physicians "on strike"--shedding light on the roots of physician dissatisfaction. Health policy (Amsterdam, Netherlands), 82(3), 357–365.

- Lysaker P, Carcione A, Dimaggio G, Johannesen J, Nicolo G, Procacci M, et al. Metacognition amidst narratives of self and illness in schizophrenia: associations with neurocognition, symptoms, insight and quality of life. Acta Psychiatr Scand. (2005) 112:64–71.

- Martiadis, V., Pessina, E., Raffone, F., Iniziato, V., Martini, A., & Scognamiglio, P. (2023). Metacognition in schizophrenia: A practical overview of psychometric metacognition assessment tools for researchers and clinicians. Frontiers in Psychiatry, 14, 1155321. https://doi.org/10.3389/fpsyt.2023.1155321

- Nantha Y. S. (2013). Intrinsic motivation: how can it play a pivotal role in changing clinician behaviour?. Journal of health organization and management, 27(2), 266–272.

- Popolo, R., Smith, E., Lysaker, P. H., Lestingi, K., Cavallo, F., Melchiorre, L., ... & Dimaggio, G. (2017). Metacognitive profiles in schizophrenia and bipolar disorder: Comparisons with healthy controls and correlations with negative symptoms. Psychiatry research, 257, 45-50.

- Semerari A, Carcione A, Dimaggio G, et al. How to evaluate metacognitive functioning in psychotherapy? The Metacognition Assessment scale and its applications. Clin Psychol Psychother. 2003;10, 238–261)

- Zangrilli, A., Conneely, M., McCabe, R., Catalfio F. & Priebe, S. (2021): Categorizing what patients with psychosis say in clinical interactions: the development of a framework informed by theory of mind, metacognition and cognitive behavioral theory, Journal of Mental Health