EDITORIAL

Metacognitions in the medical settings: An example regarding palliative care

Vittorio Lenzo, MD, Maria C. Quattropani, MD

Vittorio L, Maria CQ. Metacognitions in the medical settings: An example regarding palliative care. Clin Psychol Cog Sci 2017;1(1):1.

Palliative care is defined by the World Health Organization (1) as "an approach that improves the quality of patients and their families who are facing problems associated with life-threatening illness. It prevents and relieves suffering through the early identification, correct assessment and treatment of pain and other problems, whether physical, psychosocial or spiritual".

The complexity and difficulty of working in palliative care can produce stressful and negative emotions in workers. The burnout syndrome is often a consequence of working in helping professions and especially in palliative care.

The burnout syndrome is a state of emotional exhaustion, depersonalization, and reduced accomplishment at work (2) and the effects are not limited to physicians because it is a burden for society as whole.

However, there are few studies that have explored the prevalence of burnout in palliative care (3,4) with no coherent results. Individual differences as well as work organizations aspects can influence the development of burnout in palliative care workers. Therefore, it is difficult to build prevention programs and psychological interventions for the burnout syndrome.

Several studies have point out the relationships between metacognitions and psychopathology (5) and in the last years some studies have begun to investigate the role of this construct in non-clinical samples. Moreover, current research is engaged to deeply examine metacognitions and variables as gender and age. At this regard, a recent study (6) has explored the predictors of the three factors of burnout in the framework of metacognitive theory in palliative care workers. This study has found that metacognitions are important to predict adjustment of individual that face-off with stressful situations. The results have shown that negative beliefs and cognitive confidence predict the 21 per cent of variance of emotional exhaustion. The others two dimensions of burnout that are depersonalization and personal accomplishment showed results different. For example, variables of workers as gender and years of experience were predictors of personal accomplishment and depersonalization but not for emotional exhaustion. In addition, a task oriented coping strategy was a predictor of the personal accomplishment of the workers. Coping strategies were not significant predictors for emotional exhaustion or depersonalization. In this perspective more research is needed to clarify the different role of personality traits as metacognitions to predict burnout. On the other hand, burnout development can be different among the operators. Physicians, psychologists, nurses and other care workers are strictly involved in the psychological dynamics of patients and their family. Commons and transversal competences are needed among palliative care professionals.

On the other hand, there are specific tasks on the basis of the palliative care professionals. Hence, it is possible to hypothesize some different consequences for physicians or nurses.

For example, psychologists in palliative care services that work with the emotions of death and dying need to readjust their professional identity. Psychotherapy for clients in private practice is very different to a psychological intervention in the field of domiciliary palliative care (7).

Hence, the next step is to build psychological interventions that are tailored on the individual needs. A similar perspective is important to adopt in other medical services and more research is needed in a wide array of medical settings.

REFERENCES

1. World Health Organization. Palliative care: the solid facts. 2004.
2. Maslach C. Burnout: The cost of caring. New York: Prentice Hall Press 1982.
3. Casarett DJ, Spence C, Haskins M, et al. One big happy family? Interdisciplinary variation in job satisfaction among hospice providers. J Palliat Med 2011;14(8):913-7.
4. Kamal AH, Bull JH, Wolf SP, et al. Prevalence and predictors of burnout among hospice and palliative care clinicians in the US. J Pain Symptom Manage 2016;51(4):690-6.
5. Wells A. Cognition about cognition: Metacognitive therapy and change in generalized anxiety disorder and social phobia. Cogn Behav Pract 2007;14:18-25.
6. Quattropani MC, Lenzo V, Baio M, et al. Metacognitive beliefs and coping strategies in homecare professionals at risk of burnout. Psicologia della Salute 2017;2:121-42.
7. Rugnone L, Traina ML, Lenzo V, et al. The acrobatics of dying: A psychodynamic framework for palliative care. World Futures 2017;73(4-5):353-63.

Department of Clinical and Experimental Medicine, University of Messina, Italy

Correspondence: Dr Vittorio Lenzo, MD, Department of Clinical and Experimental Medicine, University of Messina, via A. Bivona 1, 98122 Messina, Italy, Telephone +39 090 6766085, e-mail vittorio.lenzo@unime.it
Received: October 03, 2017, Accepted: October 16, 2017, Published: October 30, 2017