Quiet Ego and Metacognitive Beliefs in Euthymic Bipolar Disorder: A Preliminary Report

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Abstract: Bipolar Disorder (BD) is associated with functional disability even during euthymia, when residual dysfunctional thinking patterns, distinct from mood symptoms and neurocognitive deficits, may persist largely untreated by standard pharmacotherapy, psychoeducation, or cognitive remediation. This preliminary study examined the association between Quiet Ego, as measured by the Quiet Ego Scale (QES), and metacognitive beliefs, as measured by the Metacognitions Questionnaire-30 (MCQ-30), in fifty euthymic patients with BD. The QES total score was entered as a continuous predictor of each MCQ-30 subscale in simple linear regression models. Higher Quiet Ego scores were associated with higher *Cognitive Confidence* (*i.e*., lower scores on the MCQ-30 *Cognitive Confidence* subscale; β = -.393, R^2 = .154, p = .005), the only association that survived Bonferroni correction (α = .01). The association with *negative beliefs about uncontrollability and danger* was significant only at the uncorrected level (*p* = .034), and all remaining associations were not significant (*p* > .05). These preliminary findings suggest that Quiet Ego may be related to how patients appraise the reliability of their own cognition. Given the small sample, the cross-sectional design, and the self-reported nature of cognitive confidence, the results should be interpreted cautiously and require replication. Longitudinal and intervention studies are needed to test whether quiet-ego-enhancing approaches could serve as an adjunct in the long-term self-management of BD.

Keywords: Bipolar Disorder, Euthymia, Quiet Ego, Metacognition, MCQ-30, QES, Personality traits, Dysfunctional beliefs, Cognitive confidence.

1. INTRODUCTION

Bipolar disorder (BD) is a chronic, recurrent condition associated with substantial disability even outside acute episodes: residual cognitive difficulties, reduced psychosocial functioning, and a high risk of relapse persist during euthymia in a significant proportion of patients (Bonnín *et al*., 2014; Samalin *et al*., 2016; Torrent *et al*., 2013; Singh *et al*., 2025). Given its lifelong course, self-management, and not only the treatment of acute episodes, is a central clinical concern.

Established interventions target two residual domains: mood instability, addressed through pharmacotherapy and psychoeducation (Colom *et al*., 2005; Miklowitz *et al*., 2021; Solè *et al*., 2017), and neurocognitive impairment, addressed through cognitive and functional remediation (Torrent *et al*., 2013; Bernabei *et al*., 2020). However, even when mood is stable and cognition is within the normal range, dysfunctional ways of thinking about one's own mind, such as maladaptive beliefs and appraisals, may persist. These are neither mood symptoms nor neurocognitive deficits in the classical sense, yet they may increase subjective distress and a sense of ineffectiveness and make patients more vulnerable to relapse (Favaretto *et al*., 2020; Singh *et al*., 2025).

In the Self-Regulatory Executive Function model, Wells and Matthews (1996) propose that psychopathology is maintained by the Cognitive Attentional Syndrome (perseverative thinking, threat monitoring, and maladaptive coping), driven by dysfunctional metacognitive beliefs (Wells, 2019). These beliefs, assessed with the Metacognitions Questionnaire-30 (MCQ-30; Wells & Cartwright-Hatton, 2004) across five dimensions (positive beliefs about worry, negative beliefs about uncontrollability and danger, cognitive confidence, need to control thoughts, and cognitive self-consciousness), are elevated across disorders and are associated with perseverative thinking, emotional vulnerability, and interpersonal difficulties independently of symptoms and personality (Strand *et al*., 2024). Despite this, metacognitive beliefs remain underexplored in BD, particularly during euthymia, when mood-related confounds are minimized and beliefs can be examined closer to a trait-like baseline. The few available findings are mixed. Patients with BD-II show higher positive beliefs about worry than patients with BD-I and healthy controls (Favaretto *et al*., 2020), while low cognitive confidence has been interpreted both as awareness of genuine cognitive deficits (Østefjells *et al*., 2017; Van Camp *et al*., 2019) and as a transdiagnostic treatment target (Sun *et al*., 2017). It is therefore unclear which

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psychological resources are associated with less dysfunctional metacognitive profiles in BD.

The quiet ego, a less egocentric and more balanced mode of self-functioning (Bauer & Wayment, 2008), is a plausible candidate. It comprises detached awareness, inclusive identity, perspective-taking, and growth. Detached awareness, in particujular, overlaps conceptually with decentering, the ability to observe one's thoughts without over-identifying with or feeling threatened by them, a stance particularly relevant for patients who must manage their thoughts under the influence of mood (Johnson *et al*., 2020). Quiet ego qualities are also considered modifiable and amenable to simple, effective interventions (Wayment *et al*., 2026), which makes them an attractive treatment target. To our knowledge, however, the quiet ego has not been examined in clinical populations, and its relationship with metacognitive beliefs has never been tested in BD.

The aim of this study was to examine in euthymic patients with BD, the association between quiet ego (QES total score) and metacognitive beliefs (MCQ-30). We hypothesized that higher quiet ego would be associated with less dysfunctional metacognitive beliefs (rather than with "better" metacognitive ability, a distinct construct not assessed here), particularly on the dimensions related to threat appraisal and hypervigilance toward thinking processes.

2. METHODS

2.1. Participants

Fifty euthymic bipolar patients were consecutively enrolled at the Neurocognitive Assessment Service for Severe Mental Health of the Adult Psychiatric Day Hospital, Parodi Delfino Hospital, ASL Rome 5 (Colleferro, Rome, Italy), between September 2023 and January 2025. Participants were eligible for the study if they met the following inclusion criteria: i) a diagnosis of BD according to the DSM-5-TR, established through the Structured Clinical Interview for the Diagnostic and Statistical Manual of Mental Disorders (DSM) 5-TR (APA, 2015); ii) age over 18 years; iii) ability to provide informed consent; and iv) euthymic phase of the disorder, defined as a Hamilton Depression Rating Scale (HAM-D) score ≤ 7 and a Young Mania Rating Scale (YMRS) score ≤ 7 (Thompson *et al*, 2005).

2.2. Procedure

Participants completed a broader assessment battery (used only for sample characterization) collected as part of the standard clinical research protocol.

The study was conducted in accordance with established ethical standards and the Declaration of Helsinki, and it received approval from the local Ethics Committee (protocol no. 477, March 14, 2019, CE Lazio 1). Written informed consent was obtained from all patients, including consent for the publication of any data contained in this article that could potentially identify them.

2.3. Measures

Metacognitions Questionnaire-30 (MCQ-30)

One of the most widely used instruments for assessing metacognitive beliefs in clinical settings is the Metacognitions Questionnaire-30 (MCQ-30; Wells & Cartwright-Hatton, 2004), a 30-item self-report measure designed to assess individual differences in metacognitive beliefs. The measure comprises five distinct factors: (1) positive beliefs about worry (*e.g*., "Worrying helps me to cope"); (2) negative beliefs about the uncontrollability and danger of worry (*e.g*., "When I start worrying, I cannot stop"); (3) cognitive confidence (*e.g*., "My memory can mislead me at times"); (4) beliefs about the need to control thoughts (*e.g*., "Not being able to control my thoughts is a sign of weakness"); and (5) cognitive self-consciousness (*e.g*., "I pay close attention to the way my mind works"). Each item is rated on a 4-point Likert scale ranging from 1 ("do not agree") to 4 ("agree very much"), with higher total scores reflecting greater levels of dysfunctional metacognitive beliefs. The MCQ-30 has shown robust psychometric properties in previous validation studies (Wells & Cartwright-Hatton, 2004).

Quiet Ego Scale - QES

Quiet ego was assessed with the Italian version of the Quiet Ego Scale (iQES; Bernabei *et al*, 2024), which measures a dispositional self-orientation, conceptualized as a personality trait that fosters connection with both oneself and others (Wayment *et al*, 2015a). The QES is a 14-item self-report measure covering four psychological characteristics (*detached awareness, inclusive identity, perspective-taking,* and *growth*) which, although forming conceptually distinct subdomains, are combined into a single composite score rather than yielding separate subscale scores. Items are rated on a 5-point scale ranging from 1 (strongly disagree) to 5 (strongly agree), with items 2, 6, 10, 11, and 14 reverse-scored (Wayment *et al*., 2015a). Higher total scores reflect a stronger quiet ego. In the Italian validation sample, the scale showed acceptable internal consistency (Cronbach's α = 0.76; Bernabei *et al*, 2024), comparable to the value reported by Wayment *et al*. (2015a; α = 0.78).

2.4. Statistical Analysis

All analyses were conducted in jamovi, version 2.7.37.0. (The jamovi project, Computer Software, 2025).

Descriptive statistics were computed for the sample, the QES, and the MCQ-30 (total score and subscales) were calculated. Distributional properties (skewness/ kurtosis) of the QES total score and MCQ-30 subscales were inspected to guide the choice between parametric and non-parametric tests.

Pearson correlations were computed between the QES total score and each MCQ-30 subscale, with 95% confidence intervals.

Simple linear regression models were then fitted, one per subscale, with the QES total score as the predictor. Standardized coefficients (β) and 95% CI are reported in Table **1**.

To account for the five subscale-level tests conducted on the same instrument, a Bonferroni correction was applied to the primary significance decisions (adjusted α = .01). Uncorrected *p*-values also reported in the tables.

3. RESULTS

The sample comprised 50 participants (21 males, 42%; 29 females, 58%). A diagnosis of Bipolar Disorder type II (BD-II) was present in 26 participants (52%) and type I (BD-I) in 24 (48%). The mean age was 48.7 years (*SD*= 14.4), and the mean level of education was 13.0 years (*SD* = 3.15). Mean duration of illness was 21.8 years (*SD* = 13.6) and mean age at first depressive episode was 26.8 years (*SD* = 9.44). Mean HAM-D and YMRS scores were 3.16 (*SD* = 1.39) and 2.02 (*SD* = 2.02), respectively. During the study, all patients were taking psychopharmacological treatment in accordance with major international guidelines, including lithium, antipsychotics, antidepressants and anticonvulsants), with a mean of 2.62 psychotropic medications per patient (*SD* = 0.725).

Distributional checks supported the use of parametric statistics: skewness and kurtosis values for the QES total score and all MCQ-30 subscales fell within acceptable limits for normality (all |skewness| < 0.9, all |kurtosis| < 1.3), justifying the use of Pearson correlations over rank-based alternatives.

Pearson correlations between the QES total score and the MCQ-30 subscales are reported in Table **1**.

Applying a Bonferroni correction for the five subscale-level tests (α = (.05/5) = .01), only one association was significant: the QES total score was negatively correlated with (lack of) *Cognitive Confidence* (r = −.393, 95% CI [−.605, −.128], p = .005). The association with Negative beliefs about uncontrollability and danger (r = −.300, 95% CI [−.534, −.023], p = .034) was significant only at the uncorrected level and did not survive correction; it is therefore considered not significant. No other subscale was significantly associated with the QES total score (*p* > .05).

Simple linear regressions, with the QES total score as the sole predictor, were fitted for the MCQ-30 total score and each subscales (Table **2**). Because each model includes a single predictor, the standardized coefficients equal the corriponding Pearson correlations, and the regressions mainly add information on the proportion of variance explained.

The model for the MCQ-30 total score did not reach conventional significance (β = -.266, R^2 = .071, *F* (1,48)

Table 1: Simple Linear Correlations [* p < .05; ** p < .01; *** p < .001]

	QES	MCQ_TOT	MCQ_Pos	MCQ_Neg	MCQ_CC	MCQ_NC	MCQ_CSC
QES	—						
MCQ_TOT	–0.266	—					
MCQ_Pos	–0.151	0.582 ***	—				
MCQ_Neg	–0.300 *	0.591 ***	–0.049	—			
MCQ_CC	–0.393 **	0.630 ***	0.251	0.447 **	—		
MCQ_NC	–0.276	0.788 ***	0.417 **	0.543 ***	0.595 ***	—	
MCQ_CSC	0.028	0.652 ***	0.594 ***	0.326 *	0.215	0.387 **	—

Abbreviation: QES: Quiet Ego Scale; MCQ_TOT: MetaCognition Questionnaire_Total; MCQ_Pos: MetaCognition Questionnaire Positive; MCQ_Neg: MetaCognition Questionnaire Negative; MCQ_CC: MetaCognition Questionnaire_ Cognitive Confidence; MCQ_NC: MetaCognition Questionnaire Beliefs about the Need of Control Thoughts; MCQ_CSC: MetaCognition Questionnaire Cognitive Self-Consciousness.

Table 2: Simple Linear Regressions [* Survives Bonferroni correction (corrected α = .01)]

Outcome	β (std.)	R^2	Adj. R^2	F (1,48)	*p*
MCQ-30 total	-.266	.071	.052	3.67	.061
Positive beliefs about worry	-.151	.023	.002	1.12	.295
Negative beliefs (uncontrollability/danger)	-.300	.090	.071	4.74	.034
(Lack of) Cognitive Confidence	-.393	.154	.137	8.75	**.005***
Need to control thoughts	-.276	.076	.057	3.97	.052
Cognitive Self-Consciousness	.028	.001	-.020	0.04	.845

= 3.67, *p* = .061) which is consistent with the expectation that a composite score would dilute subscale-specific effects.

Among the subscales, the strongest association emerged for (lack of) *Cognitive Confidence* (β = -.393, R^2 = .154, F (1,48) = 8.75, p = .005). This was the only effect surviving Bonferroni correction (corrected α = .01), with the QES total score alone accounting for approximately 15% of the variance. The association with *Negative Beliefs about uncontrollability/danger* was in the hypothesized direction and significant at the uncorrected threshold (β = -.300, R^2 = .090, *F* (1,48) = 4.74, p = .034), but it did not survive correction and should be considered tentative. For *Need to control thoughts*, the association was in the hypothesized direction but did not reach significance even at the uncorrected level (β = −.276, R^2 = .076, *F* (1, 48) = 3.97, *p* = .052). *Positive Beliefs about Worry* showed a small, non-significant association (β = −.151, R^2 = .023, *F* (1, 48) = 1.12, *p* = .295), in line with the absence of a strong a priori hypothesis for this subscale. Finally, *Cognitive Self-Consciousness* was essentially unrelated to the QES total score (β = .028, R^2 = .001, *F* (1, 48) = 0.04, *p* = .845), with a near-zero coefficient whose sign was opposite to the hypothesized direction but negligible in magnitude.

Taken together, after correction for multiple comparisons only *Cognitive Confidence* was significantly associated with quiet ego: higher quiet ego was associated with greater confidence in one's own cognitive functioning. All other associations, including the uncorrected association with Negative beliefs about uncontrollability and danger, were not significant and are not interpreted as effects.

4. DISCUSSION

The present study examined the relationship between quiet ego and metacognitive beliefs in euthymic patients with bipolar disorder (BD). We hypothesized that higher quiet ego would be associated with a less dysfunctional metacognitive profile. This question was considered within the broader framework of self-management in a chronic and potentially disabling psychiatric condition.

In this preliminary sample, higher quiet ego was significantly associated only with *Cognitive Confidence* after correction for multiple comparisons. An association with *Negative Beliefs about Uncontrollability and Danger,* was observed at the uncorrected level only and is not interpreted further. No other MCQ-30 dimension was associated with quiet ego.

Metacognitive beliefs have been extensively investigated in patients with BD (Sarisoy *et al*., 2014; Favaretto *et al*., 2020), however, to our knowledge, this is the first study to examine quiet ego in a clinical population, and specifically in euthymic patients with BD. Although preliminary, these findings extend the study of quiet ego beyond non-clinical samples and suggest that it may be relevant to understanding how patients with a chronic psychiatric condition relate to their own thoughts.

These findings can be considered within the Self-Regulatory Executive Function (S-REF) model (Wells & Matthews, 1996) and the notion of decentering. A non-threatened, non-judgmental stance toward one's own thoughts may be related to how reliable one judges one's own cognition to be, as reflected in *Cognitive Confidence*. By contrast, quiet ego was not significantly associated with *Cognitive Self-Consciousness*, although a non-significant result in a small sample cannot be taken as evidence of no association. Given the cross-sectional design and the limited sample size, any interpretation in terms of appraisal versus monitoring processes remains speculative.

The only association surviving Bonferroni correction concerned *Cognitive Confidence*: patients with higher quiet ego reported less self-doubt about their attention

and memory. However, this finding should be interpreted cautiously. *Cognitive Confidence* is a self reported belief and does not index actual cognitive performance. Low confidence may reflect accurate awareness of genuine deficits (Østefjells *et al*., 2017; Van Camp *et al*., 2019) or dysfunctional metacognitive beliefs (Sun *et al*., 2017), and the present data cannot distinguish between these possibilities, as objective neurocognitive performance was not examined here. The result should therefore be considered preliminary and in need of replication in larger samples.

Regarding clinical implications, quiet ego interventions have been shown to be trainable (Wayment et al., 2015b; 2019b), with gains in flourishing and related mechanisms such as trait emotional intelligence in randomized design (Liu *et al*., 2022). Brief quiet ego workshops have also been tested as a self-management skill to reduce compassion fatigue and improve wellbeing among professionals exposed to chronic occupational strain (Wayment *et al*., 2019a). Self-compassion training programs, which partly overlap conceptually with quiet ego, have shown benefits for self-management in chronic illness (Wayment et al., 2015b), including reduced depressive symptoms and improved metabolic outcomes in patients with diabetes (Sandham *et al*., 2023), a population that, like BD, must manage a lifelong condition.

These considerations fit with the role of psychoeducation in mental health care. Psychoeducational interventions are important not only for reducing stigma, but also for helping patients and their families understand aspects of mental health that are often difficult or "dark", as well as the dynamics of social and emotional functioning (Kaufman *et al*., 2019). In BD, psychoeducation is typically aimed at mood symptoms and relapse prevention (Lucattelli *et al*., 2023). Our findings suggest that its scope could be extended to how patients relate to and evaluate their own thoughts and cognitive functioning, for example by addressing self-doubt about attention and memory. Quiet-ego–enhancing components, such as a non-defensive and non-judgmental stance toward one's own experience, could be integrated into psychoeducational programs. They could also complement metacognitive therapy, which targets metacognitive beliefs directly. Such interventions could thus be considered a plausible adjunct within the long-term self-management of a chronic and potentially disabling illness, rather than a treatment for acute episodes.

Future studies should first replicate these findings in larger samples, in order to establish whether the association with *Cognitive Confidence* is robust and whether the uncorrected association with *Negative Beliefs about Uncontrollability and Danger* is confirmed.

Longitudinal and mediation designs are also needed to test whether quiet ego influences *cognitive confidence*, and through it clinical and functional outcomes, while controlling for objective neurocognitive performance.

Finally, intervention studies should examine whether quiet-ego–enhancing programs, including psychoeducational formats, produce corresponding changes in metacognitive beliefs in BD, particularly in cognitive confidence.

LIMITATIONS

Several limitations should be acknowledged. First, the sample was small and preliminary (N = 50), which limited statistical power and the precision of the estimates, particularly for the associations that were borderline or nonsignificant. Second, the cross-sectional and correlational design precludes causal inference and any conclusion about the direction of the associations: higher quiet ego may foster more adaptive metacognitive beliefs, but the reverse, or the influence of third variables, cannot be excluded. Third, the absence of a healthy control group prevents us from establishing whether the observed pattern is specific to BD. Fourth, five subscale-level tests were conducted on the same instrument. After Bonferroni correction only the association with *Cognitive Confidence* remained significant, while the other associations, including the uncorrected one with *Negative Beliefs about Uncontrollability and Danger*, should not be interpreted as effects. Fifth, *Cognitive Confidence* was assessed only by self-report and was not compared with objective neurocognitive performance, so it cannot be established whether it reflects accurate self-appraisal or dysfunctional beliefs. Finally, additional measures were collected but not analyzed in depth here, so the potential contribution of other clinical and personality variables was not examined.

AUTHOR'S CONTRIBUTION STATEMENT

Bernabei: Design of the study, methods and interpretation the data, writing draft, final approval.

Mentuccia: methods, revision, writing draft, final approval.

Carlone: investigation and data collection, final approval.

Marino: resources, methods, final approval.

Scardigli: investigation and data collection, final approval.

Sagliano: data cleaning and management, final approval.

Nicolò: supervision, critical revision, final approval.

CONFLICTS OF INTEREST STATEMENT

Authors declare no conflict of interest.

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