**Neurocognitive predictors of metacognition in individuals at clinical high risk for psychosis**

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**Abstract**

**Background:** Metacognition refers to the ability to evaluate and control our cognitive processes. While studies have investigated metacognition in schizophrenia and CHR, less is known about the potential mechanisms which result in metacognitive deficits. **Aims:** We aimed to investigate whether neurocognitive functions including attention, working memory, verbal learning, and executive functions predicted the tendency to focus on one’s thoughts (cognitive self-consciousness) and beliefs in the efficacy of one’s cognitive skills (cognitive confidence). **Method:** Participants (130 CHR individuals) were recruited as part of the multi-site PREDICT study. They were assessed using the Metacognitions Questionnaire (MCQ) as well as measures of executive function (WCST), attention (N-Back), working memory (LNS), and verbal learning (AVLT). **Results:** Cognitive competence was negatively correlated with N-Back while cognitive self-consciousness was positively correlated with N-Back and LNS. Linear regression analysis with N-Back, AVLT, LNS, and WCST as predictors showed that neurocognition significantly predicted cognitive self-consciousness, with N-Back, LNS, and WCST as significant predictors. The model accounted for 14% of the variance in cognitive self-consciousness. However, neurocognition did not result in a significant predictive model of cognitive competence. **Conclusions**: Neurocognition was associated with an increased focus on one’s thoughts, but it was not associated with higher confidence in one’s cognitive skills. Neurocognition accounted for less than one-sixth of the variance in metacognition, suggesting that interventions that target neurocognition are unlikely to improve metacognitive abilities.

**Introduction**

Metacognition can be defined as the ability to evaluate and control our cognitive processes. Metacognition allows us to evaluate the state of our cognitive functions (*metacognitive monitoring*), direct cognitive and behavioral performance (*metacognitive control*), and understand task difficulty and resource requirements (*metacognitive knowledge*) (Flavell, 1979). There is growing evidence that understanding the role of metacognitive functions in schizophrenia may provide solutions to long standing problems of cognitive remediation, including lack of far transfer and gains in real world functioning (Cella, Reeder, & Wykes, 2015; Quiles, Prouteau, & Verdoux, 2013). Though metacognitive deficits can exist even in the absence of neurocognitive dysfunction, there is often a close relation between metacognition and neurocognitive abilities. Evidence shows that metacognition is partly associated with neurocognitive functions like attention (Fernandez-Duque, Baird, & Posner, 2000), learning ability (Doody, Götz, Johnstone, Frith, & Cunningham Owens, 1998), working memory (Lysaker, Dimaggio, Buck, Carcione, & Nicolò, 2007), and executive functions (Greig, Bryson, & Bell, 2004).

While metacognition has been extensively studied in schizophrenia (Lysaker et al., 2013; Moritz and Woodward, 2007), fewer studies have investigated metacognition in individuals at clinical high risk for psychosis (CHR). Previous studies have highlighted three aspects of metacognition in CHR. Firstly, several studies have shown that CHR individuals perform worse than healthy controls on metacognition tasks (Morrison et al., 2002, 2015; Morrison et al., 2006; Morrison, French, & Wells, 2007) while individuals with psychosis perform worse than CHR (Morrison et al., 2007). Secondly, in CHR as well as healthy individuals metacognitive deficits are associated with psychosis proneness and paranoid beliefs (Barkus et al., 2010; Morrison et al., 2015), providing support for the view that maladaptive metacognitions may contribute to the development of unusual perceptual experiences (Morrison, 2001). Finally, findings from neuroimaging has shown that metacognition in CHR individuals is associated with altered cortical thickness in brain regions that consistently show reductions in schizophrenia, including the inferior and middle frontal gyri, superior temporal cortex, and insula (Buchy, Stowkowy, MacMaster, Nyman, & Addington, 2015).

In a previous analysis using the same data (Barbato et al., 2014), it was reported that CHR individuals performed more poorly than help seeking controls on a self-reported measure of metacognition, the Metacognitions Questionnaire (MCQ; Cartwright-Hatton and Wells, 1997). Furthermore, CHR individuals who later transitioned to psychosis performed significantly worse on the MCQ when compared to those who did not make the transition. MCQ is a self-reported measure which includes three subscales pertaining to positive and negative beliefs about thoughts and two subscales pertaining to cognition—cognitive self-consciousness and cognitive confidence. Cognitive self-consciousness refers to the tendency to focus on one’s thought processes*,* while cognitive confidence refers to belief in the efficacy of one’s cognitive skills. From a neurocognitive perspective, cognitive self-consciousness and cognitive confidence are most likely to be influenced by neurocognitive functions.

In this paper, we sought to investigate whether neurocognition predicts cognitive self-consciousness and cognitive confidence in CHR individuals. We chose neurocognitive functions which have been associated with metacognition in previous studies, including attention, verbal learning, working memory, and executive functions. We hypothesized that neurocognition will significantly predict cognitive self-consciousness and cognitive confidence in CHR individuals.

**Methods**

***Participants***

The sample consisted of 130 individuals at CHR for psychosis recruited as part of a multi-site NIMH funded study *Enhancing the Prospective Prediction of Psychosis (PREDICT)* conducted at the University of Toronto, University of North Carolina, and Yale University (for more details of recruitment, see Barbato et al., 2014). Briefly, CHR status was determined using the Structured Interview for Psychosis-Risk Syndromes (SIPS; McGlashan et al., 2010). One hundred and twenty-eight participants met criteria for attenuated positive symptom syndrome (APSS), which involves the emergence or worsening of non-psychotic level disturbance in thought content, thought process, or perceptual abnormality over the past year. Two participants met criteria for genetic risk and deterioration (GRD), which requires either a first degree relative with a psychotic disorder or the participant having schizotypal personality disorder as well as a drop of 30% in functioning on the Global Assessment of Functioning scale in the past year.

Participant were excluded if they ever met criteria for an axis I psychotic disorder, had IQ < 70, a history of neurological conditions, or received treatment with antipsychotics. Furthermore, antipsychotics were not used at any point in this study. All data for the current analysis was collected in a single session.

The study protocols and informed consents were reviewed and approved by the ethical review boards of all three study sites—the University of Toronto, University of North Carolina, and Yale University.

***Measures***

The SIPS (McGlashan et al., 2010) was used to determine CHR status. Participants were rated on the Scale of Prodromal Symptoms (SOPS) which consists of 19 items and rates the severity of CHR symptoms in four domains (positive, negative, general, and disorganized).

The Metacognitions Questionnaire (MCQ) (Cartwright-Hatton & Wells, 1997) is a 65-item scale with each item being rated on a 4-point scale from 1 (do not agree) to 4 (agree very much). MCQ is a comprehensive measure of metacognition and consists of multiple sub-scales including items on positive and negative beliefs about thoughts, cognitive self-consciousness, and cognitive confidence. The cognitive self-consciousness subscale assesses the tendency to focus on one’s thought processes and includes items like *I think a lot about my thoughts*, and *I am aware of the way my mind works when I am thinking through a problem,* while cognitive confidence subscale assesses beliefs in the efficacy of one’s cognitive skills and includes items like *I have difficulty knowing if I have actually done something or just imagined it; I imagine having not done things and then doubt my memory for doing them*, and *I have a poor memory*. The cognitive self-consciousness (7-items) and cognitive confidence (10-items) subscales were used for the present analysis.

Wisconsin Card Sorting Test (WCST) (Berg, 1948) was used to assess executive functioning. The participant has to use feedback and match cards based on a rule that changes frequently. Perseverative errors occur when the participant continues to sort the cards according to an erroneous rule, despite negative feedback. Perseverative errors was used in the current analysis as it reflects the ability for concept formation, profiting from correction, and conceptual flexibility (Lezak, Howieson, Bigler, & Tranel, 2012).

The Auditory Verbal Learning Test (AVLT) (Rey, 1964; Schmidt, 1996) requires participants to repeat a list of 15 words after hearing it. Five trials are provided. The total number of words reproduced over 5 trials was used in the current study as representing the participant’s learning ability.

In the 1-back version of the N-Back (Kirchner, 1958), participants have to respond if the stimulus presented is the same as the item presented immediately before it. N-Back total correct score is used in the current analysis as a measure of sustained attention.

In Letter-Number Sequencing (LNS) (PsychCorp, 2008a; 2008b) the participant is presented with increasingly long combinations of letters and numbers and they have to mentally organize and reproduce them with the numbers first (in ascending order) and then the letter (in alphabetical order). LNS requires holding on to and manipulation information mentally, and was hence used in the current study as a measure of working memory.

***Statistical analysis***

Missing data was imputed in IBM Amos using regression imputation with full information maximum likelihood estimation. Two linear regression analyses were performed. WCST, AVLT, N-Back, and LNS were used as predictors to determine whether neurocognitive functions predicted cognitive self-consciousness in analysis 1 and cognitive confidence in analysis 2. Bonferroni correction for multiple comparison was applied and the p-values were only considered significant if they were significant at *p* = 0.025.

**Results**

The participants in this sample (*n* = 130) had a mean age of 20.68 (*SD* = 3.91) and the majority were male (58.5%), white (80.6%), and single (93.1%). Of these participants, 56.1% has been to college or received graduate degrees or certificates, while 33% did not complete high school.

Correlational analyses shows that cognitive competence has a significant negative correlation with N-Back (*r* (128) = -0.27, *p* = 0.002) and cognitive self-consciousness has significant positive correlations with N-Back (*r* (128) = 0.25, *p* = 0.004) and LNS (*r* (128) = -0.25, *p* = 0.004).

Linear regression analysis with N-Back, AVLT, LNS, and WCST as predictors showed that neurocognition significantly predicted cognitive self-consciousness [*F* (4, 125) = 4.99, *p* = 0.001]. The significant predictors in the model were N-Back, LNS, and WCST (Table 1). The model accounted for 14% of the variance in cognitive self-consciousness (*R2*= 0.14).

Linear regression analysis with N-Back, AVLT, LNS, and WCST as predictors showed that neurocognition did not predict cognitive competence (after Bonferroni correction) [*F* (4, 125) = 2.41, *p* = 0.053; *R2*= 0.072] (Table 2).

\*\*\* Tables 1 and 2 Here\*\*\*

**Discussion**

Results showed that neurocognitive functions significantly predicted cognitive self-consciousness but not cognitive confidence in CHR. The most significant individual predictor of cognitive self-consciousness was executive function, followed by working memory and attention. However, the final model accounted for less than 15% of the variance in cognitive self-consciousness.

*Metacognitive Monitoring in CHR*

The cognitive self-consciousness subscale of MCQ comprises of items that assess the participant’s need to control their thoughts and negative consequences of not doing so (Wells and Cartwright-Hatton, 2004). The items enquire about preoccupation with one’s thoughts and thought processes, uncertainty about thoughts, and tendency to monitor and evaluate one’s thoughts. In other words, it taps into what has been referred to elsewhere as metacognitive monitoring (Flavell, 1979). We found that higher levels of attention, working memory, and executive functioning were associated with higher levels of metacognitive monitoring in CHR.

The cognitive confidence subscale of MCQ comprises of items that assess the participant’s confidence in memory and attention (Wells and Cartwright-Hatton, 2004). The items enquire about their confidence in memory for actions, words, names, and places, how much they trust their memory, and difficulties with attention and distractibility. While both subscales pertain to metacognitive monitoring, cognitive confidence differs in that the items refer to specific problems with attention, concentration, and memory rather than general preoccupation with thoughts and thought processes. We did not find higher levels of neurocognition (especially attention and memory) to be associated with greater cognitive confidence, as might be expected in a healthy population.

Taken together, these results suggest that in CHR individuals higher neurocognitive functioning is associated with an increased tendency to focus on thought processes, but it does not result in higher confidence in their thought processes. Adequate metacognitive monitoring is a prerequisite for good metacognitive control and metacognitive knowledge. To borrow an example from education, students with poor metacognitive monitoring are less likely to avoid distractions and more likely to spend time learning materials they already know instead of focusing on what they do not know.

*Role of neurocognitive functions*

Furthermore, results showed that attention, working memory, and executive functions predicted cognitive self-consciousness. Attention is a prerequisite for all upstream neurocognitive processes and is therefore expected to contribute to metacognitive functioning. Poor working memory has been associated with decreased metacognitive ability to distinguish one’s thoughts in schizophrenia (Lysaker et al., 2007). Finally, specific aspects of executive function have been associated with specific domains of metacognition in schizophrenia (Lysaker et al., 2008). Our findings suggest that, among CHR, better neurocognition is associated with increased focus on thought processes. However, given that a substantial part of metacognition is not accounted for by neurocognition, neurocognition does not predict cognitive confidence, and that this sample of CHR individuals perform worse than non-patients (but better than psychosis patients) on metacognition (see previous analysis by Barbato et al., 2014), our findings provide support for the view that metacognitive deficits in the CHR are not primarily the result of deficits in individual neurocognitive processes.

*Limitations*

The primary limitation of this study is the use of a self-report measure and the absence of an objective measure of metacognition. While the phenomena of interest in this analysis (cognitive self-consciousness and cognitive confidence) can only be reported subjectively, this study could have benefitted from the added inclusion of an objective measures of metacognition, such as The Indiana Psychiatric Illness Interview (Lysaker, Clements, Plascak-Hallberg, Knipscheer, & Wright, 2002), allowing for greater specificity and confidence in the findings.

**Conclusions**

Metacognitive deficits in schizophrenia are associated with symptom severity (Lysaker, Buck, & Ringer, 2007), and poor treatment outcomes including poor social functioning (Brüne, Abdel-Hamid, Lehmkämper, & Sonntag, 2007; Roncone et al., 2002), community functioning (Quiles et al., 2013), and decreased insight (Lysaker et al., 2005; Lysaker et al., 2007). Metacognition also possibly moderates the relation between cognition and functional impairments in schizophrenia (Koren, Seidman, Goldsmith, & Harvey, 2006; Quiles et al., 2013). Our findings show that neurocognition contributes to less than one-sixth of variance in metacognition and therefore suggests that changes in neurocognition are unlikely to substantially improve metacognition.

*Financial Support*

This work was supported by National Institute of Mental Health (NIMH) grants to J. Addington (grant number U01MH06634-02), D. Perkins (grant number U01MH066069-04), and S. Woods (grant number U01MH066160). The NIMH had no further role in study design, collection and analysis of data, writing of the report, or in the decision to submit the paper for publication.

*Conflict of interest*

M. Shakeel, L. Lu, S. Woods, D. Perkins, and J. Addington, have no conflict of interest with respect to this publication.

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Tables

Table 1. Neurocognitive predictors of cognitive self-consciousness in clinical high-risk individuals.

|  |  |  |  |
| --- | --- | --- | --- |
|  | *Unstandardized coefficients* | | *Standardized coefficients* |
|  | *B* | *SE* | *β* |
| Intercept | 6.19 | 3.048 |  |
| N-Back 1 | 0.060\* | 0.029 | 0.20 |
| AVLT | 0.040 | 0.051 | 0.078 |
| LNS | 0.31\* | 0.15 | 0.24 |
| WCST | 0.32\* | 0.12 | 0.25 |

AVLT = Auditory verbal learning task; LNS = Letter number sequencing task; WCST = Wisconsin card sorting task.

\**p*<0.05

Table 2. Neurocognitive predictors of cognitive competence in clinical high-risk individuals.

|  |  |  |  |
| --- | --- | --- | --- |
|  | *Unstandardized coefficients* | | *Standardized coefficients* |
|  | *B* | *SE* | *β* |
| Intercept | 27.177 | 5.097 |  |
| N-Back | -0.13 | 0.049 | -0.27 |
| AVLT | -0.011 | 0.085 | -0.013 |
| LNS | 0.074 | 0.25 | 0.035 |
| WCST | 0.017 | 0.20 | 0.008 |

AVLT = Auditory verbal learning task; LNS = Letter number sequencing task; WCST = Wisconsin card sorting task.