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Comments on *Interpersonal skills training for the emergency department – exploring a mentalizing approach*

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Dear Editor,

We read with great interest and appreciation the brief report by Patrick *et al.*,¹ which discusses the implementation of “mentalizing skills” as a training intervention for Emergency Department (ED) staff. We believe this work addresses a highly relevant issue in Emergency Medicine, highlighting relational competencies that are often overlooked in traditional training pathways. These skills are essential for managing the clinically and emotionally intense interactions typical in the ED.

This article prompted us to consider how the concept of mentalization can provide a valuable framework for understanding deeper and less visible forms of moral distress in the context of Italian EDs. This understanding goes beyond simply addressing burnout and can be described as “moral erosion”.^{2,3}

In Italy, EDs are currently facing increasing complexity due to overcrowding, resource shortages, time pressure, and rising clinical demands.^{4,5} The COVID-19 pandemic has further highlighted and intensified these critical issues.^{6,7} These factors not only impact the organization of services but also

the emotional and professional experiences of healthcare workers, who are required to make clinical and relational decisions under conditions of high emotional intensity.

In light of this context, our contribution is based on a multicentre study conducted from November 2025 to January 2026 among staff (physicians, nurses and healthcare assistants) in Italian EDs, with a total of 191 participants.

We used a structured, anonymous, self-administered measures composed of two validated scales and additional ad hoc items developed by our research group to investigate the professional and moral experiences of healthcare workers. Specifically, we used the Mini-Maslach Burnout Inventory (Mini-MBI) to assess burnout dimensions and the Generalized Anxiety Disorder scale (GAD-2) to screen for anxiety symptoms. The study-specific items were grouped into four domains: i) practical and organizational constraints; ii) emotional and identity-related responses; iii) intra-team communication patterns; and iv) coping strategies adopted in daily clinical practice. Items addressing the four ad hoc domains and the Mini-MBI burnout items were rated on a Likert-type frequency scale (1–5; from “never” to “always”), whereas anxiety symptoms were assessed using the standard GAD-2 response options (0–3) as commonly applied in the literature. A limited number of open-ended questions were also included to allow participants to elaborate on their experiences of moral distress. Quantitative data were analysed using descriptive statistics and Pearson correlation analyses, while qualitative responses were examined through a descriptive thematic approach.

Descriptive analyses across the four domains revealed moderate but persistent levels of moral erosion-related dimensions ($M = \text{mean}$): moral and professional constraints ($M = 3.30$), emotional and identity-related reactions ($M = 2.84$), communication and interprofessional support ($M = 2.82$), and coping strategies/moral resilience ($M = 3.31$). Higher scores indicate greater strain for the first two domains; for communication/support, higher scores indicate greater perceived criticality (i.e., poorer communication/less support), whereas for coping/moral resilience higher scores indicate more frequent use of coping strategies, which were heterogeneous (adaptive and defensive) and therefore not uniformly protective.

The Mini-MBI showed a mean score of 2.62, consistent with moderate but clinically meaningful burnout-related symptomatology, while the GAD-2 mean score was 2.10, with approximately one third of respondents reaching or exceeding the clinical cut-off (≥ 3).

Pearson correlations showed strong associations ($r > 0.70$) between the emotional/identity-related reactions domain and Mini-MBI and GAD-2 scores, indicating that greater emotional/identity-

related strain is associated with higher burnout and anxiety symptoms. The practical/organizational constraints domain and intra-team communication domain showed moderate associations ($r \approx 0.45$), whereas coping showed weaker and more heterogeneous correlations. Although we did not test direct associations between domains, the observed pattern is consistent with the hypothesis that organizational constraints may contribute to emotional/identity-related strain, which is closely associated with psychological outcomes. In this context, communication and coping may play a modulatory role in how moral distress is managed. In our study, higher scores in the intra-team communication/interprofessional support domain reflected greater perceived criticality (*i.e.*, poorer communication/less support) and were moderately associated with burnout and anxiety. Coping-related items captured heterogeneous strategies (including both adaptive and defensive responses) and showed weaker and less consistent correlations. Overall, these findings suggest that relational dynamics within teams may shape whether distress is shared and processed or, conversely, becomes normalized and silenced. Within this framework, mentalization may represent a valuable resource. Although our study did not directly assess mentalization, we refer here to the Mentalizing Skills approach described by Patrick *et al.*¹ as a potentially relevant intervention target. When supported through training, protected time, and reflective spaces, mentalization may help strengthen coping and foster more thoughtful communication, thereby supporting healthcare workers facing moral strain. Conversely, reduced reflective capacity within teams may contribute to cumulative moral wear-and-tear and, over time, moral erosion.

This perspective is consistent with the correlational pattern observed in our data—particularly the strong associations between emotional/identity-related strain and psychological outcomes—and with recurring themes in the open-ended responses, such as emotional distancing and difficulty sharing morally challenging experiences. Such dynamics may render moral erosion less visible while allowing it to persist over time.

In conclusion, we believe that the contribution of Patrick *et al.*¹ offers an opportunity to strengthen ED training by introducing relational competencies that can support clinical work in emotionally demanding situations. Based on our findings, it may be useful to develop shared, structured training pathways and tools to recognize and address moral erosion in daily ED practice, and to test whether mentalization-informed interventions can improve communication, coping, and related outcomes.

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Availability of data and materials: all data underlying the findings are fully available upon reasonable request to Paola Franceschini, p.franceschinipaola@gmail.com

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