Randomized Trial to Evaluate the Efficacy of Cognitive Therapy for Low-Functioning Patients With Schizophrenia

Paul M. Grant, PhD; Gloria A. Huh, MSEd; Dimitri Perivoliotis, PhD; Neal M. Stolar, MD, PhD; Aaron T. Beck, MD

Context: Low-functioning patients with chronic schizophrenia have high direct treatment costs and indirect costs incurred due to lost employment and productivity and have a low quality of life; antipsychotic medications and psychosocial interventions have shown limited efficacy to promote improved functional outcomes.

Objective: To determine the efficacy of an 18-month recovery-oriented cognitive therapy program to improve psychosocial functioning and negative symptoms (avolition-apathy, anhedonia-asociality) in low-functioning patients with schizophrenia.

Design, Setting, and Participants: A single-center, 18-month, randomized, single-blind, parallel group trial enrolled 60 low-functioning, neurocognitively impaired patients with schizophrenia (mean age, 38.4 years; 33.3% female; 65.0% African American).

Interventions: Cognitive therapy plus standard treatment vs standard treatment alone.

Main Outcome Measures: The primary outcome measure was the Global Assessment Scale score at 18 months after randomization. The secondary outcomes were scores on the Scale for the Assessment of Negative Symptoms and the Scale for the Assessment of Positive Symptoms at 18 months after randomization.

Results: Patients treated with cognitive therapy showed a clinically significant mean improvement in global functioning from baseline to 18 months that was greater than the improvement seen with standard treatment (within-group Cohen d, 1.36 vs 0.06, respectively; adjusted mean [SE], 58.3 [3.30] vs 47.9 [3.60], respectively; P=.03; between-group d=0.56). Patients receiving cognitive therapy as compared with those receiving standard treatment also showed a greater mean reduction in avolition-apathy (adjusted mean [SE], 1.66 [0.31] vs 2.81 [0.34], respectively; P=.01; between-group d=−0.66) and positive symptoms (hallucinations, delusions, disorganization) (adjusted mean [SE], 9.4 [3.3] vs 18.2 [3.8], respectively; P=.04; between-group d=−0.46) at 18 months. Age was controlled in the analyses, and there were no meaningful group differences in baseline antipsychotic medications (class or dosage) or in medication changes during the course of the trial.

Conclusion: Cognitive therapy can be successful in promoting clinically meaningful improvements in functional outcome, motivation, and positive symptoms in low-functioning patients with significant cognitive impairment.

Trial Registration: clinicaltrials.gov Identifier: NCT00350883

Arch Gen Psychiatry. 2012;69(2):121-127.
Published online October 3, 2011.

BETWEEN 2 AND 3 MILLION American adults currently have schizophrenia. The modal onset is in early adulthood, and roughly two-thirds of affected individuals experience a chronic or fluctuating course of illness. Annual overall direct treatment costs and indirect costs incurred due to lost employment and productivity approach $63 billion in the United States or an average of between $26 000 and $31 000 per patient, which is 5 times the per-patient cost of depression. Although antipsychotic medications have been demonstrated to reduce hallucinations and delusions, one-third to one-half of patients with schizophrenia continue to experience residual symptoms or have intolerable adverse effects. The disorganized (speech disturbance) and negative (affective flattening, alogia, apathy, anhedonia, and asociality) symptoms of schizophrenia are even less responsive to the medications than hallucinations and delusions. Importantly, the effect of medications on functional outcomes has been modest, even when medication regimens have been optimized.

For editorial comment see page 119

Author Affiliations: Perelman School of Medicine, University of Pennsylvania, Philadelphia (Drs Grant, Stolar, and Beck and Ms Huh); and Veterans Affairs San Diego Healthcare System, San Diego, California (Dr Perivoliotis).
Starting in the 1950s, patients with schizophrenia have been moved from mental hospitals to the community. In Philadelphia, Pennsylvania, for example, patients enrolled in community mental health centers are offered supported housing and a wide range of therapeutic and vocational services; however, a large proportion continue to function at a low level. We sought to determine whether a novel version of cognitive therapy (CT) would lead to an increase in functioning and decreases in negative symptoms and positive symptoms (hallucinations, delusions, and disorganization) in this population. To determine the efficacy of this targeted CT derived from basic research and adapted to this population, we selected a sample of patients who were on the low end of the continuum of psychosocial functioning. This sample was also neurocognitively impaired (difficulties with information processing on tasks of memory, attention, and executive functioning) and experienced residual positive symptoms. Cognitive therapy (often labeled cognitive behavior therapy) has an extensive empirical basis in theory and has been successfully applied to a wide range of psychiatric problems. It was initially applied to schizophrenia by investigators in the United Kingdom, and results demonstrated success at reducing positive and negative symptoms. Despite these encouraging findings, studies of CT have not focused on those patients with neurocognitive impairment and poor functioning. Similarly, studies of other psychosocial, behavioral, or neurocognitive remediation interventions have been limited by the following: a focus on acute rather than chronic psychosis, inclusion of a heterogeneous sample of patients, or a failure to find that treatment effects generalize adequately to psychosocial functioning.18-22

In adapting CT for low-functioning patients with schizophrenia, we shifted the emphasis from the predominantly symptom-oriented approach that typifies the UK protocols to a person-oriented therapeutic approach by highlighting the patients’ interests, assets, and strengths. The objective was to improve the level of functioning in the form of enhanced productivity, independence, and quantity and quality of social interactions. We developed the framework for our therapy from the finding that dysfunctional beliefs, in conjunction with neurocognitive impairment, impede functioning.23-28 In addition, our therapy is largely influenced by the principles and spirit of the Recovery Movement.27,28

We focused our treatment methods on identifying and promoting concrete goals for improving quality of life and reintegration into society. In adapting our treatment protocol to this highly regressed group, we decided to extend the duration of treatment from the originally planned 12 months to 18 months. Further, we decided to focus on global functioning as a more appropriate measure of progress than simply the reduction of negative symptoms. Our protocol, in summary, differs from previous CT protocols for patients with schizophrenia in being explicitly recovery oriented, goal directed, and adapted for neurocognitive and skills impairments; it treats functional outcomes as primary rather than secondary targets of therapy and uses therapeutic conceptualizations based on new research on dysfunctional beliefs.

We conducted a randomized controlled trial to evaluate the efficacy of CT for neurocognitively impaired, poorly functioning patients with chronic schizophrenia. The trial was conducted at a single center. The protocol and consent form were approved by 2 institutional review boards (the University of Pennsylvania and the City of Philadelphia). Each participant gave written informed consent before enrollment. Eligibility criteria included the following: diagnosis of DSM-IV schizophrenia or schizoaffective disorder; prominent negative symptoms (at least moderate severity on 2 Scale for the Assessment of Negative Symptoms global subscales, or marked severity on 1 subscale); aged 18 to 65 years; proficient in English; and able to give informed consent. Exclusion criteria included the following: neurologic disease or damage that would compromise cognitive functioning; and physical handicaps that would interfere with assessment procedures or therapy attendance. Diagnosis of schizophrenia or schizoaffective disorder was determined on a consensus best-estimate basis by research personnel (with PhD and MD degrees) using a structured interview conducted by an assessor trained to criterion (intraclass correlation > 0.80).30

We conducted a randomized controlled trial to evaluate the efficacy of CT for neurocognitively impaired, poorly functioning patients with chronic schizophrenia. The trial was conducted at a single center. The protocol and consent form were approved by 2 institutional review boards (the University of Pennsylvania and the City of Philadelphia). Each participant gave written informed consent before enrollment. Eligibility criteria included the following: diagnosis of DSM-IV schizophrenia or schizoaffective disorder; prominent negative symptoms (at least moderate severity on 2 Scale for the Assessment of Negative Symptoms global subscales, or marked severity on 1 subscale); aged 18 to 65 years; proficient in English; and able to give informed consent. Exclusion criteria included the following: neurologic disease or damage that would compromise cognitive functioning; and physical handicaps that would interfere with assessment procedures or therapy attendance. Diagnosis of schizophrenia or schizoaffective disorder was determined on a consensus best-estimate basis by research personnel (with PhD and MD degrees) using a structured interview conducted by an assessor trained to criterion (intraclass correlation > 0.80).30

In adapting CT for low-functioning patients with schizophrenia, we shifted the emphasis from the predominantly symptom-oriented approach that typifies the UK protocols to a person-oriented therapeutic approach by highlighting the patients’ interests, assets, and strengths. The objective was to improve the level of functioning in the form of enhanced productivity, independence, and quality of social interactions. We developed the framework for our therapy from the finding that dysfunctional beliefs, in conjunction with neurocognitive impairment, impede functioning. In addition, our therapy is largely influenced by the principles and spirit of the Recovery Movement.30

We focused our treatment methods on identifying and promoting concrete goals for improving quality of life and reintegration into society. In adapting our treatment protocol to this highly regressed group, we decided to extend the duration of treatment from the originally planned 12 months to 18 months. Further, we decided to focus on global functioning as a more appropriate measure of progress than simply the reduction of negative symptoms. Our protocol, in summary, differs from previous CT protocols for patients with schizophrenia in being explicitly recovery oriented, goal directed, and adapted for neurocognitive and skills impairments; it treats functional outcomes as primary rather than secondary targets of therapy and uses therapeutic conceptualizations based on new research on dysfunctional beliefs.

We conducted a randomized controlled trial to evaluate the efficacy of CT for neurocognitively impaired, poorly functioning patients with chronic schizophrenia. The trial was conducted at a single center. The protocol and consent form were approved by 2 institutional review boards (the University of Pennsylvania and the City of Philadelphia). Each participant gave written informed consent before enrollment. Eligibility criteria included the following: diagnosis of DSM-IV schizophrenia or schizoaffective disorder; prominent negative symptoms (at least moderate severity on 2 Scale for the Assessment of Negative Symptoms global subscales, or marked severity on 1 subscale); aged 18 to 65 years; proficient in English; and able to give informed consent. Exclusion criteria included the following: neurologic disease or damage that would compromise cognitive functioning; and physical handicaps that would interfere with assessment procedures or therapy attendance. Diagnosis of schizophrenia or schizoaffective disorder was determined on a consensus best-estimate basis by research personnel (with PhD and MD degrees) using a structured interview conducted by an assessor trained to criterion (intraclass correlation > 0.80).30

We conducted a randomized controlled trial to evaluate the efficacy of CT for neurocognitively impaired, poorly functioning patients with chronic schizophrenia. The trial was conducted at a single center. The protocol and consent form were approved by 2 institutional review boards (the University of Pennsylvania and the City of Philadelphia). Each participant gave written informed consent before enrollment. Eligibility criteria included the following: diagnosis of DSM-IV schizophrenia or schizoaffective disorder; prominent negative symptoms (at least moderate severity on 2 Scale for the Assessment of Negative Symptoms global subscales, or marked severity on 1 subscale); aged 18 to 65 years; proficient in English; and able to give informed consent. Exclusion criteria included the following: neurologic disease or damage that would compromise cognitive functioning; and physical handicaps that would interfere with assessment procedures or therapy attendance. Diagnosis of schizophrenia or schizoaffective disorder was determined on a consensus best-estimate basis by research personnel (with PhD and MD degrees) using a structured interview conducted by an assessor trained to criterion (intraclass correlation > 0.80).30

In adapting CT for low-functioning patients with schizophrenia, we shifted the emphasis from the predominantly symptom-oriented approach that typifies the UK protocols to a person-oriented therapeutic approach by highlighting the patients’ interests, assets, and strengths. The objective was to improve the level of functioning in the form of enhanced productivity, independence, and quality of social interactions. We developed the framework for our therapy from the finding that dysfunctional beliefs, in conjunction with neurocognitive impairment, impede functioning. In addition, our therapy is largely influenced by the principles and spirit of the Recovery Movement.30

We focused our treatment methods on identifying and promoting concrete goals for improving quality of life and reintegration into society. In adapting our treatment protocol to this highly regressed group, we decided to extend the duration of treatment from the originally planned 12 months to 18 months. Further, we decided to focus on global functioning as a more appropriate measure of progress than simply the reduction of negative symptoms. Our protocol, in summary, differs from previous CT protocols for patients with schizophrenia in being explicitly recovery oriented, goal directed, and adapted for neurocognitive and skills impairments; it treats functional outcomes as primary rather than secondary targets of therapy and uses therapeutic conceptualizations based on new research on dysfunctional beliefs.

We conducted a randomized controlled trial to evaluate the efficacy of CT for neurocognitively impaired, poorly functioning patients with chronic schizophrenia.
tively on achievable long-term goals (eg, independent housing, employment, relationships), intermediate goals, and short-term goals. Key impediments to reaching these goals are dysfunctional beliefs (eg, “taking even a small risk is foolish because the loss is likely to be a disaster” and “making new friends isn’t worth the energy it takes”). The therapists helped patients to undercut their nihilistic beliefs and concomitantly increase their motivation for constructive activity by using a variety of cognitive and behavioral techniques, including activities during the session (eg, exercises, games, role-playing, community outings) and collaboratively devised action plans for practice outside the session. Other impediments to reaching the goals such as the presence of delusions, hallucinations, and disorganized thinking were also addressed by strategies outlined by Beck et al.33 Further, specific deficiencies such as deficits in attention, executive function, and social skills were targets for the therapy. Later sessions were devoted to consolidation of functional gains and relapse prevention. The treatment was tailored to the participant’s level of functioning, such that special adaptations were made for problems due to poor engagement, neurocognitive impairment, thought disorder, and lack of insight. To accommodate neurocognitive impairments, for example, therapists made extensive use of visual aids, including whiteboards for reinforcing session material, laminated cards to help patients remember key take-home points, and colorful signs that patients posted at home to remind them of daily activities and other therapy assignments. The CT sessions followed a treatment manual and were administered by therapists at the doctoral level (PhD and MD). Sessions were video-recorded, and weekly supervision was provided by one of us (A.T.B.).

Standard Treatment

Participants in both study conditions received ST from clinicians in the community. At minimum, this consisted of antipsychotic pharmacotherapy. However, most participants were also actively engaged in services provided by local community mental health centers, including case management, supportive counseling, day treatment services, housing services, peer support, and vocational rehabilitation.

OUTCOMES

The primary objective of adding CT to ST was to aid the progress of patients with schizophrenia toward recovery by producing a clinically significant change in their functional outcome. The Global Assessment Scale (GAS)34 score was the primary outcome measure. The GAS is a single-item interviewer-scored instrument that assesses functioning level and symptoms during the previous month. The rating is made on a 100-point scale, with lower scores indicating poorer functioning. Endicott et al34 demonstrated test-retest reliability and predictive validity (rehospitalization rates) for the GAS in patients with schizophrenia. Secondary measures were the 4 global subscale scores of the Scale for the Assessment of Negative Symptoms (SANS)29 and the total score of the Scale for the Assessment of Positive Symptoms (SAPS).35 The reliability and validity of the SANS and SAPS have been demonstrated.36 A recent consensus statement has proposed the SANS and SAPS as standard measures of negative and positive symptoms.37

SAMPLE SIZE

On the basis of a meta-analysis of medical and behavioral outcomes showing that an effect size of \( d = 0.5 \) between conditions has an effect on quality of life,28 we designated \( d = 0.5 \) as the minimal clinically significant change that the trial would be powered to detect. With a sample size of 60, expected dropout rate of 20%, 2-sided \( \alpha = 0.05 \), and within-subject correlation of 0.5, we determined that the study would have 80% power to detect a true treatment difference in the rate of change of functioning of 0.5 SD.

PLANNED ANALYSES

Linear random-effects models (hierarchical regression models) were implemented with random intercepts and slopes. These models estimate main effects for change from baseline to each assessment at 6, 12, and 18 months, main effect for the treatment, and interactions between the visit and treatment indicator variables. For each of the primary (GAS) and secondary (SANS and SAPS) outcomes, separate intent-to-treat tests and estimates (with 95% CIs) of randomized group contrasts at 6, 12, and 18 months were obtained from the estimates of the respective time X treatment interactions.39 Potential con-
Between January 2007 and August 2009, 60 individuals were entered into the study, with 31 randomly assigned to CT with ST and 29 to ST alone. The mean (SD) age was 38.4 (11.6) years; 20 (33.3%) were female; and 39 (65.0%) were African American. The mean (SD) age at illness onset was 23.1 (8.5) years, and the mean (SD) duration of illness was 15.5 (12.18) years. The mean (SD) neurocognitive impairment in tasks of memory, attention, and executive functioning as measured by a validated computerized battery was a z score of −1.0 (1.2) relative to a healthy reference group, indicating considerable impairment in the sample. In terms of antipsychotic medication, 55 (91.7%) of the cohort was taking at least 1 atypical (second-generation) agent and 39 (65.0%) of the sample had a chlorpromazine equivalent dosage of 400 mg or greater, indicating a high dosage. There were no meaningful group differences in antipsychotic medications at baseline (Table 1 shows baseline sample characteristics).

As displayed in Figure 1, the 18-month trial was completed by 27 of the 31 participants (87.1%) in the CT group (1 died [hypertension] and 3 withdrew [refused treatment]) and by 24 of the 29 participants (82.8%) in the ST group (5 withdrew [2 moved away, 3 refused to continue participation]).

IMPLEMENTATION OF CT

The mean (SD) number of CT sessions for the 28 patients who engaged in treatment was 50.5 (18.9) (range, 16-81). The 8 therapists (with PhD and MD degrees), each having at least 2 years of experience with CT, treated an average of 3.5 patients (range, 1-7 patients).

TREATMENT WITH MEDICATIONS

There was no difference across the 2 conditions in the number of patients who changed medications or dosages.

OUTCOMES

The CT group improved on global functioning (GAS score) during the course of the trial (within-group Cohen $d=1.36$), whereas the ST group improved very little (within-group $d=0.06$) (Figure 2). In the intent-to-
treat hierarchical linear model (Table 2), the interaction term for the condition × GAS score at 18 months was statistically significant (P = .03), indicating that the CT group had functioning superior to that of the ST group at 18 months (adjusted mean [SE], 58.3 [3.30] vs 47.9 [3.60], respectively; between-group d = 0.56).

On the 4 SANS negative symptom subscales (Figure 3), the CT group showed greater improvement than the ST group across the trial for avolition-apathy (at 18 months: within-group d = −2.16 vs −0.45, respectively; for interaction term of condition × 18 months, P = .01; adjusted mean [SE], 1.66 [0.31] vs 2.81 [0.34], respectively; between-group d = −0.66). There were no significant group differences for the other negative symptoms (affective flattening, alogia, anhedonia-asociality).

In terms of positive symptoms (Figure 4), the CT group showed greater improvement than the ST group across the trial (at 18 months: within-group d = −0.90 vs 0.37, respectively; for interaction term of condition × 18 months, P = .04; adjusted mean [SE], 9.4 [3.3] vs 18.2 [3.8], respectively; between-group d = −0.46).

**COMMENT**

We found that patients assigned to CT had better functioning, reduced avolition-apathy, and improved positive symptoms relative to patients who received ST only. Group differences were statistically significant and clinically meaningful. This is the first time, to our knowledge, that patients with chronic schizophrenia selected from the extreme end of the low-functioning continuum have shown statistically significant and clini-
cally meaningful improvement in psychosocial functioning in response to a psychosocial intervention.

Taking the results of functional outcome, motivation, and positive symptoms together, we propose that the patients who received CT entered into a dynamic cycle of recovery. The treatment encourages the patients to set goals related to their everyday functioning, and they become motivated to engage in tasks (initially simple pleasurable, social, and constructive activities) that move them out of their withdrawn state. This increase in activity and motivation puts the patients more in touch with reality and reduces hallucinations, delusions, and disorganization. Reduced positive symptoms allow for further engagement in activity, leading to better functional outcomes and enhancement of motivation, which in turn facilitate a further amelioration of positive symptoms. Thus, we hypothesize that CT triggers the cycle of recovery by targeting self-defeating and dysfunctional beliefs that inhibit the patients’ active engagement in constructive activity. Alternatively, it is possible that improvement in avolition-apathy was largely secondary to improvement in positive symptoms. These are questions that can be addressed by future research.

There are several limitations of this study. First, the measures of functioning and symptoms have been criticized.

For instance, the GAS includes symptoms in the ratings and, as such, is not a pure measure of functional outcome. Use of the newly developed Schizophrenia Outcomes Functioning Interview and Clinical Assessment Interview for Negative Symptoms is warranted in future clinical trials of CT. More frequent assessment of symptoms and functioning would allow for better tracking of changes over time. Also, the therapy was delivered by doctoral-level therapists; generalization to masters-level community therapists who treat low-functioning patients remains to be demonstrated in future research. The CT condition involved more patient contact than the ST condition, raising the possibility that nonspecific patient contact factors are contributing to the observed group differences. Additionally, both therapists and patients were aware of the condition and participation in an experiment, introducing possible bias in the reported outcomes. Future studies can address nonspecific factors and bias due to single-blind design, as well as other factors, by comparing the CT protocol with active psychotherapy comparison conditions that feature treatments (eg, social skills) that have received empirical support for patients with schizophrenia. Finally, it remains for future studies with revised CT protocols to demonstrate efficacy relative to anhedonia, affective flattening, and alogia.

The major findings of this study—that CT improved functioning and motivation and reduced positive symptoms in low-functioning patients with schizophrenia—suggest that this treatment might have utility to help reduce public health costs for the most expensive per-patient psychiatric population while simultaneously improving patients’ quality of life.

Submitted for Publication: May 17, 2011; final revision received July 13, 2011; accepted July 16, 2011.


Correspondence: Paul M. Grant, PhD, Perelman School of Medicine, University of Pennsylvania, Room 2032, 3535 Market St, Philadelphia, PA 19104 (pgrant@mail.med.upenn.edu).

Author Contributions: Dr Grant had full access to all of the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.

Financial Disclosure: Drs Grant, Stolar, and Beck have received royalties from Guilford Press.

Funding/Support: This work was supported by a Distinguished Investigator Award from the National Alliance for Research on Schizophrenia and Depression (Dr Beck) and by grants from the Heinz Foundation and the Barbara and Henry Jordan Foundation.

Role of the Sponsors: The sponsors had no role in design and conduct of the study; collection, management, analysis, and interpretation of the data; or preparation, review, or approval of the manuscript.

Additional Contributions: We express our gratitude to the patients who participated in this research and thereby made it possible. We also thank Arthur Evans Jr, PhD, and the City of Philadelphia Department of Behavioral Health; Roy Beck, MD, PhD; Thomas R. Ten Have, PhD, MPH; Robert A. Steer, EdD; Robert DeRubeis, PhD; LaRiena Ralph, BS, and Jan A. Richard, MS, Hospital of the University of Pennsylvania; and Gail Serruya, MD, Sunil Bhar, PhD, Sally Riggs, ClinPsyD, Luke Schultz, PhD, Jarrod Reisweber, PsyD, Nadine Chang, PhD, Amy Wenzel, PhD, Maureen Endres, MS, Mary Tabit, MS, Heath Hodges, MS, Kara Devers, MSED, Sean Gallagher, MS, Jason Cha, MSED, Ashley Chambers, MS, Michael Ovalle, MEd, and Letitia Travaglini, BS, University of Pennsylvania, for their assistance with this project.

REFERENCES


©2012 American Medical Association. All rights reserved.