Negative Self-Defeating Attitudes: Factors That Influence Everyday Impairment in Individuals With Schizophrenia

TO THE EDITOR: We read with much interest the editorial by Philip D. Harvey, Ph.D., and Barbara A. Cornblatt, Ph.D. (1), in the February 2008 issue of the *Journal*. We agree that the standardization of cognitive measures in the treatment of individuals with schizophrenia unquestionably represents a major advancement in the field. However, it might be of some interest to note that neurocognitive disturbances do not—in and of themselves—directly account for the poor quality of life experienced by many individuals with severe mental illness. In our clinical research, we found that it was the impact of impairment on these patients' experiences (e.g., failure, rejection) and, consequently, their attitudes toward themselves and their expectations that were reflected in their quality of life (2). Cognitive impairment, although the primary factor in the causal chain, was only indirectly connected to quality of life and everyday functioning.

In a recent study, we found that patients' negative attitudes toward performance mediated between neurocognitive dysfunction (as measured by a battery of tests) and quality of life and negative symptoms (3). If these results are reliable, then such negative, self-defeating attitudes might be appropriate therapeutic targets.

References

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Dr. Harvey Replies

TO THE EDITOR: Drs. Beck and Grant call to our attention the very important point that the influence of cognitive functioning on everyday outcomes is affected by the presence of defeatist attitudes. These attitudes have a mediating effect and supplement the influence of cognitive impairment in the prediction of everyday outcomes. Thus, competence (i.e., what one can do, such as cognitive performance) is only one of several predictors of real-world functional performance (i.e., what one actually does). In fact, we previously demonstrated that there are multiple competence domains of importance, including neuropsychological performance and the capacity to perform everyday living and social activities (i.e., functional capacity) (1). Both of these competence variables were described in the three Measurement and Treatment Research to Improve Cognition in Schizophrenia articles discussed in our editorial. Although defeatist attitudes are clear mediators, there are other factors that may also mediate between neurocognitive functioning and everyday outcomes, including patients' psychological characteristics (e.g., depression, motivational factors, social and cognitive abilities) as well as societal and individual factors (e.g., disability compensation, ethnicity). In the effort to account for everyday impairment in individuals with schizophrenia, it appears that a well-defined separation of competence, performance, and mediating factors will lead to the most distinct analysis of contributors to this impairment. These distinctions could result in important treatment implications, since pharmacological and psychosocial treatments are unlikely to affect all of the multiple influences on impairment equally, and they are unlikely to affect some of these influences at all.

Reference

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The Value of Anorexia Nervosa Subtypes

TO THE EDITOR: In their article, published in the February 2008 issue of the *Journal*, Kamryn T. Eddy, Ph.D., et al. (1) supported the removal of the subtyping schema for anorexia nervosa. Given that some of their findings confirm the distinction between restricting-type and binge eating/purging-type anorexia nervosa, their conclusions may be premature. In their study, both the overall rate of crossover and the rate of crossover to bulimia nervosa were lower in the subgroup of patients with restricting-type anorexia nervosa. Although the authors did not report a statistical test pertaining to the rate of crossover for the two anorexia nervosa subtype groups, the differences were highly significant ($p<0.005$, using likelihood-ratio chi square).

The representativeness of the study sample should also be considered. The low number of subjects with restricting-type anorexia nervosa (as well as those with nonpurging bulimia nervosa) and the high diagnostic instability in this subgroup (1) prompts us to consider whether there may have been some form of bias in the recruitment method. The ratios between the two anorexia nervosa subtypes in an adult community sample (2) and among patients consecutively referred to our outpatient unit (anorexia nervosa subjects: N=540) were 3:1 and 2.5:1, respectively, in favor of the restricting type. Since the development of binge eating in restricting-type anorexia nervosa seems to delay the time to recovery (3), it is possible that the high duration of illness in this subgroup could explain, at least in part, any possible bias. In our com-