Early Sensory Contributions to Contextual Encoding Deficits in Schizophrenia

Elisa C. Dias, PhD; Pamela D. Butler, PhD; Matthew J. Hoptman, PhD; Daniel C. Javitt, MD, PhD

Context: The AX version of the visual continuous performance task (AX-CPT) is widely used for investigating visual working memory dysfunction in schizophrenia. Event-related potentials (ERP) provide an objective index of brain function and can be used to evaluate brain substrates underlying impaired cognition in schizophrenia.

Objective: To assess the mechanisms that underlie visual working memory dysfunction in schizophrenia relative to impairment of early visual processing.

Design: Case-control study.

Setting: Inpatient and outpatient facilities associated with the Nathan Kline Institute for Psychiatric Research.

Participants: A total of 30 individuals with schizophrenia and 17 healthy comparison subjects.

Interventions: Three versions of the AX-CPT, with parametric variations in the proportions of trial types, were used to test performance and underlying neural activity during differential challenge situations. Contrast sensitivity measures were obtained from most subjects.

Main Outcome Measures: Behavioral performance was assessed using d’ context scores. Integrity of stimulus- and task-related cortical activation to both cue and probe stimuli was assessed using sensory (C1, P1, N1) and cognitive (N2, contingent negative variation [CNV]) ERP components. Early magnocellular/parvocellular function was assessed using contrast sensitivity. Linear regression and path analyses were used to assess relations between physiological and behavioral parameters.

Results: Patients showed reduced amplitude of both early sensory (P1, N1) and later cognitive (N2, CNV) ERP components. Deficits in sensory (N1) and cognitive (N2) component activation to cue stimuli contributed independently to impaired behavioral performance. In addition, sensory deficits predicted impaired cognitive ERP generation. Finally, deficits in performance correlated with impairments in contrast sensitivity to low, but not high, spatial frequency stimuli.

Conclusions: Working memory deficits in schizophrenia have increasingly been attributed to impairments in stimulus encoding rather than to failures in memory retention. This study provides objective physiological support for encoding hypotheses. Further, deficits in sensory processing contribute significantly to impaired working memory performance, consistent with generalized neurochemical models of schizophrenia.

Arch Gen Psychiatry. 2011;68(7):654-664.
Published online March 7, 2011.
No-Go Percentage

Research have challenged both sets of hypotheses. Developments in schizophrenia and cognitive neuroscience produced by administration of the 

N-methyl-D-aspartate (NMDA) receptor antagonist ketamine to healthy vol-

unteers, consistent with glutamatergic and other distributed neural theories of schizophrenia. Third, recent studies of visual processing suggest that sensory input to prefrontal regions arises via 2 distinct pathways: a rapid, low-resolution “perception for action” system that receives input primarily from the magnocellular visual system and projects primarily via the dorsal stream visual pathway and a slower, higher-resolution “perception for identification” system that projects primarily via the dorsal stream. 

Our study also used unique parametric variations of the AX-CPT in which visual stimuli and task instructions remain the same but stimulus probabilities change, leading to a different global response set (Table 1). These variations permit subfractionation of underlying cognitive processes. Based on prior research, we hypothesized that sensor\[17\]s processes, as indexed by sensory P1 and N1 components, would be impaired across task versions in schizophrenia and would contribute significantly to overall impairments in task performance. We hypothesized that amplitude of frontal N2 and CNV potentials would be reduced as well, consistent with impaired encoding of cue-related information. Finally, we evaluated basic visual processing using contrast sensitivity to low- vs mid/high–spatial frequency (SF) sine-wave stimuli along with AX-CPT performance in a subgroup of subjects. Low-SF stimuli are processed preferentially by the magnocellular visual system, while high-SF stimuli are processed preferentially by the parvocellular system. We have previously observed that patients with schizophrenia show preferential deficits in magnocellular function. For this study, we hypothesized that preferential deficits in detection of low-SF stimuli would again be observed and would correlate with impaired AX-CPT performance, consistent with early visual contributions to overall cognitive impairment in schizophrenia.

### Methods

Participants

Thirty patients who met DSM-IV criteria for schizophrenia and 17 healthy volunteers participated. Patients were recruited from...
of 20 patients and 9 controls who had no significantly different from 3 patients and 2 controls were discarded owing to excessive participants had normal or corrected-to-normal visual acuity. Clini-
zing antipsychotic medication at the time of testing. Chlorproma-
6 months or abuse within the last month. All patients were receiv-
ting criteria for alcohol or substance dependence within the last
of SCID-defined Axis I psychiatric disorder were excluded. Pa-
for their time. This study was approved by the Nathan Kline In-
iects provided informed consent and received cash compensation
unteer Recruitment Pool at the Nathan Kline Institute. All sub-

inpatient and outpatient facilities associated with the Nathan Kline Institute for Psychiatric Research. Diagnoses were obtained using the Structured Clinical Interview for DSM-IV (SCID) and available clinical information. Controls were recruited through the Volunteer Recruitment Pool at the Nathan Kline Institute. All subjects provided informed consent and received cash compensation for their time. This study was approved by the Nathan Kline Institute internal review board. Healthy volunteers with a history of SCID-defined Axis I psychiatric disorder were excluded. Patients and controls were excluded if they had any neurological or ophthalmological disorders that might affect performance or if they met criteria for alcohol or substance dependence within the last 6 months or abuse within the last month. All patients were receiving antipsychotic medication at the time of testing. Chlorpromazine equivalents were calculated as described previously. All participants had normal or corrected-to-normal visual acuity. Clinical and demographic information are included in Table 2. Data from 3 patients and 2 controls were discarded owing to excessive movement artifacts. Contrast sensitivity was assessed in a subgroup of 20 patients and 9 controls who had no significantly different characteristics, using previously described methods.

During recordings, subjects sat in a comfortable chair inside a darkened, electrically shielded recording chamber, facing a computer monitor. Subjects were instructed to respond quickly and accurately by pressing a button on a response pad. They had a practice block of trials before the recordings were initiated.

PARADIGM

Cue-probe sequences were presented sequentially on a computer screen located 137 cm from subject’s eyes using Presentation software (Neurobehavioral Systems, Inc. Albany, California). Letters subtended approximately 2° of visual arc and were presented for 100 milliseconds, white on black, using Helvetica font.

The interval between onset of cue and onset of probe letters was 1240 milliseconds, and the interval between successive cue-probe sequences was 1390 milliseconds. Subjects were instructed to respond by pressing a button following an AX sequence while ignoring all other cue-probe sequences. Invalid (B) cues and in-
valid (Y) probes consisted of letters other than A and X. The response window following target presentation was 1 second.

In each task variant, 1 trial type was presented with 70% probability, while all other sequences were presented with 10% probability, in pseudorandom order (Table 2). Performance was assessed using the parameter d’ context, which reflects the ability to use the cue stimulus to determine the correct response to a subsequently presented valid target letter (AX vs BX sequence).

Each subject performed 6 blocks of 93 trials for each of the 3 tasks, totaling 1674 trials. In most cases, task AX-70 was presented first because this was the condition of primary interest. Task order did not significantly affect performance either across or within group (main effect of order: F[1,41] = 0.25, P = .86; group × order interaction: F[.51] = 0.76, P = .42). Subjects took breaks between blocks and did not report abnormal fatigue during the tasks.

ERP RECORDING

Data Acquisition

Continuous electroencephalography was acquired using an ActiveTwo system (Biosemi, Amsterdam, the Netherlands) from 168 scalp electrodes and digitized at 512 Hz. The continuous data were separated into epochs (~100 to 750 milliseconds) surrounding the digital event tags, baseline corrected from ~100 milliseconds to stimulus onset, and an artifact rejection criterion of ±80 µV was applied. Epochs for the correct trials were averaged separately for each trial type, for cue and probe periods, and for each subject, and a nasal reference was applied to the averaged data. Subjects with fewer than 25 accepted trials in any condition were removed from the analysis. For the remaining subjects, the mean (SD) percentage of accepted sweeps was 77.9% (12.3%) for controls and 72.0% (15.1%) for patients. Grand mean averages for each group were obtained by averaging the data from all subjects. Electrode placement was highly consistent across subjects owing to the use of an electrode cap that constrained interelectrode spacing and placement. An averaged version of the electrode locations on the head was used for group topographic data.

ERP Analysis

Spatiotemporal windows for peak detection were determined based on previous results. The averaged ERP were filtered (low pass, cutoff value, 45 Hz; zero phase shift, 48 dB), and for each component, peak amplitude was obtained from the median of 6 electrodes that covered the area of scalp where this component was best represented (Figure 1). Time windows were C1, 60 to 120 milliseconds; P1, 75 to 130 milliseconds; N1, 100 to 200 milliseconds; N2, 220 to 350 milliseconds; and CNV, 1200 to 1250 milliseconds. Peaks amplitudes were cho-

Table 2. Subject Characteristics

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<tr>
<th>Characteristic</th>
<th>Controls (n=27)</th>
<th>Patients (n=15)</th>
<th>P Value a</th>
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<td>33.3 (2.2)</td>
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<td>Chlorpromazine daily equiv, mg</td>
<td>1241.3 (122.2)</td>
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<td>ILS standard score</td>
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<tr>
<td>WAIS Performance IQ</td>
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<td>IQ (quick test)</td>
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<td>93.7 (2.2)</td>
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<tr>
<td>Duration of illness</td>
<td>14.5 (1.5)</td>
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</table>

Abbreviations: BPRS, Brief Psychiatric Rating Scale; ILS, Independent Living Scales; IQ, intelligence quotient; SANS, Scale for the Assessment of Negative Symptoms; SES, socioeconomic status, measured by 4-factor Hollingshead Scale; WAIS, Wechsler Adult Intelligence Scale.

P values from t tests.
as the dependent measure because of the large latency difference between patients and controls.

**Contrast Sensitivity**

Horizontal sine-wave gratings were presented for 32 milliseconds at spatial frequencies of 0.5, 7, or 21 cycles per degree. A spatial 2-alternative forced-choice procedure was used. On each trial, a sine-wave grating was presented on one side of a monitor and a uniform field of average luminance was presented simultaneously on the opposite side. Sides were randomly varied across trials. The viewing distance was 160 cm, and the grating and uniform field together subtended 5.7° × 5.7° of visual angle. Participants stated which side of the display contained the grating. An up-down transform rule was used to determine contrast sensitivity associated with 79.4% correct responses for each SF in steps of 1.5 dB. The mean of 8 reversals was used to estimate a threshold.

**STATISTICAL ANALYSIS**

Between-group analyses were conducted using repeated-measures multivariate analysis of variance with diagnostic group as a between-subject factor and cue type (A vs B), probe type (X vs Y), preceding cue type (A vs B preceding probe stimuli), and task variant (AX-70, AY-70, BX-70) as within-subject factors, as appropriate. The relationship between variables was determined using stepwise multivariate regression analysis, with statistical significance determined using r change parameter. Further relationship among variables was evaluated by path analysis, as implemented in AMOS 18.0 (SPSS Inc, Chicago, Illinois) (eAppendix; http://www.archgenpsychiatry.com). Effect sizes were calculated using the Cohen’s d statistic. All tests were 2-tailed with a preset level of significance of .05. Unless otherwise noted, data in text represent mean (standard deviation).

**RESULTS**

**BEHAVIORAL RESULTS**

As expected, patients showed increased AX errors ($F_{1,35}=30.3; P<.001$) and greater BX, relative to AY, errors ($F_{1,35}=5.78; P=.02$) across all task versions and in the AX-70 alone (Figure 2A). As a result, both d’ ($F_{1,35}=28.9; P<.001$) and d’ context ($F_{2,34}=18.5; P<.001$) scores were significantly reduced across task variants, with large effect size differences between groups (Figure 2B, eTable 2). The task × group interaction was also significant ($F_{2,34}=4.4; P=.02$), reflecting greater deficits in AY-70 ($F_{1,35}=4.5; P=.04$) and BX-70 ($F_{1,35}=6.7; P=.01$) relative to AX-70 in patients vs controls.

Patients also had longer reaction times to the correct target than controls (controls: 296 [84] milliseconds; patients: 435 [105] milliseconds; $F_{1,35}=34.9; P<.001; d=1.46$), and reaction times varied by task ($F_{1,35}=54.9; P<.001$) but there was no significant group × task interaction.

**EVENT-RELATED POTENTIALS**

Waveforms elicited in the AX-70 condition are illustrated in Figure 3 and Figure 4. Similar components were obtained in the other task variants (eFigure 1, eFigure 2, eFigure 3, and eFigure 4). Peak amplitudes for sensory (C1, P1, N1) and cognitive (N2, CNV) components were calculated for each subject in response to cue and target stimuli separately and analyzed across subjects. Probe trial types were grouped according to type of preceding cue (A or B) and type of probe (X or Y). Effect sizes are summarized in eTable 2.

Separate repeated-measures multivariate analyses of variance were conducted for the 2 sensory (P1, N1) and 2 cognitive (N2, CNV) potentials and for cue and probe stimuli.

**SENSORY POTENTIALS**

**Group Effects**

Amplitudes of both P1 (cue: $F_{1,35}=5.94; P=.02$; probe: $F_{1,35}=5.77; P=.02$) and N1 (cue: $F_{1,35}=7.83; P=.008$; probe: $F_{1,35}=10.9; P=.002$) were significantly reduced in schizophrenia across all conditions, reflecting significant impairment in early sensory processing (Figure 5 and Figure 6). Larger N1 responses were observed to A vs B cues ($F_{1,35}=13.1; P=.001$) (Figure 5) and X vs Y probes ($F_{1,35}=23.2; P<.001$) (Figure 6) across tasks. However, the cue type × group ($F_{1,35}=0.04; P=.80$) and probe type × group ($F_{1,35}=1.06; P=.30$) interactions were not significant, suggesting similar differentiation across groups.
AY-70 task only, resulting in a significant preceding cue \( \times \) task \( (F_{2,34}=13.2; \ P<.001) \) and preceding cue \( \times \) probe type \( \times \) task \( (F_{2,34}=2.95; \ P=.001) \) interactions. Nevertheless, all interactions involving group were not significant, suggesting similar modulation in patients vs controls.

**Latencies**

In addition to being reduced in amplitude, both cue and probe potentials showed longer latencies in patients (cue: \( P1 \ F_{1,35}=11.51, \ P=.002 \) and \( N1 \ F_{1,35}=12.94, \ P=.001 \); probe: \( P1 \ F_{1,35}=15.69, \ P<.001 \) and \( N1 \ F_{1,35}=17.93, \ P<.001 \) (Figures 3 and 4).

**C1**

A weak C1 was also present over the central occipital region in both groups (controls, -2.50 \[2.19\] µV; patients, -1.82 \[0.97\] µV). As opposed to P1 and N1, peak C1 amplitudes were not statistically different between groups \( (F_{1,40}=1.84; \ P=.18) \).

**COGNITIVE POTENTIALS**

**N2**

N2 was significantly reduced in amplitude for both cue \( (F_{2,34}=8.34; \ P=.007) \) and probe \( (F_{1,35}=4.88; \ P=.03) \) stimuli in patients vs controls across all conditions. Across groups, N2 was larger (more negative) to B cues in the AX-70 condition, larger to A cues in BX-70, and approximately equal to A and B cues in the AY-70 task (Figure 5C), leading to a highly significant cue type \( \times \) task interaction \( (F_{2,34}=14.1; \ P<.001) \). Patients showed significantly less difference in response to A vs B cues and significantly less modulation by task than controls, leading to a highly significant cue type \( \times \) task \( \times \) group interaction \( (F_{2,34}=14.1; \ P<.001) \).

In response to probes, N2 was elicited primarily by AX sequences in the AX-70 condition, and AY trials in the AX-70 condition (Figure 6C), leading to a highly significant cue type \( \times \) probe type effect \( (F_{1,35}=24.1; \ P<.001) \). Patients showed highly significant reductions in both conditions, leading to a highly significant probe type \( \times \) task \( \times \) group interaction \( (F_{2,34}=25.7; \ P<.001) \).

**CNV**

CNV was significantly reduced in patients across tasks and stimulus types \( (F_{1,35}=8.56; \ P=.006) \). Across groups, CNV was observed primarily for A vs B cues across task variants \( (F_{1,35}=115.5; \ P<.001) \). For A cues, CNV was larger in BX-70 vs other conditions, leading to a significant effect of task \( (F_{2,34}=25.8; \ P<.001) \) (Figure 7). The task \( \times \) group interaction was significant \( (F_{1,35}=5.34; \ P=.01) \), suggesting less modulation of CNV by task in patients vs controls. Despite being reduced in amplitude in patients, the slope of the CNV showed a parallel time course across groups over the course of the cue-probe interval. The period 350 to 1200 milliseconds from cue onset showed no group effect of slope \( (F_{1,35}=1.74; \ P=.20) \) (eAppendix; eTable 1).
INTERCORRELATION AMONG MEASURES

ERP vs Performance

Primary analyses were performed using regression analysis vs performance, as indexed by d’ context (Figure 8). A supplemental path analysis was performed as well to assess directional relations (eFigure 5).

Across task versions, N1 amplitude to B cues correlated significantly with performance (r = 0.28; n = 116; P = .002) (Figure 8A), as did N1 amplitude to probe Y in sequence AY (r = 0.40; n = 116; P < .001) (Figure 8B), with larger N1 amplitudes correlating with better performance. The correlation for both B cues (r = 0.20; P = .03) and AY probes (r = 0.25; P = .007) remained significant even when controlling for task type and group membership.

In the AX-70 condition, N2 to B cues correlated significantly with performance (r = 0.37; P = .02), while in the BX-70 condition, N2 to A cues correlated with performance (r = 0.47; P = .004) (Figure 8C). However, neither correlation remained significant following consideration of group status (AX-70: r = 0.23, P = .11; BX-70: r = 0.19, P = .17). Furthermore, when variables were entered simultaneously vs performance in the AX-70 condition, the contribution of N1 remained highly significant (r = 0.37; P = .004), whereas the contribution of N2 became marginal (r = 0.24; P = .05).

Path analysis showed a similar relationship, with both N1 and N2 contributing significantly to performance (eFigure 5). In addition, path analysis revealed a significant contribution of P1 to N2 amplitude and group effects at the level of both P1 and N1. Because of the small sample size, however, these findings require replication in an independent sample.

Finally, across conditions there was a significant correlation between CNV amplitude to A cues and response latency (r = 0.23; P = .01), although the correlation was no longer significant once group status was considered (r = 0.08; P = .33).

Contrast Sensitivity

Patients showed reduced contrast sensitivity at low (0.5 cycles per degree) spatial frequency vs controls (F1,27 = 10.7; P = .003) but not at middle (F1,27 = 2.28; P = .14) or high (F1,27 = 2.08; P = .16), leading to a significant main effect of group (F1,27 = 11.3; P = .002) and a significant group × SF interaction (F2,26 = 5.49; P = .01). There was a significant correlation between contrast sensitivity and performance both across conditions (r = 0.62; P = .01) and in the AX-70 condition individually (r = 0.61; P = .001) (Figure 8D). Both the overall (r = 0.53; P = .02) and AX-70 correlations (r = 0.42; P = .01) remained significant, even when controlling for group status. Finally, the correlation was significant, even in patients alone (r = 0.52; P = .02), and remained significant even when Wechsler Adult Intelligence Scale (WAIS) performance intelligence quotient (IQ) was included in the regression to control for general cognitive dysfunction (r = 0.55; P = .02).

COMMENT

AX-CPT is a widely used task for evaluating the neural basis of working memory and executive processing deficits in schizophrenia.14,18,19,48 Although reduced visual cortical activation has been observed across working memory/executive processing tasks in schizophrenia,36 contributions of sensory dysfunction to impairment in such tasks has not been studied systematically. The present study used ERP to investigate neural bases of impaired AX-CPT performance, focusing on both sensory and higher cognitive measures.

The primary findings are that patients showed reduced sensory responses along with reduced higher cor-
tical activation. Furthermore, performance deficits correlated specifically with reduced ability to process low visual spatial frequency information, consistent with impaired magnocellular input.7,33 Finally, significant task- and sequence-related modulation of sensory responses were observed in this study, reflecting potential top-down modulatory control of sensory responses. Notably, however, such modulations were not significantly reduced in patients despite the reduced amplitudes of the sensory responses. Thus, these findings suggest that sensory deficits may be observed during cognitive tasks in schizophrenia even in the face of normal top-down cognitive control.

**BEHAVIORAL FINDINGS**

In the present study, patients showed significantly increased rates of AX errors and greater deficits in BX vs AY errors relative to controls, suggesting a specific response pattern.11,15,46 Furthermore, deficits were not limited to the most commonly used version of this task (ie, AX-70) but were observed across task versions. These findings suggest that cognitive deficits in schizophrenia are not confined to those related to frontal response inhibition.49

**SENSORY EFFECTS**

Sensory processing was assessed using 2 approaches. First, ERP were collected over visual regions in response to cue and probe stimuli, and amplitudes of P1 and N1 visual components were analyzed. Second, patients were assessed using contrast sensitivity, which measures the ability of individuals to detect low-contrast stimuli across a range of spatial frequencies.

Consistent with recent studies using other sensory and cognitive paradigms,12,33,50 patients showed highly significant deficits in P1 and N1 generation. Generators of these components have been localized to the middle occipital gyrus.13,35 Notably, reduced middle occipital gyrus activation was also observed in a recent meta-analysis of fMRI studies of executive processing in schizophrenia (including some which used the AX-CPT),36 supporting our finding of reduced sensory ERP response in this task. Selective reductions in middle occipital gyrus and medial prefrontal fMRI activation have also been reported following ketamine administration in healthy subjects, suggesting a potential link to underlying NMDA dysfunction.51

In prior studies involving psychophysically precise stimuli (sine-wave gratings), we have found preferential P1 reduction to low vs high SF stimuli, consistent with preferential magnocellular vs parvocellular visual system impairment.7 In the present study, psychophysically complex stimuli (letters) were used so exact SFs could not be determined. However, readers in general use a frequency band of approximately 3 cycles per letter,52,53 suggesting that the main frequency band for letter evaluation in this task was likely centered around 1.5 cycles per degree. This frequency band is within the range of prominent magnocellular sensitivity,54 suggesting that...
the key stimulus-related information may have been contained within a preferential magnocellular SF band. Furthermore, performance deficits in patients correlated significantly with both reduced N1 sensory response (Figure 8A,B) and impaired contrast sensitivity to low- but not high-SF stimuli (Figure 8D), suggesting a significant contribution of impaired sensory processing to impaired behavioral performance in schizophrenia.

**COGNITIVE COMPONENTS**

This study also analyzed generation of 2 cognitive potentials, N2 and CNV, that have been shown to reflect activity in the prefrontal cortex (medial prefrontal and dorsolateral prefrontal cortex) based on human dipole mapping studies\(^\text{17,55}\) and direct intracranial recordings in primates\(^\text{34}\). These regions show consistently reduced activation in fMRI studies of AX-CPT in schizophrenia\(^\text{18,56}\), consistent with our present findings.

No significant correlation was observed with response accuracy (d’ context) for either N2 or CNV, suggesting that impaired function of these regions may not be directly linked to the most prominent behavioral impairment observed on this task. Nevertheless, these findings suggest that prefrontal regions may contribute to 2 alternative AX-CPT–related processes indexed by the distinct N2 and CNV ERP components.

First, N2 was larger to B cues in the AX-70 task variant and to A cues in the BX-70 variant, and thus may index conflict between the local and global prepotency.\(^\text{17}\) In a recent fMRI study of AX-CPT using the AX-70 task version, reduced frontal activation was not related to overall accuracy but only to type of error (BX vs AX).\(^\text{36}\) Given the larger N2 response to the less frequent B vs A cues in the

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**Figure 6.** Mean (standard error of the mean [SEM]) event-related potential (ERP) component amplitudes to probe stimuli across task variants. A, P1 and N1 amplitudes to preceding cue (A or B) (A); P1 and N1 to probe type (X or Y) (B); and N2 amplitudes following A cues across task variants (C) are shown. *P < .05, †P < .01, ‡P < .001.
AX-70 task variant but to the less frequent A vs B cues in the BX-70 task variant, reduced frontal activation during AX-CPT in schizophrenia may thus reflect, at least in part, reduced conflict processing, as has been reported in other response inhibition tasks.57,58 The conflict monitoring role of N2 was underscored in this study by the fact that large N2 responses were also observed to AY sequences in the AX-70 paradigm. Notably, however, patients had no increase in AY false alarms, underscoring the separability of frontal activation vs performance.

Second, CNV amplitude was maintained throughout the cue-probe interval and varied across tasks with the conditional probability of a response, consistent with a role in maintenance of response bias across delay.39,60 The fact that CNV was significantly reduced in amplitude to cue stimuli in patients, but nevertheless showed a parallel time course in patients vs controls during the cue-probe interval, is consistent with the increasing suggestion over recent years that working memory deficits are associated with impairments in stimulus encoding11,19,27,48,61 rather than memory retention.46 Furthermore, the present study suggests that ERP, because of their high temporal resolution, may be more sensitive than fMRI to differential evaluation of encoding vs retention subcomponents during working memory tasks, and thus may offer complementary information.

Figure 7. Contingent negative variation (CNV) waveform in response to cue stimuli across task variants. Waveforms reflect activity during the cue-trial interval. All spatial distributions shown at time 1248 milliseconds (ms) with the scale at 0.40 µV per step. Conventions are as in Figure 3. The shaded rectangle represents the period used for the CNV slope analysis.

Figure 8. Correlations of performance (d’ context). Shown are performance vs N1 amplitude to cue B (A), performance vs N1 amplitude to probe AY (B), performance vs N2 to cue B in task AX-70 and cue A in task BX-70 (C), and performance vs contrast sensitivity in task AX-70 (D).
TOP-DOWN MODULATION

Although the present study was not designed a priori to evaluate top-down modulations of sensory response, 3 apparent examples of top-down modulation were observed. First, in the BX-70 condition (vs other conditions), subjects showed larger sensory ERP responses to A vs B cues (Figure 5). Second, in the AY-70 task variant (vs other variants), subjects showed larger amplitude responses to X vs Y probes (Figure 6). Third, N1 was larger to all probe stimuli following A vs B cues across tasks. These context-related modulations permitted post hoc assessment of integrity of top-down control of sensory processing during this task in schizophrenia.

In the first 2 cases, the stimuli enhanced by these modulations were relatively infrequent and therefore highly informative regarding response selection. Modulation of P1 and N1 by expectation has been described previously. In the present study, no significant differences were observed in the degree of task-related modulation of either cue or probe responses between patients and controls, suggesting similar top-down effects across group.

In the case of probe N1 modulation by prior cue type, subjects must attend to the subsequent probe following valid cues to determine the correct response, whereas this is not true following invalid cues (ie, AX and AY sequences require different behavioral responses, whereas BX and BY sequences both require the same response). Thus, a greater degree of attention may be required following valid vs invalid cues and may result in increased N1 amplitude. The similar degree of N1 modulation as a function of prior cue in patients vs controls despite the overall reduction in N1 amplitude (Figure 6) therefore also suggests relatively intact top-down attentional control mechanisms despite impaired bottom-up sensory activation.

OVERALL MODELS OF COGNITIVE DYSFUNCTION

Working memory deficits in schizophrenia were, at one point, considered to reflect impairments in retention of information across delay, consistent with local dysfunction within prefrontal brain regions. In recent years, however, behavioral studies have increasingly shown that performance deficits in AX-CPT and other working memory tasks reflect primarily a failure of encoding, with limited, if any, deficit in retention. This study supports and adds to this finding and highlights the role of sensory dysfunction as a basis for encoding dysfunction. Moreover, although top-down modulations of sensory processing were observed in this paradigm, they were not significantly different between patients and controls, supporting bottom-up models.

Within the auditory system, deficits in low-level auditory processing have increasingly been shown to contribute to deficits in higher-order processing such as emotion recognition and P3 generation. This study suggests that a similar relationship may also exist in the visual system in schizophrenia. Thus, while impairments in frontal function and top-down processing undoubtedly occur, sensory deficits and bottom-up influences on cognition in schizophrenia must also be considered.

Submitted for Publication: May 17, 2010; final revision received November 18, 2010; accepted January 3, 2011. Published Online: March 7, 2011. doi:10.1001/archgenpsychiatry.2011.17

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Financial Disclosure: None reported.

Funding/Support: This study was supported by grants R3MH49334 and P50MH086385 (Dr Javitt) and MH84848 (Dr Butler) from the National Institutes of Health.

Previous Presentations: This study was presented at the American College of Neuropsychopharmacology Annual Meeting, December 7, 2009; Hollywood, Florida; and 15th International Congress on Event-Related Potentials of the Brain (XV EPIC); April 25, 2009; Bloomington, Indiana.


Additional Contributions: The authors would like to thank Stephan Bickel, MD, PhD, for comments on the article and Jeanette Piesco for technical assistance.

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