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You can start—if you haven't already—by incorporating into your practice a brief cognitive battery

Measuring cognition: Essential in clinical practice

Ever since Kraepelin used the label “dementia praecox” for the disorder Bleuler later renamed “schizophrenia,” psychiatrists have recognized cognitive impairment as a central feature of schizophrenia.¹ Cognitive deficits are an important component of many psychiatric disorders, but formal cognitive assessment still is not a part of standard clinical evaluation in psychiatric practice. It's time that it becomes so.

Almost 2 decades ago, studies in my laboratory discovered that patients with bipolar disorder have significant deficits in cognition—including short-term memory and executive function—similar to those seen in schizophrenia.² This finding has been replicated extensively, and a book on the subject was published recently.³ Cognitive dysfunction also has been reported in unipolar depression,⁴ obsessive-compulsive disorder,⁵ posttraumatic stress disorder (PTSD),⁶ attention-deficit/hyperactivity disorder,⁷ and borderline personality disorder.⁸

This should not be surprising. Cognition is a major brain function, and mental illnesses are neurobiologic disorders in which cognitive domains can be moderately or seriously disrupted. Neurocognitive studies have established that specific cognitive dysfunctions correlate with brain pathology in specific regions. For example, because the hippocampus is a key brain region for memory, memory deficits are observed in any disorder that disrupts hippocampal structure, including Alzheimer's disease, alcoholism, PTSD, schizophrenia, and depression.

Why assess cognition?

Cognitive measurement using validated test batteries as part of a thorough and systematic mental status examination is becoming essential—even required—in psychiatric practice. Formal cognitive assessment is useful for many clinical reasons:

- for diagnosis (the upcoming fifth edition of the *Diagnostic and statistical manual of mental disorders* [DSM-V] is sure to include cognitive perfor-

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- mance in schizophrenia's diagnostic criteria)
- to assess illness severity
- to localize dysfunctional neural pathways
- to formulate a reasonable prognosis
- to rule out possible mental retardation
- to tailor a pharmacologic treatment plan that does not further impair cognition but may enhance it
- to monitor response to treatment
- to assess cognitive side effects of pharmacotherapy
- to develop social and vocational rehabilitation programs that build on patients' cognitive abilities.

'Cognition enhancers'

The pharmaceutical industry's recent surge of interest in developing cognition-enhancing ("nootropic") drugs is timely, welcome, and supported by the National Institute of Mental Health. Initial targets of nootropic drug development are Alzheimer's dementia and schizophrenia, but research is likely to extend to other psychiatric disorders.

When effective cognition-enhancing agents are developed and approved for use in dementia and schizophrenia, they undoubtedly will be tested in other neuropsychiatric disorders as well. They will be used as "add-on" medications to target cognitive deficits in many psychopathologic states.

Getting started

The time to vigorously assess and treat cognitive dysfunction is here. You can start—if you haven't already—by incorporating into your practice a brief

cognitive battery that measures performance on several key domains. One example is the Brief Assessment of Cognition in Schizophrenia (BACS)⁹ that was used in the Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) study. You not only will be ahead of the curve, but your patients will benefit from increased attention to cognition in their diagnosis and treatment.



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