Commentary

Comment on Cogniform Disorder and Cogniform Condition: Proposed diagnoses for excessive cognitive symptoms

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The paper by Delis and Wetter (2007) promises to have a major impact on clinical diagnostic practice and perhaps on research. As they point out, clinicians may not feel that sub-optimal effort on neuropsychological testing is synonymous with malingering or factitious disorder. The existing DSM-IV diagnostic system does not provide an adequate means of classification for examinees with sub-optimal effort not diagnosed as malingering or the less frequently used diagnosis of factitious disorder. Properly, they suggest that their proposed diagnostic criteria are a starting point for debate rather than a finished product. This point cannot be overemphasized—the proposed criteria are a work in progress, not a finished product.

The diagnoses of Cogniform Disorder and Cogniform Condition deserve serious consideration for inclusion in the next version of the DSM, if the diagnostic criteria are improved. Clinicians sometimes are reluctant to make a diagnosis of malingering, particularly when they have a doctor–patient relationship with the patient. In a survey conducted in the mid-1990s, we found that neuropsychologists were far more comfortable using the diagnosis of malingering when there was a symptom validity test result that was significant worse than chance (Trueblood & Binder, 1997). More than a decade after these survey data were collected, clinicians have greater awareness of neuropsychological evidence of malingering and sub-optimal effort. Nonetheless, clinicians sometimes are reluctant to make the diagnosis of malingering. Clinicians also are aware of the mandates to both assess and comment on level of effort in neuropsychological reports (American Academy of Clinical Neuropsychology Board of Directors, 2007; Bush et al., 2005). Assessment of effort no longer is optional, per these recommendations by AACN and the National Academy of Neuropsychology. All cases require scrutiny to rule out poor effort as an explanation for abnormal scores.

The problem with the proposed criteria of Delis and Wetter are in the details, especially in Category A of their proposed criteria for diagnosis. Delis and Wetter concede that more research on some of their criteria is needed, and they have used the qualifying word “proposed” for their criteria. Unfortunately, words like “proposed” and “preliminary” often are soon forgotten. The criteria for malingering by Slick (Slick, Sherman, & Iverson, 1999) were labeled as “proposed,” but they have been reified by their use without modification for research.

Only two of the nine criteria listed by Delis and Wetter in Category A are necessary, in combination with the criteria in other categories. Some of these criteria are problematic. Inconsistent patterns of test results that are rare for patients with brain dysfunction or significant inconsistencies on results may be associated with poor effort (proposed criteria 5–6). In practice, what do these criteria mean? Neuropsychological tests that are labeled as measuring the same construct, such as memory, are imperfectly correlated. The WMS-R Visual Memory Index had a correlation...
of only 0.36 with the WMS-III Visual Immediate Index (Psychological Corporation, 1997). The newer versions of WAIS-III subtests had a median correlation of about 0.76 (under 60% shared variance) with the older subtest versions on the WAIS-R (Psychological Corporation, 1997). The Wisconsin Card Sorting and Category Tests both appear to measure nonverbal problem solving, concept formation, and mental flexibility, but their correlation was only about 0.55 (Perrine, 1993). In repeat evaluations, what is a significant inconsistency? The 1-year test retest correlation on Short-Delay Free Recall on the California Verbal Learning Test was only 0.36 (Delis, Kramer, & Kaplan, 1987). What degree of autobiographical memory loss is inconsistent with brain dysfunction? Clearly, total autobiographical amnesia in contrast with relatively intact recent memory is diagnostic of a psychogenic problem, but milder remote memory loss is found in patients with brain dysfunction (Paul, Blanco, & Hames, 1997). Similar criticisms apply to some of the other criteria. With some of the criteria being so imprecise, and with only two of nine of the criteria necessary for the diagnosis in this proposal, it is clear that there is potential for diagnostic confusion and error with the use of the criterion.

The diagnostic criteria imply that a significantly below chance result on a forced choice test is not always diagnostic of malingering. In their text, Delis and Wetter discuss the difficulty of understanding the intent and motivation of the examinee. In contrast, the Slick criteria (Slick et al., 1999) state that a significantly below chance result on a forced choice test is diagnostic of definite malingering if an external incentive is present. Some other experts agree with Slick et al. (Iverson & Binder, 2000; Larrabee, 2005; Reynolds, 1998). However, when deliberate negative response bias on effort tests occurs in the context of clear-cut severe traumatic brain damage diagnosed from acute neurological information such as Glasgow Coma Scale scores and neuroimaging, I generally do not diagnose malingering because the motivation to perform poorly on neuropsychological testing does not disprove the existence of the traumatic brain injury. Clear-cut negative response bias on neuropsychological testing when external incentives are present clearly shows, to a near statistical certainty determined by the level of significance, the intent to perform poorly.

In summary, the proposed new diagnostic categories are likely to prove useful to clinical neuropsychology and to psychiatric diagnosis in general, if the diagnostic criteria are more carefully developed. The publication by Delis and Wetter is an important first step. Refinement of the diagnostic criteria must take place before these diagnoses meet broad acceptance by practitioners.

References


