

FORUM

Failure to Assess Motivation, Need to Consider Psychiatric Disturbance, and Absence of Objectively Verified Physical Pathology: Some Common Pitfalls in the Practice of Forensic Neuropsychology*

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Klein (1998) suggests that Youngjohn, Spector, and Mapou (1997) misinterpreted her conclusions in a 1995 National Academy of Neuropsychology poster presentation on a series of breast implant litigants. She now appears to be stating that her patients did not have legitimate organic deficits, but rather that their poor neuropsychological test performances were due to factors unrelated to brain damage. We appreciate her clarification. It does, however, appear to be somewhat at odds with her published abstract (Klein, 1996), in which she states that although silicone was once considered biologically inert and harmless, it is now suspected of causing a variety of conditions, including neurologic- and rheumatologic-based cognitive dysfunction. She then cites unpublished reports of abnormalities on brain MRI in these patients. After reviewing her neuropsychological test results, she concludes, "While confounding variables such as pain, depression, and fatigue may have influenced these women's performances, the pattern of test results is **suggestive of legitimate organic deficits**" (highlight added; Klein, 1996, p.412). In the handout that accompanied her poster, she stated,

It is unclear to what extent if any the test results and the patients' complaints are related to physical factors such as muscle and joint

pain, sleep disturbance, fatigue, or depression noted by several of these women. According to the patients, the depression typically developed as a result of longstanding physical and cognitive dysfunction (Klein, 1995, p.6).

Klein's original conclusions (1995) and subsequent comments (1998) illustrate several important pitfalls in forensic neuropsychological practice. Specifically, it is essential to assess motivation and cooperation formally during neuropsychological testing of litigants. Klein (1995, 1996) did not report that she administered any of the many instruments for assessing cooperation that are currently available. Consequently, the impaired performances in her series of patients are difficult to interpret, secondary to questionable validity. The two neuropsychological studies of breast-implant complainants that have included formal measures of motivation and cooperation both have shown a high prevalence of poor motivation, and even motivation to perform poorly (Pimental, Green, & Iacono, 1995; Youngjohn, Spector, & Mapou, 1997).

It is also essential to assess personality formally and to consider objectively whether emotional or psychological factors may be influencing the way patients perceive and report their symptoms, rather than to uncritically and naively accept self-reports as true (Binder, 1997).

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In her comments in this issue, Klein (1998) states that her series of patients were much less psychiatrically disturbed than our patients (Youngjohn, Spector, & Mapou, 1997). Yet she reported no results from any formal personality testing. Rather, she appears to have simply accepted the patients' self-reports regarding their physical and emotional symptoms as accurate. For example, in the handout that accompanied her poster Klein (1995) stated,

During the clinical interviews, I was impressed by the similarity of many of the patients' complaints and the extent to which they had struggled to compensate for their deficits while managing to remain as active as possible in their careers and personal lives...All of these patients were seen in conjunction with the settlement of a class action suit filed against the manufacturers of silicone breast implants. The patients understood that the amount of settlement funds they received was dependent to some extent on their doctors' documentation of physical and cognitive dysfunction. My own impression is that this factor did not play a major role in these patients' presentation. They seemed quite straightforward... (Klein, 1995, pp.5-7).

By contrast, both our study and a prior study have revealed the presence of significant psychopathology and/or personality disturbance on the Minnesota Multiphasic Personality Inventory-2 in breast-implant complainants, which may have resulted in inaccurate reporting or overreporting of their physical symptoms (Whatley, Mullins, & Hartman, 1995; Youngjohn, Spector, & Mapou, 1997).

Klein (1998) suggests that neurologic patients may score higher on some MMPI-2 scales because of physical and cognitive symptoms due to legitimate medical conditions such as a brain injury, and cites the work of Gass and Wald (1997). Our MMPI-2 profiles were so highly elevated, however, that even if we had applied the head-injury correction suggested by Gass (1991), the profiles would still have reflected significant psychopathology and/or personality disturbance. Of course, applying neurologic cor-

rections to the MMPI-2 in these patients begs the question of whether or not they have any genuine neurologic disease to justify the application of the corrections. Certainly, there was no objective neurologic evidence that any of our patients had ever sustained any brain damage.

The MMPI-2 profiles in our series of breast-implant complainants are quite similar in configuration and elevation levels to those of another group of litigants claiming brain damage, but who also have no objective evidence of neurologic injury, namely, minor head-injury patients with persisting post-concussion syndrome (e.g., Youngjohn, Burrows, & Erdal, 1995; Youngjohn, Davis, & Wolf, 1997). Interestingly, when the MMPI and MMPI-2 profiles of clinical samples of symptomatic minor head-injury patients are compared to those of more severely head-injured patients, a paradoxical effect emerges (Leininger, Kreutzer, & Hill, 1991; Novack, Daniel, & Long, 1984; Youngjohn, Davis, & Wolf, 1997). The severely head-injured patients actually have much lower elevations than those with minor head injury. This paradoxical effect has been interpreted as suggesting that those patients with significant psychopathology and/or personality disturbances of the types suggested by their personality profiles are more likely to remain symptomatic and to pursue financial compensation after minor head injury (Youngjohn, Davis, & Wolf, 1997).

Klein (1998) suggests that it would be of interest to examine MMPI profiles of patients diagnosed with fibromyalgia or systemic lupus erythematosus (SLE) but without breast implants and compare them to our series of breast-implant complainants. It is noteworthy that although there are verifiable, objective rheumatologic and neurologic findings associated with SLE, these do not yet exist for fibromyalgia. Rather, fibromyalgia is a controversial condition (Goldenberg, 1987), with diagnosis based primarily on patients' subjective complaints (Bohr, 1995, 1996; Wolfe et al., 1996). The authors of one study state,

Historically, the diagnosis of primary fibromyalgia seems to have evolved out of physicians' clinical judgement that not all patients

with generalized pain for which no physical cause could be found belonged in the same diagnostic category. Some of these patients described their symptoms in a way which gave the impression that they suffered from a physical disease or malfunction not yet defined by medical science, while others, by appearing to the physician to be more emotionally disturbed, invited the hypothesis that their pain was better explained by a psychological model (Quimby, Block, & Gratwick, 1988, pp. 1267-1268).

Given the lack of objective, verifiable biologic markers after decades of investigation, some researchers have problems with the diagnosis of fibromyalgia (Bohr, 1996) and question its existence (Bohr, 1995). Others have characterized it as a "nondisease" (Meador, 1965; Wallace, 1995).

We are familiar with one MMPI study that compared a group of patients with fibrositis (the term used to categorize these patients prior to being replaced by fibromyalgia) to groups with objectively verified rheumatoid arthritis, and a variety of other objectively documented rheumatologic conditions, including SLE (Payne et al., 1982). Their results paralleled the paradoxical findings in head injury. Specifically, the fibrositis group, which had no objective signs of physical pathology, had much higher MMPI elevations, particularly on hypochondriasis (Hs) and hysteria (Hy), than did the patients with proven rheumatologic disease. Indeed, the configuration of the Payne et al. (1982) fibrositis MMPI profile was quite similar to the average MMPI-2 profile of our breast-implant complainants. Payne et al. (1982) interpreted their findings as suggesting that fibrositis patients are more psychologically disturbed than documented arthritis patients and that their psychologic disturbance is probably not the result of chronic pain and disability, since they paradoxically had much greater psychopathology on the MMPI than patients who had demonstrable organic disease.

We would like to acknowledge that our investigation of breast-implant patients was limited to a very small sample. Indeed, our study is subject to the same criticisms that apply to all of the

studies that have associated breast implants with physical disease, that is, it is uncontrolled and anecdotal. By contrast, the large epidemiologic studies that have now been completed provide reassuring evidence that there is no substantial risk associated with silicone breast implants. We do believe that our study helps to provide some understanding as to why so many persons have persisted in their claims to the contrary.

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