

## LETTER TO THE EDITOR

# My head hurts just thinking about it

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In their recent *JINS* article, Neuropsychological Deficits Associated with Complex Regional Pain Syndrome, Libon and colleagues (2010) argue for the existence of neuropsychological subtypes in patients with complex regional pain syndrome (CRPS), and conclude that CRPS is associated with cognitive compromise. Several study limitations are noted in their discussion, including the use of a chronically ill sample, a non-comprehensive testing battery, and the confounding influences of depression, and medication-related factors. However, the most glaring limitations are not referenced; that is, there is no mention as to whether subjects were compensation-seeking, and no measures of response bias were administered.

For at least a decade, studies have clarified that, in the presence of medicolegal incentives, chronic pain patients report higher levels of memory impairment and exaggerate extent of disability (see Suhr & Spickard, 2007, for review). As summarized by Iverson (2006), litigation status exerts a moderate effect on cognitive scores ( $d = -.5$ ), while the impact of exaggeration/malingering on cognitive performance is particularly large ( $d = -1.1$ ). A survey of American Board of Clinical Neuropsychology members suggests that rates of feigning of cognitive symptoms in compensation-seeking pain patients exceed 30% (i.e., 35% fibromyalgia/chronic fatigue and 31% chronic pain; Mittenberg, Patton, Canyock, & Condit, 2002). This is consistent with the findings of Gervais, Russell, Green, Allen, Ferrari, and Pieschl (2001) who documented that 35% of their disabled, or disability-seeking, fibromyalgia patients failed effort tests compared with only 4% of their non-disability-seeking counterparts. In a study published in 2003 (see summary in Suhr & Spickard, 2007), Suhr compared the performances of a group of fibromyalgia patients and a group of heterogeneous chronic pain patients to a healthy age-matched control group on a neuropsychological test battery. Approximately 18% of the fibro-

myalgia and chronic pain patients failed the effort tests included in the battery (as compared to none of the control group participants). Furthermore, after excluding individuals who failed measures of response bias, no differences in cognitive performance were found across any of the groups. Research such as this has prompted the important work of establishing criteria for malingered pain-related disability (Bianchini, Greve, & Glynn, 2005).

In the current study, Libon et al. (2010) conclude that their patients' decreased performance on neuropsychological measures is suggestive of cognitive compromise (i.e., dysexecutive). However, in the absence of adequate consideration of compensation status and effort, such conclusions are likely inaccurate, and it is our belief that the practice of continuing to publish such papers harms the field through the perpetuation of misleading information. The clinical impact of studies neglecting these factors is potentially damaging. As Suhr and Spickard (2007) point out, "Ignoring a factor that could account for a significant amount of the variance in cognitive performance in an individual patient's cognitive profile increases the likelihood of a clinician making diagnostic errors and/or suggesting consequences that are unfounded (such as cognitive-related disability)" (p. 260).

In conclusion, researchers examining the impact of chronic pain on neuropsychological functioning must consider the influential factors of compensation status and effort to ensure valid interpretation of the data.

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