Enhanced Interpretive Report

PATIENT INFORMATION

Patient Identification Number: 123456789

Patient Name (Optional) Shirley Knott	Test Date 01/17/2006
Gender Female	Relationship Status Separated
Age 39	Education Level College or Technical School
Pain Diagnostic Category Back Injury	Race White
Date of Injury (Optional) 09/12/2002	Setting Chronic Pain

PROVIDER INFORMATION

Care Provider (Optional) Dr. Smith	Practice/Program (Optional) Health Psychology Associates

This BHI 2 report is intended to serve as a source of clinical hypotheses about possible biopsychosocial complications affecting medical patients. It can also be used with the BBHI™ 2 test to serve as a repeated measure of pain, function, and other symptoms to track a patient's progress in treatment.

The BHI 2 test was normed on a sample of physically injured patients and a sample of community subjects. This report is based on comparisons of this patient's scores with scores from both of these groups. BHI 2 results should be used by a qualified clinician in combination with other clinical sources of information to reach final conclusions. If complex biopsychosocial syndromes are present, it is generally necessary to consider medical diagnostic conclusions before forming a psychological diagnosis.

Written by Daniel Bruns, PsyD, and John Mark Disorbio, EdD.

TRADE SECRET INFORMATION

Not for release under HIPAA or other data disclosure laws that exempt trade secrets from disclosure.

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BHI™ 2 Patient Profile Annotations

1. The high level of Self-Disclosure indicates that this patient is reporting an unusually high level of information about psychological difficulties.

2. This level of Somatic Complaints is outside the range seen in the average healthy person, (the white diamond is outside the central average range). This level of symptoms though, is commonly seen in medical patients (black diamond is in the average range).

3. The very high level of Pain Complaints here indicates reports of an unusually high level of pain in multiple body areas. This is associated with a high level of Muscular Bracing — a tendency to respond to stress with increased muscular tightness and guarding. Muscular Bracing may contribute to the diffuse pain symptomatology.

4. Both dots are in the central band, so this score is in the average range.

5. This indicates an unusually high level of depressive thoughts and feelings, which is higher than that seen in 92% of patients.

6. The very high Borderline score indicates the presence of borderline personality traits. Patients with this score are prone to emotional volatility and love-hate relationships. To a lesser extent, these scores also suggest that the patient has a history of difficulties with achieving a stable adult life, and may tend to respond to medical difficulties with an unusual degree of neediness and dependency.

7. The very low level of Perseverance suggests that this patient has an unusually low level of will and drive to invest in rehabilitation. She may be prone to pessimism, lack self-discipline, and is at risk for quitting. Patients with this profile could be characterized as suffering from helpless depression.

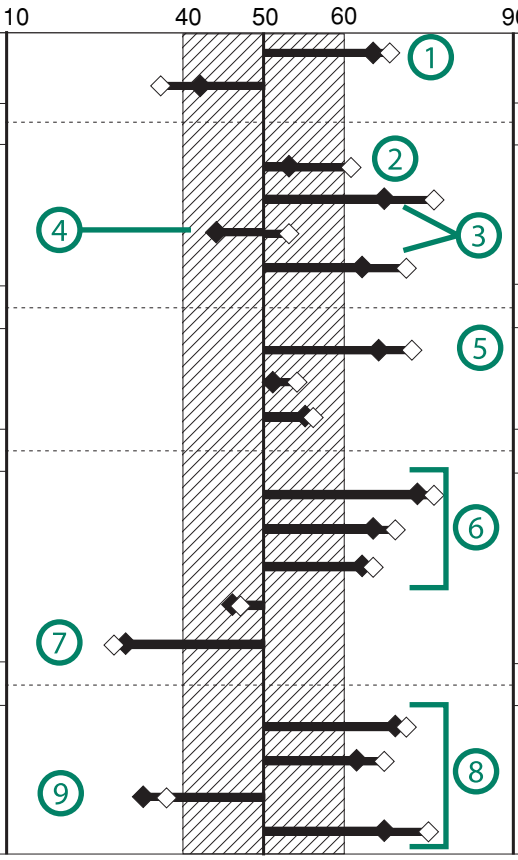
8. These scores indicate that the patient is reporting being the survivor of multiple traumatic and abusive experiences. Additionally, the patient is depicting both family and the workplace as being nonsupportive, and is probably feeling emotionally isolated.

9. The very low level of Doctor Dissatisfaction suggests that the patient has an unusually positive view of physicians. However, borderline personalities are known for idealizing those upon whom they depend, only to have very angry falling outs when others don't live up to their expectations.

Battery for Health Improvement 2

Patient Profile

Scales	Raw Score	T Scores Patient	T Scores Comm.	Rating	Percentile
Validity Scales		◆	◇		
Self-Disclosure	157	65	68	High	93%
Defensiveness	10	42	36	Mod. Low	24%
Physical Symptom Scales					
Somatic Complaints	22	53	61	Mod. High	68%
Pain Complaints	58	67	76	Very High	94%
Functional Complaints	10	44	53	Average	27%
Muscular Bracing	18	63	71	High	90%
Affective Scales					
Depression	28	66	72	High	92%
Anxiety	15	51	54	Average	52%
Hostility	20	55	56	Average	74%
Character Scales					
Borderline	28	73	76	Very High	97%
Symptom Dependency	15	65	69	High	94%
Chronic Maladjustment	17	63	65	High	91%
Substance Abuse	3	46	47	Average	46%
Perseverance	17	30	28	Very Low	3%
Psychosocial Scales					
Family Dysfunction	20	69	71	Very High	96%
Survivor of Violence	13	62	67	High	87%
Doctor Dissatisfaction	1	33	37	Very Low	3%
Job Dissatisfaction	28	67	75	Very High	95%



[V 1.0]

INTERPRETING THE PROFILE:

- The Patient Profile plots T scores based on both patient and community norms. Both sets of T scores should be used for evaluating a patient's BHI 2 profile.
- In general, community norms are more sensitive, but less specific, in detecting elevated levels of complaints than are patient norms. In other words, community norms are better at detecting lower levels of problematic symptoms than patient norms, but at the risk of increased false-positive findings.
- T scores within the 40 to 60 range are typical for the normative patient and community samples (approximately 68% of the samples scored within this range). Scores above or below the average range are clinically significant (in both cases, approximately 16% of the samples scored above a T score of 60 or below a T score of 40).
- Patient and community T scores are represented by black diamonds (◆) and white diamonds (◇), respectively. A black diamond outside the average range indicates problems that are unusual even for patients, while a white diamond outside the average range indicates that a problem may be present but at a level that is not uncommon for patients. If both diamonds are outside the average range, this indicates a problem area that is relatively unusual for both patients and members of the community. If only the white diamond is visible, the T scores are overlapping.
- The length of the bar shows a scale score's difference from the mean score. The longer the bar, the more the score deviates from the mean and the more unusual it is.
- Scale ratings are based on patient percentile scores, with the exception of moderately high and moderately low ratings, which are outside the average T-score range for community members but inside the average T-score range for patients.
- The percentile indicates the percentage of subjects in the patient sample who had scores lower than this patient's score on a particular scale.

SCALE SUMMARY

This section offers a very brief interpretation of each scales score.

This section summarizes the patient's noteworthy scale findings.

Self-Disclosure Scale: High
A high level of psychological problems was reported.

Defensiveness Scale: Moderately Low
Indicates a moderate level of psychological defensiveness that is atypical for community subjects but relatively common for patients.

Somatic Complaints Scale: Moderately High
This patient reported a level of somatic symptoms that is higher than that of community subjects but is commonly found in patients.

Pain Complaints Scale: Very High
An unusually broad pattern of pain symptoms was reported.

Muscular Bracing Scale: High
A pattern of reactive muscular tension was reported.

Depression Scale: High
This patient reported a relatively high level of depressive thoughts and feelings.

Borderline Scale: Very High
This patient reported a pervasive pattern of mood instability and conflicted interpersonal relationships.

Symptom Dependency Scale: High
A relatively high level of dependency needs was reported by the patient.

Chronic Maladjustment Scale: High
A pervasive history of problems achieving common life goals was reported.

Perseverance Scale: Very Low
This patient reported an unusually low, almost nonexistent, level of self-discipline, emotional resilience, and optimism.

Family Dysfunction Scale: Very High
Indicates a severe level of familial conflict and dysfunction.

Survivor of Violence Scale: High
This patient reported a history of physically or psychologically traumatic experiences.

Doctor Dissatisfaction Scale: Very Low
This patient reported an almost nonexistent level of dissatisfaction with her medical caregivers.

Job Dissatisfaction Scale: Very High
This patient reported a pervasive pattern of conflict and frustration in her workplace.

VALIDITY

This section summarizes BHI 2 information about the patient's test-taking atitude, such as any tendency to exaggerate or minimize symptoms.

This patient did not endorse any of the validity items. This reduces the risk that this profile was produced by random responding. Patients with this profile disclosed an unusually high level of psychological problems that exceeded the levels of 93% of patients and 78% of patients who were asked to fake bad. There are several possible explanations for this high level of self-disclosure. Patients with this profile may be both broadly psychologically dysfunctional and in acute distress. They may have significant psychological problems. However, this patient's profile could also be a cry for help, possibly motivated by the desire to impress upon others the seriousness of her psychological needs or simply as a means of eliciting a response.

When social, financial, or other incentives are present, such as in a disability evaluation, the possibility that the patient has a conscious or unconscious desire to over-report negative information to appear worse off than she actually is, should be considered.

PHYSICAL SYMPTOM SCALES

This section summarizes findings pertaining to pain, function, illness/somatization symptoms and stress reactivity.

Patients with this profile reported severe levels of pain and muscular bracing that are higher than those seen in 94% and 90% of patients, respectively. This patient's pain exceeded that seen in 92% of chronic pain patients and she reported pain in 9 out of 10 body areas. She also reported extreme peak pain (her Peak Pain score was 10 out of 10), which she perceives as disabling and intolerable (based on her Pain Tolerance Index score). The patient's range of highest to lowest overall pain in the last month is about average. The Pain Fixation content area indicates the presence of a very high level of chronic pain cognitions. Patients with this profile reported pain that is persistent and refractory to care, and they tend to be focused on their need for support and analgesic medication. This profile could be produced by a patient with a pervasive systemic condition or multiple injuries to numerous parts of his/her body. However, if objective medical findings do not corroborate this patient's broad pattern of pain reports, a psychophysiological interpretation should be considered, especially if psychosocial risk factors are present (for more information on psychosocial risk factors, see the BHI 2 test manual).

This patient acknowledged some emotional distress, which could be an understandable reaction if she has significant medical problems. However, if her level of pain exceeds what would be expected given the objective medical findings, her pain may be magnified by her emotional distress. This pattern is sometimes seen in emotionally over-reactive forms of somatizing.

This patient's elevated Muscular Bracing score may help to explain her pain. Bracing is often the product of a psychophysiological response, in which patients react to stress with affective tension and a reflexive tightening of their skeletal muscles. Bracing often occurs as part of the fight or flight response to a real or perceived threat and out of a desire for self-protection. It is typically a psychophysiological response to anxiety (flight) or anger (fight), which may be a conscious or unconscious process. Bracing tends to be associated with tension headaches, myofascial pain, and "knots" in the muscles. Bracing can

contribute to pain disorders in general and can produce diffuse pain symptomatology. Given the elevated pain reports in this profile, bracing may be playing a significant role. If the patient's pain originated with an injury or medical condition, bracing may be exacerbating or maintaining it. If there are no objective findings, bracing could be the origin of her pain.

Some of these pain symptoms are uncommon for a back injury.

PAIN COMPLAINTS ITEM RESPONSES

The pain ratings below are based on the patient's responses to the Pain Complaints items and are ranked on a scale of 0 to 10 (0 = No pain, 10 = Worst pain imaginable). The degree to which the patient's pain reports are consistent with objective medical findings should be considered. Diffuse pain reports, a nonanatomic distribution of pain, or a pattern of pain that is inconsistent with the reports of patients with a similar diagnosis increases the risk that stress or psychological factors are influencing her pain reports.

Pain Complaints Items	Patient	Median*
Head (headache pain)	9	3
Jaw or face	0	0
Neck or shoulders	6	4
Arms or hands	1	1
Chest	5	0
Abdomen or stomach	3	0
Middle back	8	4
Lower back	10	8
Genital area	7	0
Legs or feet	9	5
Overall highest level of pain in the past month	10	8
Overall lowest level of pain in the past month	5	3
Overall pain level at time of testing	10	-
Maximum Tolerable Pain	5	-

Average pain reports of back pain patients.

Highest pain the patient can tolerate and still function.

Pain Dimensions	
Pain Range	5
Peak Pain	10
Pain Tolerance Index	-5

Degree of pain variability.

She feels that her worst pains need to be reduced by 5 to be tolerable.

*Based on a sample of 316 patients with lower back pain/injury.

DIAGNOSTIC PROBABILITIES

The Back Injury Pain Diagnostic Category was selected as the area of primary concern by the clinician. This category is consistent with the one statistically predicted by the patient's overall pattern of pain complaints. The statistical findings are presented below.

Head Injury/Headache	55%
Neck Injury	62%
Upper Extremity Injury	4%
Back Injury	94%
Lower Extremity Injury	79%

Symptoms unrelated to back injury are also being reported.

Pain Diagnostic Category	
Predicted by BHI 2	Back Injury
Selected by clinician	Back Injury

The patient's primary pain reports on the BHI 2 match the diagnostic category.

SOMATIC COMPLAINTS ITEM RESPONSES

These physical symptoms may all be signs of underlying psychological conditions that the patient may or may not recognize.

The healthcare provider is encouraged to determine if the patient's complaints are consistent with objective physical findings. This patient reported a total of 15 somatic complaints out of 26. These complaints and the patient's responses are listed below. Some possible medical and psychological explanations are also listed.

How many of this patient's symptoms can be explained medically?

Somatic Complaint	Patient Response	Possible Medical Explanations	Possible Psychological Explanations
Being unable to relax	Small Problem	Hyperthyroidism	Anxiety Stress
Irritability	Moderate Problem	Corticosteroid effect Amphetamine use	Depression Anxiety Hostility
Shakiness or jitters	Small Problem	Tremor Hypoglycemia Chemical dependency	Anxiety Panic
Nervousness	Moderate Problem	Hyperthyroidism	Anxiety
Feeling that nothing seems real	Moderate Problem	Complex partial seizures Psychosis	Dissociation
Lump in throat/difficulty swallowing	Small Problem	Laryngeal cancer Status post cervical fusion	Somatization Conversion
Having your legs give out while you're walking	Small Problem	Multiple sclerosis Spondylolisthesis	Somatization Conversion
Feeling like a heavy weight is sitting on your chest	Moderate Problem	Congestive heart failure Myocardial infarction	Anxiety Panic
Feeling exhausted but being unable to sleep	Small Problem	Caffeine/stimulants	Depression
Crying easily	Big Problem	Hypothyroidism	Depression
Changes in weight	Small Problem	Gastroenteritis Cancer	Depression
Unable to find a comfortable position to sit in	Small Problem	Pain disorder	Anxiety Somatization
Feeling much more disorganized than in the past	Small Problem	Dementia Brain injury	Depression
Difficulty concentrating	Moderate Problem	Dementia Brain injury	Depression Anxiety Somatization
Problems with being sick or disabled	Small Problem	Chronic illness	Somatization

It is generally easier to explain these symptoms psychologically.

AFFECTIVE SCALES

This patient's level of depressive thoughts and feelings is higher than that of 92% of patients. If she has been diagnosed with a medical condition that has unusually severe consequences, her depression could be a reaction to it. If her medical condition is not unusually severe, patient traits or the psychosocial environment may be playing a contributing role. Patients with this depressive elevation report an unusually downcast mood and are struggling with feelings of loss. (Note: Because the physical symptoms of some medical conditions can be mistaken for depression, the Depression scale avoids false positives by focusing primarily on depressive thoughts and feelings.)

This patient reported a high level of suicidal ideation. It is important to assess her for risk of imminent danger to herself.

Cognitively, patients with this profile are prone to excessive pessimism and view themselves as powerless. They are likely to view their situation negatively, suffer from anhedonia, and make self-deprecating remarks. Patients with this depressive elevation report being morose and despondent and are openly revealing their emotional problems. This patient's low Perseverance score coupled with her elevated Depression score may signify helpless depression.

Interpersonally, patients with this level of reported depression are trying to convey the seriousness of their condition. This may be part of a cry for help, but it may also involve some relinquishing of responsibility. They may also exhibit compliance problems, passively resisting the help of others. They may lack the energy to actively participate in the course of their care. They may have trouble overcoming their inertia, pessimistically asking themselves, "What's the point? It won't work anyway."

Depression can erode the adaptive energy available to this patient and undermine her ability to tolerate frustration. Because this effectively reduces her pain threshold, she may exhibit a reduced capacity to tolerate pain or other symptoms. Her overall perceived level of suffering may be partly attributable to her physical pain and partly due to her emotional distress.

CHARACTER SCALES

This patient's Borderline scale elevation indicates that she reported extreme emotional instability. Her score is higher than that of 97% of patients. A patient with this level of borderline traits is prone to capricious and inexplicable mood shifts, conflicted relationships, and self-hatred. She reported an emotionally traumatic history, and may have a deficient capacity for self-soothing, an intolerance of frustration or ambivalence, and difficulty regulating her moods. This puts her at risk for punishing herself for her perceived weaknesses or defects. This condition tends to be characterological in nature.

Patients with borderline personalities often employ the defense mechanism of "splitting": they separate their interpersonal world into good and bad. By detaching themselves from painful, "bad" perceptions, they try to create a haven for themselves with the perception of perfect relationships. They do this by projecting an idealized image onto a person whose role is to alleviate their suffering and provide a constant supply of emotional support. They often have unrealistic fantasies about being rescued instead of pursuing more realistic but difficult plans. This can profoundly influence their relationships with their

caregivers.

Patients with this level of borderline tendencies often have volatile love-hate relationships. They may use extreme measures to pressure family members or caregivers to provide the constant support they require. Given their unrealistic expectations, these relationships tend to be fragile, and disappointment is almost inevitable. When someone disappoints them in this way, they often become extremely angry. Losing a source of support can shatter their sense of security and produce deeply contradictory feelings that they cannot reconcile. It may also have a fragmenting effect on their sense of self, unleash feelings of profound emptiness, and precipitate intense rage focused on themselves and others.

Somatization, if present, may be the result of repressed or disavowed feelings. The emotions attached to past traumatic experiences may be dissociated, leaving only a physical sense of bodily distress. Illness or injury can provide a means of seeking support, projecting blame, or rationalizing a pattern of adjustment problems. Some patients report that physical pain provides some relief by distracting them from their intolerable emotional pain. This may cause them to deliberately hurt themselves.

This patient's very low Perseverance score suggests a consistently negative and pessimistic outlook complicated by a pervasive lack of self-discipline and a feeling of being resigned to defeat. Her low Perseverance score is accompanied by elevated signs of characterological disturbance. Her emotional instability, dependent reliance on others, and past problems with adjustment probably contribute to her low self-efficacy. Additionally, her lack of emotional reserves, problems with autonomy, and history of setbacks make it likely that she will lack the resolve to deal with challenges in the future.

An additional risk factor reported by the patient was that she believes she is entitled to preferential treatment. This was coupled with a belief that her injury entitles her to financial compensation. This could negatively affect her attitude and motivation in rehabilitation.

PSYCHOSOCIAL SCALES

This patient reported more family dysfunction and job dissatisfaction than was seen in 96% and 95% of patients, respectively. She reported severe problems at home and at work, which represent two primary sources of security in life. Home life and the workplace also provide a sense of stability, belonging, emotional and financial security, common goals and values, as well as an outlet for expressing feelings. Together, they often consume the preponderance of a person's waking hours. Problems in both of these critical areas can lead to feelings of alienation. This patient feels especially betrayed and abused by her family, and she is also angry with her employer for what she perceives to be unconscionable treatment.

Feeling adrift and disconnected, this patient may be experiencing a deficiency of long-term attachments, with few social resources to help her feel secure. She may be cynical about the level of support available to her at home and at work. With little of consequence in her life to feel dedicated to, she may feel her life lacks meaning. She may have trouble adjusting to situations that involve commitment, living in accordance with guidelines, and working cooperatively with others.

Medical patients often suffer from considerable distress and are required to alter their lifestyle, including changing their work, exercise, diet, and other activities of daily living. These changes are

usually easier with support from the family, and the family is often required to adapt to the changes as well. Given the severe family dysfunction this patient reported, she is probably afraid that her family will fail to provide the level of support she desires. The needed changes will test this dysfunctional family's capacity to act in a cohesive fashion.

If her condition began in the workplace, she may blame her employer for its onset or for failing to off sufficient support. Her job dissatisfaction is very likely to undermine her motivation to get well if doi so would mean returning to a hated job.

If psychosocial risk factors are present, she may use her physical symptom complaints as a way to gai control over her environment, to compel her family to act empathetically, or to force her employer to respond to her requests for preferential treatment or changes in scheduling or work assignments. She may also use her symptoms as a tool to get retribution for real or perceived grievances, and to force h employer to compensate her for any perceived losses.

This patient reported a history of being abused, which tends to produce a survivor attitude. She may have a heightened awareness of her physical vulnerability and may exhibit increased self-protective behavior such as hypervigilance and heightened reactivity to threats. This can lead to a long-term tendency toward heightened physiological arousal and stress-related symptoms. She may also find undressing or being medically examined aversive or threatening. What may appear to be exaggerated pain behaviors during an examination may actually be expressions of distress revolving around the patient's discomfort. The fact that she revealed this abusive history is clinically significant and sugges some measure of trust in her caregiver. This information should be handled with sensitivity because s may feel vulnerable for having reported it.

CRITICAL ITEMS

This section lists the patient's response to items of particular clinical interest.

The patient responded to the following critical items in a manner that is likely to be of concern to the clinician.

Compensation Focus
Omitted Item (Strongly Agree)

Entitlement
Omitted Item (Agree)
Omitted Item (Strongly Agree)

Home-Life Problems
Omitted Item (Strongly Agree)

Special Note:
The content of the test items is included in the actual reports. To protect the integrity of the test, the item content does not appear in this sample report.

Pain Fixation
Omitted Item (Strongly Agree)
Omitted Item (Agree)
Omitted Item (Strongly Agree)
Omitted Item (Strongly Agree)
Omitted Item (Strongly Agree)

Self-Efficacy
Omitted Item (Agree)

Self-Limitations
Omitted Item (Agree)

Sleep Disorder
Omitted Item (Disagree)

Suicidal Ideation
Omitted Item (Strongly Agree)
Omitted Item (Agree)

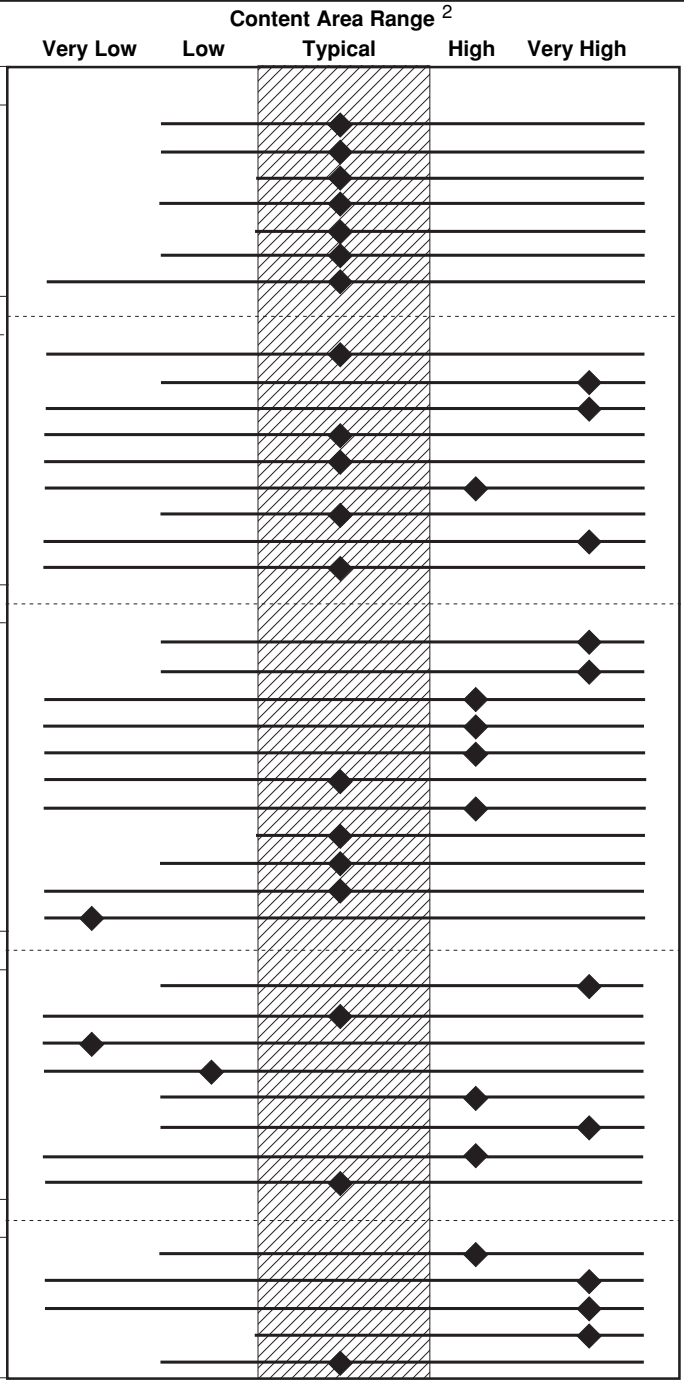
Survivor of Violence
Omitted Item (Strongly Agree)
Omitted Item (Strongly Agree)
Omitted Item (Disagree)
Omitted Item (Agree)

Most of the BHI 2 scales have "content areas." These provide additional, more specific information.

Battery for Health Improvement 2

Content Area Profile [1]

Content Area	Parent Scale
Physical Symptom Content Areas	
Vegetative Depression	SOM
Autonomic Anxiety	SOM
Cognitive Dysfunction	SOM
Somatization Symptoms	SOM
PTSD/Dissociation	SOM
Disability and Work Limitations	FNC
ADL Limitations	FNC
Affective Content Areas	
Grief Depression	DEP
Severe Depression and Helplessness	DEP
Dysphoria	DEP
Death Anxiety	ANX
Health Fears	ANX
General Worries and Fears	ANX
Aggressiveness	HOS
Angry Feelings	HOS
Cynical Beliefs	HOS
Character Content Areas	
Identity Fragmentation	BOR
Self-Destructiveness	BOR
Splitting	BOR
Interpersonal Dynamics	SYM
Internal Dynamics	SYM
Impulsiveness	CHR
Social Dysfunction	CHR
Substance Abuse History	SUB
Rx Abuse Risk	SUB
Self-Efficacy	PER
Proactive Optimism	PER
Psychosocial Content Areas	
Family Conflict	FAM
Lack of Support	FAM
Incompetent Doctors	DOC
Unempathic Doctors	DOC
Boss Dissatisfaction	JOB
Company Dissatisfaction	JOB
Co-Worker Dissatisfaction	JOB
Intrinsic Job Dissatisfaction	JOB
Critical Item Content Areas [3]	
Compensation Focus	N/A
Entitlement	N/A
Pain Fixation	N/A
Suicidal Ideation	N/A
Violent Ideation	N/A



[1] The Content Area Profile can be used to further interpret the BHI 2 scale scores by providing additional information about the types of items the patient endorsed. Although individual content areas should not be interpreted in the same manner as the BHI 2 scales because they do not have the same level of reliability and validity, they may help explain scale-level elevations by providing additional information about the nature of the patient's responses.

[2] The Content Area Range uses a simplified version of the rating system found on the BHI 2 Patient Profile. For each content area, the black horizontal line indicates the overall range of content area ratings in the patient sample. The black diamond indicates the individual patient's content area placement relative to those patients. Approximately two-thirds of the patient population fall within the Typical range, as indicated by the vertical shaded area. High and Very High content area ratings closely approximate the 84th and 95th percentile ranks, respectively, and Low and Very Low ratings closely approximate the 16th and 5th percentiles, respectively.

[3] Critical Item content areas were derived from critical items rather than from scales.

TREATMENT RECOMMENDATIONS

This section offers some treatment recommendations for each significant BHI 2 scale.

Validity Scales

- Talk to the patient about why she reported so much psychological dysfunction. Possible reasons include emotional vulnerability and histrionic tendencies. Interpret her subjective reports with these possibilities in mind.

Critical Items

- **The patient endorsed one or more items regarding suicidal ideation. Determining if she is a danger to herself should be a priority.**

Physical Symptom Scales

- If the patient's diffuse pain symptoms are not consistent with objective findings, her tension and pain focusing should be addressed in treatment.

- If no medical treatment is indicated, talk to the patient about the relationship between chronic pain and stress, anxiety, and depression. Consider a conservative course of multidisciplinary treatment that emphasizes pain management and stress management.

- Treat her excessive tension with relaxation training, EMG biofeedback, manual physical therapy, or techniques for interrupting bracing patterns throughout the day.

- This patient's peak pain greatly exceeds her pain tolerance. Treatment should include medical interventions to decrease pain and psychological interventions to manage her pain and to increase her pain tolerance.

- Determine if objective medical findings corroborate her peak pain report. If so, use psychological support as needed during medical procedures. If not, identify any psychological factors that could be contributing to her pain reports.

Affective Scales

- Consider an evaluation for psychopharmacological treatment for her depression.

- Consider cognitive therapy to address her self-defeating thoughts and to shift her attention away from negative thoughts and feelings. Offer support for reactive depression secondary to health problems.

- Without intervention, her depression may undermine her motivation in treatment.

Character Scales

- Because this patient is at risk for developing intensely conflicted dependency relationships, caregivers should avoid being drawn into such relationships.

- To reduce her symptom dependency, medical caregivers should use active treatment modalities that require patient involvement and responsibility.

- Clearly spelling out what the caregiver can and cannot do and what is expected of the patient may prevent unrealistic expectations from developing. If left unaddressed, such expectations may lead to disappointments and conflicts.

- This patient may blame her setbacks on the failure of others to provide sufficient help. She will need a structured program with regular reinforcements to function autonomously.

Psychosocial Scales

- Consider inviting a family member to one or two of the patient's sessions to promote family support. It may be useful to educate a family member about her physical problems and her treatment.

- If family support is lacking, it may be helpful to find a support group for her.

- If recovery means returning to work, her prognosis may improve if her job dissatisfaction is addressed. If available, an employee assistance person at her workplace might be able to help.

- A patient who has been a victim of abuse may be uncomfortable about being touched, even if it is for legitimate medical reasons. Having more than one caregiver present during examinations or physical therapy may reduce the patient's discomfort.

- Address the levels of distress/trauma that resulted from the abuse and the feelings of victimization that may have resurfaced since her injury or illness.

- Focus on controlling the increased psychophysical arousal often seen in survivors.

End of Report

ITEM RESPONSES

1: 9	2: 0	3: 6	4: 1	5: 5	6: 3	7: 8	8: 10	9: 7	10: 9
11: 10	12: 5	13: 10	14: 5	15: 1	16: 2	17: 1	18: 2	19: 0	20: 0
21: 2	22: 1	23: 0	24: 1	25: 0	26: 2	27: 0	28: 0	29: 0	30: 1
31: 3	32: 0	33: 0	34: 0	35: 1	36: 0	37: 1	38: 1	39: 2	40: 1
41: 1	42: 2	43: 1	44: 2	45: 0	46: 3	47: 0	48: 3	49: 0	50: 2
51: 2	52: 1	53: 3	54: 1	55: 1	56: 0	57: 0	58: 1	59: 0	60: 0
61: 1	62: 1	63: 0	64: 2	65: 2	66: 0	67: 1	68: 3	69: 0	70: 0
71: 1	72: 1	73: 0	74: 0	75: 2	76: 1	77: 2	78: 0	79: 1	80: 1
81: 2	82: 1	83: 2	84: 1	85: 1	86: 2	87: 1	88: 2	89: 2	90: 2
91: 1	92: 1	93: 0	94: 1	95: 2	96: 1	97: 1	98: 2	99: 2	100: 0
101: 3	102: 2	103: 3	104: 3	105: 2	106: 1	107: 1	108: 1	109: 2	110: 1
111: 1	112: 1	113: 0	114: 3	115: 1	116: 2	117: 1	118: 0	119: 1	120: 2
121: 3	122: 2	123: 1	124: 1	125: 1	126: 1	127: 3	128: 1	129: 1	130: 2
131: 0	132: 2	133: 2	134: 2	135: 3	136: 1	137: 3	138: 1	139: 2	140: 1
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151: 0	152: 1	153: 3	154: 3	155: 1	156: 2	157: 0	158: 2	159: 1	160: 0
161: 3	162: 2	163: 0	164: 0	165: 1	166: 0	167: 3	168: 3	169: 0	170: 2
171: 1	172: 2	173: 1	174: 0	175: 1	176: 2	177: 2	178: 3	179: 3	180: 3
181: 2	182: 2	183: 1	184: 2	185: 1	186: 2	187: 1	188: 2	189: 2	190: 1
191: 1	192: 0	193: 1	194: 0	195: 0	196: 1	197: 3	198: 1	199: 1	200: 3
201: 0	202: 2	203: 2	204: 0	205: 1	206: 3	207: 3	208: 1	209: 3	210: 2
211: 1	212: 3	213: 2	214: 3	215: 1	216: 0	217: 3			

PATIENT SUMMARY

This section summarizes the test results in language that is easier for the patient to understand and accept.

The following are the results of your BHI 2 test. These results were generated by a computer analysis, which compared your responses to the responses of national samples of rehabilitation/chronic pain patients and nonpatients in the community. This analysis indicates that you reported the following significant information about yourself. It is important to remember that although the computer generated hypotheses about your condition, only your doctor can form a final opinion about what your results mean. If you think that any of the following statements are incorrect, you should discuss them with your medical caregivers. Additionally, if the following interpretation seems to miss important points about you that your doctor or other caregivers should know, be sure to share that information with them.

- You reported a high level of pain and it appears that you are focused on seeking relief. Whatever the source of your pain, it is important to remember that there are many effective treatments available to you. Keeping track of your pain symptoms and all the factors that aggravate or relieve them will help your doctor identify the type of treatment that is most likely to be effective for you.

- The high level of negative thoughts and sad feelings that you reported suggests that you may be depressed. This may be your reaction to a medical condition or it may be due to other factors in your life. Depression could complicate your recovery and is a significant concern in and of itself. The good news is that there are many effective ways to treat depression, including medications and talking to a professional about your problems.

- You have experienced a good deal of emotional turmoil in your life. It appears that people often let you down. You may be looking for someone you can rely on, but may be afraid that if you get your hopes up, you will be disappointed again. If this continues to be a problem for you, a psychologist or counselor may be able to help you work on strategies to avoid future disappointments.

- There has been a great deal of conflict in your family, and you may be angry about not being treated fairly by family members. Their behavior may make it more difficult to deal with your illness or injury. Being a patient is stressful and may require lifestyle changes. If your family is not supportive, it may be more difficult to make these changes. The conflict and lack of support in your family may make your relationship with medical professionals that much more important. Consider looking for other ways to get the support you need (for example, family therapy or a support group).

- You are very dissatisfied with your job. You may feel that your boss is not supportive or that your company does not care about you. You may have conflicts with your co-workers, and you may dislike the job itself. You may also feel that the people at work have not been especially supportive regarding your medical condition, and this may make being at work more difficult for you. Because returning to work is often a goal of rehabilitation and medical treatment, these conflicts may make recovery more difficult for you. If you feel uncertain about what to do, an employee assistance person or a psychologist may be able to give you some helpful suggestions.