Enhanced Interpretive Report

PATIENT INFORMATION

Patient Identification Number: 555555555

Patient Name (Optional)	Test Date 03/19/2002
Gender Male	Relationship Status Never Married
Age 55	Education Level High School Graduate
Pain Diagnostic Category Back Injury	Race White
Date of Injury (Optional) 11/15/2001	Setting Physical Rehabilitation

PROVIDER INFORMATION

Care Provider (Optional) Robert Helper, PhD.	Practice/Program (Optional) Multidisciplinary Pain Clinic

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.

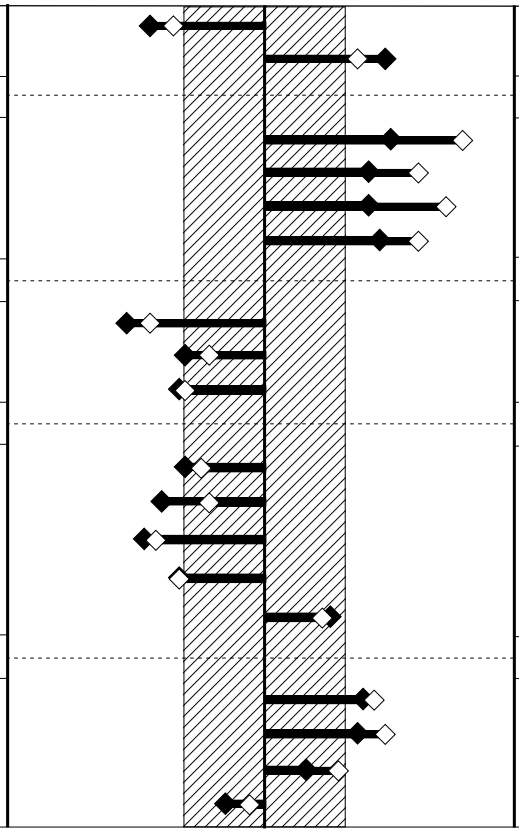
TRADE SECRET INFORMATION

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

Battery for Health Improvement 2

Patient Profile

Scales	Raw Score	T Scores Patient	T Scores Comm.	Rating	Percentile
Validity Scales		◆	◇		
Self-Disclosure	46	34	38	Low	6%
Defensiveness	21	67	62	Very High	95%
Physical Symptom Scales					
Somatic Complaints	43	68	81	High	93%
Pain Complaints	54	64	73	High	91%
Functional Complaints	21	64	78	High	92%
Muscular Bracing	19	66	73	High	94%
Affective Scales					
Depression	1	30	34	Ext. Low	2%
Anxiety	9	40	43	Low	16%
Hostility	8	39	40	Low	12%
Character Scales					
Borderline	7	40	42	Low	18%
Symptom Dependency	4	36	43	Low	12%
Chronic Maladjustment	3	33	35	Very Low	4%
Substance Abuse	0	39	39	Low	6%
Perseverance	34	58	57	Average	79%
Psychosocial Scales					
Family Dysfunction	17	63	65	High	89%
Survivor of Violence	13	62	67	High	87%
Doctor Dissatisfaction	11	55	59	Average	68%
Job Dissatisfaction	11	45	48	Average	30%



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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 summarizes the patient's noteworthy scale findings.

Self-Disclosure Scale: Low
This patient does not appear to have any problems with psychological dysfunction.

Defensiveness Scale: Very High
Indicates an unusually high level of psychological defensiveness.

Somatic Complaints Scale: High
This patient reported an unusually diffuse pattern of somatic complaints.

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

Functional Complaints Scale: High
A relatively high level of functional disability was reported.

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

Depression Scale: Extremely Low
The patient did not report any problems with depressive thoughts or feelings.

Anxiety Scale: Low
No problems with anxious thoughts and feelings were reported.

Hostility Scale: Low
This patient does not appear to have any problems with angry and aggressive feelings.

Borderline Scale: Low
This patient reported a low level of labile mood and interpersonal conflict.

Symptom Dependency Scale: Low
A low level of dependency needs was reported by the patient.

Chronic Maladjustment Scale: Very Low
This patient reported an unusually low, almost nonexistent, level of difficulty adjusting to and achieving the common milestones of a stable adult life.

Substance Abuse Scale: Low
The patient did not report any problems with chemical dependency.

Family Dysfunction Scale: High
This patient reported a relatively high level of conflict and dysfunction in his family.

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

VALIDITY

This patient did not endorse any of the validity items. This reduces the risk that this profile was produced by random responding. This patient reported an unusually low level of psychological concerns, possibly indicating a self-protective way of thinking that may introduce a strong positive bias to his responses. Only 6% of patients reported a level of psychological problems this low. In addition, this level of self-disclosure is seen in only 26% of patients who were asked to fake good. He may be claiming to have an unusually pleasant life with little, if any, distress. Such patients may not value self-examination. As a result, they may lack insight into themselves and may be emotionally disengaged. This low level of self-disclosure may be associated with psychological defensiveness and a reluctance to disclose personal information.

This patient may perceive the evaluation in adversarial terms and may be concerned that his physical symptoms will be taken less seriously if he reports any psychological problems. He may be concerned about his privacy and feel that this evaluation is an unwarranted intrusion into his personal life.

Given the fact that this patient is in litigation, he may fear that any information he reveals will be used against him. Secondary gain may also fuel a conscious or unconscious desire to bias the information presented to create a more favorable self-presentation.

PHYSICAL SYMPTOM SCALES

This patient reported a very broad pattern of disabling illness and pain symptoms compounded by psychophysical reactivity. The level of reported pain symptoms was higher than that seen in 91% of patients, and his pain level was higher than that seen in 88% of chronic pain patients. He endorsed 21 of the 26 Somatic Complaints items and reported pain in 10 of the 10 body areas on the Pain Complaints scale. He also reported extreme peak pain (his Peak Pain score was 10 out of 10), which he perceives as disabling and intolerable (based on his Pain Tolerance Index score). Of greater concern is the fact that he perceives even the mildest pain he experienced in the last month as intolerable and disabling (based on the fact that his lowest level of pain in the last month is greater than his maximum tolerable pain).

This patient reported dysfunction in multiple organ systems and an unusually high level of pain. Some patients with this broad pattern of somatic complaints suffer from a severe injury in combination with disease or medical complications. However, if there is no clear objective medical explanation for these symptoms, the possibility of a somatoform disorder should be considered. (All of these symptoms have been found to be associated with various psychological syndromes). His broad spectrum of pain and somatic complaints suggests the possibility of somatization and somatic preoccupation. The greater the number of psychosocial risk factors, the greater the likelihood that somatizing is involved (for more information on psychosocial risk factors, see the BHI 2 test manual). The diffuse symptom complex is likely to be associated with somatic reactivity under stress, with the resultant condition being perceived as disabling.

The patient has an unusually low level of emotional distress despite his high level of somatic complaints. It may be that he is coping extremely well. However, if the level of pain, disability, or symptomatology exceeds what would be expected given the objective medical findings, the reverse may be true: his physical symptoms may be associated with repressed emotional distress. This pattern is sometimes seen in alexithymic or *la belle indifference* forms of somatizing. Alexithymic individuals are unable to express or even recognize affective states. As a result, they recognize only the physiological correlates of such states. These individuals are unaware of the psychological stressors that give rise to their symptoms, which they regard as being purely physical in nature. Patients who exhibit la belle indifference syndrome may be able to recognize and express affect in some areas of life, but underlying repressive defenses mask the role that emotions play in the production of symptoms and blunt any emotional response to the symptoms that are reported.

Somatizers usually don't recognize the extent to which psychological factors play a role in their physical symptomatology. They consider emotional problems repugnant and a sign of personal weakness. They tend to avoid exploring psychological matters and are unlikely to have any coping strategies. Because they lack psychological outlets, affective pressure may build and fuel autonomic arousal. This arousal can produce a variety of pain and illness symptoms, lower the threshold of tolerance for these symptoms, and lead to a cognitive preoccupation with whatever symptoms may be present. Somatizers perceive such symptoms as entirely physical in nature and are typically unaware of the role of psychological factors. Patients with this profile may see their physical problems as a central, defining feature of their self-concept. Feeling disabled may be the core of their identity.

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 his pain reports.

Pain Complaints Items	**Patient**	**Median***
Head (headache pain)	5	3
Jaw or face	2	0
Neck or shoulders	4	4
Arms or hands	3	1
Chest	3	0
Abdomen or stomach	3	0
Middle back	9	4
Lower back	10	8
Genital area	6	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	8	3
Overall pain level at time of testing	10	-
Maximum Tolerable Pain	2	-

Pain Dimensions	
Pain Range	2
Peak Pain	10
Pain Tolerance Index	-8

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

SOMATIC COMPLAINTS ITEM RESPONSES

The healthcare provider is encouraged to determine if the patient's complaints are consistent with objective physical findings. This patient reported a total of 21 somatic complaints out of 26. These complaints and the patient's responses are listed below. Some possible medical and psychological explanations are also listed.

Somatic Complaint	Patient Response	Possible Medical Explanations	Possible Psychological Explanations
Being unable to relax	Big Problem	Hyperthyroidism	Anxiety Stress
Irritability	Big Problem	Corticosteroid effect Amphetamine use	Depression Anxiety Hostility
Shakiness or jitters	Big Problem	Tremor Hypoglycemia Chemical dependency	Anxiety Panic
Nervousness	Big Problem	Hyperthyroidism	Anxiety
Grinding your teeth together	Big Problem	Bruxism	Stress Anxiety
Flashbacks of painful memories	Small Problem	Hallucinogen flashback	PTSD
Feeling that nothing seems real	Small Problem	Complex partial seizures Psychosis	Dissociation
Lump in throat/difficulty swallowing	Small Problem	Laryngeal cancer Status post cervical fusion	Somatization Conversion
Memory loss	Small Problem	Dementia Brain injury	Somatization
Having your legs give out while you're walking	Small Problem	Multiple sclerosis Spondylolisthesis	Somatization Conversion
Visual or hearing problems that come and go	Small Problem	Multiple sclerosis Meniere's disease	Somatization Conversion
Feeling like a heavy weight is sitting on your chest	Small Problem	Congestive heart failure Myocardial infarction	Anxiety Panic
Shortness of breath when not exerting yourself	Big Problem	Asthma Emphysema Heart failure	Anxiety Panic
Pounding heart when not exerting yourself	Big Problem	Atrial tachycardia Mitral valve prolapse	Anxiety Panic
Dizziness or fainting	Small Problem	Hypotension Meniere's disease	Anxiety Panic
Feeling exhausted but being unable to sleep	Big Problem	Caffeine/stimulants	Depression
Crying easily	Big Problem	Hypothyroidism	Depression
Hearing voices that other people don't hear	Small Problem	Psychosis Complex partial seizures	Somatization

Feeling bloated or gassy	Small Problem	Food intolerance Rx side effect	Somatization
Changes in weight	Big Problem	Gastroenteritis Cancer	Depression
Lack of interest in sex	Big Problem	Low sex hormones Pain disorder Rx side effect	Depression Somatization

AFFECTIVE SCALES

This patient reported levels of depressive thoughts and feelings that are substantially lower than those of 2% of patients. Not only is this level of depression far below that of the average patient, it is even lower than that of the typical community subject who usually has fewer emotional problems than the average patient. Patients with this extremely low level of depressive thoughts and feelings may be functioning extraordinarily well. They may be able to maintain a happy-go-lucky attitude despite the stressors they face. He also reported a high level of physical symptoms, suggesting the presence of vegetative depression and autonomic anxiety.

If this is not consistent with the patient's clinical presentation or historical information, this profile may be indicative of a tendency to deny depressive feelings. He may perceive depression as a sign of mental or moral weakness, and he may conceal it because he is embarrassed. Further, he may be afraid that letting others know about his downcast and weakened state will increase his vulnerability to being taken advantage of. He may also find it difficult to acknowledge those feelings to himself because the idea of being so weak as to succumb to depression may give rise to feelings of self-contempt and a worsening of his depression.

This patient's unusually low level of depression may indicate a fear of acknowledging depressive symptoms in a medical setting. He may have feelings of shame about being perceived as emotionally weak and may fear that if he reveals his emotional vulnerability, his doctors will think that his physical symptoms are "all in his head." There may also be social or legal reasons that he is unwilling to admit to any depressive affect.

The process of somatization is often fueled by unacknowledged affective states. Because depression appears to be the feeling that this patient is least likely to acknowledge or express, this possibility should be considered if any somatized symptoms are determined to be present. If he has a serious medical problem, he may be denying its significance. (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. Consequently, this score does not rule out the possibility that physical symptoms of depression are present.)

CHARACTER SCALES

This patient reported levels of maladjustment and dependent feelings that were so low, they were seen in only 4% and 12% of patients, respectively. He reported an almost total absence of problems achieving the common milestones of stable adult life. He is also likely to express concern with social responsibility and emotional independence and exhibit a pattern of self-reliant achievement. His reports suggest that he leads a very traditional and conventional life, plays by the rules, and stays out of trouble.

Given the overall profile, the possibility of unreported adjustment problems and dependency needs should be considered. Because his low Self-Disclosure score may indicate that he denies his behavioral dysfunction, his reported history of exceptionally good adjustment should be carefully examined especially if there are indications that his report does not accurately represent his history or present behavior, or if psychosocial risk factors are present.

This patient may avoid expressing his dependency needs. He may want to appear totally independent and self-sufficient. Asking for help may embarrass or humiliate him, resulting in unmet dependency needs. He may also be afraid that he cannot rely on other people. This may produce submerged conflicts that manifest themselves somatically. If a somatoform condition is present, it should be recalled that such disorders are often associated with unacknowledged dysfunctional tendencies.

An additional risk factor reported by the patient is his belief that he deserves financial compensation for his pain and suffering. This could negatively affect his motivation in rehabilitation.

PSYCHOSOCIAL SCALES

This patient's significantly elevated Family Dysfunction score is higher than those seen in 89% of patients. His report suggests he feels unloved, mistreated, and angry about perceived familial injustices. Given his perceived lack of family support, he may react to the onset of a physical illness or injury with increased feelings of insecurity, isolation, and vulnerability. As a result, he may depend more heavily on his medical caregivers to give him emotional support and to meet his security needs.

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 the support of the family, and the family is often required to adapt to the changes as well. Given the elevated level of conflict and dysfunction this patient reported, he is probably afraid that his family will fail to provide the level of support he desires. Furthermore, his medical condition may create a hub around which family conflicts revolve, with concerns about loyalty and support being central issues.

However, if a somatoform condition is present, he may use his physical symptoms to change the family dynamics. This may include avoiding responsibility, testing loyalties, and inducing guilt. These maneuvers may get the attention and support of his otherwise distant family. Under such circumstances, medical symptoms may offer a kind of psychosomatic solution, being presented in such a way as to pressure family members to act empathetically and comply with his wishes.

This patient reported a history of being abused, which tends to produce a survivor attitude. He may have a heightened awareness of his 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. He 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 he revealed this abusive history is clinically significant and suggests some measure of trust in his caregiver. This information should be handled with sensitivity because he may feel vulnerable for having reported it.

CRITICAL ITEMS

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 (Agree)
Omitted Item (Strongly Agree)

Entitlement
Omitted Item (Agree)

Pain Fixation
Omitted Item (Agree)

Perceived Disability
Omitted Item (Strongly Agree)

Sleep Disorder
Omitted Item (Strongly Disagree)

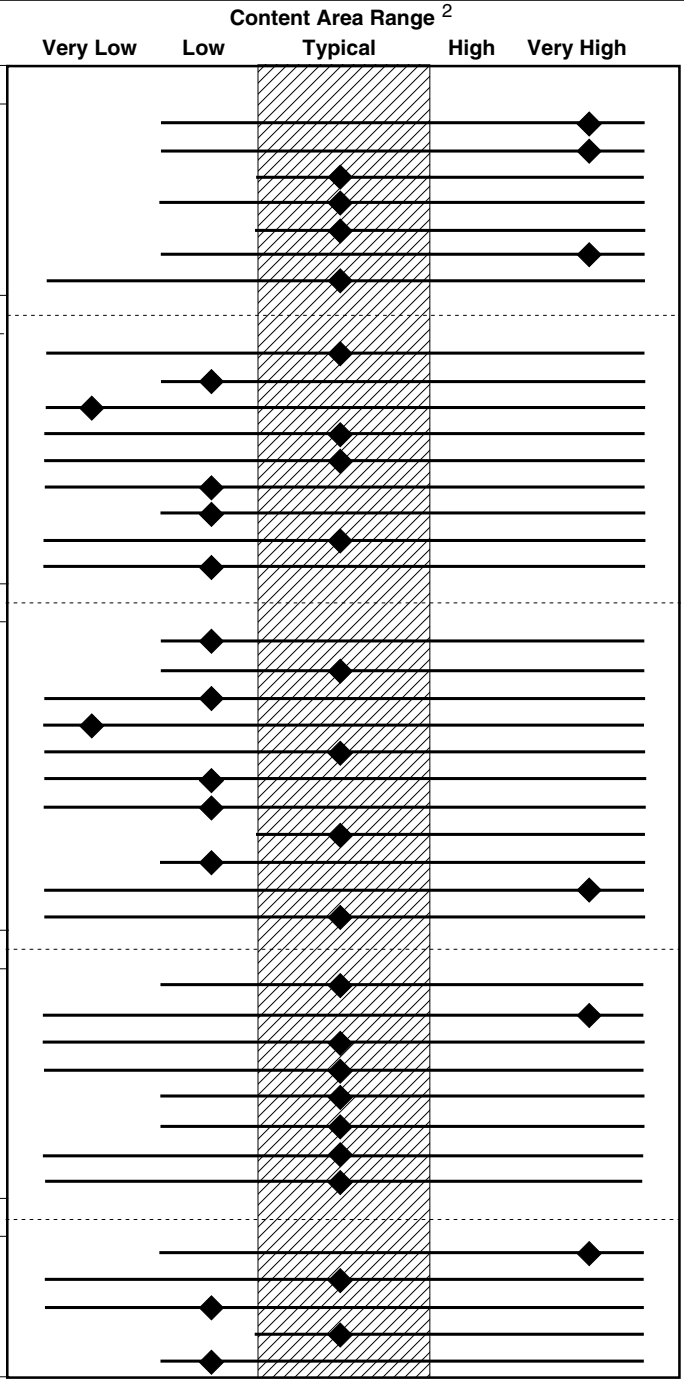
Survivor of Violence
Omitted Item (Strongly Agree)

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.

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.

End of Report

ITEM RESPONSES

1: 5	2: 2	3: 4	4: 3	5: 3	6: 3	7: 9	8: 10	9: 6	10: 9
11: 10	12: 8	13: 10	14: 2	15: 3	16: 3	17: 3	18: 3	19: 3	20: 1
21: 1	22: 1	23: 1	24: 1	25: 1	26: 1	27: 3	28: 3	29: 1	30: 3
31: 3	32: 1	33: 1	34: 0	35: 3	36: 3	37: 0	38: 0	39: 0	40: 0
41: 2	42: 3	43: 0	44: 1	45: 1	46: 0	47: 2	48: 1	49: 1	50: 0
51: 3	52: 0	53: 0	54: 1	55: 1	56: 1	57: 3	58: 2	59: 1	60: 1
61: 3	62: 0	63: 0	64: 0	65: 1	66: 1	67: 2	68: 0	69: 1	70: 1
71: 1	72: 0	73: 0	74: 1	75: 1	76: 1	77: 1	78: 3	79: 1	80: 1
81: 2	82: 0	83: 1	84: 1	85: 1	86: 0	87: 1	88: 3	89: 3	90: 1
91: 0	92: 1	93: 3	94: 0	95: 0	96: 1	97: 1	98: 1	99: 0	100: 0
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211: 1	212: 1	213: 2	214: 0	215: 0	216: 3	217: 0			