BHI™ 2

Battery for Health Improvement 2

Enhanced Interpretive Report

PATIENT INFORMATION

Patient Identification Number: 12345

Patient Name (Optional) Mr. R	Test Date 03/19/2016
Gender Male	Relationship Status Never Married
Age 55	Education Level High School Graduate
Pain Diagnostic Category Back Injury	Race White
Date of Injury (Optional) 11/15/2015	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.

PsychCorp

Daniel Bruns and John Mark Disorbio

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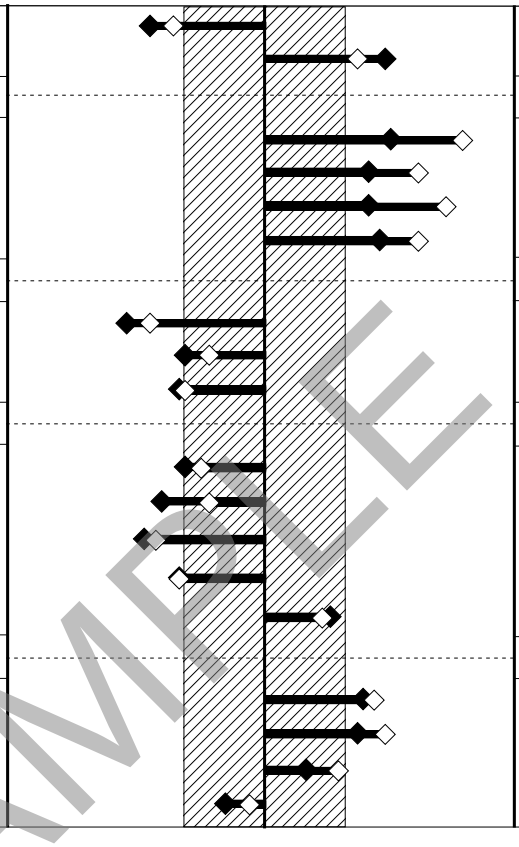
Battery for Health Improvement 2

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.

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 clinical signs of delayed recovery, the greater the likelihood that somatizing is involved (for more information on clinical signs of delayed recovery, 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*
Item omitted	5	3
Item omitted	2	0
Item omitted	4	4
Item omitted	3	1
Item omitted	3	0
Item omitted	3	0
Item omitted	9	4
Item omitted	10	8
Item omitted	6	0
Item omitted	9	5
Item omitted	10	8
Item omitted	8	3
Item omitted	10	-
Item omitted	2	3
Pain Dimensions		
Pain Range	2	4
Peak Pain	10	8
Pain Tolerance Index	-8	-5

*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	42%
Neck Injury	38%
Upper Extremity Injury	9%
Back Injury	95%
Lower Extremity Injury	71%
Pain Diagnostic Category	
Predicted by BHI 2	Back Injury
Selected by clinician	Back Injury

Note

Item numbers and content are included in the actual reports. To protect test security, the item details do not appear in this sample report.

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
Item omitted.	Big Problem	Hyperthyroidism	Anxiety Stress
Item omitted.	Big Problem	Corticosteroid effect Amphetamine use	Depression Anxiety Hostility
Item omitted	Big Problem	Tremor Hypoglycemia Chemical dependency	Anxiety Panic
Item omitted.	Big Problem	Hyperthyroidism	Anxiety
Item omitted.	Big Problem	Bruxism	Stress Anxiety
Item omitted.	Small Problem	Hallucinogen flashback	PTSD
Item omitted.	Small Problem	Complex partial seizures Psychosis	Dissociation
Item omitted.	Small Problem	Laryngeal cancer Status post cervical fusion	Somatization Conversion
Item omitted.	Small Problem	Dementia Brain injury	Somatization
Item omitted.	Small Problem	Multiple sclerosis Spondylolisthesis	Somatization Conversion
Item omitted.	Small Problem	Multiple sclerosis Meniere's disease	Somatization Conversion
Item omitted.	Small Problem	Congestive heart failure Myocardial infarction	Anxiety Panic
Item omitted..	Big Problem	Asthma Emphysema Heart failure	Anxiety Panic
Item omitted.	Big Problem	Atrial tachycardia Mitral valve prolapse	Anxiety Panic
Item omitted.	Small Problem	Hypotension Meniere's disease	Anxiety Panic
Item omitted.	Big Problem	Caffeine/stimulants	Depression
Item omitted.	Big Problem	Hypothyroidism	Depression
Item omitted.	Small Problem	Psychosis Complex partial seizures	Somatization
Item omitted.	Small Problem	Food intolerance Rx side effect	Somatization
Item omitted.	Big Problem	Gastroenteritis Cancer	Depression

Item omitted.	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 clinical signs of delayed recovery 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
Item omitted. (Agree)
Item omitted. (Strongly Agree)

Entitlement
Item omitted. (Agree)

Dysfunctional Pain Cognitions
Item omitted. (Agree)

Perceived Disability
Item omitted. (Strongly Agree)

Note

Item numbers and content are included in the actual reports. To protect test security, the item details do not appear in this sample report.

Sleep Disorder
Item omitted. (Strongly Disagree)

Survivor of Violence
Item omitted. (Strongly Agree)

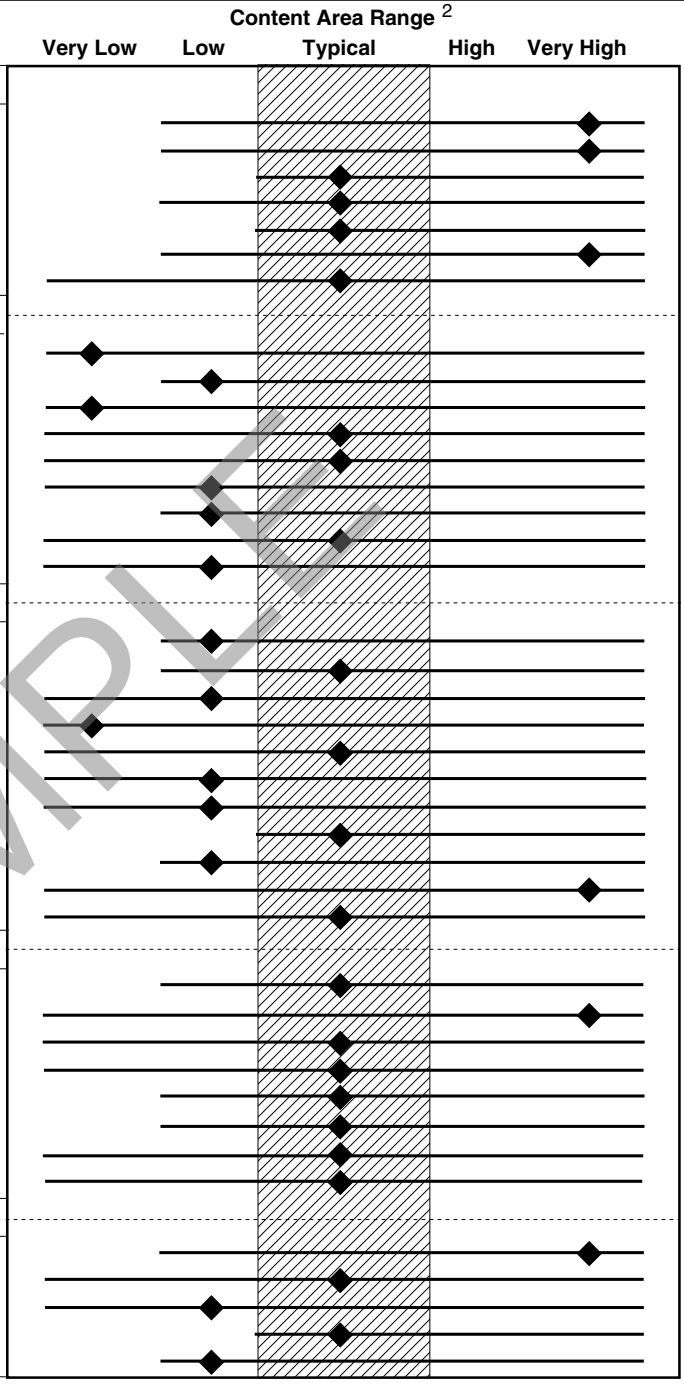
Note

Item numbers and content are included in the actual reports. To protect test security, the item details do 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	
Medical Reactive Depression	DEP
Severe Depression	DEP
Dysthymia	DEP
Death Fears	ANX
Illness Anxiety	ANX
Generalized Anxiety	ANX
Aggressiveness	HOS
Angry Feelings	HOS
Cynical Beliefs	HOS
Character Content Areas	
Identity Disturbance	BOR
Self-Destructiveness	BOR
Unstable Relationships	BOR
Somatic Secondary Gain	SYM
Dysfunctional Somatic Cognitions	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
Dysfunctional Pain Cognitions	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

Validity Scales

- Talk to the patient about why he was reluctant to disclose any psychological dysfunction. Developing a more trusting therapeutic alliance with him may help him feel more at ease and open to expressing his psychological distress.

- This patient's results suggest that he may have exaggerated the positive aspects of his life. Interpret his subjective reports with this in mind.

Physical Symptom Scales

- If the patient's diffuse pain and somatic symptoms are not consistent with objective findings, or if they lead to excessive disability, it is important to address this inconsistency in treatment.

- If no medical treatment is indicated, talk to the patient about the relationship between illness symptoms and stress, anxiety, and depression. Consider a conservative course of multidisciplinary treatment that emphasizes managing pain and illness symptoms, and increasing functional capacity where possible.

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

- If objective disability is present, help the patient establish realistic goals, and focus on his capabilities, not his disabilities. If excessive disability is present, encourage the patient to do what he can.

- The extreme difference between his high peak pain and his low level of pain tolerance is cause for concern. Treatment should include medical interventions to decrease pain and psychological interventions to manage pain and increase pain tolerance.

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

Affective Scales

- Taken at face value, his unusually low level of reported emotional distress appears to be an asset to draw upon in treatment. However, if his profile does not reflect reality, he may have alexithymic tendencies (i.e., he may have trouble recognizing or expressing emotions). If this is the case, it is important to help him increase his affective awareness, develop emotional expression skills, and differentiate emotional feelings from physical sensations.

- If he cannot express his emotions verbally, he may express them somatically. It may be worthwhile to explore this possibility.

Psychosocial Scales

- Identify any family members who may be able to offer support to the patient, and help him put their support to use.

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

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

- 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 his injury or illness.

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

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
101:	1	102:	0	103:	1	104:	1	105:	0	106:	2	107:	1	108:	1	109:	1	110:	0
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141:	1	142:	2	143:	2	144:	2	145:	3	146:	2	147:	3	148:	0	149:	0	150:	0
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161:	2	162:	2	163:	0	164:	1	165:	1	166:	0	167:	3	168:	3	169:	2	170:	0
171:	3	172:	0	173:	2	174:	0	175:	2	176:	2	177:	1	178:	0	179:	0	180:	1
181:	1	182:	0	183:	0	184:	1	185:	0	186:	0	187:	3	188:	0	189:	1	190:	3
191:	2	192:	2	193:	0	194:	0	195:	1	196:	1	197:	2	198:	3	199:	2	200:	0
201:	1	202:	3	203:	2	204:	2	205:	1	206:	1	207:	1	208:	1	209:	2	210:	2
211:	1	212:	1	213:	2	214:	0	215:	0	216:	3	217:	0						

PATIENT SUMMARY

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 that your life is going quite well despite any physical problems you have. However, it is possible that you are reluctant to talk about your feelings or other personal matters and that you are concerned about your privacy. Keep in mind that your doctors can help you best when you are open and direct with them about your problems, including both physical and emotional ones.

- You reported a high level of physical illness symptoms. There are a number of possible medical explanations for these symptoms, which should be discussed with your physician. The symptoms that you reported can also be produced by stress. Stress-related symptoms are very real and are no less important than other types of symptoms, and there are effective treatments for them. Lifestyle changes or treatments that lower your physical and emotional stress may be helpful for you.

- You reported an unusually low level of sad feelings and negative thoughts. It is possible that you are especially resistant to depression or that your circumstances are not very stressful. However, some people in your situation find that depression is an especially difficult feeling to talk about. If this is the case, you should know that it is quite common for patients to experience mild depression, and there is no reason to feel embarrassed or ashamed.

- Your life appears to be stable and successful in many respects. If you have a serious medical condition, this history may help you feel confident about tackling rehabilitation and recovery.

- 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).