Behavioral Assessment of Pain-2
Clinical Profile

(For Professional Use Only)

Validity Measures for the Behavioral Assessment of Pain-2 Questionnaire

Below are important considerations when interpreting the BAP-2

The patient's BAP-2 scores should be interpreted with caution since the following validity scales have exceeded acceptable ranges:

Consistency/Inconsistency Response: (10) This scale measures an inconsistent response style. Pairs of items were selected across the various BAP scales based on high inter-item correlations. Scores for each pair of items with differences of 4 points or greater are judged significant. Patients scoring in the 95th percentile, suggests highly inconsistent responding and could indicate carelessness, lack of understanding, or noncompliance.

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Michael J. Lewandowski, Ph.D. and Blake H. Tearnan, Ph.D.

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The Behavioral Assessment of Pain Questionnaire (BAP-2) is for the purpose of evaluating patients who are experiencing subacute and chronic benign pain. Patients who do not meet this criteria should not be administered this questionnaire. The BAP-2 should be viewed as a component of a comprehensive assessment protocol and cannot be judged definitive. The results of the BAP-2 need to be combined with additional data drawn from the clinical interview and other assessment devices. Information from the BAP-2 can serve as a useful source of hypotheses about factors which may be maintaining and exacerbating subacute and chronic pain.

Validity of the BAP-2

The patient's BAP-2 scores should be interpreted with caution since validity scales have exceeded acceptable ranges.

PATIENT IDENTIFYING INFORMATION

The patient is a 55 year old White married female who is living with her husband and 3 children. This is her first marriage. She is currently unemployed and has been for the past 12 - 18 months. She was working in a skilled trade. The patient has a high school diploma. Her spouse is employed in a semi-skilled or unskilled job.

The patient reported that she is experiencing great financial difficulty. Her annual income is between $25,001 and $50,000. This is significantly more than what she was earning before she developed pain. She is currently receiving disability payments and is somewhat satisfied with the amount of money she is receiving. Fifty percent of her family income is from disability. The patient made known that she is involved in active litigation or has retained a lawyer related to her pain problem.

PAIN COMPLAINT

Pain characteristics

The patient reported that low back pain is her most significant pain problem, but she is also bothered by neck and hand/arm pain. She described her low back pain as especially pulling, sore, tight, aching and continuous. She disclosed that when she is in pain, she often moans or winces, lies down, talks to others about her pain, tells others to leave her alone, braces herself when she sits and cries. Using a rating scale of 0 to 10, with 10 being most severe, the patient rated her average level of pain intensity as an 8. Over the past week, the patient's pain ranged from a 5 to 10.

*The BAP-2 Clinical Profile can be combined with our patient self management tools, The Chronic Pain Care Workbook and the web site http://PainCareWorkbook.com/

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Medication usage

The patient reported use of the following medications: Non-prescription pain relievers and rated them mildly effective overall. Non-steroidal anti-inflammatory drugs and rated them mildly effective overall. Prescription pain relievers - Short-acting and rapid-onset and rated them moderately effective overall. Prescription pain relievers - Time-released and long-acting and rated them moderately effective overall. Antidepressant medications and rated them mildly effective overall. Muscle relaxants and rated them not effective overall. Benzodiazepines - Anti-anxiety medications and rated them mildly effective overall. Neuropathic, Anti-spasm and other pain medicines and rated them mildly effective overall. Sleep medicines and rated them not effective overall. Natural herbal medicines and rated them mildly effective overall.

Health care utilization

In the past year, the patient has consulted 5-6 different physicians and/or chiropractors for her pain complaint. In addition, she has visited the emergency room 1 to 2 times. She has had between 11 and 15 physician and/or chiropractic visits over the past 6 month period. Since her pain began on December 23, 2007, she has been hospitalized 3 to 4 times, and has had two surgeries for her pain. She estimated the amount of improvement she has received from the health care profession at 10%.

Physical activity and pain avoidance

The patient's current level of physical activity is 45 percent below the level she reported she was experiencing before developing pain (see Figure 1). She showed reductions in heavy, social, personal care, personal hygiene and domestic/household activities (see Table 1). Her diminished activity level is highest for personal care activities, followed by domestic/household and social activities. Specific activities declining the most were shopping for groceries, walking long distances, mowing the lawn, dining out, going to parties, doing the dishes and preparing meals.

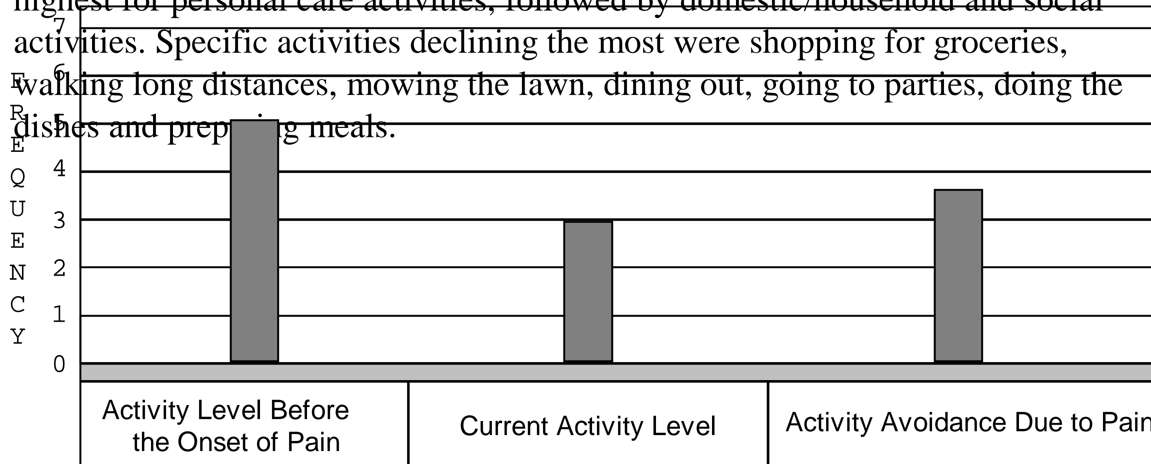
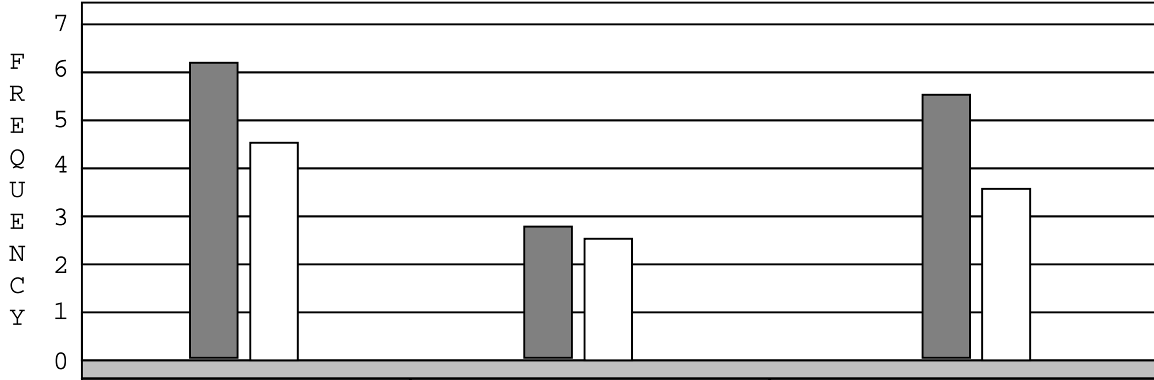


Figure 1. Activity Level Changes

Figure 1a.

Domestic / Household Activities

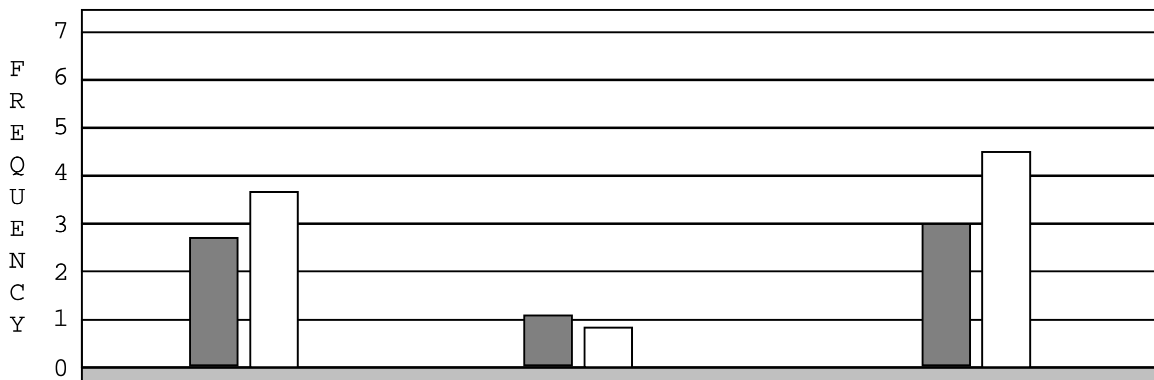


	Activity Level Before Pain	Current Activity Level	Activity Avoidance Due To Pain
Patient Score	6.22	2.78	5.56
Normative Mean*	4.5	2.6	3.6

	Before	Current	Avoidance		Before	Current	Avoidance
Running errands	6	3	4	Doing the dishes	7	3	7
Laundry	5	3	7	Preparing meals	6	2	5
Ironing clothes	6	3	7	Vacuuming	6	2	7
Dusting or wiping	7	7	0	Scrubing the floor	6	2	6
Shopping for groceries	7	0	7				

Figure 1b.

Heavy Activities

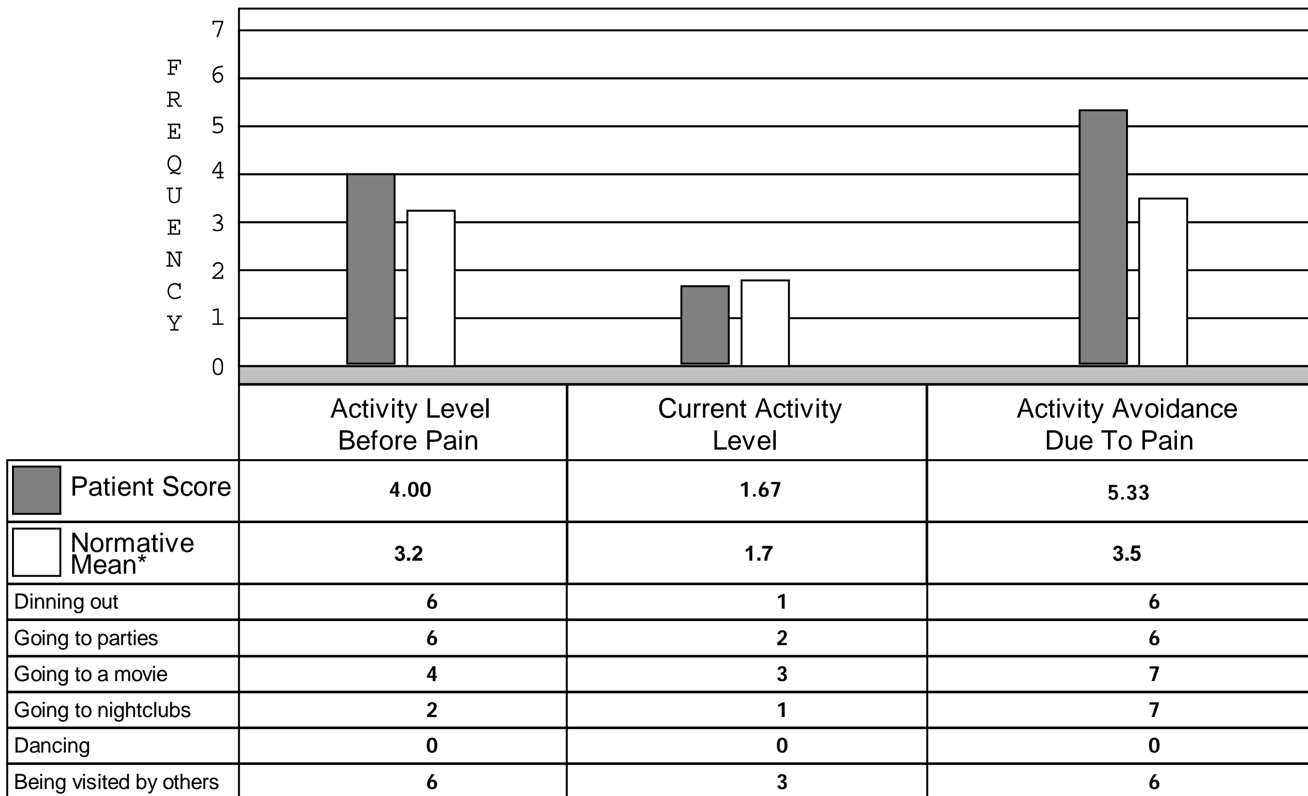


	Activity Level Before Pain	Current Activity Level	Activity Avoidance Due To Pain
Patient Score	2.70	1.10	3.00
Normative Mean*	3.7	0.9	4.5

	Before	Current	Avoidance		Before	Current	Avoidance
Moving furniture	0	0	0	Doing repairs	5	4	6
Hunting/fishing	0	0	0	Playing sports	0	0	0
Mowing the lawn	6	0	6	Washing the car	4	2	7
Working on the car	0	0	0	Driving long distances	7	3	5
Gardening	5	2	6	Doing plumbing repair	0	0	0

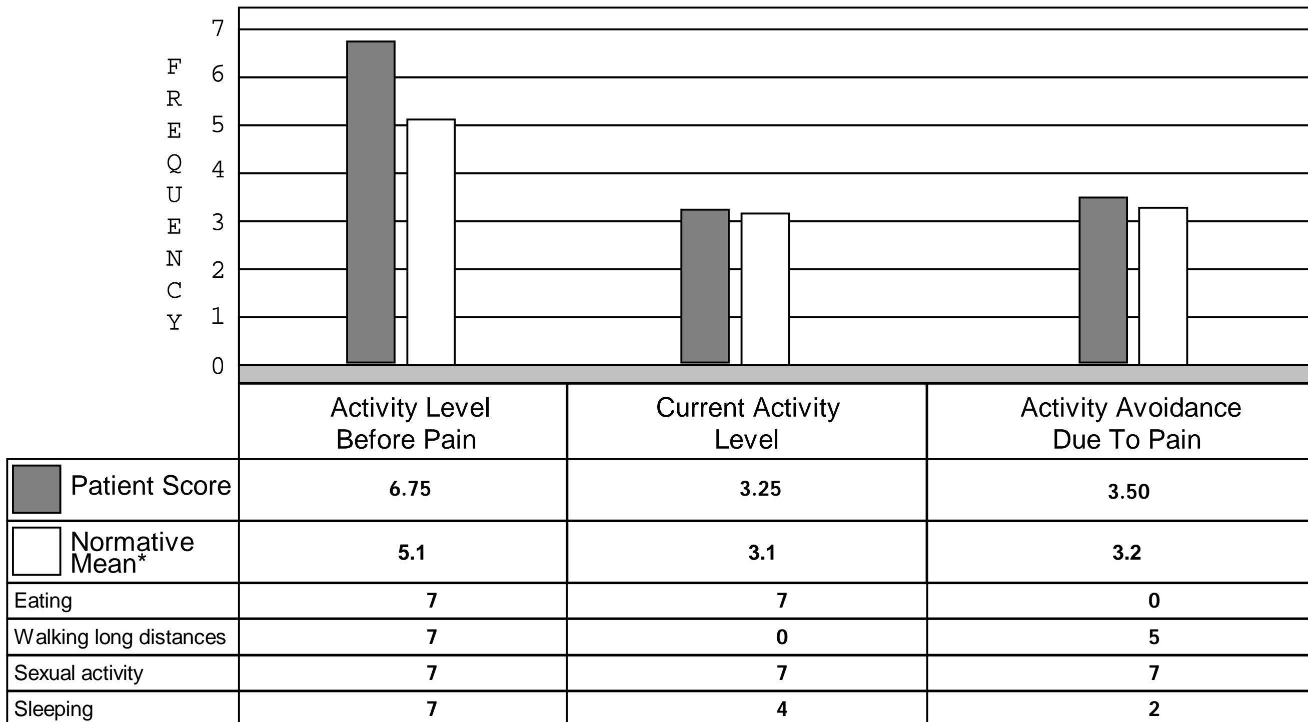
* Normative Mean - based on a sample of 1,012 subacute and chronic pain patients.

Figure 1c. Social Activities



	Activity Level Before Pain	Current Activity Level	Activity Avoidance Due To Pain
Patient Score	4.00	1.67	5.33
Normative Mean*	3.2	1.7	3.5
Dinning out	6	1	6
Going to parties	6	2	6
Going to a movie	4	3	7
Going to nightclubs	2	1	7
Dancing	0	0	0
Being visited by others	6	3	6

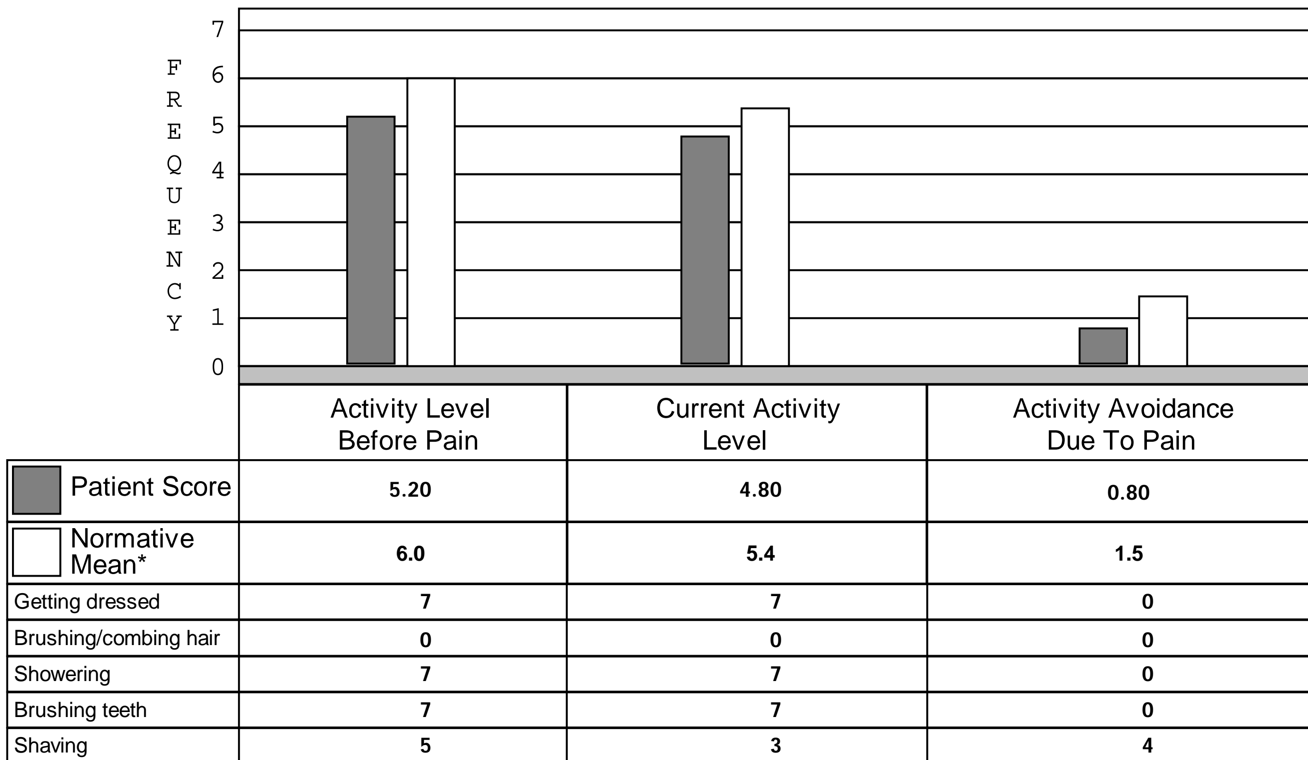
Figure 1d. Personal-Care



	Activity Level Before Pain	Current Activity Level	Activity Avoidance Due To Pain
Patient Score	6.75	3.25	3.50
Normative Mean*	5.1	3.1	3.2
Eating	7	7	0
Walking long distances	7	0	5
Sexual activity	7	7	7
Sleeping	7	4	2

* Normative Mean - based on a sample of 1,012 subacute and chronic pain patients.

Figure 1e. Personal Hygiene



	Activity Level Before Pain	Current Activity Level	Activity Avoidance Due To Pain
Patient Score	**5.20**	**4.80**	**0.80**
Normative Mean*	**6.0**	**5.4**	**1.5**
Getting dressed	**7**	**7**	**0**
Brushing/combing hair	**0**	**0**	**0**
Showering	**7**	**7**	**0**
Brushing teeth	**7**	**7**	**0**
Shaving	**5**	**3**	**4**

* Normative Mean - based on a sample of 1,012 subacute and chronic pain patients.

Table 1. Activity Level

	Patient Mean Scores (0-7)				Normative Sample Means*	
Type of activity	Pre-Pain	Current		Interference	Interference	SD
Domestic/Household	6.22	2.78		3.44	**1.91**	**1.72**
Heavy Activities	2.70	1.10		1.60	**2.74**	**1.62**
Social Activities	4.00	1.67		2.33	**1.71**	**1.49**
Personal-Care	6.75	3.25	**	3.50	**1.96**	**1.53**
Personal Hygiene	5.20	4.80		0.40	**0.62**	**0.98**

*** mean scores based on a sample of 1012 subacute and chronic pain patients**
**** +/- one standard deviation**

The patient responded that the changes in her activity level are due to pain, particularly for domestic/household tasks. She indicated she especially avoids dining out, going to parties and doing the laundry because of pain.

Spousal influence on pain and wellness behaviors

There is moderate evidence the patient's spouse is reinforcing her pain behavior (see Table 2 and Figure 2). The patient indicated that when she is in pain, her husband asks if he can help in some way, gives her a massage and takes over her chores and duties.

Table 2. Spousal influence on pain and wellness behaviors

			Normative Sample Means	
Spousal Behavior		Patient Mean Scores (0-7)	MEAN	SD
Spouse's reinforcement of pain		3.22	**3.68**	**1.78**
Spouse's reinforcement of wellness		3.33	**3.21**	**1.71**
Spouse's criticism of pain	**	2.63	**1.10**	**1.40**
Spouse's discouragement of wellness		4.25	**3.28**	**2.04**

**** +/- one standard deviation**

The patient reported her husband pays some attention to her when she is physically active and attempting to do things for herself (see Table 2 and Figure 2). For example, she communicated he occasionally encourages her to do her chores around the house.

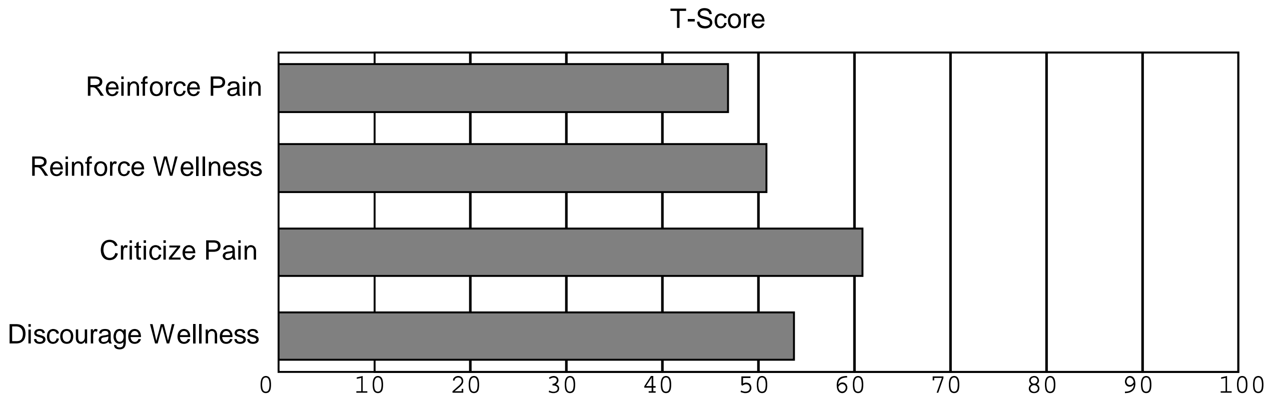


Figure 2. Spousal Influence on Pain and Wellness

The patient's husband appears to moderately discourage her efforts to increase her physical activity (see Table 2 and Figure 2). She acknowledged he often cautions her about possible re-injury when she is physically active and stops her from doing physical activities.

There was considerable indication the patient's husband is criticizing or discouraging her pain behavior (see Table 2 and Figure 2). She reported he frequently becomes irritated or angry.

Physician influence on pain and wellness behaviors

There was evidence the doctors may have reinforced her pain behavior (see Figure 3). The patient communicated her doctors on the whole prescribed narcotic medication even after six months following the onset of her pain and have said that surgery or medication are the only treatments that might help.

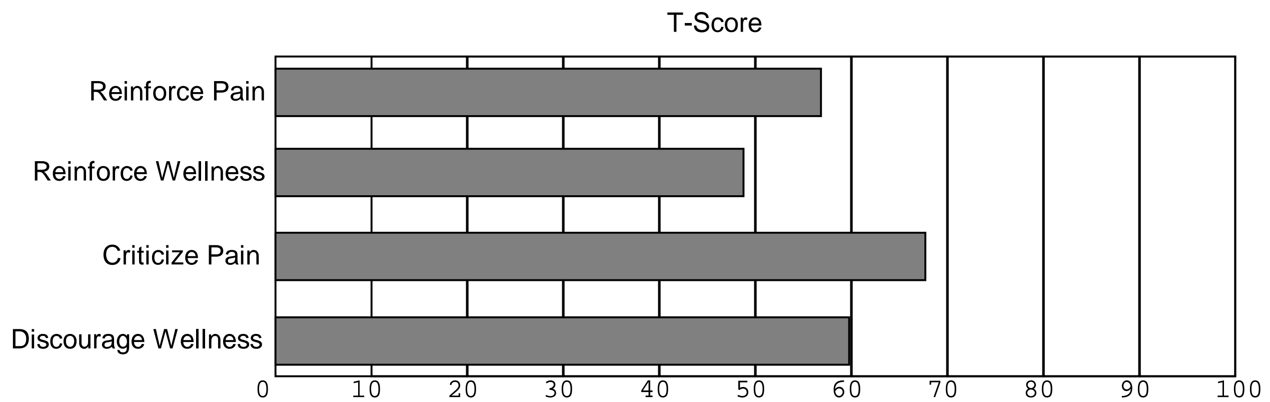


Figure 3. Physician Influence on Pain and Wellness Behaviors

The patient reported her doctors seldom encouraged her to be physically active (see Table 3). She replied they usually warned her she might harm herself if she increased her physical activity.

The patient's doctors may have strongly criticized or punished her pain behavior (see Table 3). The patient revealed her doctors became annoyed at her when she complained of pain and have accused her of exaggerating her pain.

Table 3. Physician influence on pain and wellness behaviors

Physician Behavior		Patient Mean Scores (0-7)	Normative Sample Means* MEAN	SD
Physician's reinforcement of pain		3.38	**2.51**	**1.23**
Physician's reinforcement of wellness		2.75	**3.02**	**1.82**
Physician's criticism of pain	**	4.00	**0.94**	**1.24**
Physician's discouragement of wellness	**	3.80	**2.14**	**1.53**

**** +/- one standard deviation**

* Normative Mean - based on a sample of 1,012 subacute and chronic pain patients.

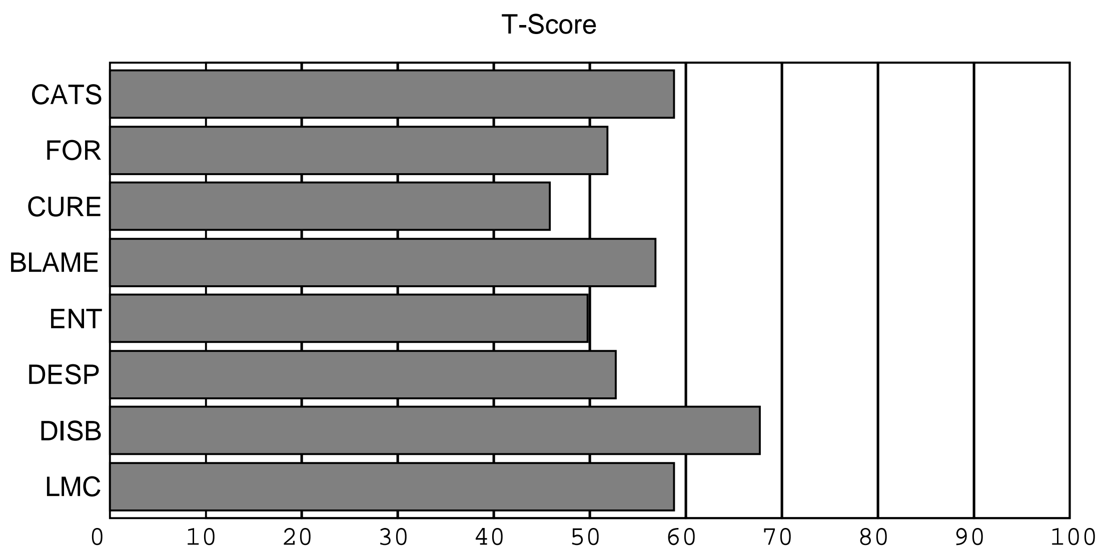
Pain beliefs

The patient endorsed numerous beliefs about her pain including thoughts that others do not believe her pain is real, thoughts that something more could be done to eliminate her pain and beliefs that her pain problem was not treated comprehensively (see Table 4 and Figure 4). She also reported fears of re-injury, thoughts of entitlement and believing her pain problem is more than she can handle.

Table 4. Pain beliefs

			Normative Sample Means*	
Pain beliefs		**Patient Mean Scores (0-7)**	**MEAN**	**SD**
Catastrophizing		4.33	**2.89**	**1.66**
Fear of reinjury		4.67	**4.18**	**1.81**
Expectation for cure		5.00	**5.42**	**2.10**
Blaming self		3.75	**2.62**	**1.65**
Entitlement		4.67	**4.42**	**2.00**
Future despair		3.00	**2.42**	**2.06**
Social disbelief	**	5.67	**1.52**	**1.75**
Lack of med. comp.		5.00	**3.20**	**1.82**

**** +/- one standard deviation**

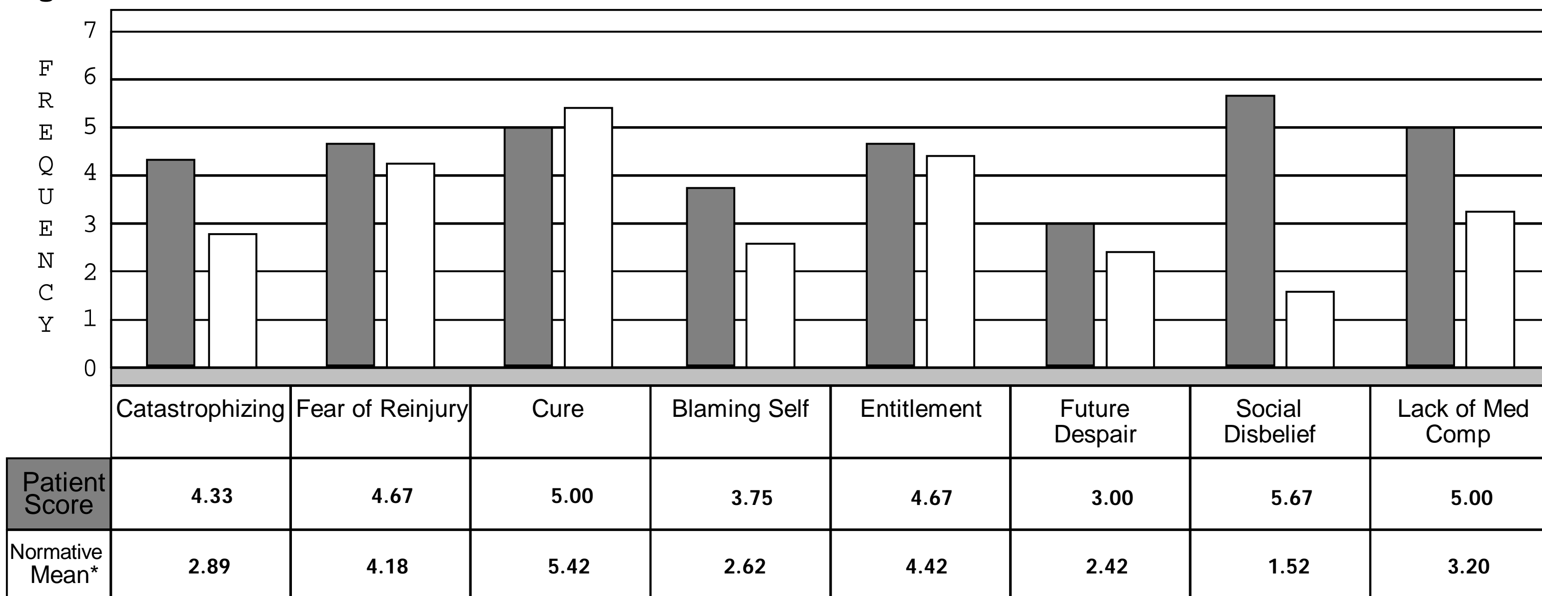


CATS = catastrophising; FOR = fear of reinjury; CURE = expectation for cure; BLAME = blaming self: ENT = entitlement; DESP = despair; DISB = social disbelief; LMC = lack of medical comprehensiveness

Figure 4. Pain beliefs

* Normative Mean - based on a sample of 1,012 subacute and chronic pain patients.

Figure 4a. Pain beliefs



	Catastrophizing	Fear of Reinjury	Cure	Blaming Self	Entitlement	Future Despair	Social Disbelief	Lack of Med Comp
Patient Score	4.33	4.67	5.00	3.75	4.67	3.00	5.67	5.00
Normative Mean*	2.89	4.18	5.42	2.62	4.42	2.42	1.52	3.20

Catastrophizing

High scoring patients report that they are not in control of their life, cannot get on with the business of living despite their pain, and believe that their pain is more than they can handle.

Fear of Reinjury

Patients that score high indicate there is a strong likelihood they could reinjure themselves if they exert themselves, and the best way to cope with chronic pain is by resting and avoiding those activities that make the pain worse.

Expectation for Cure

High scoring patients expect that their pain will be eliminated or cured.

Blaming Self

Patients that score high blame themselves for not being able to control their pain better than they do, believe they are doing something wrong since they continue to have pain, and believe they should not let the pain bother them as much as it does.

Entitlement

High scoring patients report that they deserve better than to have chronic pain, feel cheated because they have chronic pain, and they indicate that they shouldn't have to suffer from pain.

Future Despair

Patients that score high believe that their life will never be fulfilled as long as they have pain, believe they will never be completely happy as long as they have pain, and think that they will never enjoy life again with pain.

Social Disbelief

Patients that score high feel that they sometimes have to prove to others that they really do hurt, feel bothered that others don't believe their pain is real, and report that if they had some physical evidence of their pain problem, such as a neck brace or cane, people would be more convinced their pain is real.

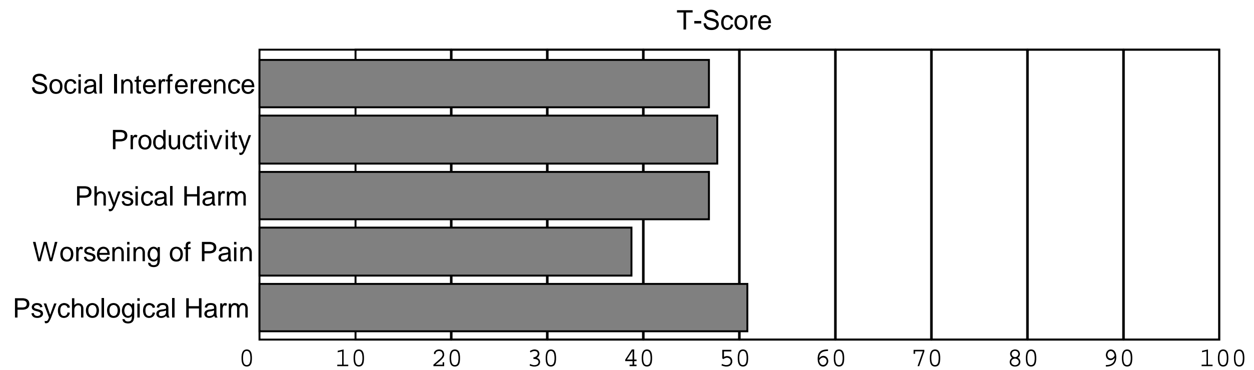
Lack of Medical Comprehensiveness

Patients scoring high report that they do not believe they have received a thorough and comprehensive medical evaluation, that they have not received every reasonable diagnostic test to determine the cause of their pain, and that their doctors have not tried everything possible to treat their pain.

* Normative Mean - based on a sample of 1,012 subacute and chronic pain patients.

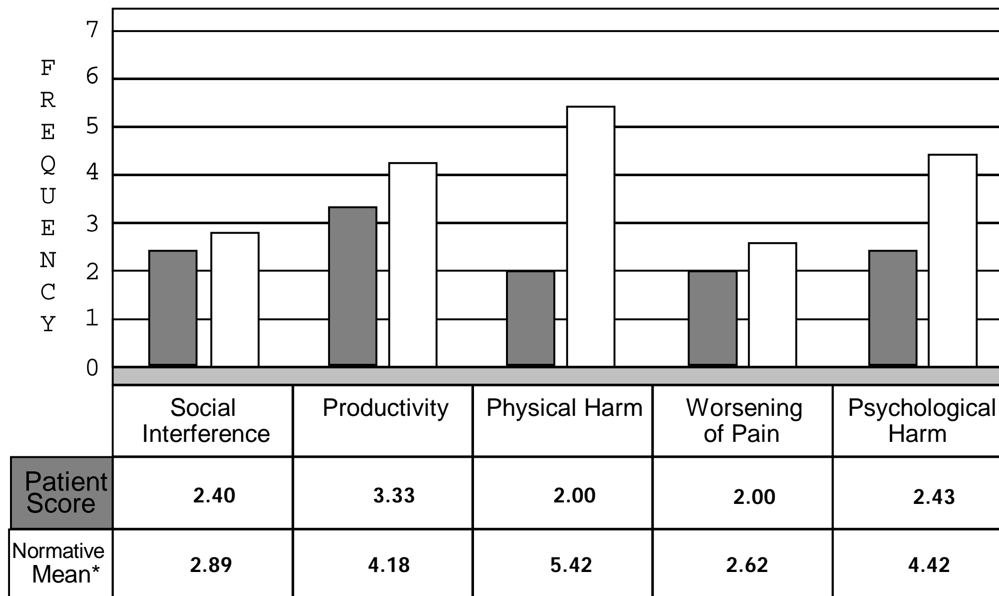
Perceived consequences

The patient made known she expects no negative consequences when her pain increases.



SI = social interference; P = productivity; PH = physical harm; WP = worsening of pain; PsyH = psychological harm

Figure 5. Perceived Consequences of Pain



	Social Interference	Productivity	Physical Harm	Worsening of Pain	Psychological Harm
Patient Score	2.40	3.33	2.00	2.00	2.43
Normative Mean*	2.89	4.18	5.42	2.62	4.42

Figure 5a. Perceived Consequences of Pain

* Normative Mean - based on a sample of 1,012 subacute and chronic pain patients.

SECONDARY PROBLEMS

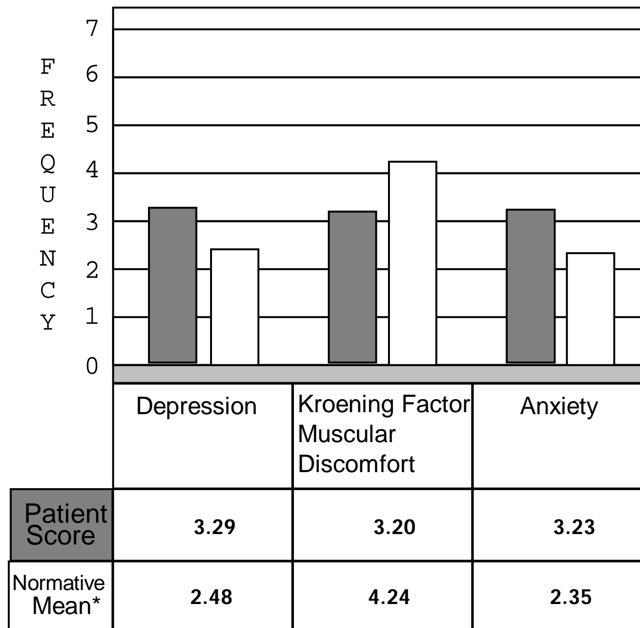


Figure 6. Mood related Symptoms

Mood

The patient revealed that in the past two weeks, she has experienced symptoms consistent with depression (see Table 5 and Figure 7). She admitted to feelings of inferiority, worrying, feelings of sadness or depression, feelings of guilt and loss of interest for a variety of previously pleasant activities and has had thoughts of harming herself and ending it all. The symptoms she rated most highly were feelings of inferiority and worrying. The patient indicated she is currently taking antidepressants.

Table 5. Mood

		Normative Sample Means	
Mood	**Patient Mean Scores (0-7)**	**MEAN**	**SD**
Depression	3.29	**2.48**	**1.66**
Kroening Factor/Muscular Discomfort	3.20	**4.24**	**1.71**
Anxiety	3.23	**2.35**	**1.41**

**** +/- one standard deviation**

* Normative Mean - based on a sample of 1,012 subacute and chronic pain patients.

The patient also revealed that she is anxious often (see Table 5 and Figure 7). She endorsed symptoms of frequent urination, trouble falling asleep, feeling shaky, racing thoughts, feeling tense and keyed up, shortness of breath and cold hands. She reported that she is bothered the most by feelings of frequent urination and trouble falling asleep. Symptoms of muscular tension or tightness, muscle soreness, muscle twitching, fatigue and restlessness were average (i.e., Kroening Factor).

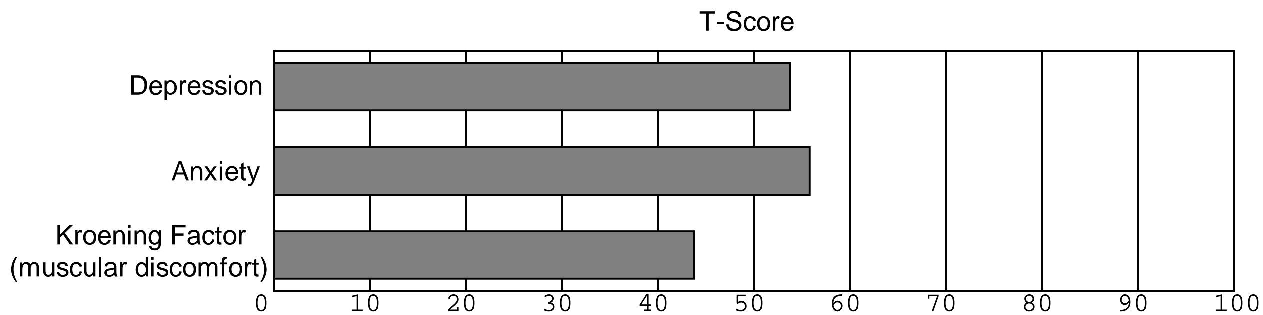


Figure 7. Mood Related Symptoms

Use of stimulants/depressants

The patient's use of stimulants is moderate to excessive (850 mg/day). She reported drinking 6 to 7 cups of caffeinated coffee per day, no caffeinated tea and 2 to 3 caffeinated soft drinks. She reported smoking 41 or more cigarettes per day. She admitted to drinking 21 or more alcoholic drinks per week and is currently taking prescription pain medications.

Disability Index

The Disabiity Index is an measure of the patient's overall level of dysfunction as calculated by their responses on the BAP-2. The patients disability index due to her pain problem is severe. Her disability index on the BAP-2 was 51. Generally, scores greater than 20 are considered significant with scores over 50 considered severe.

The patient reported that low back pain is her most significant pain problem, but she is also bothered by neck and hand/arm pain. She disclosed that when she is in pain, she displays moderate amounts of pain behavior. She reported she moans or winces, lies down, talks to others about her pain, tells others to leave her alone, braces herself when she sits and cries.

The patient's use of the health care system is high. In the past year, she made several contacts with health care providers, and she has visited the emergency room more than once. Since her pain began, she has been hospitalized 3 to 4 times and has had two surgeries for her pain. She estimated she has received minimal improvement from the health care profession.

The current activity level of the patient is significantly below the level she reported she was experiencing before she developed pain. The patient attributed the interference in her activity to pain.

There is moderate evidence the patient's spouse is reinforcing her pain behavior. The patient reported her husband pays some attention to her when she is physically active and attempting to do things for herself. The patient's husband appears to moderately discourage her efforts to increase her physical activity. There was considerable indication the patient's husband is criticizing or discouraging her pain behavior. The patient acknowledged that her doctors may have responded similarly to her pain by criticizing her pain behavior, discouraging her efforts to increase her physical activity and reinforcing her pain behavior.

The patient identified numerous non-productive beliefs about her pain, and let know she expects no negative consequences whenever her pain increases.

The patient reported use of the following medications: Non-prescription pain relievers and rated them mildly effective overall. Non-steroidal anti-inflammmatory drugs and rated them mildly effective overall. Prescription pain relievers - Short-acting and rapid-onset and rated them moderately effective overall. Prescription pain relievers - Time-released and long-acting and rated them moderately effective overall. Antidepressant medications and rated them mildly effective overall. Muscle relaxants and rated them not effective overall. Benzodiazepines - Anti-anxiety medications and rated them not effective overall. Neuropathic, Anti-spasm and other pain medicines and rated them mildly effective overall. Sleep medicines and rated them not effective overall. Natural Herbal medicines and rated them mildly effective overall.

TREATMENT RECOMMENDATIONS

The purpose of the Behavioral Assessment of Pain Questionnaire (BAP) is to help identify those factors that may be contributing to the maintenance of the patient's pain problem. Below are treatment recommendations based on the findings from the BAP. They are offered as suggestions and general guidelines for treatment:

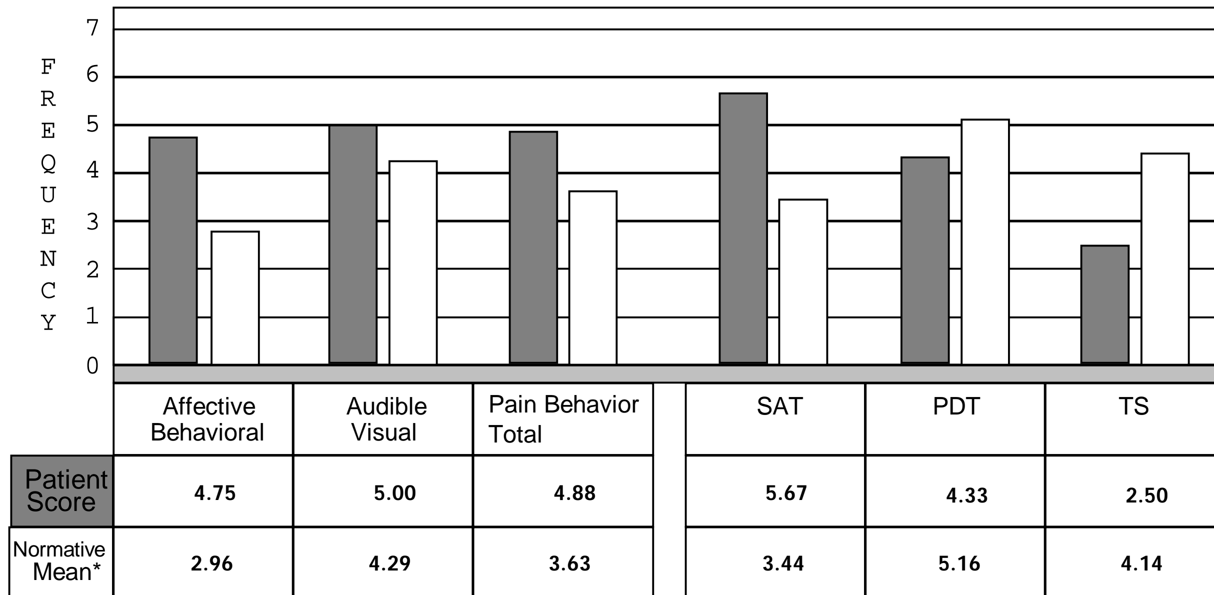
Health care utilization

The patient's use of the health care system is high. The patient's over utilization of the health care system might be reduced by helping her better control her tendency to catastrophize, blame her doctors for her pain problem and seek the help of others when her pain increases sharply. An attempt should also be made to inform all the doctors responsible for the care of the patient about the treatment program and its goals.

Pain behavior

A combination of feedback, roleplaying, coaching, ignoring by others and differential reinforcement of appropriate behaviors might help when the patient moans or winces, lies down, talks to others about her pain, tells others to leave her alone, braces herself when she sits and cries. Video taping might be an effective means of providing feedback to the patient. A biofeedback relaxation training protocol might be useful to help the patient decrease her tendency to brace herself when she is in pain.

Figure 8. Pain Behavior and Pain Descriptors



	Affective Behavioral	Audible Visual	Pain Behavior Total	SAT	PDT	TS
Patient Score	4.75	5.00	4.88	5.67	4.33	2.50
Normative Mean*	2.96	4.29	3.63	3.44	5.16	4.14

* Normative Mean - based on a sample of 1,012 subacute and chronic pain patients.

Social influence on pain & wellness behaviors

The patient's husband should be counseled to modify the way he responds to his wife's pain problem. He should be encouraged to ignore or reduce his contingent attention to her pain complaints and diminish his tendency to warn and caution his wife about engaging in physical activity. The patient should also be encouraged to reinforce her husband's efforts to modify the way he interacts with her when she is in pain.

The patient's doctors should also be told about the importance of reducing any positive reinforcement of the patient's pain behavior, avoiding any criticism of her pain problem and not always warning and cautioning the patient about engaging in physical activity.

Beliefs about pain

The patient's tendency to expect a cure for her pain, blame herself for not controlling her pain better, feel she should not have to experience pain, fear re-injury, catastrophize, being overly concerned about the opinions of others with regard to her pain and doubt that her doctors left no stone unturned in their attempts to treat her pain should be more closely examined and treated using cognitive therapies combined with attempts to increase her physical activity.

Perceived consequences

The patient appears to have realistic concerns regarding the consequences of her pain.

Opioid analgesic usage

If not medically contraindicated, the patient's use of prescription pain relievers should be gradually reduced and eliminated.

Use of Caffeine, Nicotine and Alcohol

The patient's use of caffeine is moderate to excessive. Excessive doses of caffeine have been shown to produce headaches, elevated levels of muscle tension, anxiety, tremors, nervousness and irritability. The patient should be counseled as to these effects and their potential impact upon her problem. A gradual reduction in the amount of caffeine consumed is recommended.

Sleep disturbance

The patient's sleep problems should be managed by teaching her a standard behavioral treatment protocol consisting of more consistent sleep-wake cycles, avoiding the use of stimulants, reducing catastrophizing thoughts about not sleeping, learning a distraction technique, associating getting to bed with feelings of tiredness and learning to get out of bed if a reasonable amount of time has elapsed without falling to sleep. The patient reported using a prescription sleep medication.

Mood problems

The patient's depressive symptoms should be treated by controlling her non-productive thoughts and increasing her physical activity. The patient's endorsement of suicidal ideation also needs to be addressed.

The patient's anxiety should be managed by teaching her to relax more effectively, helping her control her catastrophic thinking, reducing her fears of re-injury with gradual increases in physical activity, and diminishing any unrealistic somatic concerns.

Physical activity

The patient should be started on a quota system since her current level of physical activity is significantly below the level she reported experiencing prior to developing pain. The quota system is useful for motivating patients to gradually increase their level of physical activity. The attainment of short-term goals and therapist praise are used as positive reinforcers.

The patient's diminished activity level is greatest for the personal care category and activities such as shopping for groceries, walking long distances, mowing the lawn, dining out, going to parties, doing the dishes and preparing meals. Including a physical therapy component to help increase the patient's ability to stand, walk, lift, bend, reach, pull, push, carry, stoop and reach overhead would be important.

Since the patient reported significant fears of re-injury, her physical activity program should proceed very slowly at first with staff reinforcement for any improvement in activity.

It is important that the patient's spouse be spoken to regarding his discouragement of her attempts to increase her activity. Spousal discouragement of wellness has been found to be associated with low levels of activity.

SIGNIFICANT RESPONSES

The following is a list of significant response items the patient has answered with a score of a 6 or 7, the highest possible values on the questionnaire. Significant response items are items with the highest factor loadings on certain scales or those that at face value appear most clinically significant. While these items may be useful for gaining a better understanding of the patient, they may have been inadvertently checked so caution is urged in their interpretation.

ANXIETY
169. frequent urination

DEPRESSION/SUICIDAL IDEATION
187. feelings of inferiority
178. worrying
196. thoughts of harming yourself or ending it all

ATTITUDES AND BELIEFS ABOUT PAIN
141. I sometimes feel I have to show others I am in pain, otherwise they won't believe my pain is real.
146. I deserve better than to have chronic pain.

SUMMARY BAP-2 SCALES
Mean Scores (0 - 7) and associated T-scores

Scale	Raw	T
Activity Interference Scale		
a. domestic/household act	3.4	(59)
b. heavy activities	1.6	(43)
c. social activities	2.3	(54)
d. personal care activities	3.5	(60)
e. personal hygiene activities	0.4	(52)
Avoidance Scale		
a. domestic/household act	5.5	(60)
b. heavy activities	3.0	(43)
c. social activities	5.3	(57)
d. personal care activities	3.5	(52)
e. personal hygiene activities	0.8	(49)
Spouse/Partner Influence Scale		
a. criticism of pain	2.6	(61)
b. reinforcement of wellness	3.3	(51)
c. discouragement of wellness	4.2	(54)
d. reinforcement of pain	3.2	(47)
Physician Influence Scale		
a. criticism of pain	4.0	(68)
b. reinforcement of wellness	2.7	(49)
c. discouragement of wellness	3.8	(60)
d. reinforcement of pain	3.3	(57)
Pain Belief Scale		
a. catastrophizing	4.3	(59)
b. fears of re-injury	4.6	(52)
c. expectation for cure	5.0	(46)
d. blaming self	3.7	(57)
e. entitlement	4.6	(50)
f. future despair	3.0	(53)
g. social disbelief	5.6	(68)
h. lack of medical compre.	5.0	(59)
Perceived Consequences Scale		
a. social interference	2.4	(47)
b. physical harm	2.0	(47)
c. psychological harm	2.4	(51)
d. pain exacerbation	2.0	(39)
e. productivity interference	3.3	(48)
f. average score	2.4	(45)
Mood Scale		
a. depression	3.2	(54)
b. muscular discomfort	3.2	(44)
c. anxiety	3.2	(56)
d. change in weight	2.0	(52)
Stimulants and Depressants		
a. daily caffeine intake	850	**(mg)**
b. alcohol	21 or more per week	
c. cigarettes	41 or more cigarettes per day.	

Scale	Raw	T
Activity Before Scale		
a. domestic/household act	6.2	(58)
b. heavy activities	2.7	(44)
c. social activities	4.0	(55)
d. personal care act	6.7	(63)
e. personal hygiene act	5.2	(41)
Activity Now Scale		
a. domestic/household act	2.7	(52)
b. heavy activities	1.1	(54)
c. social activities	1.6	(54)
d. personal care act	3.2	(52)
e. personal hygiene act	4.8	(44)
Patient Ratings		
a. average pain rating		8
b. least pain		5
c. worst pain		10
Disability Index	51	(55)
Pain Behavior		
a. affective/behavioral	4.7	(61)
b. audible/visible	5.0	(54)
c. total	4.8	(59)
Pain Descriptors		
a. S.A.T.	5.6	(62)
b. P.T.D.	4.3	(43)
c. T.S.	2.5	(42)
d. total	4.3	(50)
Validity		
a. neutral	46	(63)
b. pain location	3	(48)
c. missing questions	0	(47)
d. minimum maximum	3.3	(53)
** e. consistency	10	(73)
d. missing scales	4	

*** medication usage**

Non-prescription pain relievers and rated them mildly effective overall. Non-steroidal anti-inflammatory drugs and rated them mildly effective overall. Prescription pain relievers - Short-acting and rapid-onset and rated them moderately effective overall. Prescription pain relievers - Time-released and long-acting and rated them moderately effective overall. Antidepressant medications and rated them mildly effective overall. Muscle relaxants and rated them not effective overall. Benzodiazepines - Anti-anxiety medications and rated them mildly effective overall. Neuropathic, Anti-spasm and other pain medicines and rated them mildly effective overall. Sleep medicines and rated them not effective overall. Natural herbal medicines and rated them mildly effective overall.

Answer Table

Item	Answer	Item	Answer	Item	Answer	Item	Answer	Item	Answer
Age	55	**47**	0100	**84**	2	**131**	2-1-7	**178**	6
1	1	**48**	4	**85**	1	**132**	7-7-0	**179**	4
2	1	**49**	0	**86**	3	**133**	0-0-0	**180**	3
3	1	**50**	2	**87**	6	**134**	7-4-2	**181**	2
4	1	**51**	5	**88**	5	**135**	6-3-6	**182**	3
5	3	**52**	5	**89**	3	**136**	7-3-5	**183**	3
6	2	**53.1**	Y - B	**90**	2	**137**	7-7-0	**184**	4
7	1	**53.2**	Y - B	**91**	2	**138**	0-0-0	**185**	2
8	4	**53.3**	Y - C	**92**	4	**139**	5-3-4	**186**	1
9	0	**53.4**	Y - C	**93**	5	**140**	2	**187**	7
10	1	**53.5**	Y - B	**94**	1	**141**	7	**188**	5
11	3	**53.6**	N -	**95**	3	**142**	2	**189**	2
12	0	**53.7**	Y - A	**96**	2	**143**	3	**190**	3
13	6	**53.8**	Y - B	**97**	4	**144**	0	**191**	4
14	0	**53.9**	Y - B	**98**	5	**145**	2	**192**	3
15	2	**53.10**	Y - A	**99**	6	**146**	6	**193**	2
16	06	**53.11**	Y - B	**100**	3	**147**	6	**194**	2
17	3	**54**	1	**101**	3	**148**	4	**195**	4
18	2	**55**	5	**102**	4	**149**	5	**196**	5
19	0100010000001	**56**	2	**103**	3	**150**	2	**197**	2
20	0100000000000	**57**	4	**104**	2	**151**	4	**198**	2
21	8	**58**	3	**105**	2	**152**	2	**199**	2
22	5	**59**	6	**106**	6-1-6	**153**	4	**200**	2
23	8	**60**	2	**107**	6-3-4	**154**	3	**201**	3
24	122307	**61**	2	**108**	0-0-0	**155**	1	**202**	4
25	7	**62**	5	**109**	0-0-0	**156**	2	**203**	0
26	5	**63**	4	**110**	6-2-6	**157**	6	**204**	0
27	4	**64**	3	**111**	5-3-7	**158**	3	**205**	0
28	7	**65**	6	**112**	6-3-7	**159**	4	**206**	0
29	5	**66**	7	**113**	7-7-0	**160**	5	**207**	4
30	5	**67**	4	**114**	6-0-6	**161**	2	**208**	3
31	4	**68**	3	**115**	0-0-0	**162**	5	**209**	1
32	5	**69**	2	**116**	7-7-0	**163**	4	**210**	5
33	4	**70**	5	**117**	7-0-7	**164**	2	**211**	3
34	3	**71**	4	**118**	5-2-6	**165**	5	**212**	2
35	2	**72**	5	**119**	7-3-7	**166**	4	**213**	1
36	5	**73**	6	**120**	6-2-5	**167**	2	**214**	5
37	3	**74**	3	**121**	6-2-7	**168**	4	**215**	3
38	7	**75**	2	**122**	5-4-6	**169**	6	**216**	1
39	5	**76**	1	**123**	7-7-6	**170**	5	**217**	1
40	3	**77**	1	**124**	0-0-0	**171**	4	**218**	0
41	7	**78**	4	**125**	6-2-6	**172**	2	**219**	5
42	3	**79**	4	**126**	4-2-7	**173**	3	**220**	4
43	3	**80**	2	**127**	7-0-5	**174**	1	**221**	4
44	1	**81**	3	**128**	4-3-7	**175**	1	**222**	3
45	2	**82**	5	**129**	6-2-7	**176**	2	**223**	3
46	2	**83**	2	**130**	0-0-0	**177**	4		

BEHAVIORAL ASSESSMENT OF PAIN QUESTIONNAIRE
PATIENT SYNOPSIS

The patient's BAP-2 scores should be interpreted with caution since the following validity scales have exceeded acceptable ranges:

Consistency/Inconsistency Response: (10) This scale measures an inconsistent response style. Pairs of items were selected across the various BAP scales based on high inter-item correlations. Scores for each pair of items with differences of 4 points or greater are judged significant. Patients scoring in the 95th percentile, suggests highly inconsistent responding and could indicate carelessness, lack of understanding, or noncompliance.

The patient is a 55 year old White married female who is living with her husband and 3 children. This is her first marriage. She is currently unemployed and has been for the past 12 - 18 months. She was working in a skilled trade. The patient has a high school diploma. Her spouse is employed in a semi-skilled or unskilled job.

The patient reported that low back pain is her most significant pain problem, but she is also bothered by neck and hand/arm pain. She described her low back pain as especially pulling, sore, tight, aching and continuous. She disclosed that when she is in pain, she often moans or winces, lies down, talks to others about her pain, tells others to leave her alone, braces herself when she sits and cries. Using a rating scale of 0 to 10, with 10 being most severe, the patient rated her average level of pain intensity as an 8. Over the past week, the patient's pain ranged from a 5 to 10.

The patients disability index due to her pain problem is severe. Her disability index on the BAP-2 was 51. Generally, scores greater than 20 are considered significant with scores over 50 considered severe.

Patient Strengths

- Education: high school or above
- Negative perceived consequences of pain: minimal

BEHAVIORAL ASSESSMENT OF PAIN QUESTIONNAIRE
PATIENT SYNOPSIS cont.

Areas of Concern

- Disability index on the BAP-2 was 51.
- Employment status: unemployed for more than 3 months
- Financial status: experiencing great financial difficulty
- Litigation: attorney retained
- Pain behavior: excessive pain behavior
- Pain intensity: high average pain intensity
- Health care utilization: high use of the health care system
- Response to health care treatment: little improvement reported
- Activity interference: high
- Spousal criticism of pain: significant
- Physician criticism of pain: significant
- Pain beliefs: fears of re-injury, thoughts of entitlement, believing her pain problem is more than she can handle, thoughts that others do not believe her pain is real, beliefs that her pain problem was not treated comprehensively and thoughts that something more could be done to eliminate her pain
- Mood disturbance: depression
- Sleep disturbance: trouble falling asleep

Stimulant usage: excessive use of caffeine and cigarettes

- Opioid usage