MMPI-2-RF®

Minnesota Multiphasic
Personality Inventory-2
Restructured Form®

SAMPLE REPORT

Case Description: Mr. F
Spinal Cord Stimulator Candidate Interpretive Report

Mr. F is a 59-year-old man, a former shipping/receiving clerk, who has not worked in 6 years and is on Social Security Disability. He is experiencing pain in his neck, shoulders, and arms, with weakness in his arms. The pain started spontaneously, without any trauma, and he is diagnosed with degenerative disc disease and chronic pain syndrome. He has had two previous cervical spine fusions, neither of which reduced his pain. He is not a candidate for any further surgery to correct his spine, so spinal cord stimulation is being considered as a means to achieve pain control. He is taking large doses of time-release opioid medication, supplemented by immediate-release opioid medication. He has been on antidepressant medication for three years, prescribed by his family physician, but does not feel it is working well. He has been having increasing arguments with his family, and has been isolating himself frequently. He is not very optimistic that the spinal cord stimulator will relieve his pain, and has done little to learn about this procedure.

Case descriptions do not accompany MMPI-2-RF reports, but are provided here as background information. The following report was generated from Q-global™, Pearson's web-based scoring and reporting application, using Mr. F's responses to the MMPI-2-RF. Additional MMPI-2-RF sample reports, product offerings, training opportunities, and resources can be found at PearsonClinical.com/mmpi2rf.

Pearson

Minnesota Multiphasic
Personality Inventory-2
Restructured Form®

Yossef S. Ben-Porath, PhD, & Auke Tellegen, PhD

MMPI-2-RF®

Spinal Cord Stimulator Candidate Interpretive Report

Andrew R. Block, PhD, & Yossef S. Ben-Porath, PhD

ID Number:	Mr. F
Age:	49
Gender:	Male
Marital Status:	Married
Years of Education:	Not reported
Date Assessed:	08/02/2017

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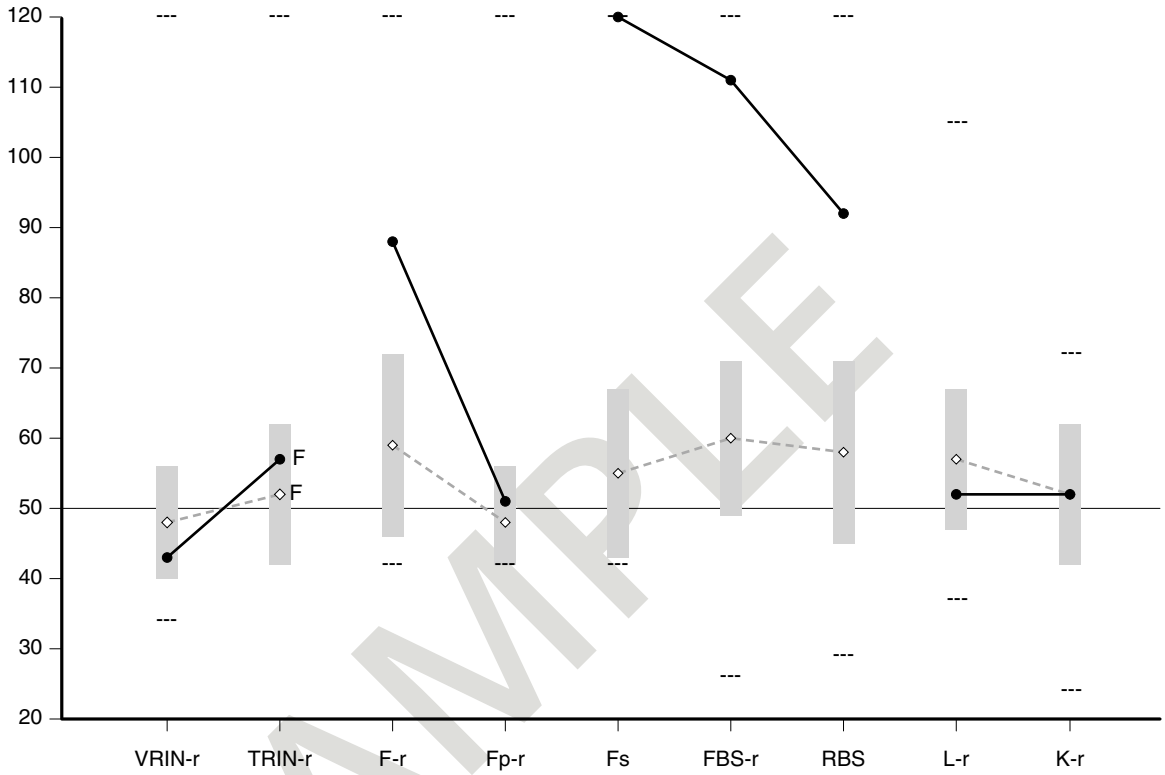
MMPI-2-RF Validity Scales



	VRIN-r	TRIN-r	F-r	Fp-r	Fs	FBS-r	RBS	L-r	K-r
Raw Score:	2	10	10	1	12	27	15	3	8
T Score:	43	57 F	88	51	120	111	92	52	52
Response %:	100	100	100	100	100	100	100	100	100

Cannot Say (Raw): 0 Percent True (of items answered): 35%

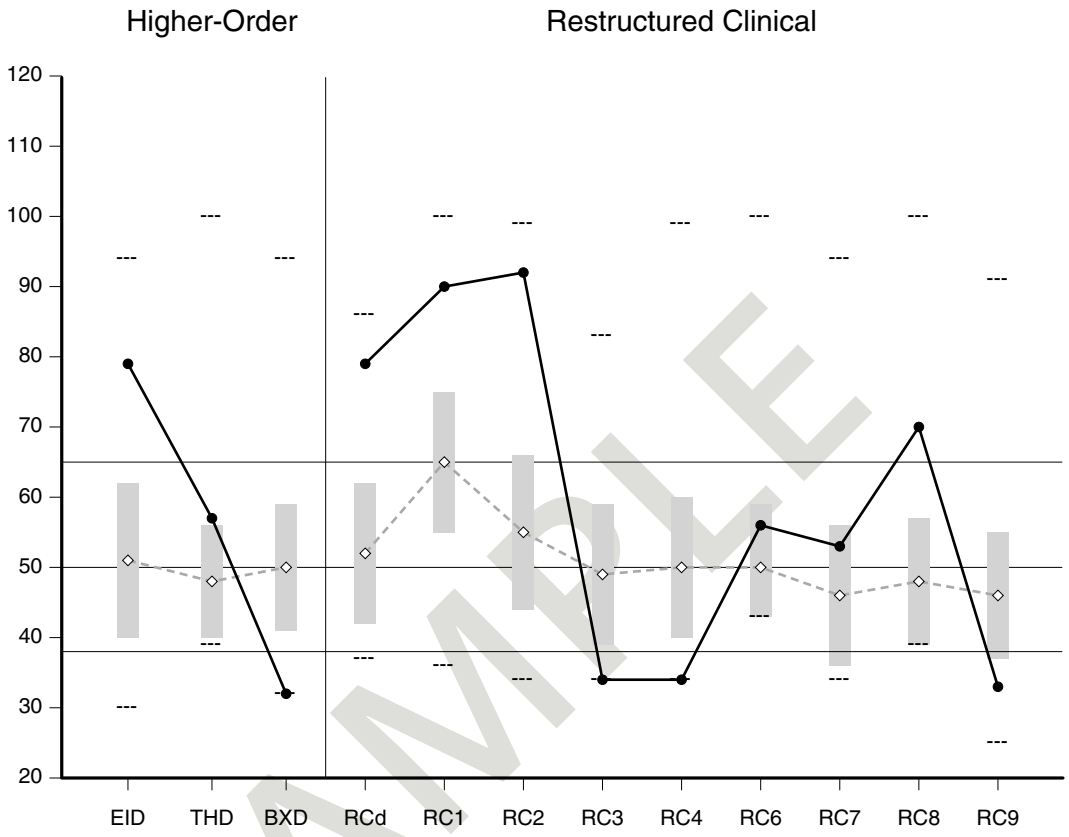
Comparison Group Data: Spinal Cord Stimulator Candidate (Men), N = 218

Mean Score (◇---◇):	48	52 F	59	48	55	60	58	57	52
Standard Dev (±1 SD):	8	10	13	8	12	11	13	10	10
Percent scoring at or below patient:	46	77	97	84	100	100	99.1	41	56

The highest and lowest T scores possible on each scale are indicated by a "---"; MMPI-2-RF T scores are non-gendered.

VRIN-r	Variable Response Inconsistency	Fs	Infrequent Somatic Responses	L-r	Uncommon Virtues
TRIN-r	True Response Inconsistency	FBS-r	Symptom Validity	K-r	Adjustment Validity
F-r	Infrequent Responses	RBS	Response Bias Scale		
Fp-r	Infrequent Psychopathology Responses				

MMPI-2-RF Higher-Order (H-O) and Restructured Clinical (RC) Scales



	EID	THD	BXD	RCd	RC1	RC2	RC3	RC4	RC6	RC7	RC8	RC9
Raw Score:	31	3	0	20	20	15	0	0	1	8	7	3
T Score:	79	57	32	79	90	92	34	34	56	53	70	33
Response %:	100	100	100	100	100	100	100	100	100	100	100	100

Comparison Group Data: Spinal Cord Stimulator Candidate (Men), N = 218

	EID	THD	BXD	RCd	RC1	RC2	RC3	RC4	RC6	RC7	RC8	RC9
Mean Score (◇---◇):	51	48	50	52	65	55	49	50	50	46	48	46
Standard Dev (±1 SD):	11	8	9	10	10	11	10	10	9	10	9	9
Percent scoring at or below patient:	98	91	3	98	99.1	100	7	8	80	86	98	6

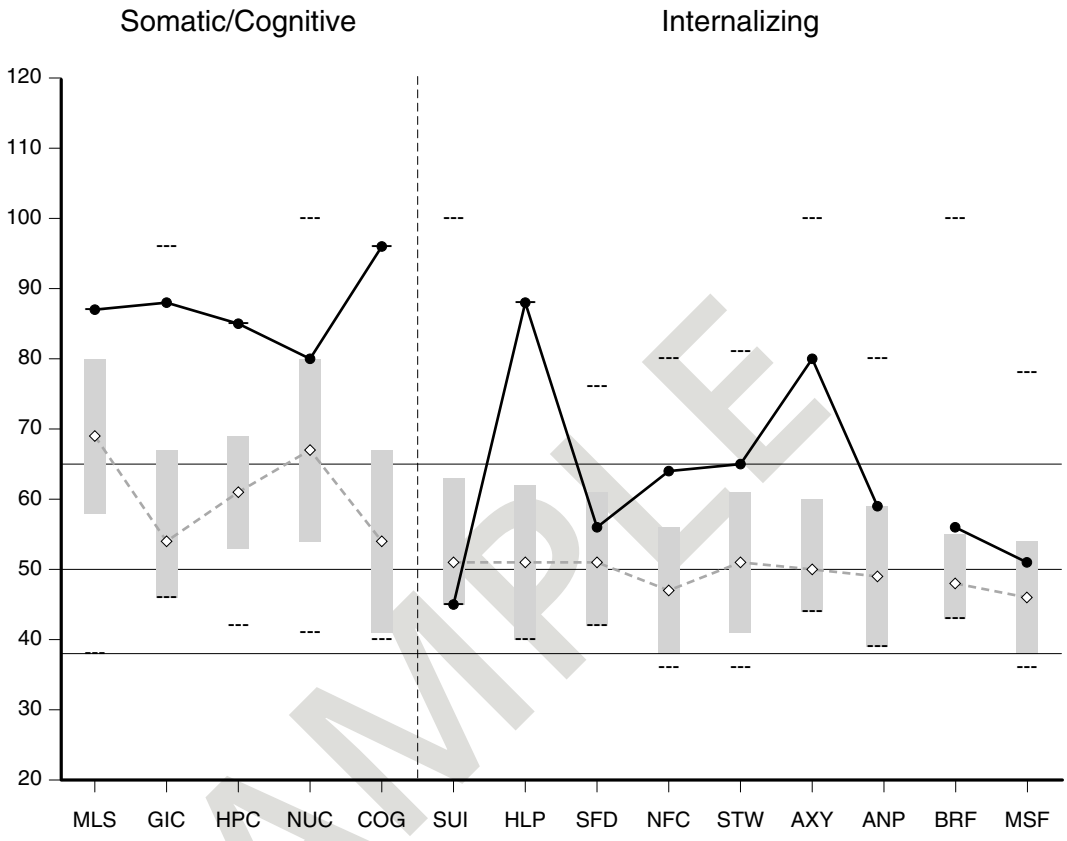
The highest and lowest T scores possible on each scale are indicated by a "---"; MMPI-2-RF T scores are non-gendered.

EID Emotional/Internalizing Dysfunction
THD Thought Dysfunction
BXD Behavioral/Externalizing Dysfunction

RCd Demoralization
RC1 Somatic Complaints
RC2 Low Positive Emotions
RC3 Cynicism
RC4 Antisocial Behavior

RC6 Ideas of Persecution
RC7 Dysfunctional Negative Emotions
RC8 Aberrant Experiences
RC9 Hypomanic Activation

MMPI-2-RF Somatic/Cognitive and Internalizing Scales



	MLS	GIC	HPC	NUC	COG	SUI	HLP	SFD	NFC	STW	AXY	ANP	BRF	MSF
Raw Score:	8	4	6	6	10	0	5	2	6	5	3	4	1	4
T Score:	87	88	85	80	96	45	88	56	64	65	80	59	56	51
Response %:	100	100	100	100	100	100	100	100	100	100	100	100	100	100

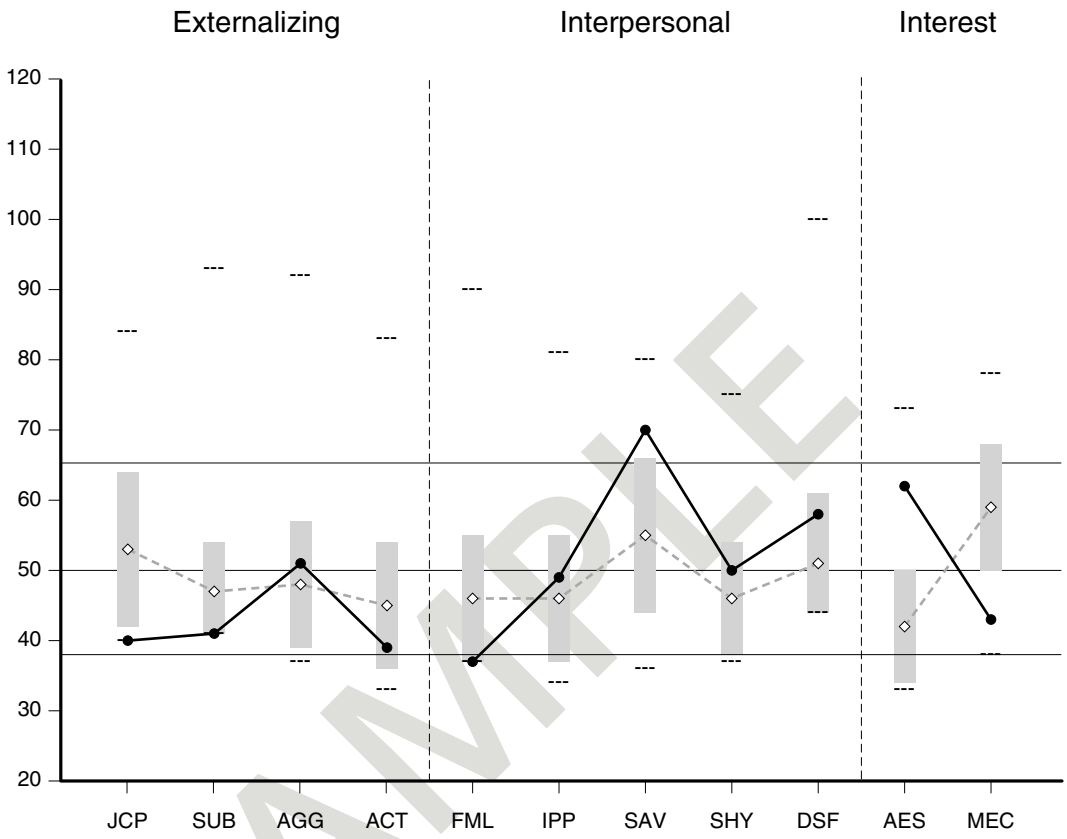
Comparison Group Data: Spinal Cord Stimulator Candidate (Men), N = 218

	MLS	GIC	HPC	NUC	COG	SUI	HLP	SFD	NFC	STW	AXY	ANP	BRF	MSF
Mean Score (◇ - - ◇):	69	54	61	67	54	51	51	51	47	51	50	49	48	46
Standard Dev (±1 SD):	11	13	8	13	13	12	11	10	9	10	10	10	7	8
Percent scoring at or below patient:	100	99.1	100	91	100	80	100	82	95	94	100	89	93	83

The highest and lowest T scores possible on each scale are indicated by a "---"; MMPI-2-RF T scores are non-gendered.

MLS	Malaise	SUI	Suicidal/Death Ideation	AXY	Anxiety
GIC	Gastrointestinal Complaints	HLP	Helplessness/Hopelessness	ANP	Anger Proneness
HPC	Head Pain Complaints	SFD	Self-Doubt	BRF	Behavior-Restricting Fears
NUC	Neurological Complaints	NFC	Inefficacy	MSF	Multiple Specific Fears
COG	Cognitive Complaints	STW	Stress/Worry		

MMPI-2-RF Externalizing, Interpersonal, and Interest Scales



	JCP	SUB	AGG	ACT	FML	IPP	SAV	SHY	DSF	AES	MEC
Raw Score:	0	0	2	1	0	4	8	3	1	5	1
T Score:	40	41	51	39	37	49	70	50	58	62	43
Response %:	100	100	100	100	100	100	100	100	100	100	100

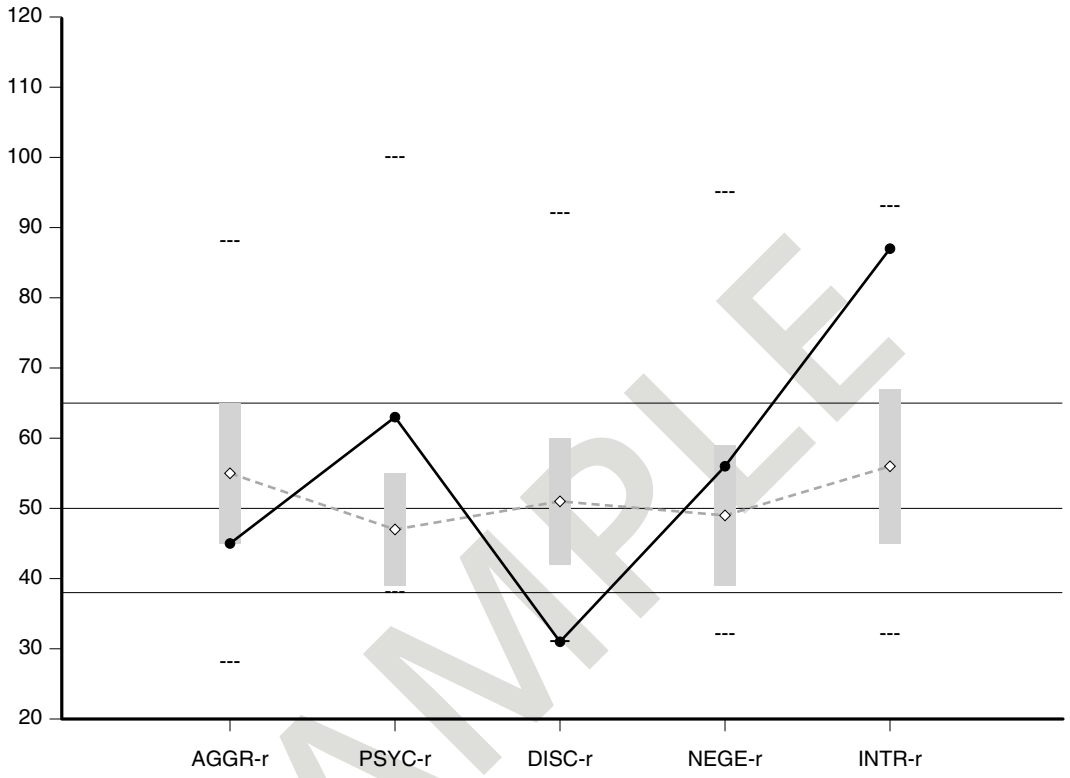
Comparison Group Data: Spinal Cord Stimulator Candidate (Men), N = 218

	JCP	SUB	AGG	ACT	FML	IPP	SAV	SHY	DSF	AES	MEC
Mean Score (◇---◇):	53	47	48	45	46	46	55	46	51	42	59
Standard Dev (±1 SD):	11	7	9	9	9	9	11	8	10	8	9
Percent scoring at or below patient:	32	50	77	43	32	78	92	80	89	98	7

The highest and lowest T scores possible on each scale are indicated by a "---"; MMPI-2-RF T scores are non-gendered.

JCP	Juvenile Conduct Problems	FML	Family Problems	AES	Aesthetic-Literary Interests
SUB	Substance Abuse	IPP	Interpersonal Passivity	MEC	Mechanical-Physical Interests
AGG	Aggression	SAV	Social Avoidance		
ACT	Activation	SHY	Shyness		
		DSF	Disaffiliativeness		

MMPI-2-RF PSY-5 Scales



	AGGR-r	PSYC-r	DISC-r	NEGE-r	INTR-r
Raw Score:	7	5	0	9	18
T Score:	45	63	31	56	87
Response %:	100	100	100	100	100

Comparison Group Data: Spinal Cord Stimulator Candidate (Men), N = 218

	AGGR-r	PSYC-r	DISC-r	NEGE-r	INTR-r
Mean Score (◇- - -◇):	55	47	51	49	56
Standard Dev (±1 SD):	10	8	9	10	11
Percent scoring at or below patient:	19	96	0.5	81	100

The highest and lowest T scores possible on each scale are indicated by a "---"; MMPI-2-RF T scores are non-gendered.

AGGR-r	Aggressiveness-Revised
PSYC-r	Psychoticism-Revised
DISC-r	Disconstraint-Revised
NEGE-r	Negative Emotionality/Neuroticism-Revised
INTR-r	Introversion/Low Positive Emotionality-Revised

MMPI-2-RF T SCORES (BY DOMAIN)

PROTOCOL VALIDITY

Content Non-Responsiveness	0 CNS	43 VRIN-r	57 F TRIN-r			
Over-Reporting	**88 F-r**	51 Fp-r		**120 Fs**	**111 FBS-r**	**92 RBS**
Under-Reporting	52 L-r	52 K-r				

SUBSTANTIVE SCALES

Somatic/Cognitive Dysfunction	**90 RC1**	**87 MLS**	**88 GIC**	**85 HPC**	**80 NUC**	**96 COG**	
Emotional Dysfunction	**79 EID**	**79 RCd**	45 SUI	**88 HLP**	56 SFD	**64 NFC**	
		92 RC2	**87 INTR-r**				
		53 RC7	**65 STW**	**80 AXY**	59 ANP	56 BRF	51 MSF	56 NEGE-r
Thought Dysfunction	**57 THD**	56 RC6					
		70 RC8					
		63 PSYC-r					
Behavioral Dysfunction	32 BXD	34 RC4	40 JCP	41 SUB			
		33 RC9	51 AGG	39 ACT	45 AGGR-r	31 DISC-r	
Interpersonal Functioning	37 FML	34 RC3	49 IPP	**70 SAV**	50 SHY	58 DSF	
Interests	62 AES	43 MEC					

Scale scores shown in bold font are interpreted in the report.

Note. This information is provided to facilitate interpretation following the recommended structure for MMPI-2-RF interpretation in Chapter 5 of the *MMPI-2-RF Manual for Administration, Scoring, and Interpretation*, which provides details in the text and an outline in Table 5-1.

This interpretive report is intended for use by a professional qualified to interpret the MMPI-2-RF in the context of a presurgical psychological evaluation of spinal cord stimulator candidates. The information it contains should be considered in the context of the patient's background, the circumstances of the assessment, and other available information.

Interpretive statements in the Comparison Group Findings section are based on comparisons with the men of the Spinal Cord Stimulator Candidate comparison group. Statements in the remaining sections of the report are based on T scores derived from the general MMPI-2-RF normative sample.

The report includes extensive annotation, which appears as superscripts following each statement in the narrative, keyed to Endnotes with accompanying Research References, which appear in the final two sections of the report. Additional information about the annotation features is provided in the headnotes to these sections and in the User's Guide for the Minnesota Multiphasic Personality Inventory-2-Restructured Form (MMPI-2-RF) Spine Surgery Candidate Interpretive Report (Spine-CIR) and Spinal Cord Stimulator Candidate Interpretive Report (Stim-CIR).

SYNOPSIS

Scores on the MMPI-2-RF validity scales raise concerns about the possible impact of over-reporting (specifically, of general psychological dysfunction and of somatic and cognitive symptoms) on the validity of this protocol. With that caution noted, scores on the substantive scales indicate somatic and cognitive complaints, and emotional, thought, and interpersonal dysfunction. Somatic complaints include preoccupation with poor health, malaise, head pain, neurological symptoms, and gastrointestinal problems. Cognitive complaints include difficulties in memory and concentration. Emotional-internalizing findings include risk for **suicidal ideation**, demoralization, depression, helplessness and hopelessness, stress and worry, and anxiety. Dysfunctional thinking relates to aberrant perceptions and thoughts. Interpersonal difficulties relate to social avoidance.

Comparison group findings point to possible concerns about somatic complaints including preoccupation with health, gastrointestinal complaints, and head pain complaints, cognitive complaints, emotional problems including unhappiness and dissatisfaction, helplessness, inefficacy, a low level of positive emotions, stress and worry, and anxiety, unusual thoughts including odd perceptions and beliefs, and interpersonal problems including social avoidance.

Possible presurgical risk factors are identified in the Demoralization and Depression, Pain and Somatic Sensitivity, Pain Coping, Health Orientation and Medical Adherence, Anxiety and Stress, Fear/Avoidance, Interpersonal, Substance Abuse, and Recovery Disincentive domains.

PROTOCOL VALIDITY

Content Non-Responsiveness

There are no problems with unscorable items in this protocol. The patient responded relevantly to the items on the basis of their content.

Over-Reporting

The patient generated a larger than average number of infrequent responses to the MMPI-2-RF items. This level of infrequent responding may occur in individuals with genuine psychological difficulties who report credible symptoms. However, for individuals with no history or current corroborating evidence of dysfunction it likely indicates over-reporting[1].

He reported a considerably larger than average number of somatic symptoms rarely described by individuals with genuine medical conditions. He also provided a very unusual combination of responses that is associated with non-credible reporting of somatic and/or cognitive symptoms. In addition, he provided an unusual combination of responses that is associated with non-credible memory complaints. This pattern of responding is uncommon even in individuals with substantial medical problems who report credible symptoms. It very likely indicates non-credible reporting of somatic and/or cognitive symptoms[2]. Scores on the somatic scales--Somatic Complaints (RC1), Malaise (MLS), Gastrointestinal Complaints (GIC), Head Pain Complaints (HPC), and Neurological Complaints (NUC)--and the Cognitive Complaints (COG) scale should be interpreted in light of this caution[3].

Under-Reporting

There are no indications of under-reporting in this protocol.

SUBSTANTIVE SCALE INTERPRETATION

Clinical-level symptoms, personality characteristics, and behavioral tendencies of the patient are described in this section and organized according to an empirically guided framework. (Please see Chapter 8, Yossef S. Ben-Porath, Interpreting the MMPI-2-RF*, for details.) Statements containing the word "reports" are based on the item content of MMPI-2-RF scales, whereas statements that include the word "likely" are based on empirical correlates of scale scores. Specific sources for each statement can be accessed with the annotation features of this report.*

The following interpretation needs to be considered in light of cautions noted about the possible impact of over-reporting (specifically, of general psychological dysfunction and of somatic and cognitive symptoms) on the validity of this protocol.

Somatic/Cognitive Dysfunction

The patient reports a diffuse and pervasive pattern of somatic complaints involving different bodily systems[4] including diffuse head and neck pain, recurring headaches, and developing head pain when upset[5]; vague neurological complaints[6]; and a number of gastrointestinal complaints[7]. He reports a general sense of malaise manifested in poor health, and feeling tired, weak, and incapacitated[8].

He reports a diffuse pattern of cognitive difficulties including memory problems, difficulties concentrating, intellectual limitations, and confusion[9].

Emotional Dysfunction

The patient's responses indicate significant emotional distress[10]. More specifically, he reports a significant lack of positive emotional experiences, pronounced anhedonia, and marked lack of interest[11]. He is very likely to be quite pessimistic[12], to lack energy[13], and to display vegetative symptoms of depression[14].

He is at risk for suicidal ideation[15], although he did not endorse any of the MMPI-2-RF Suicidal/Death Ideation (SUI) scale items. He reports feeling sad and unhappy and being dissatisfied with his current life circumstances[16]. He is likely to complain of feeling depressed[17]. He reports believing he cannot change and overcome his problems and is incapable of reaching his life goals[18]. He is very likely to feel hopeless, overwhelmed, and that life is a strain[19], to believe he cannot be helped[19] and gets a raw deal from life[20], and to lack motivation for change[19]. He is also likely to be stress-reactive[21] and worry-prone[22] and to engage in obsessive rumination[23].

The patient reports feeling anxious[24] and is likely to experience significant anxiety and anxiety-related problems[25], intrusive ideation, and nightmares[26].

Thought Dysfunction

The patient reports unusual thought processes[27]. He is likely to experience thought disorganization[28], to engage in unrealistic thinking[29], and to believe he has unusual sensory-perceptual abilities[30]. His aberrant experiences may include somatic delusions[31].

Behavioral Dysfunction

There are no indications of maladaptive externalizing behavior in this protocol. The patient's responses indicate a higher than average level of behavioral constraint[32]. He is unlikely to engage in externalizing, acting-out behavior[33]. He reports a below average level of past antisocial behavior[34].

Interpersonal Functioning Scales

The patient reports not enjoying social events and avoiding social situations[35]. He is likely to be introverted[36], to have difficulty forming close relationships[37], and to be emotionally restricted[38]. However, he describes others as well-intentioned and trustworthy and disavows cynical beliefs about them[39]. He is possibly overly trusting[40].

Interest Scales

The patient reports an average number of interests in activities or occupations of an aesthetic or literary nature (e.g., writing, music, the theater)[41]. He also reports an average number of interests in activities or occupations of a mechanical or physical nature (e.g., fixing and building things, the outdoors, sports)[42].

DIAGNOSTIC CONSIDERATIONS

This section provides recommendations for psychodiagnostic assessment based on the patient's MMPI-2-RF results. It is recommended that he be evaluated for the following:

Emotional-Internalizing Disorders

- Malingering of somatic and/or cognitive symptoms[43]
- Somatoform disorder[44] and/or conditions involving somatic delusions, if physical origins for neurological complaints have been ruled out[45]; malaise[46], head pain complaints[47], and gastrointestinal complaints[48] also suggest a possible somatoform disorder if physical origins for them have been ruled out
- Depression-related disorder[49]
- Disorders involving excessive stress and worry such as obsessive-compulsive disorder[50]
- Anxiety-related disorders including PTSD[51]

Thought Disorders

- Disorders manifesting psychotic symptoms[52]
- Personality disorders manifesting unusual thoughts and perceptions[53]

Interpersonal Disorders

- Disorders associated with social avoidance such as avoidant personality disorder[54]

SPINAL CORD STIMULATOR COMPARISON GROUP FINDINGS

This section describes the MMPI-2-RF substantive scale findings in the context of the men of the Spinal Cord Stimulator Candidate comparison group. Specific sources for each statement can be accessed with the annotation features of this report. ***Presurgical risk factors, postsurgical outcomes, and treatment recommendations associated with these results, if any, are provided in subsequent sections of this report.***

The comparison group means reported on pages 2 through 6 of this report show that male spinal cord stimulator candidates score differently from the general MMPI-2-RF normative sample on several scales. Problems discussed earlier in the Substantive Scale Interpretation section are based on clinically elevated normative T scores of 65 and above. Potential difficulties identified in this section are based on scores that are unusually high in relation to the Spinal Cord Stimulator Candidate (Men) comparison group, and thus may differ from those discussed earlier. If multiple risk factors are identified, the possibility of poor surgery results increases, but may be mitigated with psychological intervention.

The following interpretation needs to be considered in light of cautions noted about the possible impact of over-reporting (specifically, of general psychological dysfunction and of somatic and cognitive symptoms) on the validity of this protocol.

Somatic/Cognitive Complaints

The patient's responses indicate a level of somatization that may negatively affect outcomes[55]. This level of diffuse health concerns is very uncommon among spinal cord stimulator implant candidates. Only 1.4% of comparison group members give evidence of this or a greater level of somatic complaints[4]. More specifically, his responses indicate a level of head and neck pain complaints reflecting possible sensitivity to physical symptoms that may adversely impact outcomes[47]. This level of pain complaints is very uncommon in this population. Only 1.8% of comparison group members demonstrate this or a greater level of head pain complaints[5]. His responses also include a level of gastrointestinal complaints indicating possible somatization that may negatively affect outcomes[56]. This level of symptoms--such as nausea, vomiting, poor appetite, and stomach upset--is very uncommon in spinal cord stimulator implant candidates. Only 4.1% of comparison group members give evidence of this or a greater level of gastrointestinal complaints[7]. In addition, his responses indicate a level of malaise reflecting a sensitivity to physical symptoms that may adversely impact outcomes[57]. This level of self-perceived physical debilitation and poor health is very uncommon in this population. Only 9.2% of comparison group members demonstrate this or a greater level of perceived poor health[8].

His responses indicate a level of cognitive complaints that may negatively affect outcomes[58]. This level of symptoms--such as memory problems, difficulty concentrating, and confusion--is very uncommon in spinal cord stimulator implant candidates. Only 0.5% of comparison group members give evidence of this or a greater level of cognitive complaints[9].

Emotional/Internalizing Problems

The patient's responses indicate a level of emotional dysfunction that may adversely impact outcomes[59]. This level of emotional difficulties is very uncommon among spinal cord stimulator implant candidates. Only 1.8% of comparison group members give evidence of this or a greater level of emotional dysfunction[60]. More specifically, his responses indicate a level of anhedonia that may negatively affect outcomes[61]. This lack of positive emotional responsiveness is very uncommon among this population. No comparison group members demonstrate this or a greater level of low positive emotions[62].

His responses indicate feelings of unhappiness, dissatisfaction, and being overwhelmed that may adversely impact outcomes[63]. This level of demoralization is very uncommon among spinal cord stimulator implant candidates. Only 2.3% of comparison group members give evidence of this or a greater level of demoralization[16]. In particular, his responses indicate a level of helplessness and hopelessness that may negatively affect outcomes[64]. This level of belief that he cannot solve problems and reach important goals is very uncommon among this population. Only 1.4% of comparison group members demonstrate this or a greater level of helplessness[18]. He reports a comparatively high level of inefficacious decision making for a spinal cord stimulator implant candidate. Only 9.6% of comparison group members convey this or a greater level of perceived inefficacy[65]. He also reports a relatively high level of problems with stress and worry for this population. Only 13.3% of comparison group members convey this or a greater level of stress reactivity[66].

The patient's responses indicate a level of anxiety that may adversely impact outcomes[67]. This level of pervasive anxiety is very uncommon among spinal cord stimulator implant candidates. Only 2.3% of comparison group members give evidence of this or a greater level of anxiety[24].

Unusual Thoughts, Perceptions, and Beliefs

The patient reports a comparatively high level of unusual thinking for a spinal cord stimulator implant candidate. Only 21.1% of comparison group members convey such thoughts at this or a higher level[68]. More specifically, his responses indicate a level of aberrant experiences that may negatively affect the ability to give informed consent and to achieve successful outcomes[69]. This level of odd perceptions and thoughts is very uncommon among this population. Only 4.6% of comparison group members give evidence of this or a greater level of aberrant experiences[27].

Interpersonal Problems

The patient reports a comparatively high level of social avoidance for a spinal cord stimulator implant candidate. Only 16.5% of comparison group members convey this or a greater preference for avoiding social interaction[35].

PRESURGICAL PSYCHOLOGICAL RISK FACTORS

Psychological risk factors associated empirically with diminished spinal cord implant results are described in this section and organized according to nine problem domains identified in the professional literature as relevant to spinal cord implant outcomes. (Please see User's Guide for the MMPI-2-RF Spine Surgery Candidate Interpretive Report (Spine-CIR) and Spinal Cord Stimulator Candidate Interpretive Report (Stim-CIR) *for details.) Specific sources for each statement can be accessed with the annotation features of this report.*

The following interpretation needs to be considered in light of cautions noted about the possible impact of over-reporting (specifically, of general psychological dysfunction and of somatic and cognitive symptoms) on the validity of this protocol.

Demoralization and Depression Problems

Compared with other spinal cord stimulator implant candidates, the patient is more likely to be experiencing depressive affect[70] and to have a low energy level and feel exhausted[71]. He is also likely to have greater levels of self-perceived disability[72].

Pain and Somatic Sensitivity Problems

Compared with other spinal cord stimulator implant candidates, the patient is more likely to have a history of multiple somatic complaints[73], to convey a general sense of experiencing poor health[74], to complain about frequent headaches[75], and to perceive himself as deserving and needing assistance from others[76]. He is also likely to display higher levels of pain behavior (e.g., down time, facial grimacing, stationary movement)[77] and to report greater functional disability associated with pain[78].

Pain Coping Problems

Compared with other spinal cord stimulator implant candidates, the patient is more likely to catastrophize when experiencing pain[79]. He is also likely to be less self-reliant[80].

Health Orientation and Medical Adherence Problems

Compared with other spinal cord stimulator implant candidates, the patient is less likely to seek out information about health[81], to feel confident in obtaining information from the physician[81], to be able to continue with exercise/diet recommendations when under stress[81], and to be engaged in overall health maintenance and improvement[81]. He is also more likely to smoke[82].

Anxiety and Stress Problems

Compared with other spinal cord stimulator implant candidates, the patient is more likely to be diagnosed with an anxiety disorder[83] and to be taking benzodiazepines[83]. He is also likely to report higher levels of anxiety[84] and to experience higher levels of current stress[83].

Fear/Avoidance Problems

Compared with other spinal cord stimulator implant candidates, the patient is likely to express higher levels of fear and avoidance of work activities[85] and of physical activities[86] and to report more hours resting per day[87]. He is also more likely to have been out of work for more than 2 months[88].

Interpersonal Problems

Compared with other spinal cord stimulator implant candidates, the patient is more likely to have had a chaotic or disrupted childhood[89], to report a history of abuse or abandonment[90], and to report a lack of social support[91]. He is also likely to report higher levels of anger[92].

Substance Abuse Problems

Compared with other spinal cord stimulator implant candidates, the patient is likely to take more opioid medications for pain[93] and to be at increased risk for opioid abuse[94].

Recovery Disincentive Problems

Compared with other spinal cord stimulator implant candidates, the patient is more likely to over-report physical symptoms[95], to be involved in litigation or be covered by workers' compensation[96], and to express a desire to remain off work[97].

POSTSURGICAL OUTCOMES

The postsurgical outcome statements listed here are based on prospective empirical studies indicating that, relative to other candidates, this patient is at increased risk for these specific adverse results. Inclusion of an adverse outcome does not imply that it will definitely occur, nor can other negative outcomes be definitively ruled out. Specific sources for each statement can be accessed with the annotation features of this report.

The following interpretation needs to be considered in light of cautions noted about the possible impact of over-reporting (specifically, of general psychological dysfunction and of somatic and cognitive symptoms) on the validity of this protocol.

Compared to other spinal cord stimulator candidates, post-surgery this patient is likely to:

- Report higher levels of pain[98]
- Report greater levels of disability[99]
- Experience more negative affect and higher levels of psychological distress[98]
- Report greater interference of pain with lifestyle[98]
- Have lower levels of satisfaction with the results of surgery[98]
- Convey stronger feelings that surgical results did not meet expectations[98]

TREATMENT RECOMMENDATIONS

This section contains inferential treatment-focused recommendations specifically for spinal cord stimulator candidates, based on the patient's MMPI-2-RF scores. Sources for each statement can be accessed with the annotation features of this report.

The following interpretation needs to be considered in light of cautions noted about the possible impact of over-reporting (specifically, of general psychological dysfunction and of somatic and cognitive symptoms) on the validity of this protocol.

Recommendations Based on Elevated Somatic/Cognitive Dysfunction Scales

The patient has an elevated degree of sensitivity to pain and somatic symptoms. Behavioral intervention, with minimal attention directed toward minor complaints, along with reinforcement of functional improvements, may be most effective following the implant procedure[55].

The patient is also preoccupied with poor health and may feel fatigued and experience sleep disturbance and sexual dysfunction. Treatment techniques aimed at viewing spinal cord stimulation as a component of overall health improvement may be most effective. Structured techniques for behavioral change, such as weight loss, diet control, smoking cessation, sexual adaptation, and sleep hygiene, may help the patient achieve the best possible outcomes[57].

Recommendations Based on Elevated Emotional Dysfunction Scales

The patient is significantly demoralized, feels overwhelmed, and may be quite dissatisfied with life circumstances. He may have difficulty becoming motivated and following treatment recommendations. Helping the patient recognize positive aspects of his situation, and focusing on each improvement, however small, may help build momentum for recovery[63].

The patient also believes that he cannot be helped. Working with him to recognize behavioral, psychosocial, and medical problems that he experiences, to distinguish them from spine pain, and to identify paths to overcome or adapt to these problems may help him to perceive greater control and become more positive[64].

In addition, the patient appears to be experiencing a pervasive sense of anxiety. Explore the extent to which the anxiety may be triggered by past medical treatments or maladaptive cognitions about the current medical condition. Help the patient to develop balanced, realistic perspectives about the spinal cord stimulator, perhaps through cognitive behavioral techniques, and include treatments that assist in anxiety reduction such as meditation or biofeedback[67].

The patient may be experiencing depressive affect, which could impact spinal cord stimulator results. Consideration should be given to antidepressant medication, which may also help with pain reduction, as depression can increase pain awareness. Including individual psychotherapy in the overall treatment plan may help the patient identify and experience pleasurable activities while rehabilitating[100].

The patient is also experiencing a much higher level of stress/worry than other patients do, and is prone to both ruminate about disappointments and misfortunes and to feel a strong sense of time pressure to recover from the spinal pain problems. Recommended interventions include stress management training and strategies aimed at establishing and acting on priorities in the post-implant recovery process[101].

Recommendations Based on Elevated Thought Dysfunction Scales

Test results indicate that the patient may be experiencing a relatively large number of unusual thoughts and perceptions, which may include thought disorganization, unrealistic thinking, and perhaps somatic delusions. It is important to explore his understanding of the current physical problems and to determine the extent to which his expectations for the spinal cord stimulator are realistic. It may be helpful to provide the patient with a clear, written set of guidelines and suggestions for maximizing results, and to discuss these suggestions in detail with both the patient and a significant other[53].

ITEM-LEVEL INFORMATION

Unscorable Responses

The patient produced scorable responses to all the MMPI-2-RF items.

Critical Responses

Seven MMPI-2-RF scales--Suicidal/Death Ideation (SUI), Helplessness/Hopelessness (HLP), Anxiety (AXY), Ideas of Persecution (RC6), Aberrant Experiences (RC8), Substance Abuse (SUB), and Aggression (AGG)--have been designated by the test authors as having critical item content that may require immediate attention and follow-up. Items answered by the individual in the keyed direction (True or False) on a critical scale are listed below if his T score on that scale is 65 or higher. The percentage of the MMPI-2-RF normative sample (NS) and of the Spinal Cord Stimulator Candidate (Men) comparison group (CG) that answered each item in the keyed direction are provided in parentheses following the item content.

Helplessness/Hopelessness (HLP, T Score = 88)

135. Item Content Omitted. (True; NS 24.2%, CG 22.8%)
169. Item Content Omitted. (True; NS 4.3%, CG 6.9%)
214. Item Content Omitted. (True; NS 10.4%, CG 11.6%)
282. Item Content Omitted. (False; NS 17.3%, CG 22.8%)
336. Item Content Omitted. (True; NS 38.0%, CG 34.9%)

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.

Anxiety (AXY, T Score = 80)

228. Item Content Omitted. (True; NS 17.3%, CG 17.7%)
275. Item Content Omitted. (True; NS 5.0%, CG 5.6%)
289. Item Content Omitted. (True; NS 12.7%, CG 6.0%)

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.

Aberrant Experiences (RC8, T Score = 70)

32. Item Content Omitted. (True; NS 21.1%, CG 17.2%)
122. Item Content Omitted. (True; NS 3.3%, CG 5.2%)
159. Item Content Omitted. (True; NS 6.0%, CG 7.8%)
179. Item Content Omitted. (True; NS 12.6%, CG 11.2%)
199. Item Content Omitted. (True; NS 12.1%, CG 9.9%)
240. Item Content Omitted. (True; NS 8.8%, CG 2.6%)
257. Item Content Omitted. (True; NS 12.4%, CG 4.7%)

Items for Follow-up

This section contains a list of items to which the patient responded in a manner warranting follow-up. The items were identified by presurgical assessment experts as having critical content. Clinicians are encouraged to follow up on these statements with the patient by making related inquiries, rather than reciting the item(s) verbatim. Each item is followed by the patient's response, the percentage of the Spinal Cord Stimulator Candidate (Men) comparison group members who gave this response, and the scale(s) on which the item appears.

23. Item Content Omitted. (True; 20.7%; K-r, RC7, AGG, NEGE-r)
25. Item Content Omitted. (False; 83.2%; VRIN-r, EID, RC2, MLS)
30. Item Content Omitted. (True; 18.1%; TRIN-r, F-r, EID, RCd)
65. Item Content Omitted. (False; 27.2%; RC1)
76. Item Content Omitted. (True; 18.1%; FBS-r, RC1, GIC)
77. Item Content Omitted. (True; 12.5%; FBS-r, RC7, NEGE-r)
83. Item Content Omitted. (False; 3.4%; TRIN-r, F-r, EID, RC2)
101. Item Content Omitted. (True; 11.6%; TRIN-r, FBS-r, RBS, RC1, HPC)
105. Item Content Omitted. (False; 18.1%; VRIN-r, EID, RCd)
135. Item Content Omitted. (True; 22.8%; HLP)
152. Item Content Omitted. (True; 8.6%; VRIN-r, NFC)
169. Item Content Omitted. (True; 6.9%; TRIN-r, EID, HLP)
170. Item Content Omitted. (True; 10.3%; Fs)
172. Item Content Omitted. (True; 12.1%; EID, RCd)
172. Item Content Omitted. (True; 12.1%; EID, RCd)
176. Item Content Omitted. (True; 6.9%; RC1, HPC)
186. Item Content Omitted. (False; 19.0%; Fs, NUC)

210. Item Content Omitted. (True; 9.5%; FBS-r, GIC)
214. Item Content Omitted. (True; 11.6%; HLP)
261. Item Content Omitted. (True; 20.3%; VRIN-r, TRIN-r, FBS-r, EID, RCd)
275. Item Content Omitted. (True; 5.6%; VRIN-r, r, RC7, AXY)
276. Item Content Omitted. (True; 6.5%; FBS-r, RCd)
318. Item Content Omitted. (True; 10.8%; VRIN-r, RC7, ANP)
331. Item Content Omitted. (True; 8.6%; VRIN-r, EID, RCd)

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.

ENDNOTES

This section lists for each statement in the report the MMPI-2-RF score(s) that triggered it. In addition, each statement is identified as a Test Response, if based on item content, a Correlate, if based on empirical correlates, or an Inference, if based on the report authors' judgment. (This information can also be accessed on-screen by placing the cursor on a given statement.) For correlate-based statements, research references (Ref. No.) are provided, keyed to the consecutively numbered reference list following the endnotes.

[1] Correlate: F-r=88, Ref. 11, 13, 17, 30, 32, 34, 41, 51, 52, 54, 61, 62, 65, 67, 70, 77, 85, 93, 98, 99
[2] Correlate: Fs=120, Ref. 11, 13, 14, 17, 30, 32, 34, 39, 41, 54, 61, 62, 67, 68, 77, 78, 85, 93, 98, 99; FBS-r=111, Ref. 13, 14, 17, 30, 31, 32, 34, 39, 40, 41, 46, 53, 54, 59, 61, 62, 65, 67, 68, 77, 78, 85, 97, 98, 99, 101, 104; RBS=92, Ref. 11, 17, 18, 28, 29, 32, 34, 35, 39, 40, 41, 43, 53, 54, 59, 60, 61, 62, 63, 65, 67, 68, 81, 82, 83, 85, 88, 89, 92, 94, 95, 97, 98, 101, 102, 103
[3] Correlate: Fs=120, Ref. 13, 86; FBS-r=111, Ref. 13, 19, 86; RBS=92, Ref. 86
[4] Test Response: RC1=90
[5] Test Response: HPC=85
[6] Test Response: NUC=80
[7] Test Response: GIC=88
[8] Test Response: MLS=87
[9] Test Response: COG=96
[10] Correlate: EID=79, Ref. 44, 66, 86
[11] Test Response: RC2=92; INTR-r=87
[12] Correlate: RC2=92, Ref. 23, 79, 86; HLP=88, Ref. 86; INTR-r=87, Ref. 86
[13] Correlate: RC2=92, Ref. 5, 37, 58, 86; RC9=33, Ref. 86; MLS=87, Ref. 86
[14] Correlate: RC2=92, Ref. 5, 86
[15] Correlate: RCd=79, Ref. 5, 7, 37, 80, 86
[16] Test Response: RCd=79
[17] Correlate: RCd=79, Ref. 2, 5, 7, 8, 13, 20, 21, 22, 24, 25, 37, 42, 56, 57, 69, 72, 74, 75, 79, 80, 84, 86, 87, 90, 96, 100; RC2=92, Ref. 2, 5, 7, 8, 13, 22, 24, 25, 37, 42, 69, 72, 74, 75, 79, 80, 86, 87, 90, 96, 100; INTR-r=87, Ref. 86
[18] Test Response: HLP=88
[19] Correlate: HLP=88, Ref. 86
[20] Correlate: RCd=79, Ref. 86; HLP=88, Ref. 86
[21] Correlate: STW=65, Ref. 13, 16, 86
[22] Correlate: STW=65, Ref. 86
[23] Correlate: STW=65, Ref. 3, 12, 86
[24] Test Response: AXY=80
[25] Correlate: AXY=80, Ref. 2, 8, 33, 57, 64, 76
[26] Correlate: AXY=80, Ref. 33, 57, 86
[27] Test Response: RC8=70
[28] Correlate: RC8=70, Ref. 37, 86
[29] Correlate: RC8=70, Ref. 3, 13, 21, 22, 23, 25, 38, 57, 79, 86
[30] Correlate: RC8=70, Ref. 2, 22, 23, 25, 38, 57, 69, 79, 80, 86
[31] Inference: RC1=90; HPC=85; NUC=80

[32] Correlate: BXD=32, Ref. 44, 66, 86; DISC-r=31, Ref. 86
[33] Correlate: BXD=32, Ref. 44, 86; DISC-r=31, Ref. 86
[34] Test Response: RC4=34
[35] Test Response: SAV=70
[36] Correlate: SAV=70, Ref. 2, 3, 6, 21, 27, 86
[37] Correlate: SAV=70, Ref. 2, 15, 26, 27, 86
[38] Correlate: SAV=70, Ref. 86
[39] Test Response: RC3=34
[40] Correlate: RC3=34, Ref. 73, 80, 86
[41] Test Response: AES=62
[42] Test Response: MEC=43
[43] Correlate: Fs=120, Ref. 13, 30, 32, 34, 41, 68, 77, 78, 85, 99; FBS-r=111, Ref. 13, 30, 31, 32, 34, 40, 41, 46, 59, 65, 68, 77, 78, 85, 97, 99, 101, 104
[44] Correlate: RC1=90, Ref. 46, 47, 91
[45] Inference: RC8=70; NUC=80
[46] Correlate: MLS=87, Ref. 46
[47] Inference: HPC=85
[48] Correlate: GIC=88, Ref. 91
[49] Correlate: RCd=79, Ref. 36, 45, 55, 71, 80, 86, 91; RC2=92, Ref. 36, 45, 55, 71, 80, 86, 91; INTR-r=87, Ref. 86
[50] Correlate: STW=65, Ref. 91
[51] Correlate: AXY=80, Ref. 4, 76, 86
[52] Correlate: RC8=70, Ref. 45, 86
[53] Inference: RC8=70
[54] Correlate: SAV=70, Ref. 91
[55] Inference: RC1=90
[56] Inference: GIC=88
[57] Inference: MLS=87
[58] Inference: COG=96
[59] Inference: EID=79
[60] Test Response: EID=79
[61] Inference: RC2=92; INTR-r=87
[62] Test Response: RC2=92
[63] Inference: RCd=79
[64] Inference: HLP=88
[65] Test Response: NFC=64
[66] Test Response: STW=65
[67] Inference: AXY=80
[68] Test Response: THD=57
[69] Inference: RC8=70; PSYC-r=63
[70] Correlate: RCd=79, Ref. 8, 55; RC2=92, Ref. 8, 55
[71] Correlate: RCd=79, Ref. 48; RC2=92, Ref. 48; MLS=87, Ref. 48
[72] Correlate: RCd=79, Ref. 8, 10, 49; RC2=92, Ref. 8, 10, 49; MLS=87, Ref. 8, 10, 49; HLP=88, Ref. 8, 10, 49
[73] Correlate: RC1=90, Ref. 48; MLS=87, Ref. 48; GIC=88, Ref. 48; HPC=85, Ref. 48

[74] Correlate: RC1=90, Ref. 48; MLS=87, Ref. 48; COG=96, Ref. 48
[75] Correlate: RC1=90, Ref. 48; HPC=85, Ref. 48
[76] Correlate: RC2=92, Ref. 8; MLS=87, Ref. 8; COG=96, Ref. 8
[77] Correlate: RC1=90, Ref. 84
[78] Correlate: RC1=90, Ref. 84; RC2=92, Ref. 84; MLS=87, Ref. 84; HPC=85, Ref. 84
[79] Correlate: RCd=79, Ref. 8; RC1=90, Ref. 8; MLS=87, Ref. 8; HLP=88, Ref. 8
[80] Correlate: RCd=79, Ref. 8; HLP=88, Ref. 8
[81] Correlate: EID=79, Ref. 50; RC2=92, Ref. 50; MLS=87, Ref. 50
[82] Correlate: AXY=80, Ref. 8
[83] Correlate: STW=65, Ref. 84; AXY=80, Ref. 84
[84] Correlate: STW=65, Ref. 8; AXY=80, Ref. 8
[85] Correlate: RCd=79, Ref. 8; MLS=87, Ref. 8; STW=65, Ref. 8
[86] Correlate: RC1=90, Ref. 8; MLS=87, Ref. 8
[87] Correlate: MLS=87, Ref. 84
[88] Correlate: RCd=79, Ref. 8; RC2=92, Ref. 8; MLS=87, Ref. 8
[89] Correlate: STW=65, Ref. 48
[90] Correlate: SAV=70, Ref. 48
[91] Correlate: RC2=92, Ref. 8
[92] Correlate: RCd=79, Ref. 10
[93] Correlate: HPC=85, Ref. 48
[94] Correlate: MLS=87, Ref. 8, 84
[95] Correlate: F-r=88, Ref. 1; Fs=120, Ref. 1; FBS-r=111, Ref. 1
[96] Correlate: F-r=88, Ref. 10; FBS-r=111, Ref. 10
[97] Correlate: RBS=92, Ref. 48
[98] Correlate: RCd=79, Ref. 9; STW=65, Ref. 9
[99] Correlate: RCd=79, Ref. 9; RC2=92, Ref. 9; MLS=87, Ref. 9; STW=65, Ref. 9
[100] Inference: RC2=92
[101] Inference: STW=65

RESEARCH REFERENCE LIST

The following studies are sources for empirical correlates identified in the Endnotes section of this report.

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End of Report

ITEM RESPONSES

1: 2	2: 2	3: 1	4: 2	5: 2	6: 1	7: 1	8: 1	9: 2	10: 2
11: 2	12: 2	13: 2	14: 2	15: 1	16: 2	17: 2	18: 1	19: 1	20: 2
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