An Evaluation of Combined Narrative Exposure Therapy and Physiotherapy for Comorbid PTSD and Chronic Pain in Torture Survivors

– A case series

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Preface

Perhaps owing to the fact that I am the daughter of an Iranian refugee, I have grown up with an awareness of that human rights are violated in several parts of the world every day. Thus, for me, this theme has a personal connotation, but was for a long time unrelated to my academic interests. Then, a few years ago, I came across the inspiring work of Nora Sveaass and Sverre Varvin, which led to the subsequent discovery of an entire field dealing with minority health and human rights from a psychological perspective. About the same time, our clinical practice began, the curriculum was loaded with clinical research papers – and another academic curiosity awoke: Why and how does psychotherapy actually work?

So, I felt very fortunate as the opportunity to work with what interested me the most presented itself earlier this year. My supervisor put me in contact with Håkon I. Stenmark from RVTS, who just completed his doctoral thesis on treatment for traumatized refugees. Together with Joar Ø. Halvorsen and Shawkat Nomat, he had designed a case series they called the "Torture Project", for which they needed someone to systematize and process the data collected. I am very grateful to them for granting me this opportunity, as well as their collaboration throughout the process. This also extends to the therapists in the project, whose cooperation have been very helpful.

Moreover, I want to thank my supervisor, Leif E. O. Kennair, who through his clinical experience and academic expertise has provided the perfect balance between freedom and guidance that I needed in this work.

Finally, I want to thank my Kristoffer Ludvigsen for proofreading and loving support.

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Abstract

Torture is associated with adverse health consequences, with especially high rates of PTSD, depression and chronic pain. Despite the growing evidence base of the treatment for PTSD, increased awareness of the relationship between pain and posttraumatic symptoms, and the accompanying need for effective treatment strategies, few studies have examined an integrated treatment of both. In this study, using an A-B case series design with 3 and 6 months follow up, six refugee torture survivors with comorbid PTSD, depression and reported pain received 20 sessions of Narrative Exposure Therapy (NET) and 10 sessions of physiotherapy. Outcome variables included symptoms of PTSD and depression, pain intensity, physical functioning and quality of life. At the group level, medium and large effects were found for symptom reduction of PTSD and depression, while the individual results reflected variable outcomes**.** We conclude that this treatment could be effective for some, and partly effective or not suitable for others. Directions for future research regarding the improvement of rehabilitation approaches of torture survivors are discussed, highlighted through descriptions from the six therapy cases.

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Introduction

"Torture is the deliberate, systematic or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession, or for any other reason" (WMA, 1975). Reports from human rights organizations indicate that 75 % of the world's countries are practicing torture systematically (Amnesty International, 2013). In Western countries, survivors of torture are most prevalent in refugee populations, with rates ranging from 2.74 - 100 % (Quiroga & Jaranson, 2005). In general, studies have found low levels of functioning and quality of life in treatment seeking traumatized refugees in Western settings (Buhmann, 2014), also torture survivors specifically (Carlsson, Mortensen, & Kastrup, 2006; Carlsson, Olsen, Kastrup, & Mortensen, 2010). Torture is associated with adverse mental health consequences, with especially high rates of PTSD, depression and chronic pain symptoms (Carinci, Mehta, & Christo, 2010; de C Williams & van der Merwe, 2013; de Fouchier et al., 2012; Punamäki, Qouta, & El Sarraj, 2010; Quiroga & Jaranson, 2005; Van Ommeren et al., 2002). In addition, there is higher incidence of traumatic brain injury (Jacobs & Iacopino, 2001; Keatley, d'Alfonso, Abeare, Keller, & Bertelsen, 2015; Mollica et al., 2014), neurological damage (Moreno & Grodin, 2002) and a number of physical symptoms in this group (Buhmann et al., 2014; de C Williams & van der Merwe, 2013; Punamäki et al., 2010; Quiroga & Jaranson, 2005; Tamblyn, Calderon, Combs, & O'Brien, 2011). The occurrence of comorbid PTSD and depression might be particularly severe (Bramsen & Van Der Ploeg, 1999; Lie, 2002; Momartin, Silove, Manicavasagar, & Steel, 2004), and sleep disturbances are a common complaint (White, 2001). Substance abuse is relatively common as a comorbid disorder in soldiers with PTSD, however, is relatively uncommon in torture survivors that are refugees (Quiroga & Jaranson, 2005).

In refugee populations one finds higher prevalences of PTSD and depression than in the general population (Gorst-Unsworth & Goldenberg, 1998; Hauff & Vaglum, 1993; Hocking, Kennedy, & Sundram, 2015; Nickerson, Bryant, Silove, & Steel, 2011; Porter & Haslam, 2005), and a number of studies indicate that experiencing torture can lead to severe PTSD symptomatology independently of other traumatic experiences including stressors associated with living in exile (Başoğlu, Jaranson, Mollica, & Kastrup, 2001; Holtz, 1998; Silove, Steel,

McGorry, Miles, & Drobny, 2002), especially among males (Kaminer, Grimsrud, Myer, Stein, & Williams, 2008). In another vein, Elsass (1998) postulates that only specific types of torture leads to PTSD, whereas most may suffer from a proper "torture syndrome", characterized by incomplete emotional processing, depressive reactions, somatoform reactions and existential dilemmas. Mollica et al. (1998) found evidence in support of a dose-effect relationship between torture and symptoms of PTSD and depression, and some studies have even found a linear relationship between number of traumatic experiences and rates of PTSD (Catani et al., 2005; Neuner, Schauer, Karunakara, et al., 2004). Punamäki et al. (2010) found that both physical and psychological torture methods was related to PTSD symptoms, and that psychological torture also was associated with somatic complaints like weight loss, hypertension and pain. Indeed, the distinction between physical and psychological torture is increasingly abandoned (Catani, Neuner, Wienbruch, & Elbert, 2008). Defrin, Ginzburg, Mikulincer, and Solomon (2014) conclude that "torture survivors exhibit generalized diminished pain modulation and increased excitability. These alterations in the function of the pain system may underlie the chronic pain decades after the torture" (p 549). Additionally, a relationship between PTSD and high blood pressure, muscle tension and heart rate is well established (Pole, 2007), and Fields (2008) postulate that psychological torture can result in somatic and pain conditions due to its adverse effects on memory and executive functioning

Risk and Protective Factors

PTSD and depression are assumedly resulting from both shared as well as different etiological processes (Başoğlu & Mineka, 1992; Başoğlu, Paker, Özmen, Taşdemir, & Sahin, 1994; B. H. Ellis, MacDonald, Lincoln, & Cabral, 2008; Mollica, Caridad, & Massagli, 2007; Song, Kaplan, Tol, Subica, & de Jong, 2015; Velssen, Gorst-Unsworth, & Turner, 1996). PTSD symptoms are often attributed to pre-migratory traumatic experiences, such as torture (Başoğlu et al., 2001; Başoğlu et al., 1994; Holtz, 1998; Silove et al., 2002; Van Ommeren et al., 2002), whereas losses (Momartin et al., 2004; Turner & Gorst-Unsworth, 1990), and post-migratory challenges related to the life in exile and resettlement (Başoğlu et al., 1994; Beiser & Hou, 2001; Porter & Haslam, 2005) is assumed to affect depressive symptomatology. Perhaps one of the most studied variables in this regard is low social support (Carlsson et al., 2006; Fairbank, Friedman, & Başoğlu, 2001; Gorst-Unsworth & Goldenberg, 1998; Schweitzer, Melville, Steel, & Lacherez, 2006). Other identified risk factors for emotional distress in torture survivors are

other traumatic experiences (Carlsson et al., 2006), negative social support (Halvorsen & Kagee, 2010), negative coping mechanisms (Emmelkamp, Komproe, Van Ommeren, & Schagen, 2002) and being female (Halvorsen & Kagee, 2010; Shrestha et al., 1998; Van Ommeren et al., 2001). Living in exile and post-migratory stressors have been extensively studied (Nickerson et al., 2011; Quiroga & Jaranson, 2005), and includes separation and fear for family members (Nickerson, Bryant, Steel, Silove, & Brooks, 2010), detention while seeking asylum (Robjant, Hassan, & Katona, 2009; Steel et al., 2006), uncertain asylum status (Steel et al., 2006), poverty (Quiroga & Jaranson, 2005), discrimination (B. H. Ellis et al., 2008; Sundquist & Johansson, 1996), racism (Baker, 1992), poor social positioning (Van der Veer, 1999), lower educational status (Carlsson et al., 2006), restrictive immigration laws (Steel et al., 2015), adjusting to a new culture (Youngmann, Minuchin-Itzigsohn, & Barasch, 1999), long waiting time for asylum applications (Laban, Gernaat, Komproe, Schreuders, & De Jong, 2004; Silove, Sinnerbrink, Field, Manicavasagar, & Steel, 1997) and unemployment (Beiser & Hou, 2001; Carlsson et al., 2006; Porter & Haslam, 2005). Moreover, unemployment and depression have been found to constitute mutually reinforcing factors (Beiser & Hou, 2001).

Silove (2003) argue that post-migratory stressors may impede traumatized refugees in overcoming past traumas, thus implying a moderating role in relation to PTSD symptoms. In fact, in a Norwegian study on a recently arrived refugee population, Lie (2002) found that the symptom load had increased three years after resettlement. Concurrent findings regarding the chronicity of untreated PTSD symptoms have been reported in Norway (Vaage et al., 2010), Italy (Favaro, Rodella, Colombo, & Santonastaso, 1999) and USA (Weine et al., 1998). Quiroga and Jaranson (2005) postulate that PTSD symptoms could be suppressed, due to dissociative mechanisms, until basic security needs are met and therefore mushroom after resettlement. Furthermore, they argue that depressive symptoms may be ameliorated by social support, whereas PTSD symptoms cannot unless treated. Indeed, Lamkaddem et al. (2014) found that the continuous high prevalence rates in prospective studies could be explained partly by lack of treatment, however, also by the fact that many experience late onset PTSD.

Perhaps the most studied protective factor in torture survivors is social support (Emmelkamp et al., 2002; Lie, 2002). Holtz (1998) argues that the meaning the torture has for the individual will be influenced by religious, cultural and political beliefs, and thus affect

symptomatology. In this vein, empirical support has been found for superior mental health outcomes while having a strong belief system (Brune et al., 2002), being trained and prepared for torture (Başoğlu et al., 1997) and negative appraisals of the public authorities (Başoğlu et al., 1996). Religious beliefs have been identified both as a protective factor (Shrestha et al., 1998) as well as a risk factor (Halvorsen & Kagee, 2010).

Rehabilitation and Treatment Practices for Torture Survivors

Nickerson et al. (2011) divide the field of treatment of traumatized refugees into two main approaches: Multimodal therapy (MMT) and Trauma-focused therapy (TFT). Simply put, the first targets primarily the post-migratory stressors, while the latter focus on pre-migratory traumas. The MMT is based on the assumption that these persons experience a number of complex and different struggles, requiring a multidisciplinary approach targeting a broad specter of problems, including acculturation, social support, psychosocial and legal issues as well as physical and mental health (Berliner, Jacobsen, lanev, & Mikkelsen, 2005; Reid, Silove, & Tarn, 1990). Some proponents of this perspective argue that a trauma-focused approach is to narrow and risks to ignore the many and complex issues these people struggle with (Nickerson et al., 2011). In this vein, some (Lira, 1998; Patel, 2003) criticize the TFT to be medicalizing a sociopolitical problem, and there is an ongoing debate regarding the applicability of the PTSD diagnosis outside a Western context (Bracken, Giller, & Summerfield, 1995). Another concern that has been raised is whether exposure therapy could be harmful through retraumatization, or that extinction is unlikely to work, as many refugees cannot genuinely feel secure (Nickerson et al., 2011; Patel, Kellezi, & de C Williams, 2014).

There is currently a dearth of research on MMT for torture survivors, but two uncontrolled follow-up studies have been conducted in specialized centers for the treatment of torture survivors; one in Berlin (Birck, 2001) another in Copenhagen (Carlsson, Mortensen, & Kastrup, 2005). Both presented disappointing results with no or little reported change in neither depressive and posttraumatic symptoms, the Danish study additionally reported no changes in quality of life (Reeler, 1994). An American study reported decreased depression, but no effect on posttraumatic symptoms (Mollica et al., 1990). Nevertheless, a recent study found small to moderate effects regarding both PTSD, depression, quality of life and functioning after MMT (Buhmann, 2014).

Başoğlu et al. (1994) note that in survivors that have adequate social support, PTSD symptoms are still present, implying that social support is insufficient, thus pressing the need for directed treatment of posttraumatic distress. The TFT is based on the notion that torture survivors with PTSD are persons that have a normal reaction to an abnormal event (Reeler, 1994). In general, studies with traumatized refugees and torture survivors have implemented Cognitive Behavioral Therapy (CBT) or Narrative Exposure Therapy (NET), aiming to tailor evidence based therapeutic techniques to meet the needs of refugee torture survivors. Trauma-focused CBT is currently the treatment of choice according to general guidelines (Foa, Keane, Friedman, & Cohen, 2009; NICE, 2005) which has gained the most empirical support for the treatment of PTSD in Western samples (Bisson & Andrew, 2007; Bryant et al., 2008). However, a few studies have also supported its effective use in refugee populations in Western clinical settings (Hinton et al., 2005; Hinton, Safren, Pollack, & Tran, 2006), also in a sample where one third was torture survivors (Paunovic & Ost, 2001). Recently, a Cochrane review on the effective treatments for torture survivors concluded that the NET and CBT deemed moderate effects on posttraumatic symptoms and distress in the medium term, however stress the substantial holes in the current evidence base (Patel et al., 2014). This is line with Nickerson et al. (2011) review for treatment of traumatized refugees.

Narrative Exposure Therapy

Considering that exposure treatment is designed for, and mostly studied in, Western persons in Western society that have experienced single traumas, there have been raised concerns regarding its appropriateness for traumatized refugees. Samples have typically consisted of individuals that have survived horrific events, but otherwise lead stable lives. In contrast, tortured refugees may have experienced countless traumas in addition to living in unstable circumstances (Nickerson et al., 2011; Patel et al., 2014). For this reason, Schauer, Neuner, and Elbert (2005) developed Narrative Exposure Therapy (NET), a standardized short-term therapy that integrates principles from prolonged exposure (Foa, Hembree, & Rothbaum, 2007; Foa & Kozak, 1986) with Testimonial therapy (Cienfuegos & Monelli, 1983). NET is based on the theory of dual representations of traumatic memories (Elbert & Schauer, 2002). Within this framework, one distinguishes between associated, verbally available, hippocampal "cold" and non-associative, non-verbal, amygdalic "hot" memories, where the first are contextualized whilst the latter are not. Hot memories can be sensory, cognitive, emotional or physiological features. Normally, cortical

and hippocampal pathways down-regulate amygdala-activity, resulting in emotional regulation, however this is interrupted in PTSD (Metcalfe & Jacobs, 1996). Multiple traumatic experiences will lead to the creation of a complex intertwined fear network through sensitization, and thus lead to a more extreme stress reaction and with more generalized triggers than with single traumas. Prolonged exposure to single events is therefore not enough as it only targets the associative part of the fear network, while neglecting the non-associative sensitization (Costanzi, Cannas, Saraulli, Rossi-Arnaud, & Cestari, 2011). According to Catani et al. (2008), torture may alter the HPA-axis as increased cortisol harms the hippocampus, and impedes the negative feedback loop from the frontal lobes, reflecting decreased emotion regulation. In other words, hot amygdalic memories are retrieved without reference to cold hippocampal memories, that is to say, they are decontextualized. In NET the aim is to contextualize these hot memories through the narration of the patient's life story, in addition to habituate the anxiety response through exposure to the feared memories. Moreover, the act of documenting the human-rights violations is thought to bring dignity to the survivor in addition to aid the prevention of the practice of torture by facilitating prosecution of the violators. NET has since its development gained promising results for the treatment of PTSD in refugees, and to a lesser extent depression, in refugee populations (NICE, 2005; Robjant & Fazel, 2010), both in refugee camps (Neuner, Schauer, Klaschik, Karunakara, & Elbert, 2004; Schaal, Elbert, & Neuner, 2009), also delivered by lay persons (Neuner et al., 2008), and in health care settings in Western countries (Halvorsen & Stenmark, 2010; Neuner et al., 2010).

Chronic Pain and PTSD

There exist a number of studies investigating the link between pain and PTSD (Asmundson, Coons, Taylor, & Katz, 2002; Asmundson, Gómez-Pérez, & Fetzner, 2014; Defrin et al., 2008; Geisser, Roth, Bachman, & Eckert, 1996; R. S. Roth, Geisser, & Bates, 2008), also amongst torture survivors specifically (Liedl & Knaevelsrud, 2008). Chronic pain is highly prevalent in torture survivors (Olsen, Montgomery, Bøjholm, & Foldspang, 2006), often co-occurs with PTSD and is associated with poorer prognosis (Carinci et al., 2010). Trauma survivors that have suffered trauma-related bodily injury have been showed to run an eight-fold higher risk for developing PTSD (Koren, Norman, Cohen, Berman, & Klein, 2005), which could partly explain the higher incidence of chronic pain and PTSD amongst torture survivors. Furthermore, pain related fear has been found to be a predictor of chronification of pain

symptoms (Picavet, Vlaeyen, & Schouten, 2002), and PTSD is a higher risk factor for developing pain than the experience of trauma in itself (Harris, Young, Rae, Jalaludin, & Solomon, 2007; Stam, 2007).

Correlations between symptoms of chronic pain, depression and PTSD are well established (Geisser et al., 1996; R. S. Roth et al., 2008). PTSD has gained support as a risk factor contributing to more severe pain experience, poorer treatment outcome and greater pain-related disability (Geisser et al., 1996; Phifer et al., 2011). Depression has been attributed the same role (Haythornthwaite, Sieber, & Kerns, 1991), however, recent studies indicate that this notion holds more for anxiety than for depression (Burke, Mathias, & Denson, 2015; Castillo et al., 2013). There exist different theoretical models aiming to explain the relationship between chronic pain, PTSD and depression, including the Mutual Maintenance Model (Sharp & Harvey, 2001), the Shared Vulnerability Model (Asmundson et al., 2002) and the Perpetual Avoidance Model (Liedl & Knaevelsrud, 2008), the last being the only one directly used in the context of torture survivors while the two others have both gathered empirical support according to recent reviews (Asmundson & Katz, 2009; Beck & Clapp, 2011; Liedl & Knaevelsrud, 2008). R. S. Roth et al. (2008) used structural equation modeling, and found that the best fit was a model in which PTSD symptoms had a direct effect on depression, which in turn influenced pain both directly and indirectly through its effect on disability. Clapp, Beck, Palyo, and Grant (2008) found a synergistic relationship between PTSD, pain, functioning and quality of life: Numbing symptoms correlated with decreased functioning only at lower levels of pain, whereas hyperarousal was related to low life-satisfaction only at higher levels of pain. Moreover, sustaining treatment for a longer period of time was associated with higher quality of life in a sample of torture survivors in New York (Bohrer, 2000).

The above studies gives rise to several treatment implications. First, that the effective treatment of PTSD could lead to reductions in symptoms of chronic pain and depression and thus improve pain rehabilitation outcome in patients with chronic comorbid affective and pain symptoms (for a review; R. S. Roth et al., 2008; Wald, Taylor, & Fedoroff, 2004). Second, that PTSD and chronic pain can be targeted simultaneously by mode of targeting shared vulnerabilities (Asmundson, 2014) or integrated treatments (Asmundson, 2014; Liedl &

Knaevelsrud, 2008; Müller et al., 2014; Taylor, Carswell, & de C Williams, 2013). Third, succesful treatment of PTSD symptoms may lead to increased quality of life and functioning.

According to guidelines for physiotherapy for torture survivors, physiotherapy and psychotherapy is recommended to be implemented in parallel (Holten, Prip, & Tived, 1995). On the report of a survey conducted by the Center for Victims of Torture (CVT, 2014), 30 % of torture rehabilitation centers offers physiotherapy, although it is estimated that as many as 80 % could benefit from it . Becker, Sjøgren, Bech, Olsen, and Eriksen (2000) found a multidisciplinary approach to be the superior treatment for chronic pain, however torture survivors probably require further specialized treatment (Amris & Prip, 2000b). To our knowledge, there exist no systematic or controlled studies investigating the effects of physiotherapy for torture survivors. Nevertheless, a number of studies of chronic pain sequel in torture survivors have emerged in the last decade (for an overview; Amris & Prip, 2000b). Consequently, one has begun to map out the dimensions as well as mechanisms involved, but there is still a gap between this knowledge and clinical trials examining the treatment strategies currently implemented.

Few available studies have investigated structured implementation of combined physiotherapy and psychotherapy for torture survivors suffering from comorbid PTSD and chronic pain. However, one unstructured study of refugee torture survivors resettled in Denmark has been performed: Carlsson et al. (2005) reviewed the effect of Multimodal Treatment, implemented for 71 % of a sample of patients at a specialized center for trauma and torture. The treatment included psychotherapy, physiotherapy, medical attention and social assistance with a mean of 35 sessions in total. No treatment effect was found for neither PTSD, depression nor quality of life indexes. Of note, another Danish study on multimodal treatment programs from traumatized refugees (probably including torture survivors as well) has also been conducted: Palic and Elklit (2009) studied Multimodal Therapy lasting 16-18 weeks, consisting of weekly sessions of both physiotherapy and CBT with exposure therapy, in addition to social counselling and pharmacotherapy. Reported effect sizes was large, but the majority of the patients was still described as having low functioning as well as to retain their PTSD diagnosis. Thus, the inconclusiveness of the available studies call for further research efforts.

Aim of This Study

Apparently, the treatment currently offered to torture survivors is not as effective nor thoroughly studied, compared to other patient populations. Furthermore, torture survivors have the right to rehabilitation in a human right's perspective, as 158 countries' ratification of the UNCAT implicates their governments' responsibility for the retribution for the victims of torture (IRCT). For these reasons, there is a need for scientific inquiry to be able to improve and further develop and tailor treatment efforts for this group. This study builds on current knowledge regarding the relationship between chronic pain, PTSD, depression, functioning and quality of life, in addition to updated treatment reviews for tortured refugees supporting NET as a promising treatment. As described above, treatment efforts that target both PTSD and chronic pain have been requested. We have combined physiotherapy with NET, in an effort to alleviate emotional distress and pain, as well as to increase quality of life and functioning, in survivors of torture presenting with these symptoms. First, one aim of this study was to run a preliminary evaluation of the potential efficacy of this combination treatment for torture survivors, both targeting traumas and pain. Second, this study has the potential to illuminate its generalizability, as large effects across all the six different therapies would indicate higher degree of generalizability (Barlow & Hersen, 1984). Furthermore, we wish to highlight potential hypotheses for future research through clinical illustrations from these six cases.

Method

Design

To examine the treatment effect of a combination of NET and physiotherapy for torture survivors struggling with PTSD symptoms and pain disorder, an A-B-design (Barlow & Hersen, 1984) with 3 and 6 months follow-up was chosen. A case series design is deemed suitable for preliminary examinations of novel treatment approaches, especially when it is regarded as unethical to assign patients to a control group (Kooistra, Dijkman, Einhorn, & Bhandari, 2009). Its primary purpose is to generate new hypotheses, which can form the basis for research with more stringent methodology. The patients were divided into three different groups, where the onset time of physiotherapy varied between after the 3rd, 6th and 9th NET session. Three experienced professionals were involved in the psychological assessment and NET treatment, but the assessor and therapist differed for each patient to assure blind assessment. As for the

physiotherapy, all patients had the same physiotherapist, but outcomes were assessed by a different physiotherapist.

Selection of Participants

The patients recruited were referred to the outpatient clinic for refugees at The Regional Center on Violence, Traumatic Stress and Suicide Prevention, Region Mid-Norway. The center is part of the Department of Research and Development at St. Olav's Hospital in Trondheim, Norway. An invitation to participate in the study was presented to the patients that were older than 18, had experienced torture, reported pain symptoms and fulfilled the diagnostic criteria for PTSD. Exclusion criteria were psychosis, high suicide risk or a serious drug/alcohol addiction. Patients referred to the clinic were evaluated for eligibility in the project. Collaboration between the referring clinician, hospital, general practitioner and Trondheim Municipality Refugee Health Team assured that the patients had been assessed according to the Istanbul Protocol, guidelines for the examination of survivors of torture. Patients who met the inclusion criteria were invited to participate in the study. Information about the project, including contact information and the possibility of withdrawing at any time, was presented in writing and translated into the language of each patient, as well as orally with a translator present. All patients had to sign an informed consent to be included. Subsequently, those who accepted were further assessed for PTSD, depression, psychiatric comorbidity, pain symptoms, functioning and health-related quality of life. The study has been approved by the Regional Committee for Medical and Health Research Ethics (REC).

Patients

Initially, eight patients were enrolled in the project, however, two withdrew before completion. For this reason, only the six patients that completed the treatment are described.

Patient 1: Saleem. *Saleem*[1] *is a man in his 30s from a Middle Eastern country, who has been in Norway for 10 years. He lives with his wife and two children, and is currently going to school. Saleem grew up in a village that was often bombed, which led to the death of close friends and family members, including his brother. Owing to this, as a teenager he decided to*

[1] All patient names are pseudonyms. Pseudonyms were selected from amidst name registers of the patient's respective country of origin. Cross-checking was then performed to ensure that the selected pseudonym also was in use in neighboring countries, to preclude recognition based on nationality.

become politically active and started training as a soldier for the resistance movement. Seventeen years old, he was arrested and severely tortured for the first of several times. In total, he spent 7.5 months in captivity and was tortured in 5.5 of them. The torture consisted of captivity, blindfolding, beatings until he lost consciousness, threats towards self and family members, whipping, isolation, deprivation, water torture, suspension from different limbs and degrading insults. Other traumatic experiences include several bombings of his village, and witnessing other people being murdered and tortured. Saleem describes himself as healthy and well-functioning before the torture, but is now struggling with large physical disabilities and emotional distress. At the time of the pre-test assessment, he fulfils the criteria for PTSD, and current depressive episode of moderate degree. He has chronic pain symptoms that started after the torture and affects his head, face, jaw, knees, feet, ankles, elbows, lower back and legs. Sleep disturbances and lack of ability to concentrate are his main complaints. He reports large sleep disturbances and economic problems.

Patient 2: Adaam. *Adaam is a man in his 60s from a country in the Caucasus region, who has been in Norway for eight years. He is currently living with his wife. From early in his life, he has worked as a writer and was for many years politically active through critical writings about the government. About ten years ago, he was arrested and tortured twice, both episodes lasting a day. The torture methods consisted of bindings, beatings and water torture – in addition, they tortured a close family member. After the last episode, he fled with his family, living in hiding and constant fear for about three years until they came to Norway. He describes his early childhood as secure and happy, until the war began. When he was in his 30s, his village was bombed several times, and Adaam was severely injured and hospitalized. He also witnessed several people die, including friends and relatives. Other traumatic experiences include natural disasters and explosions. Adaam describes himself as functioning well after the torture as well as in his first year in Norway, but to have reduced functioning the last seven years. His pain symptoms debuted after the torture, and he reports them to grow increasingly worse. The pain is located in his head, chest, stomach, thighs, neck, lower back as well as one shoulder and one leg. At the time of the initial assessment, Adaam fulfils the criteria for PTSD, and current depressive episode of moderate degree, social phobia and lifetime panic disorder with agoraphobia. He reports large sleep disturbances and economic problems.*

Patient 3: Joseph. *Joseph is a man in his 40s from a country situated in Central Africa, who came to Norway 10 years ago. Currently, he is living with his wife and has regular contact with his one child. Joseph has two degrees, one from Norway and another from his home country. He has a paid job and volunteers in an organization, but is on a sick leave when referred. Joseph was raised in a wealthy family, but describes loneliness and distress as he his family situation was unstable. At a young age, he became politically active with the resistance party, on the grounds of which he was arrested several times. He managed to escape every time, but lived in fear and under surveillance in between the arrests, and was sentenced to death under the last capture. When in prison, the torture went on for two months. The torture methods were stabbing one leg, isolation, deprivation, threats and forced to stand in painful positions for longer periods. Other traumatic experiences include violence from adults during childhood, a traffic accident and witnessing several people being tortured and killed in prison. Joseph described posttraumatic symptoms from when he was released from captivity 15 years ago, increasing when he experienced a difficult time living in poverty in exile, with no social network. His symptoms vary in intensity across different periods. Currently, he describes increased symptom load after hearing about friends being arrested in his home country. At the time of the assessment, he fulfils the criteria for PTSD, and reports depressive symptoms in line with the criteria for a depressive episode of mild degree. His pain condition started more than 10 years ago, and has been on the current level for more than 6 years. The pain is located in his head, chest, hands, shoulders, upper and lower back and elbows. He reports some sleep disturbances as well as economical struggles.*

Patient 4: Yaqub. *Yaqub was a man in his 30s from a country in the Caucasus region, who has been in Norway for 10 years. He lives with his wife and children, has a university degree and a paid job, but is currently on sick leave. He describes a secure childhood until reaching the age of 15, when his village was affected by war. Subsequently he describes living in poverty. Due to political activity in his family, he was arrested and tortured twice, both episodes lasting for one day. The torture consisted of electricity, beatings to the head and body, degrading comments, a tight rubber band around his head, water torture, physical abuse with canes and batons, threats with weapons, being stripped naked, thrown rocks at, cigarette stumping, falanga*[2],

[2] Falanga is a form of torture in which the soles of the feet are beaten with whips or cudgels.

suspension from the arms and to be buried alive in a dark hole. Yaqub describes posttraumatic and pain symptoms shortly after the torture, but that he despite of this managed to function well at work and with his family. After three years in Norway he experienced increased symptoms and a loss of function. Other traumatic experiences reported are witnessing people being injured and killed and inclicting pain on others in war, in addition to living in poverty. At the time of the initial assessment, he fulfils the criteria for PTSD, and depressive symptoms implying a moderate depressive episode. His pain symptoms debuted more than 10 years ago, and have been stable in intensity for 1-5 years. He reports pain in his head, hands, knees, feet, neck, shoulders, elbows, lower back and legs. He reports a large sleep disturbance and some economical struggles.

Patient 5: Hassan. *Hassan is a man in his 30s, from a country in the Middle East, who prior to treatment had been in Norway for about a year. He is living with his wife and child, and is currently taking classes in Norwegian. When Hassan reached the end of secondary school, he started military training and was a guerilla soldier for three years. Subsequently, he was imprisoned five times in two different countries. During one of the captures, he was tortured for 12 days, in another for 20. The torture consisted of psychological pressure, breaking of his arm, to be stripped naked, electric shocks, deprivation and living under insanitary conditions. Other traumatic experiences were several natural disasters, fire/explosions, accidents not related to war, physical violence from older family members, to be attacked with weapon, participating in combat, witnessing sexual violence, witnessing people die and living in hunger and poverty. He describes having had psychological struggles prior to, but that the posttraumatic symptoms debuted after, the torture. At the time of the initial assessment, Hassan was diagnosed with PTSD, and he reported depressive symptoms in line with a moderate depressive episode. His pain condition started more than 10 years ago, and he describes it as worsening in the winter season. Hassan has pain symptoms in his head, neck, shoulders, breast, lower back and legs, and also suffers symptoms of pain and discomfort related to medical treatment of a somatic disease. Hassan reports having large sleep disturbances, but no financial struggles attributed to his health condition before treatment.*

Patient 6: Maryam. *Maryam is a woman in her 30s from a country in the Middle East, who has been in Norway for about a year. She is divorced and lives with her child. She has completed high school, and is currently going to school. Her family was involved in politics, and*

Maryam herself used to be politically active. When she was 5 years old, her father died and left the family to live in poverty. In her 20s, she was arrested with her daughter, held captive for 1.5 month and moved between different prisons. In prison, she and her daughter both fell somatically ill, but were refused food and medical treatment. The torture consisted of beatings with baton, falanga, deprivation, isolation, not having her own or her daughter's basic needs met, to be refused clothing, being bound and to witness the torture of others. Other traumatic experiences include several natural disasters, explosions and bombings where many of her family members were injured and killed, her daughter being in a fire accident, exposure of poisonous chemicals, threats of sexual violence and severe injury upon self and daughter. She reports to have struggled with anxiety and depressive episodes for several years before the torture, while her posttraumatic symptoms debuted after the torture. Still, she has been able to work in a human rights organization as an interpreter afterwards, while living in exile. At the time of the assessment, she fulfils the criteria for PTSD, panic disorder, recurrent depressive disorder (current episode moderate) and social phobia. In addition, she is diagnosed with fibromyalgia, somatic disease and several physical problems. Maryam has no social network in the region apart from her young daughter. Her pain condition started for 2-4 years ago and has been stable for the last year. Her pain symptoms are located in her head, chest, abdomen, hands, one knee, one foot, neck, one shoulder, upper and lower back as well as one hip. She attributes large sleep and economic difficulties to her health condition.

Procedure

After the first assessment and prior to treatment onset, two baseline recordings of pain intensity and PTSD symptoms were performed: One after 1 week, another after 3 weeks. After the baseline period, the patients received 20 sessions of NET (90 minutes each) and 10 sessions of physiotherapy (60 minutes each). Symptom recordings of PTSD and pain were assessed at the end of each treatment session. In addition, the therapists filled out a NET process form after each session, to ensure adherence and document compliance to the NET treatment manual. Post treatment, all patients went through two follow up assessments of symptoms of depression, PTSD and pain. Information about eventual changes in refugee status, marital status, living condition and social activity were also collected. The post recordings were given 3 and 6 months after ended treatment, and the 3 month follow up are labelled "post" in figures and tables for educative purposes.

Narrative Exposure Therapy (NET). The first NET session includes psychoeducation about PTSD and how the treatment works, and is adapted to each patient's individual characteristics, culture, style, abilities, etc. The patient's next of kin is given the opportunity to participate. Therapeutic metaphors are used, and highlight that the treatment may be experienced as challenging. In the second session, the therapist assists the patient in creating his/her life line: A line of rope or yarn is laid out on the floor, representing the patient's life, with the end at one side and a substantial part coiled up, representing birth and the remainder of the life, respectively. Traumatic and happy memories are briefly identified and labeled across the life line with stones (traumatic) and flowers (happy). In subsequent sessions, the narration of the patient's life begins, and the therapist will in a directive and attentive manner aid the patient in contextualizing the memories through questions and listening. The narration is re-read at the beginning of each session, and filled in with more detail or revised where necessary, and continued until present. Whenever approaching a stone, the therapist slows down and performs narrative exposure, supporting the patient in integrating the fragmented memories by putting them in context. This is continued until the anxiety is lowered, and a safe point in the story is reached. The last session consists of laying the life line once again, adding flowers representing hopes for the future and re-reading the narrative. Finally, there is a ritual where all involved sign the narrative, that is to say the patient, therapist and the eventual interpreter. Normally, NET consists of 8-10 sessions, while we in this study have doubled the number of sessions, due to the high severity level of PTSD in our sample.

Use of interpreters. All patients, except for patient 3, had an interpreter present during the therapy sessions. The same interpreter was used for all sessions.

Instruments

Sociodemographic questionnaire. A questionnaire developed to assess sociodemographic variables such as age, sex, nationality, refugee status, education level, living conditions, social network and time in Norway. The information obtained from this questionnaire was used to develop the descriptions of the patients presented above.

Clinical-Administered PTSD Scale (CAPS). The CAPS (Blake et al., 1990) is a structured interview guide based on the DSM-IV-TR, and is recognized as the gold standard for assessment of PTSD (Weathers, Keane, & Davidson, 2001). Additionally, it has convergent

validity with SCID (Foa & Tolin, 2000). It assesses all DSM-IV-TR criteria of PTSD, that is to say Criterion A to F in addition to associated features. Criterion A is exposure and response to a traumatic event. The following criteria, B to D, assess the 17 core symptoms in PTSD, where B (5 items) includes symptoms of re-experiencing, C of avoidance (2 items) and numbing (5 items), and D of hyperarousal (5 items). Further, Criterion E is about the duration and eventual delay of symptoms, while F corresponds to functional impairment. The associated features include feelings of guilt and different dissociative symptoms.

Each of the 17 symptoms is rated both for frequency and intensity, on a Likert scale from 0-4, which can be used to create a severity score for each symptom from 0-8. Furthermore, the three items on Criterion F (subjective distress and impact on social and occupational functioning) are computed into one variable. One can choose to use the CAPS dichotomously or continuously, and thus both to ascertain whether a patient meet the criteria for the PTSD diagnosis, but also to evaluate a treatment's effect on symptom development. One of the most widely used scoring is the F1/I2 rule: For a symptom to be endorsed, it has to be rated with a frequency of at least 1 and an intensity of at least 2 (Foa & Tolin, 2000; Weathers, Ruscio, & Keane, 1999). A fully diagnosis of PTSD is achieved according to the DSM-IV-TR protocol, which requires one Criterion A, and at least one symptom of Criterion B, three of Criterion C and two of Criterion D. In addition, one estimates a total severity score, where 65 or more indicates PTSD. This is called the F1/I2/TSEV65 rule (Weathers et al., 1999). Another possibility is to assess severity of PTSD within different categories based on the total severity score: 0-19 corresponds to no/few symptoms of PTSD, 20-39 to mild/subthreshold, 40-59 to moderate/threshold, 60-79 to severe and 80< as extreme PTSD (Weathers et al., 2001). In this study, we use both the dichotomous and the continuous scoring rules, thus both changes in severity level as well as in points will be described. Within this framework, a change of 15 points is used as a marker of clinical significant change. Previous clinical research with refugees (Renner, Salem, & Ottomeyer, 2006) and torture survivors (Halvorsen & Stenmark, 2010) have utilized the CAPS. The CAPS is acknowledged to have excellent psychometric properties in general (Foa & Tolin, 2000; Weathers et al., 2001), also specifically when used with torture survivors (Aker et al., 1999).

Hamilton Rating Scale for Depression (HRSD). The HRSD (Hamilton, 1960) is a clinical rating scale for assessing the severity of depression, and is acknowledged with good

psychometric properties (Traikovic et al., 2011). The scale consists of 17 items measuring the severity of depressive symptoms, as well as four items that assess the type of depression. Some items are scored on a Likert scale of 0-2, others of 0-4. Hedlund and Vieweg (1979) evaluated the HRSD as to have satisfactory psychometric properties. Still, it lacks a general consensus on how the scores should be interpreted. However, some guidelines have been proposed, where severity level corresponds to the total score; 0-3 to no depression, 4-7 to subthreshold, 8-15 to mild, 16-26 to moderate and 26< to severe depression (Furukawa, Akechi, Azuma, Okuyama, & Higuchi, 2007). To evaluate clinical significant change, Furukawa et al. (2007) proposed a 11 points change in scores, and a cut-off of 7 points for remission of depressive symptoms. In previous research on refugees and survivors of torture, the HRSD has been used to assess severity of depression (Halvorsen & Stenmark, 2010).

Mini International Neuropsychiatric Interview (M.I.N.I.). The M.I.N.I. is a structured interview manual based on the diagnostic manuals ICD-10 and DSM-IV, developed to assist clinicians in diagnostic assessments (Sheenan et al., 1998). The main benefit of this manual is its relatively time saving nature, as it is brief and easy to administer, which is preferable in clinical research trials (Sheenan et al., 1998). It is acknowledged to have good reliability (Lecrubier et al., 1997) and moderate validity (Sheenan et al., 1998). The M.I.N.I. is divided in 17 sections, based on DSM-IV axis 1 disorders in addition to the Antisocial Personality Disorder. The questions require "yes/no" answers, and use a branching tree structure for screening. In the present study, the M.I.N.I. was used to diagnose depression, and to assess eventual comorbid psychiatric diagnoses, to ensure that the patients did not meet the exclusion criteria.

The Norwegian Pain Association's Minimum Inventory for Pain Patients (NOSF-MISS). The NOSF is a self-report questionnaire that consists of a number of different validated indexes relevant for pain patients (Fredheim, Borchenvink, Landmark, Schjødt, & Breivik, 2008). It is developed to assist clinicians to assess a broad array of aspects affected for patients who suffer from chronic pain. These indexes are scored separately and according to their respective set of scoring rules. For the assessment of pain intensity, the NOSF contains three items from *Brief Pain Inventory* (BPI), which is acknowledged to have satisfactory psychometric properties (Keller et al., 2004; Klepstad et al., 2002). The BPI is reported to be sensitive to change in pain intensity, and a 2 points change is considered to be clinically significant (Fredheim et al., 2008).

One item from the BPI was used to measure pain intensity after each NET treatment session. Furthermore, two items related to sleep and economy, are included from *the European Organization for Research and Treatment of Cancer Quality of Life Questionnaire-C30 (EORTC QLQ-C30),* a questionnaire that is validated in Norway and shown to have good psychometric properties (Fredheim, Borchgrevink, Saltnes, & Kaasa, 2007). Additionally, the NOSF includes two other scales from the SF-36 *(Short Form-36),* for the measurement of physical functioning (10 items) and mental health (5 items). These are used to assess health-related quality-of-life, and a change of 10 points is proposed as an indicator of clinically significant change (Osoba, Rodrigues, Myles, Zee, & Pater, 1998). Finally, the NOSF contains two items from the *Coping Strategies Questionnaire (CSQ),* which measure catastrophizing thoughts regarding one's pain condition. This scale is validated as a screening instrument, but there are to our knowledge no published suggestions about how to interpret clinical significant change (Fredheim et al., 2008). The NOSF-MISS was administered in Norwegian, and translated by the interpreter for those not fluent in the language.

Post Traumatic Diagnostic Scale (PDS). The PDS is a brief self-report measure of PTSD symptoms developed for use in both clinical and research settings (McCarthy, 2008). It is acknowledged to have good reliability and validity, as well as diagnostic agreement with SCID (Foa, Cashman, Jaycox, & Perry, 1997). In this study, part 3 of the PDS, which consists of 17 items corresponding to the 17 core symptoms of PTSD using a Likert scale from 0-4, was administered to the patients at the baseline condition in addition to at the end of each NET treatment session, to track symptom progression throughout the treatment.

Numeric Rating Scale (NRS-11). The NRS-11 is a unidimensional measure of pain intensity, with a 0-10 verbal numeric scale, where the subjects are to indicate their perceived level of pain (Hartrick, Kovan, & Shapiro, 2003). Breivik, Björnsson, and Skovlund (2000) conclude that the NRS-11 can be used as other pain measures, whereas Hartrick et al. (2003) caution against using it in clinical trials in populations it is no validated for. To our knowledge, no specific pain measures are validated for torture survivors, and the NRS-11 is deemed superior to use when patients are not communicating in their first language (Paice & Cohen, 1997). The NRS-11 was administered at the end of each physiotherapy session.

NET Adherence and compliance. Adherence and compliance with the NET manual were rated through a self-report questionnaire, which the therapists completed after each session. This involved that they reported whether the therapeutic tasks in the manual were completed or not, how the patient responded to exposure and whether time was used on other activities or to discuss current stressors.

Data Analysis

For this design, visual analysis is recommended as the primary method, rather than the performance of statistical analyses (Kazdin, 1982). A visual analysis allows for an informal judgment of whether one can see a clear treatment effect, and will according to Parsonson and Baer (1978) reveal any treatment effect solid enough to be of importance for clinicians. However, the reliability of this method has been shown to be low to moderate (Park, Marascuilo, & Gaylord-Ross, 1990), and Brossart, Parker, Olson, and Mahadevan (2006) argue that one should use visual analysis in combination with statistical analysis, such as computing effect sizes (Busk & Serlin, 1992). Effect sizes can in this regard say something about the practical or clinical implications of the treatment, and Hedge's *g* is most suitable as it is not affected by the small sample size in this study.

Effect sizes where calculated by the following formula:

$$\text{Hedges' } g = \frac{M_1 - M_2}{SD^*_{pooled}}$$

$$SD^*_{pooled} = \sqrt{\frac{(n_1 - 1)SD_1^2 + (n_2 - 1)SD_2^2}{n_1 + n_2 - 2}}$$

where (P. D. Ellis, 2009).

According to (Cohen, 1992), an effect size of 0,2 is regarded as small, 0,5 as medium and 0,8 and above as large.

Results

Effect Sizes

In this study, effects were found for both PTSD, depression, pain, quality of life and functioning *(see table 1)*. For the sample as a whole, our results yielded large effects for avoidance/numbing symptoms, from before treatment to both follow up assessments. Medium-to-large effects were found for general PTSD symptoms, hyperarousal symptoms, functional impairment and depressive symptoms, from before treatment to both follow-up assessments. This included pain intensity, but only from pre-test to the 6 month follow-up. Medium-to-small effects were found for re-experiencing symptoms and assessor-rated global severity scores at both assessments. From the initial assessment until the final assessment, this also included sleep, economy and mental health-related quality-of-life. A small effect was found for pain intensity from the initial assessment until the first follow-up, as well as for guilt from the first to the second assessment. Finally, a negative medium-to-small effect was found for coping strategies, from the two prior assessments to the last. Most measures kept stable or experienced a further slight improvement between the two follow up assessments. In contrast, the effect on guilt was reversed and coping strategies were further worsened.

Table1

Means, Standard Deviations and Effect sizes

n=6	Pre-test		Post-test		Follow-Up		Hedge's g		
	M	*SD*	*M*	*SD*	*M*	*SD*	*Pre-post*	*Pre-Follow Up*	*Post-Follow Up*
CAPS									
Total Severity Score	80.83	18.63	60.33	25.56	54.83	31.24	**0.71**	**0.78**	0.15
Criterion B	27.67	7.71	22	10.97	20.33	12.36	0.46	0.48	0.11
Criterion C	29.50	4.76	19.67	8.52	17.67	9.42	**1.08**	**1.01**	0.17
Criterion D	23.67	7.15	18.67	8.26	16.83	10.63	0.49	**0.58**	0.15
Criterion F	8.50	1.64	6.83	1.17	6.67	3.27	**0.61**	0.47	0.04
Global severity score	3.17	0.75	2.50	0.55	2.20	1.10	0.31	0.41	0.20
Guilt	3.83	4.99	2.66	2.66	3.17	3.60	0.21	0.11	-0.21
Dissociative symptoms	1.67	1.97	1.83	3.60	1.67	3.20	-0.04	0	0.08
HRSD	18.67	4.93	14.5	5.58	13	5.66	**0.59**	**0.79**	0.20
n=5									
NOSF-MISS									
BPI	19.60	6.43	15.60	10.26	14.25	10.87	0.20	**0.52**[a]	0.10[a]
CSQ	4.80	4.55	5.00	3.55	7.00	3.65	-0.04	-0.43[a]	-0.40[a]
Physical function (SF-36)	19.80	4.82	20.40	7.20	19.00	9.20	0	0.10[a]	0.13[a]
MHI-5 (SF-36)	15.20	9.10	12.70	8.00	11.83	10.07	0.01	0.30[a]	0.07[a]
Sleep	3.50	1.00	2.75	1.89	2.75	1.50	0.04	0.37[a]	0[a]
Economy	2.50	1.91	2.50	1.29	1.75	0.96	0	0.32[a]	0.32[a]

[a] *= n=4 (Follow Up), numbers in bold are medium or large effects. CAPS = Clinician-Administered PTSD Scale for DSM-IV, HRSD = Hamilton Rating Scale for Depression, NOSF-MISS = Norwegian Pain Association-Minimum Inventory for Pain Patients, BPI = Brief Pain Inventory, CSQ = Coping Strategies Questionnaire, SF-36 = Short Form 36, MHI-5 = Mental Health Inventory - 5*

Individual Results: Visual analysis

The individual results from the pre-test assessment, 3-month follow-up and 6-month follow up, on PTSD symptoms, depressive symptoms, pain intensity and physical function are presented in figures 1-6. What emerges from a visual analysis of the individual patient data is a trend characterized by decreased PTSD symptoms, few other changes and still a persistent degree

of distress after treatment. In summary, two patients (3 and 5) have reached a relatively low level of symptom severity, two (1 and 4) have had a marked improvement but still suffer considerably, while two (2 and 6) have had unremitting symptoms. As for depression, most patients have apparently experienced a decrease, while two (1 and 2) seemingly endure continuous distress. Decreased pain and improved functioning can be seen for two patients (3 and 5), and the opposite for two others (1 and 6). Missing data precludes patient 2 and 4 from the analysis of the NOSF-MISS results. Clinically significant change, change in diagnostic status and level of severity are summarized in tables 2-5.

Fig. 1 **PATIENT 1 - SALEEM**

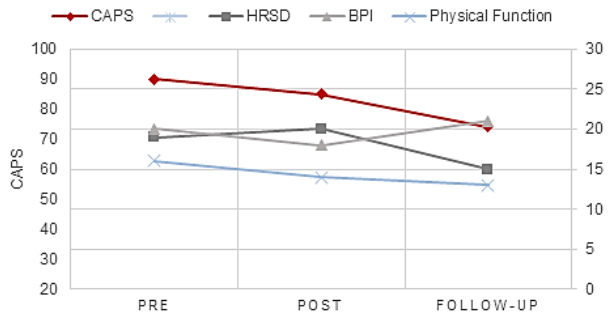


Fig. 2 **PATIENT 2 - ADAAM**

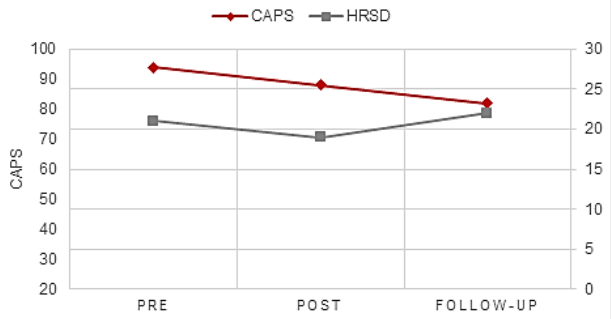


Fig. 3 **PATIENT 3 - JOSEPH**

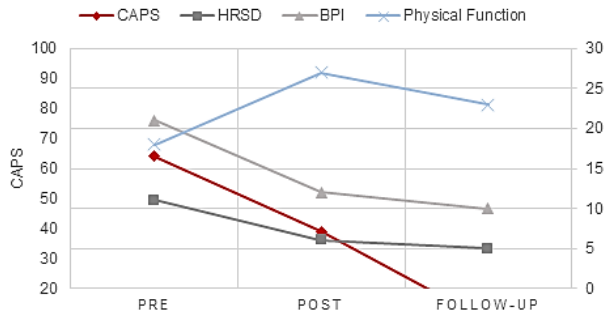


Fig. 4 **PATIENT 4 - YAQUB**

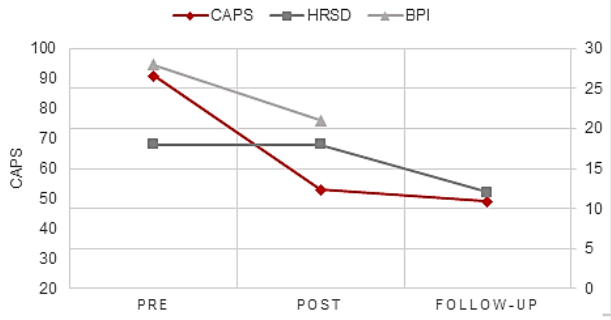


Fig. 5 **PATIENT 5 - HASSAN**

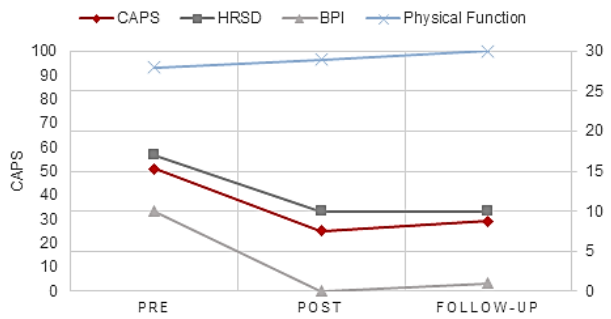
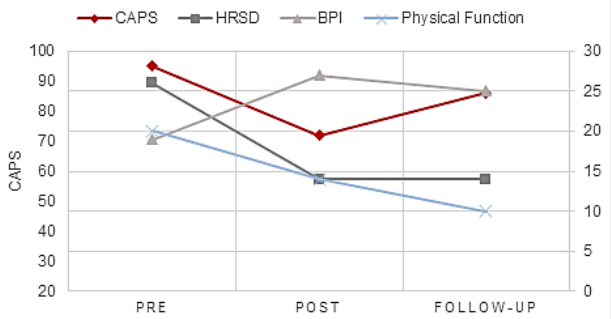
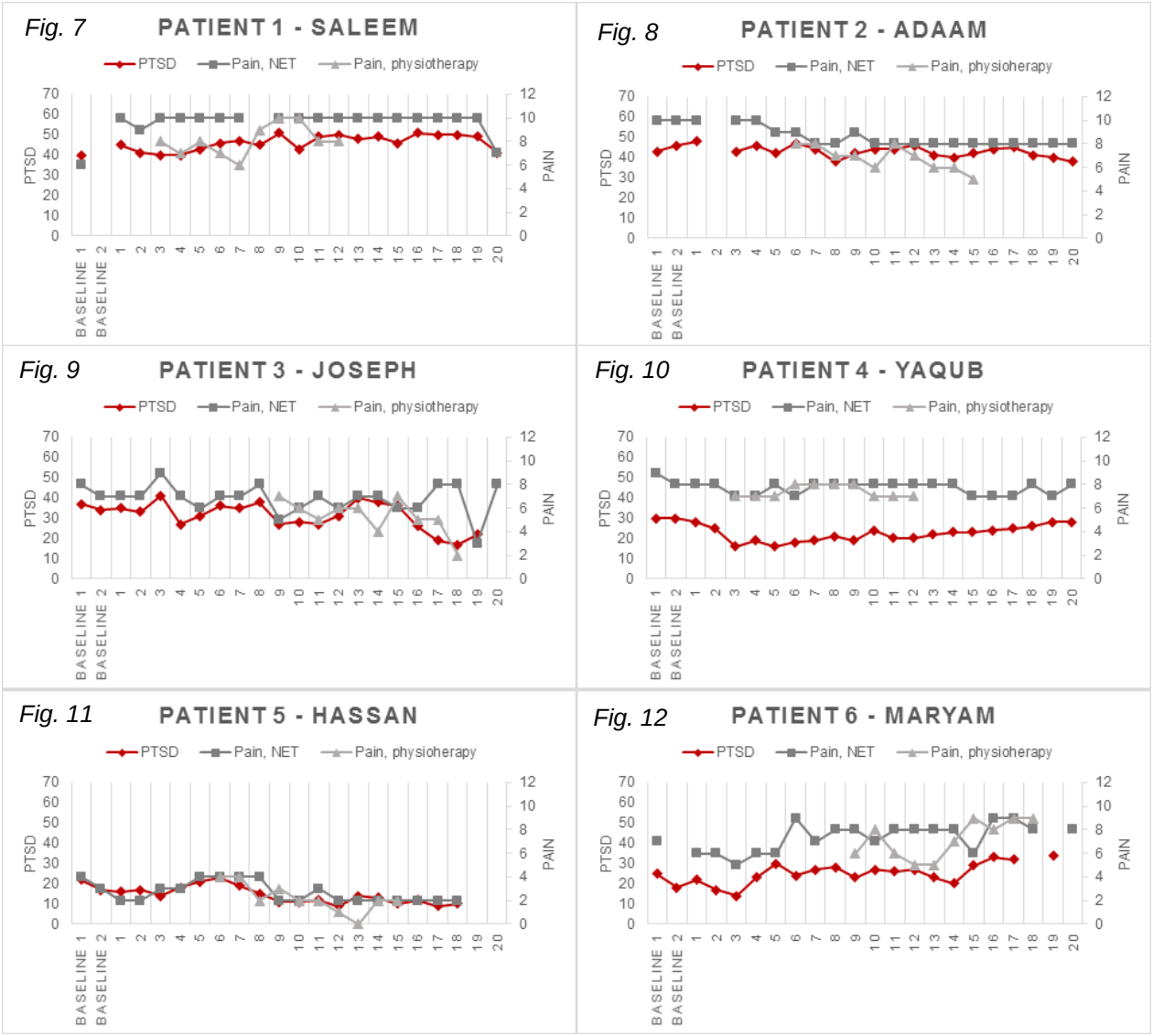


Fig. 1 **PATIENT 6 - MARYAM**



Figures 1-6. Outcomes regarding symptoms of PTSD and depression, in addition to pain intensity and physical functioning, measured prior to treatment (Pre), 3 months (Post) and 6 months (Follow-up) after ended treatment.

Course of Treatment: Clinical Descriptions



Figures 7-12. Symptom progression of symptoms of PTSD and pain intensity, measured after each NET session, as well as pain symptoms measured after each physiotherapy session.

Patient 1: Saleem *(figure 7). Overall, few treatment sessions fully complied with the NET manual, and the life line was not completed until the 6th session. Saleem is a man who talks in a*

detailed manner, and the therapist often found it challenging to moderate his flow of words as well as engaging him in exposure. Filling out baseline recordings sometimes took half of the session, and exposure often closed prematurely, as they ran out of time. Saleem frequently needed to take breaks during re-reading of the narrative, and often started to talk about politics or other subjects in the middle of exposure, leading the therapist to repeat the treatment rationale, goal and purpose. Saleem had a number of current stressors he wanted to address in therapy, including the family's living situation, his pain symptoms and physical disabilities. His physical state also made it difficult for him to sit still in the same position for longer periods.

When starting physiotherapy, Saleem was physically inactive and had some physical disabilities which impeded him in benefitting from a number of pain reducing treatments, apart from exercise in warm water (hydrotherapy) and in a sitting position. He was cooperative and motivated for the treatment. His initial skepticism towards hydrotherapy as he could not swim, ceased after a few sessions, and he enjoyed reduced pain intensity after five sessions. Still, his level of functioning did not improve much. Mid-treatment, he had surgery in a foot, which led to a relapse regarding pain intensity, as the pain increased and became worse than before starting treatment. However, the pain returned to baseline after a few further sessions. The final day he said "I feel sorry for my party fellows, as they do not receive the kind of help that I do now".

Patient 2: Adaam *(figure 8). Overall, most sessions complied with the NET manual, and the therapeutic relationship is described as being good. Some sessions included additional 5-10 minutes of relaxation exercises focusing on breathing. As Adaam is a good story-teller with a detail-rich manner of speaking, this sometimes lead to an impeded optimal activation of affect as required in exposure therapy. Although, when the therapist recurrently pointed out how this style may lead to avoidance and repeated the treatment rationale, Adaam cooperated. Adaam often wrote and lectured about his traumatic experiences, which seemed to keep him in a constant anxiety-provoking state, and the therapist attempted to raise awareness about how this might affect his condition and treatment process. In the final stages of treatment, Adaam expressed that he wanted full disability pension, because of his severe pain. He states, "This treatment has helped me see how the pieces fit together, but now I don't think there is anything left to do".*

Adaam cooperated with, and was highly motivated for the physiotherapy. He emphasized that he saw himself as a survivor of torture, not a victim. He complied with a physical exercise

program that he performed in sessions as well as at home between sessions. In addition to mastering and complying with his training program, he also engaged in hydrotherapy. Adaam's level of functioning improved, and his pain was reduced from an extreme to a moderate level of pain. His concluding remarks were "I am proud of surviving, and will manage on my own now, because you taught me what to do when in pain".

Patient 3: Joseph *(figure 9). Following completion of the lifeline within the two first sessions, Joseph experienced an increase in nightmares and flashbacks, as he became increasingly aware on how certain childhood experiences had imprinted on him. After normalization and psychoeducation around these reactions, exposure adhering to the NET manual started from session 4. In the beginning, Joseph exhibited avoidance during exposure, which manifested as him suddenly changing the topic to daily life stressors. In session 8, he reported an increase in symptom load after exposure to childhood memories, in addition to re-traumatization as he meets refugees who tell stories similar to his own through his volunteer work. Two sessions focused on reflections around these reactions, before returning to exposure. A few sessions include 10 minutes cooperation with the physiotherapist, and some focused on the process of receiving therapy; including reflections on meaning, identity and religion. Joseph states that this is the first time anyone has talked with him about his traumatic experiences, and that it is a relief to have done it.*

Joseph had a great commitment to the physiotherapy, and was eager and motivated to restore his earlier position, to be able to help others and fight injustice and poverty. He completed an exercise program in and between sessions, focusing on reducing as well as coping with his pain. The physiotherapist describes Joseph as exercising thoroughly, and that his pain level was reduced to a great extent at the same time as his functioning improved markedly. When finishing treatment, Joseph announced that "I found myself in the project, as well as the way towards becoming independent, and I now know how to ease my own pain".

Patient 4: Yaqub *(figure 10). In Yaqub's therapy sessions, the exposure was performed according to the NET manual for most sessions, and the therapeutic relationship is described as good. However, exposure was often closed prematurely or characterized by lack of activated affect in session. The therapist reported time as a hindering factor, since they seldom had time to in-depth exposure after reading through the narrative in the beginning of the sessions. Yaqub*

also arrived late a few times, adding to the time challenge. During exposure for the torture sequences, Yaqub experienced increased physical pain, but rarely displayed emotional distress. Some sessions concentrated exclusively on positive events (flowers), and a few were focused on current stressors, including the family's living situation, Yaqub's sleep problems and everyday triggers of posttraumatic symptoms. At the end of the treatment, he communicated that he did not feel that he had improved.

When starting the treatment, Yaqub was not motivated for physiotherapy and expressed lack of hope for improvement or ever being able to return to his home country. Instead of physical therapy, he wanted to focus on talking about the torture, and understanding why the torturers had localized specific body parts and targeted them with specific methods. Yaqub was anxious about hydrotherapy because of the water torture he endured, and did not meet to the first two sessions. In the third session, he complied and experienced enjoyment with activity in the warm water.

Patient 5: Hassan *(figure 11). Early in treatment, Hassan expressed ambivalence about going to treatment, but he decided to give it a try. At the same time, he is in the middle of the process of getting divorced, and 10-20 minutes of most therapy sessions focused on this process, or solicitations for statements and applications related to Hassan's living situation, school and work practice. During exposure, he sometimes experienced headaches and bodily pain, which subsequently the therapist discussed with the physiotherapist between sessions of NET and PT. Around half of the sessions complied with the NET manual, with a pause for session 7-8 as Hassan confides that he has a marijuana abuse problem. Associations between drug use, PTSD and its treatment are addressed, and the therapist offers a referral to an addiction treatment center. Hassan rejects as he believes he will manage to quit on his own. Subsequently, he complied in all sessions, but found it difficult to endure exposure in the end, as he felt most of his symptoms were gone and rather wanted to focus on his future. Some sessions were focused on religion, identity, existential issues and experienced meaning after going to therapy. Also, reflections on how his traumas are related to his and his family's current lives are the focus in one of the last sessions. At the end of treatment, Hassan had successfully ended his marijuana misuse and was working on the relationship with his wife, who was invited for the final therapy session.*

Hassan has reduced function in several joints, but is proud of his refusal of letting this hinder him in being physical active and performing his ADL activities. He was cooperative and motivated for the treatment, and had physical therapy in all 10 sessions. After treatment, his pain intensity level was halved. He expressed that he wanted to return to his home country to show that he is healthy, and described his pain symptoms as "small troubles that can't wear down a former guerilla soldier".

Patient 6: Maryam *(figure 12). In the early stages of therapy, Maryam had high compliance with NET, and was motivated for exposure. During exposure, she often exhibited avoidance, manifesting in excessive details, and did not always reach optimal activation of affect. She cooperated when the therapist corrected and repeated the treatment rationale. From the 5th session, more time (10-15 minutes most sessions, and three whole sessions) had emphasis on current stressors; Maryam had received news from her home country, where her mother had fallen seriously ill. This was especially difficult for Maryam, as she was unable to return to visit her, and she had no social network to turn to. In the 16th session, she reports increased pain and distress, as she had been involved in an accident at work, and as a consequence suffered back damage and further decreased physical function. In sessions, Maryam struggled to conceal her pain, but it was difficult for her to do so. She reported constant fatigue, was frequently cold and walking was very painful for her. Therefore, the therapist used some time to work on sitting posture, relaxation, grounding and provided blankets. Mid-therapy, Maryam expressed a wish to move to a different part of the country, where she had family and social support. The therapist helped her to arrange this, and considered the availability of social support to be of great importance for Maryam and her psychological health. At the final follow up assessment, Maryam expressed that it felt good to have talked about the traumas.*

Also in the physiotherapy sessions, Maryam was distressed because of high pain intensity in her whole body, of both musculoskeletal and rheumatic nature. Despite this, and constant fatigue and headache, she complied with and was motivated to the physical exercise program in earliest treatment sessions. However, mid-treatment she suffered a further increase in pain after the aforementioned accident.

Adherence Challenges

The therapists reported that it was sometimes challenging to keep to the treatment manual, as some of the patients had pressing needs that had to be prioritized, like help with housing applications or recurrent worries about their family. Some also received other type of help, like patient 1 who was concurrently involved in a family reunion project in the same treatment center, and patient 5 and 6 who received medical treatment. Without independent assessment of adherence, it is problematic to evaluate treatment adherence. However, in general, the adherence and compliance is considered variable, between low and moderate: For patients 2, 3, 5 and 6, adherence and compliance is evaluated as moderate, where most sessions were performed in accordance with the manual, with the exception of some time being used to discuss current stressors (3, 5 and 6) or relaxation exercises (2 and 6). For patients 1 and 4, compliance and adherence is evaluated as low, as few sessions were performed in compliance with the NET manual.

Attrition and Drop-out

Eight patients fulfilled the inclusion criteria for participation, but two was excluded from the project. One reported some psychotic symptoms in the assessment, which emerged as more pronounced than assumed when he started treatment. This patient turned up for the sessions, but did not receive NET, as stabilization was deemed appropriate. The other patient was initially skeptical to participate in the project, because of the religious affiliation of one of the therapists, however accepted it. Frequently, he did not meet for consultations, and as new appointments were scheduled, he rarely showed up. When confronted with this, he expressed a wish to continue but found it difficult to maintain a structured treatment, and the therapist decided to discontinue NET after seven no-shows. Both patients were offered a different type of treatment.

Summary of Results

Table 2
Changes in PTSD and Depression

Patient number	PTSD	Severity (total score)	Depression	Severity (total score)	CSC (CP) PTSD	CSC (CP) Depression
1						
Pre	*Yes*	Extreme(90)	*Yes*	Moderate(19)		
Post	*Yes*	Extreme(85)	*Yes*	Moderate(20)	No(5)	No(1)
Follow-up	*Yes*	Severe(74)	*Yes*	Mild(15)	Yes(16)	No(4)
2						
Pre	*Yes*	Extreme(94)	*Yes*	Moderate(21)		
Post	*Yes*	Extreme(88)	*Yes*	Moderate(19)	No(6)	No(2)
Follow-up	*Yes*	Extreme(82)	*Yes*	Moderate(22)	No(12)	No(1)
3						
Pre	*Yes*	Severe(64)	*Yes*	Mild(11)		
Post	*No*	Mild(39)	*No*	Subthreshold (6)	Yes(25)	No(5)
Follow-up	*No*	Few symptoms (9)	*No*	Subthreshold (5)	Yes(55)	No(1)
4						
Pre	*Yes*	Extreme(91)	*Yes*	Moderate(18)		
Post	*No*	Moderate(53)	*Yes*	Moderate(18)	Yes(38)	No(0)
Follow-up	*No*	Mild(49)	*Yes*	Mild(12)	Yes(42)	No(6)
5						
Pre	*No*	Moderate(51)	*Yes*	Moderate(17)		
Post	*No*	Mild(25)	*Yes*	Mild(10)	Yes(26)	No(7)
Follow-up	*No*	Mild(29)	*Yes*	Mild(10)	Yes(22)	No(0)
6						
Pre	*Yes*	Extreme(95)	*Yes*	Moderate(26)		
Post	*Yes*	Severe(72)	*Yes*	Mild(14)	Yes(23)	Yes(12)
Follow-up	*Yes*	Extreme(86)	*Yes*	Mild(14)	No(9)	Yes(12)

CSC = Clinically significant change, CP = Change in points

Table 3

Summary of results: PTSD and depression

n= 6	Pre-post	Pre-follow up
No PTSD diagnosis at follow up	3	3
Change in severity (PTSD)	4	4
Change in diagnostic status (depression)	1	1
Change in severity (Depression)	3	5
Clinically significant change (PTSD)	4	4
Clinically significant change (Depression)	1	1

Table 4

Summary of results: Pain, functioning and quality of life

n=5	Pre-post	Pre-follow up[a]
Reduction in pain experience (CSC)	3	2
Increase in pain experience (CSC)	1	1
Improved physical functioning (CSC)	1	2
Reduced physical functioning (CSC)	2	2
Improved well-being (CSC)	1	1
Reduced well-being (CSC)	0	0
Improved sleep[a]	1	1
Reduced sleep[a]	1	0
Less financial struggles[a]	1	3
More financial struggles[a]	0	0
Better coping strategies	1	1
Worse coping strategies	2	3

n=5, due to improper dating of the NOSF-MISS for patient 2 precluded the data for this patient from the dataset, [a] *n=4 as the final follow-up assessment with NOSF-MISS for patient 4 was not completed, CSC = Clinically Significant Change.*

Discussion

Evaluation of the Combination Treatment

In sum, at the group level, our study found that the treatment had effects on all symptom scales, in addition to pain and health-related quality of life *(see table 1).* In particular, large effect sizes were found for avoidance/numbing symptoms, followed by medium-to-large effects for general PTSD symptoms, hyperarousal, functional impairment and depressive symptoms. A medium effect was found for pain intensity, but only between the initial assessment and the last follow-up. As for the individual cases *(see figures 7-12),* a visual analysis of the symptom progression during the course of the treatment for these six patients does not reveal any clear trend, and there are substantial differences between the patients. Evidentially, some report a mostly steady course, while others describe a more fluctuating development – regardless of treatment response. Apparently, those who experienced lower severity at the follow-up (3 and 5) assessments also reported decreasing symptoms during the course of the treatment. Of note, two patients (4 and 6) have reported symptom relief at earlier phases of treatment, that do not appear to have been sustained at later stages. This might reflect that the therapy initially had effect, but that something happened that impeded further improvement, or that the nature of the therapy changed somehow. However, it is also possible that this initial response rather reflected measurement error or normal fluctuation in symptoms.

Despite the modest decrease in PTSD symptoms observed in tracking the PTSD symptoms session to session, half of the patients no longer met the criteria for PTSD at the 3-month follow up, and 4 out of 6 had reduced severity levels as well as experienced clinically significant change. Furthermore, this was maintained at the 6-month follow-up. Thus, the treatment effects seem to surface a while after finished treatment, where most of it is materialized 3 months after treatment, whereas slight improvement also occurs from this point and three months later. For instance, patient 4 reported not feeling better after the last NET session, but at the 6 month follow-up both his PTSD and depression are mild, and he is back to work.

As for depression, only patient 3 did not qualify for the diagnosis at follow-up, and he was also the only one with mild depression prior to treatment. In contrast, all other patients had moderate depression, and even though 5 out of 6 had decreased severity level, only patient 6 had a reduction that was classified as clinically significant. Still, at the group level, the effect on

depression was moderate, pinpointing that group level data not necessarily reflects real life improvement for individual patients, even in a small sample. As for pain experience, three patients (2, 3 and 5) have decreased pain intensity, two seems to have had no change (1 and 4) and one (6) appears to experience increased pain. In addition, we observed no differences regarding onset time of the physiotherapy in this study. The effects for pain intensity were small to moderate for the sample as a whole, however differed substantially between the patients with some having dramatic changes and others none. Even though 3 out of 5 had clinically significant pain reduction at the first follow-up, only two of them upheld these reductions 3 months later.

The effects on PTSD and depression are comparable, although somewhat smaller, to other NET studies with torture survivors, thus supporting that NET can alleviate PTSD symptoms in torture survivors (Halvorsen & Stenmark, 2010; Patel et al., 2014). Also, although we have not been able to control for confounding factors, spontaneous remission of chronic PTSD is unlikely (Halvorsen & Stenmark, 2010). Still, it cannot at this point tell us much about the additive effect of physiotherapy, or whether the increase from 10 to 20 NET sessions made any difference. Our patients experienced pain reductions as a group, but there are considerable individual differences in type of physiotherapeutic treatment received, compliance and outcome, and it was not possible to discern whether the change happened because of the physiotherapy using this study design. In sum, our study offers some promise to the potential effectiveness of a combination treatment that seems to alleviate PTSD and pain symptoms in some patients. However, as some did not improve and others dropped out of treatment, there are still many uncertainties that we need to address with further research.

Generalizability of the Treatment

The combination of NET and physiotherapy may be a promising treatment development for torture survivors with chronic pain and PTSD. However, as this study failed to illustrate an unambiguous treatment effect on PTSD and pain symptoms, we cannot conclude that it is generalizable across different clinical cases. On the contrary, our results indicate that the treatment worked for some, while not for others. Thus, it highlights the need to examine what factors influence the treatment outcome. In this regard, both identifying who might benefit from this treatment as well as those who would need something else is in order. Of course, with this research design, we cannot conclude that our patients improved because of the treatment

provided. Still, assuming that they did, we aim to discuss possible explanations for the differential outcome of our patients, as identifying what factors may mediate or moderate the outcome is of great importance for clinicians. In sum, two (3 and 5) of our patients have become much better, another two (1 and 4) have improved but still experience substantial distress and two (2 and 6) have not improved. For the sole purpose of comprehensibility, we will from here on refer to the first group as "responders", the second as "partly responders" and the third as "non-responders". One of the most intriguing questions in clinical research is "What works for whom?" (A. Roth & Fonagy, 2006). In the following, this will be the point of departure for a further discussion of our results.

PTSD. First, a possible explanation for absence of improvement of PTSD symptoms, is that lack of compliance led to that the supposed mechanisms of change was not activated in some of the therapies. Compliance and adherence issues were mainly described by the therapists of patient 1 and 4, including avoidance during exposure, lack of visible emotions and shortage of time. Apparently, compliance issues were more pertinent to the partly responders than the non-responders; thus, it might be that the partly responder would have had better outcomes if compliance and adherence improved, while the non-responders do not seem to benefit from the treatment for other reasons. If lack of compliance was a hindrance to effective treatment, it is important to find ways to increase it. Avoidance in terms of going into detailed descriptions was described as challenging in several of the cases, and can be understood as "safety behavior" from a behavioral therapy perspective (Telch & Lancaster, 2012), "experiential avoidance" in acceptance-and-commitment framework (Marx & Sloan, 2005) or "intellectualization" in the psychodynamic tradition (Messer & Warren, 1995). Either way, it is assumed to reduce activation of affect and thus impede exposure. Safety behavior is assumed a maintaining factor in anxiety disorders (Wells, 1990), and use of safety behaviors in session has been associated with reduced effect of exposure therapy (Telch & Lancaster, 2012). Activation of the fear network is assumed to be crucial in exposure therapy and avoidance impedes contextualization in NET. Thus, one suggestion to increase compliance could be to target the safety behavior specifically in treatment, especially with patients that are highly verbal, with tendencies towards intellectualization.

Another observation was that the responders had the lowest severity of PTSD prior to treatment (severe and moderate, applying Weathers' categories), whereas both the partly

responders and non-responders had extreme PTSD at treatment onset. Nevertheless, the partly responders had decreased severity levels at follow-ups. One possible explanation for this is that NET is most effective for those with lower severity of symptoms, similar to for example CBT for depression which has been found to be most effective for moderate/mild cases (Arch & Ayers, 2013). Another possibility is that our results reflect a ceiling effect, and that the treatment only has an effect up to a certain degree: Montgomery and Patel (2011) describe how improvement can be difficult to measure when patients initially report maximum levels of symptom severity. For instance, patient 4 and 5 both had approximately the same decrease in percentage, but as patient 5 had lower severity prior to treatment, he loses his diagnosis whilst patient 4 does not. Perhaps there is a dose-effect relationship between treatment and PTSD similar to that of experienced traumas and PTSD (Catani et al., 2005; Mollica et al., 1998)? In the framework of the dual processing theory, the fear networks would be more extensive in those with increased severity, and thus it might take more sessions to expose to the different traumatic memories. If this is the case, a treatment implication could be to implement intermittent therapy with time limited NET. In this way, partly responder patients like 1 and 4 could return at a later point to do another round of NET, extending the narrative and perhaps go further in decreasing their posttraumatic struggles. A hypothesis could be that patients with particular high symptom load might benefit from intermittent therapy, with stepwise symptom remission. To our knowledge, no intermittent therapy for PTSD exists, however phase-oriented therapy is used for patients with PTSD, combined with emotion regulation and interpersonal problems, and especially the STAIR-NT (Skills Training in Affective and Interpersonal Regulation) have gained some empirical support (Cloitre & Schmidt, 2015; Hassija & Cloitre, 2014).

However, the effects in this study are slightly smaller than those found in other studies, and this would not explain why the non-responders did not benefit from the treatment. In our study, what separated the non-responders from the other patients is that they have several comorbid diagnoses; they both have additional social phobia and panic disorder. Patient 6 also suffers from recurrent depressive disorder and fibromyalgia. Perhaps comorbid social phobia and/or panic disorder negatively moderate treatment, like for instance GAD does in treatment of other anxiety disorders (Wells, 1997). In fact, a group of researchers (Hinton et al., 2005; Hinton, Rivera, Hofmann, Barlow, & Otto, 2012; Hinton et al., 2006) has found support for a culturally adapted CBT for South East Asian traumatized refugees with both PTSD and panic disorder.

Another explanation could be that the comorbid disorders impede the therapeutic processes necessary for NET to work, like for example interfering with the therapeutic relationship. Alternately, these diagnoses may reflect that the PTSD symptoms have been generalized to an extent that encompasses broader areas of their lives, mental functioning and levels of anxiety. In any case, both disorders can possibly lead to social avoidance or isolation, and thus hinder social support, which is indeed a factor associated with mental health and treatment prognosis in refugees (Başoğlu et al., 1994; Emmelkamp et al., 2002; Oppedal & Idsoe, 2015; Schweitzer et al., 2006; Smyth, Siriwardhana, Hotopf, & Hatch, 2015).

A different hypothesis is that the patients comprise distinct diagnostic categories. Not only do the partly responders and non-responders have more severe PTSD, they also report inflated pain intensity after treatment compared to the responders. This is in line with earlier findings, where pain is found to moderate treatment of PTSD and vice versa. As some have suggested, comorbid pain and PTSD may constitute a special entity with shared maintaining factors, and may require distinctive treatment that targets both (Liedl & Knaevelsrud, 2008; Sharp & Harvey, 2001). Alternately, the responders may have PTSD whilst the other patients have what Elsass (1998) would label as a "torture syndrome", including depressive and somatoform reactions, incomplete emotional processing and existential dilemmas in addition to posttraumatic symptoms. In this framework, the PTSD diagnosis can explain only some of the struggles torture survivors experience, thus demanding a broader treatment approach. Moreover, opponents of using the PTSD diagnosis outside Western societies argue that the PTSD diagnosis is too narrow and ethnocentric (Chakraborty, 1991), and fails to encompass the magnitude of the traumatic effects of torture (Allodi, 1991). Indeed, if this is the case, it might explain why some patients do not respond to NET. Simply put: PTSD is an indication for NET, and if patients in reality have something else than PTSD, this may explain why they do not respond to NET. Regardless, scientific inquiry into finding effective treatment for those who do not benefit from current approaches is in order. Finally, Silove (2003) states that current stressors might impede recovery. In fact, patient 6 showed improvement in PTSD early in therapy which subsequently declined and instead was aggravated. The aggravation concurred in time with her receiving news of her mother's serious disease in her home country, and worries about being able to visit her. Of note, about the same time she had a work-related accident, a fall, which led to increased pain and reduced mobility and functioning. In addition, one patient was not included in the study because

of the toll the difficult situation in his home country put on him. In sum, this illustrates how avoidance may lead to lack of compliance to the NET manual, comorbid anxiety disorders or PTSD severity level may moderate treatment outcome, the patients may belong to distinct diagnostic categories, or that post-migratory factors, such as current stressors, might hinder effective trauma focused therapy to take place.

Depression. The lack of effect on depression might be explained by NET's targeting of pre-migratory factors with less emphasis on current, post-migratory stressors (Nickerson et al., 2011) or maintaining factors (Matthews & Wells, 2004) that are more associated with depressive symptoms. Actually, therapy with patient 6 was the one that focused most on current stressors: She received help to implement an important change in her living situation, and she was also the only one who experienced clinically significant change in depression. After finishing treatment, she received help from her therapist to move closer to her family in a different part of the country, and it is possible that this change in social support, and reduction of social isolation, brought about the observed reduction in depressive symptomatology. This highlights a point described by clinicians working with refugees (Elsass, 1998); that current stressors can be of higher priority for the patient, and that there often are extratherapeutic issues to be worked through that can be of big importance. In fact, almost all therapies (maybe except for 2 and 3) addressed housing difficulties which may be reflected in the reduced financial struggles reported. As a diminished stressor, this financial and living situation improvement may indirectly have contributed to reduced distress. On the other hand, current stressors might be understood as "therapy-disturbing factors", which implies that stabilization must be in place for effective trauma-treatment to take place. On the other hand, NET has indeed been found to be effective in refugee camps even under instable conditions (Neuner et al., 2008; Neuner, Schauer, Klaschik, et al., 2004). Saying this, it might be that the social support in a refugee camp differs from what one might experience in a foreign culture as a refugee, with limited social contact and family networks.

Pain. Notably, those who reported the most favorable outcomes on the PTSD symptom scale also achieved the lowest levels of pain at both follow-up assessments, in addition to improved physical functioning. In contrast, those with least improvement reported a steady or aggravated course of pain intensity, accompanied by a slight decrease in physical functioning.

For instance, Patient 6 suffered an accident mid-treatment, and subsequently reported increased physical complaints and pain.

These results can be interpreted in a number of ways: First, as postulated elsewhere in the literature, pain may moderate the treatment outcome of PTSD (Asmundson, 2014). However, patient 3 was the one with the highest pain score prior to treatment, and also the one with the largest symptom reduction both for PTSD and pain. Second, that pain and PTSD share mutually maintaining factors, as postulated by Sharp and Harvey (2001): These factors include attentional biases, anxiety sensitivity, trauma-reminders, avoidance, depression, reduced activity levels, pain perception and cognitive demand that limit the use of adaptive strategies. They suggest that exposure should be combined with cognitive therapy and working with coping strategies. Indeed, an increase in negative coping mechanisms was found at the group level in this study. Also, patients 1, 2 and 6 reported reduced mobility prior to treatment, which could impede physical activity and thus successful treatment. A third possibility might be that the responders experienced pain reduction as an indirect effect of successful PTSD treatment, mediated by reduced depression, as according to the R. S. Roth et al. (2008) model. In this vein, unsuccessful PTSD treatment is a hinder for reduction in depression, and indirectly pain, in addition to improved functioning. In our study, this seems to hold for the two responders where the improvement on PTSD and pain align, but not the other patients. Fourth, outcome may depend on interactions between different levels of pain intensity and PTSD symptom clusters, as in Clapp et al. (2008)'s synergistic model. Currently, we do not know how this model fits with torture survivors, but an interesting hypothesis could be that different pain characteristics moderate PTSD and its treatment differently. Knowledge about such interactional effects between symptom clusters and levels of pain could help us sophisticate the timing of our interventions. A final hypothesis apply to the availability of effective physiotherapeutic intervention, that is to say that effective physiotherapy moderate, or make possible, PTSD treatment outcome. The small sample size precludes this study from answering this question, especially owing to the fact that the six patients received differential treatment methods for different physical conditions. In theory, if we implemented effective physiotherapy treatment using the same design as in this study we should have detected a consistent pattern where pain intensity decreased at its onset, regardless of whether it started after the 3rd, 6th or 9th NET session. Despite the growing knowledge base regarding torture (for an overview; Amris & Prip, 2000a), the development of

guidelines on the subject (Amris & Prip, 2000b) and clinical experience with survivors (CVT, 2014), no systematic studies have proven the effectiveness for physiotherapy with this group. Also, despite some generalized findings on the consequences of torture – as generalized dysfunctional pain modulation (Defrin et al., 2014), and that different torture methods lead to different health outcomes – the current understanding and treatment guidelines are variable (Holten et al., 1995). With this in mind, it is possible that the responders had pain conditions that were more treatable than the others were. What is more, since they had less mobility problems it is possible that they were better able to make use of the physiotherapeutic tasks. In fact, the responders were described as complying with their physical therapy without hindrance, whereas particularly patient 1 and 6 had physical disabilities which impeded them from performing parts of the recommended treatment. We can surely expect that many future torture patients will have physical disabilities; we therefore need to be able also to provide physiotherapy this group may benefit fully from. In sum, our study did not find a clear effect of the physiotherapy for torture survivors; but highlights the need for further research in this population: Both clinical trials with physiotherapy to find effective treatment strategies, and studies that broaden our understanding of pain in torture survivors.

Quality of life and functioning. In this study, the effect on functional impairment attributed to posttraumatic symptoms was medium, whereas no effect was found for physical functioning or quality of life, except for a small effect between the pre-test and the final follow up assessment. In fact, only one patient had clinically significant improved quality of life. Moreover, two patients reported improved physical functioning, but another two seem to have reduced physical functioning. One reported improved sleep, one reduced sleep and half of the patients reported less financial worries at the final follow-up. Economic struggles may have decreased as a result of improved housing situations, as this was frequently targeted in these therapies. Otherwise, in general, the patients in this study have not experienced much improvement in quality of life or functioning. However, the impaired functioning and subjective distress attributed to posttraumatic symptoms appear to be reduced, corresponding to the decrease in symptom load. As such, this approach seems to be more effective in reducing symptoms than improving functioning and quality of life. This is contrary to the notion (R. S. Roth et al., 2008), that assumes that successful reduction of PTSD symptoms will lead to improved functioning and quality of life. However, a recent Cochrane review reported that no clinical trials with torture

survivors has reported effects on these measures, and usually the only effects found are within trials with CBT or NET, that tend to report reduced PTSD symptoms and general emotional distress (Patel et al., 2014).

According to Montgomery and Patel (2011), quality of life and functioning indexes are more appropriate outcome measures than symptom scales, thus current treatment approaches are not successful in achieving this. According to Clapp et al. (2008), there are indications of a synergistic relationship between PTSD, pain and quality of life, and a deeper understanding of such interactions in the context of torture survivors could enhance our ability to tailor better treatment strategies. With reference to physiotherapy, experienced physiotherapists working with torture survivors have developed a treatment program that does not focus on decreased pain intensity, but rather being able to "live an active life despite pain and limitation of physical function" (Amris & Prip, 2000b, p. 112). Within this framework, our use of BPI as an outcome measure is inappropriate. Also, as the indexes used in this study are not validated for use with refugee torture survivors, they may be inadequate, as use of quality of life measures outside the samples they were initially testes can be problematic with regard to cross-cultural validity (Corless, Nicholas, & Nokes, 2001). Therefore, it is of utmost importance to develop and validate instruments we can use in clinical research in this population.

Limitations of the Study

This study has a number of methodological limitations. First, using an A-B case series design and its accompanied small sample size impedes generalization to other populations, even though our results fit with those of earlier studies (Halvorsen & Stenmark, 2010; Patel et al., 2014). Second, lack of control group, only two baseline measures and no control of eventual parallel pharmacotherapy makes it difficult to assess whether the effects found are the consequence of the treatment provided, and not owing to common factors (Benish, Imel, & Wampold, 2008), regression to the mean (Galton, 1886) or spontaneous remission (Krogsbøll, Hróbjartsson, & Gøtzsche, 2009). Therefore, our results should be interpreted with great caution, while still acknowledging that spontaneous recovery is unlikely after chronic struggles at the extent the patients in this study suffered (Halvorsen & Stenmark, 2010). Third, our results may be prone to selection bias, as the attrition in this study comprised almost one third of the whole sample, and the inclusion of these patients might have led to larger or smaller effects. Fourth, the

questionnaires were administered by an interpreter, for all but one patient, which could further compromise the reliability. Fifth, the validation of the instruments might be limited by cultural factors (Corless et al., 2001), as they are not validated in refugee populations (Patel et al., 2014). Sixth, the NOSF-MISS is developed primarily for clinical use (Fredheim et al., 2008), and may be unsatisfactory for research on torture survivors who may require more sophisticated and meticulous instruments. Seventh, there was a lack of independent evaluation of adherence and compliance, thus the therapist self-report is susceptible to bias (Higgins & Altman, 2008).

In general, the scientific quality of the existing evidence regarding treatment of torture survivors has been evaluated as low (Patel et al., 2014). At the same time, there are ethical considerations that sometimes compromise methodology. For instance, it is deemed unethical to randomly assign torture survivors to a wait-list control. Also, the common practice of abandoning parallel treatment during clinical trials is problematic, and it is thus challenging to study the isolated effect of NET and physiotherapy as multidisciplinary interventions often are unavoidable. However, with regard to external validity it might be unlikely to have an exclusive focus on traumas without taking current stressors into account. Furthermore, complexities in the nature of what we study should not discourage scientific exploration. Despite its limitations, this study is original in its aim to couple physiotherapy with NET, and demonstrates that some torture survivors that suffer high symptom loads can achieve good outcomes when working parallel with traumas and pain. It highlights the complexities regearding assessment and treatment of torture survivors, exemplifies the point that no treatment works for all patients, and provides hypotheses as for why that might be. Our hope is that it stimulates further research, that will enable further sophistication of rehabilitation strategies for torture survivors.

Future Research

Our propositions include systematic clinical trials to evaluate treatment effectiveness for torture survivors, both for existent trauma-focused therapy within an intermittent framework as well as physiotherapy. If effective physiotherapy moderate PTSD treatment outcome, we need to identify what impedes it, and find innovative solutions as to how we can circumvent those obstacles as well as examine which treatment methods are most effective. One way to do this, could be to be inspired by a recent Danish study in a treatment center for tortured refugees, where patients underwent assessment before and after treatment, and their therapists registered the

particular psychotherapeutic techniques implemented after each session (Buhmann et al., 2015). If incorporated into regular practice and accomplished for a longer period, this cumulative database could enable us to examine relationship between different methods, moderating variables and treatment outcomes. Furthermore, continued exploration of how PTSD and pain interact, also specifically applied in the context of torture survivors is endorsed. As different pain characteristics may moderate PTSD and its treatment differently, an interesting study aim could be to examine how for instance neurogenic, muscoloskeletal and psychosomatic pain is related to PTSD symptoms clusters and its treatment. In addition, we encourage studies that investigate other moderating variables, such as comorbid diagnoses, using individual component analyses. Also, the search for the existence of a torture syndrome or PTSD subtypes is advised, and if found, the subsequent investigation of whether these have differing treatment outcomes. Appreciating individual differences and how they affect treatment can provide valuable insight, and inform clinicians working with torture survivors. This could enable us to discern those who might benefit from NET from those who would need something else.

Summary and Conclusions

In this study, we have evaluated a novel treatment approach coupling narrative exposure therapy with physiotherapy for torture survivors suffering from chronic pain and PTSD. It adds to existent reviews supporting NET's effect on posttraumatic symptoms in this group, but further research, with more meticulous design, is required to answer how the physiotherapy influence treatment outcome. Furthermore, we have discussed the generalizability of this combination treatment, through a series of six different cases. We conclude that this treatment seems to help some patients, whereas others might benefit from alternative approaches. In summary, the patients in this study report different outcomes regarding symptom severity, pain intensity, level of functioning and quality of life. We have observed differences in compliance and adherence to the treatment, particularly related to avoidance in sessions. In addition, in the small set of cases, there appear to be effects of events external to the therapy that might interact with symptom levels, including comorbid diagnoses and daily life stressors. At this point, we need to consider all these aspects as we plan larger studies and attempt to address the above-mentioned hypotheses. No treatment works for everyone, and finding what works for whom is among the most important questions we ask in clinical research.

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Appendices

Forespørsel om å delta i et vitenskapelig prosjekt:

«Narrativ Eksponeringsterapi og fysioterapi for tortur overlevere»

Bakgrunn og formål

Mange som har opplevd mishandling og tortur sliter med senskader, hvor det typiske er en kombinasjon av fysiske og psykiske symptomer. Selv om en vet en del om vanlige reaksjoner etter slike hendelser er det gjort lite systematisk forskning om behandling. Ved St. Olavs Hospital er det tidligere gjort en studie om hjelp til torturoverlevere, hvor resultatene indikerer at behandlingen hjelper. Nå ønsker vi i en ny studie å tilpasse behandling enda bedre, da særlig med fokus på både kroppslige smerter og psykisk ubehag. Du inviteres til å ta del i studien fordi du har oppgitt å ha både psykiske plager og smerter etter å ha opplevd grov mishandling. Studien organiseres og ledes av Ressurssenter om vold, traumatisk stress og selvmordsforebygging, Region Midt (RVTS MIDT), St. Olavs Hospital. Prosjektet er godkjent av Regional komité for medisinsk forskningsetikk.

Hva deltakelse innebærer

Deltakere i studien vil utredes med intervju, spørreskjema og fysioterapeutisk undersøkelse før behandling, samt tre måneder og seks måneder etter behandling. Selve behandlingen vil bestå av samtaler med en terapeut i opp til 20 ganger (hver samtale vil være på ca. 90 minutter), samt 10 konsultasjoner med fysioterapeut. Etter hver behandlingstime vil du også fylle ut et kort skjema om opplevelse samtalen og av smerteopplevelse. Skulle du ikke ønske å være med i studien underveis, vil du få ordinær behandling ved samme arbeidssted.

Potensielle fordeler og ulemper

Deltakelse i studien vil i utgangspunktet sikre deg en kombinert psykologisk behandling og fysioterapi. Denne behandlingen har vi indikasjoner på at vil være gunstig for psykiske plager etter alvorlig mishandling, selv om det er gjort lite forskning på dette området. Du vil få en grundig utredning av både psykiske og fysiske plager. Den psykologiske behandlingen vil medføre at en snakker inngående om den tidligere mishandlingen og vil kunne være slitsomt, hvor en kan kjenne på angst og behag knyttet til de vonde opplevelsene. Dette anses likevel å være en viktig del av det å få det bedre i ettertid. Skulle du få plager knyttet til behandlingen kan du når som helst kontakte prosjektleder Håkon Stenmark (telefon 90862914) eller koordinator for Faggruppe Flyktninger i RVTS-Midt, Solveig Gravråkmo (telefon 97757512).

Hva vil skje med innsamlet informasjon?

Informasjonen fra intervju, fysiologisk undersøkelse, spørreskjema og behandling vil oppbevares i et låsbart skap ved RVTS-Midt, hvor bare autoriserte prosjektmedarbeidere har tilgang. Alle prosjektmedarbeidere har taushetsplikt i henhold til hfl., Paragraf 7. All informasjon vil bare brukes i henhold til studiens formål. Alle data vil behandles uten at navn, personlig identifikasjons nummer eller andre direkte gjenkjennbare kjennetegn brukes. Etter studiens slutt i desember 2013 vil data anonymiseres helt. Anonymisert informasjon vil danne grunnlag for beskrivelser av behandlingsforløp, hvor dette vil brukes i undervisning og vitenskapelig publikasjoner. Av kontrollhensyn vil grunnlagsdata bli oppbevart forsvarlig fram til 1.1.2018. Deretter vil data bli slettet. Det er prosjektleder Håkon Stenmark som er ansvarlig for datamaterialet i denne perioden. Instanser som kan tenkes å kontrollere grunnlagsmaterialet er for eksempel forskningsansvarlige, Uredelighetsutvalget for forskning og Helsetilsynet.

Frivillig deltakelse

Deltakelse i studien er frivillig. Du kan trekke deg fra deltakelse når som helst i løpet av studien uten å oppgi en spesiell grunn. Dette vil heller ikke ha noen konsekvens for til tilbud om ordinær behandling. Hvis du ønsker å delta så skriv under på samtykke erklæringen på bunnen av arket. Hvis du har noen spørsmål om studiet kan du kontakte prosjektleder, Håkon Stenmark, ved Ressurssenter om vold, traumatisk stress og selvmordsforebygging, Region Midt, 7030 Trondheim. Tlf: 90862914.

Samtykke:

Jeg har lest informasjonen ovenfor, og har hatt anledning til å stille spørsmål. Jeg samtykker til å delta i prosjektet.

Underskrift: .....

Jeg bekrefter å ha gitt tilstrekkelig informasjon om prosjektet:

Underskrift, behandler:.....

Registreringsskjema for deltakelse i forskningsprosjekt

Pasient:.....

Fødelsdato:.....

Dato:.....

1. Tolk? ja □ nei □

Hvis ja, språk.....

Oppmøte tolk □ Skjermtolk □ Telefontolk □

2. Kjønn, sett kryss Kvinne □ Mann □
3. Alder, angis i fylte år ved inntak:.....
4. Hjemland.....
5. Religiøs tilknytning.....
6. Utdanning? Sett kryss på høyest fullførte.

   Ingen formell utdannelse.....□

   Elementary school.....□

   Yrkesskole/fagbrev.....□

   Videregående.....□

   Universitetet.....□
7. Sivilstand? (sett kryss)
   - □ Gift
   - □ Ugift
   - □ Separert
   - □ Skilt
   - □ Enke /-mann
8. Bosituasjon (sett kryss)
   - □ Mottak
   - □ Leilighet
   - □ Hos familie (ikke egen bolig)
   - □ Hospits eller lignende
   - □ Annet
9. Pasienten bor for tiden sammen med? (sett kryss)
   - □ Ingen
   - □ Samboer
   - □ Samboer/ektefelle med barn

10. Tid vært i Norge.....

11. Hvor mange har pasienten kontakt med av venner/bekjente i løpet av 14 dager? (skole/jobb ikke inkludert)

- ☐ Ingen
- ☐ 1-2
- ☐ 3-5
- ☐ 6-8
- ☐ Mer enn 8

12. Hvilken flyktningestatus har pasienten i Norge? (sett et kryss)

- ☐ Kvoteflyktning
- ☐ Asylsøker
- ☐ Familiegjenforening
- ☐ Politisk asyl innvilget
- ☐ Opphold på humanitært grunnlag
- ☐ Både asyl og oppholdstillatelse avslått
- ☐ I dekning
- ☐ Kirkeasyl

13. Hva er pasientens nåværende hovedbeskjeftigelse?

- ☐ Lønnet arbeid, minst halv tid (angi yrke).....
- ☐ Arbeidsforberedende tiltak
- ☐ Språkkurs
- ☐ Studier (høyskole/universitet)
- ☐ Skole
- ☐ Hjemmeværende, halv tid eller mer
- ☐ Ingen beskjeftigelse
- ☐ Annet (beskriv)

Presentert problem

14. Hva oppgir pasienten selv som viktigste grunn(er) til å komme i behandling? Kryyss av for de(n) aller viktigste grunn(ene)

Somatiske problemer:

- ☐ Hodesmerter
- ☐ Andre smerter, beskriv.....
- ☐ Andre somatiske problemer, beskriv.....

Psykologiske problemer:

- ☐ Tristhet/nedstemthet
- ☐ Savn
- ☐ Angst/frykt
- ☐ Søvnforstyrrelser
- ☐ Suicidalproblemer
- ☐ Mareritt/gjenopplevelse
- ☐ Problemer med aggresjonskontroll
- ☐ Relasjonsproblemer
- ☐ Paranoide/hallusinatoriske problemer

Sosiale problemer:

- ☐ Familieproblemer
- ☐ Problem ift. Hjelpeapparatet
- ☐ Problem ift. Norske myndigheter for øvrig
- ☐ Problem ift. Rase/diskriminering
- ☐ Isolasjon/ensomhet
- ☐ Familiegjenforeningsproblematikk

Annet:

- ☐ Andre problemer

  Beskriv

  .....

UTDRAG FRA "MEDICAL PHYSICAL EXAMINATION OF ALLEGED TORTURE VICTIMS "a practical guide to the Istanbul Protocol - for MEDICAL DOCTORS

Arr som ligger nær et ledd kan forårsake kontraktur, nedsatt bevegelighet i leddet og smerter ved aktivitet.

Informasjon om posisjonen til offeret og torturistene under tortur er spesielt viktig, samt informasjon om formen av instrumenter i kontakt med huden.

I tilfeller med ingen eller ukarakteristiske lesjoner, kan en karakteristisk historie være den eneste støtte til påstanden om tortur, som for eksempel i noen tilfeller av elektrisk tortur.

- Historie om ikke-torturrelaterte arr

Undersøkelsen bør omfatte hele kroppens overflate for å oppdage tegn på:

- Hudsykdommer
- Ikke-tortur relaterte skader/lesjoner

Tortur relatert skade

1. Beskrivelse av hudskader
- Lokalisering; (bruk kroppens figur) Symmetriske, asymmetriske
- Form; rund, oval, lineær, osv.
- Størrelse: (bruk linjal)
- Farge
- Overfalte: skjellete, sprø, ulcerøs, bulløse, nekrotisk
- Periferien: regelmessig eller uregelmessig, sone i periferien
- Avgrensning: kraftig, dårlig
- Nivå i forhold til omkringliggende hud: atrofisk, hypertrofisk, flat
2. Stump traume
3. Skarp traume: f.eks. bruk av barberhøvel, kniv eller bajonett
4. Termiske skader: brenne med sigarett, varme instrumenter eller varm væske.
5. Etsende skader
6. Elektriske skader
7. Hudsykdommer: psoriasis eller lichen planus i traumatisert området, som en "Koebner reaksjon"

Mulig lesjoner i muskel- og skjelettsystemet etter fysisk tortur:

1. Bløtvev skader
2. Muskeltonus: den normale (ubevisste) spenningen i en hvilende muskel. Motstanden i vevet mot deformasjon\formforandring. Variasjon i denne motstanden er referert til som muskler tone eller muskelspenninger (hyper eller hypo)
3. Strekning/økt av bevegelses grad
4. Ømme og triggerpunkter
5. Muskel- og senebetennelser
6. Ligaments skader
7. Bein skader

Kliniske undersøkelser ved;

A- OPPHENING ETTER ARMENE:

- Undersøkelse av skulderfunksjonen: passiv og aktiv ROM, leddstabilitet, funksjon av tilbehør til skulderledd inkludert scapula funksjonen.
- U.s. av bløt vev: muskel lindring, ømme og triggerpunkter, senebetennelser, skulder impingement "inneklemming" "pinch"
- Nevrologiske u.s.: muskelstyrke, senerefleks grundig u.s. av sensibilitet, inkludert vibrerings sans, posisjonelle følelsen, to punkt diskriminering og berøring, smerte og termosensasjon

B- FALANGA:

- inspeksjon og palpasjon av bløtvev, av føttene, hæl sålen, plantarfascien "sålbuen"
- Vurdering av funksjon i føtter og gangefunksjonen.
- Undersøkelse av bløtvev og leddene i under ekstremiteter.
- Nevrologisk u.s.

C- NEVROLOGISK: (som følge av å slå hode; hodepine, voldsom rystelse, kaste ned fra høyde).

- Subdural blødning
- Cerebral ødema
- Retina/Netthinnens rikelig blødning fra ruptured blodkar
- Akutt perifer nervesymptomer som følge av håndjern eller stramt tau ved håndleddet. Skade på nerven brachialis plexus, særlig den nedre roten har vært rapportert etter opphenging med huden/bløt vev. "Palestinske opphenging" fører til skade på plexus brachialis, som medfører til lammelse eller tap av følelse i armene.
- Mye av langvarige symptomer som tap av konsentrasjon, hodepine, hukommelses forstyrreleser svimmelhet/vertigo. Mange av disse symptomene er også relatert til PTSD.

D- Andre systemer:

1. **Hjerte og Lunge**; akutt symptomer som dyspnè/pustebesvær, kronisk bronkitt, brystsmerter, hoste, opphoste og hjertebank.
2. **Gastrointestinal** /mage; (som følge av f.eks. innsetting av fremmedlegme inn i anus, forstoppelse, smerte, blødning)

- U.s. av sprekker kan være uspesifikke funn da de kan forekomme av andre normale situasjoner, men den kan også være bevis for penetrering/inntrengning.
- Rektal væske med eller uten blødning
- Hudmerker
- Pussaktig/verkholdig utflod
- forstyrrelse av hans rurale mønster kan manifestere seg som glatt vifteformet arrdannelse. Når disse arrene er sen ute av midtlinjen, kan det være en indikasjon på penetrasjons traume.

3. **UROLOGISK**: (som følge av å slå mot nyreregionen eller urinrøre eller pung/testiklene, blåmerker og hevelse i og eller rundt nyrene, blod i urinen, atrofi av testiklene)
4. **Øre nese og hals**: slå øre eller hodet kan forårsake hørselstap eller nedsatt hørselsevne, øresus, brudd i nesebein, brudd i kjevebein, brudd i maxilla

5. **Øye**

6. **Gynekologisk**

Registreringsark ved Narrativ Eksponeringsterapi

1. time

Pasient nr.: _____
Dato: _____

Psykoedukasjon

Informert om vanlige traumeettervirkninger. Normalisert disse?	JA	NEI
Fortalt om naturlig reaksjon i forhold til de vanskeligste livshendelsene, med unngåelse av tanker/følelser/snakke om ting relatert til hendelse?	JA	NEI
Vise til forskning om effekt av det å gjennomgå hendelsene i detalj, med tanker og følelser. Normalisere det at dette vil være vanskelig, forberede på at ubehag vil komme opp.	JA	NEI
Snakke om hva å gjøre når ubehag kommer opp. Tegne angstkurve.	JA	NEI

Livslinje

Utformet livslinje?	JA	NEI
Fått med både positive og negative hendelser:	JA	NEI
Cirka tid brukt på livslinje: _____		
Startet gjennomgang fra barndom av?	JA	NEI
Laget skisse av livslinjen etterpå, for bruk i senere timer (hvis brukt tau, steiner/blomster)?	JA	NEI

Startet gjennomgang

Starte fortelling fra helt liten av?	JA	NEI
Fokusert på noen positive minner også?	JA	NEI

Hvis gjennomgang av traumatisk hendelse

Gått i detalj om hendelsen?	JA	NEI
Fokusert på handling, tanker og følelser?	JA	NEI
Framkom det synlige følelser under gjennomgang?	JA	NEI
Ble det avbrutt gjennomgang før hendelsen var fortalt gjennom?	JA	NEI

Hvis ja, hvorfor?

_____

_____

Fokus på problemer knyttet til livssituasjon

Inneholdt samtalen vesentlige deler med fokus på nåværende situasjon?	JA	NEI

Hvis ja, hvor mye av samtalen? _____

Andre kommentarer:

_____

_____

Registreringsark ved Narrativ Eksponeringsterapi

2. time

Pasient nr.: _____
Dato: _____

Livslinje (Hvis ikke gjort i 1 time)

Utformet livslinje?	JA	NEI
Fått med både positive og negative hendelser:	JA	NEI
Cirka tid brukt på livslinje: _____		
Startet gjennomgang fra barndom av?	JA	NEI
Laget skisse av livslinjen etterpå, for bruk i senere timer (hvis brukt tau, steiner/blomster)?	JA	NEI

Gjennomlesning av narrativ fra forrige time

Ferdigskrevet narrativ fra første time?	JA	NEI
Lest gjennom narrativ fra forrige time?	JA	NEI
Stoppet opp ved uklarheter/feil?	JA	NEI
Fortsatt bearbeiding av traumehendelse som arbeidet med i forrige time?	JA	NEI

Startet gjennomgang

Starte fortelling fra helt liten av? (Hvis ikke gjort i 1 time)	JA	NEI
Fokusert på noen positive minner også?	JA	NEI
Fortsatt der avsluttet i forrige time?	JA	NEI

Ved gjennomgang av traumatisk hendelse

Gått i detalj om hendelsen?	JA	NEI
Fokusert på handling, tanker og følelser?	JA	NEI
Framkom det synlige følelser under gjennomgang?	JA	NEI
Ble det avbrutt gjennomgang før hendelsen var fortalt gjennom?	JA	NEI

Hvis ja, hvorfor?

_____

_____

Fokus på problemer knyttet til livssituasjon

Inneholdt samtalen vesentlige deler med fokus på nåværende situasjon?	JA	NEI

Hvis ja, hvor mye av samtalen? _____
Andre kommentarer:

_____

_____

Registreringsark ved Narrativ Eksponeringsterapi

3 – 20 time

Time nr: _____
Pasient nr.: _____
Dato: _____

Gjennomlesning av narrativ fra forrige time

Ferdigskrevet narrativ fra forrige time før denne timen starter?	JA	NEI
Lest gjennom narrativ fra forrige time?	JA	NEI
Stoppet opp ved uklarheter/feil?	JA	NEI
Fortsatt bearbeiding av traumehendelse som arbeidet med i forrige time?	JA	NEI

Gjennomgang

Fortsatt der avsluttet i forrige time?	JA	NEI

Ved gjennomgang av traumatisk hendelse

Gått i detalj om hendelsen?	JA	NEI
Fokusert på handling, tanker og følelser?	JA	NEI
Framkom det synlige følelser under gjennomgang?	JA	NEI
Ble det avbrutt gjennomgang før hendelsen var fortalt gjennom?	JA	NEI

Hvis ja, hvorfor?

_____
_____

Fokus på problemer knyttet til livssituasjon

Inneholdt samtalen vesentlige deler med fokus på nåværende situasjon?	JA	NEI

Hvis ja, hvor mye av samtalen? _____
Andre kommentarer:

_____
_____

Name: _____

Date: _____

Post-traumatic stress symptoms and pain over the last week

Below is a list of problems that people might sometimes have after having experienced a traumatic event. Read each one carefully and circle the number (0-3) that best describes how often this problem has bothered you THIS LAST WEEK.

	0 Not at all or only once 1 Once in the week or less often/once in a while 2 Two to four times in the week/half of the time 3 Five or more times in the week/almost all the time	
(1)	0 1 2 3	You have disturbing thoughts or pictures of the traumatic event which are evoked in your mind when you don't want them to be
(2)	0 1 2 3	You have terrible dreams or nightmares about the traumatic event
(3)	0 1 2 3	You relive the traumatic event, act or feel as if it is happening again
(4)	0 1 2 3	You are emotionally upset when you are reminded of the traumatic event (for example: afraid, angry, sad, guilt-ridden, etc.)
(5)	0 1 2 3	You have physical reactions when you are reminded of the traumatic event (for example: sweat heavily, have heart palpitations, etc.)
(6)	0 1 2 3	You try not to think about, talk about or have feelings in connection with the traumatic event
(7)	0 1 2 3	You try to avoid activities, people or places that remind you of the traumatic event
(8)	0 1 2 3	You are not capable of remembering an important part of the traumatic event
(9)	0 1 2 3	You have much less interest in or participate much less in important activities
(10)	0 1 2 3	You are distanced or cut off from persons around you
(11)	0 1 2 3	You are emotionally numb (for example: not able to cry or feel love and care)
(12)	0 1 2 3	You feel that your plans for or hope for the future will not be realized (for example: that you won't have a career, get married, have children or have a long life)
(13)	0 1 2 3	You have trouble falling asleep or sleeping soundly
(14)	0 1 2 3	You feel irritable or have sudden outbursts of anger

(15)	0 1 2 3	You have difficulties concentrating (for example: fall in and out of conversations, lose the thread in stories on television, forget what you have read)
(16)	0 1 2 3	You are over alert (for example check to see who is around you, are uncomfortable with your back to the door, etc.)
(17)	0 1 2 3	You are jumpy or easily frightened (for example when someone approaches you from behind)

Please tick the box with the number that best indicates how strong pain you have felt on average during the last week

1	2	3	4	5	6	7	8	9	19
No pain									Worst pain imaginable

National Center for PTSD

Kliniker-administrert PTSD-skala for DSM-IV

Navn: _____ ID-nr.: _____

Intervjuer: _____ Dato: _____

Studie: _____

Dudley D. Blake, Frank W. Weathers, Linda M. Nagy,
Danny G. Kaloupek, Dennis S. Charney og Terence M. Keane

National Center for Posttraumatic Stress Disorder

Behavioral Science Division – Boston VA Medical Center
Neurosciences Division – West Haven VA Medical Center

Revidert juli 1998

Kriterium A. Personen har vært utsatt for en traumatiske hendelse der både 1 og 2 var til stede:

1. **Personen opplevde, var vitne til eller ble konfrontert med én eller flere hendelser som innebar faktisk eller fare for død eller alvorlig skade, eller innebar en fysisk trussel for personen eller andre.**
2. **Personens reaksjon innebar intens frykt, hjelpeløshet eller redsel. Merk: Hos barn kan dette bli uttrykt som uorganisert eller utagerende atferd.**

Jeg skal stille deg spørsmål om vanskelige eller belastende ting som mennesker noen ganger kan oppleve. For eksempel hvis man er med i en alvorlig ulykke, brann, storm, jordskjelv, blir ranet, slått ned eller angrepet med våpen, eller blir tvunget til å ha sex når du ikke vil selv. Jeg kommer til å begynne med å be deg se gjennom en liste med slike opplevelser og krysse av for det som gjelder deg. Hvis noen av dem gjelder deg, kommer jeg til å be deg kort beskrive hva som skjedde med deg og hva du følte da.

Det kan være vanskelig å huske noen av disse opplevelsene, eller de kan få deg til å huske vonde minner eller følelser. Mange synes det hjelper å snakke om det, men det er helt opp til deg å bestemme hvor mye du vil fortelle meg. Hvis du føler deg oppskaket eller ukomfortabel underveis, er det fint om du sier fra, slik at vi kan roe det hele ned og snakke om det. Hvis du har spørsmål eller det er noe du ikke forstår, er det også fint om du sier fra til meg. Er det noe du vil spørre om før vi starter?

BRUK SJEKKLISTEN, SE GJENNOM OG SPØR OM INNTIL TRE HENDELSER. HVIS DET ER MER ENN TRE HENDELSER, BESTEM HVILKE TRE DU SKAL SPØRRE OM (F.EKS. FØRSTE, VERSTE ELLER NYLIGSTE HENDELSE, DE TRE VERSTE HENDELSENE, INTERESSANT TRAUME PLUSS TO AV DE ANDRE VERSTE HENDELSENE OSV.).

HVIS DET IKKE ER KRYSSET AV FOR NOEN HENDELSE PÅ LISTEN: *(Har du noen gang opplevd å være i livsfare eller blitt alvorlig skadet?)*

HVIS NEI: *(Har du noen gang opplevd å være i situasjoner der du var i fare for å kunne dø eller bli alvorlig skadet, selv om du ikke faktisk ble skadet?)*

HVIS NEI: *(Har du noen gang vært vitne til at noe slikt har skjedd med andre eller funnet ut at noe slikt har skjedd med noen av dine nærmeste?)*

HVIS NEI: *(Hva er de mest oppskakende opplevelsene du har hatt?)*

HENDELSE nr. 1

Hva skjedde? *(Hvor gammel var du? Hvem andre var involvert? Hvor mange ganger skjedde det? Var du i livsfare? Ble du alvorlig skadet?)*	*Beskriv (f.eks. type hendelse, offer, gjerningsmann, alder, frekvens):*
Hvordan reagerte du følelsesmessig? *(Ble du svært redd eller skremt? Engstelig? Hjelpeløs? Hvordan? Var du lamslått eller i sjokk slik at du ikke følte noe som helst? Hvordan var det? Hva la andre merke til ved hvordan du reagerte følelsesmessig? Hva med etter opplevelsen – hvordan reagerte du følelsesmessig da?)*	A. (1) *Livsfare?* NEI JA [Selv ___ Andre ___] *Alvorlig skade* NEI JA [Selv ___ Andre ___] *Fysisk trussel* NEI JA [Selv ___ Andre ___] A. (2) *Intens redsel/hjelp/frykt?* NEI JA (*under*___ *etter*__) *Kriterium A oppfylt?* NEI MULIGENS JA

HENDELSE nr. 2

Hva skjedde? *(Hvor gammel var du? Hvem andre var involvert? Hvor mange ganger skjedde det? Var du i livsfare? Ble du alvorlig skadet?)*	*Beskriv (f.eks. type hendelse, offer, gjerningsmann, alder, frekvens):*
Hvordan reagerte du følelsesmessig? *(Ble du svært redd eller skremt? Engstelig? Hjelpeløs? Hvordan? Var du lamslått eller i sjokk slik at du ikke følte noe som helst? Hvordan var det? Hva la andre merke til ved hvordan du reagerte følelsesmessig? Hva med etter opplevelsen – hvordan reagerte du følelsesmessig da?)*	A. (1) *Livsfare?* NEI JA [Selv ___ Andre ___] *Alvorlig skade* NEI JA [Selv ___ Andre ___] *Fysisk trussel* NEI JA [Selv ___ Andre ___] A. (2) *Intens redsel/hjelp/frykt?* NEI JA (*under*___ *etter*__) *Kriterium A oppfylt?* NEI MULIGENS JA

HENDELSE nr. 3

Hva skjedde? *(Hvor gammel var du? Hvem andre var involvert? Hvor mange ganger skjedde det? Var du i livsfare? Ble du alvorlig skadet?)*	*Beskriv (f.eks. type hendelse, offer, gjerningsmann, alder, frekvens):*
Hvordan reagerte du følelsesmessig? *(Ble du svært redd eller skremt? Engstelig? Hjelpeløs? Hvordan? Var du lamslått eller i sjokk slik at du ikke følte noe som helst? Hvordan var det? Hva la andre merke til ved hvordan du reagerte følelsesmessig? Hva med etter opplevelsen – hvordan reagerte du følelsesmessig da?)*	A. (1) *Livsfare?* NEI JA [Selv ___ Andre ___] *Alvorlig skade* NEI JA [Selv ___ Andre ___] *Fysisk trussel* NEI JA [Selv ___ Andre ___] A. (2) *Intens redsel/hjelp/frykt?* NEI JA (*under*___ *etter*__) *Kriterium A oppfylt?* NEI MULIGENS JA

Gjennom resten av samtalen vil jeg at du skal ha (HENDELSER) i bakhodet mens jeg stiller deg noen spørsmål om hvordan det kan ha påvirket deg.

Jeg skal stille til sammen rundt 25 spørsmål. De fleste er delt i to. Først vil jeg spørre deg om du noen gang har hatt et bestemt problem, og hvis du har det, hvor ofte i den siste måneden (uken). Deretter vil jeg spørre deg i hvor stor grad dette har ført til ubehag eller stress for deg.

Kriterium B. Den traumatiske hendelsen gjenoppleves stadig på en eller flere av disse måtene:

1. (B-1) Gjentatte og plagsomme minner om hendelsen, deriblant bilder, tanker eller følelser. **Merk:** Hos små barn kan det forekomme gjentakende lek der deler av traumet uttrykkes.

Frekvens	*Intensitet*	*Sist uke*
Har du noen gang hatt uønskede erindringer om (HENDELSEN)? Hvordan er de? *(Hva husket du?)* [HVIS UKLART:] *(Kom de mens du var våken, eller bare i drømmer?)* [UTELAT HVIS ERINDRINGER BARE SKJEDDE I DRØMMER] *Hvor ofte har du hatt disse erindringene den siste måneden (uken)?* 0 Aldri 1 En eller to ganger 2 En eller to ganger i uken 3 Flere ganger i uken 4 Daglig eller nesten hver dag ***Beskrivelse/Eksempler***	**I hvor stor grad har disse minnene ført til ubehag eller plager for deg? Klarte du å glemme dem og tenke på noe annet?** *(Hvor vanskelig var det å få til det?)* **I hvor stor grad påvirket de hverdagen din?** 0 Ingen 1 Mild. Svakt ubehag og liten innvirkning på hverdagen. 2 Moderat. Noe ubehag tydelig til stede, men overkommelig. Noe innvirkning på hverdagen. 3 Alvorlig. Svært stort ubehag, vanskeligheter med å bli kvitt minner. Tydelig innvirkning på daglige gjøremål. 4 Ekstrem. Lammende ubehag, klarer ikke å bli kvitt minner, klarer ikke å opprettholde daglige gjøremål. ***QV (spesifiser)*** _____	*F* _____ *I* _____ ***Sist måned*** *F* _____ *I* _____ *Sx: J N* ***I løpet av livet*** *F* _____ *I* _____ *Sx: J N*

2. (B-2) Gjentatte opprørende drømmer om hendelsen. **Merk:** Hos barn kan det forekomme skremmende drømmer med ugjenkjennelig innhold.

Frekvens	*Intensitet*	*Sist uke*
Har du noen gang hatt ubehagelige drømmer om (HENDELSEN)? Beskriv en typisk drøm. *(Hva skjer i drømmene?)* **Hvor ofte har du hatt slike drømmer den siste måneden (uken)?** 0 Aldri 1 En eller to ganger 2 En eller to ganger i uken 3 Flere ganger i uken 4 Daglig eller nesten hver dag ***Beskrivelse/Eksempler***	**I hvor stor grad har disse drømmene ført til ubehag eller plager for deg? Har du våknet av drømmene noen gang?** [Hvis JA:] *(Hva skjedde da du våknet? Hvor lang tid tok det før du greide å sovne igjen?)* [HØR ETTER OPPLEVELSER OM OPPVÅKNINGER I FRYKT, SKRIKING, UTAGERENDE MARERITT] *(Påvirket drømmene dine noen andre? Hvordan?)* 0 Ingen 1 Mild. Svakt ubehag, våknet ikke nødvendigvis. 2 Moderat. Noe ubehag, våknet oppskaket, men sovnet raskt igjen. 3 Alvorlig. Svært stort ubehag, vanskelig å få sove igjen. 4 Ekstrem. Lammende ubehag, klarte ikke å få sove igjen. ***QV (spesifiser)*** _____	*F* _____ *I* _____ ***Sist måned*** *F* _____ *I* _____ *Sx: J N* ***I løpet av livet*** *F* _____ *I* _____ *Sx: J N*

3. (B-3) Atferd eller følelser som om den traumatiske hendelsen blir gjentatt (deriblant en følelse av å gjenoppleve hendelsen, illusjoner, hallusinasjoner og dissosiative flashback-opplevelser, også de som forekommer ved oppvåkning eller i påvirket tilstand). **Merk:** Hos barn kan det forekomme traumespesifikk utagering.

Frekvens	*Intensitet*	*Sist uke*
Har du noen gang plutselig oppført deg eller følt som om (HENDELSEN) skjer igjen? *(Har du noen gang hatt flashback om [HENDELSEN]?) [HVIS UKLART:] (Skjedde dette mens du var våken, eller bare mens du drømte?) [UTELAT HVIS BARE I DRØMMER]* **Fortell mer om det. Hvor ofte har det skjedd den siste måneden (uken)?** 0 Aldri 1 En eller to ganger 2 En eller to ganger i uken 3 Flere ganger i uken 4 Daglig eller nesten hver dag *Beskrivelse/Eksempler*	**I hvor stor grad virket det som om (HENDELSEN) skjedde igjen?** *(Var det uklart for deg hvor du faktisk var eller hva du gjorde når det skjedde?)* **Hvor lenge varte det? Hva gjorde du mens det skjedde?** *(La andre personer merke til hvordan du oppførte deg? Hva sa de?)* 0 Ingen gjenoppleving 1 Mild. Noe mer virkelig enn bare å tenke på hendelsen. 2 Moderat. Tydelig, men transient dissosiativ kvalitet, fremdeles svært oppmerksom på omgivelsene, som ved dagdrømming. 3 Alvorlig. Sterkt dissosiativ (rapporterer om bilder, lyder, lukter), men var noe oppmerksom på omgivelsene. 4 Ekstrem. Fullstendig dissosiativ (flashback), ikke oppmerksom på omgivelsene, mulig ikke-responderende, mulig hukommelsestap for episoden (blackout). *QV (spesifiser)* _____	*Sist uke* *F* _____ *I* _____ *Sist måned* *F* _____ *I* _____ *Sx: J N* *I løpet av livet* *F* _____ *I* _____ *Sx: J N*

4. (B-4) Intens psykologisk ubehag ved utsettelse for interne eller eksterne signaler som symboliserer eller ligner på en del av den traumatiske hendelsen.

Frekvens	*Intensitet*	*Sist uke*
Har du noen gang blitt følelsesmessig opprørt når noe minnet deg om (HENDELSEN)? *(Har noe noen gang utløst vonde følelser som har å gjøre med [HENDELSEN]?)* **Hvilken type påminnelse gjorde deg opprørt? Hvor ofte har det skjedd den siste måneden (uken)?** 0 Aldri 1 En eller to ganger 2 En eller to ganger i uken 3 Flere ganger i uken 4 Daglig eller nesten hver dag *Beskrivelse/Eksempler*	**I hvor stor grad ble du opprørt av (PÅMINNELSEN)? Hvor lenge varte det? I hvor stor grad hadde det innvirkning på hverdagen din?** 0 Ingen 1 Mild. Minimalt ubehag og liten innvirkning på hverdagen. 2 Moderat. Noe ubehag tydelig til stede, men overkommelig. Noe innvirkning på hverdagen. 3 Alvorlig. Betydelig ubehag, markert innvirkning på daglige gjøremål. 4 Ekstrem. Lammende ubehag, klarer ikke å opprettholde daglige gjøremål. *QV (spesifiser)* _____	*Sist uke* *F* _____ *I* _____ *Sist måned* *F* _____ *I* _____ *Sx: J N* *I løpet av livet* *F* _____ *I* _____ *Sx: J N*

5. (B-5) Fysiologiske reaksjoner ved utsettelse for interne eller eksterne signaler som symboliserer eller ligner på en del av den traumatiske hendelsen.

Frekvens	*Intensitet*	*Sist uke*
Har du noen gang hatt fysiske reaksjoner når noe minnet deg om (HENDELSEN)? *(Har kroppen noen gang reagert på en eller annen måte når noe minnet deg om [HENDELSEN]?)* **Kan du gi meg noen eksempler?** *(Fikk du hjertebank eller endret pusten seg? Svettet du, eller følte deg stiv eller skjelven?)* **Hva slags påminnelser utløste disse reaksjonene? Hvor ofte har det skjedd den siste måneden (uken)?** 0 Aldri 1 En eller to ganger 2 En eller to ganger i uken 3 Flere ganger i uken 4 Daglig eller nesten hver dag ***Beskrivelse/Eksempler***	**Hvor sterk var (FYSISK REAKSJON)? Hvor lenge varte det?** (Varte det også etter at du var ute av situasjonen?) 0 Ingen fysisk reaksjon. 1 Mild. Minimal reaksjon. 2 Moderat. Fysisk reaksjon tydelig til stede. Kan bli opprettholdt hvis eksponeringen fortsetter. 3 Alvorlig. Markert fysisk reaksjon, opprettholdt i løpet av eksponeringen 4 Ekstrem. Voldsom fysisk reaksjon, opprettholdt selv etter at eksponeringen er slutt. *QV (spesifiser)* _____	***Sist uke*** *F* _____ *I* _____ ***Sist måned*** *F* _____ *I* _____ *Sx: J N* ***I løpet av livet*** *F* _____ *I* _____ *Sx: J N*

Kriterium C. Vedvarende unngåelse av stimuli som er assosiert med traumet, og lammelse av generell respons (ikke til stede før traumet), vist ved tre (eller flere) av følgende:

6. (C-1) Forsøk på å unngå tanker, følelser eller samtaleemner som er assosiert med traumet.

Frekvens	*Intensitet*	*Sist uke*
Har du noen gang prøvd å unngå å tenke på eller prøvd å unngå følelser som er knyttet til (HENDELSEN)? *(Hva slags tanker eller følelser har du prøvd å unngå?)* **Har du prøvd å unngå å snakke med andre om det?** *(Hvorfor?)* **Hvor ofte har det skjedd den siste måneden (uken)?** 0 Aldri 1 En eller to ganger 2 En eller to ganger i uken 3 Flere ganger i uken 4 Daglig eller nesten hver dag ***Beskrivelse/Eksempler***	**I hvor stor grad prøvde du å unngå (TANKER/FØLELSER/SAMTALER)?** *(Hva gjorde du? Hva med alkohol, medikamenter eller narkotika?)* [TA MED ALLE FORSØK PÅ UNNGÅELSE, OGSÅ DISTRAKSJON, UNDERTRYKKELSE OG BRUK AV ALKOHOL/NARKOTIKA] **I hvor stor grad hadde det innvirkning på hverdagen din?** 0 Ingen 1 Mild. Minimalt forsøk, liten eller ingen innvirkning på daglige gjøremål. 2 Moderat. Enkelte forsøk, unngåelse absolutt til stede. Noe innvirkning på gjøremål. 3 Alvorlig. Betydelige forsøk, tydelig unngåelse, markert innvirkning på gjøremål eller engasjement i aktiviteter som en unngåelsesstrategi. 4 Ekstrem. Voldsom fysisk reaksjon, opprettholdt selv etter at eksponeringen er slutt. *QV (spesifiser)* _____	***Sist uke*** *F* _____ *I* _____ ***Sist måned*** *F* _____ *I* _____ *Sx: J N* ***I løpet av livet*** *F* _____ *I* _____ *Sx: J N*

7. **(C-2)** Forsøk på å unngå aktiviteter, steder eller personer som innebærer en påminnelse om traumet.

Frekvens	*Intensitet*	*Sist uke*
Har du noen gang prøvd å unngå visse aktiviteter, steder eller personer som minnet deg om (HENDELSEN)? *(Hva prøvde du å unngå? Hvorfor?)* **Hvor ofte har det skjedd den siste måneden (uken)?** 0 Aldri 1 En eller to ganger 2 En eller to ganger i uken 3 Flere ganger i uken 4 Daglig eller nesten hver dag ***Beskrivelse/Eksempler***	**I hvor stor grad prøvde du å unngå (AKTIVITETER/STEDER/PERSONER)?** *(Hva gjorde du i stedet?* **I hvor stor grad hadde det innvirkning på hverdagen din?** 0 Ingen 1 Mild. Minimalt forsøk, liten eller ingen innvirkning på daglige gjøremål. 2 Moderat. Enkelte forsøk, unngåelse absolutt til stede. Noe innvirkning på gjøremål. 3 Alvorlig. Betydelige forsøk, tydelig unngåelse, markert innvirkning på gjøremål eller engasjement i aktiviteter som unngåelsesstrategi. 4 Ekstrem. Drastisk forsøk på unngåelse, ute av stand til å fortsette aktiviteter, eller overdrevent engasjement i enkelte aktiviteter som unngåelsesstrategi. ***QV (spesifiser)*** _____	***F*** _____ ***I*** _____ ***Sist måned*** ***F*** _____ ***I*** _____ ***Sx: J N*** ***I løpet av livet*** ***F*** _____ ***I*** _____ ***Sx: J N***

8. **(C-3)** Kan ikke minnes en viktig side ved traumet

Frekvens	*Intensitet*	*Sist uke*
Har du hatt vansker med å huske viktige sider ved (HENDELSEN)? Fortell mer om det. *(Mener du at du burde være i stand til å huske dette? Hvorfor tror du at du ikke husker?)* **Hvor stor del av de viktige sidene ved (HENDELSEN) har du hatt vansker med å huske den siste måneden (uken)?** *(Hvilke deler husker du?)* 0 Ingen. Husker hendelsen klart 1 Få sider av hendelsen huskes ikke (mindre enn 10 %) 2 Noen sider av hendelsen huskes ikke (ca. 20–30 %) 3 Mange sider ved hendelsen huskes ikke (ca. 50–60 %) 4 Det meste av hendelsen huskes ikke (mer enn 80 %) ***Beskrivelse/Eksempler***	**Hvor vanskelig var det å huske viktige sider ved (HENDELSEN)?** *(Klarte du å huske mer hvis du konsentrerte deg?)* 0 Ikke vanskelig. 1 Mildt. Litt vanskelig å huske. 2 Moderat. Noe vanskelig, kunne huske ved konsentrasjon. 3 Alvorlig. Svært vanskelig å huske selv ved konsentrasjon. 4 Ekstremt. Fullstendig ute av stand til å huske viktige sider ved hendelsen. ***QV (spesifiser)*** _____	***Sist uke*** ***F*** _____ ***I*** _____ ***Sist måned*** ***F*** _____ ***I*** _____ ***Sx: J N*** ***I løpet av livet*** ***F*** _____ ***I*** _____ ***Sx: J N***

9. (C-4) Markert avtakende interesse eller deltakelse i betydningsfulle aktiviteter.

Frekvens	*Intensitet*	*Sist uke*
Har du mistet interessen for aktiviteter som du pleide å like? *(Hva slags aktiviteter har du mistet interesse for? Er det noe du ikke gjør i det hele tatt lenger? Hvorfor?* [UTELAT VED INGEN MULIGHET, VED FYSISK HEMMET, ELLER VED UTVIKLINGS-MESSIG PASSENDE ENDRING I AKTIVITETER] **Hvor mange aktiviteter har du vært mindre interessert i den siste måneden (uken)?** *(Hva liker du fremdeles å gjøre?)* **Når begynte du å miste interessen på denne måten?** *(Etter [HENDELSEN]?)* 0 Intet tap av interesse. 1 Få aktiviteter (færre enn 10 %) 2 Noen aktiviteter (ca. 20–30 %) 3 Mange aktiviteter (ca. 50–60 %) 4 De fleste aktiviteter (flere enn 80 %) ***Beskrivelse/Eksempler***	**I hvor stor grad mistet du interessen?** *(Ville du ha likt [AKTIVITETENE] hvis du kom i gang?)* 0 Intet tap av interesse 1 Mild. Noe tap av interesse, ville antakelig hatt glede av dem etter å ha kommet i gang. 2 Moderat. Absolutt tap av interesse, men har fremdeles noe glede av aktiviteter. 3 Alvorlig. Markert tap av interesse i aktiviteter. 4 Ekstrem. Fullstendig tap av interesse, deltar ikke lenger i aktiviteter. ***QV (spesifiser)*** _____ **Traumerelatert?** 1 Absolutt 2 Muligens 3 Lite trolig Nåtid ____ I løpet av livet ____	***Sist uke*** *F* _____ *I* _____ ***Sist måned*** *F* _____ *I* _____ *Sx: J N* ***I løpet av livet*** *F* _____ *I* _____ *Sx: J N*

10. (C-5) Følelse av å være på avstand eller fremmed overfor andre.

Frekvens	*Intensitet*	*Sist uke*
Har du følt deg på avstand eller avskåret fra andre? Hvordan var det? Hvor mye av tiden i den siste måneden (uken) har du følt det slik? Når begynte du å føle det på denne måten? *(Etter [HENDELSEN]?)* 0 Ikke i det hele tatt 1 Liten del av tiden (mindre enn 10 %) 2 Noe av tiden (ca. 20–30 %) 3 En god del av tiden (ca. 50–60 %) 4 Det meste av eller hele tiden (mer enn 80 %) ***Beskrivelse/Eksempler***	**Hvor sterke var følelsene av å være på avstand eller avskåret fra andre?** *(Hvem føler du deg nærmest? Hvor mange kan du snakke om personlige ting med?)* 0 Ingen følelse av å være på avstand eller avskåret fra andre. 1 Mild. Føler seg av og til "ikke helt med" i forhold til andre. 2 Moderat. Følelse av avstand klart til stede, men føler fremdeles samhørighet med andre. 3 Alvorlig. Markert følelse av å være på avstand eller avskåret fra de fleste andre. Kan føle samhørighet med en eller to personer. 4 Ekstrem. Føler seg fullstendig på avstand eller avskåret fra andre. Ingen nærhet med noen. ***QV (spesifiser)*** _____ **Traumerelatert?** 1 Absolutt 2 Muligens 3 Lite trolig Nåtid ____ I løpet av livet ____	***Sist uke*** *F* _____ *I* _____ ***Sist måned*** *F* _____ *I* _____ *Sx: J N* ***I løpet av livet*** *F* _____ *I* _____ *Sx: J N*

11. (C-6) Begrenset utvalg av affekter (f.eks. ikke i stand til å ha kjærlige følelser)

Frekvens	*Intensitet*	*Sist uke*
Har du noen gang følt deg følelsesmessig nummen eller hatt vanskeligheter med å føle følelser som kjærlighet eller lykke? Hvordan opplevde du det? *(Hvilke følelser hadde du vanskeligheter med å føle?)* **Hvor ofte har du følt det slik den siste måneden (uken)? Når hadde du vanskeligheter med å føle (FØLELSER)?** *(Etter [HENDELSEN]?)* 0 Ikke i det hele tatt 1 Liten del av tiden (mindre enn 10 %) 2 Noe av tiden (ca. 20–30 %) 3 En god del av tiden (ca. 50–60 %) 4 Det meste av eller hele tiden (mer enn 80 %) ***Beskrivelse/Eksempler***	**Hvor store vanskeligheter hadde du med å føle (FØLELSER)?** *(Hva slags følelser kunne du fremdeles føle? [TA MED OBSERVASJONER AV UTVALG AV FØLELSER UNDER SAMTALEN]* 0 Ingen følelse av å være følelsesmessig nummen. 1 Mild. Liten følelse av å være følelsesmessig nummen. 2 Moderat. Nummenhet klart til stede, men kan likevel føle de fleste følelser. 3 Alvorlig. Markert nummenhet for minst to primærfølelser (f.eks. kjærlighet, lykke). 4 Ekstrem. Føler seg fullstendig uten følelser. ***QV (spesifiser)*** _____ **Traumerelatert?** 1 Absolutt 2 Muligens 3 Lite trolig Nåtid ____ I løpet av livet ____	***F*** _____ ***I*** _____ ***Sist måned*** ***F*** _____ ***I*** _____ ***Sx: J N*** ***I løpet av livet*** ***F*** _____ ***I*** _____ ***Sx: J N***

12. (C-7) Følelse av forkortet fremtid (f.eks. venter ikke å ha karriere, ekteskap, barn eller et langt liv)

Frekvens	*Intensitet*	*Sist uke*
Har du noen gang følt at det ikke er nødvendig å planlegge fremtiden, at fremtiden din på en eller annen måte vil bli forkortet? Hvorfor er det slik? [UTELUKK REALISTISKE RISIKOER SOM LIVSTRUENDE MEDISINSKE TILSTANDER] **Hvor mye av tiden i den siste måneden (uken) har du følt det slik? Når begynte du å føle det på denne måten?** *(Etter [HENDELSEN]?)* 0 Ikke i det hele tatt 1 Liten del av tiden (mindre enn 10 %) 2 Noe av tiden (ca. 20–30 %) 3 En god del av tiden (ca. 50–60 %) 4 Det meste av eller hele tiden (mer enn 80 %) ***Beskrivelse/Eksempler***	**Hvor sterk var følelsen av at fremtiden din vil bli forkortet?** *(Hvor lenge tror du at du kommer til å leve? Hvor overbevist er du at du vil dø for tidlig?)* 0 Ingen følelse av en forkortet fremtid. 1 Mild. En svak følelse av en forkortet fremtid. 2 Moderat. Følelse av en forkortet fremtid absolutt til stede, men ingen bestemt oppfatning av livslengde. 3 Alvorlig. Markert følelse av en forkortet fremtid. Kan ha en bestemt oppfatning av livslengde. 4 Ekstrem. Overveldende følelse av en forkortet fremtid, overbevist om en for tidlig død. ***QV (spesifiser)*** _____ **Traumerelatert?** 1 Absolutt 2 Muligens 3 Lite trolig Nåtid ____ I løpet av livet ____	***F*** _____ ***I*** _____ ***Sist måned*** ***F*** _____ ***I*** _____ ***Sx: J N*** ***I løpet av livet*** ***F*** _____ ***I*** _____ ***Sx: J N***

Kriterium D. Vedvarende symptomer på økt aktivering (ikke til stede før traumet), vist ved to (eller flere) av følgende:

13. (D-1) Vanskeligheter med å falle i søvn eller med å sove.

Frekvens	***Intensitet***	***Sist uke***
Har du hatt problemer med å falle i søvn eller sove? Hvor ofte i den siste måneden (uken)? Når begynte du å få søvnproblemer? *(Etter [HENDELSEN]?)*	**Hvor stort var søvnproblemet?** *(Hvor lang tid tok det før du sovnet? Hvor ofte våknet du i løpet av natten? Våknet du ofte tidligere enn du ville? Hvor mange timer totalt sov du hver natt?)*	***F*** _____ ***I*** _____
0 Aldri 1 En eller to ganger 2 En eller to ganger i uken 3 Flere ganger i uken 4 Daglig eller nesten hver dag	0 Ingen søvnproblemer. 1 Mild. Tar litt/minimalt lengre tid å sovne. 2 Moderat. Absolutt søvnforstyrrelser, tydelig lengre innsovningsperiode, eller klare vanskeligheter med å fortsette å sove (30–90 minutters tap av søvn)	***Sist måned*** ***F*** _____ ***I*** _____
Problemer med å fortsette med å sove? J N	3 Alvorlig. Mye lengre innsovningsperiode eller markerte vansker med å fortsette å sove (90 minutter til 3 timers tap av søvn).	***Sx: J N***
Våkne i løpet av søvnen? J N	4 Ekstrem. Svært lang innsovningsperiode eller dyptgående problemer med å fortsette å sove (mer enn 3 timers tap av søvn).	***I løpet av livet***
Våkne tidlig om morgenen? J N		***F*** _____
Total antall timer søvn per natt? _____		***I*** _____
Ønsket antall timer søvn per natt: _____	***QV (spesifiser)*** _____	***Sx: J N***
	Traumerelatert? 1 Absolutt 2 Muligens 3 Lite trolig	
	Nåtid ____ I løpet av livet ____	

14. (D-2) Irritabilitet eller raseriutbrudd

Frekvens	***Intensitet***	***Sist uke***
Har du noen gang følt deg spesielt irritabel eller uttrykt sterkt sinne? Kan du gi meg noen eksempler? Hvor ofte i den siste måneden (uken)? Når begynte du å føle det på denne måten? *(Etter [HENDELSEN]?)* 0 Aldri 1 En eller to ganger 2 En eller to ganger i uken 3 Flere ganger i uken 4 Daglig eller nesten hver dag ***Beskrivelse/Eksempler***	**Hvor sint var du?** *(På hvilke måter uttrykte du sinnet?) [HVIS TILBAKEMELDING OM UNDERTRYKKELSE:] (Hvor vanskelig var det for deg å ikke vise sinnet ditt?* **Hvor lang tid brukte du på å roe deg ned? Skapte sinnet problemer for deg?** 0 Ingen irritabilitet eller sinne. 1 Mild. Minimal irritabilitet, kan heve stemmen ved sinne. 2 Moderat. Irritabilitet klart til stede eller forsøker å undertrykke sinne, men kan ta seg raskt sammen. 3 Alvorlig. Markert irritabilitet eller markerte forsøk på å undertrykke sinne. Kan bli verbalt eller fysisk aggressiv ved sinne. 4 Ekstrem. Gjennomtrengende sinne eller voldsomme forsøk på å undertrykke sinne. Kan ty til fysisk vold. ***QV (spesifiser)*** _____ **Traumerelatert?** 1 Absolutt 2 Muligens 3 Lite trolig Nåtid ____ I løpet av livet ____	***F*** _____ ***I*** _____ ***Sist måned*** ***F*** _____ ***I*** _____ ***Sx: J N*** ***I løpet av livet*** ***F*** _____ ***I*** _____ ***Sx: J N***

15. (D-3) Konsentrasjonsvansker

Frekvens	*Intensitet*	*Sist uke*
Har du hatt problemer med å konsentrere deg om det du gjør eller det som foregår rundt deg? Hvordan opplevde du det? Hvor mye av tiden i den siste måneden (uken) har du følt det slik? Når begynte du å ha problemer med konsentrasjonen? *(Etter [HENDELSEN]?)* 0 Ikke i det hele tatt 1 Liten del av tiden (mindre enn 10 %) 2 Noe av tiden (ca. 20–30 %) 3 En god del av tiden (ca. 50–60 %) 4 Det meste av eller hele tiden (mer enn 80 %) ***Beskrivelse/Eksempler***	**Hvor vanskelig var det for deg å konsentrere deg?** *[TA MED OBSERVASJONER AV KONSENTRASJON OG OPPMERKSOMHET UNDER SAMTALEN]* **I hvor stor grad innvirket det på hverdagen din?** 0 Ingen problemer med konsentrasjonen. 1 Mild. Bare noe anstrengelse nødvendig for konsentrasjon. Liten eller ingen innvirkning i hverdagen. 2 Moderat. Tydelig tap av konsentrasjon, men kan konsentrere seg ved anstrengelse. Noe innvirkning i hverdagen. 3 Alvorlig. Markert tap av konsentrasjon selv ved anstrengelse. Markert innvirkning i hverdagen. 4 Ekstrem. Fullstendig ute av stand til å konsentrere seg, klarer ikke være med i aktiviteter. ***QV (spesifiser)*** _____ **Traumerelatert?** 1 Absolutt 2 Muligens 3 Lite trolig Nåtid ____ I løpet av livet ____	***F*** _____ ***I*** _____ ***Sist måned*** ***F*** _____ ***I*** _____ ***Sx: J N*** ***I løpet av livet*** ***F*** _____ ***I*** _____ ***Sx: J N***

16. (D-4) Hypervaktsomhet

Frekvens	***Intensitet***	***Sist uke***
Har du vært spesielt årvåken eller vaktsom også når det var klart unødvendig? *(Har du følt som om du hele tiden var på vakt?)* **Hvorfor? Hvor mye av tiden i den siste måneden (uken) har du følt det slik? Når begynte du å føle det slik?** *(Etter [HENDELSEN]?)* 0 Ikke i det hele tatt 1 Liten del av tiden (mindre enn 10 %) 2 Noe av tiden (ca. 20–30 %) 3 En god del av tiden (ca. 50–60 %) 4 Det meste av eller hele tiden (mer enn 80 %) ***Beskrivelse/Eksempler***	**Hvor mye anstrengte du deg for å være oppmerksom på alt rundt deg?** *[TA MED OBSERVASJONER AV HYPERVAKTSOMHET UNDER SAMTALEN]* **Skapte [HYPER-VAKTSOMHETEN] problemer for deg?** 0 Ingen hypervaktsomhet. 1 Mild. Minimal hypervaktsomhet, noe økt oppmerksomhet. 2 Moderat. Hypervaktsomhet tydelig til stede, årvåken ute blant folk (velger f.eks. trygge steder å sitte i restauranter og kinosaler). 3 Alvorlig. Markert hypervaktsomhet, svært årvåken, gransker omgivelsene for fare, overdreven bekymring for egen sikkerhet og for sikkerheten til hjem og familie. 4 Ekstrem. Overdreven hypervaktsomhet. Anstrengelser for å sikre trygghet opptar vesentlig tid og energi og kan inkludere utstrakt sikkerhetssjekkende atferd. Markert gardert atferd under samtalen. ***QV (spesifiser)*** _____ **Traumerelatert?** 1 Absolutt 2 Muligens 3 Lite trolig Nåtid ____ I løpet av livet ____	***F*** _____ ***I*** _____ ***Sist måned*** ***F*** _____ ***I*** _____ ***Sx: J N*** ***I løpet av livet*** ***F*** _____ ***I*** _____ ***Sx: J N***

17. (D-5) Overdreven alarm respons

Frekvens	***Intensitet***	***Sist uke***
Har du opplevd sterke alarm reaksjoner? Når skjedde det? *(Hva skremte deg?)* **Hvor ofte den siste måneden (uken)? Når begynte du å reagere slik?** *(Etter [HENDELSEN]?)*	**Hvor sterke var disse alarm reaksjonene?** *(Hvor sterke var de sammen-lignet med hvordan de fleste andre ville ha reagert?)* **Hvor lenge varte reaksjonen?**	*F* _____ *I* _____
0 Aldri 1 En eller to ganger 2 En eller to ganger i uken 3 Flere ganger i uken 4 Daglig eller nesten hver dag	0 Ingen reaksjon. 1 Mild. Minimal reaksjon. 2 Moderat. Tydelig alarmreaksjon, føler seg skvetten. 3 Alvorlig. Markert alarmreaksjon, vedvarende opphisselse etter den første reaksjonen. 4 Ekstrem. Overdreven alarmreaksjon. Utilslørt mestringsatferd (f.eks. krigsveteran som kaster seg i bakken).	***Sist måned*** *F* _____ *I* _____ ***Sx: J N***
Beskrivelse/Eksempler	***QV (spesifiser)*** _____ **Traumerelatert?** 1 Absolutt 2 Muligens 3 Lite trolig Nåtid ____ I løpet av livet ____	***I løpet av livet*** *F* _____ *I* _____ ***Sx: J N***

Kriterium E. Varighet av forstyrrelser (symptomer i kriterier B, C og D) er mer enn 1 måned.

18. Forsinkede symptomer

[HVIS IKKE ALLEREDE KLART:] **Når begynte du å ha (PTSD-symptomer) som du har fortalt om?** *(Hvor lenge etter traumet startet de? Mer enn seks måneder?)*	_____ ***måneders forsinkelse totalt*** ***Med forsinkelse (≥ 6 mnd.)? NEI JA***

19. Varigheten til symptomene

		Nåtid	***I løpet av livet***
[NÅTID] **Hvor lenge har disse (PTSD-symptomene) vart alt i alt?** [I LØPET AV LIVET] **Hvor lenge varte (PTSD-symptomene) alt i alt?**	*Varighet mer enn 1 måned? Totalt antall måneder for varighet: Akutt (< 3 måneder) eller kronisk (≥ 3 måneder)?*	***NEI JA*** _____ ***akutt kronisk***	***NEI JA*** _____ ***akutt kronisk***

Kriterium F. Forstyrrelsene skaper klinisk signifikant ubehag eller nedsatt funksjonsevne sosialt, yrkesmessig eller på andre områder.

20. Subjektivt ubehag

[NÅTID] **Hvor mye har disse (PTSD-symptomene) du har fortalt om, plaget deg generelt sett?** [SE OGSÅ PÅ UBEHAG RAPPORTERT I TIDLIGERE PUNKTER] [I LØPET AV LIVET] **Hvor mye ble du plaget av disse (PTSD-symptomene) du har fortalt om, generelt sett?** [SE OGSÅ PÅ UBEHAG RAPPORTERT I TIDLIGERE PUNKTER]	0 Ingen. 1 Mild. Minimalt ubehag. 2 Moderat. Ubehag klart til stede, men fremdeles overkommelig. 3 Alvorlig. Betydelig ubehag. 4 Ekstrem. Lammende ubehag.	***Sist uke*** _____ ***Sist måned*** _____ ***I løpet av livet***

21. Nedsatt sosial funksjonsevne

[NÅTID] **Har disse (PTSD-SYMPTOMENE) påvirket ditt forhold til andre? På hvilken måte?** [SE OGSÅ PÅ NEDSATT SOSIAL FUNKSJONSEVNE RAPPORTERT I TIDLIGERE PUNKTER] [I LØPET AV LIVET] **Påvirket disse (PTSD-SYMPTOMENE) ditt sosiale liv? På hvilken måte?** [SE OGSÅ PÅ NEDSATT SOSIAL FUNKSJONSEVNE RAPPORTERT I TIDLIGERE PUNKTER]	0 Ingen negativ innvirkning. 1 Svak innvirkning. Minimalt nedsatt sosial funksjonsevne. 2 Moderat innvirkning. Klart nedsatt sosial funksjonsevne, men mange sider av sosial funksjonsevne fremdeles intakt. 3 Alvorlig. Markert nedsatt evne, få sider av sosial funksjonsevne intakt. 4 Ekstrem innvirkning. Liten eller ingen sosial funksjonsevne.	***Sist uke*** _____ ***Sist måned*** _____ ***I løpet av livet*** _____

22. Nedsatt yrkesmessig eller annen viktig funksjonsevne

[NÅTID – HVIS UKLART] **Er du for tiden i arbeid?** HVIS JA: **Har disse (PTSD-SYMPTOMENE) påvirket jobben din eller din evne til å jobbe? På hvilken måte?** [SE PÅ RAPPORTERT YRKESBAKGRUNN, DERIBLANT ANTALL OG VARIGHET TIL JOBBER, OG OGSÅ KVALITETEN PÅ ARBEIDSFORHOLD. HVIS PREMORBID FUNKSJON ER UKLAR, SPØR OM ARBEIDSERFARING FØR TRAUMET. VED TRAUMER HOS BARN/UNGDOM SE PÅ SKOLE-RESULTATER FØR TRAUMET OG EVENTUELLE ATFERDSPROBLEMER] HVIS NEI: **Har disse (PTSD-SYMPTOMENE) påvirket andre viktige deler av livet ditt?** [FORESLÅ DET SOM PASSER, F.EKS. FORELDREROLLEN, HUSARBEID, LEKSER, FRIVILLIG ARBEID OSV.] **På hvilken måte?** [I LØPET AV LIVET – HVIS UKLART] **Var du i arbeid da?** HVIS JA: **Påvirket disse (PTSD-SYMPTOMENE) jobben din eller din evne til å jobbe? På hvilken måte?** [SE PÅ RAPPORTERT YRKESBAKGRUNN, DERIBLANT ANTALL OG VARIGHET TIL JOBBER, OG OGSÅ KVALITETEN PÅ ARBEIDSFORHOLD. HVIS PREMORBID FUNKSJON ER UKLAR, SPØR OM ARBEIDSERFARING FØR TRAUMET. VED TRAUMER HOS BARN/UNGDOM SE PÅ SKOLERESULTATER FØR TRAUMET OG EVENTUELLE ATFERDSPROBLEMER] HVIS NEI: **Påvirket disse (PTSD-SYMPTOMENE) andre viktige deler av livet ditt?** [FORESLÅ DET SOM PASSER, F.EKS. FORELDREROLLEN, HUSARBEID, LEKSER, FRIVILLIG ARBEID OSV.] **På hvilken måte?**	0 Ingen negativ innvirkning. 1 Svak innvirkning. Minimalt nedsatt yrkesmessig eller annen viktig funksjonsevne. 2 Moderat innvirkning. Klart nedsatt funksjonsevne, men mange sider av yrkesmessig/annen viktig funksjonsevne fremdeles intakt. 3 Alvorlig. Markert nedsatt funksjonsevne, få sider av yrkesmessig/annen viktig funksjonsevne intakt. 4 Ekstrem innvirkning. Liten eller ingen yrkesmessig/annen viktig funksjonsevne.	***Sist uke*** _____ ***Sist måned*** _____ ***I løpet av livet*** _____

Generelle vurderinger

23. Generell validitet

VURDER DEN GENERELLE VALIDITETEN TIL SVARENE. SE PÅ FAKTORER SOM MEDGJØRLIGHET I SAMTALEN, MENTAL STATUS (F.EKS. KONSENTRASJONSVANSKER, FORSTÅELSE AV PUNKTER, DISSOSIASJON), OG TEGN PÅ FORSØK PÅ Å OVERDRIVE ELLER MINIMALISERE SYMPTOMER.	0 Utmerket. Ingen grunn til å mistenke ugyldige svar. 1 God. Det foreligger faktorer som kan ha negativ innvirkning på validiteten. 2 Ganske god. Det foreligger faktorer som har negativ innvirkning på validiteten. 3 Dårlig. Betydelig redusert validitet. 4 Ugyldige svar. Alvorlig nedsatt mental status eller muligens bevisst "simulering av dårlig" eller "simulering av bra".

24. Generell alvorlighetsgrad

VURDER DEN GENERELLE ALVORLIGHETSGRADEN TIL PTSD-SYMPTOMER. SE PÅ GRAD AV SUBJEKTIVT UBEHAG, GRAD AV NEDSATT FUNKSJONSEVNE, OBSERVASJONER AV ATFERD UNDER SAMTALEN, OG VURDERING ANGÅENDE RAPPORTERINGSSTIL.	0 Ingen klinisk signifikante symptomer, intet ubehag og ingen nedsatt funksjonsevne. 1 Svak. Minimalt ubehag eller nedsatt funksjonsevne. 2 Moderat. Klart ubehag eller nedsatt funksjonsevne, men tilfredsstillende funksjonsevne ved anstrengelser. 3 Alvorlig. Betydelig ubehag eller nedsatt funksjonsevne. Begrenset funksjonsevne selv ved anstrengelser. 4 Ekstrem. Markert ubehag eller markert nedsatt funksjonsevne i to eller flere viktige funksjonsområder.	***Sist uke*** _____ ***Sist måned*** _____ ***I løpet av livet*** _____

25. Generell forbedring

VURDER DEN TOTALE GENERELLE FORBEDRINGEN SOM FORELIGGER, SAMMENLIGNET MED FØRSTE VURDERING. HVIS DET IKKE FORELIGGER NOEN TIDLIGERE VURDERING, SPØR HVORDAN SYMPTOMENE MAN ER ENIGE OM, HAR ENDRET SEG I DE SISTE SEKS MÅNEDENE. VURDER GRADEN AV ENDRING UANSETT OM DET ETTER DIN VURDERING ER PÅ GRUNN AV BEHANDLING ELLER IKKE.	0 Asymptomatisk 1 Betydelig forbedring 2 Moderat forbedring 3 Svak forbedring 4 Ingen forbedring 5 Ikke tilstrekkelig informasjon

PTSD-symptomer for nåtid

Kriterium A oppfylt (traumatisk hendelse)?	*NEI*	*JA*
____ *(antall) kriterium B sx (≥ 1)?*	*NEI*	*JA*
____ *(antall) kriterium C sx (≥ 3)?*	*NEI*	*JA*
____ *(antall) kriterium D sx (≥ 2)?*	*NEI*	*JA*
Kriterium E oppfylt (varighet ≥ 1 måned)?	*NEI*	*JA*
Kriterium F oppfylt (ubehag/nedsatt funksjonsevne)?	*NEI*	*JA*

PTSD FOR NÅTID (kriterier A–F oppfylt)? *NEI* *JA*

HVIS PTSD-KRITERIER FOR NÅTID ER OPPFYLT, GÅ TIL ASSOSIERTE EGENSKAPER.

HVIS KRITERIER FOR NÅTID IKKE ER OPPFYLT, VURDER PTSD I LØPET AV LIVET. IDENTIFISER EN PERIODE PÅ MINST EN MÅNED ETTER DEN TRAUMATISKE HENDELSEN DA SYMPTOMENE BLE VERRE.

Har det noen gang etter (HENDELSEN) vært en periode da disse (PTSD-SYMPTOMENE) var mye verre enn de hadde vært måneden før? Når skjedde dette? Hvor lenge varte det? (*Minst en måned?*)

HVIS FLERE PERIODER TIDLIGERE: **Når plaget disse (PTSD-SYMPTOMENE) deg mest?**

HVIS MINST EN PERIODE, STILL SPØRSMÅLENE I PUNKT 1–17 OG ENDRE FREKVENSSPØRSMÅLET TIL Å INNEHOLDE SPØRSMÅL OM VERSTE PERIODE: **Kjente du (SYMPTOMENE) i løpet av den tiden? Hvor ofte?**

PTSD-symptomer i løpet av livet

Kriterium A oppfylt (traumatisk hendelse)?	*NEI*	*JA*
____ *(antall) kriterium B sx (≥ 1)?*	*NEI*	*JA*
____ *(antall) kriterium C sx (≥ 3)?*	*NEI*	*JA*
____ *(antall) kriterium D sx (≥ 2)?*	*NEI*	*JA*
Kriterium E oppfylt (varighet ≥ 1 måned)?	*NEI*	*JA*
Kriterium F oppfylt (ubehag/nedsatt funksjonsevne)?	*NEI*	*JA*

PTSD I LØPET AV LIVET (kriterier A–F oppfylt)? *NEI* *JA*

Assosierte egenskaper

26. Skyldfølelse for handling eller fravær av handling

Frekvens	*Intensitet*	*Sist uke*
Har du hatt skyldfølelse for noe du gjorde eller ikke gjorde under (HENDELSEN)? Fortell mer om det. *(Hva har du skyldfølelse for?)* **Hvor mye av tiden i den siste måneden (uken) har du følt det slik?** 0 Ikke i det hele tatt 1 Liten del av tiden (mindre enn 10 %) 2 Noe av tiden (ca. 20–30 %) 3 En god del av tiden (ca. 50–60 %) 4 Det meste av eller hele tiden (mer enn 80 %)	**Hvor sterk var denne skyldfølelsen? Hvor mye ubehag eller mistrivsel førte den til?** 0 Ingen skyldfølelse. 1 Mild. Svak skyldfølelse. 2 Moderat. Skyldfølelse tydelig til stede. Noe ubehag, men likevel overkommelig. 3 Alvorlig. Markert skyldfølelse, stort ubehag. 4 Ekstrem. Gjennomgripende skyldfølelse, selvfordømmende vedrørende atferd, lammende ubehag.	*F* _____ *I* _____ ***Sist måned*** *F* _____ *I* _____
Beskrivelse/Eksempler	***QV (spesifiser)*** _____	*Sx: J N*
		I løpet av livet *F* _____ *I* _____ *Sx: J N*

27. Skyldfølelse på grunn av overlevelse [GJELDER BARE VED FLERE OFRE]

Frekvens	*Intensitet*	*Sist uke*
Har du hatt skyldfølelse fordi du overlevde (HENDELSEN) når andre ikke overlevde? Fortell mer om det. *(Hva har du skyldfølelse for?)* **Hvor mye av tiden i den siste måneden (uken) har du følt det slik?** 0 Ikke i det hele tatt 1 Liten del av tiden (mindre enn 10 %) 2 Noe av tiden (ca. 20–30 %) 3 En god del av tiden (ca. 50–60 %) 4 Det meste av eller hele tiden (mer enn 80 %) 8 Ikke relevant	**Hvor sterk var denne skyldfølelsen? Hvor mye ubehag eller mistrivsel førte den til?** 0 Ingen skyldfølelse. 1 Mild. Svak skyldfølelse. 2 Moderat. Skyldfølelse tydelig til stede. Noe ubehag, men likevel overkommelig. 3 Alvorlig. Markert skyldfølelse, stort ubehag. 4 Ekstrem. Gjennomgripende skyldfølelse, selvfordømmende vedrørende overlevelse, lammende ubehag.	*F* _____ *I* _____ ***Sist måned*** *F* _____ *I* _____
Beskrivelse/Eksempler	***QV (spesifiser)*** _____	*Sx: J N*
		I løpet av livet *F* _____ *I* _____ *Sx: J N*

28. Redusert oppmerksomhet overfor omgivelsene (f.eks. er i en "døs")

Frekvens	***Intensitet***	***Sist uke***
Har du noen gang følt at du har stått utenfor det som foregår rundt deg, som om du var i en døs? Hvordan kan du beskrive det? [MÅ SKJELNE FRA FLASHBACK-EPISODER] **Hvor ofte har det skjedd den siste måneden (uken)?** [HVIS UKLART:] *(Skyldtes det sykdom eller virkningene fra alkohol eller narkotika?)* **Når begynte du å føle det slik?** *(Etter [HENDELSEN]?)* 0 Aldri 1 En eller to ganger 2 En eller to ganger i uken 3 Flere ganger i uken 4 Daglig eller nesten hver dag ***Beskrivelse/Eksempler***	**Hvor sterk var denne følelsen av å være utenfor eller i en døs?** *(Ble du forvirret og lurte på hvor du faktisk befant deg eller hva du gjorde på det tidspunktet?)* **Hvor lenge varte det? Hva gjorde du mens dette skjedde?** *La andre merke til hvordan du oppførte deg? Hva sa de?)* 0 Ingen redusert oppmerksomhet. 1 Mild. Noe redusert oppmerksomhet. 2 Moderat. Tydelig, men transient redusert oppmerksomhet. Kan rapportere om følelse av å være "høy" eller "fjern". 3 Alvorlig. Markert redusert oppmerksomhet, kan vare i flere timer. 4 Ekstrem. Fullstendig tap av oppmerksomhet overfor omgivelsene, mulig ikke-responderende, mulig hukommelsestap for episoden (blackout). ***QV (spesifiser)*** _____ **Traumerelatert?** 1 Absolutt 2 Muligens 3 Lite trolig Nåtid ____ I løpet av livet ____	***F*** _____ ***I*** _____ ***Sist måned*** ***F*** _____ ***I*** _____ ***Sx: J N*** ***I løpet av livet*** ***F*** _____ ***I*** _____ ***Sx: J N***

29. Derealisering

Frekvens	***Intensitet***	***Sist uke***
Har det vært perioder da det som foregår rundt deg, kjennes uvirkelig eller svært fremmed og ukjent? [HVIS NEI:] *(Hva med situasjoner der personer du kjenner, plutselig virket ukjente?)* **Hvordan var det? Hvor ofte har det skjedd den siste måneden (uken)?** [HVIS UKLART:] *(Var det på grunn av sykdom eller virkningene av alkohol eller narkotika?)* **Når begynte du å føle det slik?** *(Etter [HENDELSEN]?)* 0 Aldri 1 En eller to ganger 2 En eller to ganger i uken 3 Flere ganger i uken 4 Daglig eller nesten hver dag ***Beskrivelse/Eksempler***	**Hvor sterk var (DEREALISERINGEN)? Hvor lenge varte det? Hva gjorde du mens dette skjedde?** *(La andre merke til hvordan du oppførte deg? Hva sa de?)* 0 Ingen derealisering. 1 Mild. Noe derealisering. 2 Moderat. Tydelig, men transient derealisering. 3 Alvorlig. Betydelig derealisering. Markert forvirring om hva som er virkelig. Kan vare i flere timer. 4 Ekstrem. Dyptgående derealisering, voldsomt tap av virkelighetsfølelse eller gjenkjennelse. ***QV (spesifiser)*** _____ **Traumerelatert?** 1 Absolutt 2 Muligens 3 Lite trolig Nåtid ____ I løpet av livet ____	***Sist uke*** ***F*** _____ ***I*** _____ ***Sist måned*** ***F*** _____ ***I*** _____ ***Sx: J N*** ***I løpet av livet*** ***F*** _____ ***I*** _____ ***Sx: J N***

30. Depersonifisering

Frekvens	***Intensitet***	***Sist uke***
Har du noen gang opplevd å føle som om du var utenfor kroppen din, og sett deg selv som om du var en annen person? [HVIS NEI:] *(Hva med ganger da kroppen din føltes fremmed eller ukjent ut for deg, som om den hadde endret seg på noen måte?)* **Hvordan var det? Hvor ofte har det skjedd den siste måneden (uken)?** [HVIS UKLART:] *(Var det på grunn av sykdom eller virkningene av alkohol eller narkotika?)* **Når begynte du å føle det slik?** *(Etter [HENDELSEN]?)* 0 Aldri 1 En eller to ganger 2 En eller to ganger i uken 3 Flere ganger i uken 4 Daglig eller nesten hver dag	**Hvor sterk var (DEPERSONIFISERING-EN)? Hvor lenge varte det? Hva gjorde du mens dette skjedde?** *La andre merke til hvordan du oppførte deg? Hva sa de?)* 0 Ingen depersonifisering. 1 Mild. Noe depersonifisering. 2 Moderat. Tydelig, men transient depersonifisering. 3 Alvorlig. Betydelig depersonifisering. Markert følelse av å være utenfor seg selv. Kan vare i flere timer. 4 Ekstrem. Dyptgående depersonifisering, voldsom følelse av å være utenfor seg selv. ***QV (spesifiser)*** _____ **Traumerelatert?** 1 Absolutt 2 Muligens 3 Lite trolig Nåtid ____ I løpet av livet ____	***F*** _____ ***I*** _____ ***Sist måned*** ***F*** _____ ***I*** _____ ***Sx: J N*** ***I løpet av livet*** ***F*** _____ ***I*** _____ ***Sx: J N***
Beskrivelse/Eksempler		

CAPS-SAMMENDRAG

Navn:_____ ID-nr: _____ Intervjuer: _____ Studie: _____ Dato: _____

A. Traumatisk hendelse:

B. *Gjenopplevelse*	*SISTE UKE*			*SISTE MÅNED*			*I LØPET AV LIVET*		
	Frekv	*Int*	*F+I*	*Frekv*	*Int*	*F+I*	*Frekv*	*Int*	*F+I*
(1) Intrusive minner									
(2) Ubehagelige drømmer									
(3) Atferd eller følelser som om den traumatiske hendelsen blir gjentatt									
(4) Psykologisk ubehag ved utsettelse for signaler									
(5) Fysiologiske reaksjoner ved utsettelse for signaler									
B Deltotal									
Ant. kriterium B-symptomer (krav 1)									

C. *Unngåelse og nummenhet*	*SISTE UKE*			*SISTE MÅNED*			*I LØPET AV LIVET*		
	Frekv	*Int*	*F+I*	*Frekv*	*Int*	*F+I*	*Frekv*	*Int*	*F+I*
(6) Unngåelse av tanker/følelser									
(7) Unngåelse av aktiviteter, steder eller folk									
(8) Ute av stand til å huske viktige deler av traumet									
(9) Avtakende interesse for aktiviteter									
(10) Følelse av avstand eller å være fremmed overfor andre									
(11) Begrenset utvalg av affekter									
(12) Følelse av forkortet fremtid									
C Deltotal									
Ant. kriterium C-symptomer (krav 3)									

D. *Økt aktivering*	*SISTE UKE*			*SISTE MÅNED*			*I LØPET AV LIVET*		
	Frekv	*Int*	*F+I*	*Frekv*	*Int*	*F+I*	*Frekv*	*Int*	*F+I*
(13) Vansker med å sovne eller sove									
(14) Irritabilitet eller raseriutbrudd									
(15) Konsentrasjonsvansker									
(16) Hypervaktsomhet									
(17) Overdreven alarm respons									
D Deltotal									
Ant. kriterium D-symptomer (krav 2)									

Total frekv., int. og alvorlighetsgrad (F+I)	*SISTE UKE*			*SISTE MÅNED*			*I LØPET AV LIVET*		
	Frekv	*Int*	*F+I*	*Frekv*	*Int*	*F+I*	*Frekv*	*Int*	*F+I*
Sum av deltotaler (B+C+D)									

E. *Varighet av forstyrrelser*	*NÅTID*	*I LØPET AV LIVET*
(19) Varighet av forstyrrelser minst en måned	*NEI JA*	*NEI JA*

F. *Signifikant ubehag eller tap av funksjonsevne*	*SISTE UKE*	*SISTE MÅNED*	*I LØPET AV LIVET*
(20) Subjektivt ubehag			
(21) Nedsatt sosial funksjonsevne			
(22) Nedsatt yrkesmessig funksjonsevne			
MINST EN ≥ 2?	*NEI JA*	*NEI JA*	*NEI JA*

PTSD-diagnose	*NÅTID*	*I LØPET AV LIVET*
PTSD TIL STEDE – ALLE KRITERIER (A-F) OPPFYLT?	*NEI JA*	*NEI JA*
Spesifiser: (18) Med forsinket start (≥ 6 mnd. forsinkelse)		
(19) Akutt (< 3 mnd.) eller kronisk (≥3 mnd.)	*akutt kronisk*	*akutt kronisk*

Generell vurdering	*SISTE UKE*	*SISTE MÅNED*	*I LØPET AV LIVET*
(23) Generell validitet			
(24) Generell alvorlighetsgrad			
(25) Generell forbedring			

Assosierte egenskaper	*SISTE UKE*			*SISTE MÅNED*			*I LØPET AV LIVET*		
	Frekv	*Int*	*F+I*	*Frekv*	*Int*	*F+I*	*Frekv*	*Int*	*F+I*
(26) Skyldfølelse pga. handling eller mangel på handling									
(27) Skyldfølelse pga. overlevelse									
(28) Redusert oppmerksomhet overfor omgivelsene									
(29) Derealisering									
(30) Depersonifisering									

THE HAMILTON RATING SCALE FOR DEPRESSION

To be administrated by a health care professional

Patient's name:.....

Date of assessment:.....

Rater: .....

To rate the severity of depression in patients who are already diagnosed as depressed, administer this questionnaire. The higher the score, the more severe the depression.

For each item, write the correct number on the line next to the item. (Only one response per item).

---

1. Depressed mood (Sadness, hopeless, helpless, worthless)
0 = Absent.
1 = These feeling states indicated only on questioning.
2 = These feeling states spontaneously reported verbally.
3 = Communicates feeling states non-verbally – i.e. through facial expression, posture, voice and tendency to weep.
4 = Patient reports VIRTUALLY ONLY these feeling states in his spontaneous verbal and non-verbal communication.

2. Feelings of guilt
0 = Absent.
1 = Self reproach, feels he has let people down.
2 = Ideas of guilt or rumination over past errors or sinful deeds.
3 = Present illness is a punishment. Delusions of guilt.
4 = Hears accusatory or denunciatory voices and/or experiences threatening visual hallucinations.

3. Suicide
0 = Absent.
1 = Feels life is not worth living.
2 = Wishes he were dead or any thoughts possible death to self.
3 = Suicidal ideas or gesture.
4 = Attempts at suicide (any serious attempt rates 4).

4. Insomnia early
0 = No difficulty falling asleep.
1 = Complains of occasional difficulty falling asleep – i.e. more than 1/2 hour.
2 = Complains of nightly difficulty falling asleep.

5. Insomnia middle
0 = No difficulty.
1 = Patient complains of being restless and disturbed during the night.
2 = Waking during the night – any getting out of bed rates 2 (except for purposes of voiding).

6. Insomnia late
0 = No difficulty.
1 = Waking in early hours of the morning but goes back to sleep.
2 = Unable to fall asleep again if he gets out of bed.

7. Work and activities
0 = No difficulty.
1 = Thoughts and feelings of incapacity, fatigue or weakness related to activities; work or hobbies.
2 = Loss of interest in acitivity; hobbies or work – either directly reported by patient, or indirect in listlessness, indecision and vacillation (feels he has to push self to work or activities.
3 = Decrease in actual time spent in activities or decrease in productivity.
4 = Stopped working because of present illness.

8. Retardation: psychomotor (Slowness of thought and speech; impaired ability to concentrate; decreased motor activity)
0 = Normal speech and thought.
1 = Slight retardation at interview.
2 = Obvious retardation at interview.
3 = Interview difficult.
4 = Complete stupor.

9. Agitation
0 = None.
1 = Fidgetiness.
2 = Playing with hands, hair etc.
3 = Moving about, can't sit still.
4 = Hand wringing, nail biting, hair-pulling, biting of lips.

10. Anxiety (psychological)
0 = No difficulty.
1 = Subjective tension and irritability.
2 = Worrying about minor matters.
3 = Apprehensive attitude apparent in face or speech.
4 = Fears expressed withouth questioning.

11. Anxiety somatic: Physiological concomitants of anxiety (i.e. effects of autonomic overactivity, "butterflies", indigestion, stomach cramps, belching, diarrhea, palpitations, hyperventilation, parasthesia, sweating, flushing, tremor, headache, urinary frequency). Avoid asking about possible medication side effects (i.e. dry mouth, constipation).
0 = Absent.
1 = Mild.
2 = Moderate.
3 = Severe.
4 = Incapacitating.

12. Somatic symptoms (gastrointestinal)
0 = None.
1 = Loss of appetite but eating without encouragement from others. Food intake about normal.
2 = Difficulty eating without urging from others. Marked reduction of appetite and food intake.

13. Somatic symptoms general
0 = None.
1 = Heaviness in limbs, back or head. Backaches, headache, muscle aches. Loss of energy and fatigability.
2 = Any clear-cut symptom rates 2.

14. Genital symptoms (Symptoms such as: loss of libido; impaired sexual performance; menstrual disturbance.
0 = Absent.
1 = Mild.
2 = Severe.

15. Hypochondriasis
0 = Not present.
1 = Self-absorption (bodily).
2 = Preoccupation with health.
3 = Frequent complaints, requests for help etc.
4 = Hypochondriacal delusions.

16. Loss of weight
A. When rating by history:
0 = No weight loss.
1 = Probably weight loss associated with present illness.
2 = Definite (according to patient) weight loss.
3 = Not assessed.

17. Insight
0 = Acknowledges being depressed and ill.
1 = Acknowledges illness but attributes cause to bad food, climate, overwork, virus, need for rest etc.
2 = Denies being ill at all.

18. Diurnal variation
A. Note whether symptoms are worse in morning or evening. If NO diurnal variation, mark none.
0 = No variation.
1 = Worse in A.M.
2 = Worse in P.M.

B. When present, mark the severity of the variation. Mark "None" if NO variation.
0 = None.
1 = Mild.
2 = Severe.

19. **Depersonalization and derealization (Such as: Feelings of unreality; Nilhilistic ideas)**
0 = Absent.
1 = Mild.
2 = Moderate.
3 = Severe.
4 = Incapacitating.

20. **Paranoid symptoms**
0 = None
1 = Suspicious.
2 = Ideas of reference.
3 = Delusions of reference and persecution.

21. **Obsessional and compulsive symptoms**
0 = Absent.
1 = Mild.
2 = Severe.

Total score:.....

Referens:
Hamilton, M. A rating scale for depression. J Neurology, Neurosurg Psychiat 1960; 23: 56 - 62
Hamilton, M: Development of a rating scale for primary depressive illness. Br J Soc Clin Psychol. 1967;6:278-296

Scoring

The total Hamilton Depression (HAM-D) Rating Scale provides an indication of depression and, over time, provides a valuable guide to progress.

Classification of symptoms which may be difficult to obtain can be scored as:

0 - absent
1 - doubtful or trivial
2 - present

Classification of symptoms where more detail can be obtained can be expanded to:

0 - absent
1 - mild
2 - moderate
3 - severe
4 - incapacitating

In general the higher the total score the more severe the depression.

Total HAM-D Score Level of Depression

10-13 mild
14-17 mild to moderate
>17 moderate to severe

Assessment is recommended at two-week intervals.

Smerteenhetnr: ☐☐☐ Pasientnr: ☐☐☐☐☐☐

Vær vennlig å lese spørsmålene nøye før du svarer, og marker det svaret som passer best.

Kjønn: ☐ Mann ☐ Kvinne

Fødselsår: ☐☐☐☐

Sivilstand; (sett bare et kryss)

☐ Ugift ☐ Gift ☐ Samboer ☐ Partnerskap ☐ Enke/enkemann ☐ Skilt ☐ Separert

Har du barn? ☐ Ja ☐ Nei Hvis ja, hvor mange? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Flere

Barnas alder: ☐☐ ☐☐ ☐☐ ☐☐ ☐☐ ☐☐

Hvem bor barna sammen med?

☐ Mor ☐ Far ☐ Foreldre/steforeldre ☐ Utflyttet ☐ Annet: _____

Utdanning:

☐ Grunnskole
☐ Videregående skole
☐ Fagbrev/fagutdanning
☐ Høyskole/universitet inntil 4 år
☐ Høyskole/universitet over 4 år
☐ Påbegynt/ikke fullført utdanning
☐ Annet: _____

Yrke og arbeidsliv:

Ansettelsesforhold (kryss av):

☐ Uten beskjeftigelse
☐ Heltidsjobb
☐ Deltidsjobb
☐ Under utdanning
☐ Deltidsjobb og under utdanning
☐ Ukjent
☐ Alderspensjon
☐ Trygdet/attføring (spesifiser på neste side)

Smerteenhetnr: ☐☐☐ Pasientnr: ☐☐☐☐☐☐

Trygdestatus:
Hvis du mottar trygd, attføring eller lignende -kryss av:

- ☐ Sykemeldt
- ☐ Aktiv sykemelding
- ☐ Medisinsk rehabilitering
- ☐ Yrkesrettet attføring
- ☐ Sosialstønad
- ☐ Uførepensjon
- ☐ Annet? Spesifiser: _____

Hvordan vurderer du din økonomi? ☐ God ☐ Middels ☐ Dårlig

Har du en pågående erstatningssak med utgangspunkt i det aktuelle smerteproblemet? ☐ Ja ☐ Nei

Har du søkt om eller planlegger du å søke om uførepensjon? ☐ Ja ☐ Nei

Når startet smertetilstanden?

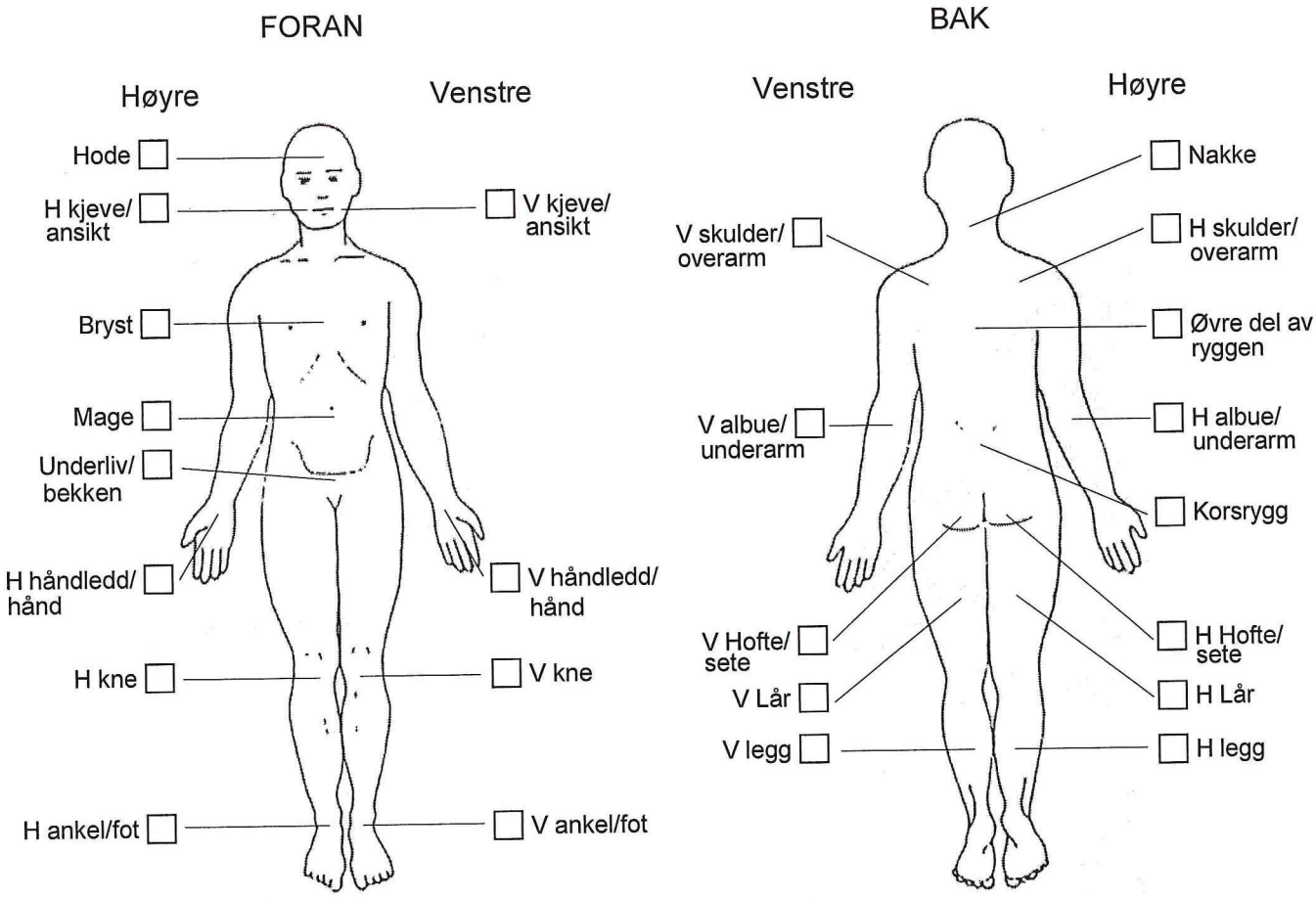
- ☐ 0 - 3 måneder siden
- ☐ 4 - 6 måneder siden
- ☐ 7 - 12 måneder siden
- ☐ 1 - 2 år siden
- ☐ 2 - 4 år siden
- ☐ 4 - 6 år siden
- ☐ 6 - 10 år siden
- ☐ Mer enn 10 år siden

Hvor lenge har smertetilstanden vært på samme nivå som nå?

- ☐ 0 - 3 måneder
- ☐ 4 - 6 måneder
- ☐ 7 - 12 måneder
- ☐ 1 - 5 år
- ☐ 6 år eller mer

Smerteenhetnr: ☐☐☐ Pasientnr: ☐☐☐☐☐☐

Dersom du har hatt smerter siste uken, hvor har du hatt disse plagene? Vennligst sett et eller flere kryss.



Vennligst sett et kryss under det tallet som best beskriver de sterkeste smertene du har hatt i løpet av den siste uka.

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Ingen smerter — Verst tenkelige smerter

Vennligst sett et kryss under det tallet som best beskriver de svakeste smertene du har hatt i løpet av den siste uka.

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Ingen smerter — Verst tenkelige smerter

Vennligst sett et kryss under det tallet som best angir hvor sterke smerter du har i gjennomsnitt.

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Ingen smerter — Verst tenkelige smerter

Smerteenhetnr: ☐☐☐ Pasientnr: ☐☐☐☐☐☐

Når jeg har smerte....

...er det forferdelig og jeg føler at det aldri kommer til å bli bedre.

0	1	2	3	4	5	6
aldri			av og til			alltid

...føles det som om jeg ikke holder ut.

0	1	2	3	4	5	6
aldri			av og til			alltid

I løpet av den siste uka:	Ikke i det hele tatt	Litt	En del	Svært mye
Har du hatt søvnproblemer?	☐	☐	☐	☐
Har din fysiske tilstand eller medisinske behandling gitt deg økonomiske problemer?	☐	☐	☐	☐

Hvordan vil du stort sett vurdere din helsetilstand i løpet av den siste uka?

Utmerket	Meget god	God	Nokså god	Dårlig	Svært dårlig
☐	☐	☐	☐	☐	☐

I løpet av den siste uka, i hvilken grad begrenset fysiske helseproblemer dine vanlige fysiske aktiviteter (spasere, gå opp trapper)?

Ikke i det hele tatt	Svært lite	En del	Mye	Kunne ikke utføre fysisk aktivitet
☐	☐	☐	☐	☐

Smerteenhetnr: ☐☐☐ Pasientnr: ☐☐☐☐☐☐

I løpet av <u>den siste uka,</u> hvor vanskelig var det for deg å utføre ditt vanlige arbeid (både i og utenfor hjemmet) på grunn av din fysiske helse?

Ikke i det hele tatt	Litt	Nokså	Meget	Kunne ikke utføre fysisk aktivitet
☐	☐	☐	☐	☐

I løpet av <u>den siste uka,</u> hvor mye overskudd hadde du?

Svært mye	Ganske mye	En del	Litt	Ikke noe
☐	☐	☐	☐	☐

I løpet av <u>den siste uka</u>, i hvilken grad begrenset din fysiske helse eller følelsesmessige problemer din vanlige sosiale omgang med familie eller venner?

Ikke i det hele tatt	Svært lite	En del	Mye	Kunne ikke ha sosial omgang
☐	☐	☐	☐	☐

I løpet av <u>den siste uka,</u> i hvilken grad har du vært plaget av følelsesmessige problemer som f. eks. å være engstelig, deprimert eller irritabel?

Ikke i det hele tatt	Litt	En del	Mye	Svært mye
☐	☐	☐	☐	☐

I løpet av <u>den siste uka,</u> i hvilken grad hindret personlige eller følelsesmessige problemer deg fra å utføre ditt vanlige arbeid, skolegang eller andre gjøremål?

Ikke i det hele tatt	Svært lite	En del	Mye	Kunne ikke utføre daglige gjøremål
☐	☐	☐	☐	☐

Hvor sterke kroppslige smerter har du hatt i løpet av <u>den siste uka?</u>

Ingen	Meget svake	Svake	Moderate	Sterke	Meget sterke
☐	☐	☐	☐	☐	☐

Smerteenhetnr: ☐☐☐ Pasientnr: ☐☐☐☐☐☐

De neste spørsmålene handler om aktiviteter som du kanskje utfører i løpet av en vanlig dag. Er din helse slik at den begrenser deg i utførelsen av disse aktivitetene nå? Hvis ja, hvor mye?

	Ja, begrenser meg mye	Ja, begrenser meg litt	Nei, begrenser meg ikke i det hele tatt
a. Anstrengende aktiviteter som å løpe, løfte tunge gjenstander, delta i anstrengende idrett	☐	☐	☐
b. Moderate aktiviteter som å flytte et bord, støvsuge, gå en tur eller drive med hagearbeid	☐	☐	☐
c. Løfte eller bære en handlekurv	☐	☐	☐
d. Gå opp trappen flere etasjer	☐	☐	☐
e. Gå opp trappen en etasje	☐	☐	☐
f. Bøye deg eller sitte på huk	☐	☐	☐
g. Gå mer enn to kilometer	☐	☐	☐
h. Gå noen hundre meter	☐	☐	☐
i. Gå hundre meter	☐	☐	☐
j. Vaske eller kle på deg	☐	☐	☐

Hvor ofte i løpet av <u>den siste uka</u> har du...

	Hele tiden	Nesten hele tiden	Mye av tiden	En del av tiden	Litt av tiden	Ikke i det hele tatt
Følt deg veldig nervøs?	☐	☐	☐	☐	☐	☐
Vært så langt nede at ingenting har kunnet muntre deg opp?	☐	☐	☐	☐	☐	☐
Følt deg rolig og harmonisk?	☐	☐	☐	☐	☐	☐
Følt deg nedfor og trist?	☐	☐	☐	☐	☐	☐
Følt deg glad?	☐	☐	☐	☐	☐	☐