How To try this

CE 2.5 HOURS Continuing Education

By Kathryn Hyer, PhD, MPP, and Lisa M. Brown, PhD

The Impact of Event Scale–Revised

A quick measure of a patient's response to trauma.

Reuters / Tim Johnson TW

Overview: A person may suffer debilitating anxiety and other physical and psychological symptoms without recognizing that they're a response to a traumatic event. And older adults in particular may be reluctant to admit to experiencing such symptoms. The Impact of Event Scale–Revised (IES-R) is an easy-to-administer questionnaire used to evaluate the degree of distress a patient feels in response to trauma. It provides a structured way for a patient to communicate distress when she or he may not have the words to do so. For a free online video showing nurses using the IES-R with an older patient, go to http://links.lww.com/A316.

Web Video

Watch a video demonstrating the use of the Impact of Event Scale–Revised at http://links.lww.com/A316.

A Closer Look

Get more information on why it's important for nurses to assess for posttraumatic stress disorder in older adults, as well as why the Impact of Event Scale–Revised is a good approach for doing so.

Try This: The Impact of Event Scale–Revised

This is the scale in its original form. See page 66.

Online Only

Unique online material is available for this article. A URL citation appears in the printed text; simply type it into any Web browser.

Four months after 93-year-old Teresa Albini moved into a nursing home in West Palm Beach, Florida, Hurricane Frances brought torrential rains and wind gusts of 120 miles per hour. When the hurricane came ashore, the force felled trees on the facility's grounds; one landed on the roof of Ms. Albini's wing. (This case is a composite of several that occurred during the hurricane seasons of 2004 and 2005.)

But a day before the hurricane was expected to make landfall, after predictions that the storm would intensify, the administrator decided to evacuate residents to a facility in Tampa—a two-hour trip under normal circumstances. Along with the nearly 100 other residents being transported, Ms. Albini was given a wristband specifying her name and medications, and was told to pack enough clothes for a two-day stay. By the time the buses got on the road, however, traffic was bumper-to-bumper, and it became clear that the residents wouldn't be going to Tampa that day.

After four hours in traffic, wind, and rain, the buses stopped at a temporary shelter set up in a community gymnasium in a small inland town. The shelter was noisy, and Ms. Albini and the other residents slept on inflatable mattresses placed on the floor. At 1:45 AM, they were awakened by alarms and a warning of tornados. In fear for her life, Ms. Albini cried as she listened to the thundering winds outside. By morning, the eye of the storm had passed and the threat of tornados diminished. The trip to Tampa was resumed.

A week after arriving in the Tampa facility, Ms. Albini learned that although other residents had returned home, she wouldn't be able to for four months—damage to her wing of the building would take at least that long to repair. As a "temporary" resident of the Tampa facility, she would need more clothing; volunteers went to a local discount department store for clothes and toiletries. Although Ms. Albini was grateful, she was also distressed by their choices: she'd spent decades wearing designer clothes. She told friends that she wanted garments "as nice" as those she was used to. She was also worried about the keepsakes that were in her room and wondered whether they'd been destroyed when the tree fell.

Now, one month later, Ms. Albini reports having problems sleeping and refuses to eat, saying that her stomach is upset all the time. Her chart shows that she has arthritis in her knees, hips, and hands; degenerative joint disease; osteoporosis; and high blood pressure. She walks short distances without assistance but needs a walker to go to meals or attend activities. Her score of 28 on the Mini-Mental State

Why Assess Older Adults After a Traumatic Event?

Older adults may be reluctant to admit to suffering from anxiety or distress and might be less willing than younger people to seek mental health care.[7] Some of this reluctance can stem from fear that symptoms with names like "numbing," "heightened startle response," "dissociative reexperiencing," and "intrusive thoughts" may mean they'll be labeled as mentally ill. Identifying mental health disorders in an older adult can be complicated by a decline in cognitive function; also, many older patients believe that memory loss is an inevitable consequence of aging.[8] By helping an older adult realize that experiencing a traumatic event commonly results in certain unpleasant feelings, the nurse can help the patient to be more willing to discuss symptoms and accept treatment.

As one of us (LMB) noted, studies conducted in the 1960s and 1970s suggested that older adults were more vulnerable to psychological distress after a disaster than younger adults, but more recent studies have found that older adults generally fare better emotionally and psychologically than younger adults after a disaster, although they do show "psychological and somatic symptoms."[9]

Exam is within normal limits. She takes several prescribed medications: metoprolol (Lopressor and others) and amlodipine (Norvasc) to manage high blood pressure, acetaminophen (Tylenol) 650 mg twice per day for arthritis pain, alendronate (Fosamax) for osteoporosis, and tolterodine (Detrol) for urinary incontinence.

After conducting a complete evaluation, her physician says that he can find no medical reasons for her symptoms. He confers with the nurse manager, and they decide that Ms. Albini should be assessed for symptoms of stress related to her experiences during the hurricane. They decide to use the Impact of Event Scale–Revised (IES-R). (To watch the portion of the online video in which a nurse administers the IES-R and brings her findings to a team meeting to discuss how to help the patient, go to http://links.lww.com/A317.)

THE IES-R

The IES-R is a self-administered, 22-item questionnaire based on three clusters of symptoms identified in the *Diagnostic and Statistical Manual of Mental Disorders,* third edition (*DSM-III*), as indicators of posttraumatic stress disorder (PTSD).[1]

- *Intrusion* is assessed with eight items on the scale.
- *Avoidance* is assessed with eight items on the scale.
- *Hyperarousal* is assessed with six items on the scale.

The IES-R is not a diagnostic or screening tool for PTSD; rather, it relies on a patient's own report of symptoms and is used to gauge response no sooner than two weeks after a traumatic event, as well as to evaluate recovery. (The National Center for PTSD defines a traumatic experience as one that "typically involves the potential for death or serious injury resulting in intense fear, helplessness, or horror." Examples of such experiences include natural disaster, terrorist attack, or physical or sexual assault. For more information go to www.ncptsd.va.gov.) Those assessed with the IES-R are asked to indicate the degree of their distress for each of 22 symptoms according to a five-point scale: 0 indicates that the symptom occurs "not at all"; 1, "a little bit"; 2, "moderately"; 3, "quite a bit"; and 4, "extremely."

The 15-item IES was first published in 1979,[2] a year before the *DSM-III* was published (the first edition to include a diagnosis of PTSD). The IES-R was published in 1997. It should be administered once it has been determined that symptoms—whether physical, such as a digestive problem or a headache, or nonspecific or cognitive, such as intrusive thoughts, flashbacks, or nightmares—are most likely due to trauma and have no other medical basis. (For more information on when to use the IES-R, go to http://links.lww.com/A558.) Determining whether a symptom is a result of trauma requires inquiry into recent experience, and we recommend the IES-R as the most effective approach when used after a recent trauma. And an advantage of using a questionnaire like the IES-R is that it gives patients a means to communicate distress when language or insight eludes them. (See *Why Assess Older Adults After a Traumatic Event?*[7-9] on this page.)

Translations. The IES-R has been translated into Chinese, Japanese, French, and Spanish; a version has also been created for Sri Lanka.[3-6]

ADMINISTERING THE IES-R

Establishing rapport with the patient is essential, although it can be made difficult by the patient's mistrust, hypervigilance, shame, anger, and avoidance, all of which can be induced by trauma.

A normal response immediately after a trauma can include intense levels of stress. Such immediate responses aren't good predictors of how well the patient will cope or of the eventual risk of developing PTSD. People who are highly symptomatic—those who startle easily, are unable to sleep, or report flashbacks or feeling numb—two weeks after a traumatic event are at risk for PTSD.

Watch It!

Go to http://links.lww.com/A316 to watch a video demonstrating the use and interpretation of the Impact of Event Scale–Revised. Then see the health care team plan preventive strategies.

View this video in its entirety and then apply for CE credit at www.nursingcenter.com/AJNolderadults; click on the *How to Try This* series link. All videos are free and in a downloadable format (not streaming video) that requires Windows Media Player.

Ms. Albini's nurse begins with the following: "Ms. Albini, I've noticed that you seem anxious. You've said that your stomach is upset and you're having a hard time sleeping. Sometimes people have such difficulties after stressful events. You've been through a lot with the hurricane, the terrifying tornado, and this unexpected relocation. I think this questionnaire could help us understand these difficulties. You should read each item on this list and then indicate how distressing each has been for you during the past week." She explains that each item refers to a person's distress level in response to recent traumatic events. She describes the rating system, asking Ms. Albini to numerically rate her responses, and after she answers the first question the nurse says, "I'll come back in about 20 or 30 minutes to review your answers with you."

Upon return the nurse looks at the scores within each subscale and talks with Ms. Albini about her responses. The nurse calculates a mean score for the eight questions on the intrusion subscale of 2.5—between "moderate" and "quite a bit"—and discusses these questions. For intrusion—the reliving of the hurricane and tornado—Ms. Albini says that she's been having reminders that bring up feelings about the hurricane, difficulty staying asleep, thoughts about the hurricane when she doesn't want them, pictures of the tornado popping into her mind, and dreams about the tornado, "quite a bit." She tells the nurse that other things like the clothes the nursing home staff bought for her reminded her of the hurricane, and that she experienced "moderate" distress with waves of strong feelings. She felt like she was back at the hurricane evacuation "a little bit." Her mean avoidance subscale score was 3.6 (she did not answer two of the questions on avoidance). While discussing these questions, Ms. Albini said she did not want to do normal activities and was "extremely" distressed and stayed away from reminders of the tornado and tried not to think or talk about it, wanting to remove it from her memory. She felt "numb" and realized she had feelings but didn't want to deal with feelings "moderately." She reported that she didn't want to go to church or any outside events because they made her think about the hurricane. Finally, her hyperarousal subscale score was just below 1. She told the nurse that she was irritable and jumpy and had trouble falling asleep and concentrating, and reminders like her new clothes kept making her think about the evacuation. Her heart pounded "a little bit," but she was watchful "not at all."

CHALLENGES THAT MAY ARISE

Before administering a questionnaire to a patient, it's important to ask about the highest grade level the patient completed. Using the Flesch–Kincaid Readability tool, we determined that several of the items on the IES-R exceed a ninth-grade reading level. If the person reports ending school before the 12th grade, ask her or him to read a question and paraphrase it. If the patient can't do so, the IES-R should be administered by interview. In addition, older adults with visual impairment should receive a copy of the IES-R that is printed in at least 14-point type; again, if that isn't sufficient, the questions can be read aloud.

The IES-R is not appropriate for people with moderate or severe memory impairment. People with moderate dementia (a Mini-Mental State Exam score of 22 or lower) can't complete the questionnaire because short-term memory is required.

SCORING AND INTERPRETING THE RESULTS

The total score for each subscale should be calculated using the mean of the scored responses. Scores will range from 0 to 4; responses that receive a rating of 0 (but not the items the patient didn't endorse) should be figured into the mean. The amount of distress the patient is experiencing corresponds, therefore, to the categories on the scale; for instance, a patient with a mean score of 3 in avoidance displays "quite a bit" of avoidance behavior. But too much emphasis should not be placed on a person's total score; it should be remembered that function is more important than an absolute score, especially in older adults.

And because most older adults will not receive high scores in all three subscales, any dysfunction revealed by the screening should indicate a need for referral for further evaluation and counseling (the nurse administering the IES-R will not have to provide counseling). We've found that after a traumatic event older adults are usually relieved when clinicians try to help and are quite willing to work with them. When making a referral, the nurse should specify which areas the patient said were most distressing. The initial goals of therapy are to relieve symptoms, enhance coping skills, and instill hope that previous functioning will return.

High scores on all three subscales indicate the need for further evaluation for past trauma—such as

Trauma Assessment Immediately After a Disaster

How first responders should intervene.

Disaster mental health evaluation and intervention differ significantly from traditional assessment and psychotherapy: they usually take place in shelters or service centers and are conducted by first responders assisting in the relief effort. In the first hours and days after a traumatic event, strong and fluctuating emotions are considered a normal response. As a part of providing psychological first aid to a survivor, a first responder conducts an unobtrusive, informal evaluation to determine the degree of distress and possibly the potential for long-term problems. (A formal evaluation may pathologize these normal strong responses and elicit false positives.)

People who express protracted and intense emotions should be referred for evaluation by a mental health professional; a preexisting psychiatric condition or undetected cognitive problem may have been exacerbated by the trauma. People who require immediate care are referred for further evaluation, and those who are deemed to be at higher risk are followed and reevaluated within a few days.

If during the second evaluation the survivor is still having a severe reaction to the event, crisis counseling is offered. Formal assessment and treatment take place only if psychological first aid and crisis counseling have not sufficiently ameliorated the symptoms.

a history of childhood or spousal abuse, combat trauma, or interpersonal violence, any of which might exacerbate the response to a current trauma—or other psychiatric disorder such as depression or anxiety. Kessler and colleagues found that people with PTSD have a higher rate of other psychiatric disorders than those who don't have PTSD.[10]

Weiss indicates that a number of factors influence the scores obtained on the scale; for example, the time that has elapsed between the traumatic event and the administration of the questionnaire influences the reporting of symptoms (the more recent the event, the higher the number of symptoms reported).[11] The severity of the traumatic event also influences scores: more severe traumas result in more extreme symptoms. Finally, Weiss states that scores are influenced by a "base rate of stress reactions" in the sample studied (for example, firefighters who are trained to deal with trauma will have less severe symptoms than civilians). Thus, Weiss writes, "it is simply inappropriate" to require or to attempt to set universal cutoff points for scoring, and clinicians should remember that the scale is not intended to diagnose PTSD.

For nurses working with distressed patients over an extended period, the IES-R can be a helpful way to monitor symptom frequency and intensity. By administering the scale repeatedly, the clinician can track progress and gauge response to interventions. If the patient is progressing slowly, a reevaluation might occur every four or five visits. But if the patient is highly distressed, it might be done more often. (To view the portion of the online video in which experts are interviewed about symptoms of PTSD and treatment goals, go to http://links.lww.com/A318.)

Ms. Albini's mean intrusion score was 2.5—between "moderate" and "quite a bit." Her mean score on the avoidance subscale was 3.6. Her hyperarousal score was low, however, being slightly below 1 on the five-point scale.

After calculating the scores, the nurse says, "I can see by the way you answered these questions that you are distressed after the tornado and the evacuation. You seem to be reliving the experience and avoiding your normal activities quite a bit. Some patients who have had similar experiences have benefited from talking to a counselor. I think it would be worthwhile for you to give this a try. I'm suggesting a few sessions with the social worker to see if you feel less anxious after talking to her about these experiences. I'd like to make an appointment with Regina Scott; is that okay with you?"

Ms. Albini agrees to counseling.

COMMUNICATING THE FINDINGS

Sharing IES-R results with the patient as treatment progresses might be therapeutically useful: the patient can see that symptoms are being alleviated over time. If on the other hand the number or intensity of symptoms increases, a review of the treatment plan might be necessary.

Likewise, if symptoms are inconsistent over time, the clinician might want to consider whether the patient is a reliable source or is cognitively intact or

try this: Best Practices in Nursing Care to Older Adults
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The Impact of Event Scale - Revised (IES-R)

By: Steven Christianson, DO, MM, Medical Director, VNS CHOICE and VNSNY Home Care and Joan Marren, MEd, RN, Chief Operating Officer, VNSNY

WHY: Like others with Post Traumatic Stress Disorder (PTSD), older adults respond to traumatic events with symptoms of re-experiencing, emotional numbing, behavioral avoidance, and increased physiological arousal. Because of age-related changes and associated disease processes, stress reaction in older adults may lead to a deterioration of function and a worsening of existing conditions. Therefore, older adults should be considered a high risk group following a disaster or specific traumatic event. Several factors in adapting to a disaster have been recognized as important in the older adult: an increased sense of insecurity and vulnerability; a loss of sense of control and predictability; a need to reaffirm familiar relationships, attachments and routines; and to remain independent. The impact of a disaster on the elderly can be magnified by chronic illness and medication, sensory limitations, mobility impairment, and literacy that place the older adult in the special needs population after a disaster. For all of these reasons it is important to evaluate an older adult's response to a disaster to detect those who are in danger of decompensating.

BEST TOOL: A short, easily administered self-report questionnaire, the Impact of Event Scale – Revised (IES-R), has 22 questions, 5 of which were added to the original Horowitz (IES) to better capture the DSM-IV criteria for PTSD (Weiss & Marmar, 1997). The tool, not diagnostic for PTSD, is an appropriate instrument to measure the subjective response to a specific traumatic event in the senior population, especially in the response sets of intrusion (intrusive thoughts, nightmares, intrusive feelings and imagery, dissociative-like re-experiencing), avoidance (numbing of responsiveness, avoidance of feelings, situations, and ideas), and hyperarousal (anger, irritability, hypervigilance, difficulty concentrating, heightened startle), as well as a total subjective stress IES-R score. There is no specific cut-off score. The IES-R revises the original IES, recognized as one of the earliest self-report tools developed to assess post traumatic stress, to add a third cluster of symptoms, hyperarousal, to intrusion and avoidance subscales. IES-R is the acronym for the test assessment purpose:
I – Impact
E – of Event
S – Scale
R – Revised

TARGET POPULATION: The IES-R can be used with both healthy and frail older adults exposed to any specific traumatic event. It can be used for repeated measurements over time to monitor progress.

VALIDITY AND RELIABILITY: The IES-R was designed and validated using a specific traumatic event as a reference in the directions to the patient while administering the tool and while using a specific time frame of the past seven days. The scale discriminates between a variety of traumatized groups from non-traumatized groups in general population studies. The subscales of avoidance and intrusion show good internal consistency. While related, the subscales measure different dimensions of stress response. African Americans have been shown to score higher than whites on the IES in general population studies, an effect that diminished with increasing relative violence, and this should be taken into account during interpretation. The hyperarousal subscale added by Weiss and Marmar has good predictive validity with regard to trauma (Briere, 1997), while the intrusion and avoidance subscales detect relevant differences in the clinical response to traumatic events of varying severity.

STRENGTHS AND LIMITATIONS: The main strengths of this revised instrument are that it is still short, easily administered and scored, correlates better with the DMS-IV criteria for PTSD, and can be used repeatedly to assess progress. It still is limited by remaining a screening tool rather than a comprehensive test and by the non-clinical focus. It is still best used for recent not remote traumatic events. The IES-R has been translated into many languages including Spanish, French, Chinese, Japanese, and German.

MORE ON THE TOPIC:

Best practice information on care of older adults: www.ConsultGeriRN.org.

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IMPACT OF EVENT SCALE – REVISED

INSTRUCTIONS: Below is a list of difficulties people sometimes have after stressful life events. Please read each item, and then indicate how distressing each difficulty has been for you **DURING THE PAST SEVEN DAYS** with respect to _____, which occurred on _____. How much were you distressed or bothered by these difficulties?

Item Response Anchors are 0 = Not at all; 1 = A little bit; 2 = Moderately; 3 = Quite a bit; 4 = Extremely.

The Intrusion subscale is the **MEAN** item response of items 1, 2, 3, 6, 9, 14, 16, 20. Thus, scores can range from 0 through 4.

The Avoidance subscale is the **MEAN** item response of items 5, 7, 8, 11, 12, 13, 17, 22. Thus, scores can range from 0 through 4.

The Hyperarousal subscale is the **MEAN** item response of items 4, 10, 15, 18, 19, 21. Thus, scores can range from 0 through 4.

1. Any reminder brought back feelings about it.
2. I had trouble staying asleep.
3. Other things kept making me think about it.
4. I felt irritable and angry.
5. I avoided letting myself get upset when I thought about it or was reminded of it.
6. I thought about it when I didn't mean to.
7. I felt as if it hadn't happened or wasn't real..
8. I stayed away from reminders of it.
9. Pictures about it popped into my mind.
10. I was jumpy and easily startled.
11. I tried not to think about it.
12. I was aware that I still had a lot of feelings about it, but I didn't deal with them.
13. My feelings about it were kind of numb.
14. I found myself acting or feeling like I was back at that time.
15. I had trouble falling asleep.
16. I had waves of strong feelings about it.
17. I tried to remove it from my memory.
18. I had trouble concentrating.
19. Reminders of it caused me to have physical reactions, such as sweating, trouble breathing, nausea, or a pounding heart.
20. I had dreams about it.
21. I felt watchful and on-guard.
22. I tried not to talk about it.

Total IES-R score:_____

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whether other factors are affecting responses. For example, two of the items on the IES-R assess sleep: "I had trouble staying asleep" and "I had trouble falling asleep." If the patient takes medication that affects sleep (that is, it can induce sleep or insomnia), the patient's responses to these questions would depend on whether the drug had been taken. It's often helpful for a nurse to look beyond the mean score in each subscale and focus more closely on specific responses to each question.

Depending on the older adult's needs and wishes, the nurse might discuss scores with family members as well as clinicians. Often, well-intentioned family members are either unaware of the patient's distress or fail to understand how vulnerable she or he is. It's important that the patient's case be discussed with an interdisciplinary committee—especially the social worker who is providing care—before it's discussed with family members. The team can determine who should speak with family and when, as well as what information should be imparted. A team member can speak to family members only if authorized to do so by the patient. If authorized, the nurse may simply say, "Your mother said that she was distressed after the hurricane, and we think she'll benefit from talking with a counselor."

Ms. Albini, continued. A social worker, Regina Scott, met with Ms. Albini. It became clear that she was worried that her belongings, especially the pictures of her husband and her family, had been "ruined." Together they called the West Palm Beach facility and discovered that there had been some water damage, but the staff had recovered most of her expensive clothes and her pictures and her mother's porcelain and placed them in safe storage. Because Ms. Albini felt uncomfortable in the clothes the volunteers had purchased, Ms. Scott took her shopping. She was relieved to be able to dress in a way that made her feel good again. Also, Ms. Scott taught Ms. Albini relaxation exercises, including deep breathing and meditation, to help reduce anxiety. Ms. Albini and Ms. Scott were scheduled to meet once a week for 10 weeks.

After three weeks of meetings with Ms. Scott, Ms. Albini took the IES-R again. Although the results indicated that she still had difficulty staying asleep, this problem occurred significantly less often. After buying new clothes and learning that her keepsakes were secure, the intrusion and avoidance subscale scores were 1.2 each, slightly above "a little bit" of distress. She had begun to go on outings, eat more, and she reported having stomach pain less often. She asked to be taken to Mass on Sundays.

Online Resources

For more information on this and other geriatrics screening and assessment tools and best practices go to www.ConsultGeriRN.org, the clinical Web site of the Hartford Institute for Geriatric Nursing, New York University College of Nursing, and the Nurses Improving Care for Healthsystem Elders (NICHE) program. The site presents authoritative clinical products, resources, and continuing education opportunities that support individual nurses and practice settings.

Visit the Hartford Institute site, www.hartfordign.org, and the NICHE site, www.nicheprogram.org, for additional products and resources. Go to www.nursingcenter.com/AJNolderadults and click on the *How to Try This* link to access all articles and videos in this series.

CONSIDER THIS

What is the evidence supporting the use of the IES-R in clinical practice? There is evidence showing that the IES and IES-R are valid and reliable as measures of intrusion and avoidance and as "a low-cost measure to detect PTSD,"[12] but there are no studies of the use of the IES-R in older adults.

- **Reliability.** For two samples drawn from people who experienced separate earthquakes in California in 1989 and 1994, the IES-R subscales all showed high internal consistency ratings, with Cronbach's α coefficients ranging from 0.87 to 0.91 for the intrusion subscale, 0.84 to 0.85 for the avoidance subscale, and 0.79 to 0.9 for the hyperarousal subscale.[13] The test–retest scores for the 1989 sample ranged from 0.51 to 0.59. The 1994 sample had a shorter interval between the test and retest, and their scores were higher, ranging from 0.89 to 0.94.
- **Validity.** A metaanalysis of 72 studies that used the IES confirmed its validity as a measure of responses to stress in various populations.[14]
  - *Sensitivity.* Beck and colleagues reported that the IES-R was able to accurately identify those with intrusion or hyperarousal responses to stress among 182 survivors in a serious motor vehicle accident.[14] The IES-R's sensitivity was 74.5.
  - *Specificity.* Beck and colleagues also identified a specificity of 63.1, indicating that it was moderately successful in being able to distinguish between subjects with and without PTSD.[15]

Despite the reliability and validity of the IES and IES-R in populations that have experienced traumatic events, no studies have explicitly tested their reliability or validity in older adults. ▼

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Routine use of Try This *tools or approaches may require formal review and approval by your employer.*

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