EDINBURGH EARLY INTERVENTION MANUAL POST TRAUMA (EIM)

An abbreviated version of Edinburgh Psychological First Aid incorporating an adaptation of Interpersonal Psychotherapy (IPT – PT); a practical manual

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Please feel free to use this manual but do so with acknowledgement. If you have comments or feedback feel free to contact us
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### Header Key

- **Blue header:** pages which can be given to the client
- **Red header:** therapist question sheets
- **Green header:** therapist information sheets
E-EIM is a three-staged tiered model of an early response programme following a traumatic event. Exit can occur at the end of each section at 2, 4 or 8 sessions depending on need and the individuals response. To complete all eight sessions can take between 11 and 19 weeks.

**STAGE ONE:** Two sessions

1 Assessment Session + 1 Session of abbreviated E-PFA

Session 1 is a general assessment to gain an impression of the nature of the trauma, the most distressing symptoms, and an impression of the individual's desire to work through the traumatic event.

Session 2 aims to provide basic psychoeducation and to normalise the traumatic response.

Exit or continue

**STAGE TWO:** Two sessions

Mapping out the interpersonal network – 2 sessions
Session 1: Pre trauma interpersonal network
Session 2: Post trauma interpersonal network

When mapping out the interpersonal networks a systematic review of relationships before and after trauma is taken, and the important relationships in the individual’s life are explored together with gaining a thorough understanding of how the interpersonal world has changed as a result of the traumatic event.

Exit or continue

**STAGE THREE:** Four Sessions

Four sessions of IPT-PT

Session 1: Initiating IPT-PT
Sessions 2 and 3: The Problem Area (Focus) grief or role transition focused
Session 4: Termination of Agreement

Exit or discuss need for further help.
The overarching principles for all stages of the programme are:

- Don’t do harm
- Offer warmth, comfort, support and advice to those who need it
- Don’t intrude unless asked by individual
- Make it clear that refusing help now doesn’t jeopardise help in the future
- If you can’t facilitate help in the future, don’t offer it now (in other words do not begin what you cannot finish and do not dip in and then opt out)
- Validate the individual’s experience and their reaction to it (nothing is too much, too little, right or wrong at this stage)

The overarching objectives of the programme are:

- To alleviate the effects of traumatic life events.
- To decrease the stress attributable to those traumatic events.
- To provide assistance with any practical concerns in the immediate aftermath of trauma and thereby prevent further discomfort and distress.
INCIDENT

UP TO THREE WEEKS

STAGE ONE
2 SESSIONS: 1 + 1

EXIT

WATCHFUL WAITING
(3-4 WEEKS)

STAGE TWO
(2 SESSIONS: IP INVENTORY

EXIT

WATCHFUL WAITING
(3-4 WEEKS)

STAGE THREE
(4 SESSIONS: IPT – PT)

EXIT
STAGE 1: UP TO 2 SESSIONS COMPRISING 1+1 APPROACH

(1) 1 assessment session
(2) 1 session of E-EIM

Essentially this will involve an assessment of the following:

- presenting symptoms
- severity of the trauma
- individual’s desire to work through the traumatic event
- basic psycho education
- normalisation of the traumatic response

At this stage, the individual will be assessed to determine how to proceed using a symptom questionnaire (PHQ) and Quality of Life Questionnaire (WHOQOL-BREF).

Following the assessment, one of three possible outcomes:

(a) an immediate move to Stage 2
(b) 3-4 week gap prior to initiating Stage 2 (watchful waiting)
(c) no further intervention: EXIT POINT 1

Stage 2 will follow immediately if the individual

(a) is deemed to be vulnerable and requires immediate response
or

(b) their interpersonal network has been disrupted by the trauma that immediate work is indicated to prevent further disruption.
STAGE 2: MAPPING OUT THE INTERPERSONAL NETWORK

1. summary of network prior to the trauma

2. summary of the network following the trauma

There is guidance on exactly how to complete the interpersonal network in the E-EIM manual, however the key points are as follows:

- *How many changes are inevitable changes as a result of the traumatic event?*
- *What did the trauma actually do the interpersonal work?*
- *What has the individual’s trauma reaction done to the way he/she now reacts to others in the interpersonal network?*

At this stage, the individual will be assessed to determine how to proceed using a symptom questionnaire (PHQ) and Quality of Life Questionnaire (WHOQOL-BREF).

Following the assessment, one of three possible outcomes:

a) an immediate move to Stage 3

b) 3-4 week gap prior to initiating Stage 3

c) no further intervention: **EXIT POINT 2**

**Stage 3 will follow immediately if the individual:**

(a) is deemed to be vulnerable and requires continued intervention

(b) their interpersonal network has been disrupted by the trauma that immediate work is indicated to prevent further disruption.
STAGE 3: INTERPERSONAL PSYCHOTHERAPY POST TRAUMA: IPT-PT

(1) initiating IPT-PT

(2) focus on the problem area

(3) focus on the problem area

(4) termination of treatment

At this stage, the individual will be assessed to determine objectively how they have responded to the intervention again using a symptom questionnaire (PHQ) and Quality of Life Questionnaire (WHOQOL-BREF).

Following the assessment, one of two possible outcomes:

(a) referral to general practitioner

(b) no further intervention: EXIT POINT 3

The individual will be discharged at this point unless they present with elevated symptoms at the assessment. If this is the case, referral to the General Practitioner would be appropriate to access further psychological treatment for possible PTSD.
EDINBURGH EARLY INTERVENTION MANUAL (E-EIM)

PROGRAMME RATIONALE
1. RATIONALE FOR E-EIM

In order for you to understand how and why E-EIM has been developed, this section contains a comprehensive rationale and an overview of the relevant literature upon which our programme has been based. If you are interested in reading about this literature in greater detail, we have provided a more in-depth discussion in our comprehensive book entitled, *Edinburgh Psychological First Aid: E-PFA* (Rivers Centre for Traumatic Stress).

The following section is an abbreviated version of our literature review. Rather than giving you a huge literature review to wade through, we have summarised and bullet pointed the main points for your convenience as follows:

- There is now indisputable evidence for significant levels of distress following a range of different traumas within the first days and weeks of the traumatic event. As an example, dysphoric-depressed emotions, anxiety and dissociative symptoms have all been reported to occur quite frequently during the first few days following an accident (Shalev et al 1996). Intrusive recollections followed by lowered mood because of loss or disruption of relationships may lead to PTSD with depressed mood and depressive thinking during the intrusions. Intrusive thoughts and flashbacks are almost universal in the hours and days after a significant traumatic event and don’t necessarily lead to PTSD.

- Brewin and Lennard (1999) have demonstrated that risk factors operating during and/or trauma, such as trauma severity, lack of social support, and additional life stress, have somewhat stronger effects than pre-trauma factors. These were all key factors we considered when devising E-EIM and form the basis of our rationale for our programme which incorporates the adapted version of Interpersonal Psychotherapy for Trauma (IPT-PT) and includes the social network part of Interpersonal Psychotherapy (IPT-PT).

- Schnyder and Moergeli (2003) lend support to the significance of peri-traumatic variables in their report that recent life events, stress attributable to these life events and daily hassles, correlate significantly with the occurrence of PTSD symptoms in patients who experienced severe accidental injuries.

- Following from research conducted by Pilgrim (1999), which examined the importance of beliefs held at the time of trauma and during its aftermath, it is suggested that if steps are taken to mitigate the development of beliefs about being ‘vulnerable and flawed’ or ‘out of control’, a positive influence may be exerted on trauma related reactions.
Within the E-EIM there is an acceptance that successful adaptation to a traumatic event will eventually involve an emotional engagement with the traumatic memories, an organisation of the memories in an adaptive manner and a correction of dysfunctional cognitions concerning the traumatic experience (Hembree and Foa, 2002) and that to intervene too early with formal psychological treatment may be counterproductive to that adaptation process.

- We do not minimise the effectiveness of exposure interventions but they need to be done in safe and secure interpersonal base.

So, given the above, why are we not suggesting that we use ‘Exposure’ first e.g. EMDR or exposure lead treatment? We suggest the following:

1. Skilled exposure treatment may not be available or with a long wait.
2. Exposure is not for everyone.
3. Exposure may not be available or appropriate because of the nature of the trauma.
4. Exposure is a highly skilled and detailed procedure which requires extensive training.
5. Exposure interventions need to be conducted within a safe and secure environment.

- The early practical support advocated within this model is not designed to be a replacement for the potential support offered by the individual’s interpersonal world (friends, family or work colleagues).
- Through the practical advice provided within the E-EIM we suggest that the individual who has experienced a traumatic event will be best placed to optimise successful adaptation in the future.
- E-EIM is a series of individually tailored, practical, collaborative suggestions designed to supplement, enhance and operationalise the potential support available from within the existing social support network and thereby optimise successful adaptation.
- We are not in a position to claim that the E-EIM will prevent further psychopathology, as to date no empirical investigations have been conducted.
- Throughout our recommendations, we urge that you should be cautious in your consideration of mandatory recommendations for any intervention following trauma, especially programme based manualised treatments unless there is unequivocal evidence that can be quoted in its support.

The Edinburgh Early Intervention Model therefore addresses the above concerns and provides guidance as to how to instigate practical, flexible, individually tailored social support and minimise additional life stress.
2. THE ESSENTIAL PRINCIPLES OF THE E-EIM

1. Console distress and offer comfort
2. Offer practical help
3. Recognise the abnormality of the experience of the trauma
4. Recognise and respect the normality of the post trauma reaction
5. Offer a narrative or narratives matched to the individual’s experience
6. Provide support that seamlessly merges into existing or professional support networks

And not to:
7. Medicalise or pathologise the individual’s reaction
8. Overwhelm with information

3. WHY AN EARLY INTERVENTION MODEL?

Although we cannot claim that E-EIM will prevent the possible outcome of Acute Stress Disorder or Post Traumatic Stress Disorder, it is an alternative to Psychological Debriefing, which did claim to be a preventative model for PTSD and as such, we propose that it will stand as the individually tailored, practical intervention prior to any formal psychological intervention, for those who may go on to develop symptoms of Acute Stress Disorder and will optimise successful adaptation to a traumatic event.

There is evidence now that the most successful early intervention, in terms of prevention of psychopathology, appears to have been achieved with a brief intervention comprising four or five sessions of Cognitive Behaviour Therapy. However, it should be noted that formal psychological treatments, such as CBT are based on the premise that there is a psychopathological condition that needs to be treated and should not be offered before two weeks has elapsed since the traumatic event (Bryant 2003). In other words they 'treat' acute stress disorder or early PTSD.

E-EIM attempts to fill that gap for immediate intervention post trauma. To the author’s knowledge, guidelines do not exist that serve the same purpose as those proposed within the E-EIM.

Although there are no good previous studies for rates of PTSD in the UK studies using very similar methodology found a rate of 1% in Australia and nearly 3% in the USA.

It is now generally accepted that those individuals who suffer from post-traumatic stress disorder are at an increased risk of developing other psychiatric disorders and are a significantly increased risk of committing suicide (Kessler, Borges and Walters, 1999).

The socio-economic consequences associated with a diagnosis of post-traumatic stress disorder are considerable and the effect on employment and work productivity is similar to that associated with depression and translates into an annual loss of productivity above £2.1bn in the United States (Merzey and Robbins, 2002).
Given the above summary, the following are the key concepts which we based our rationale for E-EIM:

- Not all individuals who experience a traumatic event will necessarily go on to develop any prolonged psychological disorder.

- Many individuals will manage their experience without any intervention at all, but how do we know who may or may not go on to develop any further psychological difficulties?

- Most instances of recovery from early responses to traumatic events will occur within the year following the trauma (Kessler et al, 1995: Shalev et al, 1997) and it also appears that the early days after a traumatic event may offer a window of opportunity, during which individuals at risk for developing chronic stress disorders, may be identified and treated (Bryant et al, 1998; Foa et al, 1995; Solomon and Benbenishty, 1986).

- Although most individuals who develop prolonged stress disorders show symptoms of distress in the early aftermath of traumatisation, not all will do so (Rothbaum and Foa, 1993) and this is an important consideration for any early intervention to bear in mind.

- One-off screening for individuals at risk in the immediate aftermath of a traumatic event is perhaps not the best way to identify those who will later go on to develop Post Traumatic Stress Disorder (PTSD).

- During the immediate aftermath of trauma, there may still be a handling of the trauma, rather than treating a posttraumatic condition (Shalev, 2002) and this is the very essence of E-EIM. Psychological response (or first aid) may therefore be a proper term for some interventions and this would certainly apply to our programme.

The advice for early intervention post trauma, derived from the most recent and relevant research is as follows:

1. Along with symptoms, current sources of stress should be in the forefront of any assessment of distress (this is incorporated into our assessment).

2. The complexity of events and responses should be noted – the mental and physical conditions that follow traumatic events are extremely complex and the resulting behaviour is unstable and rapidly changing (Rosser and Dewar, 1991; Shalev et al, 1993; Yitzhaki et al, 1991). The perception of the event may vary from one individual to another (Shalev et al, 1993).

3. Expressions of distress are often appropriate at this stage and one should be careful not to classify them as symptoms in the sense of being indicative of a psychological disorder. Pathologising an early response is often the result of a profound misunderstanding of the role of pain and anxiety as signals to the body, the psyche, and others. An essential diagnostic element at this stage is not the intensity but the appropriateness and the productiveness of the early response in engaging a healing process.

4. During rescue efforts, professionals and non-professionals may have similar roles (soothing, comforting, orienting, reassuring). Non-professionals are available in larger numbers and include the survivor’s natural supporters (relatives and peers) and often community members. We make use of this in our application and IPT-PT as part of E-EIM.
Shalev (2002) argues that the clinical assessment of the recent survivor of a traumatic event should firstly and most importantly clarify what has been particularly traumatising for the individual. Rather than imposing a particular view or assuming that threat may be a traumatic element, it is vitally important to determine the meaning for each individual.

“…understanding individual experience (as opposed to imposing one’s own template) is the key for creating a therapeutic report” Shalev 2002.

It is during the short period that follows the trauma that a stable narrative of the traumatic event and of one’s own responses is formed and consolidated and that these may shape the way in which the event is remembered.

In the days that follow the traumatic event, individuals appear to go from a period (i) being under stress to (2) a period of reappraisal and re-evaluation. The former may be characterised by the use of extreme defences such as over control of emotions or dissociation and a focus on surviving trauma whereas the latter period may be characterised by intrusive recollections of the traumatic event.

The main psychological task at this time is the assimilation of events and their consequences. Both periods can be painful and hence there is a requirement to cope effectively during each of them.

So how can coping be assessed? From a clinical point of view, what is ultimately important is the degree to which coping efforts are successful as opposed to the specific ways in which each individual may choose to cope. According to Pearlin and Schooler (1978), successful coping must protect the individual’s ability to:
- Continue task-oriented activity
- Regulate emotion
- Sustain positive self-value
- Maintain and enjoy rewarding interpersonal contacts.

One of the key principles underpinning the E-EIM model is that we should take great care not to look for or assume that there will be certain responses to traumatic events. We have found a helpful way to consider early reactions to trauma is to examine common themes, as have been described by Shalev (2002):

**Acceptance and communicability of symptoms**

Most individuals will vary as to how they will respond in the immediate aftermath of trauma. A short period of shock is regularly followed by repeated recollections of the traumatic event. Within this, some survivors are extremely disturbed, whereas others are not. This is an extremely important point to note if contemplating using E-EIM. For some survivors, the intrusive recollections may be so severe that they are fearfully avoided; experienced as a torment; seriously affect sleep; curtail conversations about the traumatic event and create a wall of silence and isolation and loneliness. In other individuals, survivors use the intrusive recollections to repeatedly tell others about the traumatic event and thereby recruit sympathy and help. Such repetitious telling of the story is so frequent that it may be useful to tolerate and accept hearing the story over and over again. Indeed, Shalev (2002) describes how effective retelling of the story shows that its content changes with time, becoming richer and including other elements and perhaps takes on a more reflective tone.

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1 Successful coping has been defined as “…the effort to increase the gap between stress and distress” (Pearlin, 1978).
Symptoms are multifaceted and unstable

Individuals will react to trauma in a myriad of ways. The intensity of the fear response may vary from flight or fight to freezing and surrender.

Symptoms are normally expressed yet some are alarming

Shalev (2002) argues that some symptoms observed immediately after trauma are “normal” in the sense of affecting most survivors and being socially acceptable, psychologically effective and self-limited. Some symptoms, however, may announce more severe reactions such as dissociation, which should be viewed as being very alarming (Eriksson and Lundin, 1996; Shalev et al., 1996). What is interesting to note is that most survivors who express intense symptoms will still recover (Shalev et al., 1997).

One of the most distressing elements of the immediate post-impact period of traumatic events can be facing losses, both real and symbolic losses as described by Foa et al., (1989). The recovery from loss involves grieving and readaptation, i.e. new learning about the self and others.

The E-EIM has two ‘focus areas’ for post-trauma, one of which is grief. We therefore provide an adapted version of IPT to help in the grieving process.

4. EXTRA CONSIDERATION FROM THE LITERATURE

The results of a follow up study by Schnyder and Moregeli (2002) are important for our consideration as they revealed relatively low levels of PTSD occurring in a group of victims who had sustained severe, mostly life-threatening physical trauma. The authors postulate that this may have arisen due to the fact that patients were psychologically healthy when they were suddenly and unexpectedly exposed to an overwhelming stressor and the during their stay in hospital they were provided with highest degree of self-control and with a maximum of professional and personal support. The relatively low levels of distress found in these patients might have been explained by low pretraumatic vulnerability combined with a maximum amount of posttraumatic control and support, which is exactly what E-EIM aims to provide. However, we must be cautious in our use of these findings, as the results of this study were based on individuals in hospitals and therefore may not be generalisable to those not in hospital.

Schnyder and Moergeli (2002) state that recent life events, stress attributable to these life events and daily difficulties, correlated significantly with the occurrence of PTSD symptoms. The authors report that this finding is particularly important as it indicates that the pretraumatic stress load may have an influence in psychologically healthy subjects on their coping with and healing from accidental injuries and their sequelae.

Any healthcare professional involved in the aftercare of individuals should pay special attention when recording case histories to the strains and stressors their patients have been and are currently exposed to; this lends a great deal of support to the E-EIM which examines the current strains and stressors of the individuals.
5. SUMMARY

- Not all individuals will react in the same way following a traumatic life event – there can be a myriad of responses and therefore it is extremely important not to generalise our approach to those in the immediate aftermath of trauma.

- Early intervention should **not** be regarded as a psychological intervention

- Not all individuals will require intervention post trauma

- Not all individuals who develop prolonged reactions to trauma will demonstrate this early in the aftermath of trauma although survivors should be considered as being **at risk** for developing traumatic stress disorders.

- Early and urgent needs of all should be addressed (although not necessarily by psychological interventions).

- The survivor’s progress towards recovery should be followed and clinical decisions made on the basis of longitudinal observations (instead of cross sectional examination).

- Intervention should be provided in the context of continuity of care and should be individually tailored to suit specific needs.
EDINBURGH EARLY INTERVENTION MANUAL (E-EIM)

STAGE 1

2 SESSIONS

1 Assessment Session + 1 Session of abbreviated E-PFA

(Using an abbreviated version of the Edinburgh Psychological First Aid Programme)
The principles of Stage 1 of the Edinburgh Psychological First Aid model are:

a) To console distress and offer comfort
b) To offer practical help
c) To recognise the abnormality of the experience of the trauma
d) To recognise and respect the normality of the post trauma reaction, whatever that may be
e) Not to medicalise or pathologise the reaction
f) Not to overwhelm with information
g) To offer a narrative or narratives matched to the individual's experience
h) To provide support that seamlessly merges into existing or professional support networks.

Useful advice:

1. The principle element here is the facilitation of normal emotional responses to any traumatic event.

2. We advocate that any professional involved in the care of an individual who has experienced or witnessed a traumatic event, should not rush into a debriefing session, nor should they encourage a re-telling of the trauma story (by it's definition, the term 'debriefing' would imply that a telling of a story is the basis of the process).

3. The initial role of the professional will be to provide practical assistance, emotional support and comfort to the individual – psychological techniques should not be incorporated into the support offered.

4. Any one of a care team may be required to offer support to an individual who has experienced or witnessed a traumatic event. Therefore, the stages offered in the following guidelines are aimed at any health care professional.
SESSION 1

(Before the session starts the patient should be asked to complete the PHQ and the therapist should score it before commencing the session).

The first session is a general assessment to gain an impression of the following:

1. Description of the most distressing presenting symptoms
2. Description of the nature and severity of the traumatic event
3. An impression of the individual’s desire to work through the traumatic event
4. What has caused the need for treatment? *What has been going on in the individual’s life that has caused the need for treatment and WHO was around (interpersonal context)* but be careful not to imply that the reaction is due to other causes (i.e. not the trauma itself)
5. Recent history of distress including a review of particular interpersonal precipitants and/or consequences of the trauma
6. Review of any presenting symptoms using the PHQ as a basis – see following page for further details
Use of the Patient Health Questionnaire (PHQ)

Purpose of it:

The purpose of the PHQ is to monitor general symptoms over time and to detect change; it is not a diagnostic instrument but a way of focusing your attention on which symptoms are present.

What to do:

The PHQ is scored using the scoring instructions at the end of this stage (scores across the sessions can be recorded in the following score sheet). Following completion attention should be paid to any areas that score above the normal ranges.

Review any such areas with the patient and monitor them over the coming weeks/sessions.

Encourage the patient to monitor these areas as well and to report any changes, with both you and the patient paying particular attention to areas that are related to any interpersonal difficulties (for use in stage 3).

After scoring the PHQ if it is your clinical opinion that any of the symptoms appear to be very severe or the patient scores indicate severe depression or anxiety then it is recommended that the patient go to their GP.
# THERAISA QUESTION SHEET
PHOTOCOPYABLE RESOURCE

## PHQ Scoring Sheet

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SESSION 2

Session 2 has two aims:

1. Providing basic psychoeducation (included with this pack)
2. Normalisation of traumatic response

The aims will be accomplished in session 2 by offering the following 7 steps

1. Practical help
2. Comfort and console distress
3. Education on normal responses to trauma which involves two essential elements:
   - Recognising the range of reactions
   - Respecting and validating the normality of the post trauma reaction
4. Protection from further threat and distress
5. Furnish immediate care for physical needs
6. Support for real world based tasks
7. Facilitation of reunion with loved ones

Following is a brief description of the steps and questionnaires and handouts for both client and therapist to help achieve these aims:
The main objective of this stage of treatment is to offer PRACTICAL support.

Examples may be simple and will vary according to the individual’s needs; individuals may feel overwhelmed, disorganised or unsafe. It is often the most simple things that need to be organised, for example:

- Organising a baby-sitting service in order for a couple to be able to spend an evening together will be practical and beneficial for the normal process of grief to be achieved.
- Picking children up from school/taking children to school because the mother feels too afraid to go out or too nervous to drive.
- Replacing or changing locks after a burglary.
- Contacting insurance companies.
- Arranging for someone to stay overnight if the person is alone.
THERAPIST QUESTION SHEET: PHOTOCOPYABLE RESOURCE

(1) PRACTICAL HELP – think about the following question:

Can we help you with any of the following?

- Time to be alone
- Time to be with loved ones
- Protection from outside world/media
- Seeking practical help

Physical health concerns:

- Can we help you make an appointment to see your GP?
- Can we go with you to the GP or help you find someone to go with?

Finances:

- Can we help you contact the most appropriate person in your bank/building society, social security?
- Are there any important bills to be paid that you are worried about?
- What is your system for paying bills?
- Can we help you with any of that so that you are comfortable that you are not falling behind with any regular payments?

Housing/Transport:

- Can we help to make sure that your rent/mortgage is paid?
- Do you feel safe to stay in your house alone? If not, what can be done immediately to ensure that you feel safe?

Safety Issues:

- What could potentially be around to help with feeling safe?
- What could be done immediately to increase the feeling of safety?

Work Issues:

- Is there someone that can be contacted to discuss any work concerns?
(2) COMFORT AND CONSOLE DISTRESS

- Is the individual receiving comfort and consolation? The professional working with an individual who has suffered/witnessed a traumatic event should ensure that the fundamental comfort for distress is available, as and when needed. It will be of the utmost importance to determine if the individual has the appropriate resources available to draw upon should he/she need them. Once this has been determined, it will be the role of the professional to organise the practical/emotional support which is required.

- Line managers and work colleagues can also play an important part in offering support following industrial accidents. It may be important that they acknowledge the distress and praise how the individual managed the situation.

BRUCE

Bruce, a 44 year old train driver was involved in a near head on collision with another train. After dealing with the incident calmly, he was asked to complete a report and then sent home. He felt unable to talk to his wife about what had happened, as she did not understand the technicalities of what had gone wrong.

After the accident, he had very little contact with either his colleagues or his line manager and therefore did not have the chance to discuss what had happened. He gradually became increasingly more isolated and found it difficult to return to work.

What was most distressing for Bruce was what he feared might happen. He knew a colleague who had been involved in a similar incident, who had to go through multiple enquiries, press intrusions, and eventually marital breakdown. He was tormented by ‘flash forwards’ about what might happen.
(2) COMFORT AND CONSOLE DISTRESS

Think about the following questions:

- Are there people around who you feel you can turn to at this time?
- Have you been able to turn to them? If not, why not?
- Is there anything we can do to help with this?

Work related incidents:

- Have you been able to speak to your line manager/colleagues about this incident?
- Is there anything we can do to help with this?
Be aware of the range of responses to trauma

These twelve reactions are not mutually exclusive; all sorts of combinations may occur though one pattern may dominate:

1. Acute Stress Reaction
2. Elation/euphoria
3. Survivor guilt
4. Survivor shame
5. No reaction
6. Numbing
7. Suspicion
8. Irreverence/black humour
9. Amnesia/missing memories
10. The death imprint
11. Quest for meaning
12. Positive response – survivor competence
NORMAL RESPONSES TO TRAUMA

Below is a list of the common responses to trauma, these are perfectly normal responses and may occur on their own or in any combination. Be aware of the range of responses to trauma:

- Disorientation, agitation – feeling numbed to what is going on around you
- Elation/euphoria – feeling glad to be alive
- Survivor guilt – feeling guilty to have survived
- Survivor shame – feelings of shame caused by the reaction to the trauma
- No reaction – feeling fine
- Numbing – not feeling anything
- Suspicion – a feeling of doubt
- Irreverence/black humour – this is normal and widely used
- Amnesia/missing memories – inability to remember all or part of the trauma
- Flashbacks of the trauma and images of the encounter with death – images as though the trauma were repeating in your head
- Quest for meaning – desperate to find some meaning behind the traumatic event in order to understand why it has occurred
- Positive response – survivor competence

Below are examples of typical reactions within each of the responses to trauma:

1. Acute Stress Reaction
   - Disorientation
   - Restricted response to surroundings
   - Stupor and fugue
   - Agitation and other physical symptoms of anxiety
2. Elation/Euphoria

Glad to be alive, “I’m so lucky… I’m invincible”

Jim

Jim was involved in a horrific car crash on the M6 in which 4 people died. It was a multiple pile up in wet weather. He was saved by his airbag. He was badly bruised but got out of his car 30 seconds before it was destroyed by an articulated lorry, ramming it from behind. Jim felt lucky to have escaped. Over the next few hours he felt calm and in control. As the day went on he began to feel high – he talked non-stop about what happened. He said he felt powerful and he could do or survive anything. He was somewhat insensitive and rude to others in the casualty department. He didn’t sleep for two nights and then his high gradually subsided.

3. Survivor Guilt

Typical responses include:
- I’m OK but what about everyone else?
- Why did I survive?
- It’s not fair. So many good people survived and I’m OK.
- I should have done more.
- I feel responsible in some way for their suffering, their loss.

There are two types of survivor guilt:

1. Existential Guilt: “Why me?”
   “Why did I survive when so many died?”

2. Appraisal Guilt: “Did I do enough?”
   “I should have done more”

Self Blame may be:

1. Behavioural: blaming own actions and behaviour – this is often more adaptive and in our experience leads to fewer long-term problems.

2. Characterological: blaming deficiencies in own personality – this is often most likely to be associated with depressive reactions.

Guilt may have positive functions:

- expression of loyalty to those who are dead or suffered
- symbolic function – a living testimonial to those who died
- recovering would mean betraying those who died
- recovering would mean forgetting the dead and maybe forgiving the persecutors
JOHN

John was an oil worker on the Piper Alpha Rig when it exploded. He managed with his boss to get to one of the crane arms, away from the fire. There was a knotted rope which you could clamber down to the sea 150 feet below. He and his boss argued at the top of the rope, each insisting the other clamber down first. John was emphatic that his boss, who was married with two children, should go first. In the end, John was ordered to go first. He clambered down the rope and jumped the last 50 sea into the sea. He was picked up by a Zephyr inflatable which was dashing in towards the rig when a man was seen in the water. As the boat backed away, he saw his boss half way down the rope, engulfed in a massive tongue of flames.

John was consumed with guilt about what happened mainly about his boss and about the risk the Zephyr boat men took in rescuing him.

Although his whole trauma story was very long and involved multiple stressors (for example, when he got to the rescue boat, he was completely black and covered in oil and was laid between two dead bodies who were blackened from burning) all he wanted to talk about was his guilt and grief. When asked to tell what had happened to him, he felt the debriefer was missing the p

4. Survivor Shame

- Communities may exhibit this by shunning survivors.
- Atomic bomb survivors in Japan, the Hiba Kusha (explosion affected persons) received little or no recognition and became stigmatised and forgotten.
- Hungarian Jews after the holocaust were badly treated and sometimes murdered by their neighbours when they returned home.
- Individuals may experience intense shame at being part of the same human race that caused the atrocity / disaster.

PETER

Peter was a regular soldier who had 3 tours of duty in Northern Ireland and fought in the Falkland War. He felt acutely uncomfortable with the heroic reception on returning from the Falklands and felt that this was not meant for him. He did one more tour in Northern Ireland, left the Army and returned home. His marriage failed and he moved to Helensdale, 100 miles north of Inverness. For 10 years he lived alone and was largely self-sufficient. He did not draw social security or unemployment. He made no contact with his family. He felt intensely ashamed. Ashamed of his reaction and inability to cope but also ashamed of being a member of the male sex. How could men do things to each other and to women that he had seen?

5. No reaction

Typical reactions such as the following:

- I feel fine.
- Should I be feeling guilty
- Is there something wrong that I’ve acted this way?”
6. Numbing

- Important defensive reactions
- The calm before the storm
- Adaptive, allows one to cope in a catastrophe and in the days and weeks after the trauma
- Individuals may say:
  - “I feel disconnected”
  - “I feel I’m floating”
  - “I feel I’m on drugs”
  - “I feel emotionally paralysed”

7. Suspicion

- Help from outsiders is distrusted
- Offers may be false
- Outsiders don’t understand
- Individuals become precious about experiences (no-one can ever really understand)
- May develop into paranoid reaction

8. Irreverence/Black humour

- Humour is normal & widely used
- It is often used by rescue personnel e.g. doctors/nurses
- It is a protective reaction for some people
- It may cause offence to bystanders

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FOUR TEENAGERS

Four teenagers were killed in a horrific road traffic accident which occurred just before A Levels at a large secondary school. The four who died were all popular and peer group leaders. One had borrowed her father’s new BMW. There was a head on crash in which two women in another car were seriously injured.

Walk in ‘clinics’ at lunch-times were offered to all pupils. The common reason for self-referral were pupils worried they weren’t reacting by asking. “Was it OK to get on with life and study for exams?”

Black humour in the playground, “What a bloody waste of a new BMW” caused some fights and was distressing to teachers.
9. Amnesia/missing memories

Amnesia in the absence of head injury/concussion is not uncommon. It is a protective mechanism and it may be for just part of the experience:
“I can’t remember how I got out of the car, I just found myself on the curb”
Or it may be for much longer:
“I can’t remember going to hospital; I have a vague image of blue flashing lights but the first 3 days were a blur. The first clear memory is greeting my dog when I got home.”

---

JOANNE

Joanne was driving her Fiat Uno back from a day shopping in Glasgow. Her two children were in the back seat. She was in the middle lane of a three lane motorway. A juggernaut in the outside lane suddenly pulled in as she was level with the cab. The car was bounced across the inside lane, missing the traffic, hit the wall, bounced out again across both lanes in front of the juggernaut and was pushed sideways down the M8 for about 100 meters. She can remember thinking several times that she was going to die and being convinced her children were already dead. She remembers turning around and seeing them alive. Her last memory for three days was the juggernaut driver pulling open the passenger door and screaming at her “What the f--- sort of driver are you, you stupid bitch?”

Joanne was uninjured, not knocked out but had complete amnesia for three days. She ‘woke up’ in a nightmare on the third night, convinced she had just attended her children’s funeral.
10. The Death Imprint

- Indelible imagery of an encounter with death
- A condensation of the entire experience
- No details spared
- Survivor may be spellbound by such images
- Triggered by multiple everyday events

**ANNA**

Anna was involved in a fairground accident. She was thrown out of a waltzer; her leg caught in the handrail. For several minutes, she was flying around, bouncing off other cars. With each collision, she thought that she was going to die. She had 17 fractures and 2 fracture dislocations. She had a complex multi-sensual experience in which the whole condensed trauma experience, the music and flashing lights and elements of her past are all mixed up. It ends with silence, a slow moving coloured lights in which she feels strangely calm. Each time, she is convinced that she is dead.

11. Quest for Meaning

- Preoccupation with questions such as:
  - *Why did it happen?*
  - *How did I escape?*
  - *Why did I escape?*
  - *Why do I feel this way?*
  - *What does this mean about my life now?*

12. Positive Response – Survivor Competence

Some people feel good when they feel that they have faced a crisis and handled it well. They may feel that life has sent them a challenge and that they have overcome it or that having gone through traumatic experiences with a colleague they have had a close and bonding experience. Others feel that life has more meaning, or that having survived a disaster they feel closer to their families and friends or they appreciate more what they would have lost if they had been badly injured or not survived. Such positive reactions are more likely to happen in situations where the individual knew they were putting themselves at risk and chose to do so and in natural rather than man made disasters. People working in teams such as a mountain rescue team, or an A&E trauma team are more likely to have such positive responses especially if this is what they have been trained and prepared for.
(4) PROTECT FROM FURTHER THREAT AND DISTRESS

- It is extremely important to determine whether or not the individual is safe. If there is any threat or potential threat to safety, it is vital to determine what can be done to ensure their safety and by whom. Again, it will be the role of the professional to organise the appropriate resources/strategies to ensure that the individual concerned is and remains safe at all times.

- Protection from well meaning helpers

MARY

Mary was a 67 year old, living alone in Lockerbie. She had part of an engine fall through her roof, demolishing her bed. She would have been killed if she had been in bed but as it was 7pm, she was downstairs watching Coronation Street.

The most helpful contact was from the council workman who came to mend her roof the next day. He made her a cup of tea, chatted about what else was going on in Lockerbie and temporarily fixed her TV aerial so that she was in contact with the world again; she found his straightforward chatty personality to be comforting.

Over the next 7 days, she was visited by her GP, a CPN, a Catholic Priest, a Social Worker, a Red Cross Worker and someone who said they were a counsellor.

She felt intruded upon and guilty. She was pleased her GP came but felt she shouldn’t take up his time and that he must have more serious cases to deal with. None of the ‘visitors’ had proper I.D., all wanted to know how she was ‘feeling’ – all were strangers to her except for her GP.

By the end of the week, she was reluctant to open the door, felt afraid and very alone. What she really wanted to do was get away from Lockerbie and visit her daughter in the South of England.

A year later, she had a major depressive illness and felt that she couldn’t now ask for help, having turned all those good people away. No professional had visited her in that year.
(4) PROTECT FROM FURTHER THREAT AND DISTRESS

- Do you feel safe right now?
- Do you feel safe when you leave here?
- How can I help you to feel safe and secure?
- Is there any way that I can help you to minimise any further distress?

Therapist point: Important to remember the following:

- THREAT CAN BE REAL OR IMAGINED
- DON’T FALSELY REASSURE – HYPERVIGILANCE MAY BE PROTECTION
(5) FURNISH IMMEDIATE CARE FOR PHYSICAL NEEDS

The first stage is to determine exactly what the physical needs are and to determine if those needs are being met. If they are not, it is the role of the professional to ensure that everything which can be done is being done. If the individual has a physical injury, does he/she understand exactly what is wrong and what the consequences of their physical illness/injury are? It is their role to ensure that there is an accurate understanding and appreciation of any consequences. If the professional is unsure him/herself, it will then be their role to ensure that another qualified member of the primary care team is enlisted to create and develop that understanding.

JESSICA

Jessica, a 36 year old mother, had been in a road traffic accident involving a head on collision. She had suffered severe physical injuries which required spending 2 weeks in hospital. On discharge, she had to take a taxi home. Over the next few days, her husband was required to care for Jessica, often feeling unsure of what to do. Eventually her GP was contacted by the hospital and home help was organised, however, Jessica now felt resentful that she and her husband had had to manage on their own at the beginning. She felt that if she had been offered support initially, this transition would have been easier.

It is important to consider both the physical injuries and psychological impact of the trauma and both should be treated with equal importance.
(5) FURNISH IMMEDIATE CARE FOR PHYSICAL NEEDS

- What are the physical needs of your client?
- Are those needs being met?
- If they are not, it is the therapist’s role to ensure that everything which can be done is being done.
- If the individual has a physical injury, does he/she understand exactly what is wrong and what the consequences of their physical illness/injuries are?
(6) SUPPORT FOR SPECIFIC REAL WORLD BASED TASKS

This is really about reinforcing the concrete world

- What have you not lost?
- Do others need help as well as you?
- What do you need to do to put your life on hold?
- Is it appropriate to do that? (such as returning to work)
- What can you keep doing?
- What do you need to stop for the present?
- Facilitate access to appropriate information

The role of the professional here is to ensure that a priority task list is created. The professional will instigate the making of such a list and ensure that it is based on a realistic evaluation of the situation and needs of the individual, perhaps enlisting the help of those closest to the individual. (Food, comfort, housing, space, continuing with work etc).
(6) SUPPORT FOR SPECIFIC REAL WORLD BASED TASKS

- What have you not lost?
- Do others need help as well as you?
- What do you need to do to put your life on hold?
- Is it appropriate to do that? (such as returning to work)
- What can you keep doing? What do you need to stop for the present?
- Facilitate access to appropriate information

Following these questions creates a priority list for the client, possible with the help of a close friend/family member based on the needs and situation of the client (food, comfort, housing, space, continuing with work etc).
(7) FACILITATE REUNION WITH LOVED ONES

This is about helping to bring about a reunion with all those who are important to the individual, not just members of the immediate family. Again, it is the practical elements which need to be considered by the professional and to respond to idiosyncratic requests. Examples include:

- *Who will screen the phone calls for the person?*
- *Is there a system for screening letters?*
- *Can we help you to write a letter to friends and relatives who are far away?*
- *Can we contact people for you?*
- *Who will be your primary advocate?*

The professional will ensure that such a system is organised and running smoothly and therefore not add to the distress of the individual.
(7) FACILITATE REUNION WITH LOVED ONES

- Who will screen the phone calls for your client?
- Is there a system for screening letters?
- Can we help you to write a letter to friends and relatives who are far away?
- Can we contact people for you?
- Who will be your primary advocate?
WHAT HAPPENS AT THE END OF STAGE 1?

At the end of session 2, we suggest that you use 2 questionnaires to determine how to proceed:

1. ‘Patient Health Questionnaire’ to measure the severity of the current difficulties.
2. ‘WHOQOL-Bref’ (WHOQOL Group, 1996) to measure any changes in the client’s perceived quality of life.

AFTER THE QUESTIONNAIRES

1. Immediate move to Stage 2 OR
2. 3-4 week gap prior to initiating Stage 2 (watchful waiting) OR
3. No further intervention ……………….. EXIT POINT 1

STAGE 2 WILL FOLLOW IMMEDIATELY IF:

1. Your client is deemed to be vulnerable and requires immediate response as defined by your clinical judgement, providing their PHQ scores are under 21. If their PHQ scores are >10 but <21, whilst it is appropriate to continue with EIM, we would suggest that the patient go and see their GP.
   **NOTE:** With a PHQ score leading to severe anxiety or depression i.e. >21, if the patient is drinking significantly, or it is your clinical judgement that they are too unwell to continue then it is not appropriate to continue with EIM and we would strongly advise that the patient should go to their GP.

2. The interpersonal network has been so disrupted by the trauma that immediate work is indicated to prevent further disruption.
**Patient Health Questionnaire (PHQ)**

This questionnaire is an important part of providing you with the best health care possible. Yours answers will help in understanding problems that you may have. Please answer every question to the best of your ability unless you are requested to skip over a question.

Name: ______________________ Age: ___________ Today's Date ________________

Sex:  Female □    Male □

1. Over the last 2 weeks how often have you been bothered by any of the following problems?

<table>
<thead>
<tr>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

a. Little interest or pleasure in doing things  □  □  □  □

b. Feeling down, depressed or hopeless  □  □  □  □

c. Trouble falling asleep or staying asleep, or sleeping too much  □  □  □  □

d. Feeling tired or having little energy  □  □  □  □

e. Poor appetite or overeating  □  □  □  □

f. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down  □  □  □  □

g. Trouble concentrating on things, such as reading the newspaper or watching television  □  □  □  □

h. Moving or speaking so slowly that other people would have noticed? Or the opposite – being so fidgety and restless that you have been moving around a lot more than usual  □  □  □  □

i. Thoughts that you would be better off dead or of hurting yourself in some way  □  □  □  □

**Diagnostic Criteria:**

If answers to number 1 a or b and five or more of 1 c – i are at least 'Most than half the days' (count number 1 i if present at all) – Major Depressive Disorder:

**Severity Criteria**

0-9 = no depression
10-20 = moderate depression
21+ severe depression
2. Questions about anxiety

a. In the last 4 weeks have you ever had an anxiety attack – suddenly feeling fear or panic?  
   NO □ YES □

If you checked “NO” go to question 3

b. Has this ever happened before?  
   □ □

c. Do some of these attacks come suddenly out of the blue – that is, in situations where you don’t expect to be nervous or uncomfortable?  
   □ □

d. Do these attacks bother you a lot or are you worried about having another attack?  
   □ □

Diagnostic Criteria
If all numbers 3 a-d are present then Panic Disorder
3. Over the last 4 weeks how often have you been bothered by the following problems?

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Feeling nervous, anxious, on edge or worrying about a lot of different things</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Feeling restless so that it is hard to sit still</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Getting tired very easily</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Muscle tension, aches or soreness</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Trouble falling asleep or staying asleep</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Trouble concentrating on things such as reading a book or watching TV</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Becoming easily annoyed or irritable</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If you checked “Not at all” go to question 4

Diagnostic Criteria
If all numbers 5a and answers to three or more of numbers 5b-g are ‘More than half the days’ – Generalised Anxiety

Severity Criteria
0-9 = no anxiety
10-20 = moderate anxiety
21+ severe anxiety
4. Have any of the following happened to you more than once in the last 6 months?

<table>
<thead>
<tr>
<th></th>
<th>NO</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. You drank alcohol even though a doctor suggested that you stop drinking because of problems to your health</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>b. You drank alcohol, were high from alcohol, or hung over while you were working, going to school, or taking care of children or other responsibilities</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>c. You missed or were late for work, school, or other activities because you were drinking or hung over</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>d. You had a problem getting along with other people while you were drinking</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>e. You drove a car after having several drinks or after drinking too much</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

It is important to ask about increase in alcohol consumption, however this scale does not make a diagnosis, use this to monitor symptoms.
EDINBURGH EARLY INTERVENTION MANUAL (E-EIM)

STAGE 2

2 SESSIONS

MAPPING OUT THE INTERPERSONAL NETWORK

Pre and Post Trauma
Mapping out the Pre-Trauma Interpersonal Network

SESSION 1

The first session involves mapping out an interpersonal network PRIOR to the trauma

Key Points to consider for this session:

- The systematic review of relationships prior to the trauma involves an exploration of the individual’s important relationships with others – information should be gathered about each person who is important in the individual’s life.
- When drawing out this network, try to get thorough understanding of exactly what the interpersonal world looked like prior to the trauma.
- Really try to gain an understanding of the interactions in this person’s life.
- Try to work out who the “key players” are by using the following questions:
  - “If you needed to ask advice from someone at 4am (before the ……. trauma), who would have phoned?”
  - “Before the (……. trauma), if you broken your leg and needed help for practical aspects of your life, who would you have asked?”
  - “Before the (……. trauma), who would you have turned to in an emergency and say you needed to borrow £2000 – and it couldn’t be a member of your family?”
- Also, try to gain an insight into how the different groups or individuals interact – i.e. are there links or is each group/individual separate?
- Is there a balance between emotional and practical support? What is the balance like?
- If very few individuals prior to the trauma – are there pets?

A NOTE OF CAUTION:

Remember in your assessment of the interpersonal networks that the pre trauma network is based on months and years of interaction and the post trauma network is based on days or weeks.
INTERPERSONAL INVENTORY PRE-TRAUMA

For each person identified, answer the following questions (consider family, social, work relationships separately):

1. Frequency of contact: “How often do you see or speak to this person?”


3. Activities shared: “What sort of things do you do together? Is it face to face or is it on the ‘phone?”

4. Expectations: What are your expectations in this relationship?”

5. Satisfactory and unsatisfactory aspects of the relationship: “We all experience good parts of a relationships and those parts that are not so good or satisfying, is it possible for you to talk through each side?”

6. Ways you would like the relationship to change: “Can you say how the relationship could change so that it would be more satisfying for you?”
Example of an interpersonal inventory pre-trauma

**Church**
- **FoC:** 1 – 2 times per month
- **AS:** enjoy going with wife
- **E:** security
- **SA:** I know it
- **UA:** nothing

**Mr Z (Brother) 43 years old, single lives away**
- **FoC:** 1 x phone every month, I phone him
- **AS:** very little/none
- **E:** very little
- **SA:** very little
- **UA:** very little contact
- I don’t really know him
- **WTC:** more contact. Become closer

**Jane and Dave (friends)**
- **FoC:** 1 x a month
- **AS:** go on holiday together
- **E:** love a good time together
- **SA:** known them for ages
- **UA:** nothing
- **WTC:** nothing

**Miss Y (daughter) 10 years old**
- **FoC:** everyday, takes her to school
- **AS:** go on holiday together
- **E:** love a good time together
- **SA:** known them for ages
- **UA:** nothing
- **WTC:** nothing

**Jim* (best friend)**
- **FoC:** x 2 a week in the pub, Fri/Sat night
- **AS:** chats, darts, pub quizzes, golf
- **E:** Jim’s always been my pal
- **SA:** don’t have to explain anything to Jim, history
- **UA:** nothing
- **WTC:** nothing

**John, Alec, Chris (work mates)**
- **FoC:** everyday
- **AS:** work
- **E:** to be part of a team, to have a laugh
- **SA:** being part of a team
- **UA:** nothing
- **WTC:** maybe see more of them outside work

**Mum 73 years old, lives alone, Supported by Mr X, recently suffered MI and stroke**
- **FoC:** phones mum everyday at least x 2, visit x 1 a day in the evenings
- **AS:** helps with practical tasks e.g. bills, some caring jobs around the house
- **E:** expect her to be there for me
- **SA:** satisfied that she looked after me, supportive of me, shares the same sense of humour
- **UA:** still treats me like a child uses guilt to get things done, always have to be there, can’t stay

**Mrs X (wife) 43 years old,**
- **Teacher, married 20 years**
- **FoC:** everyday, often phone each other during the day
- **AS:** golf, housework, certain hobbies, some friends
- **E:** listen to me, to support me, to be there for me
- **SA:** same sense of humour, enjoy the same things, companionship
- **UA:** arguments, niggles
- **WTC:** stop arguing stop niggles
THERAPIST QUESTION SHEET – PHOTOCOPYABLE RESOURCE
Mapping out the Pre-Trauma Interpersonal Network
Handout to complete

NAME OF INDIVIDUAL:
THERAPIST INFORMATION SHEET
Mapping out the Post Trauma Interpersonal Network

SESSION 2

The second session involves drawing out an interpersonal network for AFTER the trauma.

Key Points to consider for this session:

- The systematic review of relationships following the trauma involves an exploration of the individual’s important relationships with others – information should be gathered about each person who is important in the individual’s life NOW.
- When drawing out this network, try to get thorough understanding of exactly what the interpersonal world looks like after the trauma.
- Really try to gain an understanding of the interactions in this person’s life.
- Try to work out who the “key players” are by using the following questions:
  - “If you need help for practical aspects of your life, who would you ask?”
  - “After the (…… trauma), who would you turn to in an emergency and say you needed to borrow £2000 – and it couldn’t be a member of your family?”
  - “If you needed to ask advice from someone at 4am who would you phone?”
- Also, try to gain an insight into how the different groups or individuals interact – i.e. are there links or is each group/individual separate?
- Is there a balance between emotional and practical support? What is the balance like?
- If very few individuals following the trauma – are there pets?

REMEMBER: WE ARE LOOKING FOR ANY MAJOR DISRUPTIONS TO CLOSE PERSONAL RELATIONSHIPS AS A RESULT OF THE TRAUMA

A NOTE OF CAUTION:
Remember in your assessment of the interpersonal networks that the pre trauma network is based on months and years of interaction and the post trauma network is based on days or weeks.
INTERPERSONAL INVENTORY POST TRAUMA

For each person identified, answer the following questions (consider family, social, work relationships separately):

1. Frequency of contact: “How often do you see or speak to this person?”


3. Activities shared: “What sort of things do you do together”

4. Expectations: What are your expectations in this relationship?”

5. Satisfactory and unsatisfactory aspects of the relationship: “We all experience good parts of a relationship and those parts that are not so good or satisfying, is it possible for you to talk through each side?”

6. Ways you would like the relationship to change: “Can you say how the relationship could change so that it would be more satisfying for you?”

*Most important aspect of this is to gain insight into exactly how the interpersonal network has changed following the trauma.*
THERAPIST INFORMATION SHEET
Mapping out the Post-Trauma Interpersonal Network
A Worked Example

Road Traffic Accident – Not able to work, drive or write
THERAPIST QUESTION SHEET – PHOTOCOPYABLE RESOURCE
Mapping out the Post-Trauma Interpersonal Network
Handout to Complete

NAME OF INDIVIDUAL:

----------------------------------------------------------
Questions to ask about following completion of the Post Trauma Interpersonal Inventory.

1. Are there people now missing from the network – if so why?
2. How else has the network changed?
3. How have your expectations of groups changed? Has any expectations of individuals or groups changed?
4. How have your needs from the network changed?
5. How does the person feel about these changes?
   - Really try to gain an understanding of how the network has changed following the trauma and what this means to the individual.
   - How does he/she conceptualise these changes, if any?
   - Does he/she blame the traumatic event for the changes?
6. Which changes are inevitable changes that are a result of the traumatic event?
7. What did the trauma actually do to the interpersonal network?
8. What has the individual’s trauma reaction done to the way he/she now reacts to others in the interpersonal network?
9. What needs do you have now? Did you have those needs before the trauma and if so who met them?

Having completed 2 inventories, is your overall assessment:
As a result of the trauma the interpersonal word has:

1. Remain unchanged
2. Somewhat improved
3. Somewhat damaged
4. Severely damaged
WHAT HAPPENS AT THE END OF STAGE 2?

At the end of session 2, we suggest that you use 2 questionnaires to determine how to proceed:

1. ‘Patient Health Questionnaire’ to measure the severity of the current difficulties.
2. ‘WHOQOL-BREF (WHOQOL Group, 1996) to measure any changes in the client’s perceived quality of life.

AFTER THE QUESTIONNAIRES:

1. Immediate move to Stage 3 OR
2. 3-4 week gap prior to initiating Stage 3 (watchful waiting) OR
3. No further intervention.......... EXIT POINT 2

STAGE 3 WILL FOLLOW IMMEDIATELY IF:

1. Your client is deemed to be vulnerable and requires immediate response as defined by your clinical judgement, providing their PHQ scores are under 21. If their PHQ scores are >10 but <21, whilst it is appropriate to continue with EIM, we would suggest that the patient go and see their GP.
   
   NOTE: With a PHQ score leading to severe anxiety or depression i.e. >21, if the patient is drinking significantly, or it is your clinical judgement that they are too unwell to continue then it is not appropriate to continue with EIM and we would strongly advise that the patient should go to their GP.

   2. The interpersonal network has been so disrupted by the trauma that immediate work is indicated to prevent further disruption.
**Patient Health Questionnaire (PHQ)**

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability unless you are requested to skip over a question.

Name: ___________________________ Age: ___________ Today’s Date ________________________

Sex:  Female ☐  Male ☐

1. Over the last week how often have you been bothered by any of the following problems?

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Little interest or pleasure in doing things</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>b. Feeling down, depressed or hopeless</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>c. Trouble falling asleep or staying asleep, or sleeping too much</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>d. Feeling tired or having little energy</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>e. Poor appetite or overeating</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>f. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>g. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>h. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety and restless that you have been moving around a lot more than usual</td>
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<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>i. Thoughts that you would be better off dead or of hurting yourself in some way</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

**Diagnostic Criteria:**
If answers to number 2 a or b and five or more of 2 c – i are at least ‘Most than half the days’ (count number 2 i if present at all) – Major Depressive Disorder:

**Severity Criteria**
- 0-9 = no depression
- 10-20 = moderate depression
- 21+ severe depression
Questions about anxiety

a. In the last week have you ever had an anxiety attack – suddenly feeling fear or panic?  
   If you checked “NO” go to question 3
   b. Has this ever happened before?
   c. Do some of these attacks come suddenly out of the blue – that is, in situations where you don’t expect to be nervous or uncomfortable?
   d. Do these attacks bother you a lot or are you worried about having another attack?

Diagnostic Criteria
If all numbers 3 a-d are present then Panic Disorder

2. Over the last week how often have you been bothered by the following problems?

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Feeling nervous, anxious, on edge or worrying about a lot of different things</td>
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<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>b. Feeling restless so that it is hard to sit still</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>c. Getting tired very easily</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>d. Muscle tension, aches or soreness</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>e. Trouble falling asleep or staying asleep</td>
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<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>f. Trouble concentrating on things such as reading a book or watching TV</td>
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<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>g. Becoming easily annoyed or irritable</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Diagnostic Criteria
If all numbers 5a and answers to three or more of numbers 5b-g are ‘More than half the days’ – Generalised Anxiety

Severity Criteria
0-9 = no anxiety
10-20 = moderate anxiety
21+ severe anxiety
3. **Have** any of the following happened to you more than once in the last week?  

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NO</td>
<td>YES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. You drank alcohol even though a doctor suggested that you stop drinking because of problems to your health</td>
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<td></td>
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</tr>
<tr>
<td>b. You drank alcohol, were high from alcohol, or hung over while you were working, going to school, or taking care of children or other responsibilities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. You missed or were late for work, school, or other activities because you were drinking or hung over</td>
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</tr>
<tr>
<td>d. You had a problem getting along with other people while you were drinking</td>
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<td>e. You drove a car after having several drinks or after drinking too much</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*It is important to ask about increase in alcohol consumption, however this scale does not make a diagnosis, use this to monitor symptoms.*
EDINBURGH EARLY INTERVENTION MANUAL (E-EIM)

STAGE 3

4 SESSIONS

IPT-PT
THE STRUCTURE OF IPT-T

IPT-PT is based on the premise that psychological distress, regardless of biological vulnerability or personality, that occurs following a trauma does so within a psychosocial and interpersonal context. IPT-PT, just like full IPT, has three phases: Assessment; Middle; Termination. The structure for IPT-PT has been directly derived from IPT for depression (Klerman et al 1984).

OUTLINE SESSION 1: Initiating IPT-PT

1. **Dealing with the Distress**  
   Review of any presenting symptoms using PHQ

2. **Relate Distress to Interpersonal Context following the trauma**

3. **Identification of Major Problem Area**  
   Identify whether this is a transition or grief focus (related to traumatic event).

4. **Monitor Symptoms**  
   Individual will be helped to monitor their symptoms (described through the PHQ) and to keep a record of such as an inter-treatment task.

5. **Making a Story**  
   A story or 'narrative', will be described with regards to what has happened since the traumatic event (i.e. trauma to now and linked with mood changes and any potential PTSD symptoms).

6. **Explain the IPT-PT Concepts and Contract**  
   Outline your understanding of the problem, verbally and in writing.  
   Agree on treatment goals (which problem area will be the focus).

OUTLINE SESSIONS 2 and 3: The Problem Area (Focus)

In full IPT, there are four ‘Focus Areas’ described: (1) role transitions, (2) grief (3) interpersonal disputes and (4) interpersonal deficits. In IPT-PT, we have taken two of these areas as follows:

1. **Grief**
2. **Role Transition**

*Each Problem area has a set of goals and strategies as outlined by Klerman et al (1984) however, the IPT-PT model differs somewhat and therefore, is outlined in the detailed manual.*

OUTLINE SESSION 4: Termination of Treatment

Explicit discussion of the ending of contract and its implications for the individual and their interpersonal world and the Interpersonal Inventory are drawn out (using the interpersonal inventory as a guide).
SESSION 1: INITIATING IPT-PT

Before individual is seen, as to complete PHQ and score before commencing session.

1. Dealing with the Distress
Review of any presenting symptoms using PHQ or equivalent

Key points: All sorts of symptoms can occur therefore, we suggest that you do not just look for positive symptoms, look for negative ones as well e.g. social withdrawal, avoidance, look in detail at the avoidance, for example emotional, cognitive and behavioural avoidance. Try and assess which symptoms are adaptive and which are not e.g. both hypervigilance and avoidance may be adaptive but only in certain circumstances.

2. Identification of Major Problem Area
Identify whether this is a transition or grief focus (related to traumatic event).

3. Monitoring of Symptoms
Individual will be taught how to monitor their symptoms (described through the PHQ) and to keep a record of such as an inter-treatment task (between the therapist and the individual, a method of recording symptoms should be devised that suits the individual – i.e. writing down moods in a descriptive way, rating moods on a 1-10 scale).

4. Story
A story will be described with regards to what has happened since the traumatic event (i.e. trauma to now and linked with mood changes and any potential PTSD symptoms).

5. Describe procedures of IPT-PT
- “here and now” focus
- need for individual to discuss important concerns
- review of current interpersonal relations (to be carried out by individual at home),
- Discussion of practical aspects of treatment
  Length: 1 hour sessions (10 minutes at beginning to complete PHQ).
  Frequency: once a week for 4 weeks
  Times: Policy for missed appointments: every week will be counted as a session but sessions may be taken over 6 weeks.

At the end of the first treatment session, the individuals should know:

- How to measure their symptoms
- About the waxing and waning of interpersonal events with the trauma
- Have some idea of causation
This is an idea of how you might introduce a focus area – don’t feel that you have to use this verbatim.

Problems in relating to others may bring on symptoms of distress in some people whilst for others the distress may prevent them from dealing as successfully as they usually do. In this treatment, we will try to discover what you want and need from others and help you learn how to get it. You have mentioned that you do have problems and I think that will be ways in which we can help you to learn how to deal with more effectively.

You have described a clear onset of your symptoms of distress around the time of the trauma. In IPT-PT, we try to get you back to feeling how you were before the traumatic event and therefore it is very important that we spell out exactly what we are going to try to do here.

We will be discussing your life as it is right now, and reviewing your relationships with important people in your life. We will also be looking at what it was like for you prior to the trauma and what your feelings are about what has been lost and what your feelings are about what has been gained. We will also be discussing the symptoms you have talked about and your perceived lack of control of there. Therefore, another aim of IPT-PT is to give you some perceived control through monitoring and recording of the symptoms.

If we are agreed, I’d like to tell you how we will proceed. Your task will be to talk about things that concern you, particularly things that affect you emotionally. We accept that the trauma event may have markedly changed the way you view your self, your life, your future and your relationships and that for some people this change is very long lasting.
THERAPIST INFORMATION SHEET:
PHOTOCOPYABLE RESOURCE

INTRODUCING GRIEF FOCUS

This is an idea of how you might introduce a focus area – don’t feel that you have to use this verbatim.

Problems in relating to others may bring on distress in some people whilst for others the symptoms of distress prevent them from dealing as successfully as they usually do. In this treatment, we will try to discover what you want and need from others and help you learn how to get it. You have mentioned previously that you do have problems and I think that will be ways in which we can help you to learn how to deal with more effectively.

It seems to me that you have described a clear onset of your distress around ………………….. (traumatic event) and that perhaps the loss of …………………….. is as or more important than the actual event. You have told me about episodes in your life that have been very difficult for you including

In IPT-PT, we try to get you back to feeling how you were before the onset of your distress and therefore it is very important that we spell out exactly what we are going to try to do here.

We will be discussing your life as it is right now, and reviewing your relationships with important people in your life.

If we are agreed, I’d like to tell you how we will proceed. Your task will be to talk about things that concern you, particularly things that affect you emotionally. We accept that the trauma event may have markedly changed the way you view your self, your life, your future and your relationships and that for some people this change is very long lasting.
SESSION 2: TRANSITIONS or GRIEF FOCUS

Before individual is seen, ask to complete PHQ and score before commencing session.

1. Symptom Review
   The symptoms over past week reviewed using PHQ – interpersonally (how have symptoms influenced relationships?)

2. Explanation of IPT-PT basic assumptions
   Relationships are central to the experience you are having.
   Reassurance re: positive aspects.

3. Use of either transition strategies or grief focus strategies
   See following pages for the different strategies in more detail and the associated homework tasks to give the client.
ROLE TRANSITION STRATEGIES

(Not all strategies to be attempted at each session – only those that are appropriate)

- Review distress symptoms
- Relate symptoms to difficulty in coping with recent life change following on from the trauma
- Review positive and negative aspects of old and new roles
- Explore feeling about what is lost
- Explore feelings about the change itself
- Explore opportunities in new role
- Realistically evaluate what is lost
- Encourage appropriate release of affect
- Encourage development of social support system and of new skills called for in new role

RATIONALE behind this is that an individual would experience a loss which is then followed by a period of transition:

Loss → transition

In the role of transition focus, loss can be associated with all sorts of things, for example loss of a limb or loss of health. We need to come to terms with loss before we can come to terms with transition and therefore we can only do one in three sessions.
ROLE TRANSITIONS TASK FOR END OF SESSION 2:

Think about the following questions and answer each one in the space provided. After this, on a separate piece of paper, try to write a summary of your understanding of what was really happening in your life around the trauma – who was around and how you were feeling – really try to define your feelings here.

- What does the change in role mean to you?

- When you ............., how did your life change?

- What important people were left behind?

- How did you feel in this new role?

- Tell me about what it was like in the old role?

- What does the change in role mean to you?

- What were the good things?

- What were the bad things?

- What did you like?
PHOTOCOPYABLE RESOURCE

- What did you not like?

- How did it feel to give that up?

- Tell me about the details of............. - how did you feel in the new situation?

- What was it like at first?

- What is required of you now?

- How hard is it?

- What is going well?

- What is going badly?

- Feelings about the change – guilt.......
GRIEF STRATEGIES

(Not all strategies to be attempted at each session – only those that are appropriate)

- Review distress symptoms
- Relate symptoms to death of significant other
- Reconstruct the individual’s relationship with the deceased
- Describe the sequence and consequences of events just prior to, during and after the death.
- Explore associated feelings (negative as well as positive)
- Consider possible ways of becoming involved with others.
HOMETASK
PHOTOCOPYABLE RESOURCE

GRIEF TASK FOR END OF SESSION 2:

Think about the following questions and answer each one in the space provided. After this if possible, on a separate piece of paper, try to write a summary of your understanding of what was happening in your life around about when you became depressed - who was around and how you were feeling – really try to define your feelings here.

- What does the loss mean to you?
  ________________________________________

- When you lost ............... , how did your life change?
  ________________________________________

- What were the ups and downs of your relationship with................. How did you feel in this new role?
  ________________________________________

- What were the good things?
  ________________________________________

- What were the bad things?
  ________________________________________

- What did you like?
  ________________________________________

- What did you not like?
  ________________________________________

- What is your life like now?
  ________________________________________

- Have you tried to make up for the loss?
  ________________________________________
HOMETASK
PHOTOCOPYABLE RESOURCE

- Who are your friends?
- What activities might be enjoyable
- Tell me about the details of.............. - how did you feel in the new situation?
- What was it like at first?
- What is required of you now?
- How hard is it?
- What is going well?
- What is going badly?
- Feelings about the change – guilt......
SESSION 3: TRANSITIONS OR GRIEF FOCUS

Before individual is seen, ask to complete PHQ and score before commencing session

Use the following strategies for session 3:

TRANSITION STRATEGIES

- Review distress symptoms using PHQ
- Relate symptoms to difficulty in coping with recent life change
- Review positive and negative aspects of old and new roles
- Explore feeling about what is lost
- Explore feelings about the change itself
- Explore opportunities in new role
- Realistically evaluate what is lost
- Encourage appropriate release of affect
- Encourage development of social support system and of new skills called for in new role

GRIEF STRATEGIES

- Review distress symptoms
- Relate distress symptoms to death of significant other
- Reconstruct the individual’s relationship with the deceased
- Describe the sequence and consequences of events just prior to, during and after the death
- Explore associated feelings (negative as well as positive)
- Consider ways of becoming involved with others
SESSION 4: TERMINATION OF TREATMENT

Before individual is seen, ask to complete PHQ and score before commencing session

Use the following strategies for session 4:

1. Review of distress symptoms over the past week.

2. Explicit discussion of the end of treatment – possible return of symptoms – normal – anxiety raised? Make the distinction between loss and relapse – we have the opportunity to model a successful ending and discussing feelings with regards to that.

3. Explicit discussion of 8-12 months post-therapy, there is the opportunity to see changes in the interpersonal world of the individual – this gives the change to experience success.

4. Help individual move toward a recognition of his/her independent competence through re-drawing the interpersonal inventory.

5. Review of course of treatment and progress with the individual

6. Individual given the opportunity to evaluate future needs

7. Assess with individual early warning signals, and discuss procedures for re-entry into treatment if necessary.
WHAT HAPPENS AT THE END OF STAGE 3?

At the end of session 4, we suggest that you use 3 questionnaires to determine how to proceed:

1. ‘Patient Health Questionnaire’ (PHQ-9) to measure the severity of the current difficulties
2. ‘WHOQOL-BREF’ (WHOQOL Group, 1996) to measure any changes in the client’s perceived quality of life.
3. Trauma scale such as the PTSD Symptom Scale Interview (PSS-I)

AFTER THE QUESTIONNAIRES

1. No further intervention if all questionnaires score within normal ranges EXIT POINT 3

OR

2. If any scores are elevated from the norm i.e. as defined by the PHQ or trauma, scale then referral to the General Practitioner would be appropriate to access further psychological treatment for possible PTSD. Our recommendation for a brief structured treatment of psychotherapy for PTSD is the Bryant et al (1998) model of brief CBR (see following literature review).

3. We have reproduced the PHQ 9 below and given details of the PSS-I (Foa et. al. 1993) and how to obtain permission to use it.
Patient Health Questionnaire (PHQ)

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability unless you are requested to skip over a question.

Name:___________________________ Age:_______________ Today’s Date____________________

Sex: Female ☐ Male ☐

1. Over the last week how often have you been bothered by any of the following problems?

<table>
<thead>
<tr>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

   a. Little interest or pleasure in doing things
      ☐ ☐ ☐ ☐

   b. Feeling down, depressed or hopeless
      ☐ ☐ ☐ ☐

   c. Trouble falling asleep or staying asleep, or sleeping too much
      ☐ ☐ ☐ ☐

   d. Feeling tired or having little energy
      ☐ ☐ ☐ ☐

   e. Poor appetite or overeating
      ☐ ☐ ☐ ☐

   f. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down
      ☐ ☐ ☐ ☐

   g. Trouble concentrating on things, such as reading the newspaper or watching television
      ☐ ☐ ☐ ☐

   h. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety and restless that you have been moving around a lot more than usual
      ☐ ☐ ☐ ☐

   i. Thoughts that you would be better off dead or of hurting yourself in some way
      ☐ ☐ ☐ ☐

Diagnostic Criteria:
If answers to number 1 a or b and five or more of 1 c –i are at least ‘Most than half the days’ (count number 1 i if present at all) – Major Depressive Disorder:

Severity Criteria
0-9 = no depression
10-20 = moderate depression
21+ severe depression
2. Questions about anxiety

a. In the last week have you ever had an anxiety attack – suddenly feeling fear or panic?

If you checked “NO” go to question 3

b. Has this ever happened before?

c. Do some of these attacks come suddenly out of the blue – that is, in situations where you don’t expect to be nervous or uncomfortable?

d. Do these attacks bother you a lot or are you worried about having another attack?

Diagnostic Criteria
If all numbers 3 a-d are present then Panic Disorder

3. Over the last week how often have you been bothered by the following problems?

<table>
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<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

a. Feeling nervous, anxious, on edge or worrying about a lot of different things

If you checked “Not at all” go to question 4

b. Feeling restless so that it is hard to sit still

c. Getting tired very easily

d. Muscle tension, aches or soreness

e. Trouble falling asleep or staying asleep

f. Trouble concentrating on things such as reading a book or watching TV

g. Becoming easily annoyed or irritable

Diagnostic Criteria
If all numbers 5a and answers to three or more of numbers 5b-g are ‘More than half the days’ – Generalised Anxiety

Severity Criteria
0-9 = no anxiety
10-20 = moderate anxiety
21+ severe anxiety
4. **Have any of the following happened to you more than once in the last week?**

<table>
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<tr>
<th></th>
<th>NO</th>
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<tbody>
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<td>a. You drank alcohol even though a doctor suggested that you stop drinking because of problems to your health</td>
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<td>e. You drove a car after having several drinks or after drinking too much</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

It is important to ask about increase in alcohol consumption, however this scale does not make a diagnosis, use this to monitor symptoms. specific traumatic event in the **past two weeks**. It is helpful.
PTSD Symptom Scale - Interview (PSS-I)

Foa, Riggs, Dancu, & Rothbaum, 1993

Description
The PSS-I is a 17-item semi-structured interview that assesses the presence and severity of DSM-IV PTSD symptoms related to a single identified traumatic event in individuals with a known trauma history. The PSS-I takes about 20 minutes to administer and can be administered by lay interviewers trained to recognize the clinical picture in traumatized persons. Each item is assessed with a brief, single question. There are no probes or follow up questions.

Interviewees are asked about symptoms they have experienced in the "past two weeks." This time frame differs from the standard one month time frame of other measures. For each item, the interviewer assigns a rating to reflect a combination of frequency and severity (from O = "not at all" to 3 = "5 or more times per week/very much").

Sample Item
Have you had recurrent or intrusive distressing thoughts or recollections about [the event]?
0 = not at all
1 = Once per week or less/a little bit
2 = 2-4 times per week/somewhat
3 = 5 or more times per week/very much

References


To obtain scale contact
Edna Foa, PhD
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COMPARISON OF EARLY CBT TREATMENTS AFTER TRAUMA

Why CBT post trauma?

Following the lack of empirical evidence to support single sessions of psychological debriefing after a traumatic event (Bisson 2004) the appropriateness of more complex psychological interventions have been investigated. It has been shown that a brief course of cognitive behavioural therapy following a trauma can reduce the symptoms of PTSD (Ehlers and Clark 2003). The NICE guidelines (2005) have also recommended that CBT be used to treat PTSD symptoms where symptoms are present within three months of the trauma.

NICE Guidelines (2005) – Treatment of PTSD where symptoms are present within 3 months of a trauma:

Brief psychological interventions (5 sessions) may be effective if treatment starts within the first month after the traumatic event. Beyond the first month, the duration of treatment is similar to that for chronic PTSD. Trauma-focused cognitive behavioural therapy should be offered to those with severe post-traumatic symptoms or with severe PTSD in the first month after the traumatic event. These treatments should normally be provided on an individual outpatient basis. Trauma-focused cognitive behavioural therapy should be offered to people who present with PTSD within 3 months of a traumatic event. The duration of trauma-focused cognitive behavioural therapy should normally be 8-12 sessions (about 5) may be sufficient. Treatment should be regular and continuous (usually at least once a week) and should be delivered by the same person.

Treatment models for brief CBT following trauma

There have been four main models of an early intervention of brief CBR proposed to treat PTSD following trauma (they are outlined in Table 1 along with the evidence base for them, and their advantages and disadvantages). It should be noted that the models described are all for patients presenting with a diagnosable post traumatic reaction unlike EIM which is for anyone following a traumatic event.

The common factors across the models are as follows:

- Psycho education about psychological effects of trauma
- Imaginal reliving of the event
- Cognitive restructuring
- Reversal of avoidance behaviours
- (some – anxiety management)
The significant differences between the models are outlined below:

- **length of treatment** (Ehlers et al longest – 12 sessions, the rest 4/5 sessions)
- **start of treatment** (Bisson et al delays (5 to 10 weeks post trauma, Bryant two weeks post trauma, Foa et al soon after, Ehlers et al three week monitoring phase)
- **diagnosis of ASD** (Bryant et al – diagnosis of ASD as factor for treating with CBT supported by Bryant et al hypnosis studies)

**Which model to use?**

After reviewing the evidence it was felt that the most appropriate model to use would be the Bryant et al in treating any patients that present with PTSD following intervention using EIM. The Bryant et al (1998) model meets the NICE guideline most comprehensively and has the largest body of evidence to support its efficacy.