Appendix A

Acute Stress Disorder Scale (ASDS)

Name: ______________________ Date: ________________________

Briefly describe your recent traumatic experience: _______________________

____

____

Did the experience frighten you? Yes No

____

Please answer each of these questions about how you have felt since the event.
Circle one number next to each question to indicate how you have felt.

	Not at all	Mildly	Medium	Quite a bit	Very much
1. During or after the trauma, did you ever feel numb or distant from your emotions?	1	2	3	4	5
2. During or after the trauma, did you ever feel in a daze?	1	2	3	4	5
3. During or after the trauma, did things around you eve1 feel unreal or dreamlike?	1	2	3	4	5
4. During or after the trauma, did you ever feel distant from your normal self or like you were watching it happen from outside?	1	2	3	4	5
5. Have you been unable to recall important aspects of the trauma?	1	2	3	4	5
6. Have memories of the trauma kept entering your mind?	1	2	3	4	5
7. Have you had bad dreams or nightmares about the trauma?	1	2	3	4	5
8. Have you felt as if the trauma was about to happen again?	1	2	3	4	5
9. Do you feel very upset when you are reminded of the trauma?	1	2	3	4	5
10. Have you tried not to think about the trauma?	1	2	3	4	5
11. Have you tried not to talk about the trauma?	1	2	3	4	5
12. Have you tried to avoid situations or people that remind you of the trauma?	1	2	3	4	5
13. Have you tried not to feel upset or distressed about the trauma?	1	2	3	4	5
14. Have you had trouble sleeping since the trauma?	1	2	3	4	5
15. Have you felt more irritable since the trauma?	1	2	3	4	5
16. Have you had difficulty concentrating since the trauma?	1	2	3	4	5
17. Have you become more alert to danger since the trauma?	1	2	3	4	5
18. Have you become jumpy since the trauma?	1	2	3	4	5
19. When you are reminded of the trauma, do you sweat or tremble or does your heart beat fast?	1	2	3	4	5

Source: Bryant, R. A., and Harvey, A.G. (2000). *Acute stress disorder: A handbook of theory, assessment, and treatment.* Washington, D.C.: American Psychological Association.

Acute Stress Disorder:

What Educator's Should Know

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Table of Contents

What is ASD?	3
Common Symptoms	5
Facts	7
Research	8
Treatment	9
Children Stories	10
What can educator's do?	11
Child Responses to Trauma	12
Classroom Exercises	14
Obstacles and Suggestions	16
Resources	18
Glossary	22
References	23

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Glossary

- Affective: emotion or feeling
- Comorbidity: pertaining to two things which occur together
- Depersonalization: a state in which one no longer perceives the reality of one's self or one's environment; sense that one's body is detached or one is seeing oneself from another perspective
- Derealization: an alteration in perception leading to the feeling that the reality of the world has been changed or lost; perception of one's environment is unreal, dreamlike, or occurring in a distorted time frame
- Disorder: a disturbance in physical or mental health or functions
- Dissociative: disconnection or interruption of consciousness
- Epidemiology: scientific study of the causes, distribution, and control of disease in the population
- Enuresis: bedwetting
- Ideation: process of forming ideas or images
- Inoculation: introduction
- Intrusive: to intrude; interfere; distract
- Maladaptive: marked by poor or inadequate adaptation
- Meta-analysis: a quantitative statistical analysis of several separate but similar experiments or studies in order to test the pooled data for statistical significance
- Provision: providing or supplying

What is Acute Stress Disorder (ASD)?

Acute Stress Disorder (ASD) occurs when and individual experiences posttraumatic stress reactions that occur in the initial month after a traumatic experience. Approximately 80% of people, adults and children, who initially meet the criteria for ASD subsequently develop chronic posttraumatic stress disorder (PTSD) (Bryant et al., 1999).

Criteria for ASD:

- The first requirement of ASD is the experience of a precipitating stressor: the person has experienced or witnessed an event that has been threatening to themselves or another person. This event causes the person to feel fear, helplessness, or horror.
- The person must also display at least three dissociative symptoms either at the time or trauma or in the first month posttrauma. Dissociative symptoms include: (1) numbing: detachment from expected emotional reactions, (2) reduced awareness of surroundings: being less aware than one would expect of events at the time of trauma or immediately after, (3) derealization: perception of one's environment is unreal, dreamlike, or occurring in distorted time frame, (4) depersonalization: sense that one's body is detached or one is seeing oneself from another perspective, and (5) dissociative amnesia: inability to recall a critical aspect of the trauma.
- The trauma needs to be re-experienced in at least one way: recurrent images, thoughts, dreams, illusions, flashback episodes, or a sense of reliving the event.
- The person must display marked avoidance of thoughts, feelings, activities, conversations, places, and people that may remind the person of their traumatic experience.
- Marked symptoms of anxiety or arousal must be present after the trauma for at least two days (see Table 1).

Table 1

Diagnostic Criteria for ASD in DSM-IV

Criterion	ASD
Stressor	*Both*: Threatening event Fear, helplessness, or horror
Dissociation	*Minimum of three*: Numbing Reduced awareness Depersonalization Derealization Amnesia
Re-experiencing	*Minimum of one*: Recurrent images/thoughts/distress Consequent distress not prescribed Intrusive nature not prescribed
Avoidance	*Marked avoidance* of: Thoughts, feelings, or places
Arousal	*Marked arousal*, including: Restlessness, insomnia, irritability, hypervigilance, and concentration difficulties
Duration	At least 2 days and less than 1 month posttrauma Dissociative symptoms may be present only during trauma
Impairment	Impairs functioning

Source: Bryant, R. A., and Harvey, A.G. (2000). *Acute stress disorder: A handbook of theory, assessment, and treatment*. Washington, D.C.: American Psychological Association.

Organizations:

- American Academy of Experts in Traumatic Stress. 368 Veterans Memorial Highway, Commack, NY 11725. Telephone: (631) 543-2217 www.aaets.org
- Anxiety Disorders Association of America. 11900 Parklawn Dr., Ste. 100, Rockville, MD 20852. Telephone: (301) 231-9350
- International Society for Traumatic Stress Studies. 60 Revere Drive, Suite 500, Northbrook, IL 60062. Telephone: (847) 480-9028 www.istss.org

Local Resources:

- Western Psychiatric Institute and Clinic (WPIC). 3811 O'Hara Street Pittsburgh, PA 15213. Telephone: (412) 624-1000 http://www.upmc.com/HospitalsFacilities/Hospitals/wpic/Pages/default.aspx
- Local clinicians
- Social support groups relevant to the trauma
- Family/ Friends/ Teachers/ Peers

Further Resources

Children's Books continued:

- *Let's Talk About Feeling Sad*
  Joy Berry (Author), Maggie Smith (Illustrator)
  New York: Scholastic (1996)
  ISBN 0590623877
  Age Range: Preschool
- *When Dinosaurs Die: A Guide to Understanding Death*
  Laurie Krasny Brown (Author), Marc Tolan Brown (Illustrator)
  New York: Little, Brown (1998)
  ISBN 0316109177
  Age Range: 3 to 7
- *The Pop-Up Book of Phobias*
  Gary Greenburg (Author), Matthew Reinhart (Contributor)
  ISBN 0688171958
  Age Range: Adolescent
- *Stress Can Really Get on Your Nerves! (Laugh and Learn)*
  Trevor Romain and Elizabeth Verdict (Authors)
  ISBN 1575420783
  Age Range: 9 to 12
- *Good Answers to Tough Questions About Trauma*
  Joy Berry (Author)
  Joy Berry Books (2009)
  ISBN 1605775010
  Age Range: 9 to12

Book on Children's Drawings:

- Koplewicz, H. S., & Goodman, R. F. (Eds.). (1999). *Childhood revealed: Art expressing pain, discovery and hope*. New York: Harry N. Abrams.

Common Symptoms

Individuals are not effected the same way by trauma. Some may never experience symptoms and other may experience less or very severe trauma-related symptoms. Evidence of ASD may not appear on the same day as the traumatic event. Symptoms include cognitive, affective, behavioral, and/or physiological-somatic effects (Alat, 2002).

Cognitive effects: Many individuals believe after a traumatic event the event will happen again or they feel responsible for the event. Cognitive responses include:

- confusion
- academic difficulties
- learning difficulties
- developmental delays
- diminished language and communication skills

Affective effects: After a traumatic event, children may become emotionally upset or disturbed. They may display:

- Nighttime fears
- Anger
- Irritability
- Lower tolerance for stress
- Nervousness
- Compulsiveness
- Helplessness

Common Symptoms

Behavioral effects: Behaviors can shift in any direction. Children may display developmentally regressive behaviors such as:

- Enuresis
- Thumb sucking
- Loss of previously learned academic and social skills

Older children and adolescents may:

- Experiment with drugs and alcohol
- Attempt suicide

Other behaviors may include:

- Self-abusiveness
- Self-destructiveness
- Behavioral patterns that reflect anxious/avoidant or anxious/ resistant attachments

Physiological-somatic effects: Individuals may experience:

- High fever
- Vomiting
- Headaches
- Hyperarousal
- Low tolerance for stress
- Sleep disorders
- Fatigue
- Eating disorders
- Biochemical alterations in the brain

- Helping Children Cope with Tragedy
  www.pta.org/parentinvolvement/tragedy/index.asp
- Tragic Times, Healing Words: Helping Children Cope—Sesame Street Workshop
  www.sesameworkshop.org/parents/advice/article/0,4125,49560,00.html
- Project Reassure: Printable Resources for Caretakers of Traumatized Children and Youth. Retrieved from
  http:www.projectreassure.com

For Teachers:

- Health, Mental Health, and Safety Guidelines for School
  http://www.nationalguidelines.org/introFull.cfm
- After a Disaster: A Guide for Parents and Teachers—Center for Mental Health
  www.mentalhealth.org/publications/allpubs.KEN-01-0093/default.asp
- Strategies To Assist Children Manage Stress—North Carolina State University
  www.ces.ncsu.edu/depts/fcs/humandev/disas3.html

Children's Books:

Provides a list of children's books that describe mental health
http://www.baltimorepsych.com/books.htm#Sibling%20Issues

- *A Terrible Thing Happened*
  Margaret M. Holmes (Author), Cary Pillo (Illustrator)
  Washington, DC: Magination Press (2000)
  ISBN 1557987017
  Age Range: 4 to 8

Resources

Self-Report Measures:

- *Stanford Acute Stress Reaction Questionnaire (SASRQ)*: Respondents indicate the frequency of each symptom that can occur during and immediately after a trauma on a 6-point Likert scale.
- *Acute Stress Disorder Scale (ASDS)*: Respondents are asked to rate the intensity of each symptom on a 5-point Likert scale. Reproduced in Appendix A.

Web Resources:

- National Institute on Mental Health (NIMH)
  www.nimh.nih.gov
- Federal Emergency Management Agency (FEMA) for Kids
  www.fema.gov/kids
- Helping Children and Adolescents Cope With Violence and Disasters—NIMH
  www.nimh.nih.gov/publicat/violence.cfm
- Helping Children After a Disaster-American Academy of Child & Adolescent Psychiatry
  www.aacap.org/publications/factsfam/disaster.htm
- Disaster: Helping Children Cope—National Mental Health and Education Center
  www.naspcenter.org/safe_schools/coping.html
- Reactions and Guidelines for Children Following Trauma/ Disaster—American Psychological Association
  http://helping.apa.org/daily/ptguidelines.html
- Helping Children Cope With Trauma—American Red Cross
  www.redcross.org/services/disaster/keepsafe/ childtrauma.html

Facts

ASD emerges sooner than PTSD and abates more quickly. It is caused by the immediate exposure to trauma.

Trauma: A wide range of events could result in trauma including: death, motor vehicle crash, violent crime, natural disaster, terrorism, war, physical assault, physical abuse, sexual abuse, among many others. Individuals experience events different and may exhibit a wide range of behaviors and feelings after an event.

Prevalence: Both adults and children can exhibit symptoms of ASD and, if untreated, PTSD. The prevalence of ASD by itself in the general United States population is not known. Children of different sex and ages may display different symptoms. Fletcher's (1996) meta-analysis suggests that preschool children show more circumscribed symptoms than older children. Preschool children display fewer cognitive symptoms and little avoidance (as cited in Salmon & Bryant, 2002). Older adults are less likely to develop ASD, possibly because they have had more experience dealing with events.

The National Comorbidity Survey, a major epidemiological study conducted between 1990 and 1992, estimated that the lifetime prevalence among adult Americans is 7.8%, with women twice as likely as men to be diagnosed with trauma-related stress disorders at some point in their lives (Bryant & Harvey, 2000). These figures represent only a small proportion of adults. Some groups are at greater risk of developing ASD or PTSD, including people living in depressed urban areas.

Comorbidity: ASD is associated with a wide range of comorbid disorders, including other anxiety disorders, depression, substance abuse, somatoform disorders, and personality disorders.

Child Reports: While it is important to speak with a parent regarding their child's behaviors and emotions, studies have shown that parental accounts regarding their child's emotions are not necessarily accurate (Kassam-Adams, Garcia-Espana, Miller, & Winston, 2006; Meister-Stedman, Smith, Glucksman, Yule & Dalgleish, 2007). Professionals should take child reports into consideration when assessing behaviors and emotions following a trauma.

Research

The ASD diagnosis has only been formally recognized since 1994, when it first appeared in the Diagnostic and Statistic Manual of Mental Disorders, Fourth Edition (DSM-IV). Brewin, Andrews, Rose, and Kirk (1999) validated the internal coherence of the ASD diagnosis and symptom threshold. They also found that ASD was a strong predictor of eventual PTSD.

There are numerous techniques to treat ASD. In 1999, Bryant, Sackville, Dang, Moulds, and Guthrie studied treatments of ASD. They found that early provision of cognitive-behavioral therapy (CBT) and prolonged exposure may be the most critical component in the treatment of ASD. Bryant, Moulds, Guthrie, and Nixon (2005) found hypnosis may be useful in facilitating treatment effects of CBT for posttraumatic stress. They also found Supportive Counseling (SC) to be a useful intervention. They emphasized the importance of professionals utilizing SC and CBT when attempting to prevent or intervene with Children diagnosed with ASD.

Kassam-Adams et al. (2006) and Meister-Stedman et al. (2007) studied parent-child agreements regarding children's ASD.
A study completed by Kassam-Adams et al. (2006) indicates that parents' own reactions following child injury can influence their assessment of child symptoms. Further, Meister-Stedman et al. (2007) found child-reported ASD did predict later PTSD. Additionally, they found that parent-reported ASD failed to significantly predict later PTSD. Both studies suggest a child needs to be screened and the child's own feelings should be taken into account in the aftermath of a trauma.

Comorbidity: This include disorders such as depression, substance abuse, anxiety disorders and others. Offer support to contain preexisting disorder than resolve their traumatic experience.

Substance Abuse: Common response conceptualized as a form of avoidance that assists to distract from distressing symptoms. Sobriety for several months needs to be obtained before treatment.

Depression and Suicidal Ideation: Identify depression throughout therapy process. Depression should be stabilized before treatment. Individuals considered a suicidal risk require support, containment, and possibly medication.

Poor Motivation: In these cases, determine the level of motivation and attempt to educate the person regarding advantages after addressing feelings. If the client is not motivated/unwilling, treatment should not be conducted. A therapist should have the person take responsibility for not proceeding with treatment and realize advantages for continuing therapy when motivated.

Ongoing Stressors: Obstacles for treatment including: medical problems, financial loses, criminal investigations, property loss, media attention, et cetera.

Cultural Issues: Experiences can differentially affect people from different cultural backgrounds. Recognize and validate a person's outlook and attempt to restructure therapy with considerations.

Source: Bryant, R. A., and Harvey, A.G. (2000). *Acute stress disorder: A handbook of theory, assessment, and treatment*. Washington, D.C.: American Psychological Association.

Obstacles and Suggestions

Excessive Avoidance: When a person actively avoids confronting memories or feared situations; frequent during therapy. This can be seen as a warning sign that the person needs support and containment rather than exposure based interventions. If a person can cope to exposure, graded exposure may lessen avoidant behaviors.

Dissociation: When a person is able to relate to traumatic events but will not feel any distress associated with the experience. Hypnosis has been suggested to help breach dissociative reactions as it involves dissociative techniques.

Anger: A very common response after trauma. It may serve to inhibit anxiety after a trauma. Integrating anxiety management and CBT into treatment has shown to be effective.

Grief: Very common condition after trauma, which is a normal response. Grief reactions are often characterized by intrusive symptoms, numbing, and a degree of avoidance. It is important to support the person through the grieving phase.

Extreme Anxiety: In this situation, the experience can be felt as overwhelming, delaying exposure. Individuals should receive anxiety management and be able to manage anxiety before exposure therapy is considered.

Catastrophic Beliefs: Person continues to have catastrophic thoughts regarding their experience. Exposure is recommended with CBT, so the person does not reinforce maladaptive beliefs when recalling trauma.

Prior Trauma: Many who develop ASD have a history of previous trauma. Address memories of most recent trauma first.

Treatment

Opportunities exist to provide early intervention for individuals with ASD to prevent long-term PTSD. Clinical treatment studies found significant clinical gains following five sessions lasting one and a half hours each (Bryant & Harvey, 2000).

Cognitive-Behavioral Therapy (CBT) is the clinical resolution of traumatic memories. This occurs through activation and resolution of the fear network (how the brain stores information about what is threatening, which is activated by internal and external stimuli).

Supportive Counseling (SC) provides education about trauma, general problem-solving skills and provides an unconditionally supportive role.

Anxiety–Management Techniques are interventions used to reduce anxiety symptoms. These can include stress inoculation training which consists of: education, breathing control, muscle relaxation, thought stopping, cognitive restructuring, modeling, and role-playing.

Exposure Therapy leads to symptom reduction as a means to reduce stress. Person learns that (a) reminders of trauma do not cause harm, (b) recalling the trauma does not involve reliving the threat, (c) anxiety remains while a person has feared memories, and (d) the experience of anxiety does not result in loss of control. Exposure takes two forms including:

- *Imaginal*– The individual imagines feared events or memories of the trauma.
- *In vivo*– The individual remains in close proximity to the actual stimuli; reduces avoidant behaviors.

Children Stories

The following are possible scenario's of how children are exhibiting acute stress disorder symptoms:

- Timothy, age 6, was being watched by an elderly neighbor who suffered a fatal heart attack. The child, unable to call for help, spent the entire afternoon with the deceased until his mother came to pick him up after work. The mother spent the following week at home with Timothy without incident. When his mother reported back to work, the child exhibited acute separation anxiety, showing anxious attachment to his mother, afraid to let her out of his sight. Timothy's own sleep patterns changed dramatically, with periodic night terrors and occasional bed-wetting. He throws tantrums when going near the neighbors house and seems unable to recall the traumatic event.

- Sally, age 16, just received her learner's permit. Her older brother took her out to practice when a dog ran out in front of their vehicle. Sally lost control of the car and it crashed into a tree. Sally's brother suffered severe injuries and Sally walked away with nothing but a few minor scratches. Sally, who was a popular girl at school and an honor roll student, began to exhibit out of character behavior, ostracizing friends and family beginning a few days after the accident. She has developed poor hygiene, avoidance of the street of the accident, reduced awareness of her surroundings and reports feeling numb. Anger/irritability issues have also developed, along with guilt for the injuries her brother incurred. Her parents report that they have had to place the family dog with relatives.

Storytelling: Stories allow children to express their fears and thoughts. Educators may initiate activity by asking children what happened before the traumatic event. Educators can ask children to talk about a specific topic, such as: how they felt during the traumatic event, how they can help their family if another event happens, or what they learned from the event.

Writing activities: Helps children express their fears and thoughts. Children may write about a traumatic event or can write letters/cards to victims or rescue workers.

Bibliotherapy: Bibliotherapy is the use of books for social/emotional and character development, as well as for solving personal social/emotional problems. With the help of books, children can:

- Learn how others confronted and solved similar problems
- See how others have faced anxieties, frustrations, hopes, and disappointments
- Gain insight into alternative solutions to problems

Projects or Multidisciplinary Units: Educators can use disaster topics to integrate learning. Projects give children a chance to organize thoughts, gives them a sense of mastery, and a chance to make sense of confusing events. Projects could be developed to assist with other community efforts.

Source: Alat, Kazim. (2002). Traumatic events and children: How early educators can help. *Childhood Education*, Fall 2002, 1-8.

Classroom exercises

Numerous classroom exercises can help children express their emotions and work through feelings of anxiety and stress. Kazim Alat (2002) suggests:

Play-based activities: Children in an early-education setting need toys and other materials to reenact the event. Play can help children integrate their experiences and express their emotions. Materials should be selected due to their recreational and therapeutic values including: rescue vehicles, dolls and family figures.

Physical activities: This exercise helps the child relieve tension and anxiety. Gentle physical contact may give the child a sense of security.

Discussion groups: It is important to encourage children to share their experiences and feelings. Children can learn from each other and validate their feeling regarding the experience. This gives the child an opportunity to share and reduce their fears and anxieties. Educators are encouraged to share their own feelings and fears. End the discussion on a positive note, promoting a sense of security.

Art activities: Art is recommended for children to symbolically express their feelings. Coloring and drawing activities can stimulate children to draw, write, or talk about their experiences. Educators can encourage children to draw what comes to mind, prompt them with a question or topic. Children could also develop skits or puppet shows.

What can educators do?

Educators are an important part of the child's support system. Parents and teachers are usually the first to notice symptoms of ASD in children. Educators need to accommodate children's developmental factors, including knowledge, language development, memory, emotion regulation, and social cognition (Salmon & Bryant, 2002).

Educators should actively:

- Observe child in activities
- Listen
- Provide reassurance and comfort
- Ask questions
- Give support
- Build the child's self-confidence
- Be alert to the child's ongoing and changing needs
- Smile
- Attempt to stick to routine, and provide explanation if un able to
- Help the child develop their own coping skills

When you do not know what to say to a child and want to do something besides listening, try the power of touch. Ask permission, for example to hold hands, put your arm around their shoulder or stroke their hair.

Child Responses to Trauma

Shock and Surprise

- Upset with changes in routine
- Need to control what happens
- Wanting more frequent communication with parents
- Asking questions repeatedly to get information about what is about to happen
- Dependent on routines at school and at home
- Nervousness; hypervigilance (easily startled)
- Less willing to try unpredictable social situations or new experiences, including academic assignments and tests, sports competitions, and public performances
- Moodiness
- Anger

Helplessness

- Irritable when not given choices or power in decisions
- "Bossy" with family and friends
- Critical of others; judgmental; argumentative
- Stubbornness; insistence on having one's own way
- Inflexibility; narrowed focus on self
- Showing off, risk-taking behaviors

Fear

- Absentmindedness, inability to concentrate
- Poor appetite; nervous eating
- Frightened by: darkness, monsters, strangers, "bad guys", reminders of the event
- Using alcohol and other drugs to calm one's fears
- Anxious when separated from parents or caregivers
- Fearful of going to school
- Concerns about own health and that of loved ones
- Demanding reassurance and attention

Horror

- Thoughts about death and dying
- Disbelief; "numb" feeling; in a daze
- Nightmares; difficulty falling asleep; other sleep disturbances
- Intrusive thoughts; preoccupation with the event
- Flashbacks
- Fascination with morbid details of the event
- Acting out aspects of the event in imaginative play
- Questioning repeatedly the details of the event
- Making jokes about the event
- Sadness

Source: Project Reassure. (2007). Project Reassure: Printable Resources for Caretakers of Traumatized Children and Youth. Retrieved from