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Parents' descriptions of young children's dissociative reactions after trauma

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Abstract

There is limited research on the phenomenology of how young children who have been exposed to trauma express the intrusive symptom of dissociative reactions. The current qualitative study utilized interviews from a semi-structured diagnostic clinical interview with 74 caregivers of young children (age 3 to 7) who were exposed to trauma to identify parents' descriptions of their children's dissociative reactions during a clinical interview. Based on results from the interview, 45.9% of the children had dissociative reactions (8.5% had flashbacks and 41.9% had dissociative episodes). Interviews were transcribed to identify themes of dissociative reactions in young children. Common themes to flashbacks and dissociative episodes included being triggered, being psychologically in their own world (e.g., spaced out, shut down), and displaying visible signs (e.g., crying and screaming). For flashbacks, caregivers reported that it seemed as if the child was re-experiencing the trauma (e.g., yelling specific words, and having body responses). For dissociative episodes, caregivers noted that the child not only seemed psychologically somewhere else (e.g., distant and not there) but also would be physically positioned somewhere else (e.g., sitting and not responding). Caregivers also expressed their own reactions to the child's dissociative episode due to not understanding what was occurring, and trying to interrupt the occurrences (e.g., calling out to the child). Themes, descriptions and phrases to describe dissociative reactions in young children after trauma can be used to help parents and professionals more accurately identify occurrences of dissociative reactions.

Keywords

dissociation; flashbacks; young children; intrusion; posttraumatic stress disorder

Young children exposed to trauma may experience intrusive symptoms, including dissociation reactions (e.g., flashbacks), in different ways than older children and adults (American Psychiatric Association, 2013; Scheeringa, Zeanah, Myers, & Putnam, 2003). The Diagnostic and Statistical Manual of Mental Disorders fifth edition (DSM-5) includes specific diagnostic criteria for posttraumatic stress disorder (PTSD) for children 6 years and younger that are developmentally specific and include fewer total number of symptoms for the PTSD diagnoses (4 total symptoms for young children versus 6 for older children and adults). However, for all age groups, the number of symptoms required for intrusion symptoms is one of five intrusive symptoms, e.g., distressing memories, distressing dreams, dissociative reactions, psychological distress to trauma cues and physiological reactions to trauma reminders (American Psychiatric Association, 2013). Most diagnostic interviews for PTSD for young children occur with caregivers since young children are often not able to report their symptomatology (Stover & Berkowitz, 2005). If caregivers are not able to identify dissociative reactions in young children, then young children with PTSD may be underdiagnosed and possibly not treated. Research is needed to help caregivers, evaluators, and clinicians understand how young children express dissociative reactions in order to better identify these occurrences.

Dissociative reaction is defined as “(e.g., flashbacks) in which the child feels or acts as if the traumatic event(s) were reoccurring. Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings. Such trauma-specific reenactment may occur in play” (American Psychiatric Association, 2013, p. 273). The duration of the dissociative state may vary greatly where loss of reality orientation may or may not occur (American Psychiatric Association, 2013). While incidences of dissociative reactions among young children are not available, and measurement of dissociation among young children has varied (Hulette, Fisher, Kim, Ganger, & Landsverk, 2008), a substantial number of young children exposed to trauma experience dissociation reactions. For example, in a study with 140 young children (birth to 6 years old), who were exposed to interpersonal violence and whose caregivers were seeking clinical treatment, subclinical levels of dissociation were reported in 24.3% of the children (Hagan, Hulette, & Lieberman, 2015). Similarly, Bernier, Hebert, and Collin-Vezina (2013) found that 25% of preschoolers who experienced sexual abuse met clinical levels of dissociation compared to 3% of the non-abused preschoolers.

While studies on parents’ descriptions of dissociative reactions in children are limited, some parents have described dissociation as looking in the child’s eyes and “no one is home” (Silberg, 2013, p.37). Miller-Graff, Galano, and Graham-Bermann (2016) found in a study of therapists’ descriptions of young children’s (ages 4 to 6) exposure to intimate partner violence that 26.79% (15 of 56) of the children displayed “spacing out” behaviors distinct from attention problems. The researchers noted that these behaviors occurred in reaction to trauma reminders and occurred independent of other re-experiencing symptoms (Miller-

Graff et al., 2016). When a dissociative reaction occurs there may be distress and mood changes; these types of reactions may not occur with inattention as part of Attention Deficit Hyperactivity Disorder (ADHD) (Silberg, 2013). Dissociative reactions may occur during play. In a sample of 29 young children exposed to terrorism, severe re-experiencing that occurred in posttraumatic play (i.e., not able to develop a narrative, frozen, disconnected, tense or hypervigilant) was associated with a higher frequency of PTSD symptoms (Cohen, Chazan, Lerner, & Maimon, 2010). Also, pretend play and imaginary friends may be a symptom of dissociation (Macfie, Cicchetti, & Toth, 2001; Silberg, 2004).

Research with adults has provided descriptive experiences of dissociative reactions. In a qualitative study with eight adults with peri-traumatic dissociation symptoms, Mattos, Pedrini, Fiks, and de Mello (2016) described the dissociation as a “failure of synthesis among the emerging stimuli from internal and external world” (p. 8). Some participants described feelings as if they were “on another planet” or “in a fish tank” during the dissociative episode. Participants felt as if a “non-self” were taking them over and also felt a detachment from time and physical space (Mattos et al., 2016). Hellowell and Brewin (2002) found that adults had more overt behaviors (e.g., movement, vocalizations, breathing changes, stasis, facial behaviors, writing block and visuomotor behaviors such as closing eyes, and looking around the room) during flashbacks than ordinary autobiographical memories. For example, during flashbacks participants were more likely to call out content related to the trauma than during ordinary memory (Hellowell & Brewin, 2002).

The primary aim of this study was to examine parents’ descriptions of young children’s (age 3 to 7) dissociative reactions during a semi-structured diagnostic clinical interview to describe themes and descriptive words and phrases that may be used to help parents, clinicians and evaluators better identify dissociative reactions in young children. As part of this study, a descriptive report of young children’s intrusive symptoms was provided in order to provide a comparison of prevalence of dissociative reactions compared to other intrusive symptoms.

Methods

Participants

There were a total of 79 parents who consented to participate in a pilot (Salloum et al., 2014) and randomized clinical trial (Salloum et al., 2016) for young children experiencing posttraumatic stress symptoms. Secondary data from these two clinical trials was used for the current study. For the current study, data were included if there was an audio recording of the parent during the PTSD diagnostic interview. The sample for the current study consisted of 74 parents, although 73 are included in the analysis, as one parent did not report any intrusive symptoms. Four parent interviews were excluded due to no audio recording and one was excluded due to the interview not occurring because the trauma had occurred prior to age three. To be included in the clinical trials, the child must have experienced at least one traumatic event after the age of 36 months, have five or more PTSD symptoms with at least one symptom in avoidance or re-experiencing, and the child had to be between the ages of 3–7 years (for more details see Salloum et al., 2014; Salloum et al., 2016). Seven

year olds are often included as young children (e.g., Cohen, Chazan, Lerner, & Maimon, 2010; Gigengack, van Meijel, Alisic, & Lindauer, 2015).

Caregivers ranged in age from 22 to 68 years ($M = 33.26$, $SD = 8.56$). Sixty-six were mothers (89.20%), 3 were fathers (4.05%), 3 were grandmothers (4.05%) and 2 were aunts (2.70%). Forty-five (60.81%) reported a household income of less than \$35,000. Twenty-six of the parents were Hispanic or Latino (35.1%). The majority of the parents were Caucasian ($n = 56$, 75.68%) and 21.62% were Black or African American ($n = 16$) and 2.70% were American Indian or Alaskan Native ($n = 2$). The mean age for children was 5.08 ($SD = 1.38$).

Procedures

The current study was approved by the University of South Florida Institutional Review Board. Parents who participated in two treatment outcome studies for young children after trauma (e.g., Salloum et al., 2014; Salloum et al., 2016) provided written consent to participate. Parents were provided with the option to agree or not agree to having their assessments audio-recorded. Parents were informed that the audio-recorded assessment would be retained for further research purposes for at least five years after the completion of the treatment studies. Data from the audio-recordings from the baseline assessments of parents who provided written permission to audio-record were included in the current study. No identifying information was provided with the reported qualitative data in order to protect patients' privacy. The assessments were conducted by master level clinicians trained by the developer of the Diagnostic Infant and Preschool Assessment (DIPA; Scheeringa & Haslett, 2010) and were supervised by the fourth author, a psychologist trained in psychological assessments. The interviews took place in a private room in a community-based agency where the treatment occurred. Caregivers were compensated \$25 for completing the baseline assessment.

Measures

The DIPA (Scheeringa & Haslett, 2010) is a diagnostic clinical interview with young children's caregivers to assess the mental health of the young children. The PTSD module was used for the current study to assess for trauma exposure and young children's PTSD symptoms, and other diagnostic results, e.g., PTSD, major depressive disorder (MDD), ADHD, oppositional defiant disorder (ODD) and separation and generalizable anxiety disorders (SAD, GAD) and obsessive compulsive disorder (OCD) are included in sample descriptives. Parents were asked specific symptom-related questions and if the behavior seemed to be more than the average child his/her age and to provide examples in order for the interviewer to determine the presence or absence of the symptoms. For example, for dissociative reactions parents were asked (1) "since the [life event], has s/he felt as though the [life event] was happening to him/her again, even when it wasn't?" (If yes, the interviewer must get an example), and (2) "Since the [life event] has s/he had episodes when s/he seems to freeze? We call this dissociation where you try to snap him/her out of it but s/he was unresponsive." If yes, the interviewer must get an example. Lifetime was the timeframe for flashbacks and dissociation. For the PTSD module, 38.78% of the audio-

recorded interviews were reviewed, and interrater agreement was excellent ($\kappa = .95$, $p < .001$).

Data Analysis

Percentages of diagnostic status are provided. Cases ($n = 4$) with missing data from the DIPA diagnostic modules were excluded, although all 74 parents completed the PTSD module. We followed the six steps outlined by Braun and Clarke (2006) for the thematic analysis. (1) The data was transcribed by the first author and reviewed for accuracy by the third author. The transcripts were then read in order to become familiar with the data. (2) The first two authors independently generated initial codes after reading all the transcripts. Afterwards, the two authors reviewed all codes and agreed on final codes. For example, when coding responses related to the dissociative reactions, the initial codes were actual descriptive words from the parents' reports such as seems distant, seems gone, not there, goes blank, in a daze, in la la land, like child lost his/her mind, spaced out, somewhere else or in own world, just sits there, does not seem to hear parent, and child ignores parent. The authors then recoded all transcripts individually and reviewed codes for interrater reliability. The interrater agreement between the two coders was 90.73%. Consensus between the first and second author was reached on all codes. All codes were entered into an Excel database to assist with collating codes into themes. (3) The authors reread the coded transcripts and reviewed the Excel database to develop themes. For example, the descriptive words listed above were grouped into two themes describing the child not being present psychologically and in physical relation to the parent. (4) Themes were discussed and checked in relation to the initial codes and entire dataset. (5) The names of the themes were discussed and the authors worked to distinguish and refine the themes based on the data. For example, we labeled the codes describing not being psychologically present as "in their own world psychologically" (e.g., spaced out) and the codes related to not being present in relation to the parent as "in own world physically" (e.g., does not seem to hear parent). (6) Examples to illustrate the themes were extracted.

Results

Types of trauma included sexual abuse (33.78%), domestic violence (32.43%), physical abuse (8.12%), medical/illness (6.76%), death (8.11%), accidents (4.05%), crime (2.70%), and witnessed parent arrest, removed from the home and other (1.35% each). The majority ($n = 53$, 71.62%) of the children experienced more than one traumatic event ($M = 2.45$, $SD = 1.25$). Diagnostic status was as follows: PTSD = 48.65%; ODD = 64.79%; MDD = 38.89%; SAD = 38.03%; ADHD = 37.5%; and OCD = 1.43%.

Flashbacks

Triggered.—Four of the six parents reported that the flashback occurred after some type of event had triggered it. These events seemed to occur in different locations. For example, one caregiver reported that her child is triggered when he gets in trouble: *When he gets in trouble he like backs up in a corner and screams at the top of his lungs*. Interviewer: *And do you believe that he's somewhere else at that moment?* Caregiver: *Yes*. Another caregiver reported that her child had flashbacks when she dressed him or bathed him: *If I'm like*

getting him dressed he freaks out. Like he freaks out really bad and then I'm like "ok mommy's not going to hurt you" and then -or he's in the bathtub, he'll hide himself and he just gets scared.

Reoccurrence of trauma event.—Three of the parents reported that they could tell that the child was thinking about the trauma. Other signs that the child was re-experiencing the trauma in the moment included yelling words that they would have potentially stated during the trauma and having their body respond as it did during the trauma. One caregiver reported: *He'll just... he'll be playing and he'll just get tense and he'll tighten up and it's like he'll start crying. He'll just start crying for no reason and I'm like "what's wrong?" and he'll say "nothing" and he's like "I just remember everything that's happening."* Another caregiver stated: *I'm trying to comfort him but sometimes he doesn't even know I'm there. He's just yelling different things out.* Interviewer: *Like as if he's -what does he yell out?* Caregiver: *"Stop it! Stop doing that! It's so loud in here!" yeah thing like that he'll say.*

In their own world (psychologically).—Four parents reported instances of the child not being psychologically present. Parents used words such as spaced out, shut down, won't snap out of it, not focused on anything, no eye contact, or somewhere else to describe the child being in their own world. One caregiver reported: *He's not looking at me -you know- he's just somewhere else. He won't snap out of it. He won't look at me, he won't focus on me or anything, and he's just staring off somewhere else.* Another caregiver also stated: *I think he's somewhere else. I think he starts to remember. I see his eyes space out.*

Visible signs.—Four parents reported visible signs that indicated that the child was experiencing a flashback. The most frequent visible signs were crying and screaming. Other signs included getting scared, and the parent noting an *awkward moment or an unexplained fit* and no eye contact. One parent described these symptoms as: *He was just screaming and crying and he wasn't making any sense.* Another caregiver stated: *He'll hide himself and he just gets scared.*

Dissociation

In their own world (psychologically).

Twenty of 31 parents indicated that when the dissociative episode was occurring it was like the child was not psychologically present. This theme was also evident when parents described flashbacks. Parents used descriptive words such as seems distant, gone, not there, goes blank, stares, zones out, in a daze, and in 'lala' land. For example, caregivers stated, *He'll just be in his own little world somewhere else; Her affect is pretty distant like a lot of times it feels like she's in another room at another time; Like sometimes I'm talking to him and he's just staring wide like... like he's in 'lala' land.*

In their own world (physically).

Eleven parents provided physical descriptions of the child being in their own world such as the child just sitting there, not hearing the parent, ignoring the parent, not responding to the parent, physically isolating themselves and tuning the parent out. For example, one caregiver

stated: *I'll be right there and I'm calling her. I'm right there so I know she hears me, but she doesn't hear me she goes "Oh I didn't hear you!"* Another caregiver stated: *I've tried to get her attention and most of the time it's like she's ignoring me almost.*

Parent tries to interrupt.

Eleven parents reported that they both called out to the child and touched the child in order to try to interrupt the dissociative episode. Eleven parents indicated only calling out to the child to interrupt the dissociative episode, two parent reported only touching the child to interrupt the dissociative episode, and one parent tried to get in front of the child's face to interrupt the dissociative episode. Various caregivers stated that they were able to interrupt their child's dissociative episode by touching or calling for them multiple times. Interviewer: *How do you get him to basically respond to you? What do you have to do?* Caregiver: *If you say his name multiple times in a loud voice, and be like [child] and touch him and be like "hey, are you listening?"* One caregiver reported that the child would come out of the dissociative episode on their own. Caregiver: *It's just kind of something he comes out of on his own. Like I could call his name, I could move him, try to move his body. It's just on his timing.*

Visible signs.

Three parents indicated visible signs of distress that occurred after the child experienced a dissociative episode. The signs included being scared or startled when interrupted and crying after the episode. One caregiver reported: *I touch her and she'll say, "You scared me!"* Another caregiver stated: *Finally he'll snap out of it and look at you and then cry.*

Parent reacts to dissociative reactions.

Five parents expressed instances where they reacted to the child when they were dissociating because they did not understand what was occurring. For example, one parent described the child as being stubborn and became angry with the child. Two parents considered taking the child for an examination for a neurological test or to be tested for attention deficit hyperactivity disorder (ADHD). One parent indicated that they just left their child alone when it occurred. For example, one caregiver stated: *I was getting mad at her because I'm like [child]!* Another caregiver reported: *They all think he has ADD, all his teachers, speech, want him tested for ADD because he zones out into -and they can't get him to focus and stay alert, on task.* Another caregiver mentioned: *I don't touch him I'll call his name out and he'll respond after a couple of times and I'll just leave it alone.*

Triggered.

One parent indicated that the dissociative episode seemed to occur when the child was triggered by a trauma reminder. Two parents indicated that there did not seem to be any trauma reminders when the episode occurred. The dissociative episodes occurred at different places as indicated by four parents. For example, one caregiver described their child being triggered when they mentioned the perpetrator's name: *When it gets talked about like if [name] mentions it or something or is talking then he just kind of goes blank. And then he'll say "oh who are you talking about?" when you know that he knows and we won't say*

anything. Another caregiver described their child's dissociative episode occurring at home as well as in the supermarket: *Yeah probably somewhere around the beginning of September he did it once and we were sitting on the couch. And he did it again, I think he was in a shopping cart, when we were at Super Target and I was pushing him and I was like this going "Hello?" I think I was asking him if he wanted SpongeBob macaroni and cheese and I couldn't get him to say anything and he just kind of zoned out.*

Discussion

The percentage of parents who reported dissociative reactions among young children in the current study was higher than previous studies (45.95% vs. 25.00%, 24.29%, 26.79% respectively; e.g., Bernier et al., 2013; Hagan et al., 2015; Miller-Graff et al., 2016). These differences may be due to differences in assessment such as using a clinical interview that requires examples versus self-reports. However, the percentage of parents reporting flashbacks (8.12%) in the current study was only slightly lower than the percentage (12.82%) reported by Levendosky, Huth-Bocks, Sernel, and Shapiro (2002) who used a one-item self-report. Findings suggest that while dissociative reactions were not reported to occur as frequently as other intrusive symptoms, young children who are exposed to trauma are at risk for experiencing dissociative reactions.

While the occurrence of flashbacks was not as high as dissociative episodes, it seemed that parents were more certain when children were experiencing a flashback as there were signs to the parent such as yelling words that occurred during the trauma or having the child's body respond as if the trauma were occurring that made these flashbacks evident to parents. In contrast two themes that were present for dissociative episodes and not for flashbacks were parents' reactions to dissociation and parents' attempts to interrupt the occurrence. Parents seemed more unclear as to what was occurring when a child had a dissociative episode than when a flashback occurred. Many parents indicated that they tried to stop the dissociative episode by trying to bring the child back psychologically via touch or verbally, whereas it was not indicated that parents tried to stop the flashback. It is not clear why parents did not indicate that they tried to interrupt the child's flashback, but it may be since they knew what was occurring they were less likely to intervene or perhaps the flashback did not last as long as the dissociative episode. However, this finding of parents' interrupting dissociative episodes and not flashbacks may have been biased by the clinical interview questions. For example, the interview question for dissociation episodes specifically asked parents about episodes where the child "seems to freeze" and where the parent had to try to "snap him/her out of it." The interview question regarding flashbacks did not state any interruption cues but rather inquired about the child feeling like the event was happening again.

The theme of visible signs was present for both flashbacks and dissociative episodes. Parents noticed the visible signs while the flashback was occurring, but signs of visible distress were not present during the dissociative episode but rather occurred when parents tried to interrupt the episode or after it occurred. Screaming was observed only for flashbacks and being startled was noted only when disrupting the dissociative episodes. It seemed that parents were able to identify the triggers related to a flashback, but not all parents were able to

recognize the triggers before the dissociative episode. Parents observed that the child seemed in their own world and not present whether a flashback or a dissociative episode occurred.

While there is overlap in symptoms in many childhood disorders, dissociative reactions are specific to trauma-related disorders (Cohen & Scheeringa, 2009). Nonetheless, it is possible that ADHD symptoms such as difficulty sustaining attention in task or play and not listening when spoken to, or the ODD symptom of actively defying to comply with a request could be mistaken for dissociative reactions or vice versa. However, as noted by Cohen and Scheeringa (2009) good history taking about the onset of the symptoms and understanding of PTSD is important to accurate diagnosis. Importantly, the IE in the study was trained and supervised, and the DIPA requires the parents to provide examples and includes onset information of traumatic events which adds to the accuracy of endorsed symptoms. Also, in reviewing the parents' descriptions of dissociative reactions, there was a qualitative sense of complete loss of awareness or reenactment of the trauma or trauma triggers. Further, the accompanying distress and difficulty in getting the child's attention further supports the symptom of dissociative reactions rather than inattentiveness or defiance (e.g., Silberg, 2013).

There are similarities and differences in these parents' reports of their children's flashbacks and dissociative episodes compared to prior research with adults. First, parents' descriptions of children's dissociative reactions in the current study, and adults peri-traumatic dissociative responses (e.g., Mattos et al., 2016) both included themes of being in another world, not understanding or responding to what people were saying to them, and staring at nothing. However, adults described physical sensations when the dissociative episodes occurred such as being cold, shivering and chest pains (Mattos et al., 2016), whereas parents in the current study did not report somatic responses. Children may have somatic responses during dissociative reactions, but due to their limited capacity to explain these occurrences they may not have expressed these reactions. Second, adults indicated a detachment from time and space (i.e., not knowing where they are physically) and that they were aware of their memory loss (Mattos et al., 2016). Young children may have perceived these alterations of time, space and memory, although these experiences are not easily observable by parents and would be difficult for a young child still developing their cognitive abilities to describe. Third, similar to adults (e.g., Hellawell & Brewin, 2002), parents reported several overt behaviors during dissociative reactions such as body reactions, calling out words, crying and closing eyes, and being scared. However, Hellawell and Brewin (2002) found that adults were also able to describe their inner experiences from a primary point of view whereas parents were only able to give a secondary description. For example, adults were able to describe flashbacks swamping their minds and taking them by surprise (Hellawell & Brewin, 2002). Parents seemed to see a similar type of experience in their children, but described it from a secondary point of view stating that their child was crying for no reason, having unexplained fits, or not making any sense.

There are several clinical implications from the study findings to consider. Due to the exploratory nature of this study, these clinical implications are to be considered with caution.

First, parents of young children who had experienced trauma were able to describe flashbacks and dissociative episodes when asked the two dissociative questions from the DIPA PTSD module. Therefore, clinicians should consider using the clinical interview questions from the DIPA PTSD module with parents of young children to assess dissociative episodes. Asking parents for detailed examples provides more evidence to discern if a flashback or dissociative episode is occurring. Second, clinicians may want ask about dissociative episodes occurring without using the descriptive words in the interview questions such as when s/he seems to freeze or is unresponsive. However, if parents do know what a dissociative episode is then the descriptive words from the clinical interview are needed. Third, if parents deny that their child has experienced any flashbacks or dissociative episodes after asking the clinical questions, findings from this study may be used to further explain what other parents have described to see if parents have observed any episodes. For example, to probe for occurrences of flashbacks clinicians might state, “When a flashback occurs some parents have observed the child being triggered by some event that makes the child seem like he or she is experiencing the trauma again, the child yelling words that may be related to the trauma such as “stop doing that”, the child being spaced out, shut down, or just somewhere else psychologically, signs such as crying, screaming when the child seems to feel like the trauma is occurring again. Have you noticed any signs that may indicate the child is feeling like the trauma is happening to him/her again, even when it wasn’t?” Lastly, if parents have observed flashbacks and dissociative episodes, it may be helpful if parents ask if the child experienced feeling different in their body such as heart beating fast, feeling cold or hot, or shaking. Since adults have reported these type of occurrences after dissociative episodes (e.g., Mattos et al., 2015), it may help the young child to be able to let his/her caregiver know if this occurred as the physical body change could be frightening for the child.

There were several limitations to this exploratory qualitative study. First, this study only analyzed parental descriptions of young children’s dissociative symptoms. Having only parent reports and descriptions limits our ability to understand the full aspect of the child’s symptomology. Clinical observations and reports from other caregivers or daycare workers may provide a more in-depth understanding of children’s dissociative reactions. Second, due to following the semi-structured questions from the DIPA that included descriptions such as “seems to freeze” or “had to snap him/her out of it but was unresponsive,” the interviewer may have biased the parents’ responses. Also, due to the structure of the interview, parents may have provided certain types of experiences and not others. For example, if the interview inquired further about play and imaginary-related friends, results may have differed. Third, narratives from only six parents were available regarding flashbacks. However, a strength of the current qualitative study was our large and demographically representative sample size of parents who reported dissociation reactions to the specific clinical interview questions and having 31 parents describe dissociative episodes in young children.

To be able to appropriately diagnose young children with PTSD, professionals rely on caregivers to accurately report their child’s PTSD symptoms. A better understanding of how parents describe dissociative reactions in young children may help caregivers become better reporters of these occurrences. Also, having a greater understanding of the experiences of dissociative reactions in young children may help professionals be able to more clearly

describe and educate parents on how these symptoms may manifest in their young child, and to develop valid assessment tools to be used by clinicians. Having a more accurate account of dissociative reactions in young children may lead to more accurate PTSD diagnoses, prevent misdiagnosis, and lead to more effective targeted treatment for dissociative reactions.

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Table 1*Frequency of Intrusive Symptoms*

Symptom	n	%
Recurring and intrusive recollection, not required to be distressing	65	87.84
(a) Intrusive memories	52	70.27
(b) Play reenactment of the trauma	38	51.35
(c) Non-play reenactment of life events	13	17.57
Recurrent distressing dreams of the event	49	66.22
(a) Nightmares or bad dreams about trauma: child wakes up	21	28.37
(b) Increased nightmares but not sure if they are about trauma	43	58.12
Dissociative reactions	34	45.95
(a) Flashback	6	8.12
(b) Dissociative episode	31	41.89
Intense psychological distress of reminders	58	78.37
Physiological reactive at reminders	38	51.35