The Child Dissociative Checklist

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The child dissociative checklist (CDC) is a tool that compiles observations by an adult observer regarding a child's behaviors on a 20-item list. Behaviors that occur in the present and for the past 12 months are included. As a research tool, the CDC can quantify dissociative behavior for dimensional approaches and can generate cutoff scores that categorize children into low and high dissociation groups. Research shows that healthy nonmaltreated normal children usually score low on the CDC, with younger children scoring slightly higher. As a group, maltreated children score higher than those with no trauma history; however, as a group they still score substantially lower than children diagnosed with a dissociative disorder. Generally, scores of 12 or more can be considered tentative indications of sustained pathological dissociation.

As with any screening tool, a trained clinician should assess the child in a face-to-face interview before a diagnosis is confirmed. As a clinical tool, the CDC has multiple uses. It can be a routine screening instrument used in a clinic setting as a standalone tool or in addition to other reporting tools for parents. In special circumstances, teachers or others who know the child reasonably well could be asked to complete the checklist. In these circumstances, allowances need to be made for the observer's familiarity with the child and also the observer's opportunity to observe the child at night. If the observer has no nighttime observation of the child, items 17 and 18 should be ignored (**Putnam, 1997**).

For finer screening, the CDC could also be administered sequentially in an interval-based series. Putnam notes that nondissociative children often increase their scores by a small amount (1–3 points) over the first few completions, because the questions draw attention to minor dissociative behaviors that had not previously been noticed.

Finally, the CDC can be used as a rough index of treatment progress. Although evidence for this use is limited, it seems that the CDC provides a reasonable indication of whether a child is improving over time or with treatment. Putnam reports consistent results on several children from the CDC and also clinical observations (**Putnam, 1997**).

Users of the CDC are cautioned that CDC scores reported in the literature for the various groups are means that reflect the "average" child in a given group.

Individual children in any of the groups can, and often do, exhibit varying scores on the CDC. Thus, a high score does not prove a child has a dissociative disorder, nor does a low score rule it out. Also, since the CDC reports observers' ratings of a child, variations in the observers' interpretations of behavior as well as actual variations in child behavior may affect the variance. This is a potential complication in any observer-based assessment, but it may be especially important when observers are drawn from those whose perceptions may be clouded by their attachment to the child (**Putnam, 1997**).

Note

1. From the International Society for the Study of Trauma and Dissociation website (**www.isst-d.org**).

Reference

1. Putnam F. W. (1997). *Dissociation in children and adolescents: A developmental perspective*. New York, NY: Guilford Press.

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Child Dissociative Checklist (CDC), Version 3

Frank W. Putnam, MD

Date: _____ Age: _____ Sex: M F Identification: _____

Below is a list of behaviors that describe children. For each item that describes your child NOW or WITHIN THE PAST 12 MONTHS, please circle 2 if the item is VERY TRUE of your child. Circle 1 if the item is SOMEWHAT or SOMETIMES TRUE of your child. If the item is NOT TRUE of your child, circle 0.

0 1 2	1. Child does not remember or denies traumatic or painful experiences that are known to have occurred.
0 1 2	2. Child goes into a daze or trance like state at times or often appears "spaced-out." Teachers may report that he or she "daydreams" frequently in school.
0 1 2	3. Child shows rapid changes in personality. He or she may go from being shy to being outgoing, from feminine to masculine, and from timid to aggressive.
0 1 2	4. Child is unusually forgetful or confused about things that he or she should know, e.g. may forget the names of friends, teachers or other important people, loses possessions or gets easily lost.
0 1 2	5. Child has a very poor sense of time. He or she loses track of time, may think that it is morning when it is actually afternoon, gets confused about what day it is, or becomes confused about when something has happened.
0 1 2	6. Child shows marked day-to-day or even hour-to-hour variations in his or her skills, knowledge, food preferences, and athletic abilities, e.g. changes in handwriting, memory for previously learned information such as multiplication tables, spelling, use of tools or artistic ability.
0 1 2	7. Child shows rapid regressions in age-level behavior, e.g. a twelve-year-old starts to use baby talk, sucks thumb or draws like a four-year-old.
0 1 2	8. Child has a difficult time learning from experience, e.g. explanations, normal discipline or punishment do not change his or her behavior.
0 1 2	9. Child continues to lie or deny misbehavior even when the evidence is obvious.
0 1 2	10. Child refers to himself or herself in the third person (e.g. as she or her) when talking about self, or at times **insists** on being called by a different name. He or she may also claim that things that he or she did actually happened to another person.
0 1 2	11. Child has rapidly changing physical complaints such as headache or upset stomach. For example, he or she may complain of a headache one minute and seem to forget about it the next.

0	1	2	12. Child is unusually sexually precocious and may attempt age-inappropriate sexual behavior with other children or adults.
0	1	2	13. Child suffers from unexplained injuries or may even deliberately injure self at times.
0	1	2	14. Child reports hearing voices that talk to him or her. The voices may be friendly or angry and may come from “imaginary companions” or sound like the voices of parents, friends or teachers.
0	1	2	15. Child has a vivid imaginary companion or companions. Child may insist that the imaginary companion(s) is responsible for things that he or she has done.
0	1	2	16. Child has intense outbursts of anger, often without apparent cause, and may display unusual physical strength during these episodes.
0	1	2	17. Child sleepwalks frequently.
0	1	2	18. Child has unusual nighttime experiences, e.g. may report seeing “ghosts” or that things happen at night that he or she can’t account for (e.g. broken toys, unexplained injuries).
0	1	2	19. Child frequently talks to himself or herself, may use a different voice or argue with self at times.
0	1	2	20. Child has two or more distinct and separate personalities that take control over the child’s behavior.