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A Review of the Child Dissociative Checklist (CDC): Qualitative Descriptors, Psychometric Properties, and Normative Data

The Child Dissociative Checklist (CDC) is a 20-item observer-report screening measure designed to identify dissociative symptoms in children aged 5-12 years. This technical review presents normative data, psychometric properties, and qualitative descriptors to help clinicians better understand and utilize the assessment in practice.

View the CDC on NovoPsych.com.au

April 2025

Developer

The Child Dissociative Checklist (CDC) was developed by Putnam et al. (1993):

> Putnam, F. W., Helmers, K., & Trickett, P. K. (1993). Development, reliability, and validity of a child dissociation scale. *Child Abuse & Neglect, 17*(6), 731-741. https://doi.org/10.1016/0145-2134(93)90006-Q

This document was developed by NovoPsych to review contemporary literature, describe original scoring methodologies, provide interpretation material, enhance normative data and provide qualitative descriptors.

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Description

The Child Dissociative Checklist (CDC) is a 20-item observer-report measure designed to assess dissociative symptoms in children (Putnam, Helmers, & Trickett, 1993). Developed as the first validated clinical measure of childhood dissociation, the CDC serves as a screening tool for identifying children who may require further assessment for dissociative disorders. It is completed by a clinician, caregiver or adult who knows the child well, such as a parent, foster parent, or teacher, rating behaviors observed currently or over the past 12 months.

Dissociation is defined as "a disruption of and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, and behavior" (American Psychiatric Association, 2013). In children, dissociation can manifest differently from adults due to developmental differences in cognitive capacity, with symptoms often appearing as behavioral rather than subjective internal experiences. While some level of dissociation is normative in childhood (particularly among preschoolers), pathological dissociation develops when it becomes an automatic response to stress, impairing functioning and increasing susceptibility to serious psychopathology (Hornstein, 1993; Putnam, 1997).

While the CDC does not have subscales, items cover several domains of dissociative behavior in children, including:

- Dissociative amnesia: Memory gaps, forgetting personal information, not remembering traumatic experiences
- Identity confusion/alteration: Referring to self in third person, rapid personality changes, age regression
- Depersonalization/derealization: Trance states, "spacing out," staring blankly
- Perceptual disturbances: Hearing voices, imaginary companions taking control
- Mood/behavior fluctuations: Rapid mood shifts, aggressive outbursts, self-harming behaviorsCover

The CDC has demonstrated utility in multiple contexts, including child protection services, residential treatment facilities, and outpatient mental health settings. It is particularly valuable for assessment of children who have experienced trauma, especially interpersonal trauma such as physical and sexual abuse (Hulette et al., 2008; Macfie, Cicchetti, & Toth, 2001b). Research consistently demonstrates elevated CDC scores in children with trauma histories, with physical abuse showing a particularly strong relationship to dissociative symptoms in young children (Macfie et al., 2001b).

In clinical practice, the CDC helps identify dissociative symptoms that might otherwise be overlooked or misdiagnosed as attention problems, behavioral issues, or mood disturbances (Endo, Sugiyama, & Someya, 2006). Screening for and accurately identifying dissociation is critical, as these symptoms can interfere with the effectiveness of standard interventions and may require specific trauma-focused approaches. As such, the CDC can be used to inform treatment planning, as where dissociative symptoms are identified, therapy may include a focus on grounding skills and regulation strategies, with careful attention to pacing, safety and consistent attunement.

The CDC should be considered one component of a comprehensive assessment that may include clinical interviews, other standardized measures, and behavioral observations. While elevated scores warrant further investigation, the CDC is not a diagnostic instrument on its own (Putnam et al., 1993; Wherry et al., 1997).

Psychometric Properties

The CDC demonstrates strong psychometric properties across multiple studies with diverse samples of children. These findings support its use as a reliable and valid measure of dissociative symptomatology in children. Internal consistency of the scale is excellent, with Cronbach's alpha values typically ranging from .85 to .88 (Putnam et al., 1993; Wherry et al., 1997). Test-retest reliability over a one-year period has been established at rho = .69 for the full sample, with ρ = .66 for sexually abused children and ρ = .61 for control children (Putnam et al., 1993). Item-level

test-retest reliability ranges from .57 to .92. This indicates good stability of the measure over time, despite the natural variation in children's dissociative symptoms that might occur with development or changing circumstances.

Convergent validity is supported by correlations between the CDC and other measures of childhood psychopathology. Wherry et al. (1997) found significant positive correlations between the CDC and the Child Behavior Checklist (CBCL) internalizing (r = .52), externalizing (r = .61), and total problem scores (r = .72). Relationships with measures specifically assessing trauma symptoms have also been established, with Milot et al. (2013) reporting moderate to strong correlations between the CDC and both the Trauma Symptom Checklist for Young Children (r = .39) and CBCL-derived PTSD scales (r = .55).

The 20 CDC items were derived from clinical experience with dissociative children and matching predictor lists independently generated by other researchers, supporting content validity (Putnam et al., 1993). Construct validity has been supported through item analysis, showing item-total correlations ranging from .59 to .79 (Putnam et al., 1993). Putnam et al. (1993) conceptualized the CDC as unidimensional and it is predominantly used as a unidimensional assessment of dissociation (Putnam et al., 1993).

The CDC has been studied in various populations, allowing for comparative normative data. In the original validation study (Putnam et al., 1993), mean scores were: control girls (M = 2.3, SD = 2.7), sexually abused girls (M = 6.0, SD = 6.4), children with Dissociative Disorder NOS (M = 16.8, SD = 4.7), and children with Dissociative Identity Disorder (M = 24.5, SD = 5.2). These distributions demonstrate a clear continuum of dissociative experiences from normative to pathological levels. Other studies have contributed additional normative data, with consistently lower means in non-clinical samples compared to traumatized and clinically referred samples. Further normative data is described in table 1.

A score of 12 or higher has been established as the clinical cutoff for significant dissociation. This cutoff has shown a good ability to distinguish between children with dissociative disorders and non-clinical samples, with approximately 96% of children with diagnosed dissociative disorders scoring above this threshold (Putnam et al., 1993).

Category descriptors for the CDC were derived based on percentile distributions from the non-abused sample reported by Wherry et al. (2009), and in consideration of the wider literature. The clinical cutoff of 12 (Putnam et al., 1993) serves as the boundary between normal and mild-to-moderate dissociation. The percentile distribution of the non-dissociative sample shows the 1st-80th percentiles with equivalent scores of 0-11 within the typical range for most, and 81st-95th percentiles corresponding to scores 12-15 indicating elevated dissociation. The equivalent score range for the 99th-99.99th percentiles are scores 17-20, indicating high levels of dissociation, and the 99.99th percentile and greater corresponds to scores 21+, reflecting severe dissociative symptoms typically seen in dissociative disorders.

- **Normal to mild**: Score 0-11, 1st to 80th percentile: Within normal limits for most children.
- **Moderate**: Score 12-15, 81st to 95th percentile: Above the typical range for non-dissociative children and may reflect some significant dissociative symptoms. Scores are common in children with histories of abuse or significant stressors.
- **High**: Score 17-20 = 99th to 99.98th percentile: Strong indication of clinically significant dissociative symptoms and potential traumatic etiology. Most children with dissociative disorders score in this range.
- **Severe**: Score ≥ 21= ≥ 99.99th percentile: Extreme level of dissociative symptoms, strongly suggestive of Dissociative Identity Disorder or other severe dissociative condition. Scores in this range are commonly seen in children with diagnosed dissociative disorders.

Scoring & Interpretation

The CDC total score ranges from 0-40. Higher scores indicate more severe dissociative symptoms. While no formal subscales exist, clinicians may find it helpful to evaluate items in context of the domains described earlier (amnesia, identity confusion, depersonalization/derealization, perceptual disturbances, and mood/behavior fluctuations) to better understand specific symptoms.

Based on research using the CDC, the following interpretive guidelines are recommended:

- **Normal to mild**: Score 0-11, 1st to 80th percentile: Within normal limits for most children.
- **Moderate**: Score 12-15, 81st to 95th percentile: Above the typical range for non-dissociative children and may reflect some significant dissociative symptoms. Scores are common in children with histories of abuse or significant stressors.
- **High**: Score 17-20 = 99th to 99.98th percentile: Strong indication of clinically significant dissociative symptoms and potential traumatic etiology. Most children with dissociative disorders score in this range.
- **Severe**: Score ≥ 21= ≥ 99.99th percentile: Extreme level of dissociative symptoms, strongly suggestive of Dissociative Identity Disorder or other severe dissociative condition. Scores in this range are commonly seen in children with diagnosed dissociative disorders.

The total score is also expressed as a percentile rank, based on normative data from Endo et al. (2006) of non-dissocative children. This percentile contextualises the client's score relative to the general population, indicating the percentage of individuals who scored lower than the client. For example, a score at the 85th percentile means that 85% of people in the community sample scored lower than the client, placing them in the upper range of dissociative experiences.

When the CDC score is at 12 or higher, further assessment for a dissociative disorder may be recommended as this threshold identified 96% of children meeting criteria for dissociative disorders in previous validation studies (Putnam et al., 1993). Scores at or above this threshold warrant additional attention and potential follow-up with structured interviews or other more comprehensive assessment to investigate the nature and extent of dissociative symptoms.

Significant changes in the total score are indicated by shifts of half a standard deviation or greater (approximately 6 total score points or more) following the guidelines of the Minimally Important Difference (Turner et al., 2010).

On first administration a bar graph showing the CDC total score is displayed. In addition to the bar graph, a comparison graph illustrating the client's scores relative to dissociative and non-dissociative reference groups are displayed. When the assessment is administered multiple times, a longitudinal line graph of the total CDC score is generated to track changes over time.

Supporting Information

This section details the normative data for the CDC. These norms enhance the interpretability of CDC scores, table 2 shows the percentiles for community samples.

NovoPsych has computed percentiles using mean and standard deviation data reported in Endo et al. (2006) to convert the CDC total scores to percentiles as shown in table 2, according to the following equation.

$$\text{Percentile} = 100 \times \Phi(x - M)/SD)$$

Where:

- x is the score
- M is the mean
- SD is the standard deviation
- Φ is the standard normal cumulative distribution function

This equation first standardises the score to a z-score by subtracting the mean and dividing by the standard deviation, then converts the z-score to a percentile by applying the standard normal cumulative distribution function and multiplying by 100. The percentiles contextualise each score relative to typical scores among those in the general population.

Table 1. CDC means and standard deviations for various samples.

Source	N	Population	Total Score
Wherry et al. (1997)	73	Unspecified	6.90(5.53)
Kisiel & Lyons (2001)	27	Not abused	4.70(3.40)
Kisiel & Lyons (2001)	25	Physical or sexual abuse	6.0(6.10)
Kisiel & Lyons (2001)	44	Physical and sexual abuse	10.40(6.90)
Wherry et al. (2009)	232	Physical abuse	5.74(12.39)
Wherry et al. (2009)	232	Physical and sexual abuse	14.15(28.81)
Endo et al. (2006)	7	WIthout dissociative disorder	20.40(11.30)
Endo et al. (2006)	23	With dissociative disorder	7.30(4.40)

Table 2. Percentile distribution of the non-dissociative sample from Endo et al. (2006).

Children Without Dissociative Disorders	
Raw Score	Percentile
0	5
1	8
2	11
3	16
4	23
5	30
6	38
7	47
8	56
9	65
10	73
11	80
12	86
13	90
14	94

15	96
16	98
17	98.6
18	99.2
19	99.6
20	99.8
21	99.9
22	99.99
23	99.99
24	99.99
25	99.99
26	99.99
27	99.99
28	99.99
29	99.99
30	99.99
31	99.99
32	99.99
33	99.99
34	99.99
35	99.99
36	99.99
37	99.99
38	99.99
39	99.99
40	99.99

Interpretive Text

The interpretive text for the CDC follows a structured format that adapts based on the client's scores.

Normal to mild (score 0-11):

> *The client's total score indicates minimal to mild dissociative experiences within normal limits for most children. These experiences may include occasional daydreaming, absorption in play, or minor forgetfulness, particularly in younger children. Their score is lower than XX% of non-abused children.*

Moderate (score 12-15):

> *The client's total score suggests moderate dissociative experiences that exceed typical levels in non-abused children. They may experience some memory gaps, emotional inconsistency, or trance-like states that cause occasional concern. Their score is higher than XX% of non-abused children.*

High (score 16-24):

> *The client's total score indicates significant dissociative experiences that are rarely observed in non-abused children. They likely experience notable disruptions in memory, identity cohesion, or consciousness that interfere with daily functioning. Their score is higher than XX% of non-traumatized children.*
>
> *Responses to the following items contributed to the client's score:*
> <Three highest scored items>. i.e.,
> 1. Child does not remember or denies traumatic or painful experiences that
> are known to have occurred. (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. (2)
> 3. Child shows rapid changes in personality. He or she may go from being shy to being outgoing, from feminine to masculine, from timid to aggressive. (2).

Severe (score 25+):

> *The client's total score indicates severe dissociative symptomatology at levels commonly seen in children with dissociative disorders. They are likely experiencing profound disruptions in identity, memory, perception, or consciousness that substantially impair functioning. Their score is higher than XX% of non-abused children.*
>
> *Responses to the following items contributed to the client's high score:*
> *<**Five** highest scored items >. I.e.,*
> 1. Child does not remember or denies traumatic or painful experiences that
> are known to have occurred. (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. (1)

3. Child shows rapid changes in personality. He or she may go from being shy to being outgoing, from feminine to masculine, from timid to aggressive. (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. (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. (2)

Tracking score change over time.

Since the respondent was first assessed on [Date], their total score has [not changed | not shown meaningful change (if change <6) | increased | decreased]. A change of half a standard deviation (6) or more points is considered meaningful based on a minimally important difference calculation.

Example: Since the respondent was first assessed on 02 Jan 2025, their total score has not shown meaningful change (score change = 3).

Developer

Putnam, F. W., Helmers, K., & Trickett, P. K. (1993). Development, reliability, and validity of a child dissociation scale. *Child Abuse & Neglect, 17*(6), 731–741. https://doi.org/10.1016/0145-2134(93)90006-Q

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Assessment Questions

NovoPsych

Child Dissociative Checklist (CDC)

Instructions:

Below is a list of behaviors that describe children. For each item that describes your child now or within the past 12 months, please select 2 if the item is Very True of your child. Select 1 if the item is Somewhat or Sometimes True of your child. If the item is
Not True of your child, circle 0.

		Not true	Somewhat or sometimes true	Very true
1	Child does not remember or denies traumatic or painful experiences that are know 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, 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, 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 behaviour 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

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		Not true	Somewhat or sometimes true	Very true
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 him 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.	**0**	**1**	**2**

Developer Reference:

Putnam, F. W., Helmers, K., & Trickett, P. K. (1993). Development, reliability, and validity of a child dissociation scale. Child Abuse & Neglect, 17(6), 731-741. https://doi.org/10.1016/0145-2134(93)90006-Q

Administer Now

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Sample Result

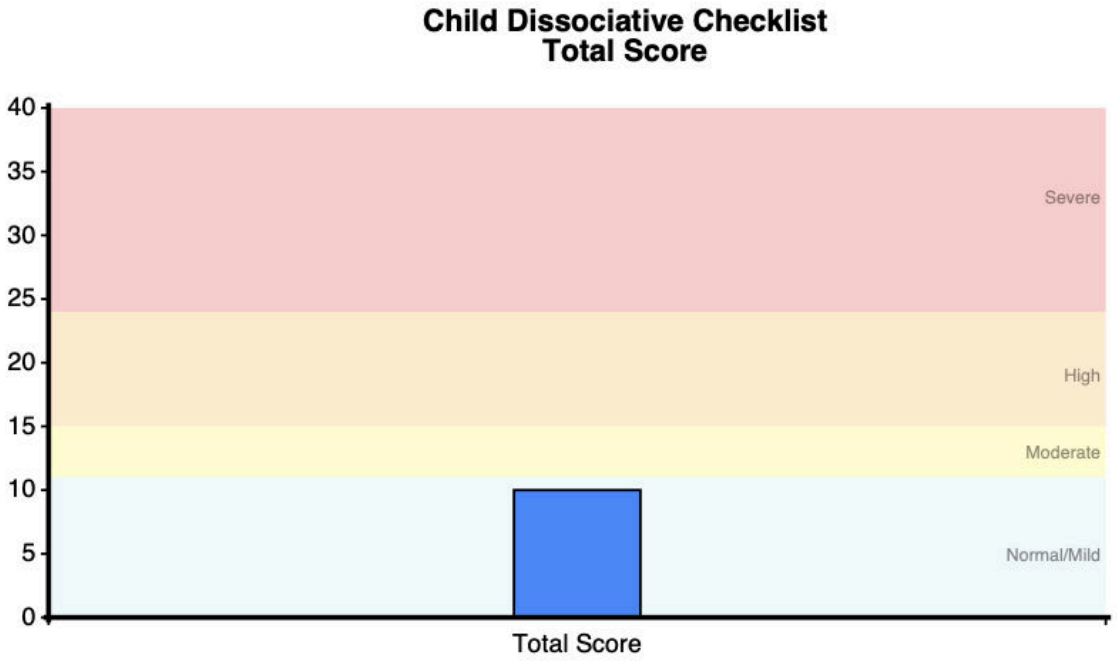
Assessment powered by NovoPsych

Child Dissociative Checklist (CDC)

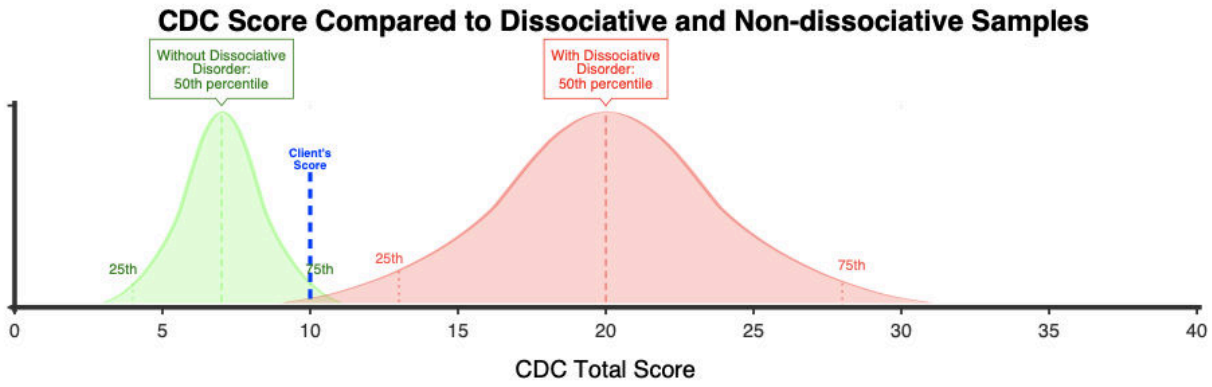
Client Name	Generic Client	*Date administered*	10 Apr 2025
Date of birth (age)	1 Jan 1999 (26)	*Time taken*	12 min 48s
Assessor	Dr Emerson Bartholomew		

Results

	Total Score (0-40)	Community Percentile	Descriptor
Total	10	73	Normal/Mild



Client Name	Generic Client



Interpretation

The client's total score indicates minimal to mild dissociative experiences within normal limits for most children. These experiences may include occasional daydreaming, absorption in play, or minor forgetfulness, particularly in younger children. Their score is lower than 27% of non-abused children.

Scoring and Interpretation Information

The CDC total score ranges from 0-40. Higher scores indicate more severe dissociative symptoms. While no formal subscales exist, clinicians may find it helpful to evaluate items in context of the domains described earlier (amnesia, identity confusion, depersonalization/derealization, perceptual disturbances, and mood/behavior fluctuations) to better understand specific symptoms.

Based on research using the CDC, the following interpretive guidelines are recommended:

Normal to mild: Score 0-11 = 1st to 80th percentile: Within normal limits for most children.

Moderate: Score 12-15 = 81st to 95th percentile: Above the typical range for non-dissociative children and may reflect some significant dissociative symptoms. Scores are common in children with histories of abuse or significant stressors.

High: Score 17-20 = 99th to 99.98th percentile: Strong indication of clinically significant dissociative symptoms and potential traumatic etiology. Most children with dissociative disorders score in this range.

Severe: Score 21+ = 99.99th+ percentile: Extreme level of dissociative symptoms, strongly suggestive of Dissociative Identity Disorder or other severe dissociative condition. Scores in this range are commonly seen in children with diagnosed dissociative disorders.

The total score is also expressed as a percentile rank, based on normative data from Endo et al. (2006) of non-dissocative children. This percentile contextualises the client's score relative to the general population, indicating the percentage of individuals who scored lower than the client. For

Client Name	Generic Client

Scoring and Interpretation Information (cont.)

example, a score at the 85th percentile means that 85% of people in the community sample scored lower than the client, placing them in the upper range of dissociative experiences.

When the CDC score is at 12 or higher, further assessment for a dissociative disorder may be recommended as this threshold identified 96% of children meeting criteria for dissociative disorders in previous validation studies (Putnam et al., 1993). Scores at or above this threshold warrant additional attention and potential follow-up with structured interviews or other more comprehensive assessment to investigate the nature and extent of dissociative symptoms.

Significant changes in the total score are indicated by shifts of half a standard deviation or greater (approximately 6 total score points or more) following the guidelines of the Minimally Important Difference (Turner et al., 2010).

On first administration a bar graph showing total scores is displayed with percentile labels on the right comparing the score to a non-abused sample. In addition to the bar graph, two/three comparison graphs illustrating the client's scores relative to different reference groups are displayed. When the assessment is administered multiple times, a longitudinal line graph is generated to track changes in the total score over time.

Client Responses

		Not true	Somewhat or sometimes true	Very true
1	Child does not remember or denies traumatic or painful experiences that are know 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, 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, 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

Client Name	Generic Client

Client Responses (cont.)

		Not true	Somewhat or sometimes true	Very true
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 behaviour 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 him 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.	0	1	2