The Child Dissociative Checklist

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CLINICAL RESEARCH ISSUES

The Child Dissociative Checklist: Preliminary Findings of a Screening Measure

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ABSTRACT. This paper reports on the use of a screening instrument for dissociative behaviors in two separate, but related studies. Study 1 examined the concurrent validity of the Child Dissociative Checklist (CDC) in a sample of children and adolescents for which no efforts were made to separate youngsters by history of abuse. Concurrent validity of the CDC was studied in relation to an accepted measure of general behavior problems, the Child Behavior Checklist (CBCL). Results indicate significant, positive correlations between CDC raw scores and CBCL Externalizing (EXT), Internalizing (INT), and Total (TOT) T scores for males ($p < .005$). For females, the CDC correlated significantly and positively with CBCL INT ($p < .05$) and TOT T ($p < .01$) scores, but not with the EXT T score. Significant and positive correlations for males were obtained between all specific CBCL factors and the CDC (all $p < .005$). For females, CDC scores correlated significantly with specific internalizing factors purported to measure depression, immaturity, and anxiety (all $p < .05$). These findings are discussed in relation to issues of misdiagnosis and comorbidity. Study 2 found that parent-completed CDC scores differentiate between sexually abused inpatient children and those with no history of sexual abuse categorized into groups based on their responses to the Traumatic Antecedents Scale. Inpatient staff-completed CDC ratings failed to differentiate between groups. Moreover, there was a negative, though nonsignificant, correlation between staff and parent CDC scores.

Child sexual abuse has been associated with a variety of symptoms and DSM-III-R (American Psychiatric Association, 1987) diagnoses including dissociative disorders (Putnam, 1985). Dissociation is a "psychophysiological process whereby information–incoming, stored, or outgoing–is actively deflected from integration with its usual or expected associations" (West, 1967; p. 890). This dissociative process results in temporary fluctuations in the normal integrative functions and consciousness. Putnam (1985) has posited that psychodynamic triggers facilitate this process. More specifically, those "triggers" may be certain discriminative stimuli or cues which serve as reminders of past or ongoing trauma.

The relationship of trauma to dissociative phenomena has been described in the literature (Bliss, 1980; Braun, 1984; Fisher, 1945; Hilgard, 1977; Jaffe, 1968; Noyes, 1977; Putnam, 1989). Child sexual abuse specifically also has been related to dissociation (Putnam, Guroff, Silberman, Barban & Post, 1986; Wilbur, 1984). For example, Putnam et al. (1986), in a survey of 100 multiple personal-

ity patients in treatment found that more than 83% of those studied had been sexually abused in early years. Braun and Sachs (1985) have suggested that for some abuse victims, dissociation becomes a defense to provide relief from the horror of the abuse.

Putnam (1991a) has indicated that dissociative disorders among children and adolescents are being diagnosed increasingly by clinicians working with traumatized children. With adults, Ross (1991) concluded in an epidemiologic study that dissociative disorders as a group are as common as the anxiety and affective disorders. Estimates for children are unclear; however, Hornstein and Tyson (1991) found that on a child inpatient psychiatric unit, dissociative disorders represent 5% of the total inpatient caseload. Despite the increasing recognition of dissociative symptoms, historically it has not been uncommon for dissociative symptoms to be overlooked or misdiagnosed in adults and children. For example, Putnam et al. (1986) reported that patients with a dissociative diagnosis (i.e., multiple personality disorder) who were being seen in treatment had been misdiagnosed for an average period of 6.8 years. With the increasing awareness of this condition and its symptoms, it has been suggested that the identification in childhood of dissociative diagnoses is not only desirable, but increasingly feasible (Kluft, 1985; Kluft, 1984). However, identification of this condition is confounded by the baseline level of normal dissociative behaviors observed in children and adolescents through the developmental continuum (Putnam, 1991b).

In order to identify dissociative symptoms in adults, Bernstein and Putnam (1986) have developed the Dissociative Experiences Scale (DES). The DES measures self-reported dissociation in normal and clinical *adult* populations. With *children*, valid *self*-report measures have not been developed. However, the Child Dissociative Checklist (CDC; Putnam, 1991b) has been used to screen for dissociative symptoms based on *parent* reports. The CDC is completed by the parent or guardian, and each of the 20 items is rated as 0 for "not true," 1 for "somewhat true," and 2 for "very true." Putnam (1991b) reports a Cronbach alpha of .89 and test-retest reliability after a year of .84 for abused children and .79 for matched controls. Raw scores of 12 and above are considered abnormal, especially among older children. Additionally, raw scores of 12 or above have

been evident in 90% of child and adolescent multiple personality disorder cases.

The present article reports on findings from two separate studies. Study 1 examines the concurrent validity of the CDC by correlating CDC raw scores with T scores on the Child Behavior Checklist (CBCL; Achenbach & Edelbrock, 1983) in a sample of children and adolescents for which no efforts were made to separate youngsters by history of abuse. Study 2 examines the CDC scores in a separate sample of inpatient children whose histories of abuse/nonabuse were established using a structured clinical interview.

STUDY 1

Method

Subjects. Subjects were 73 patients, ages 4-18, who were referred for evaluation at a children's psychiatric outpatient clinic associated with a large children's hospital in the Southwest. Seventy-one percent were male, and 29% were female; 78% were Caucasians, and 22% were African-Americans.

Measures. The CBCL includes 113 items, each rated on a zero-to-two-point scale. The items comprise different behavior problem scales derived from factor analyses. For males, these scales include: Somatic Complaints, Schizoid, Uncommunicative, Immature, and Obsessive-Compulsive. For females, the factor-analytically derived scales are: Somatic Complaints, Schizoid, Depressed-Withdrawn, Immature-Hyperactive, and Anxious-Obsessive. In addition to these specific scales, there are two broad-band scales (Internalizing and Externalizing) and a summary (Total Problem) scale. The Internalizing Scale provides a rating of inwardly-directed problems (e.g., depression, anxiety, social withdrawal). The Externalizing Scale provides a rating of outwardly-directed problems (e.g., aggression, hyperactivity, delinquency). The summary scale or Total Problem Score includes a variety of symptoms encompassing all the items from the broad-band scales plus additional items which do not load on specific scales. The CBCL also has available a social competence scale which was not used in this study. The CBCL is widely used and has excellent reliability and validity.

The CDC is a screening measure developed by Putnam, Helmers, and Trickett (in press). The CDC's purpose is to assess dissociative symptoms based on ratings by caregivers for children and adolescents. The CDC is comprised of 20 items which are rated as either "very true" (2), "somewhat" or "sometimes true" (1), or "not true" (0). These ratings are summed, and a cutoff score equal to, or greater than, 12 is considered abnormal, particularly in older children. It has a one-year test-retest reliability coefficient of rho = .69 ($N = 73$, $p = .0001$) in a sample of normal and sexually abused girls. Putnam et al. (in press) report good discriminant validity for the CDC.

Procedure. The CBCL and CDC were completed by a parent or caretaker either before the initial outpatient appointment or at the time of the outpatient appointment. No attempt was made in the current study to relate CDC scores to a history of abuse. Thus, the exact distribution of abused versus nonabused patients was not specified. However, clinical observations indicate a mixture of both abused and nonabused youngsters in the current sample.

Results

There were no significant differences in total raw scores on the CDC due to age or gender. The absence of significantly higher CDC scores for younger children differs with findings reported by Putnam (1991b). Nonetheless, subjects therefore were combined for subsequent analyses. CDC means and standard deviations are found in Table 1.

Due to the large number of correlations, Bonferroni adjustments were made to control for Type I errors; alpha levels were divided in a two-tailed test by 16, so that significance levels of .05, .01, and .005 required levels of .003, .0006, and .0003, respectively. Results indicate significant correlations between the CDC raw score and CBCL Externalizing T, Internalizing T, and Total T for boys. Correlations for girls were similar, although smaller, with one exception. That is, the correlation between CDC scores and the CBCL Externalizing T was nonsignificant for girls (see Table 2). Correlations between CDC scores and specific internalizing factors also are found in Table 2. Significant and positive correlations were obtained between the CDC and all factor scores for the CBCL with boys. For girls, significant and positive correlations were obtained

TABLE 1. CDC Means and Standard Deviations (Study 1).

		Mean	Standard Deviation
Gender			
	Male	6.9	5.53
	Female	7.0	5.66
Age			
	5 - 8 years	6.7	5.64
	9 - 11 years	5.7	4.54
	12 - 15 years	8.1	5.03
	16 - 18 years	8.3	8.04

TABLE 2. Correlations between CDC Raw Scores and CBCL T Scores (Study 1).

Males (n = 52)		Females (n = 21)	
Internalizing T	.74***	Internalizing T	.68*
Externalizing T	.65***	Externalizing T	.55
Total T	.74***	Total T	.69**
Somatic Complaints	.58***	Somatic Complaints	.50
Schizoid	.59***	Schizoid	.55
Uncommunicative	.73***	Depressed-Withdrawn	.65*
Immature	.68***	Immature-Hyperactive	.62*
Obsessive-Complusive	.69***	Anxious-Obsessive	.61*

$*p < .05$

$**p < .01$

$***p < .005$

for CBCL factors purported to measure depression, immaturity, and anxiety.

Discussion

Findings from Study 1 suggest concurrent validity for the CDC inasmuch as those youngsters exhibiting dissociative behaviors are likely to exhibit other behavioral problems as rated by parents on the CBCL. This was especially true for boys and for both genders exhibiting internalizing behaviors.

While such a finding is not diagnostically specific, it is consistent with findings from other studies which report dissociative symptoms which are misdiagnosed (Hornstein & Tyson, 1991). For example, psychiatric symptoms of dissociative disorders often mistaken for other diagnoses include trance-like behavior (Dell & Eisenhower, 1990; Peterson, 1990; Putnam, 1993), explosive outbursts (Dell & Eisenhower, 1990; Fagan & McMahon, 1984), poor attention and concentration (Peterson, 1990; Putnam, 1993), forgetfulness (Putnam, 1991a), problems with sleeping and nightmares (Putnam, 1991a), hallucinated voices (Dell & Eisenhower, 1990; Peterson, 1990; Putnam, 1993), denial of behavior witnessed by others (Peterson, 1990), and depression and suicidal behavior (Dell & Eisenhower, 1990). Thus, positive correlations with the CBCL are not surprising and are consistent with clinical observations and the aforementioned findings. However, in some cases, these varied symptoms may result in a mistaken diagnosis of Attention-deficit Hyperactivity Disorder (Putnam, 1993), Oppositional Defiant Disorder (Hornstein & Putnam, 1992), psychosis (Vincent & Pickering, 1988), and petitmal epilepsy (Putnam 1993). Therefore, if specific items on the CDC or if CDC cut-off scores are helpful in differentiating between groups who likely are dissociating, then the CDC could serve as a useful screening measure related to early recognition of trauma-related symptoms.

The failure to replicate age differences on the CDC may be related to diagnostic comorbidity factors not controlled in this study. As Putnam (1991a) suggests, child and adolescent dissociative disorders, like other psychiatric disorders, often coexist with significant comorbidity including anxiety, depression, conduct disorders, and attentional problems. Thus, those older youngsters re-

ferred for evaluation in this sample may have relatively higher rates of comorbidity assessed by both the CDC and CBCL.

A related weakness of Study 1 and/or the CDC is the possibility that the ratings by parents are indicative of symptoms which are not misdiagnosed, but rather comorbid with dissociative disorders. For boys, this may be most applicable given the significant relationships found between the CDC and all CBCL scores. Among girls studied, the nonsignificant relationship of the CDC with the Externalizing T and some specific CBCL factor scores, and the significant positive correlation with the Internalizing T necessitate further exploration. A final weakness of Study 1 is the inability to control for a history of abuse.

STUDY 2

Method

Subjects. Subjects were 26 patients consecutively admitted to a children's inpatient psychiatric unit in a large children's hospital in the Southwest. An inpatient sample was used in Study 2 since a sexually abused comparison group was sought to examine the differences between groups on the CDC. Also, an inpatient sample was utilized since as Lanktree, Briere, and Zaidi (1991) state that while the likelihood of sexual abuse in an inpatient setting is high, only a few studies (e.g, Kolko, Moser & Weldy, 1988) have studied this issue. Of the 26 patients, 25 (96%) were male, and 1 (4%) was female. The overrepresentation of males may be related to the presence of conduct-disordered behaviors which ultimately precipitated hospitalization in many cases. Additionally, the primarily male sample limits the generalizability of these findings. Seventeen (65%) were Caucasians, and nine (35%) were African-Americans. Children ranged in age from 4 to 12 with a mean age of 9.6 ($SD = 2.21$).

Measures. (For a description of the CDC, refer to "Measures" in Study 1 of this article). The TAS is a structured interview developed by Herman and Perry (cited in Herman, Perry & van der Kolk, 1989) and used elsewhere to determine a history of sexual abuse (e.g., Herman et al., 1989). The original TAS included 100 items;

however, items irrelevant to children were eliminated for this study, and the resulting total number was 71 items. Additionally, some vocabulary was modified or clarification of items was added, so that children would more clearly comprehend the questions. The TAS covers a broad content area including history related to primary caretakers, separations, moves, losses, sibling relationships, family discipline, family alcoholism, domestic violence, and physical and sexual abuse. As with efforts by other clinicians/researchers (Russell, 1986), the TAS is designed to ask a number of questions related to abuse in a variety of ways to enhance the chance of tapping memories stored under different categories in a person's mind. Like other structured, semi-structured, or unstructured interviews used to obtain a history of abuse (Briere & Zaidi, 1989; Lanktree et al., 1991; Russell, 1986), no data regarding the reliability or the validity of the TAS are available. When abuse is reported, additional specific questions are asked to determine characteristics of the abuse, the perpetrator, and the event. For example, secrecy is assessed by asking, "Was the [*sexual contact*] a secret?" Coercion is assessed by asking, "Did [*perpetrator*] force you to [*sexual act*]?" Frequency of abuse is assessed by first asking if the abuse occurred once, a few times, or many times. If "many" is endorsed, then additional probes are used. No attempt was made in the current study to examine test-retest reliability for the TAS since subjecting adolescents to the same interview might convey the unwanted message of disbelief of the allegations. Similarly, further questioning by clinicians was not indicated since most of the inpatient admissions were precipitated by other crises requiring attention during the acute, short-term inpatient stay.

Procedure. The CDC was completed by the primary caretaker at the time of admission or soon after the admission. Inpatient staff completed the CDC approximately one week after hospitalization.

A history of sexual abuse was determined by a structured clinical interview using the Traumatic Antecedents Scale (TAS). TAS interviewers were both females who received training on the use of the TAS and issues related to sexual abuse. Sexual abuse was defined as completed or attempted contact by an adult or older sibling and included exhibitionism, fondling of the child, forced fondling of the perpetrator, pornographic involvement, or penetration. In the sam-

ple, eight of 26 subjects reported sexual abuse. While the gender of the interviewers and the single interview session may have led to under-reporting of sexual abuse in this predominantly male sample, the percentage of abuse for this inpatient sample is consistent with the findings (i.e., 28%) of Kolko et al. (1988).

Results

Preliminary analyses revealed no significant differences in CDC total raw scores due to age or race. Therefore, subjects were combined for subsequent analyses.

A one-way ANOVA for parent-completed CDC scores in sexually abused ($n = 8$) and non-abused (sexually) children ($n = 18$) resulted in significant differences ($F (1,25) = 4.07, p = .0549$), with abused children rated as exhibiting significantly more dissociative behaviors on the CDC (mean = 16.1, $SD = 9.39$) than those without a history of sexual abuse (mean = 10.4, $SD = 5.07$). Due to the small sample of abused subjects, no attempt was made to analyze results by type of abuse, perpetrator, frequency, or use of coercion. However, individual abuse characteristics and CDC scores can be found in Table 3.

Staff-completed CDC ratings also were examined; however, there were no significant differences (see Table 4). The correlation between parent and staff CDC ratings was negative, though nonsignificant ($r = -.064, p = .76$).

A listing of CDC items with the percentage of endorsement by parents for abused and non-sexually abused groups can be found in Table 5. Table 5 also indicates which items differentiate between groups based on Fisher's Exact Test. Due to multiple comparisons and the probability of falsely rejecting the null hypothesis, items discriminating at the $p < .01$ level might normally be considered significant. One item (Item 13), "Suffers from unexplained injuries, hurts self," differentiated between the groups ($p < .001$). No other items were significant. However, since the sample size is small, items differentiating at the $p < .05$ level may indicate some trends toward differentiation. The two specific items modestly differentiating between groups included: (Item 19) "Frequently talks to self; may use different voice," and (Item 16) "Has intense outbursts of anger."

TABLE 3. Victim and Abuse Characteristics with Corresponding Parent-Completed CDC Scores (Study 2).

Subject Gender	Age	Perpetrator Relationship	Abuse Type	Frequency	Coercion	Secrecy	Parent CDC Score
M	6	Sister	Sexual Abuse Attempted; Exhibitionism	Few	Threats	No	27
M	7	Babysitter (female)	Fondled; Attempted Intercourse	Weekly	No	Yes	11
M	9	Neighbor (male)	Sexual Abuse Attempted	Daily	Threats	No	8
M	9	Father	Exhibition; Attempted Penetration	Daily	No	Yes	18
M	9	*	Pornography	*	*	*	5
F	10	*	*	*	*	*	17
M	10	Father	Fondled	Once	No	No	32
M	11	*	Attemped Penetration	*	*	*	11

*No information provided by subject or not available.

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TABLE 4. CSC Means and Standard Deviations for Sexually Abused and Nonabused (Sexually) (Study 2).

Rater	Group	Mean	Standard Deviation
Parent			
	Sexually Abused ($n = 8$)	16.1	9.39
	Nonabused (Sexually) ($n = 18$)	10.4	5.07
Staff			
	Sexually Abused	1.4	2.34
	Nonabused (Sexually)	1.5	2.20

Discussion

Parent ratings for those children who were sexually abused were statistically higher than those for children providing no history of sexual abuse. Additionally, group mean scores offer indirect confirmation that the clinical cutoff score of 12 has utility since the mean for non-abused inpatients was below the cutoff, and the mean for abused inpatients was above the cutoff (i.e., 16.1).

Staff ratings failed to differentiate between groups. Moreover, staff ratings were negatively, though nonsignificantly, correlated with parent ratings. Findings for staff ratings may be due to: (a) the child's positive response to the structure of an inpatient setting, (b) the child's positive response to removal from a potentially abusive or dysfunctional family, (c) a combination of (a) and (b), (d) the limited opportunity for staff to be completely familiar with the multitude of behaviors exhibited by any given child, or (e) the possibility that the parent raters exaggerated, or were overly sensitive to, behavior which the staff realized to be normal. Item 13, related to unexplained injuries and self harm, significantly differentiated between groups, and two CDC items which modestly differentiated between groups were those assessing angry outbursts and the child talking to him/herself.

TABLE 5. Percent of Parent Endorsement on CDC Item for Sexually Abused and Non-Abused Groups (Study 2).

Item	Sexually Abused	No Sexual Abuse
1. Does not remember traumatic events.	50%	24%
2. Goes into trance-like state.	63%	59%
3. Displays rapid changes in personality.	100%	71%
4. Is unusually forgetful/confused.	38%	53%
5. Has poor sense of time.	38%	47%
6. Shows marked variations in skills, knowledge, etc.	50%	41%
7. Shows rapid regressions.	38%	18%
8. Has difficulty learning from experience.	100%	88%
9. Continues lying even when evidence is obvious.	100%	88%
10. Refers to self in third person.[1]	50%	12%
11. Has rapidly changing physical complaints.	75%	53%
12. Is unusually sexually precocious.	38%	12%
13. Suffers from unexplained injuries; hurts self.[2]	88%	12%
14. Hears voices of adults/imaginary companions.	38%	12%
15. Has vivid imaginary companions.	25%	29%
16. Has intense outbursts of anger.[3]	100%	53%
17. Sleepwalks frequently.	25%	18%
18. Has unusual nighttime experiences.	38%	24%
19. Frequently talks to self; may use different voice.[4]	63%	12%
20. Has two distinct/separate personalities.	25%	35%

Fisher's Exact Test probabilities: [1] $p = .059$; [2] $p < .001$; [3] $p = .022$; [4] $p = .107$

SUMMARY

Findings from Study 1 and Study 2 suggest evidence for the validity and utility of the CDC as a research and screening measure. With additional replication and added studies, the CDC can possibly be useful not only in identification, but also in following dissociative symptoms over time. One limitation of Study 2 deserves mention. That is, the sample size was small and thus, the lack of significance for some CDC item analyses may have been obscured by the lack of power in the statistical analyses. Future studies should (a) examine the relationship of CDC scores to issues of comorbidity, (b) follow youngsters longitudinally to examine individual changes in CDC scores as a function of maturation while controlling for a history of, or subsequent onset of abuse, and (c) examine CDC scores for different diagnostic groups including dissociative disorders, Post-traumatic Stress Disorder, and other proposed diagnostic categories (e.g., Disorders of Extreme Stress, Not Otherwise Specified).

REFERENCES

Achenbach, T. M., & Edelbrock, C. (1983). *Manual for the Child Behavior Checklist and Revised Child Behavior Profile.* Burlington, VT: Thomas Achenbach.

American Psychiatric Association (1987). *Diagnostic and statistical manual of mental disorders (3rd ed.–revised).* Washington, DC: Author.

Bernstein, E. M., & Putnam, F. W. (1986). Development, reliability, and validity of the dissociation scale. *Journal of Nervous and Mental Disease, 174* (12), 727-735.

Bliss, E. L. (1980). Multiple personalities: A report of 14 cases with implications for schizophrenia and hysteria. *Archives of General Psychiatry, 37,* 1388-1397.

Braun, B. G. (1984). Towards a theory of multiple personality and other dissociative phenomena. *Psychiatric Clinics of North America, 7,* 171-193.

Braun, B. G., & Sachs, R. G. (1985). The development of multiple personality disorder: Predisposing, precipitating, and perpetuating factors. In R. P. Kluft (Ed.), *Childhood antecedents of multiple personality* (pp. 37-64). Washington, DC: American Psychiatric Press, Inc.

Briere, J., & Zaidi, L. Y. (1989). Sexual abuse histories and sequelae in female psychiatric emergency room patients. *American Journal of Psychiatry, 146,* 1602-1606.

Dell, P. F., & Eisenhower, J. W. (1990). Adolescent multiple personality disorder:

A preliminary study of eleven cases. *Journal of the American Academy of Child and Adolescent Psychiatry, 29,* 359-366.

Fagan, J., & McMahon, P. P. (1984). Incipient multiple personality in children: Four cases. *Journal of Nervous and Mental Disease, 172* (1), 26-35.

Fisher, C. (1945). Amnesic states in war neuroses: The psychogenesis of fugues. *Psychoanalytic Quarterly, 14,* 437-468.

Herman, J. L., Perry, C., & van der Kolk, B. A. (1989). Childhood trauma in borderline personality disorder. *American Journal of Psychiatry, 146* (4), 490-495.

Hilgard, E. R. (1977). *Divided consciousness: Multiple controls in human thought and action.* New York: Wiley.

Hornstein, N., & Putnam, F. W. (1992). Clinical phenomenology of child and adolescent dissociative disorders. *Journal of the American Academy of Child and Adolescent Psychiatry, 31* (6), 1077-1085.

Hornstein, N. L., & Tyson, S. (1991). Inpatient treatment of children with multiple personality/dissociative disorders and their families. *Psychiatric Clinics of North America, 14* (3), 631-648.

Jaffe, R. (1968). Dissociative phenomena in former concentration camp inmates. *International Journal of Psychoanalysis, 49,* 310-312.

Kluft, R. P. (1984). Multiple personality in childhood. *Psychiatric Clinics of North America, 7,* 3-7.

Kluft, R. P. (Ed.) (1985). *Childhood antecedents of multiple personality.* Washington, DC: American Psychiatric Press.

Kolko, D. J., Moser, J. T., & Weldy, S. R. (1988). Behavioral/emotional indicators of sexual abuse in child psychiatric inpatients: A controlled comparison with physical abuse. *Child Abuse & Neglect, 12,* 529-542.

Lanktree, C., Briere, J., & Zaidi, L. (1991). Incidence and impact of sexual abuse in a child outpatient sample: The role of direct inquiry. *Child Abuse & Neglect, 15,* 447-453.

Noyes, R. (1977). Depersonalization in response to life threatening danger. *Psychiatry, 18,* 375-384.

Peterson, G. (1990). Diagnosis of multiple personality. *Dissociation, 3,* 3-9.

Putnam, F. W. (1985). Dissociation as a response to extreme trauma. In R. P. Kluft (Ed.), *Childhood antecedents of multiple personality* (pp. 66-97). Washington, DC: American Psychiatric Press, Inc.

Putnam, F. W. (1989). *Diagnosis and treatment of multiple personality disorder.* New York: The Guilford Press.

Putnam, F. W. (1991a). Dissociative disorders in children and adolescents: A developmental perspective. *Psychiatric Clinics of North America, 14* (3), 519-531.

Putnam, F. W. (1991b, October). Phenomenology of dissociation. In D. Siegel (Chair), *Dissociative disorders in children and adolescents.* Symposium conducted at the 38th Annual Meeting of the American Academy of Child and Adolescent Psychiatry, San Francisco.

Putnam, F. W. (1993). Dissociative disorders in children: Behavioral profiles and problems. *Child Abuse & Neglect, 17,* 39-45.

Putnam, F.W., Guroff, J. J., Silberman, E. K., Barban, L., & Post, R. M. (1986). The clinical phenomenology of multiple personality disorder: Review of recent cases. *Journal of Clinical Psychiatry, 47* (6), 285-293.

Putnam, F. W., Helmers, K., & Trickett, P. K. (in press). Development, reliability, and validity of a child dissociation scale. *Child Abuse & Neglect*, in press.

Ross, C. A. (1991). Epidemiology of multiple personality disorder and dissociation. *Psychiatric Clinics of North America, 14* (3), 503-517.

Russell, D. (1986). *The secret trauma: Incest in the lives of girls and women*. New York: Basic Books.

Vincent, M., & Pickering, M. R. (1988). Multiple personality disorder in childhood. *Canadian Journal of Psychiatry, 33*, 524-529.

West, L. J. (1967). Dissociative reaction. In A. M. Freeman & H. I. Kaplan (Eds.), *Comprehensive textbook of psychiatry* (pp. 885-898). Baltimore: Williams & Wilkins.

Wilbur, C. B. (1984). Multiple personality and child abuse: An overview. *Psychiatric Clinics of North America, 7*, 3-7.