

The Validity of Childhood Sexual Abuse Checklists in the Popular Psychology Literature: A Barnum Effect?

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Because many psychotherapy clients consult popularly available childhood sexual abuse (CSA) checklists to determine whether they have abuse histories, clinicians need to be cognizant of these checklists' potential strengths and weaknesses. In particular, endorsement of CSA checklists may be attributable to the Barnum effect. One hundred ninety-six female undergraduates, 39 with self-reported CSA histories, rated lists of CSA checklist items and Barnum items for self-descriptiveness. CSA and Barnum checklist scores were moderately correlated. The CSA checklist significantly distinguished women with versus without a history of abuse, but not when global distress was controlled. Consequently, clinicians should exert caution when assigning books containing popular CSA checklists.

Psychotherapists have recognized childhood sexual abuse (CSA) as a prevalent problem for at least several decades. Although estimates have varied in the past 3 decades, most researchers believe that at least 20% of women have had an experience in childhood that can objectively be termed *sexual abuse* (e.g., see Finkelhor, Hotaling, Lewis, & Smith, 1990). However, clinicians frequently struggle with the question of how to identify individuals who have experienced CSA. For example, some researchers have argued that therapists cannot rely on the presence of specific psychopathological signs and symptoms in adulthood to ascertain a history of CSA in their clients (e.g., Kendall-Tackett, Williams, & Finkelhor, 1993), although some authors of popular self-help books disagree (e.g., Bass & Davis, 1988; Frederickson, 1992). As a consequence, many clinicians may be uncertain of whether they should attend to or ignore such signs and symptoms in clients whom they suspect were abused in childhood.

Many popular books purport to offer a means of distinguishing women with histories of CSA from other women. Some well-known examples are *The Courage to Heal Workbook: For Women and Men Survivors of Child Sexual Abuse* (Davis, 1990), *Re-*

pressed Memories: A Journey to Recovery From Sexual Abuse (Frederickson, 1992), and *Secret Survivors: Uncovering Incest and Its Aftereffects in Women* (Blume, 1990). Each of these popular books, like several others for individuals with potential CSA, contains a checklist of self-reported signs and symptoms (e.g., giving too much in relationships, often being self-critical and critical of others) that are ostensibly common among those who have experienced CSA. In most cases, the authors inform readers who endorse many of these signs and symptoms that they may have been sexually abused in childhood. Indeed, some women may come to believe that they have histories of CSA in part because the checklist items appear to apply to them. For example, when discussing how participants at CSA workshops (most of whom presumably believe that they may have been abused) respond to lists of such signs and symptoms, Davis made the following observation:

As I write the many and varied effects on a big sheet of paper, survivors around the room nod their heads, saying things like "Oh, me too. Me too. I didn't know that was connected. Oh, so that's why I space out and disappear!" They're experiencing recognition—the realization that the difficulties they face are in fact a direct result of abuse. (p. 123)

Much public discourse concerning CSA has focused on the possibility that people can forget traumatic experiences, only to remember them years, even decades, later. Some authors have contended that most recovered memories of abuse are confabulations inadvertently implanted by psychotherapists (e.g., Loftus & Ketcham, 1994; McNally, 2003), whereas others have contended that most of these memories are likely to be accurate (Brown, Schefflin, & Hammond, 1998; Pope, 1996). This controversy is relevant because popularly available CSA checklists could, in principle, serve as aids to recovering memories. Readers of such checklists are frequently encouraged to entertain the possibility of a past history of CSA if they endorse many checklist items, even if they cannot recall such a history. For example, Frederickson (1992) told readers who consult her CSA checklist that "if you check several items in each category, or nearly all the items in a single category, you will want to consider the possibility that you have repressed memories" (p. 47).

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No good data are available concerning how often clients in or out of therapy consult CSA checklists. Nevertheless, these checklists are available in many best-selling books for individuals who have experienced CSA. *The Courage to Heal Workbook* (Davis, 1990) alone has sold nearly 500,000 copies. Poole, Lindsay, Memon, and Bull (1995) found that more than one third of therapists rely on *symptom interpretation*, that is, attempting to infer a CSA history on the basis of clients' presenting symptoms—precisely the aim of the CSA checklists examined here. In addition, Polusny and Follette (1996) found that 33% of psychologists reported that they assigned *bibliotherapy*, that is, the use of self-help books intended to provide guidance to those with a potential CSA history, to clients suspected of having abuse histories. They also found that 51% of psychologists reported they found the use of bibliotherapy to be appropriate in this context. As a consequence, it is likely that many psychotherapy clients consult CSA checklists. Moreover, some clients may use these checklists to draw conclusions about their abuse histories.

There is considerable debate in the psychological community concerning the long-term consequences of CSA (see Lilienfeld, 2002). This debate is crucial to understanding the CSA checklists available in the popular literature, because the aim of such checklists is to identify those who have a history of CSA on the basis of a constellation of current signs and symptoms. Some researchers (e.g., Briere & Runtz, 1993; Cole & Putman, 1992; Greenwald, Leitenberg, Cado, & Tarran, 1990) have argued that the consequences of CSA are varied, intense, and often substantial in magnitude. In contrast, other authors, most notably Rind, Bauserman, and Tromovitch (1998; see also Beitchman et al., 1992; Fromuth, 1986; Rind & Tromovitch, 1997), have argued that the correlation between CSA and adult psychopathology tends to be small in magnitude overall. Moreover, Rind and his colleagues have contended that a causal relationship between CSA and adult psychopathology cannot be inferred because other kinds of life experiences, traumatic or otherwise, such as adverse family environment, may account for such psychopathology (see Dallam et al., 2001, and Ondersma et al., 2001, for critiques of Rind et al., 1998, and see Rind, Bauserman, & Tromovitch, 2002, for rejoinders to these critiques). Nevertheless, because Rind et al. (1998) conclusions are based on nonclinical samples, they may underestimate the magnitude of the CSA–psychopathology relationship (Lilienfeld et al., 1999).

Although widely read and consulted, popularly available CSA checklists were not validated before they were published. To our knowledge, only one team of investigators has examined the validity of a popular CSA checklist. Brandyberry and MacNair-Semands (1998) examined the widely disseminated checklist in *The Courage to Heal Workbook* (Davis, 1990). In their study, 279 college students were asked to respond to the workbook checklist, the Trauma Symptom Checklist (Elliott & Briere, 1991), the Abusive Behavior Inventory (Shepard & Campbell, 1992), and questions concerning a history of CSA. The researchers found a significant correlation ($r = .74$) between participants' scores on the Trauma Symptom Checklist and the workbook checklist, seemingly suggesting at least some validity for the latter checklist. However, the authors' findings are difficult to interpret because participants who reported histories of sexual abuse endorsed fewer symptoms on the CSA checklist than did participants who reported they were not sure whether they had such histories, although

participants in the former group reported significantly more symptoms than did participants without histories of abuse. In addition, Brandyberry and MacNair-Semands substantially overstated the magnitude of their findings in their discussion. There they implied that use of *The Courage to Heal Workbook* checklist would not risk the misclassification of women without histories of CSA as abused, even though an inspection of the means and standard deviations of participants' checklist scores in these two groups reveals considerable overlap.

Brandyberry and MacNair-Semands (1998) also did not consider whether participants' endorsement of CSA checklist items could be accounted for by the *Barnum effect*, named after the circus entrepreneur who said he always tried to have “a little something for everyone.” First noted by Forer (1949), and named later by Meehl (1956), the Barnum effect is the tendency to regard vague, high-base-rate, but nonobvious statements (e.g., statements about individuals sometimes having difficulty concentrating, using their own judgment, or having a great deal of unused capacity that they have not turned to their advantage) as self-descriptive. Barnum statements are subjectively compelling to most respondents precisely because they apply to almost everyone.

A review of 25 years of research on the Barnum effect by Snyder, Shenkel, and Lowery (1977) indicates that virtually all people, regardless of gender, are susceptible to this phenomenon. The Barnum effect appears to be particularly potent when individuals believe statements are tailored specifically to them. For example, Ziv and Nevenhaus (1972) found that individuals rated the descriptions given to them as much more true of themselves than of people in general.

Several psychologists have conjectured that the apparent validity of CSA checklists is attributable to the Barnum effect. This hypothesis is plausible given that many items on popular CSA checklists are highly nonspecific. For example, Loftus and Ketcham (1994) quoted psychologist Carol Tavris as making the following observation: “This list is general enough to include everybody at least sometimes. Nobody doesn't fit it” (pp. 154–155). Regarding the CSA checklist in Blume's (1990) *Secret Survivors: Uncovering Incest and Its Aftereffects in Women*, Dawes (2001) similarly noted that “it is easy to see how an incest survivor would tend to exhibit at least one of these ‘aftereffects’—because almost everyone exhibits at least one” (p. 172; see also Lynn, Lock, Loftus, Krackow, & Lilienfeld, 2003; McNally, 2003).

In a study that largely forms the model for the present investigation, Logue, Sher, and Frensch (1992) examined the signs and symptoms often purported to be true of many adult children of alcoholics (ACOAs) in the popular psychology literature. These symptom profiles for ACOAs are similar to CSA checklists because both have been widely circulated despite minimal evidence for their validity. In their study, 224 participants, 112 of whom were ACOAs, responded to statements concerning traits purported to be true of ACOAs. In addition, they responded to a list of commonly used Barnum statements drawn from the personality literature. All participants judged both sets of statements to be highly accurate self-descriptions, but neither group found the purported traits of ACOAs to be more accurate than the Barnum statements. The work of Logue et al. suggests that the Barnum effect largely explains ACOAs' high levels of endorsement of purported ACOA characteristics.

Our study is the first to examine the relation of the Barnum effect to individuals' endorsement of items on popular CSA checklists. We hypothesized that prototypical items drawn from CSA checklists would not distinguish women with histories of CSA from other women and that both sets of women would respond to the CSA checklist items at high rates. We further hypothesized that participants would endorse Barnum statements at least as much as the CSA checklist statements and that the Barnum effect would account entirely for the high levels of endorsement of CSA checklist items by women with histories of CSA. If so, these findings would raise concerns about clinicians' unqualified assignment of bibliotherapy to clients with potential abuse histories (e.g., Poole et al., 1995), given that many self-help books for individuals who have experienced CSA contain such checklists.

In this study, we compared the responses of undergraduate women with self-reported histories of CSA with the responses of women without such histories on the checklist items. In addition, we compared participants' responses to the CSA checklist and a list of Barnum statements. Participants also responded to a questionnaire regarding their knowledge of the CSA literature to examine the possibility that any group differences on the CSA checklist were attributable to familiarity with this literature. Finally, participants completed measures of global psychological distress and family conflict to examine the specificity of the CSA checklist to sexual abuse per se rather than to either psychological distress or familial maladjustment.

Our Investigation of the Validity of Childhood Sexual Abuse Checklists

Method

Participants

Participants were 196 female undergraduates enrolled in introductory psychology classes at a private, Southeastern university. All participants elected to take part in this study in partial fulfillment of a research participation requirement for introductory psychology students. The average age of participants was 18.82 years ($SD = 1.12$). Twenty-nine participants reported their race as African American, 29 as Asian, 125 as Caucasian, 2 as Pacific Islander, 5 as Latina, and 5 as "other"; 1 participant did not specify her race. Thirty-nine participants (19.9%) reported an experience prior to the age of 18 that they regarded as CSA. This percentage is well within the range reported by previous investigators who have examined nonclinical samples (e.g., Finkelhor et al., 1990; see Rind et al., 1998, p. 53, for a comprehensive listing of CSA prevalence in college samples).

Measures

CSA checklist. This checklist of purported characteristics of women with histories of CSA was assembled for the purpose of this study.¹ Twenty-one prototypical items were drawn verbatim from the checklists in the popular books by Davis (1990), Frederickson (1992), Blume (1990), and Bradshaw (1990). The checklists in the books by Davis, Frederickson, and Blume are specific to CSA. The checklist in the book by Bradshaw is specific to the presumed effects of severe abuse and neglect, including CSA. Each statement represented a characteristic present in at least two,

and often three or all four, of the checklists in these books. For example, respondents are asked about body image, giving too much in relationships, and daydreaming frequently. These items were selected because they appear consistently across some of the most widely used checklists.

In most published studies of the Barnum effect, a series of Barnum statements have been presented in paragraph form. A group of Barnum statements presented in immediate succession may appear more convincing to participants than a single statement. Therefore, participants were asked to read all statements first in an effort to parallel the possible cumulative effects of Barnum statements. Participants then responded to the following question for each statement: "To what extent is this statement true of you?" Participants rated each statement on a 4-point scale (1 = *not true*, 4 = *very true*). In this sample, the internal consistency of this measure was high (Cronbach's $\alpha = .82$).

Barnum checklist. This checklist was also assembled for the purpose of this study.² Eighteen items used commonly in the published Barnum literature were drawn verbatim from past studies. For example, respondents are asked about being bothered by change, having difficulty concentrating, and having unused capacity that they have not turned to their advantage. Seven of the 18 statements can be found in the initial article to describe the Barnum effect (Forer, 1949, p. 120). All of the other statements have been used in numerous subsequent studies of the Barnum effect, including Sundberg (1955); Snyder and Larson (1972); Kelly, Dickson, and Saklofske (1986); and Logue et al. (1992).

Participants were again asked to read all statements first in an effort to parallel the possible cumulative effects of Barnum statements in previous studies. Then participants again responded to the following question for each statement: "To what extent is this statement true of you?" and rated each statement on a 4-point scale (1 = *not true*, 4 = *very true*). In this sample, the internal consistency of this measure was moderate (Cronbach's $\alpha = .65$).

The first group of participants ($n = 75$) responded to the CSA checklist followed by the Barnum checklist. Subsequent participants ($n = 121$) responded to the Barnum checklist first to enable the examination of a possible order effect for these two checklists.

Familiarity with childhood sexual abuse issues scale. Designed for this study, this scale asked participants to rate their degree of familiarity with issues surrounding CSA and individuals who have experienced CSA (see Logue et al., 1992, for a similar scale assessing familiarity with issues concerning ACOAs). Participants were asked to rate their knowledge concerning characteristics of individuals who have experienced sexual abuse, their exposure in high school or college classes to information concerning individuals who have experienced sexual abuse, and their degree of contact with individuals who have experienced CSA. In addition, participants were asked about their degree of exposure to written material, television programs and films, and lectures and workshops concerning CSA issues. Participants responded to each of the six questions on a 4-point scale (1 = *none*, 4 = *a lot*). In this sample, the internal consistency of this measure was moderately high (Cronbach's $\alpha = .76$).

¹ The complete CSA checklist is available from Scott O. Lilienfeld.

² The complete Barnum checklist is available from Scott O. Lilienfeld.

Brief Symptom Inventory (BSI). This 53-item measure of global psychological distress was developed by Derogatis and Spencer (1982). The BSI is the short form of the Symptom Checklist-90 (Derogatis, 1983). The BSI includes a Global Severity Index, which is interpretable as an index of overall psychological distress, and nine symptom subscales: Somatization, Obsessive-Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation, and Psychoticism. Participants are asked to respond to all 53 symptoms by indicating how much they were distressed by each in the past 7 days. Participants responded on a 5-point scale (0 = *not at all*, 5 = *extremely*).

Since its development, the BSI has been used in numerous studies. Boulet and Boss (1991) and Hayes (1997) found that the BSI was most valid as a measure of global psychological distress and that specific subscales did not measure unique dimensions of such distress. Specifically, few BSI items uniquely measure one of the nine dimensions, and total BSI scores are highly correlated with subscale scores. In this study, the BSI total score served as a measure of global psychological distress. In this sample, the internal consistency of this measure was high (Cronbach's $\alpha = .96$).

Family conflict screening. The nine questions on this scale were drawn from the conflict scale of the Moos and Moos (1981) Family Environment Scale (FES). The nine conflict scale items are in statement form in the FES. However, for purposes of consistency with the CSA screening questions that follow, all nine items were converted to questions. For each of the questions (e.g., respondents are asked if members of their family often criticize one another), participants responded by circling either *yes* or *no*. A lower scale score indicates greater family conflict. In this study, FES conflict scale scores served as a proxy for dysfunctional family environment, which may account for much of the association between CSA and later psychopathology (Rind et al., 1998; but see Dallam et al., 2001, for a different view). In this sample, the internal consistency of this measure was moderately high (Cronbach's $\alpha = .73$).

Childhood sexual abuse screening. Finally, participants were asked to circle either *yes* or *no* to three standard questions concerning a possible history of CSA. Each of the questions describes several kinds of CSA (e.g., someone taking nude photographs of a child, someone exhibiting parts of his or her body to a child, or someone performing a sex act in a child's presence) and asks participants to indicate if they experienced any of them when they were under 18 years of age. These three questions have been used routinely in previous published research on CSA (e.g., see Finkelhor et al., 1990). Participants noting experiences they termed CSA were asked to indicate their ages when the first experiences occurred, the frequency of subsequent sexual contact, and their relationships to the abusers. For the purpose of data analysis, participants were divided into those with and without self-reported histories of CSA.

Procedure

Participants completed the response packets in groups of varying sizes in lecture halls inside an academic building. To maximize privacy, we seated each participant at least four seats away from all other participants. All participants provided informed consent. The investigator assured participants that their participant numbers

were random and could not be connected to their names or signatures on the informed-consent form.

Results

Descriptive Information

The means and standard deviations for the primary measures, for the group with and the group without a history of abuse and overall, are displayed in Table 1. Participants endorsed the Barnum checklist items at higher rates than the CSA history checklist items. The mean item endorsement for the Barnum checklist items was 2.94 ($SD = 0.30$), whereas the mean item endorsement for the CSA history checklist items was 1.82 ($SD = 0.43$).

Zero-Order and Partial Correlations

Because, with one exception, no substantial effect for order of the CSA checklist and Barnum checklist was found, results were combined for all subsequent analyses.³ The zero-order correlations between all primary measures and CSA history are displayed in Table 2.

Scores on the CSA history checklist were moderately to highly correlated with those on the Barnum checklist ($r = .49, p < .01$). The correlation between CSA history and endorsement of the Barnum checklist was close to zero ($r_{pb} = .07, ns$). In contrast, the correlation between CSA history and endorsement of the CSA checklist was statistically significant ($r_{pb} = .18, p < .05$). The test of the statistical significance of the difference between dependent correlations revealed that these two correlations did not differ significantly, $t(194) = 1.54$. CSA history and the BSI total score were significantly correlated ($r_{pb} = .21, p < .01$). In addition, CSA history and FES conflict scores were significantly correlated ($r_{pb} = -.18, p < .05$); CSA history and familiarity with issues concerning those who have experienced CSA were significantly correlated ($r_{pb} = .14, p < .05$). The CSA checklist was significantly and highly correlated with the BSI total score ($r = .71, p < .01$).

After we controlled for scores on the BSI, the correlation between CSA history and endorsement of the CSA checklist became nonsignificant ($r = .04$). In contrast, after we controlled for FES conflict scores, the correlation between CSA history and the CSA checklist remained significant ($r = .14, p < .05$). Similarly, after we controlled for familiarity with issues concerning CSA, the correlation between CSA history and the CSA checklist remained significant ($r = .17, p < .05$). After we controlled for the Barnum checklist scores, the correlation between CSA history and the CSA checklist remained significant ($r = .17, p < .05$). After we controlled for FES conflict scores, CSA history remained significantly correlated with the BSI total scores ($r = .18, p < .05$).

³ The correlation between CSA history and the CSA checklist was statistically significant for participants responding to the Barnum checklist before the CSA checklist ($n = 121$). This correlation was not statistically significant for participants responding to the CSA checklist before the Barnum checklist ($n = 75$). However, a test of the significance of the difference between independent correlations revealed that these two correlations did not differ significantly ($z = 1.46, p = .14$).

Table 1
Means and Standard Deviations for Primary Measures for Groups With and Without a History of Childhood Sexual Abuse and Overall

Measure	Abuse history		No abuse history		Overall	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Barnum	53.69	5.83	52.61	6.01	52.82	5.98
CSA	41.64	10.24	37.52	8.46	38.34	8.97
BSI	55.77	40.53	39.35	27.86	42.50	31.25
FES	13.78	2.52	14.80	2.11	14.59	2.23
FAM	13.05	3.38	11.93	3.07	12.15	3.16

Note. Barnum = Barnum checklist ($N = 196$; abuse history, $n = 39$; no abuse history, $n = 157$); CSA = childhood sexual abuse checklist ($N = 196$; abuse history, $n = 39$; no abuse history, $n = 157$); BSI = Brief Symptom Inventory ($N = 193$; abuse history, $n = 37$; no abuse history, $n = 156$); FES = Family Environment Scale ($N = 196$; abuse history, $n = 39$; no abuse history, $n = 157$); FAM = familiarity with issues surrounding childhood sexual abuse ($N = 196$; abuse history, $n = 39$; no abuse history, $n = 157$).

Implications and Applications

This study yielded several intriguing results. We found a moderate to high correlation between endorsement of the CSA checklist and the Barnum checklist, suggesting that individuals who endorse CSA checklist items tend to endorse vague and highly general descriptors that apply to almost everyone. A number of researchers have reported that people prone to acquiescence are more likely than other individuals to endorse Barnum statements (Snyder et al., 1977). These results are consistent with the possibility that acquiescence accounts in part for endorsements of CSA checklist items. In addition, in endorsing Barnum statements, participants are often admitting to minor faults and frailties. As a consequence, the correlation between the Barnum and CSA checklists may be partly attributable to negative affectivity (Watson & Clark, 1984), a pervasive dimension of personality that includes self-criticality. Because we did not administer a measure of negative affectivity, this possibility will be important to examine in future investigations.

The results offer important, albeit preliminary, information concerning the validity of popular and widely available CSA checklists. The results suggest that the Barnum effect cannot entirely explain endorsement of the CSA checklist. Participants did not endorse the CSA checklist items to the same extent that they endorsed the Barnum checklist items. Moreover, the CSA checklist distinguished women with self-reported histories of CSA from other women to a statistically significant extent, even when participants' scores on the Barnum checklist were controlled statistically. In contrast, the Barnum checklist was unable to distinguish significantly between the two groups.

Brandyberry and MacNair-Semands (1998) argued that use of the CSA checklist in *The Courage to Heal Workbook* (Davis, 1990) would result in virtually no misclassifications of women without histories of abuse as having abuse histories. Our data do not support this conclusion because history of abuse accounted for only a small proportion of the variance (3%) in CSA checklist scores. Moreover, our results revealed substantial overlap in CSA

checklist scores in women with and without self-reported CSA histories, suggesting substantial risk of misclassification.

In addition, after we controlled for BSI total scores, the CSA checklist was unable to significantly distinguish between women with and without self-reported histories of abuse. This finding suggests that CSA checklists lack specificity in clinical settings in that they discriminate slightly between women with and without histories of abuse, but not beyond global psychological distress. CSA checklists may distinguish between women with and without histories of abuse because they serve as proxies of generalized psychological distress. The high correlation between the CSA checklist and the BSI supports this contention. In addition, the rough measure of global psychological distress served as approximately as good a predictor of CSA history as did the CSA checklist itself. After we controlled for the measure of family conflict, the correlation between CSA history and the BSI declined only slightly. In contrast, the controversial meta-analysis by Rind et al. (1998) indicated that the correlation between history of CSA and global distress decreased substantially when adverse family environment was controlled statistically.

Future work should seek to remedy this study's three major methodological limitations. First, we did not obtain corroboration of abuse for the 39 participants who reported CSA histories. Obtaining such corroboration is rare in the CSA literature (Fergusson, Horwood, & Woodward, 2000) and is widely acknowledged to be extremely difficult. Moreover, the formidable difficulties involved in corroborating life events are not limited to the CSA literature (Brewin, Andrews, & Gotlib, 1993). Most research suggests that self-reports of CSA are moderately valid as indicators of corroborated CSA, although these self-reports tend to underestimate CSA prevalence (Widom & Morris, 1997; Williams, 1994). Second, we relied on a nonclinical (student) sample, which is probably less severely affected than most clinical samples. However, in several cases, participants reported their abusers as immediate family members and reported experiencing attempted or completed oral sex, anal sex, or intercourse, the most severe kinds of abuse assessed in this study. Moreover, as noted earlier, the proportion of women reporting a CSA history in our sample was broadly consistent with that reported by many investigators who have examined community samples (see Finkehor et al., 1990). In addition, the use of a nonclinical sample is defensible

Table 2
Zero-Order Intercorrelations Between Measures and CSA History

Measure	1	2	3	4	5	6
1. Barnum	—	.49**	.36**	-.07	.03	.07
2. CSA		—	.71**	-.27**	.11	.18*
3. BSI			—	-.19**	.06	.21**
4. FES				—	-.02	-.18*
5. Familiarity					—	.14*
6. CSA history						—

Note. Barnum = Barnum checklist ($N = 196$); CSA = childhood sexual abuse checklist ($N = 196$); BSI = Brief Symptom Inventory ($N = 193$); FES = Family Environment Scale ($N = 196$); Familiarity = familiarity with issues surrounding childhood sexual abuse ($N = 196$); CSA history = history of childhood sexual abuse.

* $p < .05$. ** $p < .01$.

because CSA checklists are designed for and marketed to the public. Third, because we used some judgment in selecting CSA checklist items, the 21 items we used may not be entirely representative of those in certain popularly available CSA checklists. However, all of the items selected represent characteristics present in at least two, and often three or all four, of the checklists examined here. Therefore, the CSA checklist items we selected appear to be prototypical of those in widely disseminated self-help books and workbooks.

Although popularly available CSA checklists are not standard psychological instruments, clinicians need to be aware of their limitations, particularly given their ready accessibility to psychotherapy clients. Until further research suggests otherwise, clinicians should proceed with considerable caution when assigning popular self-help books and workbooks containing CSA checklists to their clients. Moreover, clinicians who elect to use bibliotherapy with clients with potential abuse histories may want to explicitly warn their clients against relying on these checklists to draw conclusions regarding their abuse histories. They may also wish to warn clients who independently consult popular self-help books or attend CSA workshops against placing undue emphasis on specific psychopathological signs and symptoms purportedly linked to CSA.

Clinicians' reliance on specific signs and symptoms ostensibly linked to CSA risks misclassifying many women without CSA histories as abused, and vice versa. In addition, reliance on such signs and symptoms may engender confirmatory bias among clinicians, as these characteristics may lead clinicians to form initial hypotheses regarding their clients' childhoods that they later inadvertently "corroborate" using suggestive procedures. Our results therefore suggest that therapists' use of CSA symptom interpretation (see Lynn et al., 2003), even for the purposes of hypothesis generation, entails potentially serious risks.

More broadly, our findings raise questions regarding the use of other popularly available checklists designed to detect a host of psychological conditions. A plethora of popular checklists have been developed to assist clients in determining whether they suffer from reasonably well-established psychological conditions, such as attention-deficit/hyperactivity disorder and obsessive-compulsive disorder, as well as largely unvalidated psychological conditions, such as sexual addiction (Carnes, 2001), codependency (Beatty, 1997), and Internet addiction (Young, 1998). Clinicians should be aware that virtually all of these popular checklists, like popular CSA checklists, have received minimal validation. The items on these checklists were selected largely or entirely on the basis of informal and unsystematic clinical observations. Although such observations are surely useful in generating hypotheses concerning psychological conditions, they have their limitations (see Garb, 1998). In particular, because these popular checklists have not been validated by comparing the responses of individuals with the psychological conditions in question with those of other individuals, such checklists may lack specificity to these conditions and instead serve as indicators of global maladjustment. Pending validation research, clinicians should refrain from using such checklists to draw inferences regarding their clients' psychological conditions.

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