APSAC THE APSAC ADVISOR
Volume 8 Number 1 Spring 1995
AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN

EVALUATION AND TREATMENT

The Clinical Use of the Child Sexual Behavior Inventory:

Commonly Asked Questions

—by W. N. Friedrich

The Child Sexual Behavior Inventory (CSBI) seems to have met a need by clinicians and researchers to evaluate sexual behavior in sexually abused children. I have received numerous requests for information on the clinical use of the CSBI. Although preliminary comments on the clinical use of the CSBI have been published in *Psychotherapy of Sexually Abused Children and Their Families* (Friedrich, 1990), my thinking about the CSBI has evolved over time and this paper reflects new data and additional experiences. This evolution in my thinking about sexual behavior, along with strong clinician interest, prompted this article, which recounts the most common questions I receive about the CSBI.

The CSBI was developed to better assess sexual behavior in children. Empirical findings with sexually abused children indicate that sexual behavior is one of the more reliable and valid markers of sexual abuse (Friedrich, 1993b; Kendall-Tackett, Williams, & Finkelhor, 1993). The original 36-item CSBI has been researched extensively and the majority of the original items were found to differ significantly between a sample of 880 non-abused children with no history of psychiatric disturbance and 276 children with a history of sexual abuse (Friedrich, et al., 1992). The CSBI has been revised twice. The CSBI-R was the first revision, and a recent paper (Friedrich, 1993a) indicated that all but one item of the CSBI-R differed significantly between sexually abused and non-abused children. The second revision is the CSBI-3, and research is currently underway that will contrast a demographically diverse normative sample of 1200 two- to twelve-year-old children, with 300 nonabused outpatients and 500 sexually abused children. Data collection is currently underway at a number of sites in the United States and Canada. A normative sample from Sweden is also being gathered at this time.

All versions of the CSBI were designed for use with children ages two to twelve. The child's primary female caregiver is asked to complete a 36-item measure that rates the numerical frequency of each behavior over the previous six-month period. The behaviors included in the CSBI, CSBI-R, and CSBI-3 measure such aspects of sexual behavior as self-stimulation, sexually intrusive behavior with other children or adults, sexual interest, boundary permeability, and gender-based behaviors. An advantage of the CSBI-3 is the use of several validity and attitudinal items.

The CSBI must be used with interviews and other forms of assessment in order to understand the child, particularly the sexually abused child. It must

continued on page 17

NEWS

Annual Report

—by Theresa Reid

Membership Survey

APSAC's first membership-wide satisfaction survey elicited responses from nearly 900 members, more than 19% of those polled. APSAC's leaders were pleased by the high response rate, and very interested in the results. The questions of most immediate importance to the Board were, in effect, "How do you like what we're doing?" and "What do you want us to do next?"

Responses to the first question were surprising. While we weren't surprised that *The APSAC Advisor* was the highest-rated benefit of the association, we were surprised that three of the four top-rated benefits or activities of the association are intangibles. In addition to *The APSAC Advisor* they were

- belonging to an association focused on child maltreatment,
- efforts to influence media coverage of child maltreatment, and
- efforts to influence federal legislation.

Answers to the second question, "What do you want us to do next?" were illuminating as well. The proposed new activities members most endorse are

- a new practice- and policy-oriented journal,
- one-day regional trainings,
- additional practice guidelines, and
- a brief quarterly newsletter supplement with news and information.

These responses seem likely to reflect the perceptions of APSAC members generally; although, not surprisingly, those who have been members for more than three years were overrepresented among the survey respondents, the various disciplines that comprise APSAC membership were proportionally represented among respondents. Seventy-six percent of respondents said that the field of child maltreatment is a primary career choice for them.

continued on page 2

The clinical use of the Child Sexual Behavior Inventory

continued from page 1

never be used by itself, and it should never be the sole basis for a determination of sexual abuse. There is no item, or combination of items, that without fail, are solely indicative of sexual abuse. Even the CSBI-3 is a face valid measure, and it is very easy for a caregiver to exaggerate or minimize.

How should the CSBI be used?

The questionnaire is designed to be used with two- to twelve-year-old children, and norms are based on the responses of exclusively female caregivers who are familiar with the child. In addition, the behavior problem portion of the Child Behavior Checklist (Achenbach and Edelbrock, 1983) is typically obtained for the purpose of placing the CSBI responses in a larger behavior context.

The CSBI should be completed by a caregiver who knows the child very well. Preferably, two caregivers are used, particularly if the veracity of one is in doubt. Inter-rater reliability scores for the CSBI and the CSBI-3 are typically positively correlated. In the case of the CSBI, parents correlated with teachers, and with the CSBI-3, parents correlated with psychiatric nurses. These correlations are significant, but low (r = .3 — .4).

In addition to assessment, the CSBI can be used to guide treatment. The child's behaviors that are endorsed can be discussed with the caregiver, identified as treatment targets, and addressed with a variety of modalities, e.g., behavioral, cognitive, and play.

There is no item, or combination of items, that without fail are solely indicative of sexual abuse.

Other people use the CSBI information to reassure parents that their children are displaying normative behavior. I have received numerous letters from pediatricians and therapists who have been able to reassure parents that a five-year-old boy touching himself, for example, is exhibiting normative behavior.

How is the CSBI scored?

Each CSBI item can be answered 0, 1, 2, or 3. Simply total the sum of all items (less the validity items in the CSBI-3) to arrive at a total score. For example, if only two items are endorsed at the "1" level, the total score would be 2. This total score can then be contrasted with published means (Friedrich, et al, 1992). For example, a five-year-old boy who receives a CSBI score of 10 would fall within one standard deviation of the mean for two-to-six-year-old nonabused boys. A score of 38 in a 10-year-old girl is more than two standard deviations above the mean for sexually abused girls aged seven to twelve.

The version of the CSBI in the Friedrich, et al. (1992) paper is the original measure. Research with the CSBI-R has found that 35 of 36 items significantly discriminate abused from non-abused children, whereas in the original CSBI, 27 of 35 items significantly discriminated between the two groups. Thus, the mean scores have changed somewhat, with children who have no history of behavior problems and no history of sexual abuse rarely receiving a total score of more than 5. The mean scores for sexually abused children on the CSBI-R, depending on age and sex, range from 7 to 15, with younger and older girls typically scoring lower than same-aged, sexually abused boys. However, the standard deviations for each age-sex mean are typically equal to or larger than the mean, again suggesting the wide range of behaviors in both abused and non-abused children (See Table 1).

The CSBI can also be used to identify the types and frequencies of behaviors reported by parents. This is a qualitative approach that can be quite useful with individual cases. For example, a parent of a seven-year-old boy may indicate moderate levels of masturbation both in public and private, along with heightened sexual interest and the sexual touching of other children. In most cases, the combination of these behaviors, along with the fact that the child is seven, and presumably of normal intelligence, would be suggestive of exposure to adult sexuality, and possibly of sexual abuse. Again, however, these behaviors are only suggestive, not definitive.

Are there any single best questions?

In the original CSBI research, we found that every single item was endorsed by parents of at least some non-abused children. I continue to believe that non-abused children can demonstrate, at least minimally, any of the behaviors on the CSBI-R. What is important is the context of the behavior. The context implies the developmental level, setting, and history of the child. For example, a five-year-old boy who masturbates at home in his bed is likely to have a different history than a nine-year-old boy who masturbates in public. A three-year-old boy who sees his younger sister breast fed by his mother may try to touch his mother's breast. This is benign in contrast to a 10-year-old boy who impulsively grabs his teacher's breasts. In addition, initial analyses of the CSBI-3 indicate that psychiatric outpatients without a history of sexual abuse show elevated levels of sexual behavior.

Regrettably, the wording of some CSBI-3 items is confusing or misleading. For example, the item inquiring about whether the child inserts objects into her vagina or rectum is asking about a behavior that technically cannot be done, without considerable pain, to the young female's vagina. Typically, when a parent endorses that question with a young female, they do not technically mean "insertion into the vagina"; they mean insertion between the labia. There are exceptions to this rule, and sexually abused female children have been accurately reported as inserting fingers or objects into their vaginas. There are other examples of subjectively worded items which I have tried to avoid but which

continued on next page

The clinical use of the Child Sexual Behavior Inventory

continued from page 18

continue to have discriminant validity. These include "makes sexual sounds" and "knows more about sex than other children their age."

There is no single item or cluster of items that can say definitively whether or not a child has been sexually abused. To reiterate, for the CSBI to be valid, it must be used in combination with careful clinical interviewing, an assessment of other behavior problems in children, such as the Child Behavior Checklist (Achenbach & Edelbrock, 1983), and a determination of family stress, chaos, and sexual climate

What about the differences between sexually abused children and children who have not been sexually abused but who have psychiatric problems?

Children who need mental health services more likely grow up in families where greater aggression and unpredictability occur, along with a greater possibility of exposure to adult sexuality.

In collaboration with several colleagues at the Mayo Clinic, I am collecting data, with the CSBI-3, on a sample of psychiatric outpatients and inpatients. They have been carefully screened, and as far as we know, do not have a history of sexual abuse. Preliminary analyses with fewer than 100 of these children have found that they exhibit significantly more sexual behavior than the normative, non-psychiatric sample. Considerably more overlap exists between psychiatric patients and sexually abused patients regarding CSBI-3 scores than between non-abused, non-psychiatric children and abused children. However, as a group the psychiatric, nonabused children exhibit fewer behaviors, at lower frequency, than sexually abused children.

A number of factors might explain why nonabused psychiatric patients score higher on the CSBI-3 than do the normative, non-psychiatric children. Children who need mental health services more likely grow up in families where greater aggression and unpredictability occur, along with a greater possibility of exposure to adult sexuality. These children have problems with modulating behaviors of all types. In addition, life stress and exposure to adult sexuality have been shown to correlate with sexual behavior (Friedrich, et al., 1992).

Studies with the CSBI and CSBI-R, and initial studies of the CSBI-3, have also reported that life stress and exposure to adult sexuality correlate directly with behavior problems (Friedrich, et al., 1992; Friedrich, 1993b). For example, in an ongoing study on sexual behavior in children with a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD), parents frequently report problems with interpersonal boundaries and increased levels of masturbation (Friedrich, 1994a). However, as a group they report that their children exhibit less sexual interest and less sexual aggression than children who have been sexually abused. In addition, ADHD children whose parents do not have a psychiatric history and whose parents and teachers do not report accompanying oppositional or defiant behavior show low levels of sexual behavior and look quite similar to nonabused children.

Since all versions of the CSBI are face valid, do you have any problems with parents deliberately slanting their reports about their child?

If a parent wants to report more sexual behavior or less sexual behavior in their child than is actually the case, it is very easy for them to do that with the CSBI. In a recent study, the CSBI did not discriminate between sexually abused and non-sexually abused children 35 months old or younger (Hewitt, Friedrich, & Allen, 1994). A number of these children were involved in custody disputes, and several of the highest total scores on the CSBI were obtained in children that we determined most likely had not been sexually abused.

The same phenomenon occurs if the parents are denying their child's sexual abuse or if they are unsupportive of their child vis-a-vis the perpetrator. These parents are likely to report very few, if any, sexual behaviors. We attempt to counter biased reporting by enlisting other reporters who may be more objective. The CSBI can be used with day care providers and has been used with teachers, although the full range of behaviors in the measure are not likely to be seen in school settings. There can also be marked differences between parents, e.g., fathers vs. mothers, although the developmental psychological literature reports that mothers tend to be more accurate in reporting their children's behavior problems

How can the CSBI be used to monitor treatment progress?

The total score of the CSBI can be a very good marker of treatment progress. Sexual behavior is more resistant to change than more affective symptoms, such as anxiety and depression (Lanktree and Briere, 1992). However, a significant course of treatment will typically result in a drop in the CSBI score (Friedrich, Luecke, Beilke, & Place, 1992), particularly if the child's sexual behavior has been specifically addressed in therapy. In addition, specific items can be followed over time and targeted as part of treatment. If the parent endorses a number of items pertaining to masturbation, a behavior management focus on the masturbation can be developed. The CSBI can also monitor variations in behavior during treatment. The sexual behavior in some children may actually increase after disclosure of sexual abuse, at least briefly, and particularly if the child is not feeling supported in his or her home environment. I have also found that disclosure of previous sexual abuse, in a supportive context, will be followed by a reduction of sexual

continued on next page

The clinical use of the Child Sexual Behavior Inventory

continued from page 19

behavior in some children, as measured with both the CSBI and by the parent (Friedrich, 1994b).

What are the differences between younger and older children?

It is very important to look at each of the CSBI behaviors in terms of context. Developmental level is one critical context. For example, on the CSBI, 43.5 percent of two- to six-year-old boys in the normative sample were reported as touching their mother's breasts and 48.8 percent of two- to six-year-old abused boys were reported as displaying the same behavior. In the seven- to twelve-year-old range, these frequencies had dropped to 11.7 and 22.9 percent, respectively. Thus you can see that for younger boys, this behavior was hardly discriminating, whereas for older boys, it was twice as common among abused boys (Friedrich, 1993a).

On all versions of the CSBI, sexual behavior in girls decreases in terms of frequency and range as the girl gets older. That is not true with boys who have been sexually abused; in fact, there appears to be a trend towards a broader and more aggressive range of sexual behavior in older sexually abused boys.

How does parental perception influence the reporting of sexual behavior?

A number of factors influence parental report of sexual behavior in their child. They include: parental attitudes about their own and their child's sexuality; attitudes toward the child; belief in their child's victimization; the need to protect the possible perpetrator; whether the parents are good monitors of their child's behavior; the parents' history of victimization; and the SES and cultural background of the parents. Not all of them have been empirically validated with the CSBI.

There appears to be a trend towards a broader and more aggressive range of sexual behavior in older sexually abused boys.

Parents may not perceive sexual behavior in their children because they do not view children as sexual, or they are avoidant of sexuality. A parent who negatively perceives his or her child may see the child as quite sexual, as well as aggressive and exhibiting a variety of other behavior problems. Lower-income parents are also less likely to report as much sexual behavior in their children as are middle-class parents.

Has the CSBI been used with children in other cultures?

Currently, French, Spanish, and Swedish translations of different editions of the CSBI exist. These were prompted by studies of sexual behavior of children in Montreal, California, Stockholm, and Cologne. The small sample of Hispanic children in the CSBI normative study (Friedrich, et al, 1992) did not differ from other children, but a true test of cultural and ethnic differences remains to be done.

What research is currently being conducted with the CSBI?

As mentioned above, the CSBI-3 has been developed. Each item has been reworded to read simply, close to an eighth grade level. Several validity items have also been included to assess for how closely the parent pays attention to each individual item. A multi-site normative study is under way, with research sites including Bangor and Portland, Maine; Portland, Oregon; Baltimore, Maryland; Rochester and Minneapolis, Minnesota; Los Angeles, Sacramento, and San Fernando Valley, California; Seattle, Washington; Philadelphia and Pittsburgh, Pennsylvania; Salt Lake City, Utah; Calgary and Montreal, Canada; and Oklahoma City, Oklahoma. A significant subset of this new sample will have had pediatric evaluations of their sexual abuse as well. We are also attempting to pay much closer attention to family stress levels, exposure to sexuality in the home, and parental attitudes towards sexuality in children as possible moderators of sexual behavior in children.

In addition, the CSBI is an outcome measure in two NCCAN-funded grants on the treatment of sexually aggressive children. It has also been used in several other federally funded research studies. Finally, we have developed an adolescent version and are obtaining normative behavior with it as well.

What do I do if caregivers differ in their report of sexual behavior on the CSBI?

Let's assume that you have reports from both a mother and a female day care provider. The mother's report is high and the caregiver's report is low. Reasons can include 1) exaggeration by mother; 2) minimization by caregiver; 3) differences in settings, e.g., more sexual behavior at bedtime, witnessed only by the mother; more structure in day care; the mother's presence reminds child of the abuser; and 4) different attitudes about sexuality in children. In addition, don't assume that day care parents are neutral. It is important to know with whom they are allied. If an accused father also completes a CSBI, the permutations in reasons for differences increase. Again, the range of possibilities underscores the complexity of sexual behavior in children.

In summary, the Child Sexual Behavior Inventory is one measure that can be used as part of a broad-based assessment of children two to twelve years of age who are suspected of being sexually abused. It should never be used by itself, and findings of sexual abuse based largely or solely on the Child Sexual Behavior Inventory are invalid. Despite the relative primacy of sexual behavior in sexually abused children, there is no single "cutting tool" to identify sexually abused children. The validity of the caregivers' reports depends upon a

continued on next page

The Clinical Use of the Child Sexual Behavior Inventory

continued from page 20

broad range of variables, and sexual behavior is influenced by a number of contextual variables as well. These include the child's developmental level, psychiatric history, exposure to family nudity and aggression, and life stress. However, the CSBI is reasonably well validated, research with it continues, and it is a useful measure for both initial assessment and for monitoring treatment progress.

To obtain a copy of the CSBI and supporting articles, write to:

William N. Friedrich, PhD, ABPP
Mayo Clinic, Department of Psychiatry and Psychology, W11B Rochester, MN 55905

References

Achenbach, T.M., and Edelbrock, C. (1983). *The Manual for the Revised Child Behavior Checklist and the Revised Child Behavior Profile*. Burlington: University of Vermont

Friedrich, W.N. (1990). *Psychotherapy of sexually abused children and their families*. New York: W. W. Norton.

Friedrich, W.N. (1993a). Sexual behavior in sexually abused children. *Violence Update, 3*(5). 1. 7-11

Friedrich, W.N. (1993b). Sexual victimization and sexual behavior in children: A review of recent literature. *Child Abuse and Neglect 17*, 59-66.

Friedrich, W.N. (1994a). *Psychological assessment of sexually abused children: The case for abuse-specific measures*. Paper presented at the American Psychological Association Annual Conference, Los Angeles, CA, August 12, 1994.

Friedrich, W.N. (1994b). *Managing day-to-day sexual behaviors in sexually abused children*. Workshop presented at the Tenth Annual Midwest Conference on Child Sexual Abuse and Incest, Madison WI, October 19. 1994

Friedrich, W.N., Grambsch, P., Damon, L., Hewitt, S.K., Koverola, C., Lang, R.A., Wolfe, V., and Broughton, D. (1992). Child Sexual Behavior Inventory: Normative and clinical comparisons. *Psychological Assessment 4*. 303-311.

Friedrich, W.N., Luecke, W.J., Beilke, R.L., & Place, V. (1992). Psychotherapy outcome of sexually abused boys: An agency study. *Journal of Interpersonal Violence 7*. 396-409.

Hewitt, S.K., Friedrich, W.N., and Allen, J. (1994). *Assessment of very young children with suspected sexual abuse*. Paper presented at the Annual Responding to Child Maltreatment Conference. San Diego, CA, January 28. 1994

Kendall-Tackett, K.A., Williams, L.M., and Finkelhor, D. (1993). The impact of sexual abuse on children: A review and synthesis of recent empirical studies. *Psychological Bulletin 113*, 164-180.

Lanktree, C., and Briere, J. (1992). *Therapy for sexually abused children: Treatment outcome using the TSC-C*. Paper presented at the Annual Meeting of the American Psychological Association, Washington, D.C., August 16, 1992

William N. Friedrich, PhD, ABPP, is an Associate Professor in the Department of Psychiatry (Psychology) and Diplomate in Psychology at the Mayo Clinic in Rochester, MN.

Table 1. Mean Scores and (Standard Deviations) on CSBI-R

	Sexually Abused (N=191)		Non Abused (N=270)	
Males				
2-6	15.3	(12.6)	3.1	(3.4)
7-12	11.9	(11.2)	1.8	(2.1)
Females				
2-6	14.1	(12.5)	2.5	(2.9)
7-12	7.3	(8.1)	1.6	(2.4)

COLLOQUIUM UPDATE

The brochures for APSAC's Third National Colloquium should have reached you by the time you read this. (If you haven't received one, let us know!). There are, however, a few updates for your attention:

The Saturday seminar S26, "Old memories, new technologies: Current medical issues in child sexual abuse," is being changed to "Advanced medical issues in physical abuse." Carole Jenny, MBA, MD, is still the faculty. This session will present a "potpourri" of issues commonly faced by medical practitioners evaluating abused children. The list of issues to be discussed includes the following:

1. *Coagulation and head trauma*. "Shaken babies" often are found to have abnormalities on clotting studies. We will review the "clotting cascade" and how it is affected by brain and body trauma. Appropriate work-ups for coagulation disorders in child abuse cases will be discussed (and debated).
2. *Factitious illness*—How has our clinical management and perception of "Munchausen Syndrome by Proxy" changed over the last five years? Is MSBP a "treatable" condition, or should children in these families always be removed from their parents' care? We will also discuss a proposed MSBP national data base.
3. *Child physical abuse—the toughest cases*. Ten cases will be presented and discussed. Each of these cases will represent "tough calls" where abuse is in the differential diagnosis, but other conditions also need to be considered. The cases will be presented in a step-wise fashion, using group process to determine how the treating physician should proceed to reach the best clinical answer. History, physical examination findings, radiologic studies and laboratory tests will be analyzed.
4. *Perpetrators of child physical abuse*—What does the epidemiologic literature say about who is likely to abuse, seriously injure, and kill children? How does this information affect approaches to physical abuse prevention?

The program became richer as well when the U.S. Department of Justice offered two lunch-time trainings on multidisciplinary child abuse teams. These presentations will be offered from 12:15 to 1:15 on Friday and Saturday.

We hope to see you in Tucson!