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Reliability of video taped interviews with children suspected of being sexually abused

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Abstract

Objective—To determine the reliability of judgments about the likelihood of child sexual abuse based only on video recorded interviews.

Design—Blinded rating of likelihood of abuse by seven professional groups and comparison with consensus rating.

Setting—Child and adolescent psychiatry centre.

Subjects—Four people from each of seven professional disciplines: specialist psychiatrists, general psychiatrists, experimental psychologists, trainee social workers, trainee clinical psychologists, lawyers, and police.

Main outcome measure—Rating of 12 recorded interviews.

Results—Agreement between the consensus panel and professional groups was 83% (151/183) for high likelihood cases (seven cases) and 89% (118/132) for low likelihood cases (five). Specialist psychiatrists and the police were better able to identify high likelihood cases than were other groups with less experience of interviewing sexually abused children (91% (48/53) v 79% (102/129); $p=0.05$).

Conclusions—Raters could accurately distinguish children with low likelihood of abuse on interview evidence alone, but those with more experience of dealing with sexual abuse were better at identifying high likelihood cases.

Introduction

In the mid-1980s the courts and the Butler-Sloss inquiry¹ criticised methods used for interviewing children suspected of being sexually abused. These criticisms suggested that such interviews were conducted poorly and used hypothetical and leading questions and that the information elicited from children and a subsequent interpretation of this video-recorded material by clinicians were unreliable as evidence.

Anatomical dolls and other play adjuncts were used in the recorded interviews, and the play, non-verbal, and verbal responses of the child were subsequently scrutinised for evidential meaning by lawyers in court. Research into children's memory and suggestibility indicates that very young children can recall events of central importance as accurately as older children but that younger children can give less detailed accounts of such events and are more easily pressured into

compliant responses by suggestible or leading interview techniques.² Studies comparing the effects of anatomically correct dolls on the play of abused and non-abused children show that sexually abused children may show both sexualised and aggressive play with the dolls whereas non-abused children's play is unremarkable.³ There is no convincing evidence to suggest any sexualising effect of such dolls on young children's play, and sometime after the Cleveland report¹ Westcott *et al* stated that "there seems no good reason to immediately remove the dolls from use in diagnostic therapeutic interviews with suspected child abuse victims."⁴

We used anatomical dolls in video recorded interviews with children suspected of being sexually abused. The interviews were then assessed by blinded raters from five disciplines, including lawyers, to test the reliability of their professional perceptions. The experimental design in some ways reflected the artificiality of the court situation in the mid-1980s, when there was often an over emphasis on the video recorded interview and the use of anatomical dolls.

Subjects and methods

Twelve children aged between 3 and 9 years were included in the study. They had all been referred to child psychiatry teams specialising in the management and treatment of child sexual abuse to investigate the possibility of sexual abuse.

All the children were interviewed by clinicians experienced in dealing with sexual abuse by using a semistructured interview.⁵ The interviews were primarily clinical, responding to the needs of the children, and as such were not pure research interviews. Although the interviews were not chosen at random, the children were representative of those referred to the teams and the interviews were typical of those conducted by the teams. The interviews were chosen on the basis of the age of the child, the technical quality of the video recording of the interview, and the degree to which the interview conformed to the semistructured format. In addition we ensured that the interviews included children who were thought to have a high likelihood as well as a low likelihood of having been abused.

We rated the non-interview data on the children derived from information obtained at the time of the referral, including physical findings, emotional and

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behavioural factors in the child, statements made by the child or adults, and family background. In addition, MRW and EV rated the interview data by viewing the videos independently. However, one researcher (EV) had carried out the interview in five out of the 12 cases and the other (MRW) had carried out the interview in one case so these ratings were not blind to all other information about the case. After discussion of the non-interview and the interview data we assessed the likelihood of sexual abuse as either high (definite or probable) or low (possible or unlikely). We formed the consensus group and our judgment about the likelihood of abuse constituted the consensus judgment in each case.

We asked four people from seven professional disciplines to view independently the video of each of the 12 interviews. The reviewers were provided with no information about the child apart from the child's age. The seven groups were child psychiatrists specialising in child sexual abuse; experienced general child psychiatrists; experimental psychologists; trainee clinical psychologists; trainee social workers; lawyers; and police. The specialist child psychiatrists were not associated with, or trained in, the Great Ormond Street technique,⁵ and the general child psychiatrists had no special interest in child sexual abuse.

The experimental psychologists were included because of their expertise in observing behavioural data, although we recognised that they were not clinically experienced. The trainee groups were included to assess the effect of having inexperienced clinicians. A group of experienced social workers was also approached, but, unfortunately, for practical reasons they were unable to take part in the study. Lawyers were included as they are often asked to assess the likelihood of sexual abuse on the basis of interviews and other evidence. Similarly, the police were included as they too assess interviews of children suspected of having been sexually abused, as well as interviewing victims of abuse, for evidential purposes.

At the end of each interview the raters were asked to indicate their assessment of the likelihood of child sexual abuse as high (definite or probable), low (possible or unlikely), or unable to rate. They also were asked to explain why they had made their decisions. The results of the ratings of the likelihood of sexual abuse, based on the interview alone, were compared with the consensus panel's rating.

Results

Table I shows the agreement between the raters and the consensus group, based on the interview alone. For the cases rated as showing a high likelihood of abuse by the consensus group there was 83% agreement in the ratings of the experimental group. For the cases rated as low likelihood by the consensus group there was 89% agreement of the ratings. The differences between the consensus and experimental ratings were not significant.

TABLE I—Agreement of professional groups with ratings of consensus panel about likelihood of sexual abuse

	Consensus rating high likelihood (7 cases)			Consensus rating low likelihood (5 cases)		
	High likelihood	Low likelihood	t Value	High likelihood	Low likelihood	t Value
Specialist psychiatrists	23	3	0.93	2	18	0.74
General psychiatrists	14	7	1.76	2	16	0.78
Experimental psychologists	21	6	1.37	1	19	0.52
Trainee social workers	26	2	0.72	5	14	1.29
Trainee clinical psychologists	21	6	1.76	2	18	0.74
Lawyers	20	6	1.41		16	
Police	26	2	0.72	2	17	0.75
All groups	151	32	1.22	14	118	0.74

For the cases rated as having high likelihood of abuse the specialist psychiatrists, police, and trainee social workers showed the most agreement with the consensus group (table I). However, the differences between the seven groups did not reach significance. Apart from the trainee social workers, there was good agreement both between the groups and with the consensus rating for low likelihood cases. There was no significant difference between the groups or between the groups and the consensus rating. The results suggest that it may be easier to reach agreement on cases in which there is a lower likelihood of abuse than when there is a higher likelihood.

We hypothesised that professionals with specific experience of face to face interviewing with abused children (the police and specialist psychiatrists) would be more consistently accurate in their assessments of the interviews. Table I suggests that this hypothesis is correct for high likelihood cases, although the difference between specialist groups and other groups was not significant. Trainee social workers were able to identify the higher likelihood cases more consistently than the other non-experienced groups but they were also more likely to rate the lower likelihood cases as high likelihood.

We therefore combined the police and specialist psychiatrists into one group and compared their ratings with those of the other five groups, also combined into one group (table II). For the high risk cases 91% of the specialist group ratings agreed with the consensus group compared with 79% of the other groups (48/53 v 102/129; $t=1.85$, $p=0.05$), suggesting that the specialist group was better at identifying those children with a higher likelihood of abuse than were less experienced raters. For those cases judged to have a low likelihood of abuse 91% of the ratings of the specialist group agreed with the consensus group, compared with 89% of the non-specialist groups' ratings (35/39 v 83/93; $t=0.85$, NS); both groups were equally accurate in identifying cases with a low likelihood of abuse.

Discussion

This study had some methodological problems. Firstly, the 12 cases were not randomly selected and so may represent a biased sample, although knowledge of the case material suggests that they were representative of typical cases seen by the teams. Nevertheless, it is difficult to extrapolate with great confidence from this study. Secondly, the professional groups contained only four people and were a selected sample, representing highly experienced, leading members of each professional group. Thirdly, it was not possible to get a full spread of all the appropriate professionals—for example, we had a group of trainee social workers, but not of qualified, experienced social workers. Lastly, there are also difficulties about the nature of a consensus rating. In clinical practice, there are no simple means of accurately concluding that sexual abuse has definitely occurred. The consensus rating was formed by raters independently assessing each case and reaching a decision after discussion.

With these reservations our study suggests that agreement between professional groups and the consensus panel was good when raters were asked to assess the likelihood of child sexual abuse on the basis of a video recorded interview. The agreement seems to be better for those cases with a lower likelihood of sexual abuse. Cases with a higher likelihood of sexual abuse were found more difficult to identify by raters, except those professionals—police and specialist child psychiatrists—who had more experience in interviewing children suspected of having been sexually abused.

Our study shows that video recorded interviews can

TABLE II—Ratings of specialist group (specialist psychiatrists and police) compared with those of non-specialists

	Consensus rating high likelihood (7 cases)		Consensus rating low likelihood (5 cases)	
	High likelihood	Low likelihood	High likelihood	Low likelihood
Specialist group	48	5	4	35
Other groups	102	27	10	83
t Value (one sided p Value)	1.85 (0.05)		0.85 (<0.05)	

be reliably assessed and that agreement can be achieved among professionals. Whereas most professionals can spot low likelihood cases on video, specific experience in conducting these interviews gives greater accuracy in picking out higher likelihood cases.

In this experimental situation, child sexual abuse was assessed on the artificial basis of only the interview with the child. However, considerable emphasis is already placed on the interview with the child, and this will increase with the introduction of video recorded assessments in criminal as well as civil cases. Such interviews should be carried out by experienced professionals who are trained to perform the interviews.⁶

Validation of medical history taking as part of a population based survey in subjects aged 85 and over

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Observed differences between information obtained by medical history taking and from medical records of general practitioners for 60 subjects aged 85 or over. Figures are number (percentage) of diagnoses

Diagnoses	Total	Reported by general practitioner and in study	Reported by general practitioner alone	Reported in study alone
Surgery	89	64 (72)	17 (19)	8 (9)
Infections	19	4 (21)	11 (58)*	4 (21)
Tuberculosis	5	4 (80)		1 (20)
Pneumonia	8	7 (88)	1 (12)	
Chronic obstructive airways disease	14	10 (71)	3 (21)	1 (7)
Malignancies	12	8 (67)	4 (33)*	
Cerebrovascular accident	9	7 (78)	1 (11)	1 (11)
Angina pectoris	13	9 (69)	3 (23)	1 (8)
Myocardial infarction	9	7 (78)	1 (11)	1 (11)
Claudication	6	2	2	2
Hypertension	21	17 (81)	3 (14)	1 (5)
Heart failure	11	7 (64)	4 (36)*	
Osteoporosis	6	4 (67)	2 (33)	
Fractures	11	6 (55)	5 (45)*	
Arthrosis	12	6	4 (33)	2 (17)
Non-insulin dependent diabetes	13	7 (54)	3 (23)	3 (23)
Depression	3	1	2	
Dementia	13	9 (69)		4 (31)*
Visual impairment	30	11 (37)	1 (3)	18 (60)*
Hearing impairment	25	10 (40)	1 (4)	14 (56)*
Urinary incontinence	16	1 (6)	1 (6)	14 (88)*

*For this disorder one category scores considerably better than the other on χ^2 testing.

This research indicates that it may also be necessary for such professionals to assess video recorded interviews carried out by others in order to help courts to determine the likelihood of abuse having occurred.

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by medical history taking in subjects aged 85 and over has not been investigated to date. With the expected growth of this particular age group in the next decades, a significant part of gerontological-epidemiological research is directed at this group.

This study arose from a need to assess the validity of information obtained by medical history taking as part of a study of the total cohort of Dutch residents aged 85 and over in Leiden.

Subjects, methods, and results

The total cohort of residents aged 85 and over on the entry date of 1 December 1986 comprised 1259 subjects. Of these, 977 were visited at home by an internist (222 had died before they could be visited and 60 refused). All had a medical history taken and the minimal state examination performed.⁴

The medical history from 60 participants chosen randomly from four general practices was compared with the medical record of the general practitioner. Their age and sex distributions and examination scores did not differ significantly from those of the total study population (n=977) by χ^2 analysis. The distribution of the prevalences of the investigated disorders did not differ between the selected participants and the total study population. Three categories were distinguished for the most frequently occurring diagnoses and disorders: diagnoses and disorders reported both by the general practitioner and in this study, those reported by only the general practitioner, and those reported in only this study (table). For most diagnoses there was a good agreement. The general practitioners' record was more complete for some infectious diseases, malignancies, and heart failure. Urinary incontinence, visual and hearing impairments, and dementia were more frequently detected in this study.

Comment

In almost a third of all cases of dementia the diagnosis was not registered by the general practitioner, confirming the results of O'Connor *et al*, who found that general practitioners correctly identified about 60% of all cases of dementia.⁵ The fact that many of the cases of sensory impairment, urinary incontinence, and dementia in patients were not known to their general practitioner should provide a strong incentive