



Concordance between telephone survey classification and face-to-face structured clinical interview in the diagnosis of generalized anxiety disorder in Hong Kong

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ABSTRACT

Telephone surveys of estimating mental disorders have been found to generate comparable findings to large-scale community surveys but the concordance between telephone instruments and clinical interviews is rarely examined. In this study, 100 Chinese respondents who had taken part in a telephone-based population survey of generalized anxiety disorder (GAD) in Hong Kong were administered the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I) by clinical interviewers. The discriminability and predictive indicators of the telephone survey instrument were assessed using receiver operating characteristic analysis. Results showed that the telephone survey instrument identified individuals with a positive SCID diagnosis of GAD better than those without. Although its individual questions performed well in identifying the endorsement of the corresponding core SCID criterion of GAD, further studies are needed to find out the optimal combination of questions in the telephone instrument for identifying GAD in community surveys.

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1. Introduction

Although telephone interviewing has steadily replaced face-to-face interviewing for survey data collection, such a shifting of research mode has occurred to a lesser extent in the field of psychiatric epidemiology (Holbrook, Green, & Krosnick, 2003). Widely cited community psychiatric surveys are still based on face-to-face structured interviews and have been mostly carried out in Western societies that can afford this mode of research. Notwithstanding certain inherent limitations, telephone surveys of mental disorders confer several advantages such as affordability, quick turnaround time, wide geographic

coverage, anonymity and, arguably, facilitation of disclosure about stigma-sensitive information (Evans, Kessler, Lewis, Peters, & Sharp, 2004; Fenig, Levav, & Kohn, 1993; Ohayon & Hong, 2006; Rohde, Lewinsohn, & Seeley, 1997). Therefore, it is worthwhile to explore their utility in scenarios where face-to-face interviews are not feasible, such as middle and low income countries with scarce resources for mental health research (Sharan, Levav, Olifson, de Francisco, & Saxena, 2007).

Although some researchers believed that survey satisficing and social desirability bias were more likely to occur during telephone than face-to-face interviewing (Holbrook et al., 2003), various psychiatric studies found good agreement between both modes of interviewing when the same instruments for assessment were used (Allen, Cull, & Sharpe, 2003; Aziz & Kenford, 2004; Brar et al., 2002; Evans et al., 2004; Fenig et al., 1993; Kobak et al., 1997; Pridemore, Dampousse, & Moore, 2005;

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Wells, Burnman, Leake, & Robins, 1988). Nonetheless, these studies, mostly carried out in the U.S., were often based on small clinical samples of patients who were familiar with the researchers. They also tended to use rating scales instead of algorithm-based diagnostic instruments that could identify specific mental disorders. Consequently, although these studies demonstrated reliability of the methods used, they were less relevant for methodological comparison in the context of large-scale telephone surveys, especially in non-U.S. populations.

Population-based telephone surveys of mental disorders were fewer in number than clinical studies, and their results were usually not reappraised by subsequent face-to-face interviews. Nonetheless, such surveys as conducted in Western communities generally revealed prevalence estimates comparable to those of surveys using face-to-face structured interviews (Eisen et al., 2004; Ohayon, 2007; Ohayon, Priest, Guilleminault, & Caulet, 1999). The situation for Asian communities, however, appeared different. For example, although most face-to-face surveys using structured diagnostic schedules in Chinese communities showed very low rates of mental disorders (Chen et al., 1993; Shen et al., 2006), several telephone surveys of anxiety and depressive disorders in Hong Kong have revealed prevalence estimates comparable to those found in Western societies (Lee, Tsang, & Kwok, 2005, 2007a, b). Likewise, with a high participation rate of 91.4%, a telephone survey of the general population in South Korea revealed that major depressive disorder was significantly more common than what was found in previous Korean surveys based on the face-to-face mode of interviewing (Ohayon & Hong, 2006). Authors of these Asian surveys speculated that the anonymity of telephone interviewing could reduce stigma, thereby facilitating symptom expression and more accurate prevalence estimates to be found. This possibility is of cross-cultural interest given that psychiatric stigma is severe in Asian societies (Yang et al., 2007). In contrast to several studies showing that Western people often would prefer face-to-face over telephone interviews (Evans et al., 2004; Holbrook et al., 2003), stigma may render Asian people less tolerant of face-to-face interview with “strangers” in their home than telephone survey. Nonetheless, the suggestion remains speculative until the validity of diagnoses made from the telephone instruments is substantiated by clinical reappraisal interviews. In fact, the alternative possibility that telephone surveys over-estimate the prevalence of common mental disorders in Asian communities cannot be ruled out.

One reason for the frequent failure to examine the validity of telephone survey instruments used in general population surveys is the practical difficulty of re-contacting the respondents with no prior relationship to the researchers for subsequent face-to-face interviews. Telephone surveys are typically anomalous and brief. Respondents are not as personally engaged as during face-to-face interviews and usually do not expect, or presumably prefer not, to be re-contacted. In the present study, we attempt to overcome this difficulty by re-interviewing in-person a sub-sample of the same respondents who previously took part in a telephone-based general population survey of generalized anxiety disorder

(GAD) in Hong Kong. Our primary aim is to examine the concordance between telephone survey classification and face-to-face structured clinical interview diagnosis of GAD in the context of a large epidemiological survey.

2. Method

Hong Kong has a population of 6.9 million people and 96.3% of its 2,198,000 households have one or more telephones (Hong Kong Census and Statistics Department, 2005). Using a telephone-based methodology similar to a previous survey of GAD in Hong Kong which had not included a second phase of face-to-face clinical interview (Lee et al., 2007a), data collection for the present telephone survey was completed during July 10–21, 2006. Two thousand and five respondents were successfully interviewed (949 male and 1056 female; age distribution in years: 15–24 [17.5%], 25–34 [20.2%], 35–44 [25.4%], 45–54 [23.3%], 55–65 [13.7%]; mean = 39.2 years), giving a participation rate of 66.6%. All participants were ethnic Chinese (95.0% of people in Hong Kong were ethnic Chinese at that time; Hong Kong Census and Statistics Department, 2005). Following the phone survey, we selected a sub-sample of the 2005 participants who participated in the survey and administered face-to-face assessment using the non-patient research version of the Structured Clinical Interview for DSM-IV Axis I Disorders (First, Spitzer, Gibbon, & Williams, 2002). Their responses in this assessment were compared to their responses in the telephone survey.

The ethics review board of The Chinese University of Hong Kong approved the study. An independent survey research organization, the Hong Kong Institute of Asia-Pacific Studies of The Chinese University of Hong Kong, was commissioned to conduct the telephone survey. The 42 interviewers consisted of university students who had 1–3 years of part-time experience in telephone interviews, including community epidemiological surveys of mental disorders such as GAD (Lee et al., 2007a). For the purpose of the present study, they were given a briefing session to familiarize themselves with the questions and skills for eliciting the symptoms of GAD. Telephone respondents were courteously invited to participate in a survey on emotional health and were assured of confidentiality. They were asked to give verbal consent before a phone interview began.

At the end of the telephone interview, interviewers asked successfully interviewed respondents whether they would consent to a subsequent face-to-face interview conducted by clinicians. Respondents who expressed such an interest were asked to provide their telephone numbers.

We re-interviewed 100 respondents owing to time and financial constraint. Anticipating a low base rate of GAD in the community and a potentially high rate of refusal for re-interview, we did not take a random sub-sample of survey respondents according to the estimated proportion of cases in the community. Instead, from the 459 respondents who consented, we over-sampled those respondents classified as having GAD to undergo face-to-face interviews. The over-sampling was done by selecting those respondents classified as having GAD according to DSM-IV-TR (American Psychiatric Association, 2004). There were 22 respondents thus classified and willing to

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