Video Interviewing and Observed Differences in Mental Health Outcomes

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Abstract

The integration of video interviewing in survey research is relatively new and may offer similar benefits as telehealth visits in mental health research. Methodological evaluations of video interviewing are needed for large-scale surveys. Over 3,000 clinical interviews were conducted by video and over 1,500 by phone for a national study of U.S. adults, the Mental and Substance Use Disorders Prevalence Study (MDPS). Sociodemographic differences were observed among those who completed a clinical interview by video compared to phone respondents. Higher prevalence rates of all disorders, with the exception of schizophrenia spectrum disorders, were found for video respondents. Higher prevalence rates of generalized anxiety disorder (video 11.3% vs. 8.0%, $p < .05$), bipolar 1 (2.1% vs. 0.7%, $p < .05$) and obsessive compulsive disorder (OCD; 3.1% vs. 1.5%, $p < .05$) were observed among those completing an interview by video compared to those interviewed by phone. Individual logistic regression models were calculated for each disorder adjusting for sociodemographic characteristics to assess the difference in prevalence rate by mode of interview. Respondents interviewed by video had higher odds of having bipolar 1 (OR = 2.96, 95% CI [1.42, 6.17]), OCD (OR = 2.16, 95% CI [1.20, 3.90])and having two or more mental health disorders (OR = 1.64, 95% CI [1.23, 2.19]) than those interviewed by phone after adjusting for sociodemographic characteristics. While further investigation using experimental approaches is required, video interviewing may improve the ability to detect mental health conditions in large-scale survey research.

Keywords: video interviewing, mental health, prevalence, data collection, national survey, clinical interview

Because the use of video interviewing is new to large-scale survey data collection, it lacks the methodical study and evaluation that has been applied to other modes of data collection. The COVID-19 pandemic changed video interviewing from an option to a necessity for many surveys. Survey researchers and methodologists have used video interviewing as an alternative or supplement to in-person interviewing (Anderson, 2008; Jeannis et al., 2013), but its successful use during the COVID-19 pandemic proved it to be a viable mode for collecting data while face-to-face interviewing was not an option (Joshi et al., 2020; McClain et al., 2021; Thunberg & Arnell, 2021).

The Mental and Substance Use Disorders Prevalence Study (MDPS) is a national epidemiological survey of U.S. adults conducted between 2020 and 2022 designed to estimate the prevalence of serious mental and substance use disorders among adults in the United States. This study is the largest implementation of video interviewing in a national probability-based survey, as the pandemic started just a few months before data collection was scheduled to begin. Video interviewing was planned as an option, but it became the main mode for clinical interviews.

In many ways, video interviewing mimics telehealth visits, which also increased during the pandemic and have continued to be widely used for medical visits (Shaver, 2022). Telehealth visits and assessments can be especially beneficial for health conditions in which a visual assessment is critical to the overall diagnosis, such as mental health assessments. Telehealth and video interviewing allow for the assessment of behaviors, physical appearance, and potential physical manifestations commonly exhibited with some mental health conditions. Examples include motor activity (psychomotor agitation), grooming (dishevelment), and affect (a limited affect is sometimes seen in individuals with schizophrenia). There is substantial evidence that such assessments, including the *Structured Clinical Interview for the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (SCID-5®; First et al., 2015), a semi-structured clinical inter-

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Notes

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view for psychiatric diagnosis, have equivalent reliability and diagnostic accuracy in video-mediated and in-person assessments (Chakrabarti, 2015). In addition, it has been found that assessment via videoconferencing is well accepted among patients with schizophrenia (Kasckow et al., 2014) and other psychoses (Sharp et al., 2011) as well as by members of hard-to-reach populations (Durrant & Hanson, 2023; Gray et al., 2020; Miller & Gibson, 2004; Schober et al., 2023). However, not all individuals are able to participate in a video interview. Some may not have a smartphone, tablet, or computer; others may not have internet access; and some may not understand how to use the technology required for a video-based interview.

In this paper, we compare outcomes from video and phone interviews conducted in the MDPS, including differences in demographic characteristics and disorder-specific prevalence estimates for those completing a clinical interview by video. Due to the COVID-19 pandemic, close to seventy percent of clinical interviews were conducted by video and one-third by phone as in-person data collection was prohibited during much of the study period. Respondents were encouraged to participate in video-based interviews. However, for respondents who could not or would not participate in this mode, interviews were conducted by phone. Although a formal experiment was not conducted, the MDPS is the largest study to date to implement video interviewing in a national survey offering much needed information on the large-scale feasibility of this mode as well as a comparison of the demographic characteristics and the outcomes of interest attributed to video interviewing.

Methods

Study Design

The MDPS recruited participants from national probability-based samples of households and prisons and from convenience samples of state psychiatric hospitals and homeless shelters (Guyer et al., 2024; Ringeisen et al., 2023), the only probability-based study on serious mental health disorders that includes clinical interviews nationally in the United States. Interviews were conducted with 5,679 participants (4,764 household, 321 prison, 425 homeless shelter, 171 state psychiatric hospital); this paper concerns only the household data as other factors influenced the mode of interview within facilities. Data collection was conducted from October 2020 to July 2022. The MDPS was funded by a grant from the Substance Abuse and Mental Health Services Administration, an agency of the U.S. Department of Health and Human Services. The study protocol and informed consent were reviewed and approved by an external Institutional Review Board external to the research organization and funding agency. The

study methodology and preliminary findings have been published previously (Bareis, et al., 2024; Chwastiak, et al., 2025; Gibbons, et al., 2024; Guyer et al., 2024; Ringeisen et al., 2023), as well as the technical and qualitative outcomes associated with video interviewing (Jayaram et al., 2023b).

The MDPS employed a three-stage design. First, each household in a national probability sample of households was invited to complete a household roster. Next, up to two randomly chosen age-eligible residents in each household were invited to complete a mental health screener. Following the completion of the screener, respondents were categorized based on their likelihood of having a serious mental health disorder (e.g., schizophrenia spectrum disorder) and sampled differentially to complete a clinical interview. Individuals at greater risk of disorders were oversampled as follows: 100% of individuals endorsing psychotic symptoms, 80% of individuals endorsing symptoms of another MDPS mental or substance use disorder, and 20% of all others. The goal of this approach was to increase the number of participants with the rarest disorders to improve the precision and accuracy of prevalence estimates for these disorders. A total of 234,270 households were invited to complete the initial household roster and 4,764 respondents completed a clinical interview. The household roster and the screener could be completed in person or by web, mail, or telephone. Approximately 61% of respondents completed the roster via web, and this substantial reliance on web completion likely aided the video interviewing mode for the third stage, the clinical interview. Mail did not provide a reasonable number of completed roster and screener surveys, but the other two modes did.

Interview Mode

Clinical interviews were conducted by video or phone. Clinical interviewers contacted respondents selected for the clinical interview by email or phone (using an Interactive Intelligence Client Application on their laptop which masked their phone) and requested that they conduct the interview via video. Respondents who indicated they could not participate via video or would be more comfortable with a non-video interview were interviewed via phone (after the interviewer attempted to address technical or other issues raised by the respondent). Video interviews were conducted using Zoom. Clinical interviewers used a laptop and tablet computers to log into the scheduled Zoom meeting and conduct the video-based personal interviews. Zoom was an ideal platform because respondents could join the interview session through a browser without needing to download an app.

Before beginning the interview, the clinical interviewer identified a private location from which they could conduct the interview. This location was separate from shared living or working areas so others could not overhear. Clinical interviewers were required to have a neutral background (i.e., free of political or

religious imagery and other personal items) to avoid biasing the respondent or making them uncomfortable. Clinical interviewers also asked the respondent to find a private location to complete the interview so they would feel comfortable answering the questions honestly and to protect confidentiality. Clinical interviewers used their project tablet to launch and record the Zoom video and used the laptop to administer the clinical interview and record clinical notes. Respondents could join using any device that had a camera, including a smartphone, tablet, laptop, or desktop computer. At the beginning of the interview, clinical interviewers asked respondents for permission to record the interview. If a respondent did not give consent to record, the clinical interviewer stopped all recording but continued the interview. During the interview, the clinical interviewer would occasionally screen-share showcards to display a list of response options. If the interview was completed via phone, the clinical interviewer would direct the respondent to the showcards emailed to them or to the project website where the showcards were available.

Clinical Interview

The MDPS was designed to estimate the past-year prevalence of common and rare mental health disorders, including generalized anxiety disorder (GAD), major depressive disorder (MDD), obsessive compulsive disorder (OCD), posttraumatic stress disorder (PTSD), anorexia nervosa, bipolar 1, and schizophrenia spectrum disorders (SSDs). The clinical interview consisted of basic demographic questions; the NetSCID, a computerized version of the MDPS SCID-5 clinical interview (Brodey et al., 2016), questions on mental health treatment, an assessment of the severity of the disorder, and questions on the impact of the COVID-19 pandemic on mental health status and treatment.

The SCID-5 (First et al., 2015) is designed to be delivered by trained clinicians (e.g., social workers, psychologists, psychiatrists) who are experienced with diagnostic interviewing and the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5). Minimum qualifications for MDPS clinical interviewers included a graduate degree and training in a relevant field (e.g., psychology, psychiatry, social work) and clinical experience administering the SCID-5. All clinical interviewers and clinical supervisors completed extensive project training and certification. Clinical interviewers were trained to read the question on the laptop screen and to then view the respondent as they answered. Various quality control measures were conducted throughout data collection, including standardized reviews of recorded interviews, inter-rater reliability exercises with the clinical interviewers, and data quality checks. Quality control measures have been described elsewhere (Guyer et al., 2024; Ringeisen et al., 2023).

Statistical Analysis

Analyses were conducted to explore differences in demographic characteristics and disorder-specific prevalence estimates by mode of interview. First, the demographic characteristics of those completing the clinical interview by video vs. phone were compared. Demographic characteristics were assessed and included age group, sex, race/ethnicity, education, region, and urbanicity. Next, the weighted prevalence estimate of each disorder was compared for those completing the interview by video vs. by phone. The methods for calculating the MDPS prevalence estimates have been described in detail elsewhere (Guyer et al., 2024; Ringeisen et al., 2023). Finally, separate logistic regression models were calculated for each mental health disorder, with the disorder of interest as the dependent variable (yes/no) and mode as the independent variable (video compared with phone) along with the demographic covariates. This allowed for comparisons of key disorder outcomes by mode, after controlling for any demographic differences. Descriptive statistics and chi-squared tests were conducted to explore the differences by mode in respondent demographic characteristics. Unweighted counts and weighted percentages are presented; analyses were weighted for the complex sample design. Odds ratios and 95% confidence intervals (CIs) were calculated using logistic regression. All analyses were completed using SAS v9.4.

Results

Interview Mode and Mental Health Outcomes

The demographic characteristics for those who completed the clinical interview by phone and by video are shown in Table 1. Compared to those interviewed by phone, respondents who agreed to complete the interview by video were more likely to be younger (44 years or younger vs. 45 years or older), identify as non-Hispanic White or Asian rather than Hispanic or non-Hispanic Black, have a college education, have a higher income ($75,000 or higher), and live in an urban area.

Table 2 shows the disorder-specific prevalence estimates overall and by mode of interview. Higher prevalence estimates were found for those interviewed by video for all disorders except past-year and lifetime SSDs. Significantly higher prevalence rates of GAD (11.3% vs. 8.0%, $p < .05$), bipolar 1 (2.1% vs. 0.7%, $p < .05$), and OCD (3.1% vs. 1.5%, $p < .05$) were found among those completing a video interview compared to those interviewed by phone. Additionally, a 60% increase in the prevalence of having two or more MDPS mental health disorders was observed among those completing a video interview (9.3% vs. 5.8%, $p < .001$).

Table 1 Sociodemographic characteristics, by mode of clinical interview

Respondent characteristics	Video (*n* = 3,178)		Phone (*n* = 1,586)	
	N	%	*N*	%
Age*				
18–25	433	19.9	177	12.2
26–44	1,575	45.6	641	36.6
45–65	1,170	34.5	768	51.2
Sex				
Male	1,200	48.6	604	49.4
Female	1,978	51.4	982	50.6
Race/ethnicity*				
Hispanic or Latino	392	13.9	320	25.1
White, not Hispanic	2,189	65.2	897	51.6
Black or African American, not Hispanic	241	10.3	216	15.8
Asian, not Hispanic	197	5.8	65	2.3
American Indian or Alaska Native, not Hispanic	23	0.4	14	0.5
Native Hawaiian or other Pacific Islander, not Hispanic	5	0.2	5	0.1
Multi-racial, not Hispanic	129	4.2	69	4.6
Education*				
Less than a high school diploma	67	6.5	121	16.1
High school degree or equivalent	314	20.7	332	35.2
Some college or associate's degree	845	31.1	534	32.1
Bachelor's degree	1,057	27.3	334	10.2
Post-college/professional degree	895	14.4	265	6.4
Urbanicity				
Urban	2,768	84.1	1,324	79.0
Rural	410	15.9	262	21.0
Income*				
Less than $20,000	350	9.7	369	24.6
$20,000–$49,999	620	23.6	385	24.4
$50,000–$74,999	510	13.0	219	14.7
$75,000–$99,999	433	12.0	158	7.4
$100,000–$149,999	508	15.5	154	7.5
$150,000 or more	600	19.0	156	8.6
Missing	157	7.2	145	12.8

Notes: *$p \leq .001$; all percentages are weighted for the complex sample design.

Table 2 Mental health disorder prevalence estimates, by mode

MDPS disorders (past-year unless otherwise indicated)	All (*n* = 4,764)		Video (*n* = 3,178)		Phone (*n* = 1,586)		
	N	%	*N*	%	*N*	%	*p*-value
Mental health disorders							
Schizophrenia or schizoaffective disorder	73	1.2	32	0.9	41	1.6	.124
Schizophrenia or schizoaffective disorder (lifetime)	114	1.8	50	1.5	64	2.2	.265
Major depressive disorder	1,213	15.4	846	16.2	367	14.1	.317
Generalized anxiety disorder	855	10.0	623	11.3	232	8.0	.042
Bipolar 1	127	1.5	91	2.1	36	0.7	.024
Posttraumatic stress disorder	320	4.0	218	4.4	102	3.4	.326
Obsessive compulsive disorder	209	2.5	154	3.1	55	1.5	.026
Anorexia nervosa	15	0.1	11	0.2	4	0.1	.168
Any MDPS mental health disorder	1,884	24.9	1,293	26.7	591	22.3	.096
Two or more MDPS mental health disorders	731	7.9	525	9.3	206	5.8	<.001

Notes: All percentages are weighted for the complex sample design.

Disorder-specific odds ratios were calculated to further explore the difference in prevalence estimates by mode of interview (Table 3). After adjusting for demographic characteristics, those who completed an interview by video (vs. phone) had significantly higher odds of meeting criteria for bipolar 1 (Odds ratio (OR) = 2.96, 95% CI [1.42, 6.17]) and of meeting criteria for OCD (OR = 2.16; 95% CI [1.20, 3.90]). Additionally, those completing an interview by video were significantly more likely to meet criteria for two or more MDPS mental health disorders than those interviewed by phone, after adjusting for demographic characteristics (OR = 1.64; 95% CI [1.23, 2.19]). Appendix Table A1 provides the full set of outcomes for each disorder-specific logistic regression model including the odds ratios for the sociodemographic characteristics included in each model.

Table 3 Association of interview mode with each MDPS mental health disorder

Mental health disorder model (past-year unless otherwise indicated)	Adjusted odds ratios*	Lower CI limit	Upper CI limit	*p*-value
Schizophrenia spectrum disorders (SSDs)	0.80	0.31	2.06	.642
SSDs (lifetime)	1.07	0.48	2.39	.868
Major depressive disorder (MDD)	1.03	0.75	1.40	.876
Generalized anxiety disorder (GAD)	1.17	0.84	1.65	.350
Bipolar 1	2.96	1.42	6.17	.004
Posttraumatic stress disorder (PTSD)	1.35	0.82	2.23	.232
Obsessive compulsive disorder (OCD)	2.16	1.20	3.90	.011
Any MDPS mental health disorder	1.12	0.85	1.47	.418
Two or more MDPS mental health disorders	1.64	1.23	2.19	.001

Notes: CI = confidence interval.
* Odds ratios for each health disorder-specific model were adjusted for age group, sex, race/ethnicity, education, income, region, and urbanicity. Odds ratios are shown for video interviewing mode with phone mode as the reference category. Higher odds ratios indicate increased likelihood of participating in video interview.

Respondent and Interviewer Experience in Video Interviews

Additionally, clinical interviewers provided positive feedback about video interviews, with approximately 81% reporting that the functionality of the video interviewing process was excellent, 91% of respondents did not have technical difficulties with Zoom, and 93% did not get disconnected during the interview. Clinical interviewers also indicated that 91% of the interviews had very good/good visual quality and visual observations were used in making diagnoses in about 71% of cases where the respondent had at least one mental health disorder. Respondent feedback on video interviewing was positive as well; 90% of video respondents indicated they were comfortable completing the interview by video (which was comparable with other modes), and 94% indicated they were very comfortable or comfortable using Zoom. Similar positive feedback was found in studies conducted by the Australian Bureau of Statistics (Phillips et al., 2023).

Discussion

The MDPS experience provides the opportunity to better understand the potential differences the relatively new mode of video interviewing may introduce.

MDPS respondents interviewed by video tended to be younger, identify as a non-minority race/ethnicity, and have higher levels of education and income than those interviewed by phone. Significantly higher prevalence estimates of GAD, bipolar 1, OCD, and two or more MDPS mental health disorders were found in those interviewed by video compared to those interviewed by phone. To account for differences in the non-random assignment to mode, estimates were examined after adjusting for the sociodemographic characteristics: higher rates of these disorders remained significant among those interviewed by video with the exception of GAD. Respondents interviewed by video were almost 3 times more likely to meet criteria for bipolar 1, more than twice as likely to meet criteria for OCD, and almost 2 times more likely to meet criteria for two or more MDPS mental health disorders than those interviewed by phone. Consequently, differences by mode found in our study are not simply an artifact of the differences in sample composition between modes. The video mode likely helps with identification of serious mental illnesses as interviewers are able to observe the respondent's behavior, compared to telephone. Finding higher rates of diagnoses in the video mode after controlling for demographic characteristics helps to support this finding. However, this was not an experimental design and it is possible that those who are interviewed by telephone are also less likely to have serious mental illnesses.

Video interviewing enabled clinical interviewers to assess the behaviors, physical appearance, and potential physical manifestations commonly exhibited with some of the disorders of interest. It was initially planned to detect typical symptoms of SSDs that can be observed visually by trained clinicians and to accommodate potential respondents with paranoia, which is another common symptom among those with SSDs. However, the odds of meeting the criteria for SSD were no higher in video than phone interviews. Nonetheless, the odds of meeting the diagnostic criteria were higher for those who completed an interview by video for disorders whose detection was not thought, a priori, to rely on visual observation. Although this finding may be somewhat surprising from a clinical observation perspective, it is not surprising when comparing interviews in which the interviewer can see the respondent's face (i.e., video) to phone interviews. Highly skilled and extensively trained interviewers observed (and took into account) respondent behaviors during the average 77-minute video-based clinical interview that were helpful in making these diagnoses (e.g., rearranging objects to ensure a specific order or symmetry, restlessness). It could also be that video interviewing enabled development of a stronger rapport between respondent and interviewer, which could have resulted in the respondent feeling more comfortable disclosing information. Video interviewing appears to be most beneficial in detecting the less impairing mood and mania disorders compared to SSDs.

The inclusion of the telephone mode helped to bring in more respondents from underrepresented groups than the video mode: Hispanic, non-Hispanic Black respondents, those with a high school education or less, and those with lower income. However, if the lower prevalence rates in the telephone mode are the result of lower levels of rapport between interviewers and respondents and because the telephone interviewers cannot observe respondents visually, then including the phone interview data in the overall prevalence estimates may introduce measurement error despite its reducing nonresponse bias among certain subgroups. This is a tradeoff researchers will have to navigate.

A warranted concern with video interviewing is whether some respondents are less likely to participate, increasing coverage error for some subgroups: this mode requires internet access, a video-capable device, willingness to participate in a video interview, and a private location. Such mode differences in coverage could introduce bias into the estimates. We found that those who completed the clinical interview by video were more likely to be younger, to be non-Hispanic White or Asian, and to have a higher socioeconomic status (education and income). These differences were statistically significant, whereas significant differences were not observed by sex or urbanicity. Dulaney et al. (2023) reported similar findings among video respondents for the Medical Expenditure Panel Survey: video respondents tended to be younger, college educated, female and White. Higher response to video-based interviewing compared to in-person interviewing among those with higher socioeconomic status has also been observed on the European Social Survey (Hanson et al., 2023; Martin & Fradier, 2023; Thórólfsson et al., 2023). These analyses highlight the importance of considering under-representation when video is the only mode offered. Additionally, these analyses highlight the benefits of offering another mode, such as phone, to improve representation and coverage.

Data quality is an important consideration when introducing a new mode of data collection. Previous studies have reported that video interviewing has positively affected—or at least has not harmed—data quality compared to in-person interviews, possibly due to the opportunity for the respondent to develop a similar level of rapport with the interviewer in both interview modes (Sanchez et al., 2023; Sun et al., 2021). In comparison of the quality of video interviews and in-person interviews, Kelley et al. (2023) found no strong evidence of measurement effects introduced by video. But comparisons of data quality between video interviews and data collection in other modes are relatively rare. One relevant study was conducted by Conrad et al. (2023) who compared Live Video Interviewing to Web Surveys and Prerecorded Video interviews. They reported that Live Video interviewing produced higher quality in some areas (e.g., less non-differentiation) but lower data quality in other areas (e.g., more rounded numerical responding, more socially desirable responding, i.e., fewer sensitive responses).

The MDPS was designed as a pilot, or feasibility study, to determine national prevalence estimates of serious mental health and substance use disorders among U.S. adults. Many novel aspects of the study are true strengths, especially its use of video interviewing: a national sample of households were included in the study, providing a broad range of generalizable findings; video interviewing provided increased scheduling flexibility for both interviewers and respondents; and video interviewing allowed the study to be conducted during the COVID-19 pandemic rather than halting all data collection efforts. However, there are several limitations of this study as a vehicle for studying and evaluating video interviewing. First, the MDPS was not designed to evaluate mode differences at any stage, specifically not for a comparison of clinical interviews conducted by video with those conducted by phone. Respondents were not randomly assigned to the two modes which led to differently composed samples in the two modes. Second, the MDPS was conducted during the COVID-19 pandemic, which likely influenced study outcomes. For example, had in-person data collection been available, fewer sample members might have elected to participate in video interviews. Finally, video interviewing as an interview mode was available only to households with internet access, those with access to a phone or computer, and those who were comfortable using the video software. Sample members without these characteristics could well have exhibited mental health and substance use disorders at different rates than those who were able to participate by video.

Video interviewing offers many of the benefits of in-person interviewing, such as respondents developing rapport with the interviewer and enabling interviewers to incorporate a visual appraisal of the respondent and their surroundings into their clinical assessment, at a lower cost than with in-person observation. The substantial increase in video interviewing during the pandemic led to rapid integration with little time for thorough investigation of the mode differences prior to beginning data collection. However, many lessons were rapidly learned. Although video interviewing was conducted successfully on the MDPS, our results highlight the need for controlled experiments to estimate any mode effects due to video interviewing. Further investigations of the impact of video interviewing on participation, data quality, and estimates of substantive outcomes will help inform researchers' choice of data collection mode when the options include video interviewing.

References

Anderson, A. H. (2008). Video-mediated interactions and surveys. In F. G. Conrad & M. F. Schober (Eds.), *Envisioning the survey interview of the future* (pp. 95–118). Wiley. https://doi.org, https://doi.org/10.1002/9780470183373.ch5

Bareis, N., Olfson, M., Dixon, L. B., Chwastiak, L., Monroe-Devita, M., Kessler, R. C., Gibbons, R. D., Edlund, M., Guyer, H., Kreski, N. T., Graupensperger, S., Winans, K. S., & Stroup, T. S. (2024). Clinical characteristics and functioning of adults with bipolar I disorder: Evidence from the mental and substance use disorders prevalence study. *Journal of Affective Disorders, 366*, 317–325. https://doi.org/10.1016/j.jad.2024.08.133

Brodey, B. B., First, M., Linthicum, J., Haman, K., Sasiela, J. W., & Ayer, D. (2016). Validation of the NetSCID: An automated web-based adaptive version of the SCID. *Comprehensive Psychiatry, 66*, 67–70. https://doi.org/10.1016/j.comppsych.2015.10.005

Chakrabarti, S. (2015). Usefulness of telepsychiatry: A critical evaluation of videoconferencing-based approaches. *World Journal of Psychiatry, 5*(3), 286–304. https://doi.org/10.5498/wjp.v5.i3.286

Chwastiak, L., Graupensperger, S., Ringeisen, H., Edlund, M., Guyer, H., Bareis, N., Monroe-Devita, M., Dixon, L. B., Stroup, T. S., Swanson, J., Swartz, M., Hancq, E., Gibbons, R., Kessler, R. C., & Olfson, M. (2025). Impact of insurance type on outpatient mental health treatment of US adults. *PLOS Mental Health, 2*(5), 1–15. https://doi.org/10.1371/journal.pmen.0000299

Conrad, F. G., Schober, M. F., Hupp, A. L., West, B. T., Larsen, K. M., Ong, A. R., & Wang, T. (2023). Video in survey interviews: Effects on data quality and respondent experience. *methods, data, analysis, 17*(2), 135–170. https://doi.org/10.12758/mda.2022.13

Dulaney, R., Kelley, J., Arrue, J., & Edwards, B. (2023, July). *Who is choosing video interviewing? A look into respondent characteristics of video adopters* [Conference presentation]. European Survey Research Association Conference, Milan, Italy.

Durrant, G., & Hanson, T. (2023, July). *Video-assisted personal interviewing: Opportunities and challenges* [Conference presentation]. European Survey Research Association Conference, Milan, Italy.

First, M. B., Williams, J. B. W., Karg, R. S., & Spitzer, R. L. (2015). *Structured clinical interview for DSM-5—Research version (SCID-5 for DSM-5, research version; SCID-5-RV) 1–94*. American Psychiatric Association.

Gibbons, R. D., Olfson, M., Saulsberry, L., Edlund, M. J., Zangeneh, S., Bareis, N., Chwastiak, L., Gibbons, J. B., & Kessler, R. C. (2024). Social vulnerability and prevalence and treatment for mental health and substance use disorders. *JAMA Psychiatry, 81*(10), 976–984. https://doi.org/10.1001/jamapsychiatry.2024.1870

Gray, L., Wong-Wylie, G., Rempel, G., & Cook, K. (2020). Expanding qualitative research interviewing strategies: Zoom video communications. *The Qualitative Report, 25*(5), 1292–1301. https://doi.org/10.46743/2160-3715/2020.4212

Guyer, H., Ringeisen, H., Dever, J., Liao, D., Peytchev, A., Carr, C., Geiger, P., Stambaugh, L., Smith, T., Dixon, L., Olfson, M., First, M., Stroup, S., Chwastiak, L., Monroe-Devita, M., Swanson, J., Swartz, M., Kessler, R. C., Gibbons, R., … the MDPS Consortium. (2024). Mental and Substance Use Disorders Prevalence Study: Background and methods. *International Journal of Methods in Psychiatric Research,* 33(1), Article e2000. https://doi.org/10.1002/mpr.2000

Hanson, R., Briceno-Rosas, R., & Mitchell, J. (2023, July). *Video interviewing on the European Social Survey* [Conference presentation]. European Survey Research Association Conference, Milan, Italy.

Jayaram, P., Filippenko, L. V., Spain, C. J., Check, M. L., Reed, W., Carr, C. M., Guyer, H., & Suresh, R. (2023, October). *Video interviewing: An optimal solution for a national behavioral health survey* [Paper presentation]. International Blaise Users Conference, Durham, NC. https://blaiseusers.org/2023/papers/5_2.pdf

Jeannis, M., Terry, T., Heman-Ackah, R., & Price, M. (2013). Video interviewing: An exploration of the feasibility as a mode of survey application. *Survey Practice, 6*(1), 1–5. https://doi.org/10.29115/sp-2013-0001

Joshi, A., Bloom, D. A., Spencer, A., Gaetke-Udager, K., & Cohan, R. H. (2020). Video interviewing: A review and recommendations for implementation in the era of COVID-19 and beyond. *Academic Radiology, 27*(9), 1316–1322. https://doi.org/10.1016/j.acra.2020.05.020

Kasckow, J., Felmet, K., Appelt, C., Thompson, R., Rotondi, A., & Haas, G. (2014). Telepsychiatry in the assessment and treatment of schizophrenia. *Clinical Schizophrenia & Related Psychoses, 8*(1), 21–27A. https://pubmed.ncbi.nlm.nih.gov/23428781

Kelley, J., Edwards, B., Dulaney, R., & Arrue, J. (2023, July). *Evaluating potential mode effects in video interviewing* [Conference presentation]. European Survey Research Association Conference, Milan, Italy.

Martin, L., & Fradier, Y. (2023, July). *CAVIsio ESS response* [Conference presentation]. European Survey Research Association Conference, Milan, Italy.

McClain, C., Vogels, E. A., Perrin, A., Sechopoulos, S., & Rainie, L. (2021). *The internet and the pandemic*. Pew Research Center. https://www.pewresearch.org/internet/2021/09/01/the-internet-and-the-pandemic

Miller, R., & Gibson, A. M. (2004). Supervision by videoconference with rural probationary psychologists. *International Journal of Innovation in Science and Mathematics Education, 11*(1), 22–28. https://www.proquest.com/docview/2248418855?pq-origsite=gscholar&fromopenview=true&sourcetype=Scholarly%20Journals

Phillips, B., Neiger, D., Slamowicz, S., Lester, G., Luddon, S., Farrell, E., Gerlach, K., & Carmo, P. (2023, July). *Video-assisted live interviewing in comparison to other survey methods in Australia* [Conference presentation]. European Survey Research Association Conference, Milan, Italy.

Ringeisen, H., Edlund, M. J., Guyer, H., Geiger, P., Stambaugh, L., Dever, J., Liao, D., Carr, C., Peytchev, A., Reed, W., McDaniel, K., & Smith, T. (2023). *Mental and Substance Use Disorders Prevalence Study (MDPS): Findings report*. RTI International. https://www.rti.org/publication/mental-substance-use-disorders-prevalence-study-findings-report

Sanchez, C., Brown, M., Taylor, K., Spencer, S., Englefield, L., & Pun, B. (2023, July). *Experience of video interviewing in two UK national cohort studies* [Conference presentation]. European Survey Research Association Conference, Milan, Italy.

Schober, M. F., Conrad, F. G., Hupp, A. L., Larsen, K. M., Ong, A. R., & West, B. T. (2020). Design considerations for live video survey interviews. *Survey Practice, 13*(1), 1 – 11. https://doi.org/10.29115/sp-2020-0014

Schober, M. F., Okon, S., Conrad, F. G., Hupp, A. L., Ong, A. R., & Larsen, K. M. (2023). Predictors of willingness to participate in survey interviews conducted by live video. *Technology, Mind, and Behavior, 4*(2). https://doi.org/10.1037/tmb0000100

Sharp, I. R., Kobak, K. A., & Osman, D. A. (2011). The use of videoconferencing with patients with psychosis: A review of the literature. *Annals of General Psychiatry, 10*(1), Article 14. https://doi.org/10.1186/1744-859X-10-14

Shaver, J. (2022). The state of telehealth before and after the COVID-19 pandemic. *Primary Care, 49*(4), 517–530. https://doi.org/10.1016/j.pop.2022.04.002

Sun, H., Conrad, F. G., & Kreuter, F. (2021). The relationship between interviewer-respondent rapport and data quality. *Journal of Survey Statistics and Methodology, 9*(3), 429–448. https://doi.org/10.1093/jssam/smz043

Thórólfsson, A., Jónsdóttir, G., Hjaltason, A., & Guðmundsson, H. (2023, July). *Mode effects of video interviewing as a proxy of face-to-face interviewing in R10 of ESS in Iceland* [Conference presentation]. European Survey Research Association Conference, Milan, Italy.

Thunberg, S., & Arnell, L. (2021). Pioneering the use of technologies in qualitative research—A research review of the use of digital interviews. *International Journal of Social Research Methodology, 25*(6), 757–768. https://doi.org/10.1080/13645579.2021.1935565

Appendix

Table A1 Video interviewing and mental health disorders with adjustment by sociodemographic characteristics: Results of independent multivariate logistic regression models with the disorder of interest as the outcome variable

Variable and levels	SSD	SSD-lifetime	MDD	GAD	Bipolar 1	PTSD	OCD	Any	Two or more
Mode: Video	0.80 [0.31, 2.06]	1.07 [0.48, 2.39]	1.03 [0.75, 1.40]	1.17 [0.84, 1.65]	**2.96 [1.42, 6.17]**	1.35 [0.82, 2.23]	**2.16 [1.20, 3.90]**	1.12 [0.85, 1.47]	**1.64 [1.23, 2.19]**
Age: 18–25	0.79 [0.19, 3.35]	0.95 [0.31, 2.87]	**2.34 [1.47, 3.73]**	**3.67 [1.99, 6.79]**	**3.25 [1.56, 6.75]**	2.61 [1.05, 6.50]	**4.76 [2.46, 9.22]**	**3.22 [2.01, 5.13]**	**3.54 [2.37, 5.28]**
Age: 26–44	1.72 [0.72, 4.10]	1.54 [0.75, 3.19]	**1.87 [1.36, 2.57]**	**1.70 [1.25, 2.32]**	1.26 [0.63, 2.54]	**3.52 [2.24, 5.53]**	2.55 [1.37, 4.76]	**2.01 [1.53, 2.65]**	**2.02 [1.52, 2.69]**
Sex: Male	1.78 [0.84, 3.76]	1.33 [0.72, 2.46]	**0.65 [0.50, 0.84]**	**0.52 [0.38, 0.73]**	0.78 [0.39, 1.58]	0.59 [0.32, 1.09]	0.66 [0.40, 1.09]	**0.65 [0.51, 0.83]**	**0.56 [0.40, 0.80]**
R/E: Hispanic	0.30 [0.09, 1.05]	0.46 [0.20, 1.07]	0.59 [0.37, 0.94]	**0.53 [0.39, 0.72]**	0.43 [0.14, 1.28]	0.52 [0.27, 0.97]	0.97 [0.49, 1.92]	**0.49 [0.34, 0.70]**	0.72 [0.44, 1.19]
R/E: Not Hispanic (NH) Black	1.13 [0.38, 3.37]	2.43 [0.71, 8.27]	0.73 [0.44, 1.21]	0.88 [0.50, 1.55]	1.46 [0.34, 6.20]	0.68 [0.30, 1.55]	1.20 [0.47, 3.07]	0.96 [0.61, 1.51]	1.08 [0.55, 2.10]
R/E: NH Multiple	3.20 [0.92, 11.10]	4.04 [1.30, 12.60]	1.20 [0.72, 2.00]	1.99 [0.93, 4.22]	**0.08 [0.02, 0.39]**	0.79 [0.33, 1.87]	2.44 [1.07, 5.59]	1.79 [1.10, 2.89]	1.90 [0.91, 3.98]
R/E: NH Asian, American Indian/ Alaska Native or Native Hawaiian/ Other Pacific Islander	3.96 [0.67, 23.50]	2.98 [0.46, 19.41]	0.82 [0.44, 1.53]	0.62 [0.30, 1.28]	0.30 [0.08, 1.08]	**0.22 [0.10, 0.49]**	0.51 [0.18, 1.50]	0.85 [0.48, 1.51]	**0.37 [0.18, 0.75]**
Education: Less than High School (HS)	**12.65 [2.94, 54.39]**	**5.27 [1.64, 16.95]**	0.71 [0.36, 1.40]	0.55 [0.26, 1.16]	0.14 [0.02, 0.83]	1.67 [0.47, 5.96]	2.76 [1.07, 7.13]	0.70 [0.41, 1.20]	1.16 [0.58, 2.33]
Education: HS or equivalent	**14.39 [4.54, 45.60]**	**10.10 [3.75, 27.22]**	1.13 [0.72, 1.77]	0.45 [0.23, 0.90]	0.53 [0.22, 1.29]	1.71 [0.77, 3.79]	0.88 [0.36, 2.16]	0.77 [0.48, 1.23]	1.06 [0.63, 1.76]
Education: Some college or Associate	**8.24 [3.60, 18.86]**	**5.78 [2.76, 12.09]**	1.12 [0.77, 1.63]	0.77 [0.51, 1.15]	2.88 [0.95, 8.78]	**2.27 [1.21, 4.26]**	1.36 [0.82, 2.26]	0.98 [0.70, 1.38]	1.57 [0.97, 2.54]
INCOME_C4:1 = Less than $50,000	**8.08 [2.12, 30.83]**	**9.05 [3.20, 25.59]**	1.58 [1.05, 2.39]	**2.03 [1.25, 3.29]**	**5.24 [2.36, 11.62]**	2.41 [1.13, 5.12]	1.18 [0.54, 2.58]	**2.39 [1.62, 3.52]**	**1.94 [1.25, 3.01]**
INCOME_C4:2 = $50,000–$99,999	4.34 [0.78, 24.10]	4.62 [1.23, 17.32]	1.57 [1.00, 2.45]	1.47 [0.99, 2.18]	1.47 [0.63, 3.41]	1.47 [0.78, 2.76]	0.89 [0.43, 1.83]	**1.68 [1.15, 2.45]**	1.42 [0.95, 2.12]
INCOME_C4:4 = Missing	**12.99 [2.45, 68.80]**	**13.57 [3.71, 49.65]**	1.43 [0.78, 2.64]	1.44 [0.75, 2.77]	2.82 [0.95, 8.36]	**0.71 [0.27, 1.83]**	2.66 [1.11, 6.37]	**1.97 [1.17, 3.32]**	1.72 [0.87, 3.40]
REGION:1 = Midwest	1.07 [0.39, 2.92]	0.53 [0.18, 1.55]	1.11 [0.76, 1.63]	1.27 [0.80, 2.02]	1.42 [0.54, 3.73]	0.97 [0.40, 2.35]	0.89 [0.47, 1.68]	0.91 [0.62, 1.34]	1.31 [0.81, 2.14]
REGION:2 = Northeast	0.78 [0.18, 3.45]	0.30 [0.05, 1.70]	1.16 [0.74, 1.81]	1.06 [0.69, 1.61]	0.94 [0.32, 2.77]	0.74 [0.35, 1.60]	0.72 [0.34, 1.54]	0.93 [0.63, 1.37]	1.05 [0.67, 1.64]
REGION:3 = South	1.36 [0.46, 3.95]	0.57 [0.17, 1.90]	1.09 [0.72, 1.66]	1.23 [0.86, 1.77]	2.22 [0.78, 6.32]	1.20 [0.48, 2.96]	1.34 [0.76, 2.38]	1.04 [0.73, 1.49]	1.37 [0.90, 2.09]
Urban: Urban	0.86 [0.22, 3.27]	0.96 [0.31, 3.03]	1.46 [1.00, 2.14]	0.69 [0.37, 1.26]	0.70 [0.27, 1.82]	0.71 [0.31, 1.65]	0.66 [0.32, 1.35]	0.90 [0.57, 1.42]	0.83 [0.53, 1.28]

Notes: SSD = Schizophrenia spectrum disorder; MDD = major depressive disorder; GAD = generalized anxiety disorder; PTSD = posttraumatic stress disorder; OCD = obsessive-compulsive disorder; R/E: race/ethnicity; NH: Non Hispanic.
Reference groups: mode = phone, age = 45–65, sex = female, race/ethnicity = NH White, education = Bachelor's degree or higher, income > $100,000, region = west, urbanicity = rural; **Bold:** $p < .01$

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