BRIEF REPORT

“What Should We Talk About?” The Association Between the Information Exchanged During the Mental Health Intake and the Quality of the Working Alliance

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We investigated the association between the content of the information exchanged between clients and therapists during mental health intake and the quality of the therapeutic alliance. Thirty-eight therapists and 107 clients from four mental health clinics in Israel participated in the study. The content of information discussed was coded directly from the recorded intakes by blinded raters. Clients and therapists completed the Working Alliance Inventory immediately following the intake. Therapists spent the majority of intake time in collecting information about their clients’ diagnostic symptoms and personal history and sociocultural background. Due to the high negative correlation between these factors, $r(107) = -0.68$, $p < .001$, we created a measure of delta score with higher scores reflecting more discussion of personal history and sociocultural background and less discussion of diagnostic symptoms. We computed three-level hierarchical linear model analysis, with intakes nested within therapists and therapists nested within sites, to examine the association between the delta score and the working alliance, while controlling for intake duration. Results showed significant association between the delta score and clients’ rating of the working alliance ($\gamma_{200} = 0.014, p = 0.02$), indicating that discussing more personal history and sociocultural background and less diagnostic symptoms was associated with better clients’ rating of the working alliance. Therapists’ rating of the working alliance was not significantly associated with the content of the information exchanged. The restricted intake time allocated to therapists dictates use of strategies to deal with time trade-offs to complete a thorough diagnostic assessment while allowing clients to tell their personal story.

Keywords: assessment, information exchange, mental health intake, working alliance

Therapeutic alliance refers to the degree to which the client and therapist are engaged in collaborative, purposive work (Bordin, 1979; Hatcher & Barends, 2006; Horvath & Luborsky, 1993). A pan-theoretic definition of the alliance includes an agreement on the goals and tasks of therapy in the context of a positive affective bond between the client and therapist (Bordin, 1979; Horvath, 2001). The therapist’s ability to form a good alliance is considered a core ingredient of psychotherapy (Norcross & Lambert, 2011), with studies documenting a moderate but stable correlation, $r = .28$, 95% CI [0.25, 0.30], between early alliance and treatment outcomes regardless of therapy orientation, alliance measure, rating perspective, and time of assessment (Horvath, Del Re, Flückiger, & Symonds, 2011). Strong therapeutic alliance directly affects improvement in symptoms and health status as well as satisfaction with care (Falkenström, Granström, & Holmqvist, 2013; Flückiger, Del Re, Wampold, Symonds, & Horvath, 2012; Horvath et al., 2011).

Research, mostly from the general medical fields, has highlighted the role of client-therapist communication in the development of strong alliance (Pinto et al., 2012). Communication patterns, particularly those that involve client facilitation and involvement, were associated with indicators of strong alliances such as trust and agreement (Huang, Hill, & Gelso, 2013; Nakash, Dargouth, Oddo, Gao, & Alegría, 2009; Pinto et al., 2012). Despite the importance of communication styles to the establishment of good therapeutic alliance, little is known about the impact of the content of the information collected during the mental health intake (i.e., diagnostic vs. sociocultural information) on the quality of therapeutic alliance.
The mental health intake, which is often the first meeting between the client and therapist, usually includes a clinical interview. Therapists have multiple goals to the intake, including but not limited to establishing diagnosis, facilitating rapport, and planning treatment (Nakash, Dargouth, et al., 2009; Nakash, Nagar, & Levav, 2014; Nakash, Rosen, & Alegria, 2009; Rosen, Miller, Nakash, Halpern, & Alegria, 2012). Clients’ goals may focus on their wish to feel understood and supported by their therapists as they present most frequently with a more general sense of emotional distress and/or interpersonal and work-related problems (Nakash, Nagar, & Levav, 2014). Despite its importance for determining client care, the intake has been subject to little empirical investigation. Given the limited time and high level of diagnostic uncertainty that characterizes the initial intake session, investigating the actual information therapists collect during the intake, as well as the way it may affect the quality of the working alliance with their client, is of particular interest.

One of the major goals of the intake is deciding on the mental health diagnosis (Alegria et al., 2008; Nakash, Nagar, & Kanat-Maymon, in press). To achieve this goal, therapists must collect information related to the particular problem at hand. Identification of the “correct diagnosis” does not always parallel the patient’s main problem (Westen, 1997), but it forms the foundation for treatment recommendations. Categorical diagnostic systems such as the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013) employ a symptom approach, which requires therapists to evaluate each of nearly 80 criteria and then apply cutoffs that vary across disorders. Such a task is time-consuming and complex because therapists are expected to statistically quantify uncertainties as subjective probabilities in the process of arriving at the correct diagnosis (Aspinall & Hill, 1984; Reeve, 2002). The impact of the focus on described diagnostic questions during the initial interview on the quality of the working alliance remains unknown. Therapists may feel that establishing a good rapport with clients is better undertaken through a more open dialogue that includes conversation about the personal sociocultural context within which their client lives and develops (Clark & Mishler, 1992).

A person’s sociocultural context may affect what he or she reports, what the therapist asks that person to report, and how the therapist interprets the information provided (Burgess, Fu, & van Ryn, 2004; Rosen et al., 2012). Sociocultural context (including social class, educational level, gender, age, and role expectations, among other factors) provides meaning to what a person regards as being “normal” for others of similar background. Cultural values include expectations about age, gender, and family dynamics as well as beliefs about health and health care (Geertz, 1973), all potentially affecting information exchange during the clinical interview. For example, education is tied to modes of clinical presentation and symptom severity assessment (Ecclcs, 1983), religion and spirituality may be linked to the experience of illness (Lukoff, Lu, & Turner, 1995), and gender and sexual orientation are intimately connected to expectations about societal roles and may be relevant in risk assessment (Almeida, 1994; Mays & Cochran, 2001; Nakash, Nagar, & Levav, 2015).

Importantly, the information exchanged between the client and the therapist may not only affect the diagnostic assessment but also have an important implication to the quality of the alliance. Mishler (1984) suggested that allowing the patient to tell his or her story in a personal, contextually grounded manner can facilitate the development of good rapport (Clark & Mishler, 1992). Yet, no study to date has examined the actual information collected during the mental health intake and the way it relates to the quality of the working alliance during the early stages of treatment. In the current study, we investigated the association between the content of the information discussed during mental health intake and the therapists’ and clients’ rating of the quality of the therapeutic alliance. More specifically, we explored how the balance between a discussion on diagnostic symptoms and information related to personal history and sociocultural background relates to the quality of the working alliance.

**Method**

**Setting**

The study was conducted between October 2012 and April 2013 in four public mental health clinics in three large cities in Israel. All participating clinics offer services to an ethnically and socio-economically diverse adult client population. None of the participating clinics used a structured intake protocol. The primary goal of the intake at all clinics was to conduct an initial evaluation of the client to inform diagnosis and treatment planning. At each of the clinics, clients were consecutively allocated to therapists to conduct the intake based on therapist availability.

**Sample**

A convenience sample of therapists and clients participated in the study. We recruited therapist participants at the clinics through introductory informational meetings. Thirty-eight therapists agreed to take part in the study; five therapists declined participation. To ensure the diversity of the sample, we invited therapists to participate only up to five times (with five different clients; $M = 3.8$, $SD = 1.3$). We recruited client participants through direct person-to-person solicitation as they presented for the intake visit. Client inclusion criteria were adults (18 years and older) who did not require interpreter services. Exclusion criteria included people whom the therapists identified as psychotic or actively suicidal. Of the 153 clients who were invited to participate in the study, 122 agreed to participate (31 clients declined to participate: 21 were not able to stay for additional time following their intake to complete the research protocol, 3 did not feel well enough to participate, and 7 did not want to have the intake session recorded). Six additional clients were excluded from analyses due to poor recording quality and missing data. Due to the multilevel design of the study and lack of within-therapist variance for those who participated with only one intake session (nine therapists), we included only therapists who participated with a minimum of two intake sessions. Thus, a sample of 29 therapists and 107 clients remained in the current study.

The majority of therapists were women (86.2%), ages ranged from 28 to 64 years ($M = 45.0$, $SD = 10.8$), and approximately half of therapists were born in Israel (51.7%). Thirty-five percent were psychologists, 17% psychiatrists, and 48% social workers, with the majority of therapists (78%) having more than 5 years of clinical practice ($M = 14.4$, $SD = 11.2$).
All participating clients were Israeli Jews who were fluent in Hebrew. Of the 107 clients who participated in the study, the majority were women (67.9%), ages ranged from 19 to 81 years ($M = 41.9, SD = 16.1$), and most were born in Israel (71.0%). Two thirds of the sample (63.6%) had 12 or less years of education, and 61% were unemployed. Approximately 70% reported a personal yearly income of less than U.S.$15,000. Approximately half of the participants were diagnosed with mood disorder (45 participants: 41 with major depression, 4 with dysthymia), 34% were diagnosed with anxiety disorders (35 participants: 14 with generalized anxiety disorder, 3 with panic disorder, 6 with obsessive-compulsive disorder [OCD], 1 with social phobia, 16 with posttraumatic stress disorder [PTSD]), 7% were diagnosed with substance use disorders (7 participants), 4% were diagnosed with eating disorder (4 participants: 2 with bulimia nervosa, 2 with unspecified eating disorder), and 8% were diagnosed with psychotic disorders (8 participants) by their therapists.¹

**Measures**

A demographic questionnaire was administered to both clients and therapists. Clients’ information included country of birth, gender, age, years of education, employment status, and income. Therapists’ information included country of birth, gender, age, discipline, and years in clinical practice.

The Working Alliance Inventory (WAI), short client and therapist versions (Tracey & Kokotovic, 1989), was administered. The WAI is a 12-item self-report scale that measures the client’s and therapist’s view of the quality of the working alliance (Horvath & Greenberg, 1989). It has been widely used in studies on therapeutic outcomes to assess therapeutic alliance in treatment and during a single therapy session (Nakash, Nagar, & Levav, 2014). The measure has corresponding versions for clients and therapists, and both versions have shown good reliability and validity (Tracey & Kokotovic, 1989). The measure includes three original scales: (a) task (e.g., “the therapist/clients and I agree about the steps to be taken to improve my situation”), (b) goals (e.g., “We are working toward mutually agreed upon goals”), and (c) bond (e.g., “I believe the therapist/client likes me”) that are considered elements of good alliance. Each item was rated on 7-point scale, ranging from 1 (not at all) to 7 (very much). Final score included the mean score for all items, with higher score reflecting better therapeutic alliance. Internal consistency for therapist and client measures was good (Cronbach’s α = 0.93, 0.80, respectively).

The Coder Information Checklist—Revised (Alegría et al., 2008) was used to code each unit of information exchanged during the intake directly from the recorded sessions. The checklist was designed in a previous study by Alegría et al. (2008) and was expanded to include diagnostic information on personality disorders according to the DSM-IV (American Psychiatric Association, 1994) as well as additional sociodemographic information relevant to Israeli context (e.g., compulsory military service). The checklist includes 220 items and more than 100 subitems that cover potential information that might be discussed during the intake session. Items covered symptoms related to major Axis I disorders as well as Axis II disorders. All items originated from the diagnostic criteria in the DSM-IV-TR (American Psychiatric Association, 2000). In addition, the measure included items concerning personal history and sociocultural background, physical symptoms and disabilities, family history of mental health disorders, and mental health treatment history (Nakash, Dargouth, et al., 2009; Rosen et al., 2012). Previous studies provide evidence for the construct validity of the information checklist (Alegría et al., 2008; Nakash et al., in press). For example, in a study comparing the intake-therapist’s diagnosis to the one established by an independent interviewer who conducted a structured diagnostic interview with the client (the Mini-International Neuropsychiatric Interview [M.I.N.I.], which served as the gold standard for diagnosis) immediately following the intake, the information checklist was used to document the symptomatic information that was assessed during the intake. Sensitivity analyses significantly improved with increasing number of symptoms assessed, with highest value documented for the assessment of six or more symptoms (81%), whereas specificity somewhat decreased with the assessment of increasing number of symptomatic information as documented in the information checklist (62.5%; Nakash et al., in press).

Each item was coded for whether it was discussed during the intake either as a result of the therapist question or as a result of the client’s initiation (yes/no; $M = 43.62, SD = 13.3$ information units were discussed in each interview). Importantly, diagnostic information was coded independent of a disorder. As a result, nonspecific symptoms such as sleep disturbances were coded under all relevant disorders (i.e., depression, anxiety, and bipolar disorders). To capture the level of specificity in which information was discussed, the information checklist measure included items describing symptoms in different levels of specificity. For example, the measure included two items to describe levels of specificity of discussion of substance use: “any general mention of substance use” (general screener) and “recurrent substance use (Specify which—Sedatives, Tranquilizers, Painkillers, Stimulants, Marijuana, Cocaine or crack, Hallucinogens, Inhalants, Heroin, Pills, other)” (specific criteria).

Three independent raters, blind to study goals and hypotheses, coded the audiotapes of the intakes (all raters were licensed clinical psychologists). Following the training, which lasted approximately 10 hours and included gaining familiarity with the coding measure and practicing the coding, all coders independently coded five randomly selected tapes. Interrater reliability was calculated using software by Geertzen (2012). Agreement among the coders across the five tapes was 81% ($\kappa = 0.81$). To prevent coders’ drift, we assessed interrater reliability by having all raters code two additional randomly selected tapes after coding 25% (30 tapes, $\kappa = 0.77$), 50% (60 tapes, $\kappa = 0.80$), 75% (90 tapes, $\kappa = 0.70$), and 100% (120 tapes, $\kappa = 0.76$) of the total tapes. Overall agreement between all three raters in the different time points ranged from 70% to 81%. Overall interrater agreement was high, $\kappa = 0.78$.

**Procedure**

Participation in the study included three parts: (a) clients completed survey measures prior to intake, which included demographic information (for full list of measures, see Nakash, Nagar, Danilovich, et al., 2014), (b) an audio-recording was made of the intake session, and (c) clients and therapists completed a measure designed to assess the quality of the working alliance immediately following the intake directly from the recorded sessions. The checklist was used to code each unit of information exchanged during the intake, and overall agreement was high, $\kappa = 0.78$.

¹ Numbers may exceed the total number of participants due to comorbidity (approximately 70% of clients have more than one diagnosis).
following the intake session. Intake visits ranged between 14 and 99 minutes ($M = 50.6, SD = 18.1$). All aspects of the study were approved by the appropriate institutional ethics committees at each of the participating clinics. Data collection was in compliance with human subject protocols.

Statistical Analyses

We constructed five factors by conceptually grouping items discussed during the intake session according to the Coder Information Checklist–Revised (Alegría et al., 2008) as follows: (a) symptoms of DSM-IV Axis I disorders (including major depressive disorder, bipolar disorder, psychotic disorders, alcohol and substance abuse/dependence, adjustment disorder, eating disorders, and anxiety disorders, including agoraphobia, panic, specific phobia, social anxiety, OCD, PTSD, and generalized anxiety disorder), (b) symptoms of DSM-IV Axis II personality disorders (including paranoid, schizoid, schizotypal, antisocial, borderline, narcissistic, histrionic, avoidant, dependent, and OCD personality disorders), (c) personal history and sociocultural background (including history of personal loss, financial and occupational status, quality of relationships with family members and friends, developmental history, history of abuse/neglect, immigration, etc.), (d) chronic physical illnesses and disability, and (e) mental health treatment history. Because the number of items discussed varied between participants, we calculated percentage scores for each of these factors (i.e., number of items discussed in each factor divided by the total number of items discussed during the intake).

The data were hierarchically nested as each therapist participated in two to five different intake sessions, and therapists were nested within sites (4–12 therapists within each clinic). Since ignoring such nonindependence might bias significance tests and undermine power (Raudenbush & Bryk, 2002), we employed multilevel modeling analysis (Raudenbush & Bryk, 2002) that controls for therapists’ and intake’s nonindependence while simultaneously assessing the associations between the study variables. Hierarchical linear model (HLM) analyses allowed us to examine whether the intake session’s variance in quality of the working alliance (Level 1) can be explained by the proportion of items from the different factors discussed during the intake session while controlling for between-therapist variance (Level 2) and between-site variance (Level 3). The HLM equations were computed using HLM Version 7 software with restricted maximum-likelihood estimation (Raudenbush, Bryk, Cheong, Congdon, & du Toit, 2011).

### Results

Mean, standard deviation, and percentage of items discussed for each factor (DSM Axes I and II symptoms, personal history and sociocultural background, other chronic illnesses, and history of mental health treatment) are presented in Table 1. DSM Axis I symptoms and information related to personal history and sociocultural background accounted for more than 80% of the information discussed during the intake. The remaining factors accounted for less than 20% of the information discussed during the intake and were not significantly correlated with the outcome measures and therefore were excluded from the analysis. As a result, we decided to conduct further analyses using only these two factors. Clients reported significantly better working alliance, $t(106) = 5.96, p < .001, M = 5.5, SD = .9$, compared with therapists (all sample: $M = 4.8, SD = 1.1$; social workers: $M = 5.1, SD = .9$; psychologists: $M = 4.5, SD = 1.0$; psychiatrists: $M = 4.4, SD = 1.3$). Pearson correlation revealed significant association between intake duration and therapists’ rating of the working alliance, $r(107) = .21, p < .05$, but not with clients’ rating of the working alliance, $r(107) = -.06, ns$.

We first examined variance decomposition by computing interclass correlations coefficients (ICCs). Results indicated between-site variance of 5% for clients’ rating of the working alliance (ICC = .05), 0% for therapists’ rating of the working alliance (ICC = .00), 2% for percentage of DSM Axis I items discussed (ICC = .02), 13% for information related to personal history and sociocultural background (ICC = .13), and 55% for intake duration (ICC = .55). Additionally, results indicated between-therapist variance of 28% for therapists’ rating of the working alliance (ICC = .28), 0% for clients’ rating of the working alliance (ICC = .00), 8% for percentage of DSM Axis I items discussed (ICC = .08), 3% for information related to personal history and sociocultural background (ICC = .03), and 46% for intake duration (ICC = .46).

As for clients’ WAI, the between-therapist variance component was not statistically significant ($\tau_w = .00, SE = .07$), $\chi^2(25) = 25.49, ns$, meaning that there was no significant variance in clients’ reports of WAI between therapists. However, the between-site variance component was statistically significant ($\tau_s = .05, SE = .06$), $\chi^2(3) = 11.31, p = .01$, meaning that there was significant variance in clients’ reports of WAI between clinics. As for therapists’ WAI, the between-therapist variance component was statistically significant ($\tau_w = .34, SE = .16$), $\chi^2(25) = 63.63, p < .001$

<table>
<thead>
<tr>
<th>Factor</th>
<th>Number of items discussed</th>
<th>Percentage of items discussed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DSM-IV Axis I symptoms</strong></td>
<td>14.5</td>
<td>32.9</td>
</tr>
<tr>
<td><strong>DSM-IV Axis II symptoms</strong></td>
<td>1.7</td>
<td>3.8</td>
</tr>
<tr>
<td>Personal history and sociocultural background</td>
<td>21.8</td>
<td>49.8</td>
</tr>
<tr>
<td>Information related to other chronic illness</td>
<td>1.7</td>
<td>4.1</td>
</tr>
<tr>
<td>History of mental health treatment</td>
<td>3.9</td>
<td>9.5</td>
</tr>
</tbody>
</table>


* Total items discussed across intakes ranged between 14 to 80, $M = 43.6, SD = 13.3$. 

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meaning that there was a significant variance in therapists’ reports of WAI between therapists. However, the between-site variance component was not statistically significant ($\tau_b = .00, SE = .06, \chi^2(3) = 3.32, ns$), meaning that there was no significant variance in therapists’ reports of WAI between clinics. These results suggest that a large portion of the variance was embedded at the therapist level, which justified conducting the multilevel analysis.

To examine whether the quality of the working alliance within each intake could be explained by the portion of discussing DSM Axis I and personal history and sociocultural background information items within the corresponding intake, while controlling for intake duration, we constructed an intake-level HLM equation. Pearson correlation revealed significant correlation between DSM Axis I information and personal history and sociocultural background information, $r(107) = -.68, p < .001$. Due to this high negative correlation, we created a measure of delta score by subtracting scores on DSM Axis I factor from personal history and sociocultural background information factor (DELTA$_{ijk}$). Higher scoring on DELTA$_{ijk}$ reflected more discussion of personal history and sociocultural background information items and less discussion of DSM Axis I items. Analyses were performed once for each dependent variable (client’s and therapist’s rating of the working alliance). The predictors, INTAKE$_T$ ($\tau$), and DELTA$_{ijk}$, were mean-centered within each therapist across intakes to account for between-therapist and between-site variance and to ease interpretation (Raudenbush & Bryk, 2002). Thus, the generic Level 1 equation was as follows:

$$\text{OUTCOME}_{ijk} = \pi_{0ijk} + \pi_{1ijk} \times (\text{INTAKE}_T - \bar{\text{INTAKE}}_T) + \pi_{2ijk} \times (\text{DELTA} - \bar{\text{DELTA}}_{ijk}) + e_{ijk}$$

$\pi_{0ijk}$ refers to the intercept, $\pi_{1ijk}$ represents the maximum-likelihood estimate of the population slopes for the relationship between intake duration and quality of working alliance, $\pi_{2ijk}$ represents the maximum-likelihood estimate of the population slopes for the relationship between portion of discussing DSM Axis I and personal history and sociocultural background information items (DELTA) and quality of working alliance, and $e_{ijk}$ represents error.

For each $\pi_{ijk}$ in the intake-level equation, a corresponding component in the therapist-level model was created. The corresponding Level 2 equations were as follows:

$$\pi_{0ijk} = \beta_{00k} + r_{0ijk}$$
$$\pi_{1ijk} = \beta_{10k}$$
$$\pi_{2ijk} = \beta_{20k}$$

The therapist-level intercept $\beta_{00k}$ represents the average score on quality of working alliance, $\beta_{10k}$ represents the average intake duration slopes of the intake level, and $\beta_{20k}$ represents the average portion of discussing DSM Axis I and personal history and sociocultural background information items (DELTA) slopes of the intake level. The intercept ($\tau_{0ijk}$) was treated as random, and the INTAKE$_T$ ($\tau_{1ijk}$) and DELTA slopes ($\tau_{2ijk}$) were treated as fixed in the therapist-level equations. Thus, the random difference between therapists $\tau_{0ijk}$ was included for the estimates of the INTAKE$_T$ ($\beta_{10k}$) and DELTA slopes ($\beta_{20k}$).

For each $\beta_{ijk}$ in the therapist-level equation, a corresponding component in the site-level model was created. The corresponding Level 3 equations were as follows:

$$\beta_{00k} = \gamma_{000} + u_{00k}$$
$$\beta_{10k} = \gamma_{100}$$
$$\beta_{20k} = \gamma_{200}$$

The site-level intercept $\gamma_{000}$ represents the average score on quality of working alliance, $\gamma_{100}$ represents the average intake duration slopes of the intake level, and $\gamma_{200}$ represents the average portion of discussing DSM Axis I and personal history and sociocultural background information items (DELTA) slopes of the site level. The intercept ($\beta_{00k}$) was treated as random, and the INTAKE$_T$ ($\beta_{10k}$) and DELTA slopes ($\beta_{20k}$) was treated as fixed in the therapist-level equations. Thus, the random difference between therapists $\gamma_{000}$ was included for the estimates of the INTAKE$_T$ ($\gamma_{100}$) and DELTA slopes ($\gamma_{200}$). HLM regression weights are presented in unstandardized coefficients.

Results of the HLM intake-level model analyses indicated that personal information was significantly positively associated with client’s score on the quality of working alliance ($\gamma_{200} = .03, SE = .01, t = 2.44, p = .02, 95\% CI [.01, .05])$. Moreover, DSM Axis I information was inversely related to the client’s quality of working alliance ($\gamma_{200} = -.02, SE = .01, t = -1.71, p = .09, 95\% CI [-.04, .00])$, yet only marginally significant. Thus, across different intakes, discussing more information relevant to the personal history and sociocultural background information was associated with better quality of working alliance as reported by clients. Results did not indicate a significant effect of INTAKE$_T$ in predicting clients’ rating of the working alliance ($\gamma_{100} = .007, SE = .010, t = .71, ns$). Calculating effect size indicated 0.04. As for therapists’ rating of the working alliance, this was not significantly predicted by the types of information discussed during the intake ($\gamma_{200} = .001, SE = .007, t = -.24, ns$) or by intake duration ($\gamma_{100} = .010, SE = .007, t = 1.36, ns$).

To verify that the reported DELTA effect was not a function of only one type of information, DSM Axis I and personal history or sociocultural background information, while controlling for intake duration, we tested whether each of these factors is associated with the quality of working alliance as reported by clients. For this, we constructed two intake-level HLM equations, once with DSM Axis I symptoms as predictor and once with personal history and sociocultural background information as predictor. Each predictor was mean-centered prior to analysis. HLM regression weights are presented in unstandardized coefficients.

Results of the HLM intake-level model analyses indicated that personal information was significantly positively associated with client’s score on the quality of working alliance ($\gamma_{200} = .03, SE = .01, t = 2.44, p = .02, 95\% CI [.01, .05])$. Moreover, DSM Axis I information was inversely related to the client’s quality of working alliance ($\gamma_{200} = -.02, SE = .01, t = -1.71, p = .09, 95\% CI [-.04, .00])$, yet only marginally significant. Thus, across different intakes, discussing more information relevant to the personal history and sociocultural background information was associated with better quality of working alliance as reported by clients following the intake session.

**Discussion**

In the current study, we investigated the association between the information exchanged between clients and therapists and the quality of the therapeutic alliance during the mental health intake. Our findings suggest that therapists spend the vast majority of intake time in collecting information about the diagnostic symptoms and the personal history and sociocultural background of their client. Importantly, across different intakes, discussing more
personal history and sociocultural background information and less DSM Axis I symptoms was associated with better quality of working alliance as reported by clients. Our results also show that although client’s rating of the WAI was not affected by between-therapist variance, it was affected by the between-site variance. This may be a result of structural differences between clinics (e.g., availability, accessibility, quality of infrastructure) as well as other differences related to institutional policies (e.g., whether client continued with the same therapist following the intake). Interestingly, the content of the information exchanged was not significantly associated with the therapists’ rating of the working alliance. It is possible that this discrepancy is due to the fact that the therapist has the power to direct the content of the session by virtue of his or her role in the situation.

Our findings stress the need for providing therapists with strategies to deal with time trade-offs to best use the restricted time allocated to them during the intake to complete a thorough diagnostic assessment while allowing their clients tell their personal unique story. Systematic assessment procedures, which employ structured interview schedules, have often been recommended to improve clinical utility by increasing the reliability of the diagnosis and the predictive validity of the assessment (Stickle & Weems, 2006). Although common in medical models, structured interviews that focus on systematic assessment of diagnostic symptoms may challenge the existence of open communication and may affect the quality of the working alliance (Clark & Mishler, 1992).

Alternative models of conducting the initial clinical interview view it as an opportunity to “tell a story” and emphasize the role of good listening and responsiveness on the part of the therapist in facilitating good rapport (Clark & Mishler, 1992). Mishler (1984) refers to the struggle of control over the intake process as a tension between the “voice of medicine” emphasizing a technical, universalist frame of reference and the “voice of the life-world” reflecting the client’s personal contextually grounded experiences expressed in familiar terms. Mishler (1984, 2005) further suggests that this struggle often compels clients to follow the clinician’s medical discourse, which tends to dominate the interaction, while making it difficult for them to tell their unique stories in a way that makes sense to them. Interviews, which employ effective listening and allow for contextualization of client’s presentation, can facilitate “knowing” the client as an individual person. Such contextualization is pertinent to the initial encounter in which clients often present an intimately complex and unique story (Weiner, 2004). Yet, although open interviews can facilitate the development of therapeutic alliance during the intake, they may challenge the attainment of information required for accurate assessment. These goals are part and parcel of the initial interview process. Indeed, therapists tend to underuse the diagnostic system, not collecting sufficient information to base their diagnostic decisions (Alegría et al., 2008; Nakash et al., in press).

The tension between the need to follow the “voice of medicine” versus the wish to follow the “voice of the life-world” (Mishler, 1984) is particularly challenging in an era that values efficiency. To successfully complete an initial evaluation, therapists should find ways to complete a comprehensive diagnostic assessment while allowing their clients to tell their unique contextualized story. Clinical determinations in community mental health clinics must be made in severely resource-constrained environments. Therefore, models of the initial clinical interview need to address multiple and at times conflicting needs. One possible approach to increase diagnostic efficiency in this context is to examine the use of best probes for correct diagnosis for specific disorders (Nakash et al., in press) or use structured measures to complement the information collected during the mental health intake (Nakash, Rosen, & Alegría, 2009). These strategies can help the therapist to optimize the use of time for diagnostic purposes, while allowing sufficient time for getting to know the particular context within which the client developed and his or her suffering emerged.

The current study has several limitations. First, the data were collected before the publication of the DSM-5. However, because the categorical basis for the diagnostic system has not changed in this recent version, we believe our findings can be extrapolated to the current version. Second, the study was conducted among a convenience client sample, which may be subject to selection bias. Third, although therapists’ interpersonal skills are also relevant to the establishment of the working alliance in the current investigation, we collected information only on direct verbal communication between clients and therapists. Fourth, although not uncommon in the literature on quality of working alliance, the effect size here was small. Other factors pertaining to therapist characteristics and client features that were not included in the current investigation may have an important impact on the quality of the alliance. Future studies should continue to explore how therapists integrate different sources of information, including verbal and nonverbal, to establish good alliance and examine the development of the working alliance as well as therapeutic outcomes following intake session that is characterized by different models of information exchange.

Serious consideration should be given to the time constraint of the initial interview. Alternative models such as devoting significant time to complete a comprehensive assessment while allowing sufficient time to develop rapport should be considered. This might require having ancillary staff that could help clients confidentially answer a brief symptom assessment, do rapid coding, and flag areas for in-depth assessment by the therapist. Preparing the client for reviewing the brief diagnostic assessment before the conclusion of the intake process and after the client has a chance to tell his or her unique story might help fulfill clients’ and therapists’ mutual goals while reducing diagnostic bias. Models that test different ways of blending the engagement and assessment goals during clinical intake should be developed to be able to provide specific recommendations of how to best achieve both goals.

References


