“How should I do it”? Clinical dilemmas therapists struggle with during the mental health intake

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Abstract
In order to achieve the competing demands of the intake, therapists must make rapid decisions on how to use the limited time allocated for the mental health intake. No research to date has systematically examined how therapists perceive and manage these demands. Here, we investigated the clinical dilemmas therapists described facing during the intake session. We conducted in-depth interviews with therapists immediately following their intake session with 117 clients presenting for a new episode of care in community and hospital-based mental health clinics in Israel. We analyzed the interviews using thematic analysis. Overall inter-rater reliability among three raters who coded the narratives was high (kappa=0.72). The main themes that emerged from the data were: (1) systematic collection of diagnostic information versus uninterrupted flow of speech; (2) collection of sufficient diagnostic information versus attendance to client’s emotional state; (3) structural limitations of intake versus client’s flow of speech; (4) therapists’ versus clients’ goals for the intake; (5) focus on psychiatric assessment versus use of rapport-promoting techniques during intake; (6) prior data documented in the client’s medical chart versus diagnostic information collected during the intake. 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.

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The mental health intake, which is often the first meeting between the client and the 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 et al., 2009a, 2009b; Rosen et al., 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 et al., 2014b).

In order to achieve the competing demands of the intake, therapists must make rapid decisions on how to use the limited time allocated for the intake. Despite its importance for determining client care, the intake has been subject to little empirical investigation. Such investigation is particularly important since the questions and observations therapists make during the intake guide their diagnostic and other clinical decisions, which have significant impact on subsequent client care (Aklin and Turner, 2006). These decisions are particularly challenging as they are often made under conditions of time pressure and uncertainty (Howie et al., 1992).

In the current study, we examine the clinical dilemmas and challenges therapists face as they conduct the mental health intake.

A dilemma is defined as “a situation involving choice between two equally unsatisfactory alternatives” (Merriam-Webster, 2017). In a clinical context, a dilemma refers to a choice or conflict that may provoke anxiety in the therapist about what to do or what to say next. Indeed, the process of psychotherapy, and even more so the initial intake session, can be regarded as the management of ongoing dilemmas, both for the patient and for the therapist (Scaturo and McPeak, 1998).

One of the main dilemmas therapists face during the initial clinical encounter is how to structure the intake. 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 as well as reduce bias in clinical decision-making (Stickle and Weems, 2006). Although common in medical models, structured interviews may challenge open communication between clients and therapists and therefore may hinder the development of a good working alliance and the development of trust (Mishler et al., 1989; Nakash et al., 2015b).

Therapeutic alliance refers to the degree to which the client and therapist are engaged in collaborative, purposive work (Hatcher and Barends, 2006) and is one of the main goals of the clinical intake. 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 (Horvath, 2001). The therapist’s
ability to form a good alliance is considered a core ingredient of psychotherapy (Norcross and Lambert, 2011) with studies documenting a moderate but stable correlation ($r = .28$, 95% CI: .25–.30) between early alliance and treatment outcomes regardless of therapy orientation, alliance measure, rating perspective and time of assessment (Horvath et al., 2011).

Alternative models of conducting the intake view it as an opportunity to give clients the physical and emotional spaces to “tell their story” and emphasize the role of good listening and responsiveness on the part of the therapist in facilitating good rapport (Clark and Mishler, 1992). Mishler (1984), who mostly conducted his research in the general medical field, refers to the struggle of control over the assessment process as a tension between the “voice of medicine” emphasizing a technical, biomedical 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 contextualizing 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 (Alegria et al., 2008; Nakash et al., 2015a). No research to date has systematically examined how therapists perceive and manage these tensions.

One of the major goals of the intake is deciding on the mental health diagnosis. In order to achieve this goal, therapists must collect relevant information related to the particular problem at hand. Identification of the client’s main problem, i.e. the “correct diagnosis,” is the foundation for the proper treatment of psychiatric disorders. This goal can be challenging given the level of uncertainty that always exists in diagnostic decision-making (Nakash et al., 2009b). Different factors have been noted to affect the decisions therapists make regarding diagnosis, including diagnostic manuals such as the DSM-IV and the ICD-10, verbal and non-verbal information, and clinical intuition (Nakash and Alegría, 2013). Therapists vary substantially in the way they utilize the diagnostic classification systems, although by and large they tend to underuse it, not collecting sufficient information to base their decision about psychiatric diagnosis (Alegria et al., 2008; Nakash et al., 2015a).

Despite the existence of many models to conduct psychiatric assessment and construct the intake session, no study to date has empirically examined what therapists struggle with as they first meet a client. Understanding the clinical dilemmas that therapists face as they conduct the intake is pertinent to improving
care and adapting training models to the actual conditions in which therapists practice. In the current study, we investigated the clinical dilemmas therapists described facing during the intake session. We conducted in-depth interviews with therapists immediately following their intake session with 117 clients presenting for a new episode of care in community mental health clinics.

**Method**

**Setting**

We conducted the study in four community- and hospital-based mental health clinics in three large cities in Israel. All participating clinics offer services to an ethnically and socio-economically diverse adult client population. Therapists regularly complete the intake during a single clinical session that lasts approximately 50 minutes. 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 in order 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; \( M=3.8, SD=1.3 \)). Intake visits ranged between 14 and 99 minutes (\( M=51.5, SD=17.8 \)).

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 above), who did not require interpreter services. Exclusion criteria included people whom the therapists identified as psychotic or actively suicidal. Of the 184 clients who were invited to participate in the study, 122 agreed to participate (31 clients declined participation due to the following reasons: 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; 7 did not want to have the intake session recorded). Five additional clients were excluded from analyses due to poor recording quality and missing data.

The majority of therapist participants were females (86.2%), ages ranged from 28 to 64 (\( M=45.0, SD=10.8 \)) 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 five years of clinical practice (\( M=14.4, SD=11.2 \)). All participating clients were Israeli Jews.
who were fluent in Hebrew. The majority of client participants were females (67.9%), ages ranged from 19 to 81 ($M=41.9$, $SD=16.1$), who 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 15,000US$.

**Procedure**

Data for the current study were part of a larger study aimed to examine mental health intake with diverse client population (for full study description please see: Nakash et al., 2014a, 2015a, 2015b, 2015c; Nakash and Saguy, 2015). Immediately following the intake session, we conducted semi-structured, in-depth face-to-face interviews with therapists (see Appendix 1 for interview guide). These in-depth interviews were based on principles of cognitive task analysis methods to explore therapists’ experiences during the mental health intake (Crandall et al., 2006). The semi-structured interview protocol included a number of scripted questions and a list of suggested probes (Hill et al., 2005), and lasted approximately 30 minutes.

Therapists’ interviews included questions about their understanding of the client’s main problem, their evaluation process, their rapport with the client, and their views of the role of sociocultural factors in the client’s presenting problem. Trained graduate students in clinical psychology who received weekly supervision conducted all interviews. We audiotaped, transcribed, and edited these interviews to remove identifiers. All aspects of the study were approved by the appropriate Institutional Ethics Committees at each participating clinic and all clients and therapists completed informed consent prior to participation.

**Qualitative analysis**

We employed a phenomenological approach (Giorgi, 1997) to explore how individuals construct and make meaning of their actions in concrete social situations. In line with the phenomenological approach, we performed a cross-case thematic content analysis identifying major themes in therapists’ accounts of their experience during the mental health intake using ATLAS.ti version 7 (Scientific Software Development, Berlin). The research team who coded and analyzed the data included three Israeli graduate students in clinical psychology.

The qualitative analysis involved a series of steps. First, we developed a codebook for therapists’ interviews. We applied thematic analysis according grounded theory guidelines in the development of the codebooks (Corbin and Strauss, 2008) which involved three steps. We first performed open coding (Corbin and Strauss, 2008) by independently reading the accounts line by line to identify codes; afterward, we grouped and labeled key categories. In the second stage, we separately reread the accounts to perform axial coding as a means to identify the relationship among categories and to organize them into themes. We integrated the information in each theme to draw a coherent representation of the material.
The development of the codebooks lasted until we reached saturation. It lasted approximately three months and was based on 15% (n=25) of the therapists’ interviews which were randomly selected. Once we established inter-rater reliability, all remaining interviews were coded using the codebooks.

We organized all the information in the data corpus under these emerging themes (e.g. clinical dilemmas, presenting problems, barriers to care). In addition, we allowed data extracts to be placed under more than one theme depending on their relevance to the content of the thematic category. Throughout the analysis process, the team met on a weekly basis to discuss coding challenges as well as disagreements. When disagreement arose, we attempted to identify the source of the discrepancy, and coded sections were reviewed again until consensus was reached (Corbin and Strauss, 2008).

In the current study, we focused on the clinical dilemmas theme. A clinical dilemma was defined as a choice or conflict the clinician described in the clinician about what to do or what to say next during the intake session (Scaturo and McPeak, 1998).

To prevent coders’ drift, we assessed inter-rater reliability by having all raters code additional two randomly selected tapes after coding 25% (n=30; kappa=0.82), 50% (n=60; kappa=0.7), and 75% (n=90; kappa=0.70) of the total recorded interviews. Overall inter-rater reliability among all three raters across different time points was good (kappa=0.72).

**Results**

Therapists discussed struggling with various clinical dilemmas in a majority of intakes (n=83, 71%). On average, in every intake little over one dilemma was mentioned (M=1.26, SD=1.09, range: 0–4); 148 dilemmas were mentioned in total across all interviews.

Recurring themes of the therapists’ dilemmas during intake, arranged from the most to least prevalent were: (1) systematic collection of diagnostic information versus uninterrupted flow of speech; (2) collection of sufficient diagnostic information versus attendance to client’s emotional state; (3) structural limitations of intake versus client’s flow of speech; (4) therapists’ versus clients’ goals for the intake; (5) focus on psychiatric assessment versus use of rapport-promoting techniques during intake; (6) prior data documented in the client’s medical chart versus diagnostic information collected during the intake (see Table 1). In the following sections, we expand on these dilemmas and provide specific examples for illustration.

**Systematic collection of diagnostic information versus client’s uninterrupted flow of speech**

In approximately one-third of the intakes, therapists described struggling with the conflict between their ethical obligation to collect diagnostically relevant
Table 1. Therapists’ clinical dilemmas during the mental health intake (N=117).

<table>
<thead>
<tr>
<th>Theme</th>
<th>% (n) of total intakes</th>
<th>Example vignette</th>
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<tbody>
<tr>
<td>Systematic collection of diagnostic information versus uninterrupted flow of speech</td>
<td>32.5% (38)</td>
<td>“There’s something very difficult in intakes, where you need to draw out so much information and yet remain empathetic and sensitive and let her reach things in her own time”. (1044)</td>
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<tr>
<td>Collection of sufficient diagnostic information versus emotional protection of clients</td>
<td>30.8% (36)</td>
<td>“I saw in the application she wrote – suicidal thoughts. So I began asking her about it but could see that it’s really difficult for her to talk about it so I asked her – is that too much? Let’s not talk about it now and come back to it later. It was clear to me that I don’t want to pressure her, I want her to feel comfortable, then we can go back to it” (315)</td>
</tr>
<tr>
<td>Structural limitations of intake versus attendance to client’s emotional state</td>
<td>17.1% (20)</td>
<td>“She spoke at some length about her time in Israel, but I didn’t stop her. I thought about it, I was worried that the hour was passing by and we still had much to go over, but eventually I didn’t stop her” (304)</td>
</tr>
<tr>
<td>Therapists’ versus clients’ goals for the intake</td>
<td>10.3% (12)</td>
<td>“What really accompanied the session was how to re-direct it from dealing with pills and dosage to something else and see if she had any interest in that also I was conflicted about offering her to try psychotherapy. I tried gently and dropped it. She was crying real hard. I think perhaps she knew why she doesn’t want to talk, that there might be a gentle balance here” (448)</td>
</tr>
<tr>
<td>Focus on diagnosis and assessment versus use of rapport-promoting techniques during intake</td>
<td>6.8% (8)</td>
<td>“Her need to treat this session as a therapeutic session was very evident right from the start and some difficulty in accepting that I need to draw information from her” (255)</td>
</tr>
<tr>
<td>Prior data documented in the client’s medical chart versus diagnostic information collected during the intake</td>
<td>6.8% (8)</td>
<td>“Of the past usually I ask quite a lot and this time I nearly didn’t ask at all, because it’s already in the file and there’s no point in bringing it up again” (278)</td>
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information during intake and their clinical judgment that it would be beneficial to not interrupt the client’s open flow of speech. Inserting diagnostic questions as the client spoke conflicted with what they saw as an empathetic attunement toward the client. This was particularly challenging with patients presenting with high risk:

He really wanted to tell me about his history and so on, and it was really important for me to know why he came to me in the first place, so I wanted to hear about his symptoms. It wasn’t easy for him to talk about, it took some time. He told me a little but then I went back to the symptoms and what he referred to as depression and thoughts, because among other things I wanted to find out if he has suicidal thoughts, and what ‘thoughts’ are anyway. So I got him talking about that again, but after a while we went on talking about general stuff. (2189)

Therapists mentioned that clients tended not to initiate sharing information partly because they did not know what is expected of them unless asked directly. As a result, they felt mandated to direct the conversation even if clients wanted to talk about different things: “There were many times where I could have delved in and learned more but I moved on anyway. I felt that it isn’t helping us right now and I know it’s very difficult for her and let’s continue” (1173).

Some therapists indicated a preference to direct the interview, moving methodically from one topic to the next, usually trying to get a chronological description of the client’s life. This allowed the therapists to create a coherent narrative, enabling them to understand the central problem and its antecedents:

A large portion of this conversation is for me, so I’ll see things in a clear, in an organized fashion, so I get to direct the conversation. To achieve this I stop her many times; give her some directions, say we’ll talk about this later, and about that first, even though she has an easier time going from one this to the next associatively. (1178)

Other therapists preferred to allow the client to talk freely indicating they felt uneasy when interrupting the client; they also mentioned that such interruptions were often perceived by clients as hurtful, lacking in empathy, frustrating, and disappointing:

I think that a part of my role in this conversation is to be empathetic, to gain his trust, to establish a connection. And when I’m preoccupied with my own needs for organization and order I don’t necessarily accomplish these goals. (1178)

The need to interfere the client’s flow of speech was especially complicated with immigrant clients where inter-cultural gaps in language and communication existed:

It’s a combination of everything, of language, of the associative speech, of his jumping from one topic to another. There was something disorganized about him.
Now, language doesn’t help organizing him: he says one word, then something not quite related. It began with me asking him how he earns his livelihood, and then he didn’t understand what a livelihood is, and then it’s another word – livelihood – and he began an entire discussion on livelihood, livelihood, there are so many words in Hebrew, and every time I don’t understand something, and suddenly went into this roll, that was just so irrelevant. (3412)

At times therapists decided to stop the client’s flow of speech for questions when they had difficulty to construct a coherent account of the client’s narrative due to their associative speech patterns or emotional detachment:

I asked him about suicidal attempts. I asked him: do you have plans? He started talking in a very abstract way – ‘you don’t need plans, when someone wishes to commit suicide they knows how, he doesn’t need to plan it and the likes.’ It took too long and I also had this feeling that he really isn’t talking to the point, so I stopped him. I said did you think how you were going to do it? (1143)

Yet, in some cases, when the therapist felt that the client is emotionally overwhelmed and hurting, they erred on the side of not interrupting their speech:

She was a bit overwhelmed. She came into the room and spilled out her emotions and everything that was burdening her right away. So I let her vent. It was difficult to organize her. I mean it was difficult to go over things chronologically and collect all the information. (1180)

Therapists also brought up concerns in cases where the clients preferred not to speak of certain topics they saw as essential for their assessment of the client:

She’s in remission. Remembering the psychotic episodes is not very pleasant. Because there’s shame and discomfort. It isn’t easy to talk about it. Especially when you are yourself again, so there was a moment there that both she and I were experiencing difficulty. But, I insisted we go into it, because I had a diagnostic question here right from the start. (3410)

**Collection of sufficient diagnostic information versus attendance to client’s emotional state**

Approximately one-third (30.8%) of the intakes included description of dilemmas related to conflict between the therapist’s goal to collect all relevant diagnostic and socio-cultural information and the importance of emotionally supporting the client. This dilemma was especially evident when dealing with questions pertinent to understanding client’s main problem that were emotionally triggering for the
client. In many cases, questions regarding past traumatic experiences and use of substances highlighted this tension:

She gave very little information and then when I asked her questions I felt I was being really intrusive, and this really disturbed her, so I used my own judgement. It was especially evident when I asked about drugs and alcohol she seemed really anxious and uncomfortable and at first I didn’t let go, I wanted to get that information, how much she drinks, eventually I got it. (3507)

Therapists emphasized the importance of gathering as much information as possible not only on diagnostic symptoms but also about the developmental history and socio-cultural background of the client so they can better form an “understanding” of the client’s central problem. Many times, therapists who chose to forgo certain questions due to their concern these questions might be emotionally difficult for the client emphasized that they missed out on relevant information; some even regretted not asking certain questions:

...to ask more about the mother – what happened there exactly. Maybe – with her psychiatric background to find out more. This is something I wish I’d discussed with her. I did think about it and thought that it might be meaningful but it felt that these questions I needed to ask were difficult for her. I felt that they may threaten her in some way. I’m sorry I didn’t ask that. I think I didn’t find the words or timing to ask about it. (2066)

Most therapists decided that protecting the client’s emotional integrity and sense of safety was more important than asking potentially triggering questions. They stressed that they must practice judgement when collecting information, since they did not want to clients to be “left alone” to deal with emotionally charged topics that have been brought up during the intake:

Someone divulges a lot of personal stuff and I don’t see him next week, so I got a lot of general information but I didn’t press any further because I don’t want to open his wounds when there isn’t someone that can take care of him shortly after that. I asked only what I felt he could handle, because people walk out of here and they’re alone again. (4078)

In certain cases, the clients explicitly cautioned the therapist not to ask about certain topics:

She told me upfront that there are things that she won’t tell. So, I understand there are some residues there, some overflow, when she says don’t pressure me, so I was careful. You understand that everything is so fragile there, you need to be careful not to break anything. (3008)
In other situations, clients communicated their wish to avoid a topic through non-verbal communication. Therapists often responded to the client’s signals by respecting their request by not asking further, usually without checking why. Non-verbal signals included emotional reactions like crying, a change of conversational tone, or reluctance to share:

Her father passed away a month ago, and I made a conscious choice not to go there – because when I said something very minor about it she burst into tears, it was too painful. It’s an interview, not a therapeutic session, and when you’re conducting an intake you need to know what can be opened and closed and what might later leave the client emotionally undone. (4034)

In other cases, therapists decided not to collect detailed information based on the evaluation that the questioning or telling of the tale might be too hard for the clients due to their personal or psychological characteristics, such as lack of introspection and tendency to be introvert:

She’s an introvert; I imagine this also had an effect. There were a lot of things she only brought up when I specifically asked, so I’m pretty certain that if I asked more I’d get more information, but she’s really sort of closed, so I didn’t want to burden her. (3041)

In other situations therapists had a harder choice to make when deciding how to act; yet, it was evident that the decision to ask (or withhold) further questions was not based on a systematic decision-making process or clinical orientation, but on ad hoc clinical considerations arising during the meeting with a specific client. Thus, in some cases, the therapist’s position regarding sensitive questions changed throughout the intake; such was the case when the client’s sense of comfort and security fluctuated during the intake and allowed asking certain questions at the end of the session that were not suitable to ask before:

I saw in the application she wrote – suicidal thoughts. So I began asking her about it but could see that it’s really difficult for her to talk about it so I asked her – is that too much? Let’s not talk about it now and come back to it later. It was clear to me that I don’t want to pressure her, I want her to feel comfortable, then we can go back. Towards the end I reverted to it and asked her. (3015)

Structural limitations versus client’s flow of speech

In 17% of the intakes, therapists referred to the tension between allowing the client free, unstructured flow of speech, and the structural limitations the clinic imposes on the therapist. Therapists described how the clinic expects them to meet the goals
of deciding on a diagnoses and filling out the intake form in the limited time of a single clinical session usually lasting 50 minutes:

As far as receiving a full history and filling out the intake form goes, you don’t know whether it will work out or not pretty much till the end of the intake, sometimes you take a look at the clock and see that 40 minutes have elapsed and you still didn’t get to that, which can be problematic. (4090)

Needing to see clients consecutively with little time in between sessions exacerbates the sense pressure and does not allow for flexibility in the use of clinical time (e.g. extend intakes in cases it seems clinically important):

On the one hand you want to allow the client to express himself, to show your empathy and listen and all that, but on the other hand you need to make a decision. Four more people are waiting outside, and I need to press on and end the session. I mean, decisions were more about where do I stop him, where do I focus him, even when it comes in the expense of empathy and positive feeling. (4004)

Managing the time constraints mandates that therapist continuously decide how to best use the time they have to accomplish all the goals of the intake. They also described avoiding going into details when “mapping” the problems presented by the client: “But I ask a little about everything, and don’t really delve into anything, because I can’t really go any deeper given my time restriction” (4084).

Although doing so allowed them to meet their goals for the session, therapists felt that such conduct inhibits their ability to form a good therapeutic alliance. Some therapists described their frustration with being subject to such limitations; others said they believe the outcome of these limitations is that the clients do not experience the therapists as empathic with grave consequences to continuity of care:

I don’t know if she felt enough empathy on my part. I did try to be empathetic to what she said and on the other hand, I didn’t make it easy for her to tell me, she didn’t get to tell everything she would have wanted to. I stopped it at some point, because I saw we can’t possibly have enough time. So, she might have felt feeling frustrated. It’s a possibility. And if this is really the case, she might prefer not to see me again. (2069)

**Therapists’ versus clients’ goals for the intake**

Approximately one-tenth of the intakes included description of dilemmas surrounding the gap between therapists’ and clients’ intake goals. The clients came to the intake with some central, pressing problem causing them anguish; they wished to focus on that problem. Therapists stated that their primary goal during intake was to collect information regarding that problem, but also about
the client’s developmental and psychosocial history. Many therapists described the challenge to balance the need to discuss the topics important to their clients and their own need to review certain information:

There was a significant gap between the fact that I wanted to draw out as much information as possible and get a sound understanding of the problem and she really wanted to talk about what is troubling her right now. (2055)

Especially evident was the challenge of collecting information about the client’s socio-cultural background. Most therapists agreed that such information could promote their understanding of the client. They also referred to their increased ability to understand the clients’ emotional and behavioral reactions given their socio-cultural background. This information provides the framework, the context to the patient’s suffering. The following example demonstrates the importance of socio-cultural background when determining whether the anxiety described by the client is a sign of psychopathology or can be understood more in the context of an adaptive reaction to the dangerous environment she and her children reside in:

She began talking about anxiety. In this case, I couldn’t really understand it. It seemed to me these weren’t anxieties but justified concerns because I do hear more and more about kids from [dangerous neighborhood] getting into trouble. It was compatible with her reality and with a mother’s concern for her kids. It wasn’t enough to ask her a few times do you think it’s exaggerated. She didn’t think so. She couldn’t answer it, but it didn’t feel exaggerated to me. (3401)

Even though therapists acknowledged the importance of collecting broader socio-cultural information about the client, they often neglected to collect it, usually because they believed other information (e.g. diagnostic) was more critical:

I didn’t get around to it. It didn’t come up in the interview. I didn’t even ask her ethnicity. At some point I did think to ask because of her relationship with her father. Because her sister was taking care of their mother and she of their father. And in some cultures people live with their parents but I moved on. (4014)

Another issue surrounding clarification of intake goals arose when therapists identified a different central problem that the client herself did not deem important or did not want to address. Some therapists chose to follow the client’s presenting problem, emphasizing that the clients were most knowledgeable about their own lives and knew what the therapy should be focused on:

He spoke of violence at home, and didn’t really go into details. He kept saying that he was past that and it wasn’t so important, wasn’t what was bothering him right now. And I played along, I mean, maybe he’s right, maybe it isn’t so important right now. So I didn’t ask too much. (3070)
In other cases, therapists directed the conversation to include the goals they identified as important:

She came to talk about how she lacks appetite and found herself telling the family’s story with much pain and distress. And really after these things came out to the open it was really important to me to offer some therapeutic information and I was really happy I had this opportunity to offer continued therapy. (4046)

This mostly was decided on a case-by-case basis and seemed to vary as a result of the client’s openness and the clinician’s judgment.

**Focus on psychiatric assessment versus use of rapport-promoting techniques during intake**

Approximately, in 7% of the intakes, therapists described dilemmas related to the need to adhere to the intake’s goals (primarily information gathering and diagnostic evaluation) and offering a therapeutic intervention to improve the client’s state, based on rapport-promoting techniques such as empathy, encouragement and mirroring: “On the one hand I responded empathetically to what he described, on the other hand I wanted to direct him to continue, as we couldn’t stay with it for too long” (2094).

“Being with the client” at the expanse of gathering additional information was considered justified with clients who reported risk to themselves or others and those who presented with urgent crisis: “I think that since she started talking about the suicidal thoughts, then I suddenly realized – OK, this needs to be addressed here” (1302).

In such cases lingering with the client and offering encouragement and support were considered essential to form a basic therapeutic relationship:

I really tried to be with him. I did what I do in therapy, but only partially. I mostly did that to make him feel that I am interested, have a desire to learn more about him and willingness to listen to what he had to say. (2094)

In some cases therapists opted to provide some therapeutic interventions, mainly ones that involve offering new insights to the client, partly in order to examine their response and as a result adjust the treatment recommendation. Therapists partly based their decision on the clinical assessment of the client’s psychological resources to manage such interventions:

There was one moment towards the end I deliberated if I should connect the situation that brought her to Israel to the situation that made her so sad and eventually I decided to do it to throw in a line and see if it has an effect and I didn’t think it would endanger her. You know, if I would have thought that she was more psychologically fragile I wouldn’t have done it. (4032)
Prior data documented in the client’s medical chart versus diagnostic information collected during the intake

Approximately, in 7% of the intakes, therapists described clinical dilemmas surrounding the use of prior information about the client documented in the medical file, and the information they collected during the intake session. Therapists were ambivalent about accessing information from the chart, particularly before the meeting with the client. Most therapists chose to scan the information in the medical chart before seeing the client reasoning that having been privy to this information allows them to conduct the intake more efficiently, specifically not repeating questions for which the information already exists in the chart: “Of the past usually I ask quite a lot and this time I nearly didn’t ask at all, because it’s already in the file and there’s no point in bringing it up again” (2078).

Knowing certain things about the client as the therapist walked into the session allowed them to tailor the communication style to the client’s personality and inter-personal style, as well as emotionally preparing themselves to meet the client:

I know that I’m going to meet a certain personality type. I was careful because I read in the file that she can be very emotional, she can get offended and attack and really make a scene in such sessions. But, there was nothing of the sort. We had a really good conversation. I don’t know what would have happened if I didn’t know before if the file wouldn’t have prepared me for something worse. (1053)

Other therapists preferred not to read the chart prior to the meeting as they were concerned that the information will bias their listening:

Before I met her I realized it’s a case of recurring depression and that my decision will be to recommend psychiatric treatment. Now, about 10 minutes into the interview, I began wondering if things were really headed in that anticipated direction. I tried to evaluate – perhaps something else is needed here, maybe I’m not seeing something because I’m predisposed you should really check that it isn’t some routine you follow. (1054)

Therapists also highlighted the value of gathering information directly from the client as the information in the chart may not be updated or accurate:

I made an assumption based on the chart that she was alone. Then suddenly she said something so I asked and she told me she wasn’t it should have been brought up before I was supposed to bring it up before. (3064)

Therapists’ contemplated how they should address the psychiatric diagnosis already documented in the chart. Most often, therapists relied on prior diagnoses in the medical chart, yet they tried to assess whether it is still applicable, and/or
whether additional comorbidity exists. This was particularly evident with diagnoses of personality disorders that were rarely documented in the chart:

I wrote down the OCD but didn’t add the personality disorder. Again, it was a decision I made with myself not to add it. Because there wasn’t anything about it in the file so I decided I shouldn’t add anything till it’s clearer. (4008)

Discussion

The current study is the first to systematically describe the dilemmas therapists manage when conducting the mental health intake. Most frequently, therapists described struggling with tensions related to the structure of the intake and balancing the need to collect sufficient diagnostic information alongside need to be attuned to the client’s emotional needs while facilitating the establishment of trust and good working alliance. The competing and at times conflicting goals for the session as well as the impact of exposure to previous clinical information from the medical chart pose additional challenges for therapists as they decide how to conduct the intake and what to focus their questions on.

Most notable was the tension between the need to complete a diagnostic assessment and the wish to form a good connection with the client. 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 alliance such as trust and agreement (Huang et al., 2013; Pinto et al., 2012). Our findings suggest that therapists struggle with how best to support the establishment of good alliance in light of yet, another important goal for the intake, i.e. deciding on a diagnosis.

Identification of the “correct diagnosis,” does not always parallel the client’s main problem (Westen, 1997); however, it forms the foundation for treatment recommendations. Categorical diagnostic systems such as the DSM-5 employ a symptom-based 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 as therapists are expected to statistically quantify uncertainties as subjective probabilities in the process of arriving at the correct diagnosis (Aspinall and Hill, 1984; Reeve, 2002). Therapists described struggling with the negative impact of the focus on prescribed diagnostic questions during the initial interview on the quality of the working alliance. Therapists often felt that establishing a good rapport with clients is better accomplished through a more open dialogue that includes conversation about the personal socio-cultural context within which their client lives and develops (Clark and Mishler, 1992).

Furthermore, a person’s socio-cultural context may impact what they report, what the therapist asks them to report, and how the therapist interprets the information provided (Burgess et al., 2004; Rosen et al., 2012). Socio-cultural context
(including social class, educational level, gender, age and role expectations) determines therapists’ construction of what they regard as being “normal” for others of similar background. Although therapists acknowledged the importance of such information, they rarely collected it during the intake.

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 and 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 impact the quality of the working alliance (Clark and Mishler, 1992).

Alternative models of conducting the initial clinical interview stress the importance of open communication that allows the client to determine the content, pace, and flow of the session (Clark and Mishler, 1992). Mishler (1984, 2005) suggests that the struggle over the control of the session 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 contextualizing 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.

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. In order 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 initial clinical interview need to address multiple and at time 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., 2015a), or use structured measures to complement the information collected during the mental health intake (Nakash et al., 2009b). 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 client developed and their suffering emerged.

The current study has several limitations. First, the study was conducted among a convenience client sample, which may be subject to selection bias. Second, included in our study were participants whose Hebrew proficiency was high.
This limitation reflects the limited resources in public clinics to provide linguistically appropriate mental health services to minority patients (e.g. Israeli-Arab), as the majority of the clinic staff (administrative and therapeutic) speaks primarily and/or exclusively Hebrew. Thus, the lack of representation to linguistic minorities (including ethnic minorities and recent migrants to Israel) in the sample represents a larger challenge to the mental health healthcare system in Israel.

In addressing the challenges of conducting initial intakes, 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 who 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 their 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. Given our recommendations, potential barriers to implementing them may rise including but not limited to, shortage of clinical and administrative staff and limited funding for already overburdened therapists who practice in a resource-limited working environment.

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References


**Appendix 1. Therapist interview guide.**

A. Chief complaint

1. How did the patient describe their reason for coming in today in their own words?
2. How would you describe their problem, concern or reason for coming in, in your own words?

B. Goals

3. Walking into the intake what were your goals for this meeting? What were you hoping to accomplish?
3a. Of these goals -what was the most important goal to achieve? What was the least important goal to achieve? How did you prioritize these goals (what guided you in making the decision what is most/least important)? Did these priorities shift during the intake? How?

3b. What goals were easier to achieve? What made it easier to achieve them?

3c. What goals were harder to achieve? What made it harder to achieve them?

C. Decision points

4. Can you think of moments during the intake in which you had to make decisions about how to proceed with the interview? (for example when you felt you could ask about x, y, or z but had to make a decision to ask only about x). Can you tell me about some of these moments? How did you make the decisions for each moment?

5. What would you say is the most important thing to know about the patient as a human being, in order to better understand him/her?

D. DSM classification system

6. What information/observations/processes helped you decide about the DSM diagnosis?

6a. What information influenced your diagnosis the most? (e.g. DSM-IV criteria, clinical or cultural intuition, sociocontextual information)

6b. What was the contribution of (e.g. gender, age, description of symptoms, prior psychiatric history) to your diagnostic formulation of this patient?

6c. What questions did you ask the patient to probe for relevant information that would help you understand this person’s main problem? How well do you think these questions worked in getting you the information you wanted?

6d. Did you have access to prior records for this patient? How did it affect or not affect your diagnosis of this patient? How did it affect or not affect your certainty about the diagnosis?

6e. Some providers find DSM diagnostic classification to be an important part of the intake, while others feel it is not a critical part of the initial meeting. How did you use or did not use the DSM classification in the intake you conducted?

6f. What other information/guidelines/classification systems helped you make decisions with this patient?

7. What was the DSM diagnosis for the patient? What was the diagnosis used for (e.g. billing slips, treatment plans etc.)? How certain or uncertain were you about the diagnosis?

7a. which expressions such as behaviors, emotions and/or language the patient used influenced your diagnostic assessment?

7b. Did the patient exhibit any expressions or gestures that helped or hindered your ability to identify their diagnosis? (e.g. signs, movements, tone of voice, posture)
7c. Did the patient use words or terms that influenced your diagnosis? (e.g. “the disease”)
7d. What helped/made it difficult to feel certain about the diagnosis?

E. Social, cultural and racial background

8. Some providers find the social, cultural and racial background of the patient an important part of the intake process and the diagnostic assessment while others do not. What did you perceive was the patient’s social, cultural and racial background and how did it influence the diagnostic assessment of this patient?
8a. Do you think it matters whether or not the patient was from the same background as you? Why/why not?
8b. Is the patient’s background important to the way you treat, understand and respond to this person? How?
8c. Is your background important to the way you connect to the patient (therapist–patient connection)? How?
8d. How did social, cultural and racial background influence the diagnostic assessment?

F. Sources of certainty and uncertainty

9. What information, that you did not get would have been important to obtain in order to make decision about this patient? What constrained you from obtaining this information?
9a. Was the patient not disclosing some essential information?
9b. Did you run out of time to get all the information you wanted?
9c. Was there a language or communication barrier? If yes, how do you think this influenced your diagnostic assessment?
9d. Was language use, communication style, or use of interpreters a factor in both the depth and breadth of information you were able to get from the patient? If yes, please give an example or elaborate.

G. Interaction with the patient

10. How do you think your interaction with this patient went?
10a. Can you give a specific example from the session that would characterize the nature of the rapport, engagement?
10b. Do you think this patient would come back to see you? Explain why yes or no.

H. Is there anything else that would be important to mention and I haven’t asked about?