“Why Come for Treatment?” Clients’ and Therapists’ Accounts of the Presenting Problems When Seeking Mental Health Care

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Abstract
Although identification of main problems is the foundation for treatment planning, limited research has examined reasons for seeking mental health care. We identified reasons for seeking mental health care as reported by clients and therapists upon initial contact with mental health services. We conducted in-depth interviews with clients and their therapists immediately following the intake. We analyzed 117 therapist and 112 client interviews using thematic analysis. Overall interrater reliability among three raters who coded the interviews was high (kappa = 0.72). Our findings suggest that, overall, clients and therapists report similar main area problems that bring clients to care. Emotional distress and other psychiatric symptoms as well as interpersonal problems were most prevalent. Therapists tended to ignore some problem areas that clients highlighted, including physical problems and socioeconomic strains. Raising awareness to potential gaps in perception of main problems that bring clients to care will promote a shared understanding and improve quality of care.

Keywords
mental health intake; presenting problem; clients; therapists; diagnosis; thematic analysis; qualitative; grounded theory; Israel

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 for the intake including, but not limited to, establishing diagnosis, facilitating rapport, and planning treatment (Nakash, Dargouth, Oddo, Gao, & Alegría, 2009; Nakash, Rosen, & Alegría, 2009; Rosen, Miller, Nakash, Halperin, & Alegría, 2012). Although limited, some research suggests that clients’ goals may differ from that of the therapist and include a desire to feel understood and supported by their therapists, and a desire for psychotherapy to develop specific coping mechanisms to better manage their life problems (Nakash, Nagar, & Levav, 2014).

Mental health service providers must carefully attend to clients’ needs to better match the services offered to the needs of the incoming clients. Despite the importance of accurately identifying the reasons that bring individuals to care, little empirical research has systematically assessed the presenting problems of those who seek mental health services. The clinical research that has been done thus far mainly focuses on identifying psychiatric disorders that characterize those who seek care and has documented high prevalence of mood and anxiety disorders as well as personality disorders among mental health service users (Nakash, Nagar, & Kanat-Maymon, 2015a; Zimmerman, Chelminski, & Young, 2008). Limited research has been done to explore the reasons to seek care from the clients’ point of view.

In a study conducted in a university counseling center in the United States, Lucas and Berkel (2005) found reports of anxiety and depression to be the most common presenting problems among college students seeking help. Feelings of isolation and inadequacy in interpersonal relationships and difficulties associated with their role as students were also prominent. Vocational issues (goal clarification, vocational information, and assistance with vocational obstacles) were rarely identified as the main problem. In another study, considerable distress related to religious and spiritual concerns was reported.

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among 25% of students who sought help from a university counseling center in the United States (Johnson & Hayes, 2003). These students also tended to be distressed about the loss of a relationship, sexual assault, confusion about values, homesickness, and suicidal ideation (Johnson & Hayes, 2003). Consistent with other research, a study of client characteristics in a primary care behavioral health model of service delivery (Funderburk, Dobmeyer, Hunter, Walsh, & Maisto, 2013) demonstrated that the two most commonly reported presenting problems were depression and anxiety. Clients also presented issues related to coping with a medical condition, symptoms of chronic pain, and issues related to a behavior change (e.g., reduced alcohol use and smoking, weight changes). Other studies conducted in community mental health centers documented that interpersonal problems (Burstein, Loucks, Rasco, & Green, 1993) or psychiatric symptoms and nonspecific psychopathology (Nakash, Nagar, & Levav, 2014) were most frequently described as the main problems for seeking care.

A number of studies also investigated the changes in type, severity, and chronicity of presenting problems over time. Erdur-Baker, Aberson, Barrow, and Draper (2006), for example, compared two clinical samples surveyed by counseling centers in higher education institutions, from 1991 and from 1997. Service users in 1997 reported significantly more chronic and severe problems related to academic concerns, relationship and adjustment issues, depression, and romantic relationship issues as compared with the earlier year. In both samples, however, academic concerns were most prominent, with romantic relationship and adjustment issues following. Sexual issues and eating concerns were least common.

The studies that have been conducted on the topic thus far were limited in scope as they primarily used surveys, which are restricted in their ability to offer a rich understanding of the reasons that bring individuals to seek care. Identification of the client’s main problem is the foundation for the effective treatment of mental health problems. This goal can be challenging given the level of uncertainty that always exists in mental health assessment process (Nakash, Rosen, et al., 2009). Bringing the voice of the clients to bear when formulating these main problems as opposed to relying on top-down psychiatric diagnostic nosology is critical in delivering effective care. Moreover, no study to date has compared the client and therapist accounts for the presenting problems. Identifying overlap as well as potential gaps in these accounts can be helpful in promoting the understanding of client’s chief complaint and related treatment plan. In the current study, we aim to identify clients’ and therapists’ accounts of the presenting problems upon initial contact with mental health services. For that purpose, we conducted in-depth interviews with both clients and their therapists immediately following the intake session to identify their respective accounts for the presenting problems (chief complaint) for which clients were seeking care in community mental health clinics.

**Method**

**Setting**

The study was conducted in four community mental health clinics in Israel. All four participating clinics offer free mental health services to an ethnically and socioeconomically diverse adult client population. All clinics offer a variety of mental health services, including assessment, psychotherapy (including different treatment modalities tailored to client’s presenting problem, such as cognitive-behavioral therapy, psychodynamic therapy, crisis intervention, group therapy, and family and couples therapy), and psychopharmacology. Access to care does not necessitate medical referral. The primary goal of the intake session at all participating clinics was to gather information about the presenting problem and psychosocial history of the client to inform diagnosis and treatment plan. None of the participating clinics used a structured intake protocol. At each of the clinics, clients were consecutively allocated to therapists to conduct the intake based on therapist availability. All intake sessions are conducted in person with no prior screening.

**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 5 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. Clients were informed that all information gathered would be kept confidential and that no identifying information would be collected. As part of the informed consent process, research assistants also informed clients that they were free to decline participation, and/or withdraw participation at any point with no consequences to the quality of care they received from the clinic. 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. Only clients of clinicians who agreed to participate were invited to participate in the study; clients were informed that if they agreed to participate, their assigned clinician would also
be invited to participate. Of the 184 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; three did not feel well enough to participate; seven did not want to have the intake session recorded). Five clients did not complete postintake interview, and five additional clients were excluded from analyses due to poor recording quality. We analyzed a total of 112 client interviews and the corresponding 117 therapist interviews for the current study.

The majority of therapists were females (86.2%), ages ranged from 28 to 64 ($M = 45, SD = 10.8$), and approximately half of therapists were born in Israel (51.7%); 35% 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 117 clients who participated in the study, the majority 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 US$15,000.

Procedure

These data are part of a larger study aimed to examine mental health intake with diverse client population (for full study description, please see Nakash, Nagar, Danilovich, et al., 2014; Nakash et al., 2015a; Nakash, Nagar, & Kanat-Maymon, 2015b; Nakash, Nagar, & Levav, 2015; Nakash & Saguy, 2015). Immediately following the intake session, trained research assistants conducted semistructured, in-depth interviews face to face with therapists and clients. These in-depth interviews were based on principles of the cognitive task analysis (CTA) method to explore therapists’ and clients’ experiences and evaluation process during the mental health intake (Crandall, Klein, & Hoffman, 2006). The CTA method aims to understand and describe the way the mind and cognition work, and is usually achieved by providing the participants with a series of guiding questions. One of the most common CTA methods is the semistructured interview that includes probes eliciting memories of specific occurrences from participants, while focusing on the events leading to the occurrence, the interviewee’s experience as the event unfolded, and the potential consequences of the occurrence. Our semistructured interview protocol included a number of scripted questions and a list of suggested probes to help our participants recount specific interactional moments to better understand clients’ and therapists’ cognitive, emotional, and motivational processes during the mental health intake (Hill et al., 2005). Interviews lasted approximately 30 minutes (see Online Appendix for interview guides). We audio-taped and fully transcribed all interviews.

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. Clients’ interviews included questions about their presenting problem, rapport with the therapist, significance of sociocultural factors in the presenting problem, and their expectations from care. Trained graduate students in clinical psychology who received weekly supervision conducted all interviews. 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 performed a cross-case thematic content analysis identifying major themes in therapists’ accounts of their experience during the mental health intake (Charmaz, 2014; Corbin & Strauss, 2008) using ATLAS.ti version 7. The research team who coded and analyzed the data included three graduate students in clinical psychology.

The qualitative analysis involved a series of steps. First, we developed two codebooks, for clients’ and therapists’ interviews according to grounded theory guidelines (Charmaz, 2014; Corbin & Strauss, 2008) which involved three steps. We first performed open coding 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 approximately 3 months and formalized when we reached saturation. The development of the codebooks was based on 15% ($n = 25$) of the therapists’ and clients’ interviews which were randomly selected. Once we established interrater reliability, all remaining interviews were coded using the codebooks.

We organized all of the information in the data corpus under these emerging themes. In addition, we allowed data extracts to be placed under more than one category 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 identified the source of the discrepancy and reviewed the coded sections again until consensus was reached (Corbin &
Strauss, 2008). To prevent coders’ drift, we assessed inter-rater reliability by having all raters code two additional randomly selected tapes after coding 25% \((n = 30);\) therapist: kappa = 0.82; client: kappa = 0.82), 50% \((n = 60);\) therapist: kappa = 0.71; client: kappa = 0.71), and 75% \((n = 90);\) therapist: kappa = 0.70; client: kappa = 0.71) of the total recorded interview. Overall interrater reliability among all three raters in the different time points was good (therapist: kappa = 0.72; client: kappa = 0.70).

Results

Across clients’ and therapists’ interviews, eight central themes detailing presenting problems emerged: (a) psychiatric symptoms and general emotional distress, (b) medical problems, (c) referrals by another person, (d) financial difficulties, (e) familial and marital difficulties, (f) social difficulties, (g) stressors related to sociocultural background, and (h) help with dealing with authorities (Figure 1). On average, clients reported 2.84 \((SD = 1.55, \text{range} = 1–5)\) and therapists reported 1.9 \((SD = 1.31, \text{range} = 1–7)\) problem areas in each intake. In the following paragraphs, we expand on these themes and provide specific examples for illustration.

Psychiatric Symptoms and General Emotional Distress

More than half of interviews described issues relevant to psychiatric disorders as a central reason to seek care (67.9% clients, 56.4% therapists). Most common among those were mood and anxiety disorders.

Client: I visited my family doctor and he said this could be caused by depression, actually I thought so myself, but that was the last straw, that he told me to come. I guess it’s this tendency that I always had and maybe age brings along all sorts of problems.

Therapist: This means that there’s also depression, but emotional instability as well, so I think she needs guidance to deal with these experiences and traumas.

Both clients and therapists mentioned several sources that guided their formulation of the psychiatric diagnosis,
which included diagnosis carried on from previous therapeutic encounters, referral sources (usually primary care physician), and clients’ self-diagnosis (mostly based on online sources).

Therapist: She came to the clinic simply because she was invited, and being a responsible person she showed up. But I couldn’t understand what this was about from the get-go. Until I looked at her chart and saw she was hospitalized, among other things, and I understood we’re dealing with schizophrenia and she is simply in remission.

Client: I’m not sure this is the right word, I found it online, trichotillomania, do you know what that is? There’s a lot of information in the newspaper, so anyway, I have it.

In some cases, therapists described how the decision about the diagnosis was formed during the clinical interview. In these cases, therapists described challenges around formulating diagnosis for symptoms that do not correspond with criteria in the DSM, as well as uncertainty when clients described more culturally nuanced symptoms:

Therapist: I remember he used body-related words to describe his problems “my hands went numb, tickling like ants.” He told me there’s a Russian word for that, “like ants all over your body,” that he couldn’t feel parts of his body, I wasn’t sure what it all meant.

For some clients who were returning to the clinic for a new episode of care, medical charts were available for the therapist conducting the intake. Particularly challenging were cases where the information documented in the medical chart conflicted with the information the client presented during the session. This was especially evident with clients diagnosed with personality disorders. In few cases, discovering inconsistencies between various sources of information raised a sense of distrust of the client, which was more prevalent in cases of substance abuse.

Therapist: Her central complaint is of depression but there’s a discrepancy here between what she complains about and what we observe. She has complaints of depression, complaints of her environment, and what we see is that the central problem is cluster B personality disorders—probably narcissist. And that’s the reason for her mental state.

In other cases, both clients and therapists referred to nonspecific psychopathology (14.5% of therapists, 25% of clients) and mentioned a general state of emotional distress using general descriptors such as “I’m unwell,” “distress,” and “I don’t have any strength left.” The difficulty in conceptualizing the problem was also evident among therapists who expressed greater uncertainty in these cases:

Therapist: I’m still uncertain. I tend to agree that he’s distressed, he’s a very complex person. He says that he wants to address several issues that in the past he’s been unable to address but he had a hard time specifying them.

**Medical Problems**

More clients than therapists mentioned medical problems as cause for seeking care (33.9% and 17.1%, respectively). Clients described chronic medical problems such as cardiac disease, hypertension, various medical procedures, and specific physical symptoms that disrupt their lives such as vertigo, physical weakness, and/or headaches. Most clients indicated that the medical problems caused their emotional problems (especially anxiety and depression). Most frequently, they describe psychological difficulties stemming from the medical condition that impacted their ability to function, increased their dependency on family members, and resulted in greater familial conflicts and financial difficulties.

Client: I’ve undergone a hip replacement surgery two and a half months ago. It was supposed to take a month and a half and became two months, and I can’t work and became depressed, I don’t know how to overcome it, and in the meantime at home there’s no money. I can’t work, I can’t pay rent all that, a lot of concerns and I became depressed.

Many clients described engaging in a medical evaluation process in which their physical symptoms were diagnosed as psychiatric problems after physical explanations were ruled out. A minority of clients resisted the psychiatric diagnosis and claimed that their complaints were not adequately assessed.

Clients: I’ve had some injury, and I went to see my family doctor, and they couldn’t find what my medical problem was. They said the x-ray was fine. I don’t know. I told the doctor as well and she didn’t want to understand that. I know that there are pains that doctors can never identify the real reason for and then they make you feel like an idiot.

While therapists mostly tended to ignore physical problems and often attributed nonspecific physical symptoms (headaches, nausea) to emotional difficulties, others emphasized the complex interaction between physical and emotional problems in the context of social stressors.

Therapist: I think she’s really experiencing some kind of depression but surrounding things related to old age, physical problems, less social ties. She also has familial difficulties...
and feelings of failure as a mother; as a grandmother. All sorts of things that combine together and create depression.

**Referrals**

Significantly more clients than therapists mentioned that a referral was the main reason they sought care (62.5% and 16.2%, respectively). A majority of clients stated that members of their close environment, especially friends and family, urged them to seek care. Another central source for referrals was other health care professionals (primarily primary care physicians).

Client: My daughter-in-law prompted me a bit, set the appointment up and everything. She asked me—would you agree, I said—OK, but she set the appointment.

Some clients described a sense of being coerced into coming to care.

Client: The welfare worker pressured me to come here. I didn’t want to come. I don’t know. I feel that I’m down, I can’t sleep, I’ve got nothing, I’m not well.

Therapists, unlike clients, focused less on the referral source and were more concerned about the reason for referral. Most often, they considered the referral source important only in the context of assessing the client’s motivation, which was perceived to be more external when they followed a referral from another source rather than self-referred. Of particular concern were cases in which the clients came as part of the process needed for evaluation to receive social benefits. In these cases, issues of trust and concerns about secondary gains were raised:

Therapist: I think I got her right from the start. She now also wants income and that’s understandable, yet it bothers me a bit personally. Because we’re talking the person’s soul and what does social security have to do with that. But the soul cannot exist without money. That was clear but now her request is processed, and I do think that’s justified, but there is this secondary gain she’s receiving. This secondary gain is difficult for me.

**Financial Difficulties**

Clients mentioned financial difficulties as the main reason to seek care more often than therapists (23.2% and 10.3%, respectively). Many clients described the negative effects of financial difficulty on the emotional state that brought them to therapy. The financial strain was usually one of several stressors effecting the client’s negative downward spiral:

Client (describing the events leading to her emotional state worsened): My husband started having financial difficulties and went bankrupt, I sold the apartment and remained with nowhere to live, my husband really took it to heart, he tried to commit suicide, I’m crying now because I have no strength left, I have nothing in this world.

Financial difficulties included events such as losing one’s job, interpersonal conflict at the workplace, poverty, and unemployment. Some clients sought services requesting help with dealing with authorities as a result of their financial state or asking for help maintaining or finding a job. Unlike clients, therapists often underestimated or ignored the role that financial problems played in the presenting problem as manifested in the reports of presenting problem by the following client and his therapist:

Client: That I didn’t work, I don’t work, I’m unemployed. I was volunteering here and there but that’s not it, I need a place to work. What was I asking for? I asked—give me some place to work.

Therapist: There’s a background of drug abuse, he’s caused himself all sorts of psychiatric states and on top of that there was this surgery he went through which was also a trigger. There are many background diseases. Some trigger that caused him to be unable to work and he spent a lot of time at home. And also now—I’m feeling ambivalent about that—they determined he had disability percentage- but I’m not sure this is justified.

Inconsistencies between how clients and therapists perceived the association between financial difficulty and psychological distress seemed to disrupt the rapport. This was especially evident when clients requested help with social services as evident in the following quotes in which the therapist pathologizes the financial concerns raised by the client:

Client: So maybe he (the therapist) didn’t really attend this fear of the future. And he said that really I can choose not to go back to work now, and that’s not true, there’s only so much sick leave I can take and this fear is also about our financial state. We belong to the social class that went to the streets to demonstrate, the income is lower than expenses.

Therapist: There are several focus points, several of them in the present that she’s really concerned about, that she spends a lot of energy on. But that’s secondary, I mean she becomes anxious over anything. She has no capacity to deal with everyday pressures. So there’s something at work, there’s something with her son, who’s about to join the army. There’s the financial situation, and there are a number of things occupying her, but I think that fundamentally she overreacts, she’s very anxious.
Familial and Marital Difficulties

Some therapists and clients (25.6% and 31.3%, respectively) mentioned familial difficulties when describing the main reason to come to care. This was more prevalent among women who mentioned especially difficulties relating to the relationships with their children: taking care of them, concerns about grown children and their future, intergenerational conflicts, and difficulties being a single parent. Some of the older clients reported worry around burdening their grown children that was particularly distressing for them. Men who referred to familial conflicts mostly described feelings of abandonment and estrangement from their children that caused their emotional distress.

Client: Why am I here today? Because I have an urgent need for a psychologist or a social worker who I can vent my anger with my kids with.

Many clients mentioned problematic relational patterns that originated in their family of origin and carried over to their current relationships with their own children:

Client: By and large there are two things I always wanted help with because I had a difficult childhood. It’s left these stains that are leading me through life. And the second reason is that I’ve taken my nephew as fosterage now and I can’t handle it and help him the way I want to. I feel that what I’ve been through as a child or teenager no one held her.

Therapists highlighted the role of early “attachment patterns,” especially experiences of childhood traumas and loss in the client’s current emotional distress:

Therapist: I think she’s a woman who grew up in a very difficult reality to say the least. When she was 10 her father shot her mother. And even so she’s not angry with her father. She doesn’t blame him. She also grew up with him because in the divorce settlement later the court decided so—her mother lived—and the court decided her father is more fit than her mother to raise her. So really what I feel she says today—“I can’t hold myself, I can’t gather myself” stems from this sense that as a child or teenager no one held her.

Therapists tended to emphasize early childhood experiences and their role in shaping present relational difficulties while few clients made such links and usually tended to focus on relational difficulties in the present. In the following example, the client described originally coming to care for difficulties in her relationship with her daughter. During that therapy, her own difficulties emerged that encouraged her to seek help for herself:

Client: I started therapy with my daughter, more for her, and we talked about things from my past. So it all emerged. It got me very depressed and suicidal. Basically I had problems with my mother, we didn’t get along and after that I went to boarding school.

Therapist: I think she had traumatic things in life that emerged when taking care of her daughter, all sort of things that she denied and didn’t touch for years are now emerging. She’s overwhelmed by it and needs therapy to process and deal with them.

Marital problems were mentioned by 19.6% of clients and 21.4% of therapists as the main reason to seek help. Most clients and therapists described difficulties following separation and divorce, as well as marital conflict and abuse leading to psychological difficulties, which included loneliness, depression, and anxiety.

Client: I was married to a physically and verbally abusive husband and he’s the one that caused all these problems. When we separated and during the divorce the anxiety started. Because he would always threaten to murder me. So I was really scared, I was shaking, and then I needed the pill to calm myself down a bit.

Social Difficulties

Therapists and clients described feelings of loneliness and social estrangement as well as lack of social support as key factors to seeking care (15.4% and 22.3%, respectively). While both clients and therapists addressed social difficulties (usually chronic throughout life) as a source for suffering, many times clients believed it was the cause of their emotional distress while therapists emphasized psychiatric problems as leading to emotional and relational difficulties as illustrated in the following quotes:

Client: I’ve always felt inferior compared to others and I didn’t feel like I belong anywhere, not school, not at the university and its social cycle. I always felt like an outsider, and it always hurt me, made me distance myself and be lonely, finally I just preferred loneliness and loneliness is harsh.

Therapist: Well, I believe he’s suffering from anxiety. All sorts of jobs he had were lost because of it. You can see a lot of his life revolves around drugs, not taking the drug in addition to other things. He told me that he first used with a friend he used to study with and then there’s a big chance there were anxieties before.

Sociocultural Background

A small percentage of therapists and clients referred to sociocultural background when describing the cause for
seeking care (7.7% and 5.4%, respectively). These included the effect of immigration and acculturative stress and changes in life habits (e.g., religious observance). The following client, for example, mentioned the conversion from a religious to secular lifestyle that underlined his emotional difficulties:

Client: The main reason is that I changed my life 3 years ago. I used to be ultra-religious, I was on the right path until one day I just left and it isn’t easy and there are many things to deal with in the new society, in my new life, it’s a change both in how I think and in life habits and I feel like I’m racing on and don’t stop to observe that I’m going through and I know I’m going through things. I want to get things in order, I want to understand myself.

Like clients, therapists too referred to difficulties stemming from immigration such as financial and social difficulties. Religious lifestyle and its effects on the formation of gender identity were also mentioned as related to the problems of female clients—especially those who underwent changes in their religious identity, which required them to deal with loss of social support and social sanctions by members of their original community.

Therapist: She has difficulty with interpersonal relationships, she fears expressing her impulses. Like she has this perception of what a religious woman should think and how she should behave and she needs to love and accept everybody and under no circumstances can she be sexual. And I think that there’s a lot of difficulty surrounding going out, and all these things are linked to sexual impulses and that’s really repressed.

In some cases, therapists were not sure how to assess and conceptualize diagnostic information in a way that is culturally appropriate, as can be seen in the following example of a client who immigrated from Ethiopia; she described the phenomena of “Zar,” which the therapist was only marginally familiar with:

Therapist: She described what I think is a psychotic state that was culturally contained by her community as something called “Zar.” I’ve heard some general things about that, but really I’m not too familiar. So a lot of the intake was really spent on hearing what that is, how it’s manifested, and I really think it’s psychotic but she’s borderline. I didn’t want to ask her directly if she thinks it’s psychotic, I felt it would be disrespectful and anyway I can hear in what she says things that seem psychotic.

Help With Dealing With Authorities

A minority of clients referring to therapy mentioned a request to deal with authorities as a cause for referral (5.4% of clients, 5.1% of therapists). In some of these cases, the clients were referred by welfare, social security, and/or the judicial system. The main reason for referral was to receive a psychiatric evaluation for issues such as disability or custodial rights. In some cases, referrals were meant to help the distressed client.

Client: First I sued social security, I have physical as well as psychological problems and I didn’t come here for the therapy only. I need them to support my claim to social security. I can’t work because physically I also have medical problems, and also psychological. My debts are mounting.

Some therapists viewed requests for assistance empathetically, whereas others mentioned difficulty establishing trust with clients, questioning their motivation, even when recognizing the detrimental impact of the financial strain on the client’s well-being:

Therapist: Her motivation really needs to be looked into, she also wrote this whole thing with social services . . . so maybe she doesn’t really want it and now she comes with a specific request to receive help from social services so it makes me think not to refer her to therapy at all, or at least to understand that it’s very superficial.

Discussion

In the current study, we identified clients’ and therapists’ accounts of the presenting problems for seeking mental health services in community mental health clinics based on in-depth interviews with both clients and therapists immediately following the intake session. Our findings suggest that, overall, clients and therapists describe similar main concerns with problems relating to both general emotional distress and other psychiatric symptoms as well as interpersonal problems both within the family and in other social relationship being most prevalent. The findings are consistent with previous research (Burstein et al., 1993; Lucas & Berkel, 2005) and further expand it to show that both clients and therapists identify the presenting problem upon entry to care mostly in a similar manner. Importantly, a complex set of stressors including interpersonal (familial and other social conflict and isolation), financial, and physical concerns provide the background for the emergence of emotional distress and decision to seek care.

It is challenging for clients and therapists to clarify the main reason to come to care and together to formulate the main problems that need attendance. Our findings suggest that clients and therapists can differ when formulating the understanding of the main problem, which often directs the treatment plan. This is particularly evident when evaluating the role of exposure to childhood experiences of trauma in the client’s presenting problem. While
therapists tended to view early exposure to trauma as critical in the development of the client’s present emotional distress, clients often preferred to focus on the current stressors that brought them to care (e.g., present relational conflict, financial distress, medical problem). Indeed, extensive research shows the significant impact accumulative trauma can have on mental health and particularly points to the adverse impact of exposure to childhood traumatic events (Carr, Martins, Stingel, Lemgruber, & Juruena, 2013). However, as our study shows, understanding of the role of these experiences in the development of emotional distress that brings individuals to seek care as well as in the agreement on a treatment plan can be more challenging. Explicit discussion can overcome potential misunderstandings and facilitate a shared decision-making process (Barry & Edgman-Levitan, 2012; Drake, Deegan, & Rapp, 2010; Nakash, Dargouth, et al., 2009).

Similarly, therapists tend to underemphasize the role of medical problems, while primarily focusing on psychiatric symptoms and general emotional distress. This is despite contrary evidence documenting that physical illness occurs among more than 45% of psychiatric outpatients and that it is often goes undiscovered (Carson, Katz, Gao, & Alegria, 2010; Hert et al., 2011), leading to poorer quality of life, decreased functioning, and increased risk of early death (Baumeister, Hutter, Bengel, & Härter, 2011; Lawrence, Hancock, & Kisely, 2013). Awareness of physical conditions disproportionately affecting psychiatric clients may facilitate prevention through appropriate referrals and support of client self-care (Carson et al., 2010). Special attention should be given to referral paths to mental health care (Alegria, Canino, & Pescosolido, 2009; Nakash, Nagar, Danilovich, et al., 2014) as they determine the point of entry to specialized treatment. Indeed, our findings show that many clients mentioned the main reason to come to care was referrals by other care providers, primarily from primary care physicians.

Furthermore, our findings suggest that although, overall, clients and therapists mention similar main problems, therapists tend to understate the role of financial difficulties that contribute to the clients’ main concerns. The hegemonic psychotherapeutic discourse has been criticized for emphasizing intrapersonal processes while ignoring—or at best underestimating—the sociocultural context in which the individual lives and through which suffering emerges (Nakash, Rosen, et al., 2009; Prilleltensky, Prilleltensky, & Voorhees, 2008). This is despite the accumulation of research attesting to the impact of social determinants of mental health disparities (Alegria et al., 2009). Alternative approaches such as the ecological discourse see the person as part of the sociocultural systems that largely shape people’s identity and lives and resist the separation between the social world and the personal world. The daily personal reality is understood as an expression of social structure where socioeconomic status plays a critical role in shaping their struggles and reality (Morley & Macfarlane, 2012).

A political discourse to psychotherapy includes an ongoing social critique of social exclusion and oppression (Chester & Bretherton, 2001; Prilleltensky et al., 2008) and an acknowledgment of the political context of psychotherapy (Prilleltensky et al., 2008). The basic assumption is that it is not possible to properly understand and address well-being and suffering without looking at the context of the power relationships in which suffering occurs (Totton, 2006). Such power imbalance can impede the shared understanding of the client’s main problem and lead therapists to ignore the client’s presentation of the main problem. This discourse defines therapy not as a neutral action but rather as one that is led by values such as social justice and protection of human rights. Therapists can be more effective if they integrate the understanding of how power influences oppression, liberation, and ultimately well-being into their practice (Morley & Macfarlane, 2012; Prilleltensky et al., 2008).

The current study has several limitations. First, the study was conducted among a convenience sample of therapists and clients, 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 clients (e.g., Israeli-Arab), as the majority of the clinic staff (administrative and clinical) 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 care system in Israel.

**Clinical Implications and Future Directions**

Encouraging effective and explicit communication concerning the main problems that prompts the clients to seek treatment is recommended. Before delving into a deeper understanding and information collection of the main problem that brings clients to care (which is usually the first one the client mentions in the session), therapists should carefully and explicitly make sure they identified all their clients’ concerns. The therapist should also reflect back their understanding to the client, for the client to confirm that the therapist understands correctly what they he or she said. Using explicit therapeutic contracts can also ensure that the client and the therapist are in agreement about the nature of the problem. In addition, continued effort to help therapists be more aware of potential neglected problem areas (e.g., medical
problems, financial concerns) through training will increase the likelihood that they will collect the essential information and improve the quality of care. Promoting critical thinking that involves discussions on the political context of psychotherapy should also be an integral part of training to improve political empathy (Nakash, Cohen, & Nagar, in press). Finally, the importance of client education needs to be emphasized. In particular, communication skills building can facilitate client engagement in providing and seeking information and improve quality of mental health care. Future research should examine how clients’ expectation from treatment affects their reasons and decision to seek care as well as ways to improve effective communication of their main problems with their therapists.

The formulation of treatment plan can be particularly challenging when clients and therapist do not share the same understanding of the main problem. This could happen when therapists neglect to collect important information (e.g., information about physical problems and/or financial constraint) or when the formulation of the importance attributed to information provided is different (e.g., report of childhood experiences of traumatic events). Future research should examine how potential differences in clients and therapists perceptions of the main problem affects the way a therapeutic contract and/or plan of care is negotiated and retention in care.

**Conclusion**

Understanding of the main problems that bring clients to care should be the basis for treatment plan and has the potential to improve client retention in care and quality of care (Shay & Lafata, 2015). Our findings suggest that, overall, clients and therapists mention similar major area problems and often use similar words to describe them. Yet, some areas highlighted by clients such as the role of physical problems and socioeconomic strains tend to be ignored by mental health clinicians. Despite the time limitations and high level of clinical uncertainty that characterizes the mental health intake, therapists should strive to adopt a bio-psycho-socio-political approach to formulating mental distress during early phases of treatment.

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**Supplementary Material**

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