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# Uncovering the Intricacies of the Clinical Intake Assessment: How Clinicians Prioritize Information in Complex Contexts

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# Uncovering the Intricacies of the Clinical Intake Assessment: How Clinicians Prioritize Information in Complex Contexts

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**ABSTRACT**   *Objective:* Based on a single intake interview, mental health clinicians must distill their assessment to brief statements reflecting essential information. We explored how clinicians organize and prioritize the clinical information they collect during the initial assessment of their clients. *Method:* We conducted in-depth semistructured interviews with a convenience sample of 38 clinicians in four community- and hospital-based mental health clinics in Israel. Clinicians were interviewed immediately following an intake session with 117 clients and were asked about the client's main problem, evaluation process, rapport with the client, and role of sociocultural factors in assessment. We identified primary themes across interviews. *Results:* Clinicians prioritized a psychiatric diagnosis based on DSM-5 categories, followed by psychological processes and family and social relationships. Less than a third of clinicians (29.1%) viewed sociocultural and socioeconomic factors as important in discerning expressions of distress. *Conclusions:* Our findings raise questions about how the structured expectation of diagnosis may influence how clinicians gather and prioritize information.

**KEYWORDS**: assessment, mental health intake, culture, psychiatric diagnosis, socioeconomic

C linical records of intake sessions in mental health settings are largely informed by the medical model and reimbursement structures. Based on a single interview, mental health clinicians (hereafter referred to as clinicians) must distill their assessment process to brief statements reflecting essential information. The information clinicians collect during the intake often includes, but is not limited to, presenting issues, brief history of these concerns, source of referral, mental status, cursory treatment history including current medications, and a differential diagnosis based on the *Diagnostic and Statistical Manual of Mental Disorders, Fifth*

*Edition* (DSM-5; American Psychiatric Association, 2013) and the *International Classification of Diseases, Tenth Revision* (ICD-10; World Health Organization [WHO], 2016; Nakash et al., 2015a, 2018; Rosen et al., 2017). Despite the importance of the assessment process, little is known about how clinicians process and prioritize the information they gather during the assessment process. There are no empirical studies addressing these questions to date.

Because the initial interview in community- and hospital-based mental health clinics guides the direction of treatment planning and intervention, implications for client retention and care are substantial. For example, studies have documented that close to 30% of individuals who drop out of treatment do so after the intake interview, and among minorities these estimates are higher (Nakash, Nagar, Danilovich, et al., 2014; Olfson et al., 2009; Shim et al., 2017). Given the limited time and high level of diagnostic uncertainty that characterizes the mental health intake, understanding how clinicians consider the information gathered during the intake session to conceptualize their understanding of the client's main problem is of interest.

## Literature Review

### The Intake Interview

The intake interview involves gathering and organizing complex information (Jordan & Franklin, 2016; Nakash et al., 2009, 2015b; Sommers-Flanagan & Sommers-Flanagan, 2017). Clinicians across disciplines are trained in the skills and art of clinical and diagnostic interviewing with varying emphases. Common tasks include explaining the purpose and flow of the clinical interview and clinician role; building rapport with the client (individual, couple, or family); listening reflectively and actively, asking questions in a manner that is respectful of the client's vulnerabilities; exploring client strengths and coping patterns in relation to adverse circumstances; inquiring about clinical symptoms to inform diagnosis (DSM/ICD); observing communication and behavior patterns; ascertaining the client's understanding of the current concerns; gathering personal, medical, and family history; and identifying social support, school, and employment experiences (Jordan & Franklin, 2016; Sommers-Flanagan & Sommers-Flanagan, 2017). In most clinics in Israel, as influenced by common practices in the United States and other Western approaches, providers must also determine the presence of a psychiatric diagnosis based on psychiatric diagnostic manuals (DSM/ICD; Carlat, 2017; Frances, 2013a; Hersen & Thomas, 2007; Jenkins, 2007; Jordan & Franklin, 2016; Nakash et al., 2018; Nordgaard et al., 2013; Sommers-Flanagan & Sommers-Flanagan, 2017).

There is much to achieve during the intake interview during a limited amount of time, and the stakes are high for clients. Accurate diagnosis and clinical formulation determine access to and direction of treatment planning, interventions, and related outcomes. When the intake and diagnostic assessment process goes awry, clients may

not receive appropriate interventions, reducing the possibility of positive outcomes and in some cases increasing risk of harm (Frances, 2013b; Harkness, 2011; Jordan & Franklin, 2016; National Collaborating Center for Mental Health, 2011; Sommers-Flanagan & Sommers-Flanagan, 2017; Wallen & Lorman, 2008).

Social workers comprise the majority of clinical mental health service providers in community- and hospital-based mental health clinics in many Western countries, including the United States and Israel (Heisler, 2018). Although training orientations differ across mental health providers' disciplines with some overlap, social workers are generally trained in a person-in-environment perspective, psychologists focus on individual and psychological functioning, and psychiatrists develop specialized knowledge regarding biological and neurological processes to inform decisions about pharmacological interventions (Heisler, 2018). Such distinctions diminish in the context of community- and hospital- based mental health clinics, particularly in the context of the intake interview, where a common set of requirements often guides the intake process across disciplinary differences.

## The Role of Sociocultural Factors in the Intake Session

The role of social determinants of mental health (including sociocultural, economic, and political factors) in mental health disparities has been well documented (Braveman et al., 2011; Shim & Compton, 2018; WHO, 2014). It follows that such factors would be of prime importance in determining clinical understanding during a mental health assessment in the intake session. However, the individual medicalized model of mental health assessment central to Western perspectives of mental health and illness (Summerfield, 2000) emphasizes evaluation of psychopathology as expressed through clustering of symptoms and their interference with an individual's capacity to function. These medicalized models are further supported by the influence of third-party reimbursement structures, including government supported care (Pickersgill, 2013). These perspectives shape the assessment process and, to an extent, may limit attention to sociocultural factors.

It is generally acknowledged that experiences of mental health conditions do not exist in isolation; rather, these experiences interact with the context of the social world (Jordan & Franklin, 2016; Lund et al., 2011; Whomsley, 2018). Risks and vulnerabilities are intertwined across systems throughout an individual's development and include social, cultural, economic, societal, and political environmental forces. Included in the term *sociocultural context* for this paper, these forces include but are not limited to poverty, lack of educational opportunities, stigma and associated prejudice and discrimination, violence and abuse, social and economic inequities, structural disparities associated with intersectional social identities and group membership, and exposure to political violence (Allen et al., 2014; Lund et al., 2011; Patel et al., 2010). Deleterious sociocultural forces can lead to personal isolation, sadness and depression, anxiety, loss and grief, psychological trauma, and heightened experiences

of untreated mental health conditions (Patel et al., 2010; WHO, 2013, 2014). Exposure to these risk factors is disproportionately high in socioeconomically disenfranchised groups, including those who are poor and living with mental health conditions (Lund et al., 2011; National Collaborating Center for Mental Health, 2011; Patel et al., 2010).

Resilience and holistic models speak to the capacities of individuals, families, and communities facing adverse circumstances and emphasize the power of capacity (Miller, 2012; Miller & Pescaroli, 2018; Vindevogel et al., 2015; Whomsley, 2018). Yet, the intricate systemic and structural sociocultural, economic, and political forces affecting the lives of people living with serious mental health conditions are imposing. A person's sociocultural context may further impact what they report, what the clinician asks them to report, and how the clinician interprets the information provided (Burgess et al., 2004; Rosen et al., 2012). Sociocultural context (including social class, educational level, gender, age, and role expectations, among other factors) provides meaning to what a person regards as "normal" for others with similar backgrounds (Nakash et al., 2009). Cultural values include expectations about age, gender, family dynamics, and beliefs about health and health care—all potentially affecting information exchange during the clinical interview. It follows that assessment of sociocultural factors should be embedded in the intake assessment process.

This qualitative study aims to expand our understanding of the assessment process undertaken by clinicians during the mental health intake and identify what informs the diagnostic decision-making process. Specifically, our research question investigated how clinicians organize and prioritize the multifarious information gathered during the intake session to inform their understanding of a client. We examined which factors (e.g., symptomatic/diagnostic, psychological, relational, occupational, sociocultural) clinicians considered and how they applied these factors to understand a client during the intake assessment process. We explored clinicians' prioritization in the context of the need to determine a psychiatric diagnosis while also considering the complex contextual realities of their clients' lives. We conducted 117 in-depth interviews with 38 clinicians immediately following their intake session with a client presenting for a new episode of care in community- and hospital-based mental health clinics.

## Method

### Approach and Setting
The study was conducted October 2012–April 2013 in three community-based and one outpatient hospital-based mental health clinics in three large cities in Israel. All participating clinics provide free mental health care to a socioeconomically diverse population with universal health care coverage (Nakash, Nagar, & Levav, 2014; Nakash et al., 2018). Client population characteristics and the services provided were

similar across all clinics. At each clinic, clients were consecutively assigned to clinicians based on clinician availability. Of note for this study, clinicians did not follow a standardized structured or semistructured intake interview protocol. Common practice in each of the clinics was to use an open approach to questioning and exploring information in intake interviews (Nakash et al., 2018).

The primary goal of the intake session at all participating clinics was to thoroughly assess the client and gather information about the presenting problem and psychosocial history of the client to inform the diagnosis and treatment plan. Intake sessions in each of the settings typically last approximately 50 minutes, though they are subject to time constraints depending on provider caseload. Intake visits in the current study ranged from 14 to 99 minutes ($M = 51.5$, $SD = 17.8$). Following the intake session, each intake assessment was discussed with the clinical team to develop a treatment plan that could include 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 or a combination of interventions. The intake clinician is not expected to become the therapist for the case. Approaches to mental health assessment in Israel are like those used in the United States and other Western countries.

## Recruitment and Sampling

We conducted 117 in-depth semistructured interviews with a convenience sample of 38 clinicians. Clinicians were recruited through informational meetings conducted on site with the study principal investigator (second author). To augment representation, there were no exclusion criteria for clinicians participating in the study. Five clinicians chose not to participate. Clinicians were interviewed immediately after completing an intake interview with 117 distinct clients. A limit of five intakes with individual clients was established to allow for a diverse range of intake interviews. Approximately half of the clinicians interviewed had one client. On average, we interviewed clinicians three times ($SD = 1.6$) based on three individual clients. For client participants, we imposed minimal exclusion criteria that included active suicidality or psychosis.

Table 1 presents the sociodemographic and clinical characteristics of the clinician and client participants in the study. Clinicians were Jewish and predominantly female (84.2%), 28–64 years of age ($M = 45.2$, $SD = 10.8$), and born in Israel (57.9%). Clinicians were social workers (47.4%), psychologists (36.8%), and psychiatrists (15.8%), with 78.0% having more than 5 years of clinical practice experience ($M = 14.6$, $SD = 11.6$). Clients were Jewish and mostly female (68.0%), 19–81 years of age ($M = 41.6$, $SD = 16.3$), born in Israel (70.4%), and ethnically diverse. Of clients, 63.6% had 12 years or less of education, 60.8% were unemployed, and 70.0% reported an annual income less than $15,000 US.

**Table 1**

*Sociodemographic and Clinical Information for Client and Clinician Study Participants*

| Sociodemographic Variables | Clients (N = 117) % (n) | Clinicians (N = 38) % (n) |
|---|---|---|
| Gender | | |
|   Male | 31.2% (36) | 15.8% (6) |
|   Female | 68.0% (81) | 84.2% (32) |
| Age [years; M (SD)] | 41.6 (16.3) | 45.2 (10.8) |
| Country of birth | | |
|   Israel | 70.4% (82) | 57.9% (22) |
|   Other | 25.6% (30) | 42.1% (16) |
| Relationship status | | |
|   Single | 39.2% (46) | – |
|   With longtime partner, not married | 3.2% (4) | – |
|   Married | 24.8% (29) | – |
|   Separated/divorced | 26.4% (31) | – |
|   Widowed | 5.6% (7) | – |
| Education [years; M (SD)] | 12.5 (3.2) | – |
| Currently employed | | |
|   No | 60.8% (71) | – |
|   Yes | 38.4% (45) | – |
| Household income[1] | | |
|   Much below average | 52.0% (61) | – |
|   Below average | 12.8% (15) | – |
|   Average | 16.0% (19) | – |
|   Above average | 11.2% (13) | – |
|   Much above average | 0.8% (1) | – |
| Religiosity | | |
|   Secular Judaism | 40.8% (48) | 71.1% (27) |
|   Traditional Judaism | 32.8% (38) | 15.8% (6) |
|   Religious Judaism | 16.8% (20) | 10.5% (4) |
|   Orthodox Judaism | 4.0% (5) | 2.6% (1) |
|   Other | 4.0% (5) | (0) |
| Ethnicity | | |
|   Mizrahi (Middle East/North African descent) | 51.0% (60) | 2.6% (1) |
|   Ashkenazi (Europe/North American descent) | 29.6% (35) | 73.7% (28) |
|   Ethiopian | 0.8% (1) | (0) |
|   Russian (former Soviet Union) | 4.0% (5) | 2.6% (1) |
|   Mixed ethnicity | 8.8% (11) | 15.8% (6) |
|   Other | 2.4% (3) | 2.6% (1) |
| Discipline | | |
|   Psychiatry | – | 15.8% (6) |
|   Psychology | – | 36.8% (14) |
|   Social work | – | 47.4% (18) |

**Table 1** (*Continued*)

|  | Clients (N = 117) | Clinicians (N = 38) |
|---|---|---|
| Sociodemographic Variables | % (*n*) | % (*n*) |
| Level or expertise |  |  |
|   Licensed | – | 65.8% (25) |
|   Trainee | – | 34.2% (13) |
| Years of experience after training [*M* (*SD*)] | – | 14.6 (11.6) |

*Note.* Numbers do not add up to 100% due to missing data.
[1]Mean household income in Israel is approximately $4,000 US per month.

## Data Collection

Clinicians were interviewed immediately after completing an intake interview with 117 distinct clients. Interviews took place in private rooms in the clinics. Clinicians and clients received $30 U.S. dollars (equivalent in Israeli currency) for their participation in the study.

Clinicians were asked about their understanding of the client's main problem, evaluation process, rapport with the client, and views of sociocultural factors in relation to the assessment. Three trained clinical psychology graduate students who received weekly supervision from the principal investigator conducted all interviews following the semistructured interview protocol (see the Appendix, online). The semistructured interview protocol guided the interviewers, who were free to shift the order of questions to allow the interviewee to emphasize areas as they chose. All clinician interviews included a specific probe regarding the role of the sociocultural context in the client's assessment (i.e., "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?"). Interviews were audiotaped, lasted approximately 30 minutes (range = 27–36 minutes), did not include identifiers, and were transcribed and edited by professional services. All interviews were conducted in Hebrew. Selected quotes that were most illustrative of the themes and representative of the different disciplines were translated into English by the same professional service and reviewed by the second author, who is bilingual (Hebrew/English). Institutional ethics committees at each participating clinic approved all aspects of the study, and all clients and clinicians completed informed consent prior to participation.

## Qualitative Analysis

We used ATLAS.ti (Version 7) to perform a thematic analysis (Braun & Clarke, 2006) to identify major themes in clinicians' accounts of their assessment process during the intake visit. The research team that coded the data included three graduate students in clinical psychology under the supervision of the study principal investigator. Team members were Jewish women, native Israeli, fluent in Hebrew, and from different ethnic groups.

The qualitative analysis involved six steps (Braun & Clarke, 2006). First, we became familiar with the data by reading and rereading the transcripts. We developed a codebook, which included large bucket themes developed in Steps 2–4. In Step 2, we performed open coding by independently reading the accounts line by line to identify codes; afterward, we grouped and labeled key categories. In Step 3, we separately reread the accounts to perform axial coding to identify the relationship among categories and organize them into themes. We then integrated the information in each theme to draw a coherent representation of the material (Step 4). During Step 5, themes were refined and relationships among them were developed clearly. We ensured that themes responded to our research questions. In Step 6, a narrative was constructed describing how themes built upon each other. Development of the codebook took approximately 3 months and was formalized when we reached saturation. Codebook development was based on 15% ($n = 25$) of the interviews, which were randomly selected. We examined interrater reliability for the thematic coding using ATLAS.ti, which allows comparison across coders of selected transcripts and provides a measure for interrater reliability (i.e., kappa statistic). Once we established interrater reliability, all remaining interviews were coded using the codebook. We organized information in the data corpus under the emerging themes. 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.

The team met weekly throughout the analysis process. Team discussions focused on the developing coding scheme to ensure consistency between coders and validity of the emerging findings. Analysis was inductive, with themes and codes emerging from participants' narratives and not from preconceived codes or categories. The team continuously reviewed questions related to coding and considered new codes if the need emerged (under the themes identified in the codebook). We used constant comparison to examine relationships within and across codes and categories. Team meetings also included an open invitation for reflexivity, and team members were encouraged to reflect on sources of potential bias stemming from their intersecting social locations. Much of the reflection was grounded in the coders' evolving professional development and personal lenses. Examples of critical reflection regarding the coders' thoughts and experiences of coding the interviews included the importance of listening to clients, particularly in relation to understanding suffering and pathology in context; exploring thoughts about judgments and assumptions regarding

what is culturally normative and what represents psychopathology in context; understanding familial relationships in cultural context; and the role of loss, etc. When disagreement regarding coding arose, the source of the discrepancy and coded sections were reviewed again until consensus was reached (Corbin & Strauss, 2008).

The potential for coders' drift was managed by assessment of interrater reliability of transcripts at selected intervals. All raters coded two additional 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 interrater reliability among all three raters across different time points was good ($\kappa = 0.72$).

## Results

Clinicians reported a rich, complex information-gathering process that guided their clinical assessment. Although a biopsychosocial model of assessment was affirmed, the organization and prioritization of information described suggests centrality of a psychiatric diagnosis based on DSM/ICD categories. Clinicians endorsed the following primary themes, presented in order of significance (determined by prevalence):

- Clinicians largely endorsed the DSM diagnostic system ($n = 114$, 97.4%), with approximately a third of the clinicians ($n = 30$, 25.6%) identifying limitations of the DSM system and others favoring general over criteria-based questions.
- Most clinicians expressed the importance of psychological processes ($n = 96$, 82.1%), including emotional ($n = 66$, 56.4%), behavioral ($n = 51$, 43.6%), and cognitive ($n = 31$, 26.5%) processes.
- The quality of family and social relationships was also prevalent ($n = 79$, 67.5%) and revealed client capacities, vulnerabilities, risks, and patterns, which informed the diagnosis and conceptualization of the client's main problem. Clinicians viewed relational trauma, including childhood exposure to violence ($n = 13$, 11.1%) and death of a loved one ($n = 14$; 12.0%), as specifically informative.
- Close to one third of the clinicians identified information from other sources, including medical charts ($n = 37$, 31.6%) and the referral source ($n = 16$, 13.7%), as important.
- Less than a third of clinicians viewed sociocultural factors ($n = 34$, 29.1%) as important in discerning expressions of distress, and even fewer affirmed socioeconomic factors ($n = 29$, 24.8%) as important. Of those who did affirm sociocultural context as important, these factors were noted as particularly relevant for immigrants.

Clinicians across professional disciplines reported similar themes. We did not detect significant differences by professional background. Although we did not investigate

differences by professional background in this study, this finding may be due to role blurring and socialization of clinicians from varying disciplines into the medical model. In the following sections we expand on these themes and provide specific examples for illustration.

## Diagnostic and Statistical Manual System

As expected, virtually all clinicians ($n = 113$, 97.4%) mentioned using DSM criteria as part of their assessment process, particularly to guide their decision about a client's diagnosis. Many highlighted the diagnostic system as less clinically useful due to the large number of criteria. Clinicians reported difficulty remembering the criteria of various disorders and reported that the DSM directs them in a more general fashion. A major limitation described was the difficulty in providing a diagnosis when the client does not meet all required criteria and the need for subthreshold diagnoses to capture the client's clinical status. One social worker said,

> I gave her a mixed anxious–depressive disorder diagnosis. She has depressive symptoms. I acknowledge that this was a compromise because she has some symptoms but maybe not all of them . . . No, I can't say with 100% certainty that she has major depression, but it's possible.

Related is the clinician's perception of the DSM's binary system as reductionist—essentially not allowing for a rich description of distress and leaving out an understanding of the etiology leading to the development of the distress. A psychologist noted,

> It didn't really help me to diagnose him because it seemed that it wasn't something that was presently on a phenomenological level . . . Presently, there are phenomenological things, but they do not provide the whole picture. Presently, there is something occurring in his internal world. Perhaps I would describe the things more in the area of personality structure, defense mechanisms, and conflicts. A certain experience of being "broken apart."

Other limitations related to transdiagnostic criteria that, if positive, can result in clients meeting criteria for multiple diagnoses, which makes it difficult for the clinician to decide. As one psychiatrist said, "*Sometimes there are difficult areas because there are alternate diagnoses that are very appropriate, and it is a very difficult question if it is this or that.*"

## Psychological Processes

Most clinicians highlighted the importance of psychological processes ($n = 96$, 82.1%), including emotional ($n = 66$, 56.4%), behavioral ($n = 51$, 43.6%), and cognitive ($n = 31$, 26.5%) functioning.

### Emotional Functioning

The identification of certain emotions—such as anxiety, fear, depressed mood, and despair—guided clinicians toward diagnoses that are characterized by such emotions. As a social worker recounted,

> She really cried. This sort of weeping, there are different sorts, this sort of sobbing. It's not that she's telling me about something that already took place, it's happening now. And yes, that pointed to posttrauma for me.

Similarly, a psychologist said,

> It is important to know how much he is suffering and is overwhelmed by social situations. How lost he is in them. How much he is disconnected in interpersonal situations.

Sometimes, identifying the emotional process at the foundation of a certain behavior was necessary for a differential diagnosis. A psychologist stated,

> It is important if the person did this out of a deep sense of depression and planned it—the suicide attempt—or the individual engaged in a certain impulsive move because of his personality patterns.

Also relevant to emotional functioning, clinicians viewed a client's level of insight and personal awareness as differentially informing the client's description of their background, mental health, and functioning as aiding diagnosis. This influenced the clinicians' evaluation of their clients' honesty and credibility and sometimes had ramifications for a personality diagnosis. As one psychologist recalled,

> It wasn't clear to me if the symptoms that he described, the coping that he described, was everything. I have a sense that there is something that is beyond this. Not that he is hiding it, but that he also doesn't really know it, a question regarding his personality structure.

In addition, the client's capacity for introspection led the clinicians to notice strengths, the best prognosis, and the client's ability to gain from psychotherapy. A social worker noted,

> I don't know if I would really give a personality diagnosis, and certainly not an illness [diagnosis]. The woman is, perhaps, on one hand, insecure and with low self-esteem, and on the other hand with a really good capacity for a certain type of introspection and self-work.

### Behavioral Functioning

Clinicians were assisted in developing a diagnosis by information about the client's daily behavioral functioning—such as relationship development and perseverance at the workplace—which they considered particularly important in determining a

personality disorder diagnosis. Clinicians attempted to identify personality patterns and prominent instability in the clients' descriptions of their daily lives, as well as from clinical observations of the clients' behavior during the session. A social worker said,

> *It was possible to identify the personality disorder as the session went on. There were things that happened to her throughout life about which she has very limited insight and deliberation. The fact that she became pregnant every time she had an infant of a few months, even though she didn't want to be [pregnant]. Small decisions like these. Something that is, also personality, it isn't just a response to a crisis.*

Clients' expressions of concealment and suspicion within the session guided the clinicians to diagnoses of personality disorders. A psychiatrist shared,

> *I was shocked that he has many friends. That wasn't my sense. In the way that he is—with his suspicion. I have questions about more severe disorders. The concealment, in my opinion, is a very strong indicator. It could be that the very concealment points to something paranoid.*

Information regarding the client's daily behavioral functioning and quality of interaction during the session helped clinicians to examine the client's fulfillment of criteria for certain diagnoses. A psychologist explained,

> *I debated whether it was social anxiety or if it was more schizoid personality disorder. He did develop a bond with me; I don't think that this is something that a schizoid individual would do so easily.*

Information regarding the client's daily behavioral functioning was also important for the diagnostic decisions made for other disorders, especially depression, as a social worker noted:

> *She cried the whole time. However, she wasn't slow; she did say that she really functions. She has terrible pains, but her home is always clean. It was more a chronic lack of strength from years [of terrible pains]. I less think it is real depression.*

### Cognitive Functioning

Clinicians paid special attention to the client's richness of language, facility for self-expression, level of abstract thinking, and ability to offer coherent descriptions. One psychologist said,

> *She was very, very concrete. This gave me another mapping [for her diagnosis]. I believe that she conducts herself with this concreteness. In my opinion, there is a possibility for developmental disability in her case. She had a very colloquial language, very simple.*

As a social worker described, a high level of cognitive functioning expressed in the client's verbal capacities, thought processes, and organizational ability during the session were particularly informative for psychotic spectrum and personality disorder diagnoses:

> He suffers from some sort of psychotic state. He is relatively aware; he also has relatively high intelligence and also insight . . . very rare—from what I know. He is continuous in his content; there are no jumps. This is not, let's say, severe schizophrenia.

In addition, as one psychiatrist noted, a person's high cognitive capacity assisted clinicians with diagnoses mainly because it enabled the client to communicate difficulty in a productive and accurate fashion during the short intake:

> He described it very clearly. His way of speech was helpful. His emotional connection was helpful. Also, his ability to understand that there was little time and that he needs to organize himself around this.

However, more disrupted cognitive functioning contributed to a more challenging intake session, as a psychologist explained:

> This is not exactly a successful intake. There was a lot of stress, and I also knew that I didn't have a long time to be with him, so I tried to push him along. And, also, he wasn't very clear. In general, he also has a language barrier. It was slightly difficult to understand if I was dealing with an issue with thought processing, or just with a language barrier. But he was very diffuse and very unfocused. It wasn't so clear why he really came today.

## Quality of Familial and Social Relationships

Over two thirds ($n = 79$, 67.5%) of clinicians considered a client's present and past relationships with partners, parents, children, siblings, and friends to varying degrees in the assessment process (Table 2). Information regarding relationships that are characterized by trauma and by the death of a loved one had specific contributory effects in the assessment process.

Notably, clinicians addressed the client's attachment experiences as influencing the client's current mental health status—particularly for the conceptualization of the client's main problem and less as they considered the differential psychiatric diagnosis. One social worker described,

> I have difficulty extracting something aligned with the DSM. I think that the dynamic diagnosis is clearer to me. She was hurt from the beginning of her life in relations with primary caretakers. She had a mother that was very unavailable and a father that was not there at all. She assumed that she needs to manage on her own. I think that this is very important to understand how she grew up in order to understand her.

**Table 2**

*Contribution of the Quality of Client Relationships in the Clinician Assessment Process During the Intake Session*

| Contribution of Quality of Relationships to Assessment and Frequency | Illustrative Example from Clinicians' Interviews |
|---|---|
| **Romantic relationship** (*n* = 32, 27.4%) | |
| Stability | *"I, primarily, try to get to know the person, strengths, support, capacity to be in a relationship, ability as also based on history, if he remained in long term stable romantic relationships." (Social Worker)* |
| Risk | *"I think that there is a high potential for self-harm, and then you know that there is a young man, without support, a bachelor that uses [drugs]. This means, all this includes a scale of [different] levels of risks." (Psychiatrist)* |
| Psychiatric diagnosis with emphasis on personality disorders | *"I think that she copes with crises. I provided an adjustment disorder diagnosis with a minor depressive episode. I did ask her about [her] relationship with [her] mother and father, with her partner, with supportive networks, and it seemed that the things were relatively maintained and standard, so I didn't go in the direction of a personality disorder with her." (Psychologist)* |
| **Relationship with parents** (*n* = 32, 25.0%) | |
| History of distress | *"The depression is responsive to some sort of breakdown of all sorts of systems in his life. But, additionally, he had some sort of psychotic crisis beforehand and he had a difficult childhood in and of itself. A mother that doesn't function, and also the parents were second generation Holocaust survivors—so there are a lot of factors and baggage that can also bring about depression, and it is also possible to see this as complex PTSD [posttraumatic stress disorder]." (Psychologist)* |
| Conflict | *"I definitely think that it is dynamic. Independence, dependence vs. independence, like, in relation to the parents, to the family and her rearing. The anxiety, I think that it is a symptom. On one hand, at first it was as if she grew up in a perfectly nice home. And on the other hand, there was also room to see other things. Regarding the story with the guy, I think that she also slightly left the bubble. She specifically opposed [her] father. It was hard for her. I could have understood that [these are] really symptoms of a certain conflict." (Social Worker)* |
| **Relationship with children** (*n* = 23, 19.7%) | |
| Functioning | *"She said that her husband blames her that she starves the children. They just don't want to eat because they ate well at preschool. Now, I didn't succeed in understanding here what is the reality. And I wondered if she isn't telling the truth, if she doesn't understand the truth, if something in her reality isn't standard." (Social Worker)* |

**Table 2** (*Continued*)

| Contribution of Quality of Relationships to Assessment and Frequency | Illustrative Example from Clinicians' Interviews |
|---|---|
| Stress | "She began to have panic attacks in the past 2 weeks I think. This is so hard for her at work, even, that she didn't keep up at work. Perhaps there is now something that triggers her. Perhaps the difficulty in raising a child, I don't know." (Psychiatrist) |
| Relationship with siblings (n = 14, 12.0%) | "She has a schizophrenic brother, she has another sister that also seems to be [schizophrenic], though the diagnosis isn't clear. So now I don't see anything like this with her, so this doesn't help me in understanding her. She says, basically, that her story is a story of insecurity. That she comes from a background of severe neglect. Only from an older age she understood. She was preoccupied with home, and at home there was a sick brother, a schizophrenic, this brother is older than her, there are five children younger than her that she has to rear—that's cooking, washing, cleaning, that's everything—the mother didn't do anything, so she did." (Psychologist) |
| Relationship with friends (n = 12, 10.3%) | |
| Loneliness | "She didn't seem to me as also depressed. No, the affect isn't depressive, and she spoke a lot. She is just very lonely. She is very bored, and she's alone." (Social Worker) |
| Personality factors | "What helps to diagnose? In general, social relationships. She really said that she was never very social. Social patterns, how she manages in the social group, how she views others? Narcissistic? A little less? More? She doesn't seem to me [as having a] personality disorder." (Social Worker) |

Although assessment of quality of attachment to significant others was not necessary for the determination of a psychiatric diagnosis, many clinicians said they were curious to understand the source of the client's difficulties. As a psychologist noted, developmental relational experiences were critical to understand the client's current difficulties even when time constraints of the intake session limited in-depth of assessment of early relationships:

> This is most important, what caused the anxiety attack. Her early development, in which family she grew up in, what personality she has, why she is anxious. I know that these attacks started recently, but I didn't clarify what happened. I think that at intake, there's no possibility to clarify this. I don't know, perhaps she grew up in a single-parent family; perhaps she went through something in childhood. Because her anxieties don't come about for no reason.

## Information From Other Sources

Close to half ($n = 54$, 46.2%) of the clinicians affirmed the contribution of information received from other sources in determination of diagnoses. This included information located in the medical file ($n = 37$, 31.6%) and from referral sources ($n = 16$, 13.7%). Information from the client's chart regarding earlier diagnoses was most central to the provision of current diagnoses. The contribution was specifically significant in situations in which clients did not initiate the sharing of important clinical/psychiatric information. A psychiatrist said,

> She didn't provide me with anything. She told me that there is depression in her past, she was treated with medication, she is still treated with medication. Yes, it matters if this depression is just current or if it was there her whole life.

Similarly, a social worker noted,

> What really helped me was her chart. It had a diagnosis: schizophrenia . . . That's not a disorder you can change. You can say the person is in remission or not, but you can't change her.

As a psychologist noted, clinicians who expressed opposition to using the client's chart emphasized concern about bias in their assessment of the client:

> I usually try not to look at the medical chart before the session. I open it at the end once I decide on a diagnosis. But this time I did open the chart beforehand. It was just a very busy day and I looked at the chart before I saw her. On the one hand, this provides confidence because you already have some background, something. On the other hand, this decreases your confidence because you feel less free. Someone else already decided what she has so I may feel more confined in my interview.

Fewer clinicians relied on the referral source, expressing its value in providing basic information, such as the reason for referral.

## Sociocultural Background

Under a third of the clinicians ($n = 34$, 29.1%) related to the contribution of the client's sociocultural background in the assessment process. Understanding the client's cultural background was central to understanding the client's familial and developmental background, not necessarily for the psychiatric diagnosis. These clinicians discussed the importance of the ethno-cultural match between their social identities and those of their clients in the assessment process, augmenting clinicians' confidence in their clinical understandings of clients. A social worker said,

> I am also originally Mizrahi [Jews of Middle Eastern and North African descent], so it was easy for me to evaluate and easy to discern between what is accepted in the cultural

*background and what isn't. So, I can discern between delusional beliefs and beliefs against "the evil eye" and these things that are a part of the culture and within her clinical picture. I always think that the influence of background can be very, very basic and very important for the diagnosis, and it is easy to make mistakes here.*

Yet, clinicians underplayed the role of sociocultural background in understanding the client's suffering. A few clinicians related to the discordant cultural background of the clinician and client but did not see these differences as influential in the assessment process; rather, they were aware of the impact it might have on the quality of the therapeutic bond. For example, one psychologist noted,

*This [client's religiosity] had importance. She's religious. This changed the interaction between us. Being with someone who is an atheist and also a man. I felt that it was hard for her to speak with me, that it was hard for her to open up . . . No, I don't think that this had too much influence on the diagnosis.*

In the context of diagnosis, information regarding the client's sociocultural background guided the clinician in understanding whether the client's behavior, emotions, or cognitions are pathological or normative and culturally appropriate. Information regarding the individual's sociocultural environment was perceived, for example, as necessary in understanding if anxieties are exaggerated or match the client's environment and background. A psychiatrist recalled,

*She began to speak about anxiety. In this case I wasn't able to completely understand. For me, it didn't sound like anxieties but like worries that are justified also because, in truth, I hear more and more about children from Beitar (an ultra-Orthodox lower socioeconomic status town) that get "caught up." It was reality-appropriate and a normative worry of a mother for her children in this environment.*

Information regarding the client's ethno-religious background and familiarity with the client's culture were important in discerning between appropriate religious beliefs and delusional beliefs that hint at a diagnosis of psychosis, as a psychologist described:

*This is important because it is easy to over diagnose. For them [people from the particular social group] this is normal background, let's say all sorts of Voodoo-related illness and for me this sounds like psychotic and I could have easily be wrong and give the individual antipsychotic medications, even though we are dealing with something that is acceptable in the community they live in.*

Understanding the client's sociocultural background was particularly salient in work with immigrants. Clinicians described situations in which sociocultural information was imperative to the assessment process. For example, as a social worker described, when a client is not conversing in her native language, it is vital yet

challenging to discern between dementia and the cognitive difficulty inherent in speaking a foreign language:

> *The fact that she doesn't know how to say a word—this could be a symptom of dementia, but this can also be a result of her being a woman that immigrated to Israel at 48, and it is miraculous that she has such good command of the language. But it could be that a year ago she was able to find these words, and this is dementia. It is really impossible to really know.*

In addition, clinicians described that during an intake session with immigrants, it is important to recognize that cultural and language gaps have ramifications on the provision of accurate diagnoses. Clinicians described a preference for sending clients to culturally similar and same-language clinicians for assessments, as a social worker noted:

> *It could be that he was PDD [pervasive developmental disorder] as a child. From the mother it was hard to understand because we used translation. I hope that [clinician from similar background] will be able to understand better because he speaks the language, because he knows the culture; to be a bit more accurate in the diagnosis.*

In addition, information regarding immigration experiences that were perceived as distressing and difficult added to clinicians' understanding of clients' distress but did not influence the diagnosis. A psychologist offered this example:

> *The client was an immigrant. She came earlier from Italy to Germany and then from Germany to Israel. [Her] immigration experience was very hard. I think that there was a crisis in her life. It is very important to know and to relate to this. It matters more that she is an immigrant than where she immigrated from. In her case, the very fact that she immigrated seems to me important.*

In other cases, such as substance abuse, information regarding the individual's sociocultural background was perceived as important in understanding how much substance abuse is prevalent and accepted in the client's community and, therefore, does not indicate personal pathology but instead indicates a wider problematic sociocultural context. A social worker shared,

> *He always mentions that in Russia it is like this, and also the people, themselves, that come from there indicate this. If they drink for many years, this leaves effects on the body, really irreversible effects. Perhaps I think that this is cultural and they, themselves, indicate this. Drinking is more rampant [in Russia].*

### Socioeconomic Background

A quarter of the clinicians ($n = 29$, 24.8%) considered the contribution of the client's socioeconomic background—including education level and occupation—in the determination of diagnoses, with most identifying economic difficulties as

influencing factors in the development of mental health issues. Clinicians noted that most clients that come to public clinics have dealt with or presently deal with economic difficulties. Current low socioeconomic status was perceived by clinicians as a factor that can trigger anxiety and depression among clients, as a social worker described:

> His current socioeconomic status is very, very severe. It really contributes to the anxieties and depression that he suffers from anyway. His socioeconomic [context] is really relevant to the assessment of his status.

This was particularly important for clients for whom there was a dramatic sudden decline in socioeconomic status. A psychologist said,

> She's not a person that was anxious. I don't understand why this event caused such a harsh response. My hypothesis is more in the direction of the socioeconomic status. They lived for 20 years in the U.S. in a wonderful economic state and then there was a very big economic fall.

Other clinicians mentioned gender differences in the impact of socioeconomic difficulties, highlighting that for men these difficulties were more significantly associated with emotional distress. For example, a social worker said,

> There is something in the Georgian culture that attributes a loss of strength to the man. The man is the head of the family. He can't finance [his] wife. He hardly finances himself. He isn't respected in the community, he isn't a doctor here. It is very logical that someone in his situation would be depressed. The diagnosis was the same diagnosis. The cultural background helped me, basically, understand his situation, meaning, all the factors that impacted the depression.

In addition, information regarding the client's developmental economic struggles helped to further inform the clinical picture. For example, several clients had minimal formal education because they had to join the family's survival efforts and, therefore, give up on education. A psychiatrist shared,

> She's the middle child of 13 children. Her parents did not rear her at all. She studied 2 years at school and after this didn't study any more. Basically, we're speaking of a woman, aged 64, who started to work at age 14 in cleaning. So, this is very, very, very important.

Low self-image and difficulty forming social connections were also seen as related to socioeconomic factors, as a psychologist described:

> From a dynamic perspective it was possible to see that at every stage, from adolescence and army and school, there were friendships that didn't last because he didn't have

*economic means. On the other hand, he doesn't persist in any job. He starts to work, and he doesn't stay because he always sees in society his mirror. Via the society he sees that he is at an inferior position to them.*

In certain situations, increased risk of exposure to criminal activities or substance abuse were also associated with socioeconomic status, as a social worker described:

*He simply wasn't born in the right place, in my opinion. [This] person is born in an environment that he says that from a very young age he began to use [drugs] because all the friends and [his] father were using [drugs]. He also seems to be associated with an environment that from a young age enters a wave of criminality, and this is prominent also according to his approach in conversation, to his vocabulary, to his behavior.*

## Discussion

We examined how mental health clinicians organize and prioritize multifarious information to determine a psychiatric diagnosis and formulate a clinical understanding of a client during an intake session. As expected, we found that clinicians gather and hold a vast amount of information during an intake assessment. The clinicians expressed respect for the client and common interest in conducting a sound clinical assessment to determine the most appropriate next steps for client care, recognizing risks associated with misdiagnosis (Frances, 2013a). Not surprisingly, assessment based on DSM/ICD diagnostic systems emerged as the primary outcome of the intake assessment, with psychological processes and intrapersonal and interpersonal relationships informing the diagnosis and a more complex clinical understanding of the client. Clinicians in community- and hospital-based clinics in Israel are required to provide a DSM/ICD diagnosis upon intake, establishing a central focus of the assessment. Clinicians are also charged with determining a clinical understanding of the client, integrating the presenting concerns, relevant biological/physical, psychological, social, and developmental information.

The clinicians in this sample expressed concerns about the binary nature of the DSM system and the narrow focus on specific criteria. However, the expectation of a DSM diagnosis served as a primary organizing question. Community- and hospital-based clinics are beholden to a range of regulations for reimbursement or government financing. These requirements support and potentially advance the provision of mental health care services and undergo ongoing policy changes that significantly influence access to and scope of care, often driven by cost-saving aims. Whether fee for service or an integrative care model of reimbursement, diagnosis remains central to reimbursement systems (O'Donnell et al., 2013). These structural forces reify a Western individual medicalized model of mental health assessment (Summerfield, 2000) and emphasize evaluation of psychopathology as primary supported by the influence of third-party reimbursement structures, including

government-supported care (Pickersgill, 2013). The United States is a dominant force in emphasizing the medicalized diagnostic system and provision of mental health care throughout the Western world and beyond. Although our study took place in Israel, our findings raise similar concerns for U.S.-based clinicians' intake assessment priorities, an area for future research.

Access to treatments that work (i.e., empirically supported interventions) may also influence how clinicians prioritize information. Although not highlighted by clinicians in this sample, access to appropriate treatment based on DSM diagnosis was implied. Empirically supported treatments are linked to mental health conditions and diagnoses (e.g., cognitive behavioral therapy and interpersonal psychotherapy for depression and emotion focused therapy, exposure, and structured psychodynamic treatment for posttraumatic stress disorder; Castelnuovo, 2010). Dissemination of such treatments is encouraged by the National Institutes of Health in the United States and the WHO (2013, 2014), which strongly emphasizes the interrelationship between social, economic, and political contexts, stressing the significance of poverty, discrimination, restriction on human rights and associated deleterious living conditions, and heightened health risks associated with such social and mental health conditions.

Our findings show that clinicians prioritized intrapersonal and interpersonal processes (e.g., psychological functioning, relational history, and current functioning) over the macro context that includes clients' social, cultural, and economic backgrounds. Notably, in only a quarter of the interviews in this sample were sociocultural, economic, and political factors considered as contributory to the initial mental health assessment. The clients participating in this study met several of the markers of social determinants of health and mental health: poverty, lack of educational opportunities, stigma and associated prejudice and discrimination, violence and abuse, social and economic inequities, isolation and structural disparities associated with intersectional social identities and group membership, and exposure to political violence, among others (Braveman et al., 2011; Lund et al., 2011; Shim & Compton, 2018; WHO, 2013). In this study, attention to these factors emerged most prominently with the small sample of immigrant clients. Yet, the influence and importance of sociocultural, economic, and political context, though variable and disparate, is universal. A concerning gap exists in a mental health assessment process that requires a DSM diagnosis without an integration of social determinants of mental health. This gap is particularly worrisome in the context of community- and hospital-based clinics that primarily serve socioeconomically disenfranchised individuals and families in communities that are most directly affected by social, structural, and increasingly political forces of oppression and subjugation. This is an area of concern for the social work profession as it emphasizes the interconnectedness of environment and person in the influence of social determinants of health and mental health.

In the present study, we found no significant differences in themes as a function of the clinician professional background. It is possible that workplace socialization (Glisson & Williams, 2015) and organizational power dynamics (Hall, 2005) related to limited resources shape the professional identity of the practicing clinicians and contribute to role blurring and socialization into the dominant medical model (Burns, 2004; Maddock, 2015). Future research should explore where and how disciplinary differences emerge (e.g., greater attunement among social workers to factors related to social-cultural-economic background) among early career clinicians across disciplines in mental health clinics and possibly homogenize over time. Extending such research across countries and mental health clinics would be elucidating.

## Limitations

Our study has several limitations. First, we used a convenience sample, which may be subject to selection bias. Second, as noted earlier, we found no differences among clinician professional disciplines and thus did not investigate this factor further. We did not include exclusion criteria for clinicians, which resulted in a heterogeneous sample and may have made it difficult to detect significant disciplinary differences. We also did not identify subgroups of clinicians as the sample was more similar than different. This was perhaps influenced by the Israeli Ministry of Health, which emphasizes the medical model wherein diagnosis is required. Although we do not know how our findings might apply to other Western systems and clinicians, we hope that our findings raise questions for further investigation. Third, the clinician interviews were constrained by time, as were clinicians' intake assessment interviews with clients. Time may be a significant variable that merits further research in the context of intake assessments and the effects that time may have on clinical understanding and diagnosis. Forth, although the interview protocol was designed with open questions to give clinicians the opportunity to emphasize a range of factors that informed their clinical understanding of the client and included prompts regarding a wide range of possible foci, the interview protocol did not include more specific questions about sociocultural issues. Such specificity might allow for more nuanced and informative exploration of factors that influence the mental health intake assessment. This is an area for potentially intriguing research. Finally, although our analytic approach included continuous reliability checks and deliberate discussion on potential bias stemming from the social location of the members of the analytic team, it is possible that bias in coding occurred.

## Practice Implications

A core perspective in social work education, practice, and research is understanding the intricate relationships among individuals, families, communities, and organizations and their complex environments. The priorities expressed by the WHO

align with those articulated by the Council on Social Work Education (2015) and National Association of Social Workers in the United States (Moniz, 2010; National Association of Social Workers, 2017) and the International Federation of Social Workers (IFSW, 2018), of which the Israeli Association of Social Workers is a member (IFSW, 2012). Capacity-building and resilience-focused models attend to the inherent processes of individual, family, and community care, growth, and recovery in the face of imposing social, structural forces of oppression and their complex manifestations across sociocultural contexts (Tol et al., 2013) and do not focus on psychopathology. These models aim to advance natural processes of individual and community resilience (see Miller, 2012) while acknowledging the realities of suffering associated with mental health conditions and the value of targeted, effective interventions.

Further research is needed to identify best practices for clinicians across disciplines to integrate information about complex sociocultural, relational, and diagnostic factors to inform clinical understanding of a client's life situation, which includes living with a mental health condition in a complex context. For example, how might changes in structural factors of the clinical intake interview (e.g., more time, semistructured interview instruments that include sociocultural factors as essential to contextualizing diagnosis) shift how clinicians organize and prioritize complex information? What effects might these have on client/clinician congruence regarding priority areas of concern?

We are calling for social work clinicians to broaden the scope of clinical assessment at intake to include a sociocultural, economic, and political lens as well. Our findings raise concerns that the influence of structural and systemic forces on the intake assessment process in community- and hospital-based clinics emphasizes psychiatric diagnosis, limits clinical conceptualization, and misses critical social, economic, and political realities affecting clients' experiences of mental health conditions. Explicit questions about the client's social-cultural-political context should be included as part of standard intake protocols. If the structure of clinical assessment remains geared to existing diagnostic schemes and medical models, this shift will be difficult.

The Cultural Formulation Interview provides an example of adopting a culturally sensitive approach to assessment process and includes specific questions about the client's definition of the problems as well as their perceptions of the cause, context, and support (Lewis-Fernandez et al., 2017). Social workers who use person-in-environment and critical lenses to examine the social and structural power dynamics that affect individual and interpersonal experiences are best suited to develop assessment tools that integrate social determinants of health in micro-level assessment. In addition, social workers are needed to take a prominent stance and assume leadership positions across the mental health care system—from the direct-service level to policymaking (e.g., National Institute of Mental Health, state offices of mental health

and public health, professional mental health associations, etc.)—to focus attention across disciplines and systems on the interrelationship of social, economic, and political forces and mental health.

## Conclusions

The intake session has considerable influence on access to and direction of biopsychosocial treatment. Findings from this study raise questions about how the structured expectation of psychiatric diagnosis may influence clinicians' gathering and prioritizing of information.

Not surprisingly, most clinicians in this study prioritized a psychiatric diagnosis; one third identified limitations of the DSM system, and others favored general over criteria-based questions. Most clinicians affirmed psychological processes and the quality of family and social relationships as revealing of capacities, vulnerabilities, risks, and patterns that inform diagnosis and conceptualization of the client's main problem. Notably, a minority of the clinicians considered sociocultural and socioeconomic factors as contributing to diagnoses. Those who did consider these factors highlighted the importance of cultural expressions and understanding, impact of the instability of poverty, and histories of trauma. These findings raise a critical question: Are we paying enough attention to the impact of sociocultural, political, economic, and structural forces as they inform an individual's presenting concerns and diagnosis?

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## References

Allen, J., Balfour, R., Bell, R., & Marmot, M. (2014). Social determinants of mental health. *International Review of Psychiatry*, *26*(4), 392–407. https://doi.org/10.3109/09540261.2014.928270

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Braveman, P. A., Egerter, S., & Williams, D. R. (2011). The social determinants of health coming of age. *Annual Review of Public Health*, *32*(1), 381–398. https://doi.org/10.1146/annurev-publhealth-031210-101218

Burgess, D. J., Fu, S. S., & Van Ryn, M. (2004). Why do providers contribute to disparities and what can be done about it? *Journal of General Internal Medicine*, *19*(11), 1154–1159. https://doi.org/10.1111/j.1525-1497.2004.30227.x

Burns, T. (2004). *Community mental health teams: A guide to current practice.* Oxford University Press.

Carlat, D. (2017). *The psychiatric interview* (4th ed.). Wolters Kluwer.

Castelnuovo, G. (2010). Empirically supported treatments in psychotherapy: Towards an evidence-based or evidence-biased psychology in clinical settings? *Frontiers in Psychology*, *1*(27), 1–10. https://doi.org/10.3389/fpsyg.2010.00027

Corbin, J., & Strauss, A. (2008). Strategies for qualitative data analysis. In C. Juliet & S. Anselm (Eds.), *Basics of qualitative research. Teaching and procedures for developing grounded theory* (3rd ed., pp. 65–86). SAGE Publications. https://doi.org/10.4135/9781452230153

Council on Social Work Education. (2015). *Educational policy and accreditation standards*. https://www.cswe.org/getattachment/Accreditation/Accreditation-Process/2015-EPAS/2015EPAS_Web_FINAL.pdf.aspx

Frances, A. (2013a). *Essentials of psychiatric diagnosis*. The Guilford Press.

Frances, A. (2013b). *Saving normal: An insider's revolt against out-of-control psychiatric diagnosis, DSM-5, big pharma, and the medicalization of ordinary life*. William Morrow & Company.

Glisson, C., & Williams, N. J. (2015). Assessing and changing organizational social contexts for effective mental health services. *Annual Review of Public Health*, *36*, 507–523. https://doi.org/10.1146/annurev-publhealth-031914-122435

Hall, P. (2005). Interprofessional teamwork: Professional cultures as barriers. *Journal of Interprofessional Care*, *1*, 188–196. https://doi.org/10.1080/13561820500081745

Harkness, D. (2011). The diagnosis of mental disorders in clinical social work: A review of standards of care. *Clinical Social Work Journal*, *39*(3), 223–231. https://doi.org/10.1007/s10615-010-0263-8

Heisler, E. J. (2018). *The mental health workforce: A primer*. Congressional Research Service. https://fas.org/sgp/crs/misc/R43255.pdf

Hersen, M., & Thomas, J. C. (2007). *Handbook for clinical interviewing with adults*. SAGE Publications. https://doi.org/10.4135/9781412982733

International Federation of Social Workers (IFSW). (2012). *Code of professional ethics of the social workers in Israel*. The Union of Social Workers. https://www.ifsw.org/code-of-professional-ethics-of-the-social-workers-in-israel/

International Federation of Social Workers (IFSW). (2018). *Global social work statement of ethical principles*. International Federation of Social Workers. https://www.ifsw.org/global-social-work-statement-of-ethical-principles/

Jenkins, S. (2007). Unstructured interviewing. In M. Hersen & J. C. Thomas (Eds.), *Handbook for clinical interviewing with adults* (pp. 7–23). SAGE Publications. https://doi.org/10.4135/9781412982733.n2

Jordan, C., & Franklin, C. (2016). *Clinical assessment for social workers: Quantitative and qualitative methods*. Oxford University Press.

Lewis-Fernandez, R., Aggarwal, N. K., Lam, P. C., Galfalvy, H., Weiss, M. G., Kirmayer, L. J., Paralikar, V., Deshpande, S. N., Díaz, E., Nicasio, A. V., Boiler, M., Alarcón, R. D., Rohlof, H., Groen, S., van Dijk, R. C. J., Jadhav, S., Sarmukaddam, S., Ndetei, D., Scalco, M., . . . Vega-Dienstmaier, J. M. (2017). Feasibility, acceptability and clinical utility of the Cultural Formulation Interview: Mixed-methods results from the DSM-5 international field trial. *The British Journal of Psychiatry*, *210*(4), 290–297. https://doi.org/10.1192/bjp.bp.116.193862

Lund, C., De Silva, M., Plagerson, S., Cooper, S., Chisholm, D., Das, J., Knapp, M., & Patel, V. (2011). Poverty and mental disorders: Breaking the cycle in low-income and middle-income countries. *The Lancet*, *378*(9801), 1502–1514. https://doi.org/10.1016/S0140-6736(11)60754-X

Maddock, A. (2015). Consensus or contention: An exploration of multidisciplinary team functioning in an Irish mental health context. *European Journal of Social Work*, *18*(2), 246–261. https://doi.org/10.1080/13691457.2014.885884

Miller, J. L. (2012). *Psychosocial capacity building in response to disasters*. Columbia University Press.

Miller, J. L., & Pescaroli, G. (2018). Psychosocial capacity building in response to cascading disasters: A culturally informed approach. *International Journal of Disaster Risk Reduction*, *30*(B), 164–171. https://doi.org/10.1016/j.ijdrr.2018.04.018

Moniz, C. (2010). Social work and the social determinants of health perspective: A good fit. *Health and Social Work*, *35*(4), 310–313. https://doi.org/10.1093/hsw/35.4.310

Nakash, O., Cohen, M., & Nagar, M. (2018). "Why come for treatment?" Clients' and therapists' accounts of the presenting problems when seeking mental health care. *Qualitative Health Research*, *28*(6), 916–926. https://doi.org/10.1177/1049732318756302

Nakash, O., Nagar, M., Danilovich, E., Bentov-Gofrit, D., Lurie, I., Steiner, E., Sadeh-Sharvit, S., Szor, H., & Levav, I. (2014). Ethnic disparities in mental health treatment gap in a community-based survey and in access to care in psychiatric clinics. *International Journal of Social Psychiatry*, *60*(6), 575–583. https://doi.org/10.1177/0020764013504562

Nakash, O., Nagar, M., & Kanat-Maymon, Y. (2015a). The clinical utility of DSM categorical diagnostic system during the mental health intake. *Journal of Clinical Psychiatry*, *76*(7), e862–e869. https://doi.org/10.4088/JCP.14m09214

Nakash, O., Nagar, M., & Kanat-Maymon, Y. (2015b). "What should we talk about?" The association between the information exchanged during the mental health intake and the quality of the working alliance. *Journal of Counseling Psychology*, *62*(3), 514–520. https://doi.org/10.1037/cou0000074

Nakash, O., Nagar, M., & Levav, I. (2014). Presenting problems and treatment expectations among service users accessing psychiatric outpatient care: Are there gender differences? *Israeli Journal of Psychiatry*, *51*(3), 212–217. PMID: 25618286

Nakash, O., Rosen, D., & Alegría, M. (2009). The culturally sensitive evaluation. In P. Ruiz & A. Primm (Eds.), *Disparities in psychiatric care: Clinical and cross-cultural perspectives* (pp. 225–235). Wolters Kluwer Lippincott Williams and Wilk.

National Association of Social Workers. (2017). *Code of ethics*. https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English

National Collaborating Center for Mental Health. (2011). *Common mental health disorders: Identification and pathways to care*. RCPsych Publications. https://www.ncbi.nlm.nih.gov/books/NBK92266/

Nordgaard, J., Sass, L. A., & Parnas, J. (2013). The psychiatric interview: Validity, structure, and subjectivity. *European Archives of Psychiatry and Clinical Neuroscience*, *263*(4), 353–364. https://doi.org/10.1007/s00406-012-0366-z

O'Donnell, A. N., Williams, M., & Kilbourne, A. M. (2013). Overcoming roadblocks: Current and emerging reimbursement strategies for integrated mental health services in primary care. *Journal of General Internal Medicine*, *28*(12), 1667–1672. https://doi.org/10.1007/s11606-013-2496-z

Olfson, M., Mojtabai, R., Sampson, N. A., Hwang, I., Druss, B., Wang, P. S., Wells, K. B., Pincuz, H. A., & Kessler, R. C. (2009). Dropout from outpatient mental health care in the United States. *Psychiatric Services*, *60*(7), 898–907. https://doi.org/10.1176/ps.2009.60.7.898

Patel, V., Lund, C., Hatherill, S., Plagerson, S., Corrigall, J., Funk, M., & Flisher, A. J. (2010). Mental health disorders: Equity and social determinants. In E. Blas & A. S. Kurup (Eds.), *Equity, social determinants and public health programmes* (pp. 115–134). World Health Organization.

Pickersgill, M. D. (2013). Debating DSM-5: Diagnosis and the sociology of critique. *Journal of Medical Ethics*, *40*(8), 521–525. https://doi.org/10.1136/medethics-2013-101762

Rosen, D. C., Miller, A. B., Nakash, O., Halperin, L., & Alegría, M. (2012). Interpersonal complementarity in the mental health intake: A mixed-methods study. *Journal of Counseling Psychology*, *59*(2), 185–196. https://doi.org/10.1037/a0027045

Rosen, D. C., Nakash, O., Kwong, A., & Branstetter, H. (2017). Culturally responsive assessment and diagnosis in the mental health intake. *The Behavior Therapist*, *40*(3), 93–98. https://psycnet.apa.org/record/2017-13135-008

Shim, R. S., & Compton, M. T. (2018). Addressing the social determinants of mental health: If not now, when? If not us, who? *Psychiatric Services*, *69*(8), 844–846. https://doi.org/10.1176/appi.ps.201800060

Shim, R. S., Compton, M. T., Zhang, S., Roberts, K., Rust, G., & Druss, B. G. (2017). Predictors of mental health treatment seeking and engagement in a community mental health center. *Community Mental Health Journal*, *53*(5), 510–514. https://doi.org/10.1007/s10597-016-0062-y

Sommers-Flanagan, J., & Sommers-Flanagan, R. (2017). *Clinical interviewing* (6th ed.). John Wiley & Sons.

Summerfield, D. (2000). Childhood, war, refugeedom and "trauma": Three core questions for mental health professionals. *Transcultural Psychiatry*, *37*(3), 417–433. https://doi.org/10.1177/136346150003700308

Tol, W. A., Song, S., & Jordans, M. J. (2013). Annual research review: Resilience and mental health in children and adolescents living in areas of armed conflict—A systematic review of findings in low- and middle-income countries. *Journal of Child Psychology and Psychiatry*, *54*(4), 445–460. https://doi.org/10.1111/jcpp.12053

Vindevogel, S., Ager, A., Schiltz, J., Broekaert, E., & Derluyn, I. (2015). Toward a culturally sensitive conceptualization of resilience: Participatory research with war-affected communities in northern Uganda. *Transcultural Psychiatry*, *52*(3), 396–416. https://doi.org/10.1177/1363461514565852

Wallen, M., & Lorman, W. J. (2008). Special issues in patients with comorbid psychiatric and chemical dependency disorders. In J. Brick (Ed.), *Handbook of the medical consequences of alcohol and drug abuse* (2nd ed., pp. 579–621). Haworth Press.

World Health Organization (WHO). (2013). *Mental health action plan, 2013–2020*. World Health Organization Press. https://apps.who.int/iris/bitstream/handle/10665/89966/9789241506021_eng.pdf;jsessionid=DB8AEF96B67AD7C9ACA8FF940B0CA1D0?sequence=1

World Health Organization (WHO). (2014). *Social determinants of mental health*. World Health Organization Press. https://apps.who.int/iris/bitstream/handle/10665/112828/9789241506809_eng.pdf;jsessionid=15CDBC772F78038F8669ECA8A24E99AC?sequence=1

World Health Organization (WHO). (2016). *International statistical classification of diseases and related health problems* (10th ed.). https://icd.who.int/browse10/2016/en

Whomsle, S. (2018, May). Working holistically: Body, mind, spirit, social world and political context. *Clinical Psychology Forum*, *305*, 32–37. https://shop.bps.org.uk/clinical-psychology-forum-no-305-may-2018