Tools, Referrals, and Gut Feelings: How Clients Search for and Assess Fit with Mental Health Clinicians

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Telehealth and digital platforms have expanded access to mental health clinicians, yet many individuals continue to struggle with finding a clinician who is a good fit. Because a strong therapeutic alliance is a critical determinant of treatment success, understanding how clients search for and assess fit with clinicians is essential. In this study, we explore clients' journeys through clinician selection and engagement, drawing on interviews with 22 participants in the U.S. who interacted with multiple clinicians. While participants recognized the importance of clinician characteristics noted in prior research, they reported difficulty assessing these before engagement. Some determinants of fit could be assessed before ever meeting a clinician, while others emerged only within the relationship; when participants recognized a poor fit, they often disengaged gradually — reducing investment while continuing care — rather than terminating, because the costs of searching again were high. Our findings highlight opportunities for technology to support therapeutic fit at three critical moments: the initial search, periods of uncertainty about fit, and when client goals evolve.

CCS Concepts: • **Human-centered computing → Empirical studies in HCI**.

Additional Key Words and Phrases: mental healthcare, clinician search, client experience, therapeutic alliance, therapeutic fit

ACM Reference Format:
Hyeonjeong Byeon, John C. Fortney, and Sean A. Munson. 2027. Tools, Referrals, and Gut Feelings: How Clients Search for and Assess Fit with Mental Health Clinicians. *Proc. ACM Hum.-Comput. Interact.* 11, 1, Article GROUP52 (January 2027), 29 pages. https://doi.org/10.1145/3859438

1 Introduction

Interpersonal connection between client and clinician is a major determinant of successful treatment in mental health services [43]. Building a trusting and emotionally supportive relationship is essential for effective care: the therapeutic alliance [65]. Yet forming such a relationship requires first finding a clinician with whom it can develop, a process constrained by provider shortages, geographic limits, and insurance restrictions that often result in clients being matched to clinicians based on availability rather than fit [15].

New options have been built to support this process. Online directories like Psychology Today[1] provide searchable profiles of therapists, filterable by specialty and insurance. Telehealth lets patients seek out therapists they could not travel to see in person [37, 57], and digital mental health

[1]https://www.psychologytoday.com

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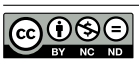

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ACM 2573-0142/2027/1-ARTGROUP52
https://doi.org/10.1145/3859438

platforms advertise the opportunity to quickly match to therapists [27]. Even so, clients continue to face barriers to navigating constraints and finding a fit [98]. To design better technological supports, we must better understand how people use resources to navigate decisions, where existing resources fall short, and opportunities for better support.

The HCI and CSCW communities have contributed to understanding how people seek mental health support, including how peer support communities and social media can prompt or scaffold help-seeking [54] as well as the role of resources like helplines [69]. What has received less attention is the specific process of finding a clinician: which resources people use and why, how they assess fit both before and during treatment, and how their needs and strategies change over time — often across years and multiple clinicians. Understanding this process, and the role technology plays in it, can reveal opportunities to design better support.

In this research, we sought to answer two research questions:

- **RQ 1**. What is the process by which clients seek mental health clinicians and how do they use digital and non-digital resources as part of that search?
- **RQ 2**. What information, tools, and technologies do clients use to evaluate clinician fit, and how do they assess their alignment with a clinician over the course of treatment?

We conducted in-depth interviews with 22 individuals in the United States who had multiple prior experiences with mental health clinicians. By focusing on people with repeated experiences finding and evaluating clinicians, we were able to examine not just initial clinician search, but a longitudinal process: how clients assess therapeutic fit during treatment, what leads them to stay or leave, and how they re-enter the search when they do. We asked participants about the tools and resources they used at each stage, the factors they weighed in continuing or changing clinicians, and how their understanding of what they needed evolved across their care journeys.

Our findings reveal a persistent gap between the resources available and what people actually need from them. While most participants used online directories to generate initial lists of clinicians, many ultimately relied on word-of-mouth referrals from primary care providers, family, or prior clinicians when directories proved insufficient. Once individuals found a professional, digital tools rarely appeared in their mental health care journey. In the absence of better signals, participants fell back on heuristics of uncertain value, such as demographic similarity, or described the process as largely a matter of luck. Many stayed in unsatisfying therapeutic relationships not because they failed to recognize a poor fit, but because the logistical and emotional costs of searching again were too high.

These findings point to opportunities for the HCI and CSCW communities to better support clients in finding and assessing fit at three critical moments: the initial search, periods of uncertainty or dissatisfaction during treatment, and when a client's goals evolve. We discuss implications for the design of matching tools, between-session support, and the broader sociotechnical systems through which people navigate mental healthcare — contributions we situate within ongoing HCI and CSCW conversations about care navigation, help-seeking, and the design of digital mental health tools.

2 Related Work

Because our study focused on U.S. participants, we first describe the U.S. mental healthcare system, then review therapeutic alliance research and current technological supports for clinician matching.

2.1 Access to Mental Health Services in the United States

The U.S. healthcare system consists of a complex mix of public and private entities. Coverage comes from a mix of public programs like Medicare and Medicaid, employer-based insurance, and

ACA marketplace plans, though approximately 8% of the U.S. population remains uninsured [64]. Regardless of one's insurance, primary care physicians often serve as the first point of contact for individuals seeking mental health services, particularly in cases where specialized mental healthcare is inaccessible or where stigma surrounding mental illness prevents individuals from reaching out to mental health professionals directly [50]. The proportion of primary care visits addressing mental health concerns has increased over time [78]. However, navigating this system can be challenging. Treatment rates remain uneven, with over half (55%) of adults not receiving adequate treatment [58]. Health insurance status plays a pivotal role in determining access to mental health services, and adults with any form of insurance were more likely to receive mental health treatment compared to uninsured individuals [95].

Beyond structural aspects of the U.S. healthcare system, disparities exist in access to mental health services. One of the most prominent barriers is the shortage of mental health professionals, particularly in rural areas where access to specialized care is severely limited [47]. This shortage disproportionately affects individuals in these regions, exacerbating existing treatment disparities [61]. Another critical factor influencing access is socioeconomic status. This includes barriers like childcare needs or work commitments [97] as well as intersectional stigma [92].

While barriers to accessing well-matched mental health clinicians exist across healthcare systems globally, the US context presents a distinctive configuration: clients must simultaneously navigate insurance coverage, provider availability, and a fragmented landscape of directories and platforms largely without institutional guidance. In more centralized systems, referral pathways provide more structure but also constrain patient choice in different ways. Our findings should be read with this context in mind, though the underlying tension between access and fit is not unique to the US.

2.2 Therapeutic Alliance and Mental Health Outcomes

In mental healthcare, the quality of the clinician-client relationship is a critical determinant of successful therapeutic outcomes. This relationship is conceptualized through the lens of the therapeutic alliance: the collaborative and affective bond between client and clinician, comprising agreement on therapeutic goals, consensus on tasks, and the establishment of a personal bond [8]. A strong therapeutic alliance is consistently predictive of client satisfaction and improved clinical outcomes [16, 26, 45, 55, 79]. Importantly for design, alliance can be identified early in treatment and client perceptions of it are relatively stable after a few sessions, with early ratings predictive of eventual outcomes [22].

Research has identified a range of clinician characteristics that foster a strong alliance, including interpersonal warmth, empathy [1, 21], cultural competence [86, 91], and clinical expertise in evidence-based approaches [96]. Critically, many of these qualities are difficult to assess before a therapeutic relationship has begun.

Three related constructs anchor our study, and we use them in distinct ways. The *therapeutic alliance* is a dyadic construct: it describes the collaborative bond between client and clinician and is typically measured from both perspectives, which can diverge [94]. Clients' experiences of therapy constructs also do not always mirror researchers' definitions [4]. We therefore use *therapeutic fit* to refer to the client's side of this relationship — their perceived compatibility with a particular clinician — which is closer to the folk concept clients invoke when they describe a good match. Finally, *continuity of care* — the opportunity to see the same clinician over time — is a structural condition rather than a relational quality. Continuity supports the trust on which alliance depends [32, 42]; in turn, as our findings show, clients' assessments of fit shape whether they preserve, tolerate, or abandon continuity. Because clients navigate search and treatment through their own perceptions, our study centers fit, motivated by the alliance literature's evidence that the underlying relationship matters.

2.3 Help-seeking and Pathways to Connecting with Mental Health Clinicians

Various models describe factors that determine whether and how individuals engage with mental health care. We briefly review how these models support understanding client behavior across the care journey while identifying the gaps our study addresses.

Foundational models of health behavior, such as the Health Belief Model [36, 76] and the Behavioral Model of Health Services Use [3], explain why individuals seek care by identifying beliefs, perceived barriers, and social determinants of access. However, research on how people actually enter care reveals a more contingent process. Rickwood *et al.*'s model identifies prerequisites for help-seeking—symptom awareness, willingness, and availability of support [73]. Pescosolido *et al.* [70] found that fewer than half of first-time mental health patients described a self-directed entry; nearly a third drifted into treatment through circumstance rather than choice, a pattern confirmed in more recent studies [7, 60]. Entry to care is often facilitated by informal, serendipitous interactions, including through online communities and social media [54], and by technology-mediated resources such as helplines [69].

To model entry into care and ongoing engagement on digital mental health platforms, the Integrative Engagement Model [98] characterizes key determinants of engagement across the arc of a digital treatment journey: which platform to use, which treatment modality to pursue, which provider to pair with, and the ongoing appraisals that sustain or disrupt engagement throughout. While it highlights structural constraints and relational dynamics in provider selection, it does not characterize how individuals make these decisions in practice.

In this research, we sought to pick up from the rich explanations previous literature provides of help-seeking and the decision to access care to better understand subsequent steps. Because choice of therapy medium is part of this decision-making process, we did not restrict our focus to people using digital mental health platforms.

2.3.1 Patient choice among clinicians. Across health domains, patients value the freedom to choose healthcare providers [34]. This can improve care quality, enhance patient satisfaction, and foster increased trust and treatment compliance, ultimately leading to better health outcomes [23, 24, 40]. Despite recognition of the importance of patient choice of provider, logistics often are determining factors in which clinician a patient will see [28, 31, 56].

In mental health, while there is recognition of the importance of the therapeutic alliance in therapy outcomes (Section 2.2), translation of these insights into the client and clinician matching process has proven difficult. As in other healthcare domains, structural factors such as convenience or insurance coverage [63] constrain patient choice. When patients do have a choice, they indicate an interest in matching based on a combination of clinician expertise with their problems and clinician characteristics [10]. However, clients often have limited information available about therapist expertise: typically online profiles and word-of-mouth recommendations, without a documented record of the clinician's experience in dealing with problems like theirs [10]. Despite the importance of this information gap, we lack research on how people seeking therapists actually use the contemporary tools available to them, such as online directories (*e.g.*, *Psychology Today* or insurer-specific directories) or general purpose business review sites (*e.g.*, *Yelp*, *Google Maps*).

Among clinician characteristics, some patients desire demographic similarity in clinician matching. This preference is stronger among people who hold marginalized racial [25] or gender identities [49, 87]. However, evidence that demographic matching improves treatment outcomes is mixed at best, with reviews finding no strong effects [14, 25, 84] and more recent studies yielding results ranging from no improvement [71] to weak effects [80] to modest gains in engagement [44]. Notably, informing patients of this evidence does not reduce their preference for demographic matching [39].

Mismatches can also arise from less visible characteristics, such as religiosity [19, 63], which tend to surface during therapy rather than the search process and can then lead to disengagement.

In practice, most client-clinician matching remains manual, guided more by logistics and availability than therapeutic compatibility [31], with demographic preferences inconsistently accommodated [88]. Because many therapy practices are individual or small group, much of the matching process happens outside of any formal clinical processes, shaped by which therapists clients contact and which therapists respond affirmatively. Matching is more common and formalized on digital mental health platforms, and often an advertised feature. A recent large-scale study of a digital mental health platform found that patients who self-selected a provider specialty showed modestly better clinical outcomes, while those who selected a provider identity characteristic showed higher engagement but no symptom improvement [27] — though the study did not examine how patients navigated the selection process.

Because demographic similarity is one of the more common forms of matching used by patients and clinics, readers should note associated ethical challenges. First, the U.S. psychology workforce is overwhelmingly white [52], and so if patients, clinicians, and health systems emphasize racial matching, this can have the effect of delaying treatment for people whose race or ethnicity is less represented in the psychology workforce—particularly problematic if clients are not likely to have better therapeutic outcomes as a result of waiting for a match. Second, demographically matched clients and therapists can make assumptions that they are more similar than they are and engage in confirmation bias about the other's experiences or situations, actually making therapy *less* responsive to the client [72]. These challenges further motivate the need to design ways to support matching on more evidence-based factors that can also promote equitable access to care.

2.4 Technological supports for help-seeking, care navigation, and care matching

Technology has increasingly been positioned as a means of improving how patients find and connect with healthcare providers. Recommender systems have been among the most studied approaches [83], using large-scale data on consultation histories and patient preferences to generate personalized provider recommendations [33, 34]. Within mental health specifically, outcomes-based matching — pairing clients with therapists based on therapists' prior performance with similar presenting concerns — has shown promising results in clinical trials, producing larger reductions in symptoms and functional impairment compared to standard assignment [18]. Patients express interest in having access to such outcomes data when selecting a therapist [9, 10], and therapists have indicated willingness for such data to be collected and used [10]. These approaches remain confined to multi-clinician health systems with the infrastructure to collect and act on performance data, and have not yet been integrated into the individual-clinician directories most clients encounter.

Research has documented the serendipitous and socially embedded nature of pathways into care, and highlighted the limitations of formal systems in surfacing legible entry points [70]. The HCI and CSCW communities have examined the role of online communities, social media, and informal care encounters [54] in facilitating help-seeking. As described in section 2.3, the Integrative Engagement Model [98] provides one account of how decisions unfold across a digital mental health treatment journey, and identifies relational and structural factors that sustain or disrupt engagement throughout. This work has shown that effective technology-mediated support for help-seeking must meet people where they are: structurally, temporally, and in terms of the information they need in the moment. Work on technology-mediated pathways to mental health support shows that systems are often unavailable or poorly designed for the moments when people most need them [69]. From the clinician side, telehealth platforms restructured therapist work practices in ways that were not always visible to clients, highlighting that the platforms mediating client–clinician contact carry their own limitations that shape what kinds of connection are possible [75].

Taken together, past work demonstrates the potential for using richer data beyond surface-level characteristics to facilitate better matches between clients and therapists, and shows that such tools must integrate into the complex, often non-linear process of seeking and accessing care. Yet the tools most clients actually encounter remain understudied from this perspective. This gap is compounded by the tendency of HCI research to evaluate individual platforms in isolation. Burgess *et al.* argue that mental health technology supports are better understood as an ecosystem of digital and nondigital tools that individuals assemble, navigate, and adapt over time [12, 13]. However, we have limited empirical understanding of where they support clients effectively, where they fall short, and what the experience of using them looks like across the full process of seeking and evaluating mental health clinicians.

3 Methods

In this study, we examine clients' lived experiences of finding mental healthcare clinicians and their ongoing assessment of fit. Our study builds on large-scale surveys and experiments of patient preferences (e.g., [39, 49, 87]) as well as interviews that examine specific and potential approaches to matching (e.g., therapist recommendations based on outcomes [10]). We extend this work by focusing on the nuanced decision-making processes clients employ when navigating clinician selection and the resources and technologies they currently use in this process. Following the tradition of practice studies in HCI [17, 66], we treat understanding how people navigate clinician search—including where technology is limited or absent—as a foundation for informing design.

We conducted semi-structured interviews with people who have engaged in mental healthcare services to understand patient experiences of working with clinicians. The University of Washington Human Subjects Division determined our study exempt from Institutional Review Board oversight. All participants provided informed consent before the interview and were reminded that they could decline any question or end the interview at any time without consequence. Given the sensitivity of the topic, participants set the level of detail they shared about their histories. The interviewer did not probe for clinical specifics beyond what participants volunteered, and redirected away from topics that appeared distressing.

3.1 Eligibility and Recruitment

We recruited participants who have engaged in any type of mental healthcare services with a clinician at least once. To be eligible for the study, participants needed to be 18 years or older and fluent in English. Participants were recruited through the Participate in Research website hosted by the Institute of Translational Health Sciences (ITHS). This site was not affiliated with any particular clinical system.

Among the 58 participants who showed interest during the recruitment period, 31 participants responded to the pre-interview survey, and 22 participants decided to participate in the in-depth interview (Table 1). Participating in the pre-interview survey and the interview were voluntary, and participants were not compensated for participation in the study. Consequently, our study likely attracted individuals with relatively high digital literacy and who were more motivated to tell their stories or had more affinity for research. Participants were more likely to be White and highly educated than the U.S. population. At the same time, we did not encounter the challenge of fraudulent participants that HCI and health researchers have increasingly experienced in compensated studies [48, 68].

3.2 Pre-interview Survey

We distributed a pre-interview survey to all potential participants who expressed interest in our study. The survey was designed to ensure eligibility and gather information that would help us adapt the semi-structured interview questions to each participant's specific experiences.

In the survey, participants specified the types of services they had engaged in, described their current engagement with mental health services, and were asked to provide a brief overview of their experiences, including the duration of each engagement and the decision-making process behind each change. We sought to learn from participants with a diverse range of experiences and backgrounds. To support this, we collected demographic information, state of residence, living environment, education level, annual household income, and household size. This information also helped us to contextualize participant experiences.

3.3 Semi-Structured Interview Procedure

To gain an in-depth understanding of participants' perspectives, we conducted interviews about their engagement with mental healthcare services. The interview explored satisfaction with past and current clinicians, reasons for discontinuing services, factors shaping the selection of new providers, and how they evaluated the success of their treatment. We asked participants how they sought out clinicians, including the resources and technology they used, and the challenges they encountered during the search. Consistent with calls to take an ecosystem or toolkit view toward mental health resources [12, 13], we asked about digital and non-digital resources, and mental-health specific as well as general purpose tools.

We designed the interview protocol to be flexible, adapting to each participant's responses to the survey. We asked about experiences chronologically to understand their decision-making across interactions with different clinicians. All interviews were conducted remotely through a video conferencing platform. During the interview, the researcher shared a screen displaying a timeline of the participant's reported care history from the survey. Notes were taken throughout the discussion, and the timeline was updated as participants provided further details. Participants were informed that the interview would last approximately 30-40 minutes. Depending on availability and willingness to share, some interviews lasted up to 1.5 hours, with a median duration of 45 minutes.

3.4 Participant Backgrounds

A total of 22 participants enrolled in our study. While geographic location was not an exclusion criterion, all participants resided in the United States at the time of the interview. Fourteen participants identified as women, four as men, two as genderqueer, one as female non-conforming, and one as transmasculine. Fifteen participants identified their race as White, two as Asian, two as Black/African American, one as Hispanic, and two participants as multiracial (White & Middle Eastern, White & Hispanic). In reporting, we took steps to reduce re-identifiability: we present ages in ranges, generalize potentially identifying details (e.g., locations, institutions, and specifics of legal or family circumstances), and report clinical details only as participants framed them, without inferring diagnostic specifics. Please refer to Table 1 for more details. All participants had worked with three or more clinicians over their lifetime. All had received psychotherapy, and 20 had accessed psychiatric medication management.

While four participants (P5, P10, P12, P21) had undergone inpatient treatment, our analysis focused on outpatient services, including telehealth. We made this decision for two reasons. First, our research questions concern how clients search for, select, and evaluate fit with clinicians, which presuppose some degree of client choice. Inpatient and acute care placements are typically driven by

crisis and clinical necessity rather than client-led search, and so are less informative for questions of how people navigate and assess fit. Second, these four participants described their inpatient and acute experiences not as decisions about fit, but as entry points and turning points that shaped how they subsequently sought and evaluated outpatient care. We therefore excluded inpatient and hospitalization experiences from our analysis, except where these experiences shaped how participants later sought and evaluated outpatient services. We return to this as a direction for future work in Section 5.4.

3.5 Data Analysis

We transcribed all participant interviews for analysis and used the timeline we generated of each participant's encounters with mental health services to support analysis. The research team met regularly throughout the interview phase to discuss emerging insights and to suggest additional prompts or follow up questions for our interview protocol.

Our analysis followed a reflexive thematic analysis approach [11], in which we treated coding and theme development as interpretive work grounded in our engagement with the data. The first author was the primary analyst, using inductive coding followed by theme development through an affinity diagram [38] and memoing, with analytic decisions developed and refined through regular team discussion. The first author reviewed transcripts and timelines for familiarization, and then conducted an open coding process using an affinity diagram. Passages relevant to our research aims were open-coded and transferred to a Miro board, where the first author grouped notes by related content and began constructing themes. Memos were prepared to capture preliminary themes and illustrative examples from the data. Throughout this process, the first and last authors met regularly to discuss and refine the emerging thematic structure. When team members interpreted a passage or theme differently, we resolved these differences through discussion and by returning to the underlying transcripts. Later in the process, the second author, a clinical researcher, reviewed the developing analysis and helped ensure that our interpretations remained grounded in the patient perspective.

Initial themes we developed during this phase included variations in participants' first experiences with mental healthcare, their perceptions of having found a "good match" with a clinician (and the resulting decisions to continue or discontinue care), and experiences of poor fit that either led to disengagement or, in some cases, a continued but unsatisfying therapeutic relationship. Other early themes included different pathways into care, such as parental influence, on-campus referrals, or self-directed searching, as well as evolving clinician preferences.

In a second round of coding, the first author organized data around participants' care trajectories, beginning with recognition of the need for mental health support, the means by which participants encountered their clinicians, the decisions made during treatment (such as continuing, discontinuing, or resuming care), and their current evaluations of care outcomes and future plans. Based on these successive rounds of coding and memo writing, the authors met to review and refine the thematic structure. In these discussions, we decided to move away from a purely sequential representation of care journeys and instead focus on cross-cutting themes that captured recurring patterns across participants. We also recognized that participants' assessments of therapeutic fit were grounded primarily in subjective perception rather than objective markers.

As participants' relationships with clinicians ended, paused, or persisted in varied ways, we did not treat discontinuation as a single analytic category. In coding care trajectories, we distinguished among the different forms these transitions took, including formal termination, gradual drop-off without an explicit ending, reduction in session frequency or a shift to maintenance, and continuation despite dissatisfaction. We also distinguished participants' appraisals of fit (satisfaction or dissatisfaction with the relationship or the therapeutic approach) from their behavior (whether

PID	Age	Gender	Race/ Ethnicity	Setting	Education	Annual House-hold Income	Treatment Settings	Technology Tools Used
P1	25-34	Female	Asian	City	Master's	>$80K	In-person, Online	Psychology Today, clinician directory through insurance, ADDitudemag online health communities and clinician directories, podcasts, self-diagnosis websites through social media, online video platforms, Google Docs for worksheets and homework
P2	25-34	Male	Black/African American	City	Master's	>$80K	In-person, Online, Async digital	Psychology Today, online video platforms
P3	25-34	Female	White and Middle Eastern	City	Master's	$20–50K	Online	Online video platforms
P4	25-34	Female	White	City	Bachelor's	>$80K	In-person	Clinician directory through insurance
P5	35-44	Female	White	Suburban	Some college	>$80K	In-person	Research articles, podcasts, YouTube videos, Google
P6	35-44	Female	White	Rural	Bachelor's	<$20K	Online	Online video platforms
P7	18-24	Female	White	Town	Some college	$20–50K	In-person, Online, Phone	N/A
P8	55-64	Female	White	City	Bachelor's	>$80K	In-person, Online, Phone	Psychology Today, Podcasts, Self-diagnosis tests, Research articles, News articles, Online video platforms
P9	65+	Male	White	Suburban	Master's	>$80K	Online	Internal directory from health system
P10	18-24	Female non-conforming	White	Suburban	Some college	<$20K	In-person, Online	Psychology Today, Google, Online video platforms, Online health communities
P11	35-44	Genderqueer	White	City	Master's	>$80K	Online	Psychology Today
P12	45-54	Male	White	Rural/ Suburban	Some college	$20–50K	In-person, Online	Google
P13	18-24	Female	White and Hispanic	Suburban	Some college	$50–80K	In-person, Online	Clinician directory through insurance
P14	35-44	Female	Hispanic	City	Master's	>$80K	Online	Social media, Clinician directory through insurance
P15	55-64	Female	White	City	Some college	<$20K	In-person, Online	Psychology Today, Online worksheets (DBT Tools), Online communities
P16	55-64	Female	Black/African American	Suburban	Master's	$50–80K	Online	Internal clinician directory through workplace as a clinician herself
P17	18-24	Female	Asian	Suburban	Bachelor's	$50–80K	In-person, Online	Psychology Today, Clinician directory through insurance, Online video platforms
P18	18-24	Transmasc	White	City	Some college	<$20K	In-person, Online	Research articles, Clinician's personal websites, Psychology Today
P19	25-34	Male	White	Suburban	Some college	$20–50K	In-person, Online, Phone, Case mgmt groups	Online video platforms, Psychology Today
P20	25-34	Female	White	Town	Bachelor's	<$20K	In-person, Online	Clinician directory through insurance, Clinician directory (Rula), Online video platforms, Social media
P21	18-24	Genderqueer	White	Town	High school	<$20K	In-person, Online, Phone	Online health communities
P22	25-34	Female	White	Rural	Some college	<$20K	In-person, Online	Google, BetterHelp, Podcasts, Online video platforms

Table 1. Participant Demographics; participant ages are presented in ranges to reduce the risk of re-identifiability.

and how they stayed, reduced, or left), as these did not map onto one another straightforwardly. This distinction became central to our analysis, as several participants remained in relationships they appraised negatively, as noted in Section 4.4.

Through this process, we developed three overarching themes, drawing on all 22 participants' care journeys: (1) clients' perceived needs and expectations for clinicians, (2) ongoing assessment of therapeutic fit, and (3) the evolving nature of needs and therapeutic goals.

4 Findings

Our findings center on clients' decision-making across three recurring challenges: identifying and selecting a clinician, navigating the resources available to support that search, and assessing therapeutic fit over time.

4.1 Vignettes of Clinician Search and Ongoing Evaluation

We first present four illustrative vignettes to ground the cross-cutting findings that follow in the texture of individual care journeys. Together they span the variation we observed in how participants entered care, used digital and interpersonal resources, and managed continuity across clinicians.

4.1.1 P1's accumulated frustrating experiences lead to self-reliance in treatment. P1's navigation was characterized by a high degree of self-reliance and extensive use of digital resources. Rather than relying primarily on clinicians for guidance, she actively sought information online to understand and manage her condition. She frequently engaged with online communities of individuals experiencing similar symptoms and consulted a wide range of digital materials, including podcasts, research articles, magazines, and online self-assessment tools. Because she had difficulty traveling, P1 also preferred meeting clinicians through video-based platforms. She felt that the type of support she expected from clinicians could be adequately provided through video sessions.

P1 has worked with more than ten clinicians over the past eleven years. Her early experiences started in college, where both her first and second clinicians, assigned through the university health clinic, turned out to be terrible experiences. After just one session with each, she decided to stop. These frustrating experiences shaped a negative perception of on-campus services, prompting her to seek clinicians outside of the university.

Through her experiences with multiple clinicians and seeking new ones, P1 became more aware of her diagnosis and began conducting her own research to better understand her symptoms. Factors such as moving between states, changes in insurance, and ongoing negative experiences made it difficult for her to maintain consistent care.

At the time of her interview, P1 had been seeing a psychiatrist for a few months, whom she found through her insurance company's website. Although she found the care unsatisfactory, she had no intention of stopping treatment in the near future, as the psychiatrist respected her autonomy over her medications. This was important for P1, as she felt confident in her ability to manage her condition, and was aware of her needs to treat it.

When searching for clinicians, P1 placed a high value on expertise, focusing on credentials such as degree levels and educational background. Since she was less interested in building a personal connection with the clinician, factors such as the clinician's personal beliefs or demographic information were of little importance to her.

4.1.2 P22's experience with using digital mental health platforms to prevent a treatment gap. P22's care journey combined in-person services with digital tools used to search for clinicians and maintain continuity of care. She often relied on online search tools to identify clinicians who accepted her insurance and had strong ratings. Because the area where she lives has limited mental

health providers covered by her insurance, she frequently used telehealth services for psychiatric medication management. When local therapy options temporarily disappeared, she also turned to an online therapy platform to prevent a treatment gap. She appreciated that the platform asked questions about therapist preferences, communication methods (e.g., messaging, video sessions), and areas of expertise, as it allowed her to express preferences about her care.

P22's first encounters with mental health services began when her parents arranged for her to see a clinician as part of a family legal matter during childhood. Later, her parents again arranged therapy because they believed social difficulties were affecting her wellbeing. P22 did not find this experience helpful and felt the sessions were overly conversational and did not address deeper concerns. Because the therapy had been arranged by her parents, she had little control over the process and eventually stopped attending.

In early adulthood, P22 sought therapy on her own after experiencing significant distress related to a legal case. She searched for clinicians online and selected a clinic that accepted her insurance and had strong ratings. Although the therapist assigned to her was helpful in supporting her through the legal situation, P22 again felt that the therapy remained too surface-level and did not explore underlying causes of her struggles.

Several years later, P22 attempted to re-enter therapy while living in an area with very limited mental health resources covered by her insurance. Only one clinic and one therapist were available, leaving her with no choice in providers. Although she found the therapy unhelpful, she continued attending sessions because it was her only available option. Around the same time, she also sought psychiatric medication for the first time. Her initial intake appointment for medication management was a negative experience, but because those services were offered through telehealth, she was able to quickly switch to a different provider.

Her next psychiatric provider became the first clinician who actively tried to understand the root cause of her symptoms. This provider scheduled frequent follow-up appointments, carefully monitored medication adjustments, and spent additional time ensuring that P22 felt stable. After this provider left, P22 continued medication management with another telehealth clinician who focused primarily on managing symptoms and assigned small tasks between sessions, such as journaling and practicing labeling emotions.

When her local therapist later left the clinic, P22 temporarily lost access to therapy. Because she believed regular sessions were important for maintaining stability, she signed up for an online therapy platform to fill the gap. The intake process allowed her to specify preferences about the kind of therapist and communication style she wanted, which made her feel hopeful about the possibility of finding a better match. However, the therapist she was matched with again used a conversational approach that felt too casual and did not address deeper issues. Her dissatisfaction with the clinician led her to doubt the algorithm that matched her with the clinician.

At the time of the interview, P22 had recently begun seeing a newly hired therapist at the same clinic where she receives medication management. Although she had only completed an introductory session, she felt cautiously optimistic about continuing treatment there. Because she expects to need ongoing mental health care in the long term, although with low expectations, digital platforms and telehealth services have become important tools for her to maintain access to care when local options are limited.

4.1.3 P18's selective use of referrals and online search to find a more suitable therapy modality. P18's pathway to care combined family-mediated referrals, clinician recommendations, and later, more active use of digital resources. His early treatment experiences were largely arranged by others. Over time, however, he became more engaged in the search process and began using digital tools more actively. He reviewed therapists' websites, checked whether they were accepting new patients,

compared insurance options, and sent emails to request consultations. He also used telehealth when insurance changes made in-person sessions harder to sustain. For psychiatric care, he relied on an online directory.

P18's earliest therapy began in middle school after he told his mother about his symptoms. His first therapist was assigned through a nearby clinic that provided free therapy under state insurance coverage. Because he was unfamiliar with therapy and had difficulty opening up, this first experience was brief and only somewhat helpful, though it did contribute to an initial diagnosis. When that therapist left the office, he was automatically transferred to a second therapist at the same clinic. By that point, he had become more comfortable in therapy, and this clinician was a better fit. He described her as patient and supportive, and he especially valued that she respected his gender identity. This treatment ended when his family lost their state insurance coverage.

After losing insurance coverage, P18's therapist helped him identify LGBTQ-affirming offices, leading him to a third therapist, whom he saw for the longest period. This therapist helped him connect his symptoms to family dynamics. Later, after P18 moved out of his family home, this same clinician recognized that ordinary talk therapy was no longer enough and suggested that internal family systems (IFS) might better address the deeper, longstanding issues. This therapist also helped him look for IFS providers in his city and offered a list that included information about insurance and sliding-scale payment options.

Using that list, P18 became more active in the search process himself. He researched therapists' websites, verified whether they were still accepting patients, and emailed several to ask for consultations. His current therapist was one of the few who responded. This transition marked a shift from passive assignment to more intentional selection based on treatment modality. P18 reported that once IFS was explained more clearly in consultation and again in the first session, he quickly understood why it might help him more than standard talk therapy. He found this approach more productive and better suited to working through complex family-related issues. He also appreciated his current therapist's flexibility in switching from in-person visits to telehealth when insurance coverage changed, as well as the therapist's ease of communication through a website-based messaging system. In parallel, P18 also sought psychiatric care for medication management. Unlike therapy, he found the psychiatric search process relatively smooth because the online directory he used provided clear and practical information.

4.1.4 P4's progression from parental influence to self-directed, ongoing therapy. P4's pathway to finding clinicians reflects a shift from externally guided, non-digital navigation to more self-directed use of online resources once she gained the opportunity to choose clinicians after college. After graduating from college, when she had financial and insurance coverage of her own, P4 began using digital resources to search for clinicians. She used her insurance company's online provider directory, where she was able to filter options according to her personal preferences. All of her therapeutic encounters have taken place in person, and no digital tools were incorporated into the sessions themselves.

P4 has worked with three or more clinicians, all of whom were counselors. Her first experience with a clinician came through a recommendation from her parents, who were guided by their church. She worked with her first clinician for two years and had a generally positive experience. P4 decided to stop seeing this clinician when she felt that the tools provided had helped her manage her challenges.

Her second experience took place during college, when her parents suggested relationship counseling to improve communication within the family. Her parents found the clinician online, prioritizing shared religious beliefs and a convenient location for both P4 and her parents. P4 recalled that the counselor was a compassionate mediator who empowered her to speak up by

taking her side. Although P4 wished to continue both group and individual therapy with this counselor, her parents felt that no progress was being made and were unwilling to continue paying. Since P4 could not afford the sessions on her own, the therapy was discontinued. As a result, P4 turned to on-campus resources for support, which were readily accessible and affordable. While she found these services helpful, she noted that she wasn't able to build a continuous relationship with a single counselor, as the counselor changed at each appointment and advance scheduling was not possible. She also felt that the student counselors (trainees) lacked professionalism.

P4 has been seeing her current clinician for the past ten years. She found him on her own through her insurance company's website. For the first time, she knew exactly what she wanted in a clinician—someone who was male and non-religious—since her previous counselors had all been women and religious figures recommended by her parents. P4 believed these traits would allow the clinician to offer a more objective and distinct perspective. After working with him for a decade, their sessions are now primarily focused on maintenance, as she has resolved the issues that initially led her to therapy. Although the clinician has suggested that she could discontinue therapy, P4 values the support he provides and chooses to continue, feeling that his deep understanding of her history is essential for her ongoing mental health.

4.2 Clients' Perceived Needs and Expectations for Clinicians

Participants described a range of qualities and characteristics they sought in mental healthcare providers. Their goals were shaped by personal preferences, diagnostic histories, access to resources, and prior experiences with clinicians. The type of clinician they sought also varied depending on how much prior experience they had working with clinicians (*e.g.,* those in earlier stages versus those with more accumulated experience). Those new to mental healthcare often lacked clear searching goals. Speaking about early experiences seeking a counselor, P10 commented: "*I think at the time I also wasn't entirely sure what to look for or where to look.*"

Logistical factors, such as availability for new patients, insurance coverage, and location, mostly guided their search. When they did have preferences, participants often relied on visible characteristics of clinicians' personal identities. In recalling their early experiences, several participants explained that they prioritized gender, racial, or cultural alignment with clinicians. Their preferences reflected the expectation that clinicians who shared their identity would more fully understand their perspectives and lived experiences. Female participants often preferred clinicians with the same gender (P11, P13, P14, P17, P20). P2, who identified as BIPOC, prioritized clinicians who shared lived experiences of being part of marginalized racial groups. Some participants, such as P17, expected that working with a clinician of the same cultural background and similar in age would lead to a better treatment outcome: *"I would also really want to try and find the younger Asian American therapists…So far I haven't really been able to find someone who gets where I'm coming from*" (P17).

In contrast, some clients who experienced multiple clinicians over time had developed specific preferences based on past therapeutic relationships. When their experience included a specific diagnosis or condition, this often informed the expertise they sought in clinicians (P1, P5, P13, P18). Others, informed by their interests and prior experiences with mental health, sought specific modalities (P2, P8, P10).

4.2.1 Early Experiences of Childhood/Adolescence Services. Participants who had clinical encounters during childhood or adolescence showed somewhat distinct trajectories. These early experiences — typically initiated by parents, teachers, or school systems — shaped their expectations of treatment and served as a heuristic guiding later searches, either as positive models to recreate or negative

ones to avoid. For some, they also provided a practical resource: several participants reconnected with an earlier clinician or used them as a referral point when re-entering care as adults.

Participants who had positive early encounters described how these shaped their willingness to engage with mental health services later. P4 recalled: "*being able to express myself to another person in the privacy of a clinic room was important to me as a kid and kind of set that foundation of like, oh, I do have an environment to go to... That foundation was really set with that first clinician*" (P4). Several participants (P3, P4, P13) reported seeking out the same clinician again as adults or obtaining referrals through them when re-engaging with care later in life. The early sense of psychological safety and continuity helped normalize the idea that therapy could be a recurring and supportive presence over time. Not all participants had positive early experiences. For some, sessions arranged by parents or teachers felt mandatory and clinician-controlled, with little room for the child's perspective. These experiences generated lasting skepticism: P13 and P17 carried distrust of school counselors into adulthood, and P7's difficulty connecting with school counselors led to skepticism about therapy overall.

4.3 Enacting Preferences and Navigating Resources

After recognizing the need for support from a mental health professional, clients varied in the resources they used. As they began to invest more time and effort into mental healthcare, participants became aware of a wider range of resources and often engaged with multiple sources simultaneously.

4.3.1 Educational resources. Participants in our study showed a high level of interest in mental well-being and psychology. These resources included podcasts, research papers, magazines, online communities, books, self-assessment surveys, content from social media platforms, and online resources such as DBT Tools[2], Therapist Aid[3], and ADDitude magazine[4]. Many actively sought out educational resources to better understand their needs and to identify the most compatible form of clinical support. Several participants (P1, P6, P14, P22) also mentioned that they relied on educational resources to better understand their diagnosis after receiving one. Participants believed that gaining knowledge about their symptoms and available treatments would help them understand their experiences more objectively and from a professional perspective. This, in turn, could help them tune their searches for therapists or get more out of their current treatment.

P14 specifically described using social media to self-diagnose ADHD, which prompted her to seek professional support:

> I was at the time well, the whole thing TikTok and Instagram about ADHD were going around and I got caught in that. I basically look at it and said, yeah, that's the problem it's not just anxiety that's probably it. So I went to [my health system] and I told them that I wanted to be evaluated with a psychiatrist. (P14)

Participants described these educational resources as helping them make more informed treatment decisions. As they learned more about diagnoses and treatment options, they began to prioritize clinicians with specific expertise or familiarity with certain therapeutic methods. Even when not actively searching for a new clinician, these resources shaped their therapeutic engagement by giving them more confidence to ask targeted questions and request additional support from providers.

4.3.2 Search and referral resources. Participants used a variety of resources when searching for clinicians. Many turned to online directories, with *Psychology Today* being the most frequently

[2]https://dbt.tools/
[3]https://www.therapistaid.com/
[4]https://www.additudemag.com/

mentioned (P1, P2, P8, P10, P11, P15, P17, P18, P19), valued for its filters and clinician profiles. Others used insurance provider directories to identify in-network clinicians (P1, P4, P13, P14, P17), or Google and Google Maps to locate nearby providers (P1, P5, P10, P12, P22). For these participants, Google served as a quick first pass: P10 described reaching out to "the top three or four that come up in your Google," and P22 relied on ratings shown in search results to choose a clinic.

For some, referrals were the primary pathway. Participants relied on family members (P2, P11, P18), primary care physicians, or previous clinicians to identify their next provider. Participants generally accepted therapists recommended by trusted sources. Those routed through institutional systems—clinic intake, campus counseling—had limited opportunity to express preferences, while those receiving personal referrals from family, physicians, or prior clinicians generally accepted the recommendation on the basis of trust. Pathways also varied by life stage: participants who first sought care during college (P1, P2, P6) often began with walk-in campus counseling centers, while those who entered care during childhood or adolescence (P3, P4, P7, P13, P15, P17, P18, P21, P22) were typically guided by parents or guardians.

4.3.3 Difficulty of expressing needs and assessing fit through current resources. Across participant experiences, we found a disconnect between intake processes and actual mental health needs. Some participants (P19, P20) reported that intake forms and search filters were designed with implicit assumptions about clients' symptoms, especially for relatively common diagnoses such as depression and anxiety. Participants expressed frustration that these systems often reduced their complex emotional struggles to a checklist of symptoms. For example, P20 explained: *"(intake forms) are like . . . Let's see, okay, do you have generalized anxiety disorder?, okay, major depressive disorder?, okay, social anxiety disorder? I don't know if they [providers] see that. Actually that's a presumption in and of itself"* (P20). This posed challenges for individuals whose experiences were more nuanced or who had not yet received a formal diagnosis. P19 attempted to navigate these barriers by directly communicating with providers, but found it challenging.

Meanwhile, P6 and P22 both described detailed intake procedures—P6 through an employee advocacy service, and P22 through BetterHelp— but their outcomes differed. P6 described:

> An actual person advocate, an actual person who met with me got to know me and my situation. . . . And then we would talk about things like insurance plan, location, type of counselor, you know, whatever modalities . . . they would interview me and then they would create a short list and they would engage me again usually via email, asking, 'Is there anyone you want to immediately remove right away or do you have any preferences?' (P6)

Through back-and-forth discussions with the agents, P6 was matched with a provider well-suited to her needs.

P22 described initially feeling a similar sense of empowerment with BetterHelp:

> It asked a lot of questions on my preferences on what kind of provider I'd like to see. I was like, oh my God I get a real choice to put in some input for the first time. I felt a little hopeful in doing that because, I was like if I can select the things that I want, you know, maybe they're more able to help me. . . . it had like a, like a little input piece where you could write a few sentences on why you're going to therapy and what you'd like to get out of it. (P22)

However, P22 was let down by how the matching process used these preferences: "*So they don't let you pick your therapist, and after you've filled out the stuff, it doesn't filter and lets you pick . . . It asks you questions and then it kind of picks one* ***for*** *you based off of that information.*" (P22).

Especially because the match was not a good fit, P22 wished she had been given insight into why the recommendation had been made.

Another challenge participants faced was the limited information available in online resources. Whether through directory websites or insurance provider listings, participants felt the details provided were often insufficient for evaluating fit. Several (P12, P19) expressed a desire for richer profiles, such as detailed biographies or videos, to get a better sense of the clinician.

However, P12 also pointed out challenges of predicting whether the clinician would be a good fit based on website profiles: "*You're never going to know until you meet that person. Their tone of voice could set you off for crying out loud, the way their body language*" (P12).

Three participants (P1, P8, P19) reported that their directory included filters for intervention methods, but they lacked sufficient knowledge to use them effectively. P1, for example, knew the listed methods but was unsure how to describe the treatment she wanted. Similarly, P9 reflected that he only came to understand many intervention methods later, after becoming a peer support counselor himself. Participants who were more familiar with different approaches emphasized that even within the same modality, clinicians often varied in how they applied it.

4.4 Ongoing Assessment of Therapeutic Fit Throughout the Client Journey

Once clients engaged in mental healthcare, they continually assessed their compatibility with clinicians. Most participants noted that they had become better at recognizing a good fit over time. P9 mentioned that his 'gut feeling' has become an indicator he developed to gauge whether someone is a good fit. However, this ongoing assessment was often delayed or not effectively reflected in their decisions. Many participants reflected that they only recognized a poor fit after a significant amount of time, or after a traumatic event had happened, and only then did they begin to incorporate those insights into future decisions. One participant (P22) even noted that it was during the interview for this study that she realized a recurring pattern in her past therapeutic experiences.

4.4.1 How Clients Assessed Fit with a Clinician. Participants assessed whether a clinician was a good fit based on four recurring factors: experiencing progress, feeling understood, having communication needs met, and receiving tailored care. Participants linked the perception of a good fit to noticeable progress in their mental health journey. For some, this meant acquiring new insights or becoming more self-aware, even if that led to identifying more complex issues. The process of uncovering things to work on was seen as a sign that the clinician was helping them move forward. Several participants also described a good match in terms of how well a clinician could tailor care (P5, P11) and provide access to resources they would not have found on their own—such as recent research findings related to a participant's diagnosis (P1, P8, P14).

Yet a good fit was not just about progress and care tailored to a diagnosis; it was also about relational alignment, shared values, and being treated as a whole person. Clients perceived the strongest fit when clinicians understood their experiences holistically, whether through shared lived experience or deep empathy with their identities and circumstances. P9, a veteran, highlighted the value of working with someone who understood trauma in the context of military service; P2, who identified as BIPOC, prioritized clinicians who could recognize and hold space for racialized experiences. Communication mattered too: participants perceived a good fit when they felt safe enough to share openly and to question things without the clinician interpreting it as a challenge to their expertise (P14).

4.4.2 Responding to Poor Fit in Therapeutic Relationships. Participants made careful appraisals of whether a clinician was a good fit, but appraisal and behavior did not always align: even when participants perceived a poor fit with their provider, many continued with the therapeutic

relationship, sometimes for extended periods, due to concerns about continuity of care. For many, the burden of searching again, the risk of losing support, or logistical barriers (*e.g.,* insurance, scheduling) shaped the decision to stay. These dynamics were particularly prominent among participants with limited clinical access or financial resources. Given that many of our participants reported low household incomes relative to household size, continuity often meant tolerating poor fit, planning around insurance transitions, and anticipating therapist turnover. In these contexts, participants made strategic compromises, prioritizing consistency of care over the ideal of a perfect therapeutic fit.

Another challenge was the psychological burden clients faced when searching for a new clinician. In particular, clients who had previously experienced frustration with clinicians were seeking help, but were also afraid of starting over and building a new therapeutic relationship from scratch. For example, P7 and P10 described entering a new therapeutic relationship as "*rolling the dice*," expressing uncertainty and concern about what to expect before the session begins. P10 described the process as being like a "door-knocking salesman" and P19 emphasized the role of luck. Participants pointed out the emotional burden of initial sessions, particularly repeatedly recounting their mental health history: "*Maybe part of me was like tired, not honestly yeah not wanting to go through the damn process again*" (P20). P20 particularly called out the mental and emotional burden of intake forms. The hesitation to repeat one's "*mental medical life history*" also shaped P22's decision to wait for a clinic to hire a replacement therapist rather than go through another clinic's onboarding process. This work carries over to sessions with a new therapist. As P15 put it: "*It's very hard when you're in that active space of needing services to go and look for services and, you know, and having to recount some of the past issues…So it's always hard to start over*" (P15).

Some participants took an approach of maintaining their relationship with a current, less-than-ideal provider while simultaneously seeking a new one. P18 described proactively planning to ensure there would be no gap in support:

> So there might be some time in between there where if it hasn't gone through fast enough, I might need to stop seeing …for a short time but I plan to at least try to go back. …So far it hasn't interrupted our sessions yet and I did contact my third therapist just in case I needed to have therapy between that time. (P18)

These compromises sometimes became unexpectedly prolonged. P10 labeled one of their therapists as a *"filler"*:

> It kind of felt like, talking to the grocery cashier. …it turned into five months and you're like, I need to get out of here. …It's like using soda instead of oil to make the wheels keep going. I think a lot of it comes from an anxiety of what happens if I don't put any liquid at all on it. Then what? I tend not to like specifically search for filler but more so like if I end up with someone and you start to kind of find out that they're more of a filler person than a concrete person you kind of have to, well, I have to suck it up and deal with it because there's not a lot of options. And taking a suck-it-up-and-deal-with-it approach to therapy is not the best. (P10)

Across these experiences, participants did not describe receiving or accessing any explicit support for evaluating whether a therapeutic relationship was working for them.

4.5 The Evolving Nature of Client Needs and Therapeutic Goals

As participants accumulated therapeutic experiences, their mental health needs, goals, and understandings of what they sought in a clinician changed.

Participants reflected on how their initial preferences, often shaped by identity-based alignment (as mentioned in 4.2) or urgency of symptoms, shifted as their needs evolved. As they accumulated

positive experiences with clinicians who recognized their perspectives without necessarily identifying as part of the same community, identity alignment became less of a priority. For instance, this shift was observed in P2 (BIPOC) and in P9, P18, and P21 (LGBTQIA+). One of our participants (P4) reported that she intentionally sought a clinician with *different* identities. Initially, she preferred a clinician who, as a woman, could better empathize with her lived experiences and who shared a similar religious background. However, she later came to believe that working with a male clinician without a religious background might provide a more objective perspective, which led her to change her preference.

Another point mentioned by participants was how their perspectives on fit changed over time, as they accumulated experiences and gained knowledge through resources. When participants were unfamiliar with specific therapeutic approaches, it was difficult for them to form realistic expectations, and this unfamiliarity often led them to perceive a clinician as a poor fit (P12, P19).

Participants who experienced improvement through working with a therapist talked about their desire to shift to more of a maintenance approach while preserving their relationship—and a regular appointment—with their therapist. P4, for example, shifted to quarterly visits with her long-term therapist in her life as an ongoing support:

> Since I've been seeing them for a decade, it's really like right now it's more maintenance. And just because mental health support is so important to me, it's not something that I ever want to let go. …I just feel like I want to take him with me through each stage of life that I go through. (P4)

P4 emphasized the importance of a therapist "who knows so much of my history." Others shared similar views, describing therapy as something they expected to engage with long-term, even indefinitely. They shared that their mental health needs fluctuated but rarely disappeared completely.

5 Discussion

Our findings highlight the challenges of repeatedly finding and assessing fit with clinicians in mental healthcare as a longitudinal process. While participants navigated an assemblage of interpersonal and digital resources, we identified opportunities where existing resources were insufficient to support clients from their perspective. Critically, while all participants made some use of digital tools at one point or another, most did not rely on them when making consequential decisions about care. Online directories were used to generate lists of clinician profiles, and general-purpose search tools located nearby providers. However, the relational judgments at the heart of finding and choosing a clinician happened elsewhere, such as through conversations with trusted others, accumulated experience across multiple clinicians, and slow-forming intuitions about what a good match felt like. This pattern of selective, peripheral digital tool use sits in tension with the framing that motivates much HCI research in this space, which tends to position technology as a promising lever for improving matching and therapeutic engagement.

In what follows, we first examine what our findings reveal about the relational work of therapeutic fit and its implications for those who would design tools to support assessment of therapeutic fit. We then turn to the broader question of technology's role (and absence) in how clients navigate care, engaging directly with Burgess et al.'s call to understand mental health technology not as a set of individual platforms but as an ecosystem that people assemble, navigate, and adapt across time [13]. We close with three opportunities at critical moments in the care journey where we believe HCI and CSCW research and design can contribute.

5.1 Fit as relational work: implications for assessment

Much of the difficulty participants described in finding and sustaining therapeutic fit was often relational and interpretive. Participants struggled to assess fit because the qualities that made a match feel right were difficult to anticipate before a relationship had developed, and difficult to evaluate once inside one.

Our findings extend the Integrative Engagement Model [98]. Participant experiences align broadly with the Deciding, Selecting, Engaging, and Terminating phases, but our data reveal that the Engaging phase carries a burden the model does not yet describe: clients were assessing the quality of their therapeutic relationship throughout treatment, often without any structured support for doing so, and often reaching conclusions only after extended periods of uncertainty or dissatisfaction. Many stayed in relationships they recognized as poor fits, because the costs of starting over, emotionally and logistically, were high.

P10's concept of the "filler" therapist explains another rationale behind these decisions. Their description of knowingly staying with a clinician who wasn't helping, because some continuity felt better than none was not unique to them; several participants described accepting compromises in care quality to avoid gaps in support. Treating discontinuation as the primary outcome of poor therapeutic fit would miss this dynamic.

Our findings reveal multiple forms of disengagement, ranging from formal termination and leaving care altogether to more gradual forms of emotional withdrawal while continuing to attend sessions. Participants often remained with providers they considered inadequate, sometimes reducing their openness, investment, or expectations long before formally ending the relationship.

Our data also suggests that therapeutic fit is not a single attribute that can be fully predicted at the point of search. Its components differ in when and how they become assessable. Some determinants of a workable fit are relatively stable and can be evaluated before contact, including logistical compatibility, treatment modality, area of expertise, client preferences, and therapists' track records with clients presenting similar concerns. Outcomes-based matching currently provides the strongest evidence for improving initial matches [18], while eliciting and accommodating client preferences measurably reduces dropout [90]. Other dimensions become assessable during the first few sessions. Early alliance ratings, for example, are relatively stable and predictive of eventual outcomes [22]. These can help identify the point at which support must shift from informing initial selection to helping clients assess a developing relationship. This temporal account reframes fit as an ongoing process of search, early assessment, adjustment, and, when necessary, transition, rather than a one-time selection. Zech et al. identify a need for tools that support clients in evaluating therapeutic engagement [98]; none of our participants described using one. Our findings suggest three forms of support that such tools could provide.

First, our findings suggest that assessment tools could help clients distinguish between dissatisfaction with a therapeutic relationship and dissatisfaction with a therapeutic approach, something our participants found difficult to separate. Some participants (P12, P19) described what they later understood as a mismatch between their expectations and the underlying treatment modality (*e.g.,* expecting reflective, open-ended dialogue and receiving structured, manualized intervention) as a mismatch with the therapist personally — a dynamic consistent with prior research noting that clients may experience structured, manualized interventions as 'childish—or not even a therapy' [62]. Without vocabulary for making this distinction, clients who might have benefited from a different therapeutic approach instead cycled through therapists, reproducing the same mismatch. An assessment tool that supports clients in reflecting on what specifically feels misaligned, such as the relationship, the approach, the pace, the communication style, could help interrupt this cycle.

Current search tools may contribute to this conflation. As described in Section 4.3.3, several participants found directory filters for therapy type and area of expertise difficult to use without prior knowledge of treatment approaches or a diagnosis. When clients lack the vocabulary to distinguish therapeutic approaches, they have difficulty forming realistic expectations, and unmet expectations are a well-documented driver of alliance rupture and treatment discontinuation [53, 74]. Some participants were unaware of alternative therapeutic approaches or of the possibility of seeing clinicians with different expertise. As a result, some continued with approaches that were not helping until a clinician suggested a different one (e.g., P18's move to IFS).

Second, participant decisions about whether to act on a perceived mismatch reflected emotional burden, financial access, perceived alternatives, and fear of losing continuity. The experience of assessing a match cannot be separated from the experience of anticipating what comes next if the match is ended. Assessment tools that focus only on the relationship in isolation without acknowledging or addressing the weight of what comes after may not translate into action for the clients who need them most. Tools designed to support clients in evaluating their therapeutic relationships would need to be embedded in a broader infrastructure that reduces the cost of acting on that evaluation, whether through better information about alternatives, support during transitions, or mechanisms that preserve continuity across providers.

Third, most participants described becoming better at assessing fit over time, as they accumulated experience with different clinicians and modalities. Participants who had encountered multiple therapeutic approaches described being better able to recognize what was and was not working. This suggests that assessment support may be most valuable and most difficult to provide at the beginning of the care journey, when clients lack the experiential vocabulary to name what they are seeking or evaluate what they are receiving. Any tool designed to scaffold this process would need to account for the developmental arc of clients' self-knowledge, which varied across participants and was shaped by accumulated experience and engagement with educational resources. How clients develop this experiential literacy, and how it might be scaffolded earlier in the care journey, is a productive direction for future HCI and CSCW research — one that might draw particularly on reflective informatics and its attention to how tools can support people in transforming their understanding of their own needs and experiences [5].

5.2 Rethinking the role of technology in supporting clients' mental health care journey

Among all participants, P6 and P22 encountered the most explicitly designed matching processes in our data — and their divergent experiences may suggest implications about what clients actually need from matching support. P6, working with a human advocate through an employee assistance program, described a process of iterative back-and-forth: an initial interview, a shortlist, and an explicit opportunity to remove candidates before a match was made. She was matched with a provider well suited to her needs. P22 encountered what appeared to be a structurally similar process through BetterHelp — detailed preference elicitation, an open-ended text field to describe her needs in her own words — and initially felt the same sense of hope. That hope did not survive the matching process. The algorithm produced a recommendation she had no ability to interrogate, redirect, or understand. P22 was asked for her preferences but could not see how they shaped the recommendation, and had no way to redirect when it missed. This opacity is not just a usability failure, but an ethical one, as the person absorbing a poor recommendation is often already in distress, and a match that fails without explanation or recourse can mean delayed care, self-blame, or disengagement. P22 illustrates this pattern, as her inability to see how her preferences shaped the outcome led her to doubt the matching process altogether. Platform incentives sharpen this tension: selecting providers by identity characteristics increases engagement without improving

symptoms [27], so platforms may have reasons to offer and emphasize demographic matching that diverge from clients' clinical interests.

This contrast is instructive not as a comparison of BetterHelp against a human advocate, but as an illustration of what the matching process requires from the client's perspective: not just the opportunity to input preferences, but the ability to remain a legible participant throughout — to understand how preferences were used, to redirect when a recommendation misses, and to maintain a sense of authorship over the process. Current digital matching tools, even well-designed ones, tend to treat preference elicitation as an input stage and recommendation as an output, with little between them that the client can see or act on. P22's experience suggests that what clients may value is not the automation of matching, but structured support for articulating their own needs in a way that remains legible to them throughout the process.

This points toward the pattern noted above: digital tools were peripheral to most participants' consequential decisions about care. General-purpose and educational resources were valued, particularly for building vocabulary to understand one's own needs, while tools designed specifically for matching or assessing fit were rarely mentioned. Taken together, these experiences reveal an assemblage of tools that clients encounter opportunistically — each sufficient for a narrow purpose and insufficient for the broader task of finding a clinician who fits. This is the pattern Burgess et al.'s ecosystem framing predicts [12, 13], and it suggests that peripheral or non-use of these tools reflects a mismatch between what tools offer and what clients need [6, 17]. Designing better support may therefore require less focus on improving any individual tool and more focus on the connective tissue between them: the transitions, the information carried forward, and the moments where clients lose their footing and have no resource that meets them there.

5.3 Opportunities for supporting client-clinician fit

The temporal account in Section 5.1 — in which fit is assessed before contact, revisited in early sessions, and renegotiated as needs evolve — points to three moments where clients need support in finding and assessing fit: (1) the initial search for a clinician, (2) emerging dissatisfaction or uncertainty during treatment, and (3) shifts in a client's treatment goals over time. We discuss each as a moment where available tools and clients' actual needs differ, and where HCI and CSCW research can contribute.

5.3.1 Initial search for a clinician. Participants fell back on heuristics of questionable efficacy—such as demographic similarity—not because they believed it would reliably result in a strong fit, but instead due to a lack of alternative approaches for identifying promising potential clinicians. This finding may help explain why informing patients that racial or ethnic matching is not predictive of better treatment outcomes does not change their preference [39]: they do not have alternatives to inform their preferences. This fallback, combined with the harms outlined in Section 2.3, highlights an ethical consideration for the design of matching systems: systems that simply accommodate demographic preferences would likely delay care for clients whose identities are underrepresented in the clinician workforce and invite the assumed-similarity biases that can make therapy less responsive. Providing better signals for clients to act on is thus an equity intervention as much as a matching improvement.

Our findings support the need for research like that by Constantino, Boswell, and colleagues [9, 10, 18] to develop approaches for (1) assessing the efficacy of therapists in supporting patients in addressing different symptomatic/functional domains and then (2) using this history to match patients to therapists based on therapists' historical success in supporting patients in domains which a patient reports as problematic. Approaches like this may be more readily implemented in multi-clinician health systems which have the ability to assess performance of clinicians and use

that data in their intake process. Integration into clinician directories (e.g., Psychology Today or directories provided by insurers) could make this form of matching more broadly available, but presents challenges around monitoring of individual outcomes and clinician performance.

While such initiatives may improve the quality of matches, they are unlikely to address mismatches between patient expectations of therapy and actual therapy. In our study, participants who had made use of educational resources, or who had prior experience with therapy, were able to use that knowledge to seek out therapy more aligned with their expectations. However, people experiencing mental health challenges may not wish to delay seeking care to learn more about options. One direction is to build on single-session interventions, which have been proposed as support for people on waitlists for care [81], and adapt them as part of an intake process that simultaneously supports the client and informs matching — helping people learn what to expect from therapy before they are committed to a particular approach. A related opportunity is to make the search process more interactive and reflective. Conversational tools that scaffold self-disclosure and preference articulation have precedent in HCI research as a bridge to professional care [51, 77]; a similar approach integrated into a clinician directory could help clients translate their experiences and needs into the therapist attributes and specialties that directories currently expose but that clients often cannot use effectively.

5.3.2 Responding to dissatisfaction or uncertainty about treatment. As reported in Section 4.4, participants often had difficulty assessing the quality of fit as they engaged in therapy. When participants perceived a poor fit, many were uncomfortable openly discussing it with the clinician, fearing an awkward conversation. As a consequence, many clients stayed with clinicians despite dissatisfaction or ambivalence about the fit, or engaged with multiple therapists while searching for a better fit. Others became disillusioned and discontinued treatment, often abruptly or by just no longer scheduling appointments—forms of termination that can leave patients feeling abandoned and may disrupt treatment continuity or reinforce negative experiences with care [46].

This pattern aligns with broader CSCW findings on how the quality of care encounters shapes subsequent engagement. Liu et al. found that care encounters actively shape subsequent help-seeking; disempowering interactions can foreclose future engagement in ways that extend well beyond the immediate relationship [54], a pattern visible across several participants in our study. While that work identifies what makes encounters transformative, our data suggest that clients often lack the communicative tools or vocabulary to act on their assessments of therapeutic fit, even when they recognize a mismatch. Related computational research has examined how patterns of therapist-client communication reflect and shape the therapeutic relationship [93]. Such computational analysis could help clients assess fit, and our findings from patients' longitudinal journeys can help inform about next steps after the assessment. CSCW research has also examined technology-supported communication in collaborative care settings, finding that tools which document shared understanding and support timely patient-provider dialogue can meaningfully improve care coordination [59, 89]. That work has focused primarily on task and goal coordination between patients and providers; our findings suggest that the therapeutic relationship itself—whether it is working, and how to communicate when it is not—represents an adjacent and underexamined dimension of the same design space. Recent work has examined technology's role in supporting therapist-client collaboration around between-session goals, finding that clients' reluctance to share, due to trust concerns, embarrassment, or uncertainty about what to communicate, creates barriers that technology might help bridge [67]. Our findings extend this line of inquiry from between-session goals to the therapeutic relationship itself: clients in our study similarly lacked vocabulary and tools for communicating about whether therapy was working, and similarly avoided raising concerns directly with their clinician.

Tools designed to support this need not be framed around the decision of whether to stay in therapy, a framing that may raise the stakes too high for clients already reluctant to act on their assessments. Drawing on patient communication training research in other health domains [35], such tools might instead support clients in having productive conversations with their clinician that adjust the relationship or therapeutic approach without requiring a rupture. Between-session support tools have begun to explore adjacent territory [29, 41, 82], including tailoring between-session activities to client skills, discomfort, and barriers [66]. Extending that work toward relational assessment specifically is an open design opportunity.

5.3.3 Responding to changing treatment goals. HCI research has examined how clients and therapists collaboratively set and adjust goals in mental health contexts [2], and personal informatics research has recognized adaptive goal evolution as a core design challenge [20]. Our findings extend this work in a specific direction: in mental health care, goal evolution is not only a goal-setting problem but also a problem of fit. When participants' therapeutic goals shifted — from symptom relief toward maintenance, or from general support toward modality-specific expertise — relationships that had been working could become misaligned, and clients rarely initiated conversations about those shifts with their clinicians. When those conversations did not happen, relationships sometimes ruptured, or drifted into a maintenance mode that no longer served the client's evolving needs [30]. This points to a design opportunity related to what Oewel et al. identify [67]: tools that help clients recognize and articulate shifts in what they need—in a way that can be carried into the therapeutic relationship rather than accumulating silently—represent an underexplored direction for HCI and CSCW research, one that recent work on LLM-supported self-reflection [85] begins to open.

5.4 Limitations and Future Work

Many participants talked about constraints on their ability to choose clinicians, because of availability where they lived, insurance or other financial constraints, or a combination. Telehealth may make clinician choice available to more people, and, among our research team, we believe that improving client and clinician matches also has the potential to improve mental healthcare capacity (i.e., if people more reliably have good treatment outcomes). However, even if matching is improved, many structural barriers to mental healthcare and choice of clinician will remain.

Additionally, as noted in the methods section, not compensating participants in this study, combined with our recruitment approach, meant that we were more likely to learn about the experiences of people who had stronger opinions about our research topic or an affinity for research overall. We designed this study to learn in-depth about their experiences and inform design opportunities, and results should not be taken as representative. Relatedly, our participants were more likely to be White and highly educated than the U.S. population (Section 3.1), which likely shaped how they navigated care: participants comfortable with formal systems may search for clinicians and advocate for themselves in ways that people with fewer resources or less system familiarity cannot, and the challenges we describe may be more acute for the latter group. Experiences of participants are also grounded primarily in the U.S. healthcare system, and facilitators and barriers to good clinician matches may vary across cultures and countries.

Further, several participants described the importance of early interactions with childhood and adolescent mental healthcare services. Unlike in adulthood, where they could choose their own clinician, before age 18 they were typically matched with a clinician assigned by parents, legal guardians, or the school system. Although our study does not focus on childhood or adolescent experiences, future research could examine how to support children's self-advocacy, strengthen their authority in decision-making, and ensure their preferences are meaningfully considered

within systems of parental or institutional control. Similarly, although we excluded inpatient and acute care episodes from our analysis of fit (Section 3.4), participants described these experiences as shaping their later expectations of and trust in clinicians; how transitions into and out of acute care affect clinician search and assessment is a direction for future work.

6 Conclusion

In this work, we examined how clients with experience seeing multiple mental health professionals navigate the process of finding and evaluating fit with clinicians. Our findings show that clients, especially clients new to care, face difficulties due to limited resources, unclear search goals, or challenges expressing their needs within digital matching tools or educational platforms. Over time, as clients accumulate experiences and their needs evolve, they engage in ongoing assessments of therapeutic fit. However, these appraisals do not always lead to action due to concerns about disrupting care. Our analysis offers a temporal account of therapeutic fit—some determinants are assessable before contact, others only within the first sessions—and shows that disengagement from a poor fit takes many forms, from formal termination to quiet withdrawal while continuing to attend. Alongside rich accounts of participant care journeys, we identify opportunities at critical moments in that journey where HCI and CSCW research and design can better support clients in finding, assessing, and sustaining fit with clinicians.

Acknowledgments

We thank our participants for generously sharing their experiences of seeking and receiving mental health care. This research is supported by funding from the US National Institute of Mental Health under award P50MH115837. The content is solely the responsibility of the authors and does not necessarily represent the official views of funders. The Participate in Research website we used to recruit participants is provided by the Institute of Translational Health Sciences; NIH awards to the institute did not provide direct funding for this project.

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Received 31 March 2026; revised 17 July 2026; accepted 17 September 2026