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Chacko K. Poovathumkal  
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THE EFFECTS OF AN INTAKE INTERVIEW  
IN AN OUT-PATIENT CLINIC  
ON  
THE CLIENT'S ANXIETY AND "MALADJUSTMENT"

by

Chacko K. Poovathumkal

A Thesis Submitted to the Faculty of the Graduate School  
of Loyola University, Chicago  
In Partial Fulfillment of  
the Requirements for the Degree of  
Master of Arts  
in  
Clinical Psychology  
January  
1969

## Life

Chacko K. Poovathunkal was born in Keezhoor, Kerala State, India on January 6, 1929.

After graduation from St. Joseph's High School, Piravom, he worked in his own parish as an elementary school teacher during the school year 1947-1948. The following year, he entered St. Xavier's College, Palamcottah and then St. Joseph's College, Thiruchirappalli, two Jesuit institutions, and received the degree of Bachelor of Science (chemistry major, mathematics and physics minors) from the University of Madras in 1952.

The same year, he became employed in the government service for the State of Kerala as a higher secondary school teacher. He taught chemistry, physics, mathematics and English.

Majoring in educational psychology, he received his B.T. (a special advanced degree in education) with distinction from the University of Kerala in 1957, after a year of full-time studies in the Maharaja's Training College, Trivandrum. Thereafter he returned to his teaching position for the State. At home he was actively engaged in many community development projects and was instrumental in establishing a public library and constructing a few rural high ways.

In September, 1959 he began his graduate studies at Loyola University,

Chicago, and received the degree of Master of Education, specializing in counseling and guidance, in June, 1961.

After graduation he joined the Catholic Charities of the Archdiocese of Chicago as a counselor at the Counseling Center. He continued his graduate studies in the Department of Psychology at Loyola University. He took his clerkship at Charles F. Read Zone, a mental health center of the Illinois State Department of Mental Health. Currently he is a supervising counselor at the Counseling Center of the Catholic Charities.

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## Chapter I

### Introduction.

The effects of counseling or psychotherapy on clients has received considerable attention. In this connection, the clinical significance of the intake interview becomes very important. This importance has been greatly emphasized in the reports published in 1966 by the Group for the Advancement of Psychiatry. The reports view the intake interview as the first of a series of evaluations which are an integral part of the psychotherapeutic process. The document concluded: "Initial interviews may be likened to the beginning of a journey, the careful preparation for which will insure the greatest comfort and most fruitful assimilation of the many new scenes, of the new discoveries and experiences that may be encountered along the way (p. 456)."

The clinical significance of the intake interview is highly important as clarified by the following explanation: "Whatever may be the treatment of choice--which is usually not predictable at the outset--the initial approach to the individual struggling with incipient illness is highly important since it affects the ultimate help given to the client and may affect the ultimate course the illness takes (Marcus, 1958, p. 559)."

Coleman, Short, and Hirschberg (1948) recognized the following



facets in the intake process: "(a) the patient's request for help is recognized; (b) attitudes of initial resistance are identified; (c) the nature of psychiatric treatment is clarified; and (d) the function of the clinic is interpreted (p. 183)." They recommended that in the first interview the patient should have an experience of what treatment is like and suggested: (a) no effort should be made to define or delimit the problem outside the immediate situation; (b) the patient's psychopathology should not be considered sufficiently descriptive of the treatment problem, but rather equal consideration should be given to the interplay of forces in the total current situation; (c) the first interview should be kept at a level of free expression of feeling with the goal of providing a framework for therapeutic movement.

The remark made some 14 years ago by Merton Gill (1954), that "The literature on initial interview as such is relatively meager (p. 14)," continues to be true even to the present day.

Gill (1954) has described some possibilities whereby the intake interview could heighten the client's anxiety:

If the interviewer feels that he is finished with the case after the initial interview and will not have the patient in psychotherapy, he may be inclined to allow himself more latitude. For example, in his zeal to track down an interesting piece of psychopathology which will enable him to make a nice diagnostic distinction, he may be less sensitive to the patient's growing anxiety than if he knows that he is the psychotherapist who will have to deal with any prematurely awakened anxiety... The technique of quickly leaving painful subjects may be interpreted by the

Patient as a reluctance to attack major difficulties. A patient's anxiety may even be heightened by the feeling that if the therapist is fearful, the problem must be serious indeed (p. 67).

The 1966 report by the Group for the Advancement of Psychotherapy (GAP) stated:

It is common knowledge that anxiety about a psychiatric interview and the implications of psychiatric treatment are ubiquitous. A large number of patients fail to keep their initial appointments at psychiatric clinics. In varying degree, every individual shares in a fear of mental illness. Embarrassment, shame and guilt are some of the other feelings that often accompany the patient's recognition that he needs psychiatric help. It is important to estimate in a particular individual, the degree to which the recommendation of psychotherapy will be felt as an emotional threat rather than as reassurance. This may determine the manner and the timing of therapeutic suggestions. The prospect of therapy may also mobilize an unconscious fear of change in the patient in contradiction to his stated wish to be different. Many apparently successful initial interviews, rich in information, have been followed by an unexplained disappearance of the patient whose anxiety about psychiatric treatment may not have been sufficiently recognized and alleviated during the interviews (pp. 442-443).

The same report recommended to make an attempt to relieve anxiety about treatment as something appropriate for the patient even at the first contact.

Pope and Siegman (1962) studied 12 verbatim transcripts of initial

interviews to investigate the relationship between "activity level" and "specificity" in therapist remarks, and such aspects of patient verbal behavior as clause units (productivity) and speech disturbance ("anxiety") in immediately following responses. The therapist's activity level was conceptualized in terms of ambiguity, lead, and inference. Therapist specificity (asking specific questions) was seen as the crucial variable in therapist informational output; the higher his specificity, the greater his informational output. One conclusion from the study was that low-specificity interviewer remarks have an anxiety arousing effect on the patient during the initial interview. The authors suggested that the ambiguity and the uncertainty which are associated with a low-specificity interviewer remarks are a source of interviewee anxiety which manifests itself in speech disturbances. A more recent study by Pope and Siegman (1966) showed that low-specificity interviewer remarks elicited more cautious and hesitant speech in the interviewee than high-specificity remarks during the initial interview.

Mattsson (1960) conducted a study to investigate the increase and reduction of anxiety in an interpersonal setting. The Ss were 80 male students at Columbia University. The interaction of pairs of Ss in a cooperative task situation was examined. During the experiment, one S received electric shock (in order to introduce anxiety) while his partner received no shock. The anxiety communicated was measured in terms of changes in blood pressure, finger sweat, and scores on a rating scale. The results indicated that a person who interacts with a more anxious person will himself become more anxious. However, the hypothesis that a

person who interacts with a less anxious person will himself become less anxious was not supported by the results.

In summary, it appears that the initial interview can be an important first step in psychotherapy. One major concern in this interview is the arousal of anxiety--a factor which may lead to a premature termination of the treatment relationship or unnecessarily burden the patient. It has been suggested that changes in the patient's anxiety arising from the initial interview depend on a variety of factors (e.g., anxiety of interviewer, therapist's over-emphasis on diagnosis, therapist's own fears about the seriousness of the psychopathology, "specificity" in therapist remarks). The comments cited above suggest, however, that anxiety is especially likely to be exacerbated by the initial interview unless various precautions are taken. This possibility raises the question of what effects the standard intake interviews conducted at a counseling center have on the clients.

At the Counseling Center of the Catholic Charities of the Archdiocese of Chicago, where this study was conducted, there is often a long waiting period varying from one week to three or four months between the intake interview and the beginning of counseling on a regular basis with weekly interviews. With the accumulation of a large number of applications in the waiting list for counseling, the center has adopted the system of giving everyone an intake interview, assuming that it shall be helpful even though there will be a period of waiting before treatment. However, if the initial interview tends to increase anxiety, it might be better to delay the initial interview until the time when regular appointments

could be given for treatment.

At present, only one study has been discovered which provides data relevant to this issue in terms of patients' estimates of severity of their complaints both before and after extensive psychiatric evaluation. This is the study by Battle, Imber, Hoehn-Saric, Stone, Nash, and Frank (1966) in which the target complaints of 40 out-patients in a psychiatric clinic were examined. Of the 89 target complaints identified, 40% were concerned about specific interpersonal problems (with spouse, children, parents and so on), 31% were anxiety or depressive symptoms, and 12% were physical complaints. The remaining complaints were not classified but included desire for increased self-knowledge, higher achievement, and so forth. It was found that the severity ratings of the target complaints did not change to any significant degree from the period before the psychiatric evaluation interview to the postinterview period.

The purpose of this study was to determine whether an intake interview in a clinical setting produces any significant changes in the client's anxiety that can be measured using the Manifest Anxiety Scale (MAS) and the Nicolay-Walker Personal Reaction Schedule (PRS).

This study was also designed to investigate whether the intake interview has any significant influence on the "adjustment" or "mal-adjustment" of the client as measured by the Rotter Incomplete Sentences Blank (ISB).

## Chapter II

### Design of Experiment

#### Subjects

Fifty subjects were selected from 71 consecutive applicants for counseling help (psychotherapy) at the Counseling Center of the Catholic Charities of the Archdiocese of Chicago. All adolescents and adults who applied during the period of study were considered as prospective Ss. Of the 71 who completed the pre-interview tests, 19 failed to keep their next appointments for intake interviews or withdrew applications for treatment, one refused to take the tests after the intake interview, and a 68-year-old woman who had taken the pretest was excluded from the study because she was considerably older than the rest of the sample (age range: 13 to 48 years). None of the Ss had received counseling previously.

Twenty-five Ss each were assigned to the control and the experimental groups. The first person that took the tests was assigned to the control group by tossing a coin; the next person was assigned to the experimental group, the next one to the control group and so on. This assignment approach was continued until both groups had twenty subjects each. The rest of the assignment was done in such a way that the two groups were made comparable in terms of age, sex, and race (Table 1).

In addition, the two groups were comparable in terms of the pre-interview scores on the MAS and the ISB (Table 2). The difference of .80 between the mean ages of the two groups was not significant ( $t = .26$ ).

Table 1

Composition of Control and Experimental Groups.

	Sex			Race			Age (Years)		
	M	F	Total	White	Negro	Total	<u>M</u>	<u>MDN</u>	<u>SD</u>
Control	11	14	25	20	5	25	23.80	17.00	11.57
Experimental	10	15	25	19	6	25	23.00	17.00	10.16

Table 2

Comparability of The Experimental and Control Groups on The Pretest Scores and Interval Between Tests.

	Pretest MAS			Pretest ISB			Interval (in Days) Between Pretest and Posttest		
	<u>M</u>	<u>MDN</u>	<u>SD</u>	<u>M</u>	<u>MDN</u>	<u>SD</u>	<u>M</u>	<u>MDN</u>	<u>SD</u>
Control	21.04	21.00	5.33	158.00	155.00	21.35	20.20	15.00	13.92
Experimental	23.32	25.00	8.76	159.00	160.00	21.91	18.92	14.00	14.04
<u>t</u>	1.11			.17			.32		
<u>p</u> *	> .10			> .50			> .50		

\* p value for two tail test



## Instruments

The Nicolay-Walker Personal Reaction Schedule (PRS) was used to measure anxiety (Walker & Nicolay, 1963). It is a true-false questionnaire type examination with a total of 160 items (e.g., "Most people certainly aren't very helpful." "I cry easily." "I am usually nervous and easily upset." "I cannot keep my mind on one thing."). The subject is instructed to read each statement and mark on the IBM answer sheet whether it is true or false as applied to himself.

The PRS was developed to provide scores on three scales representing three types of anxiety. These three scales are defined as follows (Walker & Nicolay, 1963, p. 3):

### Anxiety Type M (Motor Tension)

Type M anxiety is characterized by concern with external achievement coupled with physical tension which acts as a defense against feelings of inadequacy. When frustration occurs, energy is channeled somatically instead of psychically. Type M anxiety results in hyperactivity, physical and mental restlessness, or jumpiness.

### Anxiety Type O (Object)

Type O anxiety is characterized by concern that external demands and perceived expectancies may be overwhelming and one may suffer harm. It represents a protection or rationalization of one's personal inadequacy. It results in a magnification of personal problems out of proportion to objective reality. The emphasis is here on the external as a source of anxiety or unrest.

### Anxiety Type P (Personal Inadequacy)

Type P anxiety is characterized by the concern that one may not be capable of meeting the difficulties of life. The person himself feels inadequate and the inadequacy lies within himself. There is a certain helplessness and self-evaluation which may give rise to guilt feelings. The focus of the uncertainty is one's own inadequacy.

Thirty K-scale items from the MMPI are included in the 160 items of the PRS as are also the items from the Manifest Anxiety Scale (MAS), the best known index of anxiety (Taylor, 1953).

It has been reported (Walker & Nicolay, 1963) that MAS scores and total PRS scores (the sum of the scores for M, O, and P) are positively correlated ( $r = .71$ ,  $p < .01$ ). The same report stated that the PRS test-retest reliability for the three scales and the total scores based on 197 college students was: M Scale-- $r = .79$ ; O Scale-- $r = .79$ ; P Scale-- $r = .85$ ; Total PRS-- $r = .87$ . Also the various means for the sample of 37 psychiatric patients and those for the college sample were found to be significantly different ( $p < .001$ ). Nicolay, Walker, and Riedel (1966) showed that the total number of personal problems reported on the Mooney Problem Check List correlated positively ( $p < .01$ ) with the subtypes and total anxiety scores on the PRS.

Crumpton, Grayson, and Keith-Lee (1967) have found that three types of anxiety (subjectively experienced fear, anxiety expressed in physical tension, and generalized uncertainty) are related to scores on the Taylor Manifest Anxiety Scale (MAS) scale, with uncertainty less related than either subjectively or physically felt anxiety. The MAS was found to be related to subjective feelings of depression and to an absence of

positively toned emotional reactions. The MAS was inversely correlated with words connoting drive level.

The second instrument used was the Rotter Incomplete Sentences Blank (ISB) and its manual (Rotter & Rafferty, 1950). The ISB consists of 40 sentence stems which are to be completed by the subject (e.g., "I feel..."; "At home...", "Dancing...", "Most girls...").

The manual provides a numerical scoring system. In scoring any numerical weight from 0 to 6 is assigned to each sentence, where 0 indicates the best adjustment and 6 indicates the worst maladjustment. No scores are assigned for incomplete thoughts or omissions. The unscored items are prorated by the formula:  $\left(\frac{40}{40 - \text{omissions}}\right)$  times the total score. However, a paper with more than 20 omissions is considered unscorable for all practical purposes.

Rotter, Rafferty and Schachtitz (1965) reported that using a cutting score of 135, the test identified 68% of the maladjusted and 80% of the adjusted in a sample of 82 females. With the same cutting score, 69% of the maladjusted and 89% of the adjusted were correctly identified in a sample of 123 males. They have claimed satisfactory reliability for the test in terms of split-half coefficients (.83 for women and .84 for men). The interscorer reliability was also high (.96 for women and .91 for men)

### Procedure

The purpose of the intake interview as practiced at the center is defined in the job description of the agency as follows:

Besides the evaluation and screening done by the secretary in taking the application by phone, preliminary or intake sessions (individual or

group) are usually offered, particularly during periods of long waiting for regular appointments, to evaluate the problem situation, to recommend counseling or some other service, and to offer some interim support and clarification for the client.

The following excerpt from the same job description outlines the procedure followed during an intake interview:

The basic purpose of the initial interview is to determine whether counseling is needed and whether the client is ready. If counseling is needed and case is accepted:

1. discuss with client aims and techniques of counseling
2. explain the mechanics of fees, appointments, cancellations
3. determine definitely whether client is planning to continue
4. when necessary secure reports from other agents
5. complete record card by summarizing situation in long hand on reverse side of record card
6. give record to secretary for clerical processing.

When a potential subject called the Counseling Center to apply for assistance, the secretary asked him to come to the center at his earliest convenience to take a test which would require less than an hour to complete. Upon his arrival at the center, the secretary administered the PRS and the ISB and instructed the subject to return them to her when completed.

The following instructions were included on the information blank that each subject completed at the time of testing:

Please read the following carefully: Your test results will be held

strictly confidential. After a few days from today, not less than a week, you will be given an appointment for your first interview with a counselor. This counselor will not have any information about the test results. Please do not ask your first counselor any questions about your tests. A few days after your first interview, you will be given an appointment with a counselor who will continue to see you regularly every week until you stop your counseling. Your test results would be made available to your regular counselor, if seen as useful as decided by the supervisor of this department.

When completed, the tests were collected by the secretary. It was arranged that the subject did not talk to any counselor at this time.

A minimum of one week after the first testing and upon the availability of appointments for the intake interview, the secretary notified the subject that he might come for his first interview with a counselor.

Upon arrival at the center, the subjects in control group were given the PRS and the ISB before seeing the counselors for their interviews. Those in the experimental group were not given these tests until they had completed their intake interviews.

The following instruction was included on the information blank that each subject had to fill in before taking the tests the second time:

Please read the following carefully: Make your responses to all the items on both the tests to express your ideas and feelings at the moment of your reacting to each of them at present.

Your test results will be held strictly confidential. The counselor for your first interview is not furnished with any information on your tests.

A few days from today, you will be given an appointment with a counselor who will continue to see you regularly every week until you stop your counseling. Your test results would be made available to your regular counselor, if seen as useful as decided by the supervisor of this department.

To minimize the effect of the subjects' anxiety related to the testing environment on the PRS results, all were instructed to finish the ISB first before proceeding to the PRS, on both occasions of testing. Also, on both occasions they were allowed to be alone in a room while taking the tests.

Most of the interviews conducted for the study were individual intakes, but in some cases parents and children or husbands and wives were seen together. The general principles and procedures adapted by the center for an intake interview were followed by all of the counselors who did the interviewing. All the counselors at the center have at least a master's degree in psychology, social work, or counseling and guidance as required by the agency.

The regular procedures of the center were followed in assigning the counselors for the intake interview, except that no subject in the experimental group was interviewed by this investigator who is a counselor at the center. Seven different counselors participated in the interviews for the experimental subjects. Counselor participation varied the following way. Three counselors interviewed one subject each, two interviewed three subjects each, one interviewed five subjects and the remaining one interviewed eleven subjects.

For the most part, the counselors that did the interviewing did not know about the study, and even when some became aware of its existence, they were unaware of the details of the design and the purpose of the study.

### Scoring

The PRS scales were scored using the objective scoring keys designed by its authors. However, the subjective nature of the scoring procedure for the ISB required special precautions so that the scorer (the investigator) would not be biased by the knowledge of the time of the measure and subjects' assignments to one of the groups. Therefore, all the ISB answer sheets of the first and second testing of both control and experimental groups were shuffled and scored together. All identifying information (except for code numbers assigned by the secretary) was removed from the answer sheets.

The investigator, who had considerable previous experience in scoring the ISB answers did the scoring. To improve the accuracy in scoring, all difficult to score items were compared with similar examples in the manual. In order to determine the investigator's reliability in scoring the ISB answers, 15 records were rescored after a period of three weeks. These scores were seen to have a very high correlation ( $r = .93$ ) with the previous scores for the same records.

In order to calculate the difference between the pretest and posttest results, the scores for the different scales of the posttest were subtracted from the respective scores of the pretest. A positive score means a reduction in the measure on the posttest while a negative score means an

increase in the measure on the posttest.



## Chapter III

### Results

Table 3 shows the means and standard deviations of all the measures for the PRS and the ISB, both pretest and posttest.

For the pretest, the mean values for the subscales of the PRS and their total (Table 3) were higher than those for the 948 Loyola undergraduates, but a little less than those for the 37 psychiatric patients as reported by Walker and Nicolay (1963) in the normative data for the PRS. On the ISB the mean score for the control group was 158 while that for the experimental group was 159.04. Thus the subjects in both the control and the experimental groups were sufficiently anxious and maladjusted (accepting a score of 135 on the ISB as the cutting point between adjusted and maladjusted as suggested by Rotter) to be in need of psychological help.

Table 4 provides a comparison of the differences between the means of the first and second test scores for both groups. None of the  $t$  values for the differences between the means of the control and experimental groups approached significance. Four of them have probabilities greater than .40 while three of them have probability values greater than .50. Thus there was no evidence that the intake interview had any significant effect on the client's scores on the ISB or

PRS. The mean values of the differences between the pretest and post-test for all the scales of the PRS except O and K are positive for both the control and experimental groups as also for the ISB (Table 4). These suggested a slight tendency for reduction indicative of decreased anxiety and maladjustment for both groups when taking the tests a second time. However, the negative values for the O and K scales of the PRS for both groups suggested a slight tendency for those scales to increase in value when the test was taken a second time.

**Table 3**  
**FRS and ISB Scores.**

			MAS	M	O	P	K	MOP	ISB
Pretest	Control Group	<u>M</u>	21.04	11.80	10.88	12.92	12.60	35.20	158.00
		<u>SD</u>	5.33	3.64	4.92	3.20	3.28	8.11	21.35
	Experimental Group	<u>M</u>	23.32	12.84	12.92	14.12	11.52	39.48	159.04
		<u>SD</u>	8.76	5.18	4.97	5.37	4.37	14.38	21.91
Posttest	Control Group	<u>M</u>	19.96	11.44	10.96	11.68	13.64	34.08	156.04
		<u>SD</u>	5.78	3.69	4.30	4.32	3.71	8.83	12.97
	Experimental Group	<u>M</u>	22.08	11.84	13.20	13.88	11.80	39.00	154.88
		<u>SD</u>	9.72	5.98	5.77	5.70	4.73	15.68	31.59

Table 4  
Differences Between Pretest and Posttest Scores  
for All Measures

Pretest - Posttest								
		MAS	M	O	P	K	MOP	ISB
Control Group	<u>M</u>	1.08	0.36	-.08	1.24	-1.04	1.12	1.96
	<u>SD</u>	4.69	3.11	2.32	3.33	3.34	7.12	11.60
Experimental Group	<u>M</u>	1.24	1.00	-.28	.24	-.28	.48	4.16
	<u>SD</u>	4.05	2.86	3.41	3.10	3.78	7.18	10.23
<u>t</u>		.13	.76	.24	1.10	.75	.32	.71
<u>p*</u>		>.50	>.40	>.50	>.40	>.40	>.50	>.40

\* p value for two tail test

## Chapter IV

### Discussion

The results definitely suggested that an intake interview does not bring about any significant changes in the client's anxiety as measured by the MAS and the PRS. The "maladjustment" scores of the client on the ISB were also unaffected by the intake interview. These results are very much in line with the findings of Battle et al. (1966) that the severity ratings of the target complaints did not change to a significant degree based on measures obtained before and after the psychiatric evaluation. This is contrary to Gill's (1954) idea that an intake interview could heighten the client's anxiety. However, the fact that all the measures (and especially the ISB) are seen to have a greater variability in the case of the experimental group for the posttest when compared with the pretest would tend to support the idea of the Reports in Psychotherapy (1966) that an intake interview could bring about a change in the client's anxiety either way, even though the evidence is against the chance of any statistically significant change. The possibility that persons high and low in anxiety or maladjustment at the time of the pretest might be differently affected by the interview was checked by comparing the eight subjects who scored at the extremes of the MAS, PRS, and ISB. This comparison failed to reveal

any consistent or significant trends, except possibly a tendency toward regression to the mean.

The fact that there was no difference among the different subscales of the PRS in relation to the change in the client's anxiety is in line with the moderate correlations among them as reported by Walker and Nicolay (1963). The failure to find significant changes for the PRS and MAS may have been due, at least in part, to the fact that these scales are not susceptible to situational effects and largely reflect a rather enduring level of anxiety. However, this criticism seems less applicable to the ISB. That there was no significant change in the maladjustment score on the ISB as a result of the intake interview could be due to the possibility that a substantial change in one's adjustment is very much a function of time besides any intervening factors.

Finally, the possibility that the 20 Ss dropped from the study differed from the Ss who participated in both test sessions was investigated. Specifically it seemed possible that these 20 Ss (19 failed to return after the pretest; one refused to take the tests after the interview) were higher in anxiety or maladjustment and were most reactive to the test situation. However, comparison of the pretest scores obtained by these 20 Ss showed only negligible differences from those of the actual Ss on all measures.

The results of this study would stand against the idea of conducting an intake interview for the purpose of bringing about an immediate change in the client's anxiety or in his maladjustment. However, the study does not rule out the value of the intake interview nor support the

argument that a client who had an intake interview should be given regular treatment sessions immediately because the intake interview is liable to arouse a lot of anxiety in him. Also, the report by Battle et al. (1966) that several patients noted that they felt better after the evaluation interview, and that the particular problem did not bother them as much as in the period immediately before the interview, could be held in favor of the intake interview. Whether it is more profitable therapeutically to give the client an intake interview in an out-patient clinic before being assigned to regular psychotherapy, has to be decided on the basis of further studies.

## Chapter V

### Summary

Fifty persons who applied for counseling help (psychotherapy) at the Counseling Center of the Catholic Charities of the Archdiocese of Chicago, an out-patient clinic for counseling (psychotherapy), were administered the Rotter Incomplete Sentences Blank (ISB) and the Nicolay-Walker Personal Reaction Schedule (PRS) at the center by the secretary, soon after they had contacted the agency for help. They did not have any direct contact with any counselors at the agency at this time. Their ages ranged from 13 to 48 years, and they were all able to read and write well. Those selected for the study had not received any previous counseling.

The subjects selected were divided into a control group and an experimental group of 25 each, in such a way that the two groups were well matched in terms of age, sex and race.

After a minimum of one week from the time of the pretest, the subjects were called in for an intake interview with a counselor at the center. Those in the control group were given the same two tests again by the secretary before they saw their counselors for their intake interview. Those in the experimental group were given the same two tests again by the secretary right after they were through with their intake interviews. The study was started on 10-26-1967 to be ended on 8-3-1968.



The purpose of the study was to determine whether an intake interview in an out-patient clinic produces any significant changes in the client's anxiety that can be measured using the Manifest Anxiety Scale (MAS) and the Nicolay-Walker Personal Reaction Schedule (PRS). The study was also designed to investigate whether the intake interview has any significant influence on the "adjustment" or the "maladjustment" of the client as measured by the Rotter Incomplete Sentences Blank (ISB).

The results of the study failed to indicate any significant influence by the intake interview on the client's PRS and ISB scores. There is sufficient statistical evidence to claim that an intake interview does not bring about any changes in the client's anxiety that can be measured by a psychometric test like the PRS. It can also be concluded that the client's maladjustment score on the ISB is unaffected by the intake interview.

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APPROVAL SHEET

The thesis submitted by Chacko K. Poovathumkal has been read and approved by the director of the thesis. Furthermore, the final copies have been examined by the director and the signature which appears below verifies the fact that any necessary changes have been incorporated, and that the thesis is now given final approval with reference to content and form.

The thesis is therefore accepted in partial fulfillment of the requirements for the degree of Master of Arts.

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