DOCUMENT RESUME

ED 025 779 CG 002 106

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Counselor-Client Diagnostic Agreement and Perceived Outcomes of Counseling: A Progress Report.

American Personnel and Guidance Association, Washington, D.C.

Pub Date Apr 68

Note-12p.; Paper presented at the American Personnel and Guidance Association Convention, Detroit, Michigan, April 7-11, 1968.

EDRS Price MF-$0.25 HC-$0.70

Descriptors-Communication (Thought Transfer), *Counseling Effectiveness, *Counselor Acceptance, *Counselor Evaluation, *Counselor Performance, *Educational Diagnosis, Interpersonal Relationship, Prediction, Self Evaluation

Identifiers-Missouri Diagnostic Classification Plan

This study was designed to investigate the effect of congruity of counselor and client diagnoses upon client-perceived success in counseling. The Missouri Diagnostic Classification Plan (MDCP) was used as the basic diagnostic method. Agreement in the 15 categories was related to client-perceived success of counseling. Subjects, all clients at the Oregon State University Counseling Center, were each diagnosed as his case was closed. Responses to follow-up questionnaires, designed for this purpose, were tabulated with demographic information. The strength of the relationship between counselor-client diagnoses and perceived outcomes is demonstrated in both multiple counselor-client agreements and in counselor-client argument-disagreement. The results support the growing evidence that interpersonal sensitivity and openness of communication are vital characteristics of successful counselors. (KP)

Counselor-Client Diagnostic Agreement and Perceived Outcomes of Counseling: A Progress Report[1]

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The fundamental purpose of diagnosis in counseling is to enable the counselor to make predictions about client behavior from which he in turn constructs his plans for handling the case (Callis, 1965). It is apparent that the accuracy of the counselor's predictions, based upon his evaluation of the client's problem, is critical to the handling of the case and the success of the counseling process. Recent evidence, (Borresen, 1965), however, suggests that counselors develop systematic biases in their use of diagnostic constructs which would interfere with the accuracy of their evaluations. It might be expected that such biases could adversely effect the counseling process through the development of an incongruity between the goals of the counselor and the client. It may well be that this variable accounts for many previously unexplained unsuccessful counseling cases. The present study was designed to investigate the effect of congruity of counselor and client diagnoses upon client-perceived success in counseling.

Diagnostic Categories

Since the 1930's, there has been continuing interest in the development of

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a set of diagnostic constructs for use in counseling (Williamson & Darley, 1937; Bordin, 1946; Pepinsky, 1948; Berezin, 1957; Byrne, 1958; Robinson, 1963). Of these approaches, the system known as the "Missouri Diagnostic Classification Plan" (hereafter: MDCP) has been the most fruitful. The system was constructed by Berezin (1957), and refined and tested by Apostal and Miller (1959). It has subsequently been employed as a research tool by Callis & Clyde (1960), Myers, Johnson, & Cacavas (1960), Kirk (1962), Borresen (1963, 1965), Callis (1965), Johnson (1965), Shepherd (1965), and Weigel, Cochenour, & Russell (1967). The MDCP is presented in Figure 1. Problem-Goal refers to the content of the problem for which the client desires assistance, and the goal of counseling. The other dimension, Cause, refers to the underlying causal factors of the content problem.

	Cause					
Problem-Goals	*Lack Information about Self (1)*	*Lack Information about Environment (2)*	*Conflict with Self (3)*	*Conflict with (Significant) Others (4)*	*Lack of Skill (5)*	*Total*
Vocational (1)	1-1	1-2	1-3	1-4	1-5	
Emotional (2)	2-1	2-2	2-3	2-4	2-5	
Educational (3)	3-1	3-2	3-3	3-4	3-5	
Total						

Figure 1 Missouri Diagnostic Classification Plan

This highly researched and conceptually meaningful diagnostic classification system was incorporated as the basic diagnostic methodology in the present study.

Counselor-Client Diagnostic Agreement and Success Criteria

There is a paucity of research on the agreement of counselor and client diagnosis in counseling. Weigel, Cochenour & Russell (1967) found an agreement of .84-.87 in counselor and client diagnosis based on two categories: 1) vocational-educational, and 2) personal-social. However, the categories used in this study lack the necessary discreteness to be optimally useful. In

addition, no attempt was made to relate agreement to subsequent success of counseling. In the present study, agreement in the fifteen categories (the three Problem-Goals, and the five Causal dimensions) were related to client-perceived success of counseling.

The MDCP has been related to success in counseling, operationally defined as graduation from college (Johnson, 1965; Shepherd, 1965). This, however, is a tenuous criterion of success since: 1) leaving school may reflect counseling success for some clients, and 2) the criterion is limited to use in an educational setting.

Client satisfaction, as a criterion of success in counseling, has been related to the MDCP by Weigel, Cochenour & Russell (1967). Recognizing the criticisms of Shoben (1953) and Patterson (1958) that gross client satisfaction alone is a tenuous criterion of counseling effectiveness, they asked clients to report specific positive and negative outcomes associated with counseling. However, these outcomes were not constructed to differentiate between those benefits felt to relate to each specific problem and cause dimension. In the present study, clients were asked to report specific outcomes which are directly related to the Problem-Goal and Cause dimensions.

Hypothesis

It was hypothesized that: 1) agreement of counselor-client diagnoses is positively related to general and specific client-perceived beneficial outcomes of counseling.

Method

To prepare for the study, the Counseling Center staff at Oregon State University participated in three two-hour training sessions in the use of the MDCP. During the final session, blind diagnoses of actual cases were made and then compared and analyzed until a criterion of inter-staff agreement was

reached. These training sessions were designed to provide diagnostic consistency among the staff so that resulting data would be comparable and subject to meaningful analysis.

Obtaining a meaningful self-diagnosis and perceived therapeutic self-growth assessment was one of the more difficult tasks of the study. A follow-up questionnaire satisfactory for this purpose was developed that elicited from each counselee: 1) a primary and secondary self-diagnosis in the MDCP categories; 2) an assessment of satisfaction with counseling; and 3) perceived growth in behaviors representative of each of the five MDCP Cause categories. Likert-type response items were employed to assess counselee perceptions of satisfaction and growth.

Subjects

The potential subjects were the 199 students comprising the total population of clients who received counseling at the University Counseling Center during the spring term, 1967.

Data Collection

During the academic term counselors, using the MDCP, diagnosed each client as his case was closed. Within a two-week period the client was sent the follow-up questionnaire and a stamped, self-addressed envelope. Accompanying these materials was an individually-typed cover letter signed by the client's counselor requesting assistance in the Counseling Center's self-evaluation. Two follow-up letters were sent to slow respondants, resulting in a return of 154 questionnaires (77%). The questionnaire responses, along with demographic information secured when counseling was originally requested, were tabulated and prepared for computer analysis.

Results

The hypothesis tested, stated that the agreement of counselor-client diagnoses is positively related to general and specific client-perceived

beneficial outcomes of counseling. Table I lists the results of Pearson Product Moment correlations between the number of agreements of counselor and client primary and secondary diagnoses on each dimension, and the degree of client-expressed satisfaction on the Likert Scale response items. Statistical significance at the .05 level was noted for the correlations related to each of the items, on both the Problem and Cause dimensions, except for item 5. In spite of this one exception, these results provide firm support for the positive relationship between diagnostic agreement and perceived counseling outcome. However, it must be recognized that although the correlations reported in Table I are statistically significant, the size of the r's themselves obviously restrict the practical value of their use in predictive efforts. Further analysis is currently being undertaken in an effort to determine separately the relationship of agreement on each of the fifteen diagnostic categories to individual items.

The lack of significance of the correlations for item 5 (I was able to remedy my lack of skill) may be partially explained by the relatively smaller number of cases, or by the absence of any specific program within the Counseling Center itself designed to remedy reading, study, and work skills. The latter could have the effect of producing a comparatively low client-perceived satisfaction score regardless of the diagnostic agreement or lack thereof. This possible explanation is supported by the apparent lower mean satisfaction score for this item as later reported in Table III.

Additional data relevant to the hypothesis are presented in Table II. Bi-serial correlations between the dicotomous variable of whether or not counselor-client agreement exists (yes or no) in any of the possible combinations of primary and secondary diagnosis, and the continuous variable of client-expressed growth and satisfaction, are reported for the items previously considered. The statistical significance of the correlations are reported

TABLE I

PEARSON PRODUCT MOMENT CORRELATIONS BETWEEN THE DEGREE OF COUNSELOR-CLIENT DIAGNOSTIC AGREEMENT AND THE AMOUNT OF CLIENT-PERCEIVED GROWTH AND SATISFACTION

ITEM	Correlations for the Problem dimension	Correlations for the Cause dimension	N
1. I was able to gain information about myself.	.42*	.41*	136
2. I was able to gain needed information about the environment.	.35*	.30*	109
3. I was able to resolve conflict within myself.	.21**	.26*	125
4. I was able to resolve conflict with others.	.31*	.26*	71
5. I was able to remedy my lack of skill.	.07	.16	47
6. How would you rate your overall counseling experience?	.42*	.41*	156
7. I found my counselor(s) to be:	.40*	.36*	156

*$p < .01$

**$p < .05$

TABLE II

BI-SERIAL CORRELATIONS BETWEEN COUNSELOR-CLIENT DIAGNOSTIC AGREEMENT AND PERCEIVED OUTCOMES OF COUNSELING

ITEM	Correlations for the Problem dimension	Correlations for the Cause dimension	N
1. I was able to gain information about myself.	.54*	.43*	136
2. I was able to gain needed information about the environment.	.49*	.34*	109
3. I was able to resolve conflict within myself.	.35*	.26*	125
4. I was able to resolve conflict with others.	.31**	.22	71
5. I was able to remedy my lack of skill.	.06	.15	47
6. How would you rate your overall counseling experience?	.48*	.44*	156
7. I found my counselor(s) to be:	.50*	.38*	156

*$p < .001$

**$p < .01$

and again, except in the case of item 5, the positive relationship between the two is clear. The tendency of the Cause dimension to yield lower correlations is thought to be a factor of the greater number of choices (5 vs. 3) on this dimension of the diagnostic system. This effect is being examined in further detail.

Table III lists mean client satisfaction scores associated with diagnostic agreement as well as those associated with disagreement between counselor and client. The difference is in the predicted direction in each case, and is statistically significant in all but item 5 and the Cause dimension of item 4. Possible explanations for the lack of significance of item 5 have been suggested earlier.

Conclusions

The strength of the relationship between counselor-client diagnoses and perceived outcomes of counseling is aptly demonstrated by the fact that it emerges whether it is examined on the basis of multiple counselor-client agreements (Table I) or on the basis of counselor-client agreement-disagreement (Tables II and III). The results seem to encourage, in therapeutic practice, the explicit communication of counselor and client on diagnoses. Covert diagnosis by the counselor entails the risk of disagreeing with the client's goals, leading to reduced chances of client perceived growth and satisfaction. This in turn appears to emphasize the importance of 1) accurate skills of diagnosis in counseling, and 2) adequate discussion techniques with the client, and says something about their place in training. The results support growing evidence that interpersonal sensitivity and openness of communication are vital characteristics of successful counselors. It is, after all, this sensitivity and openness that provides accurate understanding and communication of client desires and motivations.

TABLE III

MEAN SCORES OF CLIENT PERCEIVED GROWTH AND SATISFACTION AND COUNSELOR-CLIENT DIAGNOSTIC AGREEMENT

ITEM	MDCP Dimension	Diagnostic Agreement	Diagnostic Disagreement	N	Mean Difference
1. I was able to gain information about myself.	Prob. Cau.	3.33 3.21	1.54 1.80	136 136	1.79* 1.41*
2. I was able to gain needed information about the environment.	Prob. Cau.	3.19 3.02	1.55 1.85	109 109	1.64* 1.17*
3. I was able to resolve conflict within myself.	Prob. Cau.	3.59 3.47	2.42 2.60	125 125	1.17* .87**
4. I was able to resolve conflict with others.	Prob. Cau.	3.11 3.08	2.16 2.41	71 71	.95** .67
5. I was able to remedy my lack of skill.	Prob. Cau.	2.40 2.54	2.18 2.00	47 47	.22 .54
6. How would you rate your overall counseling experience?	Prob. Cau.	4.03 4.05	2.41 2.58	156 156	1.62* 1.47*
7. I found my counselor(s) to be:	Prob. Cau.	4.55 4.45	2.75 3.10	156 156	1.80* 1.35*

*p < .01

**p < .05

Conclusions (Con't)

At the present time, analysis is continuing in an effort to provide more specific information relevant to the stated and other hypotheses in this study. It appears likely that further results supporting the hypotheses and yielding more specific information pertaining to each of the diagnostic categories individually will be forthcoming.

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