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presented by Heidi H. T. Schwenn

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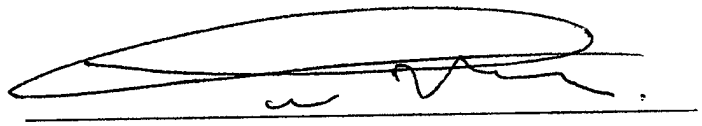

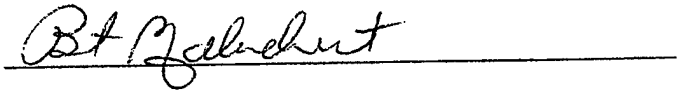

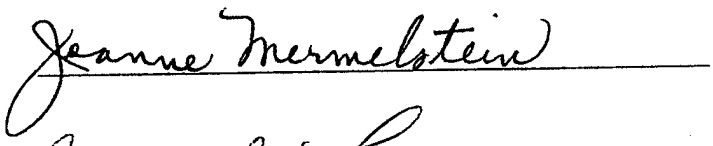

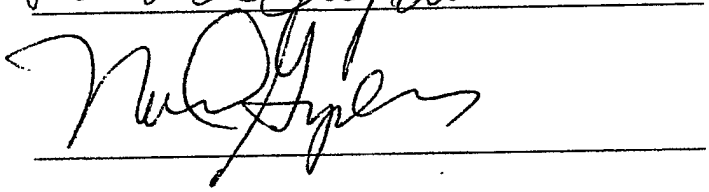

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THE RELATIONSHIP BETWEEN CLIENT-ESTABLISHED GOALS AND OUTCOME IN COUNSELING

A Dissertation
presented to
the Faculty of the Graduate School
University of Missouri-Columbia

In Partial Fulfillment
Of the Requirements for the Degree

Doctor of Philosophy

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by
HEIDI H.T. SCHWENN

Dr. Dennis M. Kivlighan, Jr., Dissertation Supervisor

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THE RELATIONSHIP BETWEEN CLIENT-ESTABLISHED GOALS AND OUTCOME IN COUNSELING

Heidi H. T. Schwenn

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ABSTRACT

Use of goals as outcome measures has received some attention in the counseling literature, but little attention has been paid to the role of goal setting as a potential catalyst for change to enhance counseling outcome. Using a goal construct framework developed by Austin and Vancouver (1996), this research was a preliminary study to consider the relationship of client-established counseling goal content and dimensions (difficulty, specificity, and temporal range) to counseling outcome as measured by the Outcome Questionnaire (Lambert & Burlingame, 1996). Counseling goals of 51 participants (aged 18-25 years) were rated using the Ford and Nichols Taxonomy of Human Goals (Ford & Nichols, 1987; Ford, 1992); this research provides evidence of empirical validity for the use of this taxonomy to categorize counseling goals. A series of chi-square analyses, analyses of variance and linear regression analyses revealed relationships between goal specificity and counseling outcome. Client established counseling goal content was not related to counseling outcome. However, regardless of goal content, having specific goals was related to better counseling outcome, and if the content of the counseling goal had external consequences, it was critical to counseling outcome that the goal be set specifically. Counseling goals with internal consequences were more specific than those with external consequences, and in particular, affective

goals were more specific than self-assertive social relationship goals. These findings are evidence that setting specific counseling goals can serve as a catalyst to increase the change occurring in counseling.

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CHAPTER 1

INTRODUCTION

At a local community mental health agency, the management has established a requirement to complete a form documenting treatment goals for each client in individual counseling by the end of the 2nd session. Goals are expected to be written in specific, measurable terms, each with accompanying subgoals. The form includes expected completion dates for each goal and subgoal, as well as room to document completion of each. Both the therapist and the client sign the form when the goals are developed. The agency requires that goals be reviewed with the client once a quarter, with documentation of progress toward the goals. Upon termination, progress toward the goals is also documented, on this form as well as on the treatment summary form. Signatures are required again at review as well as at termination. This form exists to meet requirements set by external funding sources for counseling services (e.g., state and county government programs, private healthcare insurance).

Although the agency requirement to document treatment goals described above is perhaps more extensive and structured than many, all mental health agencies use some form of treatment planning or goals, with many having specific procedures set up for the documentation of such treatment planning or goal setting. Setting goals in counseling potentially serves two purposes: a) as a measure of the change occurring in counseling (outcome measurement) and b) as a catalyst to increase the change occurring during counseling (outcome enhancement).

The current emphasis on documented goal setting can largely be ascribed to the

managed care environment in which most counseling is conducted, and primarily serves the purpose of measuring outcome. Cooper and Gottlieb (2000) indicate that one of the defining characteristics of managed care organizations is a mandate for brief therapy with a requirement for clearly defined treatment goals. Jongsma and Peterson (1999) go so far as to state that "Review agencies (e.g., JCAHO), HMOs, and managed care organizations *insist* [emphasis added] that psychological treatment outcome be measurable" (p. 5).

Measurement of outcome is an important topic, and it has received a great deal of attention in the counseling literature, particularly with respect to development of standardized outcome measures. Far less attention has been paid to the role that setting goals in counseling might have as a catalyst for change to enhance counseling outcome. This study begins investigation into the role of goal setting in enhancing counseling outcome.

Although a vast amount of psychological literature exists on goal constructs across the cognitive, personality, and motivational domains (Austin & Vancouver, 1996), there exists a surprising lack of research devoted to effective goal setting in counseling. Goal setting experiments have been conducted on a wide variety of tasks. Locke and Latham (1990) identified 88 different tasks on which goal setting experiments have been conducted. They reported one study on mental health services, out of 395 studies of goal setting. In a chapter on applications, Locke and Latham cite research applying principles of goal setting to work, sports, and education; they indicate goal setting also has been used in psychotherapy in the form of homework assignments, but cite no references to support their assertion. In fact, a literature search using PsychLit for the years 1984-1999 using the search phrase "counseling goals" only identified 19 articles. Other search

phrases yielded similar results.

However, despite the lack of empirical evidence regarding the use of goal setting in counseling, it could be argued that setting counseling goals is considered a fundamental concept in conducting therapy. Commonly used basic counseling texts such as Egan's *The Skilled Helper* (1990), Corey's *Theory and Practice of Counseling and Psychotherapy*, 5th Edition (1996), and Patterson and Watkin's *Theories of Psychotherapy*, 5th Edition (1996) include sections outlining goals inherent theoretically to each type of psychotherapy. In his chapter on an integrative approach to therapy, Corey (1996) recommends setting specific goals with client involvement but does not cite references to support the recommendation; rather, he indicates that he borrows the concept from behavior therapy, cognitive-behavior therapy, Adlerian therapy, and reality therapy.

In their chapter on convergence in therapy methods, Patterson and Watkins (1996) identify goals or objectives as one of the three major elements of psychotherapy. They discuss goal setting in primarily theoretical terms, offering little practical advice regarding how to effectively set goals with clients. They cite Parloff (1967) in suggesting that self-actualization is the ultimate goal of therapy, while mediate goals (the goals usually considered by therapists, such as reduction of symptoms, reduction of anxiety, and good relationships) are steps toward the ultimate goal. However, they also indicate that mediate goals can be byproducts of self-actualization and as such do not necessarily need to be directly achieved or even specifically sought. Egan (1990), in his discussion of goal setting in counseling, relies on general goal setting references (i.e., Locke & Latham, 1984; Locke, Shaw, Saari, & Latham, 1981).

As early as 1966, John Krumboltz argued in a theoretical article that counselors should state goals of counseling in terms of specific behavioral change that are "(a) desired by each client, (b) compatible with his counselor's values, and (c) externally observable" (p. 24). A literature review reveals a number of other theoretical articles addressing goal setting in counseling (e.g., Dyer & Vriend, 1977; Hackney, 1973; Hill, 1975; Vriend & Dyer, 1974) but offering no empirical evidence for the goal setting techniques espoused. Interestingly, theoretical statements such as this can sometimes be taken as fact, as these articles often appear cited in later works as evidence of the efficacy of goal setting. There are no theoretical articles addressing goal setting in counseling in more contemporary literature.

It appears that much of the research in the area of goal setting in therapy has centered on the use of Goal Attainment Scaling (GAS) as a measure of outcome (e.g., Austin, Liberman, King, & DeRisi, 1976; de Beurs, et al., 1993). GAS is a method of goal setting and assessment of goal attainment originally developed by Kiresuk and Sherman (1968) to serve as an outcome measure for use in community mental health programs. At the time, there were no standardized outcome measures available. Some literature considers GAS as an adjunct to therapy, as opposed to simply an outcome measure. Only the portion of the GAS literature that addresses the relationship of goal setting to outcome will be included in this review.

Although intuitively one might guess that research findings from cognitive, personality, and motivation psychology regarding goal setting would apply to effective use of goal setting in counseling, the mandates of science would discourage application without scientific evidence of the merits of doing so. Oddly, despite the relative lack of

research on goal setting in counseling and the mixed results of the research that is available, goal setting appears to be an integral part of the counseling process. It appears that research findings from cognitive, personality, and motivation psychology have been extrapolated to the field of counseling, without sound research evidence that such an emphasis is warranted. Despite the apparent lack of research on the basic utility of goal setting in counseling, in recent years a large variety of treatment manuals that include prescribed treatment goals for specific diagnoses have become available for use. It has been touted that these treatment manuals are in response to pressure from managed care to provide evidence of empirically validated treatments and measurable outcomes. However, it would appear that there is a need to investigate the relationship of goal setting to counseling outcome, since there is a large gap in the literature with respect to evidence of the actual utility of goal setting in counseling, other than as a means to measure outcome.

Previous studies did not attempt to systematically use the wealth of goal setting literature available in general psychology. The current research will use the goal construct framework developed by Austin and Vancouver (1996) in their review of the goal construct literature. Austin and Vancouver (1996) use a framework of goal processes, goal structure, and goal content to organize their review. There are four goal processes: establishing, planning, striving and revising. Using this framework provides a theoretical basis for focusing on the process of goal establishment in counseling, from which is derived a focus on the content and dimensions of client-established counseling goals as related to counseling outcome.

In their review of the literature on goal dimensions, Austin and Vancouver (1996)

identified six common factors: a) importance-commitment, b) difficulty-level, c) specificity-representation, d) temporal range, e) level of consciousness, and f) connectedness-complexity. This research will address difficulty-level, specificity-representation, and temporal range; Chapter 2 provides rationale for inclusion or non-inclusion of each of the six dimensions in the current research.

A review of the counseling literature revealed relatively few articles that empirically examined the impact of goal content or goal dimensions on counseling outcome, and these tended to have serious design flaws. Only one study examined goal content. Greer (1980) reported that goal attainment and outcome were not related to specific types of goals (personal, family, social, or work), with all types associated with improvement. A total of 11 studies examining the role of goal specification were identified, but did not reveal conclusive results. For example, King and Voge (1982) found that specification of goals had no impact upon changes concerning client's self concept, client's or counselor's perception of goal attainment, or counselor's perception of the therapy process. In a more recent investigation of a method for setting specific goals, Howell (1986) found mixed results.

A critique of earlier studies reveals a lack of sophistication in the outcome measures used. Since the time of most of those studies (the late 1970s and early 1980s), the measurement of outcome in therapy has seen a virtual revolution, with an emphasis on development of standardized outcome measures. The Outcome Questionnaire (OQ; Lambert & Burlingame, 1996) is one such measure. The OQ includes three subscales: symptom distress, interpersonal relations, and social role performance (Burlingame, Lambert, Reisinger, Neff, & Mosier, 1995). This measure provides an assessment of the

client's inner life as well as his or her functioning in the environment. Chapter 3 presents a detailed description of the OQ, including the psychometric properties of the measure and rationale for selection of this measure. The validity of the results of this study will be improved by use of a standardized measure of therapy outcome.

Another area in which previous studies can be critiqued is for the manner in which goal content was categorized. In order to investigate differences in outcome by type of goal content, it is necessary to have a method of categorizing goal content into types. In the previous studies, goal categorization was not empirically derived. As discussed in Chapter 2, the literature review revealed that there was no empirically validated means for categorizing counseling goals. Therefore, as a preliminary step for conducting the current research, this study proposes to empirically validate the use of the Ford and Nichols Taxonomy of Human Goals (Ford & Nichols, 1987; Ford, 1992) to categorize counseling goals.

Validation of the taxonomy has implications for future use of the taxonomy in both applied and research settings. A validated taxonomy might be used to simplify identification of counseling goals on intake at a counseling center, as well as aiding in treatment planning for particular categories of goals. With the current interest in establishing the efficacy of particular treatments for clients presenting problems, this last issue is of particular importance. In addition, if some goal content categories are found to have varying degrees of relationship with counseling outcome, this information might be used to assist in prioritizing goals when clients have multiple goals.

The relationship between goals and outcome is confounded by a variety of issues, such as expertise of the counselor in setting goals and providing feedback. In addition,

there has been extensive debate regarding the importance of client participation in goal setting. In three studies examining client participation in goal setting, results were not consistent. Hill (1969) investigated patient satisfaction in psychotherapy by examining therapist goals and patient wants, but did not find client involvement to be a significant factor. In another study examining client involvement in goal setting, Willer and Miller (1976) reported mixed results for a relationship to counseling outcome. However, Falloon and Talbot (1982) found support for a positive relationship between client participation in goal setting and outcome. In order to examine the type of goal in the most parsimonious, clearest fashion possible, this study used goals identified by clients at intake, prior to intervention by a therapist.

Obviously, factors other than client goal setting are related to outcome. This research minimizes those other factors by controlling for the length of therapy (number of sessions) as well as which therapist was seen. It is expected that this study might provide an essential building block for research in this area. Once the relationship of outcome to types of goal set by a client is established, other factors impacting the relationship can be assessed independently.

Research Questions

The literature review reveals that little empirical work has been done to investigate goal constructs in counseling. This research is conceptualized as a preliminary study to consider the relationship of client-established goal content as well as client-established goal dimensions of difficulty-level, specificity-representation, and temporal range to counseling outcome. Based upon the findings of the literature review,

the following research questions will be addressed in this study:

1. Can raters reliably use the Ford and Nichols Taxonomy of Human Goals (Ford & Nichols, 1987; Ford, 1992) to identify the content of client-established counseling goals?

2. Is client-established counseling goal content type related to the goal dimensions of difficulty-level, specificity-representation, and temporal range?

3. Is client-established counseling goal content type related to counseling outcome as measured by the OQ (Lambert & Burlingame, 1996)? Insufficient evidence exists to establish hypotheses regarding this relationship.

4. Are client-established goal dimensions (difficulty-level, specificity-representation, and temporal range) related to counseling outcome as measured by the OQ (Lambert & Burlingame, 1996)? It is hypothesized that counseling goals that are specific and difficult will be related to better outcome.

5. Does the relationship of client-established counseling goal content type to counseling outcome as measured by the OQ (Lambert & Burlingame, 1996) have explanatory power above and beyond that explained by the relationship of client-established goal dimensions (difficulty-level, specificity-representation, and temporal range) to counseling outcome as measured by the OQ?

6. Does the relationship of client-established counseling goal dimensions (difficulty-level, specificity-representation, and temporal range) to counseling outcome as measured by the OQ (Lambert & Burlingame, 1996) have explanatory power above and beyond that explained by the relationship of client-established counseling goal content type to counseling outcome as measured by the OQ?

CHAPTER 2

REVIEW OF THE LITERATURE

As detailed in Chapter 1, setting goals in counseling has been assumed to be a routine part of the counseling process. Setting goals in counseling potentially serves two purposes: 1) as a measure of the change occurring in counseling (outcome measurement) and 2) as a catalyst to increase the change occurring in counseling (outcome enhancement). However, closer examination of the literature reveals little empirical evidence specific to goal setting in counseling. This study begins investigation into the role of goal setting as a catalyst for change to enhance counseling outcome.

In this chapter, the literature will be examined to determine the direction of the current research. The first section, Goal Constructs, will review a framework for conceptualizing goal constructs, from which will be derived the tasks of goal establishment, goal content and dimensions. The second section, Goal Content, will review taxonomies for characterizing goal content, concluding with the rationale for the taxonomy chosen for use in this research. The third section, Goal Dimensions, will describe each dimension, review counseling literature on each, and provide the rationale for inclusion or non-inclusion of each dimension in the current research. The final section, Research Questions, will detail the questions this research will address.

Goal Constructs

The topic of goal setting has been covered in great depth in the psychological literature. In a review of the literature across the cognitive, personality, and motivational

domains regarding goal constructs, Austin and Vancouver (1996) use a framework of goal processes, goal structure, and goal content to organize their review.

Goal processes are described by Austin and Vancouver (1996) as "...the behaviors and cognitions related to striving toward multiple goals" (p. 347). There are four goal processes: establishing, planning, striving and revising. During goal establishment an individual selects goal content and develops its dimensions. Goal planning is the development of specific strategies by which a goal can be attained. According to Austin and Vancouver, "Planning links goals to various behavioral scripts, tactics, and alternatives; it also facilitates prioritization decisions among different goals, and supports the revision or conversion of unachieved goals in accordance with higher level goals, or incoming information (i.e., feedback)" (1996, p. 350). The striving process is where the behavioral action occurs. Energy is transferred from the cognitive resources of the planning process to the behavioral resources of the striving process. The revising process occurs when a goal is not easily attained using the original strategy. Goal revision may be considered a revisiting of goal establishment. Austin and Vancouver describe potential revisions as ranging from "...abandoning the goal altogether (i.e., quitting) to establishing new plans or increasing resources toward the old plans (e.g., redoubling one's efforts)" (1996, p. 353).

While all of these processes appear to be pertinent to goal setting in counseling, there currently exists little research that specifically addresses goal setting in counseling (e.g. Howell, 1986; King & Voge, 1982). Further evidence of the lack of the research in this area is found in the fact that basic counseling texts (e.g., Egan, 1990; Corey, 1996; Patterson & Watkins, 1996) either do not provide references at all for goal setting, or

provide references to the general goal setting literature. The current research is conceptualized as a first step in exploring goal processes in counseling. Therefore, the focus of this dissertation will be limited to the first process, goal establishment.

Goal establishment, both in terms of content and dimensions, may originate externally, internally, or jointly (Austin, 1989; Erez & Kanfer, 1983). Geen (1995) notes that there has been extensive debate regarding the importance of participation in goal setting. The issue of participation is discussed in greater detail in the Importance-Commitment goal dimension section. Given this debate, for the sake of parsimony and clarity in the current research, only internally established goals will be included. In addition, there is evidence that goals set by counselors and clients are incongruent (Howell, 1986). A possible explanation for these incongruent goals is suggested in a study conducted by Sharf and Bishop (1979). Their findings suggests that intake counselors' liking of a client is related to their assessment of the realism of the client's stated goal as well as their assessment of the client's motivation for counseling. It makes sense that if a counselor believes a client's stated goal to be unrealistic then the counselor would attempt to alter the client's goal. In order to avoid possible external influence by the counselor, this research will investigate goals listed by clients during intake, prior to actually meeting with a counselor.

Since goal establishment is comprised of goal content and goal dimensions, the following sections will discuss those constructs in greater detail.

Conclusion

This section has provided a brief overview of a conceptual organization of goal constructs in the psychology literature, as delineated by Austin and Vancouver (1996) in a review of the literature. While all aspects of goal constructs are conceivably relevant to counseling, it is client goal establishment that is the focus of the present study. During goal establishment an individual determines goal content and goal dimensions. Therefore, the following sections will review the literature on goal content and goal dimensions.

Goal Content

Little research attention has focused on assessing goal content (Austin & Vancouver, 1996; Ford & Nichols, 1987, 1991). Austin and Vancouver (1996) indicate that much of the research on the topic of goal content has considered only a limited domain of goals. They recommend use of a taxonomy to understand goal content, and review attempts that have been made to develop comprehensive taxonomies. The use of a more comprehensive goal taxonomy in research helps to give definition to the type of content reflected in a goal, and allows for more consistent comparison across goals. Bobko and Russell (1991) indicated that taxonomies are designed to reduce within-group variance. Since units in a category are as similar as possible, statements about the specific categories will be more accurate than global statements about all the units in the population. Austin and Vancouver state that "Like theory, a taxonomy should be comprehensive, parsimonious, and internally consistent."(1996, p. 356).

In this section, several taxonomies will be reviewed in terms of utility to assess

the content of goals identified by participants in the current study of client goal establishment. The taxonomies will be analyzed using the criteria of comprehensiveness, parsimony, and internal consistency.

Counseling Goal Taxonomies

It would be ideal to use a goal taxonomy developed for use in categorizing counseling goals, if a taxonomy exists that meets the criteria of comprehensiveness, parsimony, and internal consistency. A review of the literature reveals three counseling goal taxonomies. Each will be described and the suitability for use in this study will be discussed.

A Taxonomy of Counseling Goals and Methods (Frey & Raming, 1979)

Frey and Raming (1979) used content analysis and multivariate procedures to generate a taxonomy of counseling goals and methods. Content analysis methods were used to derive counseling process and goal statements from texts of 14 theorists in counseling and psychotherapy (Alexander, Berne, Dollard & Miller, Dreikurs, Ellis, Frankl, Kelly, Krumboltz, Perls, Rogers, Sullivan, Thorne, Williamson, & Wolpe). Process was defined as "the activity that occurs in the counseling interview" (Frey & Raming, 1979, p. 28), while goals were defined as "expected outcomes of the counseling process" (Frey & Raming, 1979, p. 28). Graduate students then rated the approximately 1400 items. Factor analysis reduced the item pool to 84 process and 84 goal statements. Cluster analysis of expert ratings of the reduced item pool revealed seven goal clusters (transfer, awareness, symptom removal, ego functioning, inner resources, control

environment, and negative reactions) and six process clusters (acceptance, questioning, unconscious material, manipulate anxiety, reeducation, and support autonomy) were identified. Since the current research will only address the goals of counseling, not the process of counseling, only the goal portion of the taxonomy will be addressed further.

The goal clusters can be represented by the item that loaded most highly on the cluster (Frey & Raming, 1979). The transfer goal cluster included goals that addressed the transfer of therapy learning to outside situations. The representative item from this cluster is "The patient should have worthwhile interpersonal relationships with others" (Frey & Raming, 1979, p. 30). The awareness goal cluster reflected goals regarding awareness and acceptance of the self in conflict. The example item from the awareness cluster is "The counselor wants the client to look at his conflicting feelings" (Frey & Raming, 1979, p. 30). The third goal cluster was titled specific symptom removal, and was represented by the following item "The only valid measure of any therapy is bringing about lasting remission of the undesirable reactions that distress the patient" (Frey & Raming, 1979, p. 30). The ego functioning cluster included items relating to strengthening ego functioning, and was represented by the item "A goal that is the important aspects of the parent, adult, and child ego states are all harmonious with each other" (Frey & Raming, 1979, p. 30). The awareness of positive inner resources goal cluster was found to be best represented by the item "The counselor wants the client to feel he has full control over himself" (Frey & Raming, 1979, p. 30). The control environment goal cluster included goals reflecting learning to respond to and control the environment. The example item from this cluster was "The client must meet the demands of society" (Frey & Raming, 1979, p. 30). The final goal cluster, negative

reactions, included goals directed at awareness of negative thoughts and feelings. The item most representative of this cluster was "The primary aim of therapy is to change the patient's most intensely and deeply held emotions as well as, along with, his feelings" (Frey & Raming, 1979, p. 30).

While this taxonomy appears to be parsimonious and internally consistent for it's purpose, there appears to be a problem with the comprehensiveness of the goals included in the taxonomy. The taxonomy was developed as an aid to the practitioner in understanding and utilizing the wide variety of counseling theories to select interventions. Consequently, the goals analyzed were not identified by clients, rather were the result of what a subjectively chosen set of theorists believed client goals *should or would* be. As can be seen from the representative items for each cluster, the goals in this taxonomy appear to be based on a counselor (external) perspective, rather than a client (internal) perspective. The current research is interested in client-established counseling goals. The Frey and Raming (1979) taxonomy is not well suited for categorizing client-established counseling goals.

A Problem Taxonomy for Classifying Clients' Problems (Celotta & Telasi-Golubcow, 1982)

Celotta and Telasi-Golubcow (1982) developed a taxonomy for classifying clients' problems. They conceptualized their taxonomy as a learning hierarchy that is arranged in terms of influence over other classes (types of problems) within the hierarchy as well as difficulty in learning behaviors, cognitions, or expectations. The levels are (in order of lower to higher order problems): behavior problems, information problems,

specific cognition problems, general cognition problems, and general expectation problems. Behavioral problems are simply an excess or lack of some behavior (Celotta & Telasi-Golubcow, 1982, p. 75). A client at this problem level is able to adapt by practice of new behaviors, without the complications of hidden agendas or resistance. Client distress is lowest at this level. Information problems are characterized by inadequate information or facts. Client distress is relatively low, and supplying the necessary information easily solves the problem. Specific cognition problems deal with "...ideas, attitudes, or beliefs that seem to effect the problem at hand" (Celotta & Telasi-Golubcow, 1982, p. 74). The specific cognition does not have negative consequences across all areas of the client's life, but rather the distress is confined to a specific problem area, thereby limiting the impact on the client's life. The authors indicate their belief that these specific cognition problems are culturally derived. Since these specific cognitions have deep meanings for the client, simply providing information will not resolve the problem and the client must engage in self-examination within the specific problem area. The general cognition problem level represents a more severe level of distress, with this type of problem affecting a broader spectrum of roles and activities. The authors define this problem as "...the client is making broad maladaptive statements about self or others on either an unconscious or conscious level" (Celotta & Telasi-Golubcow, 1982, p. 74). The most severe problem level is general expectation problems. Clients at this level experience difficulty in all interpersonal relationships because they see themselves as passive victims in a threatening environment.

There are also major problems with use of this hierarchy. The taxonomy is not internally consistent since it was not formulated with respect to any specific theoretical

model, but rather appears to be the subjective musings of the authors. The taxonomy is based on the authors' subjective examination of presenting problems derived from their clinical experience and from counseling classes. One consequence of the subjective nature in which the categories were derived is that the taxonomy seems to focus only on the cognitive aspect of presenting problems. The article does not provide a description of any empirical investigation of presenting problems. In addition, the authors state explicitly that the taxonomy is not meant to represent the full range of pathology. Obviously, this violates the requirement of comprehensiveness. Therefore, this taxonomy is not suited for use in the present study.

Continuum of Counseling Goals (Bruce, 1984)

Bruce (1984) developed a continuum of counseling goals based on Maslow's hierarchy of needs that was meant to serve as a framework for differentiating counseling strategies. The author explains that in counseling there are both content and process goals. Content (outcome) goals refer to the specific purposes of the client, while process goals refer to the approaches and strategies used by the counselor to meet the content goals of the client. This continuum includes only process goals. Since the current study is designed to examine client goal establishment, it by nature is limited to content goals. Therefore this continuum is not suited for use in this study.

Conclusion

A review of the literature reveals three counseling goal taxonomies. These taxonomies are not suited for use in the current research because they do not address

client-established goals, they are not empirically derived, or the content of goals included is limited in nature. Therefore, a taxonomy must be sought in the general psychology literature. Several such taxonomies will be reviewed.

Maslow's Hierarchy of Needs

Early taxonomies focused on needs. The best known of this category of taxonomy is Maslow's Hierarchy of Needs (Maslow, 1943, 1987). Three editions of Maslow's classic text *Motivation and Personality* were published. Maslow's need theory maintained that all individuals are motivated by five basic needs, arranged in a hierarchy. The five basic needs can be considered to be classes of goals. These needs (from most basic to least basic) are the physiological needs, the safety needs, the belongingness and love needs, the esteem needs, and the self-actualization need. While Maslow declined to strictly define physiological needs, stating that "...it seems impossible as well as useless to make any list of fundamental physiological needs for they can come to almost any number one might wish, depending on the degree of specificity of description" (1987, p. 16), he does refer to hunger, sex, and thirst as classic physiological needs. Maslow asserts that physiological needs are the most dominant. If all needs were unfulfilled, the major motivation for an individual would be physiological, and the other needs would be ignored. However, Maslow argues that this situation rarely exists in "normally functioning peaceful society" (1987, p. 17). Maslow (1987) provides a more specific definition of safety needs, listing "...security, stability; dependency; protection; freedom from fear, anxiety, and chaos; need for structure, order, law, and limits; strength in the protector; and so on" (p. 18). He argues that safety needs are also largely satisfied in the

American culture, with safety needs serving as an active motivator only in extreme cases. He indicates that expressions of safety needs can be seen in striving for job security, a savings account, and insurance (i.e., medical and dental insurance). Maslow stated that the belongingness and love needs "...involve giving and receiving affection" (1987, p. 20). He indicates his belief that unfulfilled belongingness and love needs are the most commonly found core of maladjustment and psychopathology. Maslow (1987) divided the esteem needs into two parts; a) "...the desire for strength, achievement, adequacy, mastery and competence, confidence in the face of the world, and independence and freedom" (p. 21) and b) "...the desire for reputation or prestige (defining it as respect or esteem from other people), status, fame and glory, dominance, recognition, attention, importance, dignity, or appreciation" (p.21). The final category in the need hierarchy is the self-actualization need. Maslow (1987) indicates that his use of the term "...refers to people's desire for self-fulfillment, namely, a tendency for them to become actualized in what they are potentially" (p. 22). Maslow considered individual differences to be the greatest at this level of the hierarchy, since self-actualization can be expressed in countless ways.

According to Maslow (1987), an individual's behavior is directed to satisfy unfulfilled needs in the hierarchy. While the hierarchy is often presented as though a need must be satisfied 100 percent before the next need emerges, Maslow was actually careful to clarify his belief that normal members of our society are partially satisfied in all their basic needs. That is, lower level needs must be sufficiently (although not necessarily completely) satisfied before behavior is directed toward the next highest need.

While Maslow's ideas had a major impact on the practice of psychotherapy in

their contribution to the "Third Force" of Humanistic psychotherapy (Cox, 1987), and as a theory of motivation in general, they have not been subjected to empirical scrutiny (Monte, 1995). In fact, Maslow's research has been described as experimental or exploratory, rather than an attempt to verify his theory, and his work has been criticized for its apparent disregard for information that contradicted his theory (Frager & Fadiman, 1998). Interestingly, a comparison of the original publication of the hierarchy (Maslow, 1943) to the final version (Maslow, 1987) reveals little change; in fact, the majority of paragraphs are exactly the same.

Although it has not been empirically validated, the Hierarchy of Needs does appear to be internally consistent. However, the simplicity of the hierarchy decreases its explanatory power, making it less than ideal in terms of use as a taxonomy of goals. Ford and Nichols (1987, 1991) have criticized Maslow's hierarchy for use as a taxonomy based on a failure to explain the great diversity of goals involved in each of the "needs." For example, many, if not most, counseling goals could probably be classified under only two categories of goals, Belongingness or Self-Actualization. The theory does not expand on the types of goals that would fall under each of these categories. While the Hierarchy of Needs is perhaps comprehensive, it appears to be so parsimonious that it's utility as a taxonomy for categorizing counseling is minimal.

Conclusion

Maslow's hierarchy of needs had a significant impact on how we think of motivation today as well as the practice of psychotherapy. However, most counseling goals would fit into only two categories of needs. Hence, the hierarchy is less than ideal

for use as a taxonomy of goals due to the simplicity of its structure.

Ford and Nichols Taxonomy of Human Goals

Ford and Nichols Taxonomy of Human Goals (Ford & Nichols, 1987; Ford, 1992) is based theoretically upon the Living Systems Framework (LSF), D. Ford's (1987) conceptual framework of individuals as self-constructing living systems. Ford and Nichols (1987) built upon previous work in motivation and personality theory to develop a taxonomy of human goals, recognizing that more specification of the goals that direct and organize behavior was needed to understand and evaluate behavior. Although the taxonomy was developed with the intention that it be particularly applicable in the education and human service professions (including psychology), the taxonomy has not yet been validated for use in the counseling environment.

Ford and Nichols (1987) developed their taxonomy of human goals over the course of several years. They report that the main strategy used in developing the specific categories in the taxonomy was to discuss with a variety of people their thoughts about their wants, needs, desires, and objectives. Over a course of several years, they interviewed students and colleagues formally and informally, and conducted structured interviews with counseling clients. An extensive literature review of achievement motivation, personality, and social motivation revealed the initial categories in the taxonomy. The 24-category final taxonomy was the result of an iterative process of evaluating and refining (Ford, 1992). The taxonomy is depicted in Table 1. The comprehensive list of goals that an individual may pursue is divided into a two-part hierarchy. Within-person goal categories are affective, cognitive, and subjective

organization, while person-environment goal categories are self-assertive relationship, integrative relationships, and task goals. The authors maintain that the taxonomy describes a number of different kinds of consequences that people may desire. The goals are stated in terms of the desired outcomes rather than in terms of behaviors themselves. When goals are stated in terms of behavior, one must account for all the reasons a behavior might be engaged in. Ford and Nichols (1987) give the following example: "...one could engage in sex to feel good, maintain a social relationship, acquire resources, satisfy one's curiosity, or improve one's skills" (p. 293). There is no implication in the arrangement of the categories that some goals are more important than others, and there is not an assumption that some goals serve as prerequisites for others. They also assume that goal-directed behavior could serve multiple purposes simultaneously. That is, behavior can be directed by multiple goal categories simultaneously. A final assumption is that individuals may seek and attain almost any combination of the goals listed in the taxonomy; none of the goals is considered to be mutually exclusive.

Austin and Vancouver (1996) characterize this taxonomy as " major effort to categorize goals" (p. 356), and state that "the integration of goal content into a single two-part structure that can subsume the life domains of interest to psychologists" is a "key contribution" (p. 356). They also praise the taxonomy for it's internal consistency with a comprehensive theoretical framework (Ford's self-constructing living systems framework; Ford, 1987), as well as their extensive use of idiographic techniques to construct and refine their taxonomy. The only criticism they have of the taxonomy is the failure to include intrinsic, basic needs and motor and other lower level goals. Examples

of these are internal body temperature and other physical states, as well as biologically determined goals and muscle tensions goals. While this level of goal might be relevant to goals set in biofeedback therapy, it is unlikely that clients would establish such goals upon intake without the intervention of a counselor. Since the current research will strictly addressed client-established goals, the lack of such goal categories in the taxonomy does not appear to significantly decrease its potential usefulness for this dissertation.

Conclusion

Since the Ford and Nichols Taxonomy of Human Goals (Ford & Nichols, 1987; Ford, 1992) is comprehensive, parsimonious, and internally consistent, it appears to be the best choice as a taxonomy to characterize the content of client goals. The criticisms of the taxonomy appear to not be relevant to the types of goals that would be set in counseling. Although the taxonomy was developed for use in the human service professions, it has not yet been empirically validated for use in the counseling environment.

Counseling Goal Content Research

Only one study has considered the content of treatment goals and outcome in therapy. In a study examining the relationship of goal content to outcome in brief therapy, Greer (1980), correlational analysis indicated that each goal category produced goal attainment, as well as positive outcome. Using a sample of first-time clients at a community mental health clinic (n=19), the researcher had volunteer therapists use a

form of Goal Attainment Scaling (GAS) in the first hour of counseling to assist clients in writing counseling goals in four areas: (a) personal (feelings, attitudes, and behaviors), (b) family (wife, mate, lover, parents, and children), (c) social (activities, socializing, and new skills), and (d) other. Goal attainment was assessed after four weeks with client and therapist ratings of the goals on a nine-point rating scale (Impossible to Reach = -4, Completely Attained = +4). Outcome was assessed with a series of items from short outcome measures, administered at followup (after approximately 3 sessions). There are a number of critical flaws in this study. The sample size is small, bringing into question the validity of the findings. There are several problems with the manner in which goal content was categorized. The goal categorization, while parsimonious, does not appear to be comprehensive, nor internally consistent. In the methods section the author describes the four goal categories described above. However, in the results section the author discusses personal, social, family, and work goal categories. In addition, the author reports that 85 percent of the goals that clients classified as "other" were actually personal goals. However, in the analysis the client goal categorizations were used. Perhaps the most fatal flaw is that the "outcome" measures were only administered posttest, thereby providing no means of comparison to functioning prior to the intervention. It is clear that the question of whether goal content is related to counseling outcome is still largely unanswered.

Summary of Goal Content

Goal content has primarily been explored either within a very circumscribed range of content, or through the development of goal taxonomies. Using the criteria of

parsimony, comprehensiveness, and internal consistency, this section has investigated five goal taxonomies for use in categorizing client-established goals in counseling.

The Ford and Nichols Taxonomy of Human Goals (Ford & Nichols, 1987; Ford, 1992) appears to be parsimonious, comprehensive, and internally consistent. Therefore, it appears to be the best choice for use as a taxonomy to categorize goal content in the current research. Since the taxonomy has not been validated for use in categorizing counseling goal content, one purpose of this study will be to investigate whether raters can reliably categorize client-established counseling goals using this taxonomy.

The next section will review the available literature on goal dimensions, and identify the goal dimensions that will be investigated in the current research.

Goal Dimensions

In their review of the literature on goal dimensions, Austin and Vancouver (1996) identified six common factors: a) importance-commitment, b) difficulty-level, c) specificity-representation, d) temporal range, e) level of consciousness, and f) connectedness-complexity. The empirical literature cited by Austin and Vancouver primarily focuses on a subset of these dimensions, usually investigating one or two dimensions at a time. In the following sections, each factor will be addressed in terms of definition, related research findings, and inclusion or non-inclusion in the current research.

Importance-Commitment

Locke, Shaw, Saari, and Latham (1981) define goal commitment as the

determination to try for a goal. Since the early research on goal setting, goal commitment has played a critical role, primarily for it's moderating effect on the relationship between goal difficulty and task performance (Hollenbeck & Klein, 1987). In a meta-analytic study of goal commitment Klein, Wesson, Hollenbeck, and Alge (1999) report that there is considerable confusion in the literature about this relationship. They cite a lack of variance in goal commitment as a probable explanation for the failure to observe a significant interaction between goal difficulty and performance. Locke, Latham, and Erez (1988) used a similar argument to explain why the relationship is not always observed.

One important factor in goal importance-commitment is the issue of participation in goal setting. Geen (1995) indicates that research evidence suggests participants usually commit themselves to goals that are given to them, essentially making the assigned goal their own. There appear to be several explanations for this relationship. Locke, Latham, and Erez (1988) report that the legitimacy of the person assigning the goal is a critical factor in goal acceptance; if the goal is perceived as a legitimate demand, it is likely to be accepted. The manner in which an assigned goal is communicated as well as the self-efficacy of participants with respect to accomplishing the goal was also identified as factors effecting goal commitment. However, there appears to be little controversy regarding commitment to self-set goals. Evidence suggests that when goals are self-set, participants, regardless of individual differences, tend to demonstrate high and relatively invariable goal commitment (Hollenbeck and Brief, 1987).

The available counseling literature focuses on client participation in goal setting, and reflects similar conflicting results regarding the role of goal importance-commitment.

Using a sample of 28 female patients (race/ethnicity not reported) at a private, urban psychiatric outpatient clinic, Hill (1969) investigated patient satisfaction in psychotherapy by examining therapist goals and patient wants. Sixteen therapists (9 psychiatrists, 3 psychologists, and 4 psychiatric social workers; 9 male, 7 female) conducted the therapy. Each of the 28 client-counselor dyads reported their experiences during a segment of treatment. Experiences were reported using scales to measure the therapist's report of his/her therapeutic goals, the patient's report of purposes or wants, as well as the patient's report of satisfaction. The psychometric properties of the scales were not reported. The mean number of sessions in a segment was 14 (range = 7-25), and for approximately half the sample the time period covered was the first 3-6 months of therapy. The author reported that time-in-therapy exerted a negligible effect on clients' reported satisfaction. In addition, no systematic effect was found for any one therapist over another. Factor analysis was applied to determine the dimensions of each scale. A series of analyses of variance revealed that patient satisfaction was not significantly related to the client wanting something from therapy. This finding implies that client involvement in goal setting is not a necessary component of goal importance-commitment. However, the results of this research are questionable given the exceeding small number of subjects used in this factor analysis. Tabachnick and Fidell (1996) recommend at least 300 subjects to conduct factor analysis.

In another study examining client involvement in goal setting, Willer and Miller (1976) reported mixed results for a relationship to counseling outcome. The participants were 72 randomly selected clients (38 male, 34 female; race/ethnicity not reported) at a psychiatric hospital in Canada. Each was interviewed individually by a hospital

volunteer at admission, discharge, and 3 months after discharge; however, the information collected at admission was not used in this study. The discharge interview collected client assessment of goal attainment for each goal recorded by the individual's therapist. Clients were also asked to rate their level of involvement in setting the goals. This rating revealed three groups: (a) actively involved in setting the goals (N = 15), (b) not actively involved in setting the goals, but had been informed (N = 21), and (c) no knowledge of the goals that were set (N = 23). The design also included a control group (N = 13) of clients for whom no goals had been set during their hospital stay. The authors indicate that clients also completed a 24-item true-false questionnaire of client satisfaction from which was derived a global client satisfaction score, but do not report the psychometric properties of the questionnaire. During the follow-up interview, clients completed an assessment designed to measure client community functioning in the areas of physical health, general affect, interpersonal skills, personal relations, control of aggression, use of leisure time, and support. Both a global adjustment score (average score across all seven subscales), as well as goal-specific adjustment score (average of a client's scores across all subscales that matched the goals set during hospitalization) was computed for each participant. Psychometric properties of the instrument are not reported. Therapist assessment of goal attainment, demographic data, and length of stay in the hospital were collected from client records. Analysis of variance revealed significant differences for the four levels of patient involvement in goal setting for length of stay in the hospital, client satisfaction, as well as client and therapist rating of goal attainment. However, no significant differences were found for global community adjustment or goal-specific community adjustment. A priori analyses were conducted as

well. Those participants who had goals (regardless of involvement in setting the goals) stayed in the hospital longer than those who had no goals set, and participants who were informed but not involved stayed longer than those directly involved in goal setting. Participants who had goals set indicated higher client satisfaction than participants with no goals set. Participants who were involved or informed of goals also indicated higher satisfaction than participants who did not know about the goals, while participants who were involved were significantly more satisfied than participants who were only informed of goals. Analysis of goal attainment ratings by both clients and therapists revealed that involvement in goal setting led to significantly higher attainment of goals than being informed of goals. These findings suggest that client involvement in goal setting leads to greater client satisfaction and goal attainment, but is not related to more long term community adjustment. However, these findings must also be viewed with caution because the unknown psychometric properties of the instruments used. In addition, the strictly post-test measurement of outcome calls into question the validity of the results, since an index of change cannot be computed. Using only post-test outcome measurement assumes that the level of functioning can be attributed to the treatment, without consideration of whether there is a significant change from pre-test to post-test.

Falloon and Talbot (1982) found support for a positive relationship between client participation in goal setting and outcome. Using a sample of severely ill psychiatric patients in an intensive time-limited (three month) day treatment program (N = 82; 40 male, 42 female; race/ethnicity not reported), the authors examined the effect of a behavioral treatment strategy for developing goals in three categories (social-interpersonal, work-vocational, and symptom-intrapersonal). Patients were assigned to a

primary therapist, who was responsible for defining the patient's goals, developing an individualized treatment plan, assessing progress toward the goals, and developing discharge plans. Patients were encouraged to participate in goal setting and therapists on a percentage basis (0 to 100 percent) estimated patient involvement in goal setting. Subgoals were developed as steps in a hierarchy leading progressively to the goal, with the first step defined as "one that the therapist believed the patient could readily achieve with supportive prompting only" (p. 281). The remaining four subgoals required specific learning designed to take place in group or individual therapy. Progress toward goals was assessed weekly by the therapist, with modifications made as necessary to the goals or subgoals. Goal achievement was rated by the therapist at the end of the three-month period, measured as the highest step achieved on each goal (0 = no steps achieved, 6 = goal achieved). Goal achievement was defined as Good (steps 4-6) and Poor (steps 0-3). The authors report that 16 participants dropped out prior to completion of three months treatment. The results of a chi-square analysis were reported as a "strong" relationship between patient involvement in goal development and achievement. This statement is based upon the finding that 59 percent of goals where the patient was involved at least equally achieved a good result, compared to 6 percent for those goals where the therapist was more involved than the patient in goal setting. This study can be criticized for the subjective nature of the data ratings, which were all done by a client's individual therapist. The study would have been improved by having the rating conducted by expert raters. In addition, the data analysis is primarily descriptive in nature with the exception of the chi-square analysis.

The literature regarding the importance-commitment dimension of counseling

goals is inconclusive. Each reports different results regarding the relationship of client involvement to outcome, and each has serious research design flaws. Consequently, it is concluded that the counseling literature provides few clues of how to best examine this dimension.

Rationale for Inclusion or Non-Inclusion

The literature suggests that there are a number of factors which effect goal importance-commitment for assigned goals. However, the literature indicates that self-set goals are associated with high levels of commitment. The available counseling literature is inconclusive regarding the importance of client participation in goal setting. Given the lack of conclusive evidence in the literature regarding whether clients are equally committed to goals set with therapist involvement and the evidence in the motivation literature that commitment to self-set goals is high, the goals examined in this research will be strictly client established. For the purposes of this study it will be assumed that the goals are self-set and that commitment to goals is high, since participants are voluntary clients and the goals are established prior to intervention by a counselor. Given this assumption of relative invariance in goal commitment, goal importance-commitment will not be measured as a dimension in this study.

Specificity-Representation

This dimension is most often described in terms of specific, quantitative goals versus nonspecific, qualitative goals (Austin & Vancouver, 1996). Specificity is described as how clearly a goal is defined (Geen, 1995). Goal specificity has been found

to be related to goal difficulty, and is seldom investigated independently (Locke, Chah, Harrison, & Lustgarten, 1989). A review of the literature reveals consistent evidence for goals that are both specific and difficult to result in higher effort and performance than "do your best" goals (Locke & Latham, 1990; Locke et al., 1981; Mento et al., 1987).

This dimension has received more attention in the counseling literature than any other goal dimension. The behavioral counseling psychology literature provides some clues regarding the role of the specificity dimension of goal setting. There is evidence of a positive relationship between goal specificity and outcome in pain management research. In a study of the effects of providing participants with a specific goal and temporal cues on pain tolerance using a cold pressor test, Stevenson, Kanfer, and Higgins (1984) found that if a reasonable goal was provided, participants tolerated aversive stimulation longer than if a goal was not specified or left to the participant's own discretion. This study was a laboratory investigation that used a cold pressor test (submersion of the participant's dominant hand in ice water) as the pain to be tolerated. Using 84 female volunteer participants, the researchers compared six goal and time cue combinations: time-remaining cues (implying the goal), time-passed cues (with and without a specified goal), tone cues (without a specified goal), and no time cues (with and without specified goal). The presence of the cues did not enhance tolerance in this study. However, the researchers found that the presence of a cue significantly increased the probability the participant would decide they could not tolerate the cold water any longer. Although this study offers important clues for the management of pain, any study using the cold pressor test can be critiqued due to the limited generalizability of this test since it does not induce long-lasting pain (Thorn & Williams, 1989).

Thorn and Williams (1989) took laboratory research a step closer to chronic pain management with a study of 80 introductory psychology students (40 male and 40 female) comparing fixed and open instructioal paradigms using an ischemic pain technique. This technique produces a slow-building, long-lasting aching sensation produced by subjecting the participant's non-dominant arm to 160 mm Hg from a blood pressure cuff, then having the participant squeeze a dynamometer. Participants rated pain intensity, and number of minutes of toleration was measured. Participants in the open-time groups were instructed to endure the pain as long as possible, while participants in the fixed time groups were instructed to endure the pain for 15 minutes. In the first trial, baseline tolerance was measured. For the second trial, half the participants were given cognitive strategy training (treatment), while the other half engaged in conversation with the experimenter for an equivalent amount of time (control). The study revealed that participants given specific time goals had lower absolute pain ratings and higher tolerance times than participants given nonspecific goals, whether given cognitive strategy training or not.

In a study of an actual clinical population with chronic headache pain, James, Thorn, and Williams (1993) reported similar findings. Using 33 patients (5 males, 28 females) with chronic headache pain, three groups were formed by random selection for a six-week course of treatment: (a) a goal group, given specific time goals for using cognitive-behavioral coping strategies; (b) an open group, given instructions to use strategies for as long as possible; and (c) a waiting-list control group. Results of the study indicated that providing explicit time goals for coping-strategy use decreased pain intensity and medication intake at posttreatment.

These studies provide laboratory and clinical evidence that setting specific goals is associated with increased pain tolerance. However, the studies were conducted on very limited goal content (pain management). While the range of presenting problems in counseling can include specific behavioral goals such as this, the pain management literature only provides one piece of the puzzle.

Review of the general counseling literature revealed eight studies investigating the effects of goal specification on counseling outcome. While the studies employed a variety of methods for developing counseling goals, several of the studies used some variation of Goal Attainment Scaling (GAS), a method of goal setting originally developed by Kiresuk and Sherman (1968) to serve as an outcome measure. In this method, the client and counselor specify each counseling goal, then for each goal develop behavioral expectations ranging from worst possible outcome to best possible outcome, including expected outcome. Attainment of goals is assessed on a numerical scale. If used correctly, GAS results in setting specific counseling goals. Therefore, the literature assessing the relationship between use of the GAS method and counseling outcome is of immediate relevance to understanding of the dimension of specificity-representation for counseling goals.

Smith (1976) investigated whether goal attainment scaling (GAS) is valuable as an adjunct to counseling. Using a sample of 20 suburban, white adolescents in a time-limited counseling situation, Smith compared an experimental group receiving GAS to a control group that did not receive GAS. Dependent measures were a positive mental health instrument, a locus of control instrument, an author developed outcome assessment sheet, and a consumer satisfaction questionnaire. The first three instruments were

administered at pre- and post-test, with the fourth only administered at post-test. The data was analyzed using a series of *t* tests. The experimental group was found to have made significantly greater gains toward improved time competence (this construct was not defined in the article) as well as greater changes toward internality than the control group when comparing gain scores. In addition, the experimental group scored significantly higher on outcome assessment than the control group, and reported a significantly higher level of consumer satisfaction than did the control group. Smith reports that the results strongly suggest that GAS enhances counseling outcome. It was hypothesized that GAS is beneficial due to several aspects: establishing behavioral criteria, identification of mutually defined goals, fostering meaningful communication, establishing clear expectations, and providing continuous, mutual feedback. The author identified several potential confounds in this research. One concern was a bias on the part of counselors in the experimental condition. Another concern was that the results reflect the impact of the feedback that is part of the GAS, rather than the impact of having set specific goals using this methodology. It was also considered that perhaps the significant findings were the result of an enhancement of the therapeutic relationship resulting from GAS techniques, rather than the goal setting itself.

Burton and Nichols (1978) investigated the impact of goal setting in a sample of university and community clients in brief therapy limited to seven sessions (N = 20; 6 male, 14 female, race/ethnicity not reported). While the sample was split into an experimental group that received formal goal setting and a reference group that did not, the authors do not report the sample size for each group. The goal setting method used was a variation of GAS. Outcome was assessed pre- and post-test with the Personal

Satisfaction Form and the Adult State-Trait Anxiety Inventory. Specificity of goals was independently rated, with an acceptable level of interrater reliability. Results of a *t* test indicated that the experimental group set significantly more goals, and that those goals were more specific than the control group goals. Chi-square analysis indicated that setting behavioral goals had no effect on clients' expectations of amount of improvement as measured in the first session. Using analysis of variance procedures, comparison of pre- and post-test scores on the outcome measures indicated that both groups showed significant improvement on the personal satisfaction form and the state anxiety measure, but that there were no significant differences between the two groups. These results indicate that goal attainment scaling did not have a positive effect on therapy outcome. The findings of this research must be interpreted with caution due to the small sample size of this study.

LaFerriere and Calsyn (1978) investigated the outcome of short-term therapy at a community mental health center for clients receiving a variation of GAS compared to control clients who did not receive formalized goal setting. Clients were seen 5-6 sessions on average, and were randomly assigned to the GAS group (N = 34) or the control group (N= 31). The authors report that 75 percent of the participants were female, while 100 percent of the participants were White. For participants in the GAS condition, goals were set (with client involvement) during the first two sessions. At an approximately 5 week follow-up, the first author and her assistant (both whom had not served as therapists) administered a battery of tests and a questionnaire to the participants. The psychometric properties of the instruments were not reported. Since attrition was high (the analysis was conducted with only 15 GAS clients and 17 control

clients), the authors performed analyses to ensure no significant differences existed on demographic variables for the two groups, as well as to ensure that there were no significant differences between those who dropped out and those who remained. Analysis of variance indicated that clients in the GAS condition were more aware of specific goals, as well as reported greater use of goals. In addition, GAS clients indicated significantly more motivation to change; both GAS clients and their therapists perceived the client as having changed more as a result of therapy than did the control clients and their therapists. The authors report that GAS clients were significantly less depressed after treatment than controls, exhibited less anxiety, and higher self-esteem as indicated by the standardized measures. GAS clients attended more sessions than did control clients, but the difference was not significant. As a precaution, the authors performed analysis of covariance controlling for number of therapy sessions, finding similar results to the analysis of variance. While these results seem to strongly support goal setting in counseling, the results must be interpreted with some caution based upon the small sample size and the lack of psychometric data for dependent measures.

A third study (DePauw, 1980) investigating the impact of GAS on counseling outcome did not support use of GAS as a therapeutic technique. Using a sample of 41 counselor-client dyads in a university counseling center the author compared a goal-setting counseling group to a attention-placebo control group. The final analyses were conducted on 31 clients (22 female, 9 male; race/ethnicity 27 Caucasian, 3 African-American, and 1 Hispanic). The counselors in this study were practicum students who each chose one client to participate in the study. Clients were seen a minimum of 3 counseling sessions. Counselors in the goal setting group received extensive training on

GAS, and were instructed to develop counseling goals collaboratively, as well as to discuss and assess progress toward goals in each session. The author assumed that all the counselors might have had previous training on counseling goal-setting procedures, but did not attempt to control for that factor. It was assumed that the difference between the groups was the training and materials provided to the experimental group. Outcome was investigated with expert review of the effectiveness of counseling determined by examination of client files, as well as with client responses to a 35-item questionnaire designed to evaluate client satisfaction and perceived outcome. The client questionnaire was developed using items from a variety of other assessments, as well author developed items; psychometric properties were not reported for the entire questionnaire. Chi-square analysis and analysis of percentage differences between judges ratings revealed no significant findings of difference between the goal setting and control groups. However, client judgement indicated that a significantly lower level of counseling outcome effectiveness for the goal setting group. No significant differences were found for client satisfaction. While primarily well designed, this study could have been improved with the use of a standardized outcome measure.

A more recent investigation of GAS (Howell, 1986) for clinical goal setting in an occupational therapy setting (including both day and inpatient participants, most of whom were psychotic) found mixed results. A randomly assigned experimental group (N = 13, 8 male, 5 female; race/ethnicity not reported) who experienced a variation of GAS was compared to a control group (N = 11; 6 male, 5 female; race/ethnicity not reported) who received social reinforcement for an equivalent duration. Goals were developed by the researcher therapists for participants in both groups; however, the experimental group

developed actual treatment goals with their therapist, and reviewed their progress weekly. Outcome was assessed pre- and post-test with a work performance scale and a measure of social interaction (psychometric properties of the measures were not reported), as well as with therapist ratings of goal attainment. *T* tests indicated that the experimental group had a higher goal attainment and were more involved in sessions. However, no significant differences between the groups were found for work performance or social interaction. The authors recommended that further research is necessary to establish a positive relationship between goal setting and clinical outcome. The design of this research would be improved with the use of a larger sample size, as well as standardized outcome measures. It is difficult to interpret the results due to the lack of information provided about the outcome measures.

Results have also been mixed in studies employing some other method of goal setting. In a descriptive report, Levendusky, Berglas, Dooley and Landau (1983) indicate that use of specific goals in counseling was related to reduce length of stay in a psychiatric hospital. In this inpatient setting, clients contract for weekly treatment goals, and are then socially reinforced for progress on the goals. At the end of the week, clients are given feedback on goal completion by a contract-evaluation group. The authors report that for a sample of over 500 clients, the mean length of hospitalization was 71 days, as compared with a hospital-wide mean of 107 days. Client ratings (N = 50; demographic data not provided) of treatment outcome indicated 2 percent rated as worse, 0 percent rated as having no change, 10 percent rated as somewhat improved, 45 percent rated as improved, and 43 percent rated as very improved. Treatment team evaluation was somewhat more conservative, with 0 percent rated worse, 8 percent rated as having

no change, 44 percent rated as somewhat improved, 24 percent rated as improved, and 24 percent rated as very improved. The authors did not conduct any statistical analyses of these data. While this article provides anecdotal evidence of the value of goal setting, it does not provide empirical data.

Avraham, Mikulincer, Nardi, and Shoham (1992) reported a positive relationship between goal setting and outcome in a study of the use of individualized goal setting with a sample of clients (N = 41, demographic data not reported) suffering from combat-related chronic post-traumatic stress disorder. Goals were developed in coordination with the participant's counselor during the first two days of treatment. Every two days, clients and therapists rated goal attainment on an 11-point scale (0 = worst condition; 10 = best condition). The authors independently analyzed the goals listed, grouping them into 14 categories (anger control, extinguishing civilian avoidances [ex: walking in a dark place], anxiety/thought control, extinguishing military avoidances [ex: overcome fear of guns], health improvement, fitness improvement, sleep improvement, memory and concentration, leisure, self-discipline, assertiveness, work skills, social skills, familial skills) for use in the quantitative analysis. Inter-judge agreement for all categories was reported as higher than 90 percent; items that could not be agreed upon were not included in the analysis. The eleven point scale was divided into five points of time to examine effects of time. Analysis of variance with Duncan post hoc analysis of client ratings indicated a gradual but significant improvement across time in all of the target behaviors except health and sleep improvement, utilization of leisure time, and self-discipline. Similar analyses using therapist ratings indicated a gradual but significant improvement across time in all categories except health improvement. While this study offers some

evidence of the utility of specific goal setting in counseling, the study would be improved by the inclusion of independent raters as well as inclusion of a standardized outcome measure.

In a study of family therapy conducted at a clinic in the United Kingdom, Macdonald (1994) found that good outcome was linked to having specific goals in treatment. In this study, clients who participated in therapy utilizing goal setting techniques were followed up one year after their last session (N = 41; 14 male, 27 female; race/ethnicity not reported). The number of sessions ranged from 1 to 13. The specific goal setting methods were not described in detail. Follow up questionnaires were sent to patients as well as their general practitioner. Details of the contents of the questionnaires were not provided. Good outcome was defined as either the patient or the general practitioner reported that the problem was solved. If the patient responded, their response was used; if not, the general practitioner's response was used. Good outcome was reported in 70 percent of the cases. No significant differences were found for the good outcome group versus the total sample on demographic variables. Good outcome was associated with longer attendance, although the authors did not report whether this difference was significant. Results of this study should be considered with extreme caution. The author does not provide sufficient detail of the goal-setting procedure, the level of specificity of goals set, the outcome questionnaire used, and mixes ratings of outcome by therapists and clients. In addition, little detail is provided regarding the statistical analyses used to produce the reported findings.

In a study of the effects of goal specification on counseling outcome, King and Voge (1982) did not find a significant outcome effect for goal specification in a sample

of university counseling center clients. The design included both counseled (N = 117) and noncounseled (N = 113) groups, with both groups split into goal setting (counseled, N = 41; noncounseled, N = 82) and nongoal setting. It is difficult to discern the actual sample size for each group, since reported numbers of participants in each subgroup does not add up to the total sample size reported. In addition, the authors do not report demographic data. All clients completed a goal checklist. Outcome was assessed with the use of a self-concept scale; psychometric data was not reported for the scale. Both participants and counselors assessed goal attainment using a 9-point scale (not described further), with mean scores calculated for all goals, behavioral goals, and internal state goals (the distinction between behavioral and internal state goals was not provided). In addition, counselors completed a separate therapist rating of process (again, psychometric data was not provided). Using analysis of variance, the authors found that there were no significant differences on the outcome measures across all groups between participants who had specified goals and those who had not. The counseled group reported attaining their goals to a greater extent than did the non-counseled group. This study would be improved with the use of more standardized measures of outcome. In addition, the authors did not provide sufficient details of the study to allow careful interpretation of the results.

In general, the review of the literature reveals only mixed evidence for the relationship of goal specificity to counseling outcome. While the evidence seems clear for the benefits of specific goal setting with a strictly behavioral goal content (pain management), the evidence in more general counseling studies is questionable. The research appears to have serious design flaws in that few standardized outcome measures

were used (or, at least, psychometric properties were not reported), objective raters were rarely used, and sample sizes tended to be inadequately small. In addition, in these studies collaborative setting of goals confounds the measurement of specificity of goal. That is, it is impossible to ascertain whether a positive effect on outcome is due to the level of specificity of the goals set by participants, or whether it is due to collaborative goal setting between counselor and participant.

Rationale for Inclusion or Non-Inclusion

The general goal setting literature provides strong evidence of the impact of goal specificity on performance outcome. A review of the counseling literature reveals mixed support for a relationship between goal specificity and counseling outcome. In general, the quality of this literature can be assessed as poor, with a number of methodological problems. However, given the strong evidence in the general goal setting literature for the importance of this dimension, it will be included in the current research. It is hypothesized that there will be a strong significant positive relationship between goal specificity and counseling outcome.

Difficulty-Level

Goal difficulty has received a great deal of attention in the goal setting literature, as well (Austin & Vancouver, 1996). Goal difficulty refers to how hard or how easy it is to accomplish the goal. As indicated in the previous section on the specificity-representation goal dimension, difficulty has consistently been linked with specificity in the goal setting literature (Locke, et al., 1989). In most cases, adoption of difficult goals

have been found to lead to better performance than adoption of easier ones (Mento, Steele, & Karran, 1987; Tubbs, 1986).

Although evidence for the relationship between difficulty and performance level appears substantial, examination of the literature reveals substantial discrepancies in the reported strength of the relationship. Wright (1990) pointed out that despite using a large percentage of the same studies meta-analytic studies by Mento et al. (1987) and Tubbs (1986) found very different effect sizes for goal difficulty, with Mento et al. finding an effect size of .581, and Tubbs an effect size of .816. Wright conducted another meta-analysis of the studies used in by Mento et al., to examine whether the operationalization of goal difficulty moderated the relationship between goal difficulty and performance. He discovered that four categories of goal operationalization (assigned goal level, self-set goal level, performance improvement, and difficulty perceptions) did moderate the relationship between goal difficulty and performance, accounting for 26 percent of the variance in effect sizes. While all the operationalizations were positively related to performance, the relationships differed significantly in strength (assigned level = .7477, self-set level = .5729, performance improvement = .3798, difficulty perception = .2663).

Although a review of the literature did not produce any counseling research examining the relationship of goal difficulty to counseling outcome, the general goals setting literature does provide some direction for the current research. Since the current research is examining client-established counseling goals, difficulty would most accurately be operationalizaed as a self-set goal level. Wright (1990) hypothesized that the varying effect sizes of the difficulty operationalization could be attributed to the range in difficulty represented by each. He hypothesized that in self-set goal level

operationalizations subjects are likely to medium range goals that are neither extremely easy nor extremely difficulty. Therefore, in the current research it is expected that there will be a small, but significant positive relationship between goal difficulty and counseling outcome.

Rationale for Inclusion or Non-Inclusion

While review of the counseling literature reveals no clues regarding the impact of the difficulty goal dimension on outcome, there is strong evidence in the general goal setting literature of a positive relationship between goal difficulty and performance. Given the evidence in the literature that it is critical to operationalize goal difficulty in research, the current research will operationalizes difficulty as being a self-set goal level. The current research will include goal difficulty as a measured goal dimension, and it is hypothesized that there will be a small but significant positive relationship between goal difficulty and counseling outcome.

Temporal Range

This dimension refers to how long- or short-term a goal is. While theorists often argue that immediate goals exert a stronger motivational impact on behavior than goals for the future, actual research evidence is inconclusive (Karniol & Ross, 1996). Karniol and Ross hypothesize that it may be that the motivational effectiveness of immediate or long-term goals depends upon the type of activity. It has been suggested that people wish to have both kinds of goals, and generate proximal goals to go with distal goals and vice versa (Locke & Latham, 1990). It is also possible that there are individual differences in

whether they employ a backward or forward planning strategy, (i.e., setting long-term goals first, then developing more immediate goals as subgoals, or vice versa) (Karniol & Ross, 1996).

A review of the literature reveals no studies assessing temporal range of counseling goals. However, it may be extrapolated from the general goal setting literature that different categories of counseling goals may be associated with varying levels of immediacy. Although the general goal setting literature does not suggest a hypothesis regarding a relationship between the temporal range goal dimension and counseling outcome, if one does exist, it would have critical implications for goal setting in counseling. If a relationship exists, adjusting the temporal range of counseling goals would be a relatively simple adjustment to make, with potential significant gains for counseling outcome.

Rationale for Inclusion or Non-Inclusion

There are no studies examining temporal range of counseling goals. However, the general goal setting literature suggests that temporal range may be related to type of goal content. Existence of a relationship between goal temporal range and counseling outcome would be have important implications for goal setting in counseling. Therefore, it will be important in the current study to examine not only the relationship of temporal range to counseling outcome, but also whether temporal range is related to type of counseling goal content.

Level of Consciousness

Goals can be conscious or unconscious (Austin & Vancouver, 1996; Geen, 1995). Debate on this dimension has centered on whether or not goals need to be conscious to effect behavior (Bargh & Barndollar, 1996). Wyer and Srull (1989) describe goal consciousness as dynamic; they view goals as shuttling in and out of working memory as required. Weinberger and McClelland (1990) suggest that there are two types of motivation, which operate essentially independently of one another. One type is tied to self-concepts and is best understood through cognitive principles. The authors argue that self-concepts are conscious, and hence this type of motivation is best assessed via self-report. The second type is more primitive, and is based on biological needs. The motives are triggered by events in the environment, but are essentially unconscious. McClelland, Koestner, and Weinberger (1989) have suggested use of projective tests to assess unconscious goals.

A review of the counseling literature reveals no research addressing the consciousness of counseling goals. However, using the conscious versus unconscious models of motiation provided by Weinberger and McClelland (1990), it can be concluded that articulated goals fall into the conscious type of motivation.

Rationale for Inclusion or Non-Inclusion

There is no counseling research that addresses level of goal consciousness. However, in terms of initial client goal establishment, it is logical to assume that if a goal is articulated it is conscious. Using projective tests to assess unconscious counseling goals is beyond the scope of the current study. Therefore, the assumption will be made

that if a goal is articulated, it is conscious.

Connectedness-Complexity

More complex goals have connections to other goals, subgoals, and behaviors (Austin & Vancouver, 1996) and thus have more potential for conflict. This dimension is less understood than goal specificity and difficulty (Geen, 1995), given that much of the goal setting literature has explored relatively straightforward tasks (Locke & Latham, 1990). Wood, Mento, and Locke (1987) offer evidence from a meta-analysis of studies involving more complex tasks that as the complexity of the task increases, the amount of goal effect on performance decreases, with performance increasing by setting goals by an average of 7.79 percent for tasks high in complexity compared to 12.15 percent for tasks low in complexity. It is thought that this relationship is altered by the need to develop more complex goal strategies when faced with complex goals (Locke & Latham, 1990).

Counseling goals certainly can be classified as complex goals. However, there are no studies examining goal complexity in counseling. While it is likely that counseling goals might conflict with other goals, the issue of how goal conflict-complexity is determined is unresolved (Austin & Vancouver, 1996). They suggest that goal complexity-conflict should be analyzed with the aid of individually generated goal maps or directed graphs as described by Cox and Wermuth (1993).

Rationale for Inclusion or Non-Inclusion

Having each participant construct such a goal map is beyond the scope of this study. In addition, goal complexity/conflict is the one dimension that overlaps with the

goal process of striving. Since the current research is concerned solely with client goal establishment and measurement of goal complexity-conflict requires such time and labor intensive effort, the dimension of complexity/conflict will not be addressed in the current study.

Summary of Goal Dimensions

This section has reviewed the literature on the six goal dimension factors identified by Austin and Vancouver (1996) in their review of goal construct literature. The research on goal dimensions has traditionally focused on a subset of these dimensions, usually investigating one or two dimensions. Difficulty-level, specificity-representation, and temporal range have been selected for inclusion in the current research. Importance-commitment, level of consciousness, and connectedness-complexity will not be included.

Research Questions

The literature review reveals that little empirical work has been done to investigate goal constructs in counseling. This research is considered to be a preliminary study to consider client-established goal content as well as client-established goal dimensions of difficulty-level, specificity-representation, and temporal range. Based upon the findings of the literature review, the following research questions will be addressed in this study:

1. Can raters reliably use the Ford and Nichols Taxonomy of Human Goals (Ford &

Nichols, 1987; Ford, 1992) to identify the content of client-established counseling goals?

2. Is client-established counseling goal content type related to the goal dimensions of difficulty-level, specificity-representation, and temporal range?

3. Is client-established counseling goal content type related to counseling outcome as measured by the OQ (Lambert & Burlingame, 1996)? Insufficient evidence exists to establish hypotheses regarding this relationship.

4. Are client-established goal dimensions (difficulty-level, specificity-representation, and temporal range) related to counseling outcome as measured by the OQ (Lambert & Burlingame, 1996)? It is hypothesized that counseling goals that are specific and difficult will be related to better outcome.

5. Does the relationship of client-established counseling goal content type to counseling outcome as measured by the OQ (Lambert & Burlingame, 1996) have explanatory power above and beyond that explained by the relationship of client-established goal dimensions (difficulty-level, specificity-representation, and temporal range) to counseling outcome as measured by the OQ?

6. Does the relationship of client-established counseling goal dimensions (difficulty-level, specificity-representation, and temporal range) to counseling outcome as measured by the OQ (Lambert & Burlingame, 1996) have explanatory power above and beyond

that explained by the relationship of client-established counseling goal content type to counseling outcome as measured by the OQ?

CHAPTER 3

METHOD

This chapter provides details of the methodology for this dissertation. The first section, Participants, discusses characteristics of the participants in this research. The second section, Instruments, describes the instruments used to collect data. The third section, Procedures, details data collection, as well as rating of the data for use in statistical analysis. The final section, Analysis, outlines the statistical analyses that are used to address the research questions of this dissertation.

Participants

The participants in this study were voluntary clients receiving individual counseling at a military academy. The military academy is a four-year degree program from which individuals graduate with a Bachelor of Science degree. The participants were 51 undergraduate clients, 62.8 percent male, 37.2 percent female, and 84.3 percent Caucasian, with ages ranging from 18 to 25 years ($M = 20.04$, $SD = 1.51$). Since the academy comprises individuals from all 50 states, as well as national territories, the individuals were representative of a cross section of the United States. The sample included an insufficient number of non-Caucasian participants to conduct analyses on potential racial/ethnic differences beyond categorization into majority (Caucasian) versus minority (non-Caucasian) status. Forty-three participants identified themselves as Caucasian and 8 participants said they were non-Caucasian.

While the student population at this military academy is similar to student

populations at other academic institutions in most respects, they do differ on several dimensions. Students are selected to attend the academy in a very competitive process, with selection criteria based upon academic, leadership, and athletic achievement. The majority of students graduated in the top 10 percent of their high school classes. In addition, students are expected to carry a higher than average academic course load (averaging 18 credit hours per semester), while also required to participate in athletics and to hold military positions within their squadrons.

The presenting issues of the client population at this counseling center tend to be relatively non-severe, with the issues of the vast majority of clients not warranting diagnoses as established by DSM IV criteria. A diagnosis is not required to receive treatment. The length of treatment ranged from 2 to 35 sessions ($M = 7.9$, $SD = 6.15$).

Instruments

Data for this research was collected using two instruments, the counseling center intake form, and the Outcome Questionnaire (OQ; Lambert & Burlingame, 1996). Each instrument is described in detail below.

Intake Form

Each participant completed a self-report intake form prior to meeting with a counselor. The intake form included a statement of limited confidentiality, as well as demographic information (year in school, gender, age, race/ethnicity, referral status, previous counseling experience, family psychological history, probation status, current positions/activities, academic major, military grade point average, and academic grade

point average). The intake form asked participants to describe in writing their reasons for coming to counseling, and asked participants to rate their coping with the matter on a scale of 1 (Not at All Well) to 4 (Quite Effectively). Responses to the statement, "Describe your reason(s) for coming to the Cadet Counseling and Leadership Development Center", were examined as goal statements. The intake form included an informed consent document describing the ongoing research project under which the data for this study were collected. In addition, the intake form concludes with the OQ (Lambert & Burlingame, 1996), described below.

Outcome Questionnaire (OQ; Lambert & Burlingame, 1996)

Counseling outcome was measured by the OQ (Lambert & Burlingame, 1996). The selection was made because the measure provides an assessment of the client's inner life as well as their functioning in the environment, and is intended for use in a practice setting. In addition, the measure is self-administered and takes no longer than five minutes to complete. The OQ contains 45 five-point Likert scale (Never = 0, Almost Always = 4) items divided into three subscales.

The Total scale is comprised of all the items together, and provides a measure of overall distress. It is scored on a scale of 0-180; a reliable change is indicated by a score change of 14 or greater. The Symptom Distress (SD) scale is heavily loaded with items that measure an individual's depression and anxiety, as well as items for detection of substance abuse. SD is scored on a scale of 0-100; a reliable change is indicated by a score change of 10 or greater. The Interpersonal Relations (IR) scale includes items that deal with friction, conflict, isolation, inadequacy, and withdrawal in intimate

relationships. IR is scored on a scale of 0-44; a reliable change is indicated by a score change of 8 or higher. The Social Roles (SR) scale focuses on dissatisfaction, conflict, distress, and inadequacy in tasks related to work, family roles, and leisure life. SR is scored on a scale of 0-36; a reliable change is indicated by a score change of 7 or higher. For the Total scale as well as each of the subscales, the higher the score, the more disturbed the individual.

However, a confirmatory factor analysis failed to support the multi-factor structure of the OQ (Mueller, Lambert, & Burlingame, 1998) due to high correlations and poor overall model fit. Based on these findings, the authors recommended that only Total scores should be used to track clinically significant change in clients. Therefore, in this study only Total scores were used to assess counseling outcome.

The psychometric properties of the OQ have been examined by using normative samples (Burlingame, et al., 1995). The sample consisted of 1,000+ individuals ages 17-80, across seven different states. Sixty percent of the sample was female. No significant differences based upon age or gender were found. A range of settings was included in the normative sample, including community mental health, private outpatient, Employee Assistance Program, asymptomatic community, and undergraduate. Internal consistency reliability estimates across the settings ranged from .70 to .93, while test-retest (3 weeks) ranged from .78 to .84. The OQ was able to reliably discriminate the level of disturbance across the different client populations in the normative sample, yielding evidence of construct validity. Additional evidence of construct validity was found using the outpatient sample given the OQ prior to treatment and again after their seventh session. Significant pretest/posttest differences were found on all scales. Evidence of concurrent

criterion validity was demonstrated using the undergraduate sample. Total Score was correlated with The Beck Depression Inventory (.80), the Taylor Manifest Anxiety Scale (.86), and the Symptom Checklist 90-Revised (.78). The Inventory of Interpersonal Problems was significantly correlated with IR (.62), but not with Total Score.

Using a sample of community (non-patient) participants as well as patient participants from a community health clinic, a college counseling center, and an inpatient psychiatric unit, Umphress, Lambert, Smart, Barlow, and Clouse (1997) conducted another investigation of the concurrent and construct validity of the OQ. In an assessment of discriminant construct validity, there were significant differences in SD and Total scores between patients and community participants, as well as differences between the patient samples. In addition, Total, SD and SR scores could accurately be used to discriminate between patients with a diagnosis and those with a V code. Further evidence of concurrent validity was also found, with Total score significantly correlated across all three patient samples with the Symptom Checklist 90-Revised General Symptom Index (.78 - .88), the Inventory of Interpersonal Problems (.66 - .81), and the Social Adjustment Scale-Self Report version (.71 - .81). While all three subscales also were significantly correlated with each criterion measure the Total and SD scores were generally more highly correlated than IR and SR scores.

While the studies described above report inclusion of a small percentage of racial/ethnic minorities, they do not report investigation of any statistical differences by racial/ethnic category. One study has explicitly explored this topic. In a study of racial differences on the OQ (Nebeker, Lambert, & Huefner, 1995), no significant differences were found for Total and subscale scores of Caucasian and African-American clients in a

clinical sample. This demonstrates evidence that the OQ does not over- or underpathologize African-American clients.

Procedures

This section describes how the data were collected for this research. In addition, it describes the procedures used to conduct ratings of the goal content and dimensions of the data.

Data Collection

The current study used archival data collected as part of ongoing research on the outcome of counseling conducted by the counseling center of the military academy. The International Association of Counseling Services (IACS) accredits the counseling center.

Voluntary participation of clients in the research was solicited during initial intake paperwork with an informed consent document. If clients chose to participate, their data were included in the sample. Participants completed the intake paperwork package prior to meeting with a counselor for the first time. In addition to taking the OQ (Lambert & Burlingame, 1996) during intake to establish baseline scores, participants were supposed to complete the OQ monthly during the course of counseling, as well as at termination. Because there was a varying number of outcome scores available for participants, the unit of comparison for outcome was the slope of the line created by plotting the initial outcome score and the final outcome score.

To be eligible for this study, participants had to have at least two OQ scores. Whereas participants were supposed to complete the OQ monthly, the actual number of

OQ completions varied greatly across participants. This expected variation occurred due to variation in treatment length, as well as attrition and noncompliance with the treatment protocol. 65 percent of participants had two OQ scores, 31 percent had three OQ scores, 2 percent had four OQ scores, and another 2 percent had six OQ scores. A change score was created that took into account the variability in the number of OQs completed by the participants. For each subject, a regression equation was calculated by regressing the OQ scores onto the number of OQs that that participant completed. The slopes (b's) from these regression equations can be interpreted as the rate of change in OQ score over time. This rate of change score was used in the analyses examining the relationship between goal content, goal dimensions, and client change.

Goal Content and Dimensions Rating

Four raters were used to assess the content and dimensions of the counseling goals self-reported by participants on the intake form. If participants identified multiple goals, those goals were separated into individual goal statements by the researcher. The raters were doctoral students in a counseling psychology program, with clinical experience. They were given copies of chapters on the goal taxonomy by Ford and Nichols (1987) and Ford (1992). The raters were trained on the goal taxonomy as well as the dimensions in an effort to ensure standardized interpretation by the raters. The training used a sampling of goal statements collected at the same counseling center during a previous academic year. During the training, interrater reliability was calculated for a set of 10 sample goal statements that were independently rated, then the raters discussed any discrepancies in rating until a consensus was reached. The process

continued with new sets of goal statements until an acceptable level of interrater reliability was achieved. It took approximately 3 ½ hours of training, conducted in a single session for all raters, to establish reliability of rating. An acceptable level of reliability was defined as .70 or better, as suggested by Heppner, Kivlighan, and Wampold (1999).

Raters categorized the content of the goals according to the Ford and Nichols Taxonomy of Human Goals (see Table 1). However, due to the small sample size, goal content type was redefined for statistical analyses into the three different categorical variables rather than using the most detailed level of categorization (48 goal content categories). The Approach-Avoidance goal variable describes participants' goals on the basis of whether the goal is defined as a positive consequence to be attained (positive-approach) or a negative consequence to be avoided (negative-avoid) (Ford & Nichols, 1987). The Internal-External goal variable describes participant goals on the basis of whether the goal refers to desired consequences within the person (internal) versus the goal referring to desired consequences of the relationship between the person and the environment (external) (Ford, 1992). The Goal Type variable represents six groupings of goal types: Affective, Cognitive, Subjective Organization, Self-Assertive Social Relationship, Integrative Social Relationship, and Task.

The goal dimensions (difficulty-level, specificity-representation, and temporal range) were rated using six-point Likert scales. For the difficulty-level dimension, the scale ranged from very difficult to achieve (1) to very easy to achieve (6). The Likert scale for the specificity-representation dimension ranged from very vague (1) to highly specific (6). For the final dimension, temporal range, the scale ranged from very short

term (1) to very long term (6).

Analysis

Since this study addresses six separate research questions, the analysis for each question is discussed separately in this section. Type of counseling goal content, as discussed in the Procedures section of this chapter, was categorized using the Ford and Nichols Taxonomy of Human Goals (Ford & Nichols, 1987; Ford, 1992). Goal dimensions refers to the goal dimensions of difficulty-level (hereafter referred to as "difficulty"), specificity-representation (hereafter referred to as "specificity"), and temporal range. Counseling outcome refers to outcome scores as measured by the OQ (Lambert & Burlingame, 1996).

Research Question 1

Can raters reliably use the Ford and Nichols Taxonomy of Human Goals (Ford & Nichols, 1987; Ford, 1992) to identify the content type of client-established counseling goals?

The answer to this research question was determined by examination of interrater reliability to assess the degree of agreement between the raters regarding classification of goals into content types. Percent agreement was computed as the measure of interrater reliability. Heppner, Kivlighan, and Wampold (1999) recommend that reliability estimates of .70 are considered adequate, but indicate that obviously higher reliability estimates are preferable.

Research Question 2

Is client-established counseling goal content type related to the goal dimensions of difficulty-level, specificity-representation, and temporal range?

A series of one-way ANOVAs were conducted to answer this research question. Type of counseling goal served as the categorical independent variable, with ratings of the three goal dimensions serving as continuous dependent variables.

Research Question 3

Is client-established counseling goal content type related to counseling outcome as measured by the OQ (Lambert & Burlingame, 1996)? Insufficient evidence exists to establish hypotheses regarding this relationship.

Since this research question involves a categorical variable predicting a continuous variable, it was answered with a series of one-way ANOVAs. The independent variable was type of counseling goal content while the dependent variable was counseling outcome.

Since the individual counselor seen by a participant and the number of counseling sessions attended were likely to have a significant impact on the outcome of counseling, these variables were assessed by one-way ANOVA procedures during the preliminary analysis of the data.

Research Question 4

Are client-established goal dimensions (difficulty-level, specificity-representation, and temporal range) related to counseling outcome as measured by the OQ (Lambert &

Burlingame, 1996)? It is hypothesized that counseling goals that are specific and difficult will be related to better outcome.

Since both goal dimensions and counseling outcome are continuous variables, this research question was addressed using simultaneous linear regression to assess the amount of variance attributed to each goal dimension variable. Again, it seemed likely that there might be a significant relationship between goal dimensions and both the individual counselor seen by a participant and the number of counseling sessions attended, so these variables were assessed using one-way ANOVA during preliminary data analysis.

Research Question 5

Does the relationship of client-established counseling goal content type to counseling outcome as measured by the OQ (Lambert & Burlingame, 1996) have explanatory power above and beyond that explained by the relationship of client-established goal dimensions (difficulty-level, specificity-representation, and temporal range) to counseling outcome as measured by the OQ?

This question was addressed through the use of hierarchical linear regression to examine the interaction effect between goal content type and goal dimensions on counseling outcome, over and above the influence of goal dimensions on outcome. In the first step, the goal dimension variables and the type of goal content variable was entered. In the second step, the interaction terms for the goal dimensions were entered.

Research Question 6

Does the relationship of client-established counseling goal dimensions (difficulty-level, specificity-representation, and temporal range) to counseling outcome as measured by the OQ (Lambert & Burlingame, 1996) have explanatory power above and beyond that explained by the relationship of client-established counseling goal content type to counseling outcome as measured by the OQ?

This question was also addressed through the use of hierarchical linear regression to examine the interaction effect between goal content type and goal dimensions on counseling outcome, over and above the influence of goal content on outcome. In the first step, the goal content variables were entered. In the second step, the goal dimension variables were entered.

CHAPTER 4

RESULTS

This chapter reports the results of the statistical analyses used to assess the research questions previously identified. The first section reports the results of research question number 1 regarding interrater agreement of goal content and interrater reliability of goal dimension ratings, which was a preliminary analysis for the remainder of the research questions. The next section reports descriptive statistics, as well as discusses preliminary statistics necessary for the rest of the analyses. The remainder of the sections reports the results of research questions 2-6.

Research Question 1

Can raters reliably use the Ford and Nichols Taxonomy of Human Goals (Ford & Nichols, 1987; Ford, 1992) to identify the content type of client-established counseling goals?

In rating the type of goal content, all four raters agreed on the type of goal content for seven of 51 participants (13.7 percent agreement) and three of four raters agreed on the type of goal content for nine of 51 participants (17.7 percent agreement). Two of four raters agreed on the type of goal content for 27 of 51 participants (52.9 percent agreement), while none of the raters agreed on the type of goal content for 8 of 51 participants (15.7 percent agreement). Classification of the type of goal content was determined when at least three of four raters agreed on the type of goal content. On 31.4 percent of the ratings, at least three of four raters agreed on the type of goal content. This

percent of agreement was clearly far below the 70 percent agreement level desired to proceed to the remainder of the analyses.

Examination of the results revealed that a particular rater was consistently not in agreement with other raters. Dropping that rater and using only three raters resulted in all three raters agreeing on the type of goal content for six of 51 participants (11.8 percent agreement), and two of three raters agreeing on the type of goal content for 28 of 51 participants (54.9 percent agreement). None of the raters agreed on 17 of 51 participants (33.3 percent agreement). Classification of the type of goal content was determined when at least two of three raters agreed on the type of goal content. Using this criterion, on 66.7 percent of the ratings at least two of three raters agreed on the type of goal content. Although 66.7 percent agreement is slightly less than the desirable level of 70.0 percent agreement, it was decided that this level of percent agreement was acceptable given the difficulty of the task of making these ratings using the extensive goal taxonomy. Therefore, it was concluded that the raters were able to reliably use the Ford and Nichols Taxonomy of Human Goals (Ford & Nichols, 1987; Ford, 1992) to identify the content type of client-established counseling goals. As a result, further analyses were conducted using goal content type as a variable. For the remaining 33.7 percent of ratings, goal content type was determined by discussion among the raters.

It also was necessary to conduct interrater reliability analyses for ratings of each goal dimension (difficulty level, specificity representation, and temporal range). For this study, using all four raters, alpha for the three dimensions were .85, .85, and .84, respectively. Since these reliabilities were above the desirable level of .70, it was concluded that the raters were reliably able to assess the dimensions of participants'

counseling goals. As a result, further analyses were conducted using each of the three goal dimensions. The remainder of the analyses used the mean rating of each dimension, averaged across the three raters who were retained for the goal content type analyses described above.

Descriptive and Preliminary Statistics

As stated in the Method chapter, goal content type was redefined into three different categorical variables due to the small sample size. Five participants did not set goals, and therefore had no associated goal content type. The Approach-Avoidance goal variable describes participants' goals on the basis of whether the goal is defined as a positive consequence to be attained (positive-approach, N = 35) or a negative consequence to be avoided (negative-avoid, N = 11) (Ford & Nichols 1987). The Internal-External goal variable describes participants' goals on the basis of whether the goal refers to desired consequences within the person (internal, N = 29) versus the goal referring to desired consequences of the relationship between the person and the environment (external, N = 17) (Ford, 1992). The Goal Type variable represents six groupings of goal types: Affective (N = 15), Cognitive (N = 14), Subjective Organization (N = 0), Self-Assertive Social Relationship (N = 9), Integrative Social Relationship (N = 2), and Task (N = 5).

Means and standard deviations for the three goal dimensions, as well as the OQ slope are shown in Table 9. The assumptions required for use of linear regression and analysis of variance were met. Linearity and homoscedasticity were examined by viewing of residual plots; there was no evidence of heteroscedastity or nonlinearity.

Standardized residuals and DFBETAS were examined for evidence of outliers. While six participants showed evidence of being outliers, no systematic reason was identified to indicate that they were influential observations; therefore, they were retained.

The results of chi-square analyses conducted to determine if differences existed on the goal variables (Approach-Avoid, Internal-External, and Goal Type) based on demographic characteristics (race, gender, and year in school) and the counselor seen by participant are shown in Tables 2, 3, and 4. Year in school will hereafter be referred to as "class" and counselor seen by participant will be referred to as "counselor." A chi-square analysis indicated that the actual frequency of approach versus avoid goals was not significantly different from the expected frequency of approach versus avoid goals based on race (see Table 2), χ^2 (1, N = 46) = .69, $p > .05$, gender, χ^2 (1, N = 46) =. 05, $p > .05$, class, χ^2 (3, N = 46) = 1.08, $p > .05$, and counselor, χ^2 (7, N = 46) = 4.38, $p > .05$.

Chi-square analysis indicated that the actual frequency of internal versus external goals was not significantly different from the expected frequency of internal versus external goals based on race (see Table 3), χ^2 (1, N = 46) = 2.71, $p > .05$, gender, χ^2 (1, N = 46) = .05, $p > .05$, class, χ^2 (3, N = 46) = .43, $p > .05$, and counselor, χ^2 (7, N = 46) = 8.10, $p > .05$. Chi square analysis also indicated that the actual frequency of goal type (affective, cognitive, self-assertive social relationship, integrative social relationship, and task) was not significantly different from the expected frequency of goal type based on race, χ^2 (4, N = 45) = 4.21, $p > .05$, gender, χ^2 (4, N = 45) = 3.11, $p > .05$, class, χ^2 (12, N = 45) = 6.97, $p > .05$, and counselor, χ^2 (28, N = 45) = 32.06, $p > .05$ (see Table 4).

A one-way ANOVA was conducted to assess whether a relationship existed between the number of counseling sessions attended (hereafter referred to as "sessions")

and the three goal variables (Approach-Avoid, Internal-External, and Goal Type). These findings are summarized in Tables 6, 7, and 8. Results indicate no significant finding for sessions based on Approach-Avoid goals, F (1,38) = 1.26, $p > .05$, Internal-External goals, F (1,38) = .13, $p > .05$, or Goal Type, F (4,37) = .98, $p > .05$. In summary, there was no relationship between a participant's race, gender, class, counselor seen, or number of counseling sessions and the type of goal a participant set.

One-way ANOVAs were conducted to investigate whether demographic variables (race, gender, class, and counselor) were related to the three goal dimensions (difficulty-level, specificity- representation, and temporal range). Results indicate no significant finding for difficulty based on race, F (1,45) = 1.31, $p > .05$, gender, F (1,45) = .47, $p > .05$, class, F (3,45) = .78, $p > .05$, or counselor, F (7,45) = .93, $p > .05$. Results also indicate no significant finding for specificity based on race, F (1,45) = 1.54, $p > .05$, gender, F (1,45) = 2.01, $p > .05$, class, F (3,45) = .02, $p > .05$, or counselor, F (7,45) = .22, $p > .05$. Similarly, there were no significant findings for temporal range based on race, F (1,45) = .19, $p > .05$, gender, F (1,45) = .37, $p > .05$, class, F (3,45) = .83, $p > .05$, or counselor, F (7,45) = .76, $p > .05$. These findings are summarized in Table 5. In summary, there was no relationship between a participant's race, gender, class, or counselor seen and the difficulty, specificity, or temporal range of the goal a participant set.

Research Question 2

Is client-established counseling goal content type related to the goal dimensions of difficulty-level, specificity-representation, and temporal range?

To determine if differences existed on the dependent variables difficulty-level, specificity- representation, and temporal range based on the three independent goal variables (Approach-Avoid, Internal-External, and Goal Type) one-way ANOVAs were conducted. Results indicated no significant differences for difficulty level based on Approach-Avoid goals, F (1,45) = .52, p > .05, Internal-External goals, F (1,45) = 2.20, p > .05, or Goal Type, F (4,44) = .65, p > .05. Similarly, there were no differences for temporal range based on Approach-Avoid goals, F (1,45) = .11, p > .05, Internal-External goals, F (1,45) = 2.08, p > .05, or Goal Type, F (4,44) = 1.45, p > .05. Results also indicated no significant differences for specificity based on Approach-Avoid goals, F (1,45) = .67, p > .05. However, a significant difference was found for the relationship between specificity and Internal-External goals, F (1,45) = 4.16, p < .05, with goals that were internal tending to be more specific. In addition, there was a significant relationship between specificity and Goal Type, F (4,44) = 2.71, p < .05. See Tables 6, 7, and 8 for a summary of the results of these analyses of variance. Post hoc analysis revealed that affective goals were more specific than self-assertive social relationship goals.

In conclusion, only two relationships were identified between counseling goal content type (approach vs avoid, internal vs external, and affective, cognitive, subjective organization, self-assertive social relationship, integrative social relationship, and task goals) and the three goal dimensions (difficulty, specificity, and temporal range). Internal goals tended to be more specific than external goals. Affective goals tended to be more specific than self-assertive social relationship goals.

Research Question 3

Is client-established counseling goal content type related to counseling outcome as measured by the OQ (Lambert & Burlingame, 1996)? Insufficient evidence exists to establish hypotheses regarding this relationship.

A one-way ANOVA was conducted to determine if significant differences existed on the dependent variable counseling outcome (OQ slope) based on the three independent goal variables (Approach-Avoid, Internal-External, and Goal Type). There were no significant differences on OQ slope based on Approach-Avoid goals, F (1,45) = .05, p > .05, Internal-External goals, F (1,45) = 1.99, p > .05, or Goal Type, F (4,44) = .83, p > .05. See Tables 6, 7, and 8, for a summary of these findings. Therefore it was concluded that counseling goal content type was not related to counseling outcome.

Research Question 4

Are client-established goal dimensions (difficulty-level, specificity-representation, and temporal range) related to counseling outcome as measured by the OQ (Lambert & Burlingame, 1996)? It is hypothesized that counseling goals that are specific and difficult will be related to better outcome.

Initially, Pearson product-moment correlations were calculated among the criterion variable (counseling outcome) and the predictor variables (difficulty, specificity, and temporal range). Results (see Table 9) indicate a significant negative correlation between difficulty and temporal range, r = -.79, p< .01. This means that difficulty and temporal range are strongly related; that is, goals that were more long term were more difficult to achieve. Since the strength of this relationship is evidence of multicolinearity

between difficulty and temporal range, temporal range was removed from the regression analysis because the variable appeared to be slightly less defined than difficulty. A significant positive correlation existed between specificity and difficulty, $\underline{r} = .27$, $\underline{p} < .05$. The correlation between specificity and difficulty means goals that were more specific were easier to achieve. There also was a significant negative correlation between specificity and counseling outcome, $\underline{r} = -.30$, $\underline{p} < .05$, meaning that as specificity of goals increased, more change occurred during counseling.

The remaining goal dimensions (specificity and difficulty) were entered into a simultaneous linear regression model predicting counseling outcome. Results indicate that the model was significant, $\underline{R}^2 = .13$, $\underline{F}\ (2,43) = 3.25$, $\underline{p} < .05$, accounting for 13 percent of the variance. A significant association was found between specificity and outcome, $\underline{\beta} = -.36$, $\underline{p} < .05$ (see Table 10). This means that counseling goals that were more specific were associated with greater change occurring during counseling.

Research Question 5

Does the relationship of client-established counseling goal content type to counseling outcome as measured by the OQ (Lambert & Burlingame, 1996) have explanatory power above and beyond that explained by the relationship of client-established goal dimensions (difficulty-level, specificity-representation, and temporal range) to counseling outcome as measured by the OQ?

In the first step of the hierarchical linear regression (see Table 11), the overall model using specificity, difficulty, and internal-external goal type as predictors did not account for a significant amount of variance in counseling outcome, $\underline{F}\ (3,45) = 2.30$, $\underline{p} >$

.05, although a significant association again was found between specificity and counseling outcome, $\underline{ß} = -.33$, $\underline{p} < .05$. In the second step, the interaction terms (specificity x internal-external and difficulty x internal-external) accounted for a significant amount of variance (11 percent) in counseling outcome after controlling the variance explained by specificity, difficulty, and internal-external goals, $\underline{R}^2 = .24$, $\underline{R}^2$ change = .11, $\underline{F}$ (5,43) = 2.69, $\underline{p} < .05$.

A significant association was found between specificity and outcome, $\underline{ß} = -1.32$, $\underline{p} < .01$, as well as between the specificity interaction term and outcome, $\underline{ß} = 1.39$, $\underline{p} < .01$. This means that the interaction between specificity and internal-external goal type is a moderater of the relationship between specificity and counseling outcome. While in general the change in counseling outcome increased as specificity increased, there was a difference in that relationship based upon whether a goal was internal or external. For goals that were internal, counseling outcome increased as specificity increased, but for external goals the increase in counseling outcome was more dramatic as specificity increased. This means that if a client has an external goal, it is more critical that the goal be set very specifically.

Research Question 6

Does the relationship of client-established counseling goal dimensions (difficulty-level, specificity-representation, and temporal range) to counseling outcome as measured by the OQ (Lambert & Burlingame, 1996) have explanatory power above and beyond that explained by the relationship of client-established counseling goal content type to counseling outcome as measured by the OQ?

Since there was no relationship between counseling goal content type and counseling outcome, it was not necessary to perform this analysis.

CHAPTER 5

DISCUSSION

This chapter discusses the results of the data analysis reported in the previous chapter. The sections of this chapter are a summary of the study, a summary of findings and implications in relation to research questions, the limitations of the study and recommendations for future research, and finally, conclusions.

Summary of the Study

Setting goals in counseling potentially serves two purposes: a) as a measure of the change occurring in counseling (outcome measurement) and b) as a catalyst to increase the change occurring in counseling (outcome enhancement). Measurement of outcome has received attention in the counseling literature, but far less attention has been paid to the role that setting goals in counseling might have as a catalyst for change. Despite the relative lack of research on this topic, goal setting appears to be an integral part of the counseling process. Although a vast amount of psychological literature exists on goal constructs across the cognitive, personality, and motivational domains (Austin & Vancouver, 1996), there exists a surprising lack of research devoted to effective goal setting in counseling. This study begins investigation into the role of goal setting as a catalyst for change to enhance counseling outcome.

The current research used a goal construct framework developed by Austin and Vancouver (1996) in their review of the goal construct literature. The framework provided a theoretical basis for focusing on the process of goal establishment, from which

was derived an emphasis on the content and dimensions of client-established counseling goals. The research was a preliminary study to consider the relationship of client-established goal content as well as client-established goal dimensions of difficulty-level, specificity-representation, and temporal range to counseling outcome. Four raters used the Ford and Nichols Taxonomy of Human Goals (Ford & Nichols, 1987; Ford, 1992) to identify the content of client-established counseling goals. In addition, they rated the dimensions of those same goals. A series of chi-square analyses, one-way analyses of variance, and linear regressions were conducted to ascertain the relationships between goal content, goal dimensions, and counseling outcome.

Summary of Findings and Implications in Relation to Research Questions

1. Can raters reliably use the Ford and Nichols Taxonomy of Human Goals (Ford & Nichols, 1987; Ford, 1992) to identify the content of client-established counseling goals?

Raters were able to reliably use the goal taxonomy to identify goal content. However, it was clear that the range and breadth of goals included in the goal taxonomy were not represented in the goals established by participants of this study. It was not possible to use the most detailed level of description available in the taxonomy (48 goal content categorizations) due to the number of specific goal content categorizations not represented. Even using a six-category subdivision of goal content, one category was not represented (subjective organization). When the data were assessed using two dichotomous schemes (Positive-Approach vs. Negative-Avoid, and Internal vs. External), goal content categorizations were not equally distributed, with 76 percent of the goals rated as Positive-Approach, and 63 percent rated as Internal.

So, while raters were able to reliably rate goal content using the taxonomy, the data suggest that counseling goal content may be represented by only a subset of the Ford and Nichols Taxonomy of Human Goals. The data also suggest that the content of counseling goals is more usefully described using major categorizations of goals, rather than a fine level of detail. However, the results of this study are evidence that the Ford and Nichols Taxonomy of Human Goals is valid for categorizing counseling goal content.

2. *Is client-established counseling goal content type related to the goal dimensions of difficulty-level, specificity-representation, and temporal range?*

Specificity was the only goal dimension related to counseling goal content type. Specificity was related to the dichotomous Internal vs. External goal categorization, with goals that were internal tending to be more specific than goals that are external. This finding may indicate that clients require more assistance in specifying goals with external consequences. It may be that it is more natural and intuitive to generate specific goals when the goal relates strictly to the individual because the individual has more control over him or herself than over the environment. Relatively speaking, it may be that we are more expert about ourselves than about the environment, and therefore have more knowledge available about what is needed to solve an internal problem than a problem in the environment. Such an increased level of knowledge allows a goal to be set more specifically when the desired consequence is strictly internal.

In addition, affective goals were more specific than self-assertive social relationship goals. It may be that affective goals are more readily identifiable (and

therefore more specifiable) to an individual than self-assertive social relationship goals because they are less complex and possibly more intuitive. Essentially, affective goals might be simply more familiar as a type of goal than self-assertive social relationship goals.

Another interesting hypothesis is that individuals might be more reluctant to articulate self-assertive social relationship goals than affective goals in specific terms because self-assertive relationship goals might be deemed less socially appropriate. Kelly, Kahn, and Coulter (1996), in a study examining client self-presentations at intake, found evidence that clients try to look like good people, even when they are willing to report low well-being. If the types of goals were arranged in a continuum based upon social acceptableness/appropriateness, affective and self-assertive social relationship goals would be at opposite ends of such a continuum.

Self-assertive social relationship goals are those goals that involve individuality, self-determination, superiority, and resource acquisition, while affective goals involve entertainment, tranquility, happiness, bodily sensations, and physical well being. It may be that self-assertive relationship goals are perceived, at least subconsciously, as being at the expense of others, or at least, as a more aggressive type of goal because the goals represent a desire to maintain or promote the self. Having this type of goal could be associated with being a bad person. This might result in an avoidance of considering these goals to avoid the negative affect (e.g., selfishness, guilt, and shame) associated with being a bad person.

On the other hand, those goals classified as affective are possibly viewed as more inalienable rights in our culture and therefore consideration of such goals would not have

negative affect associated. Following this line of reasoning, affective goals would be considered more fully and in depth, resulting in a greater level of specificity than self-assertive social relationship goals. It also seems possible that even if an individual had given sufficient consideration to a self-assertive social relationship goal to be able to provide specifics, they might be reluctant to share that extent of goal specificity on the intake form.

3. Is client-established counseling goal content type related to counseling outcome as measured by the OQ (Lambert & Burlingame, 1996)? Insufficient evidence exists to establish hypotheses regarding this relationship.

There were no significant findings of a relationship between counseling goal content type and counseling outcome. This was consistent with the one previously available study examining the relationship of goal content to counseling outcome (Greer, 1980). This indicates that counseling outcome cannot be simply attributed to the type of counseling goal set by a client.

However, this finding must be interpreted with caution given the large number of factors that might impact upon outcome. It is important to stress again that this research only addressed client goals established prior to interaction with a counselor. Obviously, there are a number of factors that impact outcome over the course of therapy. One such factor is the skill level of the counselor. While this study attempted to control for the effect of individual counselor seen by examining differences in outcome by counselor (there were no differences), it is possible that this particular set of counselors were equally capable across all goal types, while other counselors might not be.

Another factor to consider is counseling goals developed with both client and counselor input, which may be the same or different than that initially identified by a client prior to interaction with a counselor. In the current research, it is possible that the goal investigated (client-established, prior to intervention by a counselor) might not have been the goal actually worked on in counseling. Essentially, the finding that client-established counseling goal content type was not related to counseling outcome should be considered a starting point for an examination of the relationship between goal content type and outcome. Future research should continue in a step-wise fashion to consider the relationship of goal content type and outcome across the goal processes of establishment, planning, striving, and revising. In addition, future research should consider internal, external, and joint goals across those goal processes.

4. Are client-established goal dimensions (difficulty-level, specificity-representation, and temporal range) related to counseling outcome as measured by the OQ (Lambert & Burlingame, 1996)? It is hypothesized that counseling goals that are specific and difficult will be related to better outcome.

The hypothesis was only partially supported. Temporal range was so closely associated with difficulty that it was removed from the analysis. The difficulty level of a goal was not related to outcome. However, an increase in goal specificity was associated with greater change occurring during counseling.

The strong relationship between difficulty and temporal range is not surprising. It makes intuitive sense that goals that are more long term are more difficult to achieve. It may be more useful to consider temporal range as a component of difficulty. It is

possible that the current research design was not sufficiently sophisticated to tease out the differences in these two dimensions. However, given the range and complexity of issues regarding goals in counseling that remain unexplored, teasing out subtle differences between difficulty and temporal range should probably not receive high priority.

The finding that difficulty was not related to outcome is somewhat more surprising, given that the literature indicates that adoption of difficult goals leads to better performance than adoption of easier goals (Mento, Steele, & Karran, 1987; Tubbs, 1986). However, the literature provides some clues as to why this relationship did not occur in the current study. Recall that this research did not attempt to measure the goal importance-commitment dimension because the goals investigated were client established, and the literature indicates that commitment to self-set goals is high (Hollenbeck & Brief, 1987).

Several authors (Klein, Wesson, Hollenbeck, & Alge, 1999; Locke, Latham, & Erez, 1988) hypothesized that a lack of variance in goal commitment explained the failure to observe a relationship between goal difficulty and performance. Therefore, it is reasonable to conclude that since the goals investigated in the current research were self-set, commitment to goals was high, and therefore, no relationship was found between difficulty and counseling outcome.

The finding that more specific counseling goals were associated with greater change occurring in counseling was consistent with the strong evidence of the impact of goal specificity on performance outcome that is found in the general goal setting literature. Previous counseling literature investigating the relationship between goal specificity and counseling outcome was mixed. The results of this study have important

implications for counseling, as it adds to the body of evidence that setting goals that are specific increases the likelihood of change occurring in counseling. Since the relationship was found even in the current research that was limited to self-set goals, it may be that the relationship will be even more pronounced in an investigation that included interventions designed to increase goal specificity.

5. Does the relationship of client-established counseling goal content type to counseling outcome as measured by the OQ (Lambert & Burlingame, 1996) have explanatory power above and beyond that explained by the relationship of client-established goal dimensions (difficulty-level, specificity-representation, and temporal range) to counseling outcome as measured by the OQ?

It was found that whether a goal had desired consequences within the person (internal consequences) or desired consequences of the relationship between the person and the environment (external consequences) moderated the relationship between specificity and outcome. While in general increased specificity was associated with better counseling outcome, there was a more dramatic relationship between specificity and external consequence goals. This means that if a counseling goal had internal consequences, while it was good to specify the goal, it was not critical to outcome.

If goal content had external consequences, however, it was critical that the goal be set specifically. It may be that goals with internal consequences are easier to conceptualize and understand than goals with external consequences. In addition, perhaps goals with internal consequences are perceived as being more within a client's control. Specificity can provide a level of organization and structure to a complex,

difficult-to-understand goal. Perhaps developing specifics in a goal increases understanding and empowers a client to recognize the control they have even in a goal that has external consequences.

This finding has important implications for the practice of counseling. Assisting clients in specifying their goals is an intervention that can increase change in outcome. When a client has a counseling goal with external consequences, helping the client specify that goal to the fullest extent possible is critical to facilitating change in counseling.

6. Does the relationship of client-established counseling goal dimensions (difficulty-level, specificity-representation, and temporal range) to counseling outcome as measured by the OQ (Lambert & Burlingame, 1996) have explanatory power above and beyond that explained by the relationship of client-established counseling goal content type to counseling outcome as measured by the OQ?

As discussed earlier, there was no relationship between counseling goal type and counseling outcome, so there was no additional analysis to perform.

Limitations of the Study and Recommendations for Future Research

This study is clearly preliminary in nature. A primary contribution of this research is the recognition that the topic of goals in counseling has scarcely been tapped. This study only explored counseling goals in a very circumscribed way. However, this research clearly establishes that the study of counseling goals is a promising and useful area for further investigation.

A limitation of this study is the fact that only client-established goals were analyzed. The choice to investigate only client-established goals was made because this was an initial study that focused on internally established goals. Narrowing the range of investigation to client-established goals avoided possible external influence by a counselor while a client was setting the goal, increasing the parsimony and clarity of the research. However, doing so may have decreased the generalizability of the results, since frequently the goals that a client enters therapy with are revised throughout the therapeutic process. It is possible in this study that the goal identified at intake was not the goal that the client actually worked on in therapy.

The generalizability of the results of this study is also limited by several factors related to the sample used. The sample size used was relatively small. While it is likely that the results reported here would again be shown, it is possible that additional significant effects would be detected if the research were replicated with a larger sample. A larger sample size might increase the range of goals represented, or at least increase the number of participants choosing a particular goal category so that a more detailed analysis could be conducted. In this study, it was not possible to conduct analysis of the finer level of category detail due to insufficient cell size to conduct statistics, therefore requiring that goal type be analyzed on the basis of the broader category types.

In addition, characteristics of the sample used in this study decrease the generalizability of the results. Since the sample was drawn from college students, the results cannot be generalized to the general population. In addition, while students from this particular academic institution are similar to other college students, they may vary from the general population and even the college student population in several important

ways. Entrance into the institution is highly selective, accepting only students who have excelled based on academic, leadership, and athletic criteria, and were in the top 10 percent of their high school class. It is possible that this sample might set goals that differ from the general population and the college population due to higher levels of task orientation, self-efficacy, and achievement orientation.

It might also be hypothesized that this sample has had more experience with goal setting than the general population, given their level of achievement. The participants in this study may differ from other individuals who seek counseling in that few were diagnosable by DSM IV criteria. It may be that goals set by a non-clinical counseling population differ from those set by a clinical population.

A final criticism of the sample used is that there was insufficient representation of racial/ethnic groups to explore differences beyond those based on minority/majority status. While no significant differences were found by minority/majority status for either goal type or goal dimensions in this study, it could be that the small number of participants, and even smaller number of minority racial/ethnic participants, masked significant differences. Future research should use larger samples, exploring possible differences in the setting of counseling goals based upon the variables described above.

Future research should continue to validate the Ford and Nichols Taxonomy of Human Goals (Ford & Nichols, 1987; Ford, 1992) for use in categorizing counseling goals. Validation should include evidence across a variety of populations, as addressed above in the discussion of limitations of the sample used in the current study. While a larger sample size may reveal a wider range of goal type represented, it may be that it is possible to identify a subset of the taxonomy that represents types of goals set in

counseling. It also would be important to validate use of the taxonomy for categorization of counseling goals set by a counselor or set in conjunction with a counselor.

Future research should expand to include the other goal processes of planning, striving, and revising identified by Austin and Vancouver (1996). The goal revision process may be particularly interesting to explore. Clinical experience indicates that clients frequently revise their counseling goals as they work on their issues, often arriving at different goals from those initially indicated upon intake. It may be that exploration of the revising process offers more clinical insight than exploration of the goal establishment process.

In addition, future research should explore the other goal dimensions not addressed in this study (Importance-Commitment, Level of Consciousness, and Connectedness-Complexity). While Importance-Commitment and Level of Consciousness were not included in the current research because the goals examined were client-established, these dimensions could be examined with a research design addressing goals set in conjunction with a counselor. While examination of the Connectedness-Complexity dimension was beyond the scope of the present study, now that it has been established that the study of effective goal setting in counseling is a promising area of research, efforts should be made to develop a scheme to measure Connectedness-Complexity.

It would be interesting to examine how, if at all, goal content and dimensions change over the course of therapy, as well as the relative contribution of client and counselor to each goal process. For example, it would be useful to explore the possible moderation effect of a client's readiness for change, using the model set forth by

Prochaska and DiClemente (1992). It is clear that goals do not operate in a vacuum, and exploration of goal establishment is just the first step in an understanding of the relationship between counseling goals and counseling outcome.

Conclusions

A primary contribution of this research is the identification of the gap in the counseling literature regarding effective setting of goals in counseling. This research has established that the study of counseling goals is a promising and useful area for further investigation. In general, the results of this study indicate that setting goals can serve as a catalyst to increase the change occurring in counseling.

This research provides evidence of empirical validity for the use of the Ford and Nichols Taxonomy of Human Goals (Ford & Nichols, 1987; Ford, 1992) to categorize counseling goals. However, the data suggest that counseling goals are more usefully described using major categorizations of goals rather than a fine level of detail. The taxonomy might serve as a useful tool to categorize counseling goals in both practice and research settings.

Several important conclusions relevant to the counseling process can be drawn from the findings of this research. Client established counseling goal content was not related to counseling outcome, which indicates that outcome cannot be simply attributed to the type of counseling goal set by a client. Increased goal specificity was related to better counseling outcome (more change in counseling) for all types of goals. Moreover, if the content of the counseling goal had external consequences (desired consequences of the relationship between the person and the environment), it was critical to outcome that

the goal be set specifically. Counseling goals that had internal consequences were more specific than those with external consequences, with affective goals in particular being more specific than self-assertive social relationship goals. This finding may indicate that clients require more assistance in specifying goals with external consequences.

These findings are evidence that setting specific counseling goals serves as a catalyst to increase the change occurring in counseling. While all types of counseling goals benefit from being set specifically, if a client has a goal with external consequences facilitating the setting of specific goals is a critical intervention that can be made to enhance counseling outcome.

It is clear that this research is preliminary in nature. There remains much work to be done in the investigation of the role of goal setting in enhancing counseling outcome. However, practitioners should consider implementing facilitation of setting specific counseling goals to serve as a catalyst for change in counseling.

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Table 1
Ford and Nichols Taxonomy of Human Goals

Goal	Desired Consequences: Positive-Approach	Desired Consequences: Negative-avoid
	Within Person	
Affective		
Entertainment	Experiencing excitement or heightened arousal	Avoiding boredom or stressful inactivity
Tranquility	Feeling relaxed and at ease	Avoiding stressful overarousal
Happiness	Experiencing feelings of joy, satisfaction, or well-being	Avoiding feelings of emotional distress or dissatisfaction
Bodily sensations	Experiencing pleasure associated with physical sensations, physical movements, or bodily contact	Avoiding unpleasant or uncomfortable bodily sensations
Physical well-being	Feeling healthy, energetic or physically robust	Avoiding feelings of lethargy, weakness, or ill health
Cognitive		
Exploration	Satisfying one's curiosity about personally meaningful events	Avoiding a sense of being uninformed or not knowing what is going on
Understanding	Gaining knowledge or making sense out of something	Avoiding misconceptions, erroneous beliefs, or feelings of confusion
Intellectual creativity	Engaging in activities involving original thinking or novel or interesting ideas	Avoiding mindless or familiar ways of thinking
Positive self-evaluations	Maintaining a sense of self-confidence, pride, or self-worth	Avoiding feelings of failure, guilt, or incompetence
Subjective organization		
Unity	Experiencing a profound or spiritual sense of connectedness, harmony, or oneness with people, nature, or a greater power	Avoiding feelings of psychological disunity or disorganization
Transcendence	Experiencing optimal or extraordinary states of functioning	Avoiding feeling trapped within the boundaries of ordinary experience
	Person-environment	
Self-assertive social relationship		
Individuality	Feeling unique, special, or different	Avoiding similarity or conformity with others
Self-determination	Experiencing a sense of freedom to act or make choices	Avoiding the feeling of being pressured, constrained, or coerced
Superiority	Comparing favorably with others in terms of winning, status, or success	Avoiding unfavorable comparisons with others
Resource acquisition	Obtaining approval, support, assistance, advice, or validation from others	Avoiding social disapproval or rejection
Integrative social relationship		
Belongingness	Building or maintaining attachments, friendships, intimacy, or a sense of community	Avoiding feelings of social isolation or separateness
Social responsibility	Keeping interpersonal commitments, meeting social role obligations, and conforming to social and moral rules	Avoiding social transgressions and unethical or illegal conduct
Equity	Promoting fairness, justice, reciprocity, or equality	Avoiding unfair or unjust actions
Resource provision	Giving approval, support, assistance, advice or validation to others	Avoiding selfish or uncaring behavior
Task		
Mastery	Meeting a challenging standard of achievement or improvement	Avoiding incompetence, mediocrity, or decrements in performance
Creativity	Engaging in activities involving artistic expression or creativity	Avoiding tasks that do not provide opportunities for creative action
Management	Maintaining order, organization, or productivity in daily life tasks	Avoiding sloppiness, inefficiency, or disorganization
Material gain	Increasing the amount of money or tangible goods one has	Avoiding the loss of money or material possessions
Safety	Being unharmed, physically secure, and free from risk	Avoiding threatening, depriving, or harmful circumstances

Table 2

Chi-square Analysis Summary of Approach/Avoid Goal Variable and Demographic and Counselor Variables

Variable	Approach (Observed/Expected)	Avoid (Observed/Expected)	χ^2
Race Majority	28/28.9	10/9.1	.69
Minority	7/6.1	1/1.9	
Gender Male	21/21.3	7/6.7	.05
Female	14/13.7	4/4.3	
Class Senior	6/6.8	3/2.2	1.08
Junior	13/12.2	3/3.8	
Sophomore	7/7.6	3/2.4	
Freshman	9/8.4	2/2.6	
Counselor 1	8/6.8	1/2.2	4.38
2	7/6.1	1/1.9	
3	4/3.8	1/1.2	
4	4/3.8	1/1.2	
5	2/3	2/1	
6	4/4.6	2/1.4	
7	1/.8	0/.2	
8	5/6.1	3/1.9	

*$p < .05$

Table 3

Chi-square Analysis Summary of Internal/External Goal Variable and Demographic and Counselor Variables

Variable	Internal (Observed/Expected)	External (Observed/Expected)	χ^2
Race Majority	26/24	12/14	2.71
Minority	3/5	5/3	
Gender Male	18/17.7	10/10.3	.05
Female	11/11.3	7/6.7	
Class Senior	5/5.7	4/3.3	.43
Junior	10/10.1	6/5.9	
Sophomore	7/6.3	3/3.7	
Freshman	7/6.9	4/4.1	
Counselor 1	4/5.7	5/3.3	8.10
2	7/5	1/3	
3	3/3.2	2/1.8	
4	2/3.2	3/1.8	
5	2/2.5	2/1.5	
6	5/3.8	1/2.2	
7	0/.6	1/.4	
8	6/5	2/3	

*$p < .05$

Table 4

Chi-square Analysis Summary of Goal Type Variables and Demographic and Counselor Variables

Variable	Affective (Observe/Expect)	Cognitive (Observe/Expect)	Self-Assertive Social Relationship (Observe/Expect)	Integrative Social Relationship (Observe/Expect)	Task (Observe/Expect)	χ^2
Race Majority	13/12.3	13/11.5	6/7.4	1/1.6	4/4.1	4.21
Minority	2/2.7	1/2.5	3/1.6	1/.4	1/.9	
Gender Male	18/17.7	10/10.3	18/17.7	10/10.3	18/17.7	6.97
Female	11/11.3	7/6.7	11/11.3	7/6.7	11/11.3	
Class Senior	5/5.7	4/3.3	5/5.7	4/3.3	5/5.7	.43
Junior	10/10.1	6/5.9	10/10.1	6/5.9	10/10.1	
Sophomore	7/6.3	3/3.7	7/6.3	3/3.7	7/6.3	
Freshman	7/6.9	4/4.1	7/6.9	4/4.1	7/6.9	
Counselor 1	4/5.7	5/3.3	4/5.7	5/3.3	4/5.7	8.10
2	7/5	1/3	7/5	1/3	7/5	
3	3/3.2	2/1.8	3/3.2	2/1.8	3/3.2	
4	2/3.2	3/1.8	2/3.2	3/1.8	2/3.2	
5	2/2.5	2/1.5	2/2.5	2/1.5	2/2.5	
6	5/3.8	1/2.2	5/3.8	1/2.2	5/3.8	
7	0/.6	1/.4	0/.6	1/.4	0/.6	
8	6/5	2/3	6/5	2/3	6/5	

*$p < .05$

Table 5

One-Way Analysis of Variance for Goal Dimension Variables and Class, Gender, Race, and Counselor

Variable	*M*	*SD*	(*F*) Class	(*F*) Gender	(*F*) Race	(*F*) Counselor
Difficulty-Level	3.59	.58	.78	.47	1.31	.93
Specificity-Representation	3.35	.89	.02	2.01	1.54	.22
Temporal Range	3.20	.61	.83	.37	.19	.76

*$p < .05$, $N = 46$

Table 6

One-Way Analysis of Variance for Approach-Avoid Goal Variable and Number of Sessions, Difficulty, Specificity, Range, and OQ Slope

		Approach		Avoid		
Variable	*N*	*M*	*SD*	*M*	*SD*	*F*
Sessions	39	7.43	4.88	9.91	8.84	1.263
Difficulty-Level	46	3.62	.57	3.48	.61	.52
Specificity-Representation	46	3.29	.89	3.55	.93	.67
Temporal Range	46	3.18	.65	3.25	.45	.11
OQ Slope	46	-15.06	17.27	-13.73	21.46	.05

*$p < .05$

Table 7

One-Way Analysis of Variance for Internal-External Goal Variable and Number of Sessions, Difficulty, Specificity, Range, and OQ Slope

		Internal		External		
Variable	*N*	*M*	*SD*	*M*	*SD*	*F*
Sessions	39	8.38	6.88	7.62	4.87	.13
Difficulty-Level	46	3.49	.63	3.75	.46	2.20
Specificity-Representation	46	3.55	.85	3.02	.88	4.16*
Temporal Range	46	3.29	.68	3.03	.41	2.08
OQ Slope	46	-17.60	19.61	-9.88	14.47	1.99

*$p < .05$

Table 8

One-Way Analysis of Variance for Goal Type Variable and Number of Sessions, Difficulty, Specificity, Range, and OQ Slope

		1		2		4		5		6		
Variable	*N*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*F*
Sessions	38	9.73	8.60	6.55	2.88	6.38	4.31			10.33	4.16	.98
Difficulty-Level	45	3.57	.59	3.41	.67	3.75	.60	3.63	.18	3.80	.33	.65
Specificity-Representation	45	3.78	.92	3.30	.73	2.67	.75	3.63	.88	3.55	.91	2.71*
Temporal Range	45	3.08	.52	3.52	.78	3.08	.52	3.13	.18	2.95	.33	1.45
OQ Slope	45	-15.15	19.80	-20.21	19.80	-16.72	14.04	-6.50	9.19	-5.10	6.68	.83

*$p < .05$

1 = Affective

2 = Cognitive

4 = Self-Assertive Social Relationship

5 = Integrative Social Relationship

6 = Task

Table 9

Means and Standard Deviations for and Correlations Among OQ Slope and Goal Dimension Variables

Variable	*M*	*SD*	1	2	3	4
1. OQ Slope	-14.75	18.11	–			
2. Difficulty-Level	3.59	.58	.11	–		
3. Specificity-Representation	3.35	.89	-.30*	.27*	–	
4. Temporal Range	3.20	.61	-.17	-.79*	-.17	–

Note. $N = 46$

*$p < .05$

Table 10

Summary of Simultaneous Regression Analysis on Counseling Outcome with Goal Specificity and Difficulty as Predictors

Variable	R^2	Change in R^2	F (2, 43) of change	β	t
Specificity	.13	.09	3.25*	-.36	-2.43*
Difficulty				.21	1.40

*$p < .05$

Table 11

Summary of Hierarchical Regression Analysis on Counseling Outcome with Goal Specificity and Difficulty and Internal-External Goal Type as Predictors

Variable	R^2	Change in R^2	F (3, 45) of change	β	t
Step 1					
Specificity	.13	.13	2.30	-.33*	-2.18*
Difficulty				.18	1.19
Internal-External				.07	.45
Step 2					
Specificity	.24	.11	2.70*	-1.32*	-2.93*
Difficulty				.83	1.85
Internal-External				.37	.36
Internal-External X Specificity				1.39*	2.33*
Internal-External X Difficulty				-1.47	.15

*$p < .05$ *NOTE: In Step 2, ; dimensions were not entered again, but are listed in order to reflect new β values.*

VITA

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