Goals Form
Guidance on use

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The Goals Form is a simple, personalised tool that can be used to set goals in counselling and psychotherapy, and to routinely monitor clients' progress towards them.

Aims of the Measure
The Goals Form was developed as a means of establishing, and tracking, the outcomes of therapy that are important to clients. We wanted to develop a tool that, in contrast to more standardised measures (like the 'CORE-OM' and 'PHQ-9'), allowed clients to say, for themselves, what they wanted to change in therapy; and then to be able to track their progress on these personalised and self-created objectives. The Goals Form is one of a family of *idiographic patient reported outcome measures* (I-PROMs),[1] that are trying to introduce a more empowering and individualised element to routine outcome monitoring.

Therapy Goals
Therapeutic goals can be defined as projected states of affair that clients hope to achieve through participating in therapy. It refers to what clients want to get *out* of therapy (e.g., 'Not worry what others think about me', 'Have close relationships in my life') rather than how they want therapy, itself, to be (e.g., 'Feel valued by the therapist', 'Talk about my problems'). Goals may be specific (e.g., 'I want to lose two stone') or more amorphous (e.g., 'I want to feel better about myself as a person'). It is the direction that clients want to travel in through the therapeutic process.

Some clients (and therapists) do not like the term 'goals'. It may be perceived as being too 'success-oriented', too rigid, or too focused on outcomes rather than the processes of change. Here, it is quite acceptable to use alternate terms for directions in life, such as 'aims', 'wants', or 'hopes'. As always, the priority is to engage with clients in ways that are dialogic, meaningful, and helpful to them.

The Potential Value of Goal Setting and Monitoring
Within the psychological literature, there is robust evidence that people—in general—are more likely to get to their goals if they set, and record their progress, towards them.[2, 3] Within the counselling and psychotherapy field, there is also some evidence that goal setting may have a positive effect on treatment outcomes, and that clients find this a helpful process—including through the use of the Goals Form.[4-7] Additionally, recent research suggests that approximately 60% of clients, and laypeople, would like specific goals to be set in therapy; with 20% not wanting this, and 20% not minding.[8, 9] There is also evidence that agreement between client and therapist on the goals of therapy is associated with positive outcomes.[10]

Within the psychological field, goal setting and monitoring has been hypothesized to enhance outcomes through directing the individual's attention to the identified goal, mobilizing effort, supporting persistence, and motivating people to develop strategies for their attainment.[2] These effects have also been found in the mental health field; with evidence that it may also help to establish realistic expectations of therapy, facilitate insight, provide a safe and predictable

structure for therapy, increase cooperation between therapists and clients, and support clients to see the progress that they are making.[4] In addition, it has been argued that goal oriented practices may increase clients' feelings of hope and empowerment, by 'constructing' them as agentic, intelligible beings, with the potential to act upon their worlds. Goal oriented practices in psychotherapy may also have an ethical imperative.[11] McLeod and Mackrill write:

> [A]voidance of clarification around client goals could be regarded as an ethical breach, as it would make it impossible to know whether the direction and focus of therapy was congruent with the client's views. That is, some kind of explicit checking-out of therapeutic goals is a necessary aspect of respect for client autonomy.

The Potential Limits of Goal Setting and Monitoring

Some clients may find it difficult to formulate goals, particularly at the start of therapy, and may feel 'put on the spot' by being asked to do so.[4] Their self-identified goals may also not match their deeper wants and needs, or may become irrelevant over time. Consistent with this, research has suggested that explicit goal agreement is not necessarily present in the work of experienced, high alliance psychotherapists.[12] This suggests that formal goal setting and monitoring may not be essential to establishing high levels of goal agreement. From a humanistic therapy standpoint, goal oriented practices have also been criticized for reinforcing clients' 'extrinsic' desires—to achieve and 'do'—rather than helping clients to 'be'.[13] In support of this, some clients may feel that they have failed if they do not progress towards their set goals; and others may feel that the concept of goals is too mechanistic or does not fit their way of being.[4]

Goal setting and monitoring, then, may have the potential to be helpful to some clients; but it cannot be assumed that all clients, at all times, will benefit from this. The Goals Form provides a means of offering clients the opportunity to set and monitor their goals, but its value will always be dependent on the preferences and context of the individual client. Research also suggests that goal setting is most helpful when it is done in a collaborative, flexible, and unhurried way, with the therapist guiding and supporting the client through the process.[4]

Setting Goals

Therapy goals can normally be set in a first/assessment session. However, some clients may need longer to identify meaningful goals, such that initial goal setting may not be concluded until a second or third session.

Goals for therapy should be determined by clients, in collaboration with their therapists. The process should be a dialogic and iterative one. For instance, the client may give a rough idea of where they would like to get to, which the therapist then summarises, and the client then adds greater detail and nuance.

It should be explained to clients that any goals can be modified, removed, or added to as the work progresses.

Typically, therapists may start the goal setting process by inviting clients to describe what has brought them to therapy. This process should be given sufficient time (for instance, at least 20 minutes), and it is important that therapists develop a general, holistic sense of what their clients' current concerns are. Asking clients about their life circumstances—e.g., work, relationships and family—as well as some historical background, may help to deepen an

understanding of where the client is 'at', and what they are wanting from therapy. Clients can also be asked more direct questions like:

- 'Where would you like to be by the end of our work together?'
- 'What would you like to get from therapy?'
- 'What are your goals/hopes/wants for the therapeutic process?'
- 'What would you like to change in your life?'

Based on the client's narrative and their answers to the above questions, the therapist can begin to reflect/summarise what the client seems to be wanting from the therapeutic process. For instance, 'It sounds like you want to feel more self-confident, is that right?' Therapist and client can then work together to agree specific wording for goals. Typically, clients will identify about four goals for therapy, [6] though less or more is entirely acceptable if clients show preferences in those directions. In agreeing goals for therapy, the following pointers should be borne in mind:

- ***Clarify.*** Try to establish a *specific* sense of what the goal is. For instance, if a client says they want to be 'happier', you can clarify what that actually means for them (e.g., 'Feel more energy in the mornings'). However, it is important that the goal remains broad enough to be meaningful and important for the client.
- ***Concise***. The wording of the goal should not be more than one sentence long (one or two lines of written text), so that it can fit on the Goals Form and can be easily assessed by the client. For instance, 'Feel able to stand up to my father and tell him what I really think.'
- ***Single goals.*** Try to avoid having too many diverse goals within one goal. Ideally, each goal should represent one main thing, so it is better to separate out diverse goals. For example, 'Feel vibrant' (Goal 1), 'Feel on top of things' (Goal 2), rather than 'Feel vibrant and on top of things'.
- ***'Absolute'.*** Goals should be stated in 'absolute', rather than 'relative', terms. For example 'feel happy' rather than 'feel happ*ier*'; 'feel *good* about myself' rather than 'feel *better* about myself'. This is so that clients do not need to refer back to some reference point when rating.
- ***Approach goals.*** There is some evidence to suggest that it may be better to formulate goals in *approach* terms (something the client wants to achieve) rather than as *avoidance* goals (something the client wants to get away from). [14] For example, 'Feel happy and at ease' rather than 'Feel less sad and tense.'
- ***Intrinsic.*** Research suggests that clients do better when they progress towards personally desired outcomes (e.g., 'Be closer to friends'), rather than the standards and expectations of others (e.g., 'Lose weight to make my boyfriend happy').[15]
- ***Achievable/realistic***. There is some evidence that clients do better when their goals are achievable and realistic, rather than representing unattainably high standards.[7] Larger goals can be broken down into smaller subgoals/substeps.

Once wording is agreed, each goal can be written down on a blank Goals Form (by client or therapist).
For each goal, clients should then be asked to indicate how much they currently feel they have achieved it, by circling a number from 1 (*Not at all achieved*) to 7 (*Completely achieved*). They can also be asked to indicate which of the goals they would most like to prioritise/start working on.

Although research indicates that most clients find it helpful to establish goals, some do not. It is therefore important to discuss with clients, before commencing a goal-setting process, whether they would like to establish goals and/or have them written down and rated on a weekly (or fortnightly, monthly) basis. There may also be times when it is inappropriate or unhelpful to focus on agreeing goals (for instance, if risks issues are present). Clinical issues should always take priority.

Transposing Goals onto a Goals Form

Once sessions are complete, therapists should type up, or, write down clients' goals (without ratings) onto a blank copy of the Goals Form. They should then make some copies of this personalised master form for use in subsequent sessions.

Using the Goals Form

At the start of each session, clients should be presented with their personalised Goals Form, and asked to spend a few moments rating how close they now feel they are to achieving each of their goals.

Clients' responses to the Goals Form may form the starting point for the therapeutic dialogue (for instance, if clients indicate that they have moved towards, or away from, particular goals; or if one goal shows much lower attainment than the others).

Note: clients should not be presented with a blank Goals Form at the start of each session and asked to re-articulate their goals.

A video demonstrating use of the Goals Form is available at https://vimeo.com/210940525 .

Revising Goals on the Goals Form

At any point in the therapy, clients or therapists may suggest that the goals on the Goals Form should be revised to more accurately represent the client's goals for therapy. This may involve the deletion of goals, the addition of goals, or the revision of the wording of goals. Our research suggests that around 40% of goals are introduced at some point during the therapeutic process (i.e., post-assessment).[6] Particular times this may be most likely to happen are:

- When goals are achieved or no longer feel relevant to clients
- At review sessions
- Following completion of the Goals Form, for instance if clients note they are balking at particular goals or feels that something is missing.

The client and therapist should agree revisions to the Goals Form through dialogue. A new master Goals Form of the client's revised personalised goals should then be produced by therapists and copies made before the subsequent session, and this should then be used for following sessions.

Clients are able to revise their goals as frequently as possible. However, for purposes of statistical analysis (and also, potentially, to maintain consistency in the therapeutic work), it is better if the goals stay relatively stable throughout the therapeutic work (e.g., each goal remains active for at least five sessions or so).

Scoring

As clients' goals on the Goals Form may be relatively independent of each other, we generally recommend scoring and tracking goals on an individual basis, rather than focusing on an aggregate session score.[6] At the start of sessions, for instance, clients can be invited to reflect on how achievement on each goal has changed since previous sessions. Simple graphs can also be made (for instance, on Excel) to plot changes in clients' individual goals over time. At the end of therapy, clients can be invited to reflect on which goals have shown improvement, and which have not.

However, for individual- and service-level evaluation, it is also possible to calculate an *aggregate change score* on the Goals Form. This is an indicator of the overall amount of change that clients have shown over the course of therapy. Note, as clients may add, revise, or delete goals over the course of therapy, this aggregate change score is not simply the difference in aggregate (mean) session scores from the start to end of therapy. Rather, to calculate change over the course of therapy, use the following procedure:

- *For each client, calculate the mean score for the goals at first rating* (the mean is the sum score for all of the goals divided by the number of goals). If a goal was established at the assessment meeting, this will be the assessment score; if it was established later on in the therapy, this will be the score at that time point. Note, if goals are modified in any way, even with just small revisions in wording, treat them as new goals.
- *For each client, calculate the mean score for the goals at last rating*. If a goal is active until the end of therapy, this will be the score in the final session. If it is deleted or modified prior to the end of therapy, this will be the last time it was rated.
- *Reliable change*: For each client, calculate the difference between the mean scores at first rating and the mean scores at last rating. If this difference is more than 1.5 points, it indicates that that client has shown *reliable change* in therapy (meaning that their amount of change is unlikely to be due to measurement error).[6]

It is also possible to calculate how much clients are achieving their goals across a service as a whole. You can do this by calculating the percentage of your clients that are showing reliable change on the Goals Form. You can also:

- *Average the mean first score across all clients, and the mean last score across all clients.* The difference between these two scores indicates how much, on average, clients have changed in your service. For evaluation reporting purposes, you can plot these scores on a graph.
- *Calculate an 'effect size' by dividing the mean amount of change (the difference between the average mean first score, and the average mean last score) by the 'standard deviation' of the mean first scores.* An effect size is an indicator of the magnitude of change. An effect size of 0.2 is typically defined as 'small', 0.5 as 'moderate', and 0.8 as 'large'. The standard deviation of the first scores can be calculated using the Excel command 'stdev'. Example: The average of the mean first scores = 2.4, the average of the mean last scores = 4.7, standard deviation of the mean first scores = 1.5, Effect size = (4.7-2.4/1.5) = 1.53).

Although the Goals Form has the potential to be used for service-level evaluation, the evidence for its ability to function in this way is limited. Therefore, we recommend that it is used alongside more standardised evaluation tools, such as the CORE-OM, PHQ-9, or GAD-7.

Psychometric Properties

Our recently published paper—Cooper, M., & Xu, D. (2022). The Goals Form: Reliability, validity, and clinical utility of an idiographic goal-focused measure for routine outcome monitoring in psychotherapy. *Journal of Clinical Psychology*. https://doi.org/10.1002/jclp.23344—provides good evidence that the Goals Form is a reliable and valid tool for routine outcome monitoring in counselling and psychotherapy. In particular:

- There was good 'test–retest correlations' at baseline (r = .71) and endpoint (r = .88), meaning that scores on the Goals Form items were relatively stable over time.
- Scores on the Goals Form showed acceptable levels of 'convergent validity' with other measures of psychological distress and wellbeing. This means that Goal Form scores were associated with—but not entirely overlapping—scores on questionnaires like the CORE-OM measure of psychological distress and the PHQ-9 measure of depression (r = -.14 to -.68 at baseline). This association between measures existed both across clients, and within clients (i.e., from session to session for the same client).
- Scores on the Goal Form showed sensitivity to the therapeutic intervention: increasing as therapy progressed (by approximately 0.12 points per session)

Frequently Asked Questions (FAQs)

What happens if my client does not want to set goals?

As indicated above, prior to any goal setting, clients should be asked if they think they might find it helpful, or not, to set goals, and monitor their goal progress on a regular basis. If clients indicate that they do not want to do this, the Goals Form should not be used.

What happens if clients say they cannot think of any goals?

It is always worth asking this question in a range of different ways, as above. For instance, 'Where would you like to get to by the end of therapy?' or 'What would you like from our work together?' The assumption, here, is that clients are intelligible beings who have come to therapy for a reason, and that therapists can help them reflect on—and articulate—what those reasons are. However, if clients continue to indicate that they do not know what they want from the work, it may be best to leave this question and come back to it at a later date.

Who should write the goals down?

The ideal is probably that this is done by the client, so that they have most ownership over the goals. However, it is fine if this is done by the therapist, provided that the client agrees to the wording of the goal.

Is it ok to use the Goals Form alongside a more standardised symptom-rating measure, like the CORE-10?

Yes. Both measures are quite brief and measure somewhat different things, so they can work well in tandem.

How often should I use the Goals Form?

Probably the most important thing is to get into a routine in how you use the Goals Form, so that it is completed on a regular basis and does not become burdensome to remember. Weekly, or sessional, use is quite common and acceptable to many clients. However, for some clients this may be too frequent, and it may be more appropriate to use the Goals Form at fortnightly

or monthly intervals, or at review points in the work. Ideally, this is something that should be discussed with clients to see how frequently they, themselves, would like to use the form.

What happens if a goal become redundant?
A client can delete this goal from their Goals Form.

Should I comment on a client's goal progress, as indicated on their Goals Form?
This may not be relevant each week, but clients' ratings of goal progress can certainly be drawn on in the therapeutic work: for instance, if a client is showing steady progress towards a particular goal, or is struggling to achieve a particular desired outcome.

Is it ok for clients to talk about things in sessions that are not related to their goals?
Of course. The Goals Form provides only a rough guide to what clients want to work on, and is not intended to cover every issue and eventuality. If clients come to therapy with pressing issues that are not represented on their Goals Form, it is entirely acceptable for them to make these the focus for the session. However, if these new issues continue to remain focal to the therapeutic work, it may be appropriate to add to, or revise, the explicitly recorded goals.

Permission

Cooper, M., & Xu, D. (2022). The Goals Form: Reliability, validity, and clinical utility of an idiographic goal-focused measure for routine outcome monitoring in psychotherapy. *Journal of Clinical Psychology*. https://doi.org/10.1002/jclp.23344

You can also reference the original source:

Cooper, M. (2014). Strathclyde pluralistic protocol. London: University of Strathclyde. See www.pluralistictherapy.com

Further Reading

Cooper, M. (2019). *Integrating counselling and psychotherapy: Directionality, synergy, and social change*. Sage. This sets out the philosophical and psychological principles on which the use of the Goals Form is based. Chapter 14 specifically covers goal-based practices.

Cooper, M., & Law, D. (Eds.). (2018). *Working with goals in counselling and psychotherapy*. Oxford: Oxford University. A range of practical, theoretical, and empirical chapters on goal oriented practices in counselling and psychotherapy.

Cooper, M., & Xu, D. (2022). The Goals Form: Reliability, validity, and clinical utility of an idiographic goal-focused measure for routine outcome monitoring in psychotherapy.

Journal of Clinical Psychology. https://doi.org/10.1002/jclp.23344 This is the key paper providing the empirical evidence for the reliability and validity of the Goals Form.

Sales, C. et al. (2022). Idiographic patient reported outcome measures (I-PROMs) for routine outcome monitoring in psychological therapies: A position paper. *Journal of Clinical Psychology*. https://doi.org/10.1002/jclp.23319 Sets out the rationale for use of individualised outcome measures, and discusses their strengths and challenges.

References

[1]Sales C, Ashworth M, et al. Idiographic patient reported outcome measures (I-PROMs) for routine outcome monitoring in psychological therapies: A position paper. *Journal of Clinical Psychology*. 2022.

[2]Locke EA, Latham GP. Building a practically useful theory of goal setting and task motivation - A 35-year odyssey. *American Psychologist*. 2002;57(9):705-17.

[3]Cooper M. The psychology of goals: A practice-friendly review. In: Cooper M, Law D, editors. *Working with goals in counselling and psychotherapy*. Oxford: Oxford University; 2018. p. 35-71.

[4]Di Malta GS, Oddli HW, et al. From intention to action: A mixed methods study of clients' experiences of goal-oriented practices. *Journal of Clinical Psychology*. 2019;75(10):1770-89.

[5]Lloyd C, Duncan C, et al. Goal Measures for psychotherapy: A systematic review of self-report, idiographic instruments. *Clinical Psychology: Science and Practice*. 2019;26(3).

[6]Cooper M, Xu D. The Goals Form: Reliability, validity, and clinical utility of an idiographic goal-focused measure for routine outcome monitoring in psychotherapy. *Journal of Clinical Psychology*. 2022.

[7]Cooper M. *Integrating counselling and psychotherapy: Directionality, synergy, and social change*. London: Sage; 2019.

[8]Cooper M, Norcross JC, et al. Psychotherapy preferences of laypersons and mental health professionals: Whose therapy is it? *Psychotherapy*. 2019;56:205-16.

[9]Cooper M, van Rijn B, et al. Activity preferences in psychotherapy: what do patients want and how does this relate to outcomes and alliance? *Counselling Psychology Quarterly*. 2021.

[10]Tryon GS, Birch SE, et al. Meta-analyses of the relation of goal consensus and collaboration to psychotherapy outcome. *Psychotherapy*. 2018;55(4):372-82.

[11]McLeod J, Mackrill T. Philosophical, conceptual, and ethical perspectives on working with goals in therapy. In: Cooper M, Law D, editors. *Working with goals in counselling and psychotherapy*. Oxford: Oxford University; 2018. p. 15-34.

[12]Oddli HW, McLeod J, et al. Strategies used by experienced therapists to explore client goals in early sessions of psychotherapy. *European Journal of Psychotherapy & Counselling*. 2014;16(3):245-66.

[13]Grey N, Byrne S, et al. Goal-oriented practice across therapies. In: Law D, Cooper M, editors. *Working with goals in counselling and psychotherapy*. Oxford: Oxford University; 2018. p. 181-203.

[14]Elliot AJ, Church MA. Client articulated avoidance goals in the therapy context. *Journal of Counseling Psychology*. 2002;49(2):243-54.

[15]Kasser T, Ryan RM. Further examining the American dream: Differential correlates of intrinsic and extrinsic goals. *Personality and Social Psychology Bulletin*. 1996;22(3):280-7.

Client code:	Therapist:	Date:	Session:

Goals Form

Goal 1:						
Not at all achieved						Completely achieved
1	2	3	4	5	6	7

Goal 2:						
Not at all achieved						Completely achieved
1	2	3	4	5	6	7

Goal 3:						
Not at all achieved						Completely achieved
1	2	3	4	5	6	7

Goal 4:						
Not at all achieved						Completely achieved
1	2	3	4	5	6	7

Goal 5:						
Not at all achieved						Completely achieved
1	2	3	4	5	6	7