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GRADUATE COLLEGE

EFFECTS OF GOAL ATTAINMENT SCALING AS AN ADJUNCT TO COUNSELING

A DISSERTATION

SUBMITTED TO THE GRADUATE FACULTY

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DAVID LEE SMITH

Norman, Oklahoma

1974

EFFECTS OF GOAL ATTAINMENT SCALING

AS AN ADJUNCT TO COUNSELING

APPROVED BY

DISSERTATION COMMITTEE

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TABLE OF CONTENTS

ABSTRACT

The profession of counseling psychology faces a need for accountability and evaluation as do the other helping professions. Kiresuk & Sherman (1968) have proposed a method of evaluating programs and counseling which appears to combine theoretical approaches that may be beneficial to the counseling process itself. This study hypothesized that counseling with the Goal Attainment Scaling (GAS) evaluation procedures would improve the conduct of counseling. The Shostrom Personal Orientation Inventory (POI), Nowicki & Strickland Children's Locus of Control scale (CNS-IE), a Consumer Satisfaction Questionnaire (CSQ), and behavioral measures were used to assess outcome. Results were in the hypothesized direction and significant. Several points are discussed which may have affected these findings.

EFFECTS OF GOAL ATTAINMENT SCALING AS AN ADJUNCT TO COUNSELING

It is quite probable that one of the more crucial issues to be faced by counseling psychologists, as well as others in the helping professions, is the issue of accountability. Accountability and its component, evaluation, have become increasingly debated, required, and resisted topics (Salasin, 1972). While Eysenck's article in 1952 is often cited as the beginning point for effective evaluation within the profession of psychology (Pascal & Zax, 1956), more recently the consumer demand for effective evaluation and accountability has become a prime source of evaluation motivation (Nader Report, 1972).

In an effort to improve the evaluation and accountability of psychotherapy, Kiresuk & Sherman (1968) have proposed a method termed Goal Attainment Scaling (GAS). This method calls for the development between client and counselor of a written follow-up guide, specifying each problem area or concern for which the client wishes assistance. Under each concern is listed behavioral expectations ranging from the worst possible outcome, through expected outcome, to the best possible outcome. At a specified point in time the client is contacted and asked what his behavior is regarding each of the problem areas originally presented. From this information a GAS score is computed which indicates in a quantifiable way, qualitative data regarding the success of this client in achieving his expectations of personal change through counseling.

The use of this method as an evaluation tool also seems to embody several benefits to the counseling process. Krumboltz (1966) emphasized the importance of setting behavioral goals. However, research by Brill, Koegler, Epstein, & Forgy (1964) found a great disparity between goals of counselors and goals of the client. Thompson & Zimmerman's (1969) data suggest counseling would be enhanced if goals were mutually determined.

Goldstein (1962) found a curvilinear relationship between client expectations and success, the client with moderate prognostic expectations showing the greatest change through counseling. Several authors have developed methods to assist clients and counselors in clarifying expectations of counseling (reported in Strupp & Bloxom, 1973), so that more effective counseling might be done.

The GAS approach appears to combine the theoretically beneficial aspects of: (1) behavioral criteria, (2) mutually defined goals, (3) meaningfulness of communication, (4) clear expectations, and (5) continuous, mutual feedback. Therefore, its use should improve the outcome of counseling. While the thrust of research effort on GAS has been to determine its usefulness as an evaluation tool, the present study will focus on its value as an adjunct to counseling. This focus is made in the hopes that evaluation procedures such as GAS may be seen as an asset not only to a program evaluator but to the counselor and his client. Rather than being seen as an annoying intrusion into the counseling hour, it would be preferable for evaluation to be seen as a vital part of the counseling process.

This study investigates the influence of using the GAS procedure in specified counseling situations and comparing this to similar counseling situations that do not use GAS.

Method

Subjects

The subjects (N=25) were suburban, white adolescents within the age range 13–17. (Mean age for experimental group was 14.5; control group was 14.7). They were assigned to counselors on a first available basis following normal agency procedures. Only newly referred, non-psychotic adolescents experiencing adjustment problems related to school and/or home, and those adolescents referred by police for pre-delinquent acts were included in the sample. The sample chosen for this study was determined to be representative of a majority of cases seen by the three junior high schools, three child guidance centers, and three youth/family service agencies participating in this study. Agencies were chosen which provided service on a gratis basis or with a low, sliding fee scale.

Counselors

Counselors (N=23) were volunteers, representing the following professions and levels: social work (5), master's level guidance and counseling (8), master's level psychology (8), (clinical, child, etc.), doctoral level psychology (2). The average level of experience was two years and ranged

from practicum to six years. Counselors were paired according to their profession, years of experience, and self-ratings on the Therapist Orientation Sheet (Paul, 1966). They were randomly assigned to experimental or control groups.

Counselor Training - Control Group

Counselors were aware they were part of an experiment, and that other members of the same agency could be counseling differently for this study. Those in the control group were told the study had to do with "counselor orientation and outcome". They were instructed to conduct sessions as usual but to note the client's reaction to their style (active, passive, interpreting, and role-playing) and sex-role comments. ("You'd feel that way because you're a man/woman"). They were to note this reaction in a process note form. The author met with each control counselor twice on a bi-weekly basis. Sessions were placebo type contacts.

Counselor Training - Experimental Group

Counselors in this group were trained in the technique of developing the goal attainment follow-up guide following the format "Guide to Goals" published by the Program Evaluation Project. They were instructed to develop the guide within the first two interviews. The author met with experimental counselors twice on a bi-weekly basis discussing only how to write behavioral objectives, not how to conduct counseling. Counselors were instructed to refer to the GAS guides three times during each client session. At the beginning, note was made of where the client was that day

on each of the concerns listed. At the mid-point of the session, or when it was felt to be appropriate for focusing reference was again made. At the end of the session reference to the guide was made to consolidate gains. By consulting with the counselors the author sought to insure that appropriate, realistic behavioral goals would be set, and that counseling would be done as the study had been designed (Aspy, 1972).

Instruments

Personal Orientation Inventory. The POI is a 150 item two-choice comparative value judgment scale, purporting to measure self-actualization or positive mental health (Knapp, 1971). Knapp further reports that "as therapy progresses, pathology as measured by the MMPI decreases and health as measured by the POI, increases [p. 301]." Although there has been some concern over the fakability of the POI (Rowe, 1973), other evidence seems to indicate that the POI is rather resistant to faking (Braun & LaFaro, 1969; Foulds & Warehime, 1971). The inclusion of an instrument such as the POI, which taps growth and positive mental health aspects of an individual, appears to be an appropriate match to symptom reduction such as the GAS purports to measure.

Locus of control scale. The locus of control dimension was measured by the Nowicki & Strickland (1973) children's locus of control scale (CNS-IE). The value and use of the Internal-External (IE) or locus of control assessment has been amply reviewed by several authors (Joe, 1971). The use of this particular IE scale is recommended due to its improvements over the

original Rotter scale. It is non-related to social desirability or intelligence test scores, has a more appropriate reading level and little confounding of personal and ideological causation (Nowicki & Duke, 1972).

Outcome Assessment Sheet. The OAS was developed by the author. It is used to provide behavioral criteria for determining change as a result of counseling. It is in essence the "expected outcome" portion of the GAS follow-up guide. The interviewer asks the client what the areas are that bring him to counseling. He is asked what he expects, in behavioral terms, to be different in each area of concern, after eight sessions of counseling. The client's present level of functioning is also recorded. At follow-up, the client is asked what his behavior is in each of the original concern areas. If his level of behavior is not on the expected level the client is asked to place the behavior in one of four remaining categories: worse, much worse, better, much better. This five point scale is then scored in the same manner as the GAS follow-up guide.

Consumer Satisfaction Questionnaire. The CSQ used in this study is a ten question form administered verbally to the client. The basic seven question form was developed by the Program Evaluation Project (501 Park Ave. So., Minneapolis, Minnesota 55415). As used in this study the form additionally asks three questions: (1) specific things the counselor did (technique or approach) that was helpful to the client in solving problems, (2) if anything outside of the counseling sessions helped in resolving problems, and (3) which was the most helpful, counseling or outside events.

Procedure

After assignment to experimental or control group, the counselor was asked to accept for counseling the first client, fitting the design of the study, referred to him. Prior to the first visit with the counselor the client was seen by one of three trained interviewers who administered the POI, CNS-IE, and OAS. Clients were seen in individual counseling for eight sessions over a four week period. At the end of the agreed upon eight sessions, clients were again administered the POI, CNS-IE, OAS, and the CSQ.

Each S that dropped out prior to completion of five sessions was followed-up and included in the comparison group. Five dropped out: one from the experimental group, four from the control. Three were available and/or agreed to follow-up testing.

Results

For experimental and control groups, t tests were computed comparing each group, between each group (pre-pre, post-post) and over gain scores (recognizing the caution to be exercised in utilizing gain scores, Cronbach & Furby, 1970). Table 1 shows means and standard deviations. The obtained t values will be discussed for each dependent variable. The assumption of initial similarity of groups was held except in the Inner-directed scale of the POI ($t = 1.91$ $p < .05$). All t tests were one tailed, with $df = 9$, and degree

of relationship (ω^2.) predetermined to be .30 at the .05 alpha level.

Due to the small number of comparison group subjects available for follow-up and the inclusion of unmatched counselor/client pairs in this group, direct interpretation from this group is inappropriate. Scores are shown for comparison purposes only.

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Personal Orientation Inventory

Time Competence scale. Experimental S's made significantly greater gains toward improved time competence ($t = -3.48$, $p < .005$) than did controls when compared on the basis of gain scores. Within the experimental group, pre-post scores were also significant ($t = 3.62$, $p < .005$). Post scores were not significantly different but reflected a negative move in the control group. While the control group did not change from pre to post significantly, the experimental group changed positively and significantly ($t = -1.74$, $p < .05$).

Inner Directed scale. Caution must be exercised in interpreting the results of scores for this scale. Reference to Table 1 will show that at pre-testing the experimental and control groups were significantly different from each other ($t = 1.91$, $p < .05$) with the control group higher and pushing the top of the non-self-actualized range as given by Shostrom (1966), and about one standard deviation above the mean for normative

high school S's. Following counseling, the experimental group made significantly higher scores ($t = 3.92$, $p < .005$), but with their mean below the pretest mean of the control group. The controls also made significant gains over pretest scores ($t = 2.87$, $p < .01$). When gain scores were compared the experimental group change was significantly greater ($t = -2.54$, $p < .05$). Variability was also increased in this group, while the control group showed slightly less variability after treatment.

Locus of Control

Changes toward increased internality in the experimental group were significant ($t = -5.84$, $p. < .0005$), as were changes between groups comparing gain scores ($t = 3.52$, $p < .005$), again with the experimental group making greater changes toward internality than the control group. Variability was slightly decreased for this group while the control group showed an increase. The nonsignificant finding comparing post scores can partially be explained by observation of means in Table 1. While the experimental group made significant moves toward internality, the control group moved very little, remaining almost in the center of the experimental range of scores.

Outcome Assessment Sheet

Outcome scores were computed by the procedures outlined in Baxter (1973, Available from Program Evaluation Project.) for goal attainment scaling grids with equally weighted scales. The experimental group attained a significantly higher score ($t = 2.12$, $p < .05$) than the controls.

This indicates that they were slightly more successful in reaching their expectations of counseling. No significant counselor profession difference was found in outcome scores.

Consumer Satisfaction Questionnaire

Level of consumer satisfaction was determined by scoring the three five point scales contained in the instrument (lowest total score possible was 3, highest 15). The experimental group scored significantly higher ($t = 3.63$, $p < .005$) than the controls.

In addition to the three scored items, five questions were asked which were designed to contribute more specific information about how the client perceived his counseling experience. These questions, as a whole, indicated clients attributed their change due to counseling more often under the experimental treatment than the control.

Correlation between IE and I scales

Based upon definitions advanced, it was hypothesized that there should be a high negative relationship between the Inner-directed (I) scale of the POI and the CNS-IE scale. Results were in the negative direction and substantial but only one of the four r's reached significance.

Discussion

This study examined the effect the addition of Goal Attainment Scaling evaluation format would have upon the level of outcome of a time limit-

ed counseling situation. Since GAS seemingly embodies significant aspects from several counseling theories, it was reasoned that use of this method would improve the level of outcome over a control condition. The results of this study strongly suggest this to be correct. However, certain limitations should be pointed out.

There is the possibility a bias or set was communicated to the counselors concerning the merit of their particular task (ie., experimental is important, control is not important.) While this Rosenthal-like effect was anticipated and its effect controlled through use of programmed materials, control task assignment, and equal contact by author with both groups, it may still have influenced the counselors to some extent.

Also, the question arises as to what it is that we really are testing. Are we testing the effects of a clearly defined (expectations clarified) structure against a more ambiguous or no-structure situation? Is the issue really technique (theoretical position) or is it more realistically clarity versus ambiguity? The results of this study as well as much of the current outcome studies published, (Archer & Kagan, 1973) when taken together may suggest it is the relative level of structure/organization and clarity of the treatment program that is a significant variable influencing the outcome - a variable possibly as important as the experimental technique itself. Brown (1973), in his recent study of expectancy manipulation in the systematic desensitization procedures, sought to analyze the effect structure (in this case progressive, positive feedback) had on outcome.

Although his hypothesis that a "major portion of the effect of systematic desenitization could be accounted for by the progressive nature of the feedback...[p. 409]" was not supported, it did point up the fact that it was a significant underlying variable.

Another question or concern of legitimate interest has to do with the use of goal attainment scaling in this design. Although GAS seems to embody several theoretically valuable aspects, this study does nothing to assist the researcher in teasing out the most crucial variables causing change in the client. This criticism is valid. However, it was the intention of the study to call attention to the fact that an evaluation tool such as GAS may also have therapeutic benefit.

In addition to these factors which may have affected the outcome of this study two sources of possible gain through use of GAS were noted. In that fewer experimental group S's dropped out (1 Experimental vs. 4 Control), it is possible that the procedures involved in development of GAS and its use early in the counseling process may act to keep clients in counseling. In this study GAS grids were developed mutually by the counselor and client within the first two sessions. This may have served to more clearly align client expectations and counselor direction preventing misunderstanding of what was to take place in counseling. As noted earlier, Strupp & Bloxom (1973) briefly reported on their work and others in attempting to clarify expectations of counseling experience. All of these efforts reported speak to the clarification of expectations about counseling, an

aspect which GAS seeks to make explicit. Following this reasoning, it was noted nearly half ot the S's complained to some degree about the pre-testing (testing in general), while all dropouts contacted indicated it was one reason they didn't continue. It is therefore possible that more of the clients in the experimental group felt building the GAS grid offset some of the negative experience of the testing. In effect this made more clear the area in which counseling was to take place and may have forestalled their early termination. Information beyond this was not elicited in the post interviews. The extent to which the GAS grid serves as a mini "anticipatory socialization interview" or functions much as "vicarious therapy pretraining" is worth investigating further.

Secondly, an effect which has been noted elsewhere was also noted in this study. Meldman, Ullman & Squire (1973, Available from Program Evaluation Project), reported that the feedback of GAS scoring to adolescent inpatients assisted them in becoming more responsible for working on the problems which brought them into hospitalization. While the adolescents did not assist in the scoring, they did seem to profit from feedback from the staff who rated them. In the present study it was noted by several experimental group counselors that their clients seemed to become more quickly aware of their personal responsibility in the counseling process through use of the GAS method. Even when the client was resistive he seemed to accept responsibility for not wanting to work on the concerns he initially presented. It appeared to them that the GAS procedures contributed to a

better counseling relationship.

In summary, Goal Attainment Scaling, as used in this study, appears to provide significant benefit to the counseling process itself, in addition to its established benefit as an evaluation tool. Perhaps the thing which counselors in the field resist so strongly--evaluation--can become an asset to the counseling process. It may well be that the very thing boards of directors, school boards, and city councilmen are asking for, need not impede the counseling process but may improve it.

TABLE I

Means and Standard Deviations by Group

Scale	Experimental (N=10)			Control (N=10)			Comparison	
	Pre	Post	Change	Pre	Post	Change	Pre (N=5)	Post (N=3)
POI-TC								
Mean	12.70	14.60	+1.90	13.30	12.50	- .80	12.40	9.33
S D	2.83	2.17	1.65	2.83	3.34	1.86	1.52	.57
POI-I								
Mean	73.00	79.40	+6.40	82.00	83.30	+1.30	77.80	63.66
S D	2.85	6.92	5.12	11.94	10.94	1.65	6.46	10.41
IE								
Mean	14.50	10.90	-3.60	13.10	13.00	- .10	12.00	17.33
S D	3.44	2.84	2.00	3.04	4.11	5.00	3.74	4.16
OAS								
Mean		52.56			47.05			30.26
S D		5.91			5.05			2.67
CSQ								
Mean		12.80			10.50			7.33
S D		1.03			2.50			1.15

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APPENDIX A

PROSPECTUS

Introduction

Purpose. The purpose of this study will be to examine a technique of evaluation, Goal Attainment Scaling (GAS, Kiresuk, 1968), to determine if its use improves to any significant degree the outcome of counseling. This study addresses two separate but related parts of the counseling process: (1) the conduct of counseling and (2) the evaluation of counseling.

Related literature and theoretical rationale: Evaluation. It is quite probable that the most critical problem facing the helping professions of the 70's and facing those practicing Counseling Psychology, in particular, is that of accountability. Accountability and its counterpart, evaluation, have become increasingly important parts of any program and now even extend into private practice sectors, long immune from public scrutiny.

Starting effectively with Eysenck's article in 1952, the demand for evaluation has grown (Pascal & Pax, 1956). This consumer and professional demand has been felt most directly as a response to the growth of the Encounter/Sensitivity movement (Yalom, 1972), Consumerism (Nader Report, 1972), Family Therapy (Parsons & Alexander, 1973), and the Behavioral Therapies (Franks, 1969). While the number of articles and books concerning evaluation has increased dramatically, it is questioned by many whether the quality of the evaluation has increased proportionately (Guy & Gross, 1967; Meltzoff & Kornreich, 1970; Zusman & Ross, 1969) or has improved the theoretical understandings of the science of psychology (Rotter, 1973).

Of the two types of evaluation studies seen --outcome and process-- several authors (Schulberg & Baker, 1968; Zusman & Ross, 1969), recognize the necessity for more effective outcome evaluation, while noting that this type of evaluation has been the most difficult. While process evaluation has been amply and increasingly more professionally reported in the literature, it will not be the focus here. It is in the realistic specification of level of outcome that practitioners and researchers have been faced with extreme difficulties.

Guy & Gross (1967), state:

> Treatment results are reported simply as percent improved with no reference to criteria of improvement. Success rates reported by one author cannot be compared with another as, neither the population, the treatment program, nor the methods of assessment are identified with adequate precision [p. 112].

To compound the problem much of the evaluation of treatment has been undertaken by those who had performed the treatment. McPartland & Richart (1966) are concerned with what they call "intramural" evaluation where pre and post clinical tests are administered, but no evaluation of the parient's life situation is made following discharge. Paul (1967) sums up several authors' position on outcome criteria with:

> Irrespective of any theoretical position, the real question of outcome on logical and ethical grounds is whether or not the clients have received the help with the distressing behaviors which brought them to treatment in the first place [p. 112].

Zax & Klein (1960) point out in an early but significant article that the least used but most promising criteria are behavioral criteria.

Related Literature and Theoretical Rationale: Behavioral Criteria.

While the mention of goals in psychotherapy is common, the discussion is most often concerned with what goals the therapist should have for a specific client (Hill, 1969; Liberman, 1970), or the disparity between goals of the therapist and goals of the client (Brill, Koegler, Epstein & Forgy, 1964). Thompson & Zimmerman (1969) in asking "Goals of Counseling: Whose? When?" found, ". a marked discrepancy between the goals of clients and of counselors, ... [p. 121]." Brill et al., in their longterm study of drug and psychotherapy effects found a discrepancy between patients' and families' ratings of goals and improvement and therapist ratings. The therapists rated improvement lower than patients and families. Ravensborg & Reyerson (1970) reported hospital social workers ascribed less importance to patient behaviors as discharge criteria than did other groups, (judges, sheriffs, relatives). Feifel & Eells (1963) analyzed the perceptions of both patients and their psychotherapists at the close of therapy. Their findings were:

> (a) therapists stressed changes in symptomatic relief and improvement in social relationships, whereas patients focused on self-understanding and self-confidence; (b) patients underlined the opportunity to talk over problems and the 'Human' characteristics of the psychotherapist as helpful and the therapists highlighted therapeutic technique and support to the patient as most beneficial; (c) expectancy and conceptual disparities about therapy between patient and therapist should be minded to maximize treatment benefits [p.310].

Hill (1969) reported that it was the "therapist's goal-setting behavior rather than the patient's intention which had a greater influence in deter-

mining what the patient reported receiving from therapy [p. 458]." Polak (1970) concludes:

> communication, understanding, and ultimate agreement between patients, clinicians, and community members about goals of treatment are essential to the formulation and assessment of any effective treatment program. The evidence suggests that such communication, understanding, and agreement do not presently exist in psychiatric hospitals [p. 283].

Beck (1966) in his discussion of communication and psychotherapy cites Birdwhistell's comment that successful therapy has comething to do with communication and, in knowing that, efforts should be made to make the communication more explicit. It is to this task that Schulman, Kasper & Berger (1964) spoke:

> The technique of goal setting has a number of concrete advantages. This process provides the therapist and his patient with an opportunity to arrive at an agreement to discuss areas of the patient's life which both believe to be important, and which the therapist believes will lead to productive exploration of basic conflicts in the patient's life. It defines the purpose of the conversations which constitute therapy and assists the patient in overcoming his initial confusion about his role in therapy, confusion which interacts with and can be mistaken for resistance. It forces the therapist to become aware of and deal with the patient's purposes in entering therapy. It demonstrates to the patient the therapist's conviction that the patient's decisions and impetus are essential to the success of the therapeutic undertaking. It can serve as a bridge between the therapist's dynamic understanding of his patient and the subsequent formulation of strategies of behavior which will serve to guide the therapist in the therapeutic interaction. Finally, explicit goal setting can lead to recognition of a variety of circumstances which tend to put limitations and constraints on the therapy plan [p. 55].

Rickard (1965), Zax & Klein (1960)& Zubin (1964) both in criticism of

phenomenological measures and intratherapy measures, alone, point out that changes must be tied to the client's life experiences outside the clinic; that the comfortable, appropriate daily functioning of the client in his specific life space must be the treatment goal. Krumboltz (1966) states that:

> The use of behavioral goals would result in (a) a clearer anticipation of what counseling could accomplish, (b) a better integration of Counseling Psychology with the mainstream of psychological theory and research, (c) a facilitation of the search for new and more effective techniques for helping clients and (d) the use of different criteria for assessing the outcomes of counseling with different clients [p. 153].

He further states that self-understanding and self-acceptance as goals for clients may not be as helpful in their changing overt behavior and cites Brayfield (1962) in his argument that "counseling psychologists had placed undue emphasis on egocentric self-regarding internal states and should instead use a performance criterion which would stress dependability, accountability, obligation and responsibility [p. 153]." Pascal & Zax (1956) sought to use the client's prior behavior and personal goals as a baseline to determine the effect of therapy. Krumboltz (1966) cites an article by Brayfield as anticipating his own position when Brayfield stated, "it remains now for someone to suggest that the counselee set the goals and that evaluation be undertaken in that context [p. 157]." After all, as Weiss & Schaie (1964) note in their study of the assessment problem in psychotherapy research, the presenting complaints of patients were the most obvious and objective measures of their problems. It does

not seem a too strange leap of logic to ask the client to set some degree of goal as to how he would like to feel or behave if he were to be rid of his problems. Ernst Ticho (1971), representing the psychoanalytic school of therapy, feels treatment goals--goals which are concerned with the removal of obstacles to the realization of potentialities--should be discussed with the client at the beginning of analysis and repeatedly throughout the analysis. Magraw (1958) states:

> In my experience problems in diagnosis and treatment have been traceable repeatedly to the fact that about as often as not we physicians do not get this basic understanding of exactly how the patient is 'hurting', and thus we do not exploit the potentialities for improved diagnosis and care that lie embedded in the presenting complaint. [p. 329]. So far I have regarded the patient's presenting complaint simply as a signpost in diagnosis. Now I should like to suggest that what is bothering the patient does more than point to what the patient has. In a very real sense it is what he has. It is the diagnosis..The patient, on the other hand, thinks of his symptoms as the disease: indeed the very word 'dis-ease' indicates that that was the original meaning. We regard the patient's symptoms as subjective and inexact and not really what is wrong, and we try to fit them into exact disease patterns. Because of our long familiarity with the concepts of diseases and because they are very helpful generally, we forget that they are essentially theoretical models, artifacts that we have introduced to give us some direction in working with complicated phenomena [p. 335].

Dulit & Magraw (1958), in a follow-up to the above theoretical position, conducted a study to determine how often the chief complaint of patients went undetermined. They found the frequency high and finally determined that, "Understanding this complaint, which at first we regarded as a signpost, seems, on closer examination, to appear more and more as the

goal [p. 340]." Battle, Imber, Hoehn - Saric, Stone, Nash & Frank (1966), summarizing their study dealing with target complaints as criterion for success in therapy felt, "Target complaints certainly do not present an ideal outcome measure but, at present, they seem to be more promising than many other outcome measures [p. 192]."

At this point, the Gould, Paulson & Daniels - Epps (1970) study is relevant to our concern. They found that people who 'no show' at psychiatric clinics were not doing so out of social class reasons or subcultural style but due to, "poor definition of the problem at the time of contact [p. 171]." It would thus appear that behavioral goals then can serve both to evaluate the therapy and to make it more clear and meaningful to the client.

Related Literature and Theoretical Rationale: Meaningfulness to Communication. The use of behavioral goals which are arrived at by client and therapist working together may then serve a function not ordinarily considered--clarification of personal constructs of meaning--(Kelly, 1955). Landfield & Nawas (1964) wishing to test aspects of this theoretical position explored two hypothesis:

> (1) A minimal degree of communication between client and therapist within the client's language dimensions, is essential for improvement in psychotherapy. (2) Improvement in psychotherapy is accompanied by a shift in the present-self of the client toward the ideal of the therapist as described within the framework of the client's language dimensions [p. 336].

The results of their study supported the hypotheses. What it means to

this study is that there must be a minimal commonality of perspective, and that the convergence prerequisite must be within the client's own language dimensions rather than those of the therapist. In this same vein, Cromwell & Caldwell (1962), again using Kelly's theory of personal constructs, found that individuals rate their own personal constructs more extremely than the personal constructs of others. The relationship this finding has to the therapeutic hour was examined by Landfield (1965). The findings were that "clients at the beginning of therapy will find their own personal language dimensions more meaningful than those of the therapist... [p. 605]." Weigel & Weigel (1969) in examining this phenomenon as it related to self-concept measurement found that items of high personal meaningfulness were rated more extremely than items of low meaningfulness. They comment:

> Observed differences between individuals' scores may reflect the number of personally meaningful items (personal constructs) for each individual rather than true differences in characteristics the instrument is designed to measure [p. 413].

Ourth & Landfield (1965), in examining meaningfulness and termination in therapy, found that two of three predictions made in the study would not have been supported, had they not weighed the scores according to the rater's personal constructs. They conclude:

> How many studies utilizing the experimenter's own language preferences rather than the subject's language have failed to support hypotheses simply because rating items either do not communicate or do not communicate in relationship to subject individuality [p. 371].

But it is not just in the practice of psychotherapy that communication be-

comes a critical factor. The field of education also has increasingly become aware of the necessity for improved communication.

Related Literature and Theoretical Rationale: Education and Behavioral Goals. In actuality the use of behavioral objectives in specifying educational unit content is more common than it is in the literature associated with the practice of counseling (Walbesser & Eisenberg, 1972). Studies (Dalis (1970), Olsen & Lookard (1972), Robertson (1971) & Webb (1972)) have shown that students perform better academically when behavioral objectives are arrived at for the unit as a joint teacher-student effort; student behavior is more classroom appropriate; and retention of the subject matter is improved. Criticism of behavioral objectives has been that it may lead to a dehumanizing product/output orientation and to the use of preconceived learning objectives. Both points are relevant to counseling psychology, have arisen in connection with the behavior therapies in particular (Franks, 1969), but might also be leveled at traditional methods of medicine (Magraw, 1958) and psychotherapy (Krumboltz, 1966). The importance of and difficulty in stating clear, realistic behavioral objectives was commented on by Ammons (1962), Baker (1969), and Comerford & Fleury (1972). In particular, Baker found teachers could not distinguish between behavioral and nonbehavioral objectives. Findings of this nature have lead to a proliferation of 'how to' books and articles, the classic being Mager (1962) and recent adaptions, such as pamphlets published by various state educational associations. All are designed to insure that the teacher knows, at the cognitive level at least, what it is that

he is supposed to be doing. The difficulty of insuring that good behavioral objectives will be used is of crucial importance, as Aspy's (1972) study regarding knowledge of learning theory and actual classroom behavior suggests. In his study, Aspy found little correlation between teacher knowledge of learning theory and actual classroom behavior.

Related Literature and Theoretical Rationale: Goal Attainment Scaling. In an effort to improve the evaluation of psychotherapy, Kiresuk (1968) has proposed a method (Goal Attainment Scaling, GAS) which appears to combine the better features of each of the above mentioned areas--behavioral criteria, agreed upon goals, meaningfulness--into an evaluation package with multiple applications. The potential for this method was recognized by the National Institute of Mental Health, and in 1969 it funded the Program Evaluation Project for a four year period. The main value recognized was that it:

> proposed a study with the objective of shifting the emphasis away from reliance on those types of measurements that describe input factors (ie., resource commitment) towards a stress in outcome factors that reflect attainment of specific, individualized social and clinical goals [Kiresuk, Salasan & Garwick, 1972]. [1]

The project has comprised approximately four major research areas: (1) direct implementation at the Hennepin County Health Service; (2) Hennepin County Crisis Intervention Center; (3) Adult Outpatient Drug Study and (4) various validity and reliability studies. Published information is limited;

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[1] The program evaluation project: Overview. Available from Program Evaluation Project, 501 Park Avenue South, Minneapolis, Minnesota 55415 Phone (612) 348-7811

to date only the Crisis Intervention Center (Stelmachers, Lund & Meade, 1972) report has been officially published. However, based upon early inhouse information, the overall method is workable and becoming more widely utilized (87 utilizers as of May, 1974).[2] The thrust of research effort has been to determine if this method is an appropriate evaluation tool. This study will focus on its value as an adjunct to counseling.

Statement of the Problem. Based upon the literature reviewed, it would appear that a method such as that proposed in Kiresuk's GAS, combining the theoretically beneficial (therapeutic) aspects of; (1) mutual therapist-client agreement upon specific treatment approach, (2) behavioral criteria spelled out in the client's own language, and (3) continuous, mutual feedback as to how treatment is progressing, can be an effective adjunct to any treatment modality. Although the literature cited contains several statements to the effect that this is true, an even more overwhelming bulk of the literature testifies that in practice these conditions are not utilized nor practiced. In that no experimental study has been reported in which an analysis of the differences between usual treatment methods and similar methods with GAS has been done, this study proposes to do so. Specifically, with all variables constant, will the addition of the GAS to a given treatment program produce discernable benefit to the client above that which exists in a normal treatment program without GAS?

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[2] Information obtained from Program Evaluation Project, 501 Park Avenue South, Minneapolis, Minnesota 55415 Phone (612) 348-7811

Definition of Terms.

Experimental Group: Counseling with the addition of therapist/client agreed upon behavioral criteria arranged into levels of treatment success.

Control Group: Counseling as would normally be accomplished but without the use of GAS in the counseling process.

Comparison Group: Those clients who after being pre-tested attend less than five sessions and/or drop-out. This client will be post-tested if he is available and scores used for comparison purposes.

Research Hypotheses:

1. Subjects (Ss) counseled with GAS will score lower on the locus of control (as measured by Nowicki & Strickland's 1973, scale) dimension - than subjects in the control group.

H_o There is no significant difference between experimental and control groups on the I E dimension.

2. Ss in the control group will score lower on the locus of control dimension than Ss in comparison group.

H_o There is no significant difference between control and comparison groups on the I E dimension.

3. Ss counseled with GAS will score higher on the Time Competence (TC) and Inner-directed (I) scales of the Personal Orientation Inventory (POI Shostrom, 1966) than subjects in the control group.

H_o There is no significant difference between experimental and control groups on the TC and I scales of the POI.

4. Control group Ss will score higher on the TC and I scales of the POI than comparison group subjects.

H_o There is no significant difference between control and comparison groups on the TC and I scales of the POI.

5. Ss counseled with GAS will report greater reduction in severity of problems (according to scoring on assessment sheet) than control group.

H_o There is no significant difference between experimental and control groups in reduction of problems as measured by assessment sheet.

6. Ss in control group will report greater reduction in severity of problems (according to scoring on assessment sheet) than comparison group.

H_o There is no significant difference between control and comparison groups in reduction of problems as measured by assessment sheet.

7. Ss counseled with GAS will show higher scores on consumer satisfaction questionnaire than control group.

H_o There is no significant difference in consumer satisfaction scores between experimental and control groups.

8. Scores on the locus of control scale and the I scale will be correlated in a high negative direction.

H_o Scores of the locus of control scale and I scale will not be correlated.

Method

Setting. It was decided to conduct an experimental study so that the variables of interest could be manipulated in a prescribed way, leading to the prediction of results which might more clearly point to a causal relationship among the variables. A field setting was chosen as it was felt by the author that this setting most appropriately reflects outpatient counseling as it is commonly practiced. It is felt that this selection of setting further assists in the generalization of findings to other outpatient settings. Clinics were chosen by the author which provided service on a gratis basis or with a low, sliding fee scale.

Clients. Clients will be adolescents within the age range 13-17. They will be assigned to counselors on a non-selection basis following normal clinic procedures. Only new, non-psychotic adolescents experiencing adjustment problems related to school and home will be included in the sample. Pertinent research on this population (including pre-delinquent and delinquent) includes Gersten (1951) and Persons (1966, 1967), with the bulk of the delinquent studies done in institutional settings. The population chosen for this study is felt to be representative of a majority of cases seen by guidance centers and family service centers. Those agencies included in the study report that this age range accounts for an average of 80% of their caseload. Oklahoma, in particular, through Federal Law Enforcement Assistance Act monies has identified this population as one needing specialized attention and action. The growth of a "Youth Service System" within the state is anticipated as a result of this

increased attention.

Counselors. Counselors, (20 in number), will be volunteers, self-selected from the larger population. They will be paired according to their profession, self-ratings on the Therapist Orientation Sheet (Paul, 1966), and years of experience in counseling. They will be randomly assigned to Experimental or Control condition. Counselors will receive no remuneration above their normal salary for participating in this study. Counselors will be aware they are part of an experimental study, and that other members of the same clinic may be counseling differently for this study. They will be told that at the end of the study the complete design will be revealed, and each will be shown the 'other' method. Counselors in the Control group will be told the study has to do with "counselor orientation and outcome". The author will instruct that they conduct sessions as they always do but to note the client's reaction to their style (active, passive, interpretation, and role-playing) and sex-role comments ("You'd feel that way because you're a man/woman."). They will make notes of this in their process notes (see appendix F).

Variables affecting Client and Counselor: Therapist experience was reviewed by Meltzoff & Kornreich (1970). They conclude it does seem to make a difference. Barrett-Lennard (1962); Katz, Lorr & Rubinstein (1958); Mensh & Watson, (1950) concur. Dissenting opinion is made by Myers & Auld (1955), after they found no significant differences in therapist experience and client outcome. It should be noted, however, that none of the clients improved in their study. It is an assumption of this

study that counselor experience is an appropriate variable to be controlled. This will be done thru pairing counselors of similar experience level.

Therapist Sex/Client Sex Match. Cartwright & Lerner (1963), Mendelshon (1966), Mendelshon & Geller (1963) found no significant differences attributable to like-sex, different-sex match of client and therapist. However, Meltzoff & Kornreich (1970) note that this variable is usually not part of the experimental design but a fall out of analysis of results. Fuller (1963) finds no significant difference in outcome but notes that when one member of the dyad is a female, more feelings are expressed. It will be an assumption of this study that there is no significant difference, and this will not be considered a variable to study or control.

Professional Discipline. The effect of professional discipline on outcome is as yet open to question, with essentially equivocal results being reported, (Michaux & Lorr, 1961). Essentially, it appears that the various disciplines are more alike than different, but owing to a lack of well controlled research, no definitive statements can be made. It is the assumption of this study following Meltzoff & Kornreich (1970) that a relatively simple questionnaire can determine essential differences for research purposes. Paul[3] confirms this view and, in more recent work with the Illinois Zone Centers, has found his Therapist Orientation Sheet to be satisfactory for this purpose. It is felt by this author that more than likely when appropriate research is accomplished, more difference will be

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[3] Personal communication with Dr. Paul. The Therapist Orientation Sheet is not included in the appendix of the dissertation at Dr. Paul's request.

seen between therapist's personality than between professional disciplines. The Holt & Luborsky (1958) study stands as testimony to the difficulty of this type of research.

Procedure

GAS Training for Experimental Group Counselor. The author will instruct each counselor in the technique following the format "Guide to Goals" published by the Program Evaluation Project. Counselors will be told to conduct one or tow interviews with the client before making a GAS Guide. The author will consult with each group twice on a bi-weekly basis. With the Experimental Group he will discuss only how to write behavioral objectives, not how to conduct the therapy. With the Control Group the bi-weekly sessions will be 'how goes it' type with no real information being presented. Experimental Group counselors refer to the GAS Guides three times during each session. First, the counselor notes where the client is on each of the problem areas outlined. Second, reference is made at the midpoint of the session, or when appropriate. Third, reference is made at the end of the session to consolidate gains made during the session. It should be noted that by consulting with the therapists the author seeks to insure that appropriate, realistic behavioral goals will be set and treatment done as outlined in the study. The setting of realistic behavioral goals has been a major difficulty in previous studies reported (Aspy 1972, Breedlove & Krause 1966, Meltzoff & Kornreich 1970).

Intake. Clients will be seen in normal intake procedures for each clinic.

They will be administered the POI and Locus of Control (IE) scales as well as a brief form which asks them to note the things they want help with and what the expected outcome of contact with the clinic will be (Assessment Sheet). Clients will be seen in individual counseling for eight sessions of four weeks duration. At the end of the agreed upon eight session time limit, clients will again be administered the POI, IE, Assessment Sheet and Consumer Satisfaction Questionnaire.

Factors affecting this procedure. Temporal limitation is an important variable which may have been under-researched (Smith, 1972)[4] Muench (1965), reporting on his research and reviewing others, found time-limited therapy to be no less effective than longer term therapy. Meltzoff & Kornreich (1970) conclude that there is no reason not to use time-limited approach. Sifneos (1972) argues convincingly that it is the treatment of choice for selected types of patients. Lorr, McNair, Michaux & Raskin (1962) in a related study analyzed frequency of treatment and outcome and found no significant observable difference for an initial four month period. Reviews (Bergin & Garfield, 1971) showing length of treatment indicate median number of sessions is between 6 to 9, for all reported studies. So, the discussion may be academic at base, as most treatment is in fact time-limited or short-term. Whether or not this is by design is not always made clear.

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[4] Smith, D. L. Time-limited therapy. Unpublished manuscript, University of Oklahoma, 1972.

Drop-outs. Each subject from either the experimental or control group that drops out prior to five completed sessions will be followed up and included in the "comparison" group.

Instruments

Personal Orientation Inventory. This scale developed by Shostrom (1966) is a 150 item two-choice comparative value judgment scale. It takes, as its theoretical base, writings of humanistic authors such as Maslow, Perls, Reisman, Rogers and Shostrom himself. It purports to measure degree of self-actualization which is defined by Knapp (1971) as:

> one who utilized his talents and capabilities more fully, lives in the present rather than dwelling on the past or the future, functions relatively autonomously, and tends to have a more benevolent outlook on life and on human nature than the average person [p. 1].

Knapp also reports two studies which assessed reliability; (1) the Klavetter & Mogar (1967) study, which found reliability coefficients on the TC and I scales to be .71 and .77 respectively, (2) the Ilardi & May (1968) study, which found the POI well within ranges of somewhat comparable MMPI and EPPS test-retest reliability studies. Shostrom & Knapp (1966) report the POI to correlate most highly with the Si and D scale of the MMPI and that in their study, "as therapy progresses, pathology as measured by the MMPI decreases and health, as measured by the POI, increases [p. 201]." It is felt by this author that the inclusion of an instrument such as the POI which appears to tap growth and positive mental health aspects

of an individual is an appropriate match to symptom reduction measures such as the GAS.

Internal-External dimension. The Nowicki & Strickland (1973) children's locus of control scale (CNS-IE) will be used. The value of the locus of control dimension has been documented in well over 300 studies (MacDonald, 1972), and has been amply reviewed by several authors (Joe, 1971; Lefcourt, 1966; and Rotter, 1966). The use of this particular scale is recommended due to its improvements over the original Rotter (1966) scale. It is non-related to social desirability or intelligence test scores, has a more appropriate reading level and no confounding of personal and ideological causation. (Nowicki & Duke, 1972). The Adult Nowicki & Strickland scale (1972) has been used by this author and appears to be quite sensitive to movement in individuals as a result of therapy.

Experimental Design. The design of this experiment will test significance of difference among and between groups with the simple t test for related groups (Hays, 1963). There will be one treatment condition (Goal Attainment Scaling method) and one control condition. A third group, made up of drop-outs from both conditions, will be included in this study for descriptive purposes only. The basic design most nearly approximates Campbell & Stanley's (1963) Pretest-Posttest Control Group Design. Assuming 10 subjects to a cell, W^2 =.30, B = 87 with alpha = .05 (Hayes, 1963).

Data Processing and Analysis. Pre-Testing: Although the experimental

design assumes that the Experimental and Control samples will differ insignificantly from each other and are for all intents and purposes equivalent, the means and standard deviations will be computed for each of the groups on the two measures for comparison purposes. Post-testing: The t test for related groups will be used to determine significance of difference between change score means for the CNS-IE and POI scales, within each group and between groups. For the GAS and Consumer Statistical Questionnaire Scales, t tests for related groups will be computed over post-test scores. The relationship between the CNS-IE scale and POI, I scale will be determined by correlational methods. Possible difference between professional groups will be examined thru simple t test procedures.

Inferential Statistics

1. Hypotheses 1-4 will be tested by t test for related groups, over change scores.

2. Hypotheses 5-7 will be tested by t test for related groups over post test scores.

Descriptive Statistics

1. Hypothesis 8 will be tested by the Pearson Product Moment computational formula over both pre and post test scores.

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APPENDIX B

ASSESSMENT SHEET

ASSESSMENT SHEET

PROBLEM(S)	PRESENT BEHAVIOR	EXPECTED OUTCOME

APPENDIX C

CONSUMER SATISFACTION REPORT FORM

CONSUMER SATISFACTION REPORT FORM
(Adopted from Program Evaluation Project form)

1. How would you describe your feelings about seeking service at _____?

   Very Negative Negative Indifferent Positive Very Positive

2. Did you have any trouble getting service here?

   Yes No

3. Were there any services that you felt you should have received and didn't?

   Yes No

4. How satisfied were you with the services that you received?

   Very Dissatisfied Dissatisfied Indifferent Satisfied Very Satisfied

5. Would you return here if you felt a need for further service?

   Yes No

6. How do you feel about your problems now?

   Much Better Better The Same Worse Much Worse

7. Do you attribute the feeling reported in question six to the treatment you received at this center?

8. Was there a technique, approach, or method the counselor used that was particularly helpful to you in solving your problems?

9. What kinds of things outside the visits with the counselor has helped you in solving your problems?

10. Which do you feel all-in-all was the most helpful? (8 or 9)

APPENDIX D

CONTROL COUNSELOR INSTRUCTIONS

COUNSELOR INSTRUCTIONS

1. Make sure a time limited contract is set. In this case the contract will be for four weeks, with two visits per week. At the end of the contract the client will have the option of stopping, being referred elsewhere, continuing with you or continuing with someone else in your agency.

2. Explain to client and family that you will see the whole family at the beginning of the session; then you will work with the adolescent for the majority of the hour; then you will get them all together at the end of the session.

3. Use the approach with this client that you normally would. Whatever techniques, activities, games or methods you feel would be appropriate for this client can be used. Please note briefly in your process notes what it was that you did, (Dream Interpretation, a la Perls, Reality Therapy Gestalt Exercise, etc.).

4. Please note the content areas discussed in each session.

5. Above all RELAX!!!! Please enjoy the client and note what you do. Don't fake anything please. My concern is not determining your worth as a counselor but looking at process within the session.

6. If you have any questions that cannot be answered by your supervisor you may contact me at one of these numbers:

APPENDIX E

EXPERIMENTAL COUNSELOR INSTRUCTIONS

COUNSELOR INSTRUCTIONS

1. Use programmed guide for obtaining Goal Attainment Follow up Guide.

2. Make sure behavioral indicators are used in guide. Emphasize with the client that the indicators should be observable by some outside person.

3. Make sure a time limited contract is set. In this case four weeks, with two visits per week. At the end of the contract client will have the option of stopping, being referred elsewhere, continuing with you or continuing with someone else in your agency.

4. Explain to client and family that you will see the whole family at the beginning of the session; then work with the adolescent for the majority of the hour; then get them all together at the end of the session.

5. At the beginning of the hour establish with the family where the client is regarding each of the problem areas contracted to work on. Note this in your process notes. As appropriate refer to the Guide at about mid-point in the session (focus). In summing up the session with the family establish gains made and future direction with reference to the Guide.

6. Use the approach with this client you normally would. Whatever techniques, activities, games or methods that you feel would be appropriate for this client can be used. Please note briefly in your process notes what you did, (Dream Interpretation, a la Perls, Reality Therapy, Gestalt Exercise, Etc.).

7. Please note content area of session.

8. If new goals come up include them in the Guide and outline them as done earlier. These are legitimate goals for counseling.

9. Above all RELAX!!! The purpose of this study is to explore the effects of using GAS if it gets in your way note it in your process notes. If it seems to help note it. If for some reason you must deviate for the good of the client note it and do what you feel necessary. The main thing I would not want to have is any faking. I recognize the problems you are facing in a field setting--this is the real test of an approach anyway--but please don't say you've done something when you haven't.

10. If you have any questions that cannot be answered by your supervisor you may contact me at one of these numbers:

APPENDIX F

PROCESS NOTES FORM

PROCESS NOTES

Content	Approach	Content	Approach
	1.		5.
	2.		6
	3.		7.
	4.		8.

APPENDIX G

SUMMARY STATISTICS

TABLE 2

Pretest between Group *t* Values

POI-TC	POI-I	IE
.42	1.91*	-1.10

* *p* < .05

TABLE 3

Correlation between POI-I and IE Scales

Experimental		Control	
Pre	Post	Pre	Post
-.55	-.50	-.70*	-.40

* $t=2.78$, $p < .025$.

TABLE 4

Comments Made on Consumer Satisfaction Questionnaire

Question	Experimental		Control	
	Yes	No	Yes	No
7	9	1	7	3
	Grid	Nothing	Technique	Nothing
8	9	1	2- behavioral 3-advice	5
	Outside	Nothing	Outside	Nothing
9	2-feedback from teacher	8	4	6
	Counseling	Other	Counseling	Other
10	10	0	7	3