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GRADUATE COLLEGE

EFFECTS OF EXHORTATION, INSTRUCTIONS AND MODELING ON HELPER GOAL-SETTING BEHAVIOR

A DISSERTATION

SUBMITTED TO THE GRADUATE FACULTY

in partial fulfillment of the requirements

for the degree of

DOCTOR OF PHILOSOPHY

BY

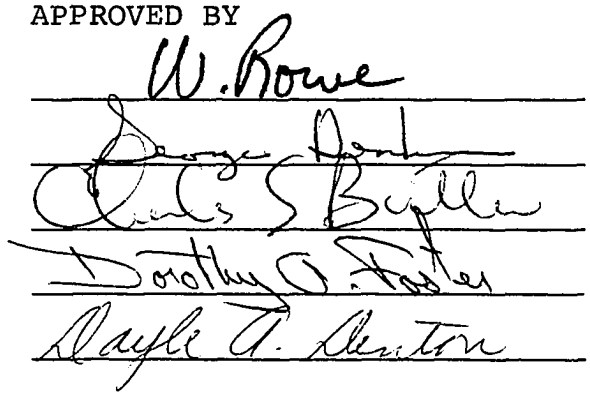
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1978

EFFECTS OF EXHORTATION, INSTRUCTIONS AND MODELING ON HELPER GOAL-SETTING BEHAVIOR

APPROVED BY



DISSERTATION COMMITTEE

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EFFECTS OF EXHORTATION, INSTRUCTIONS AND MODELING ON HELPER GOAL-SETTING BEHAVIOR

OMOWALE AMULERU-MARSHALL

UNIVERSITY OF OKLAHOMA

Running Head: Exhortation, Instructions and Modeling

ABSTRACT

A counseling goal-setting analogue study was conducted comparing exhortation, instructions and modeling as methods of training helpers to establish specific and behavioral goals with clients. Sixty-six subjects were randomly assigned to one of three experimental conditions: Exhortation; Exhortation and Instructions; and Exhortation, Instructions and Modeling, with exhortation serving as a control. Each subject was required to perform the target skill with a coached-client after exposure to one of the three experimental conditions. Although the additive effects of instructions and modeling, respectively, were in the hypothesized direction, progressively greater, only in combination were they demonstrated to be statistically significant as methods of training specific and behavioral goal-setting with clients.

EFFECTS OF EXHORTATION, INSTRUCTIONS AND MODELING ON HELPER GOAL-SETTING BEHAVIOR

In recent years, depleting resources and increasing activism in the interest of consumers have contributed to a general climate of accountability. The helping professions have not avoided the "ripple effect" of this phenomenon and are consequently being forced to defend their use of human and fiscal resources. Specifically, as it pertains to the field of counseling or psychotherapy, the impact of accountability advocacy has been acknowledged in the literature ("Nader Report", 1972; Salasin, 1972; Smith, 1975; Stone, 1975). This impact on counseling and psychotherapy is a positive one for at least two very important reasons. It provides an opportunity for the entire professional area to reaffirm its credibility in the prevention and remediation of psychosocial dysfunction. And, more importantly, it fosters the demonstration of whether or not and to what extent a given client is helped by a given counselor. Several writers (Brammer & Whitfield, 1973; Lessinger, 1973; Winborn, 1973) concur that this is an influence for more efficiency as counselors and counselor educators are forced to become more responsible and answerable to the public.

As the profession seeks to respond with greater efficiency and accountability, its evaluative efforts hinge on the specificity with which goals and tasks are defined (Hackney, 1973; Horan, 1972). Even limited involvement with

evaluative efforts should reveal that often goals can be so global and comprehensive that they are functionally imprecise and elusive. This is contrary to the purpose of goals identified by Hackney (1973), namely to focus problem areas and specify action plans. The skill of specifying goals in counseling with sufficient precision so that there is agreement by the largest possible audience as to their specific intent is a quite difficult one (Delaney & Eisenberg, 1972; Hackney & Nye, 1973; Hill, 1975; Hosford & de Visser, 1974; Krumboltz, 1966a; Krumboltz & Thoresen, 1976; Thompson & Miller, 1973). Although this preceding fact may indeed discourage their popular use, when specific and behavioral goals are set in therapeutic relationships, they yield undeniable clinical advantages. According to Brill et al., (1964), one of these is the reduction of the disparity which often exists between the counselor's and client's respective perceptions of counseling outcome. Fundamentally, they enhance and improve the therapeutic endeavour (Krumboltz, 1966a; McCarthy, 1973; Thompson & Zimmerman, 1969). It bears pointing out that these goals are neither static during the course of counseling (Thompson & Zimmerman, 1969), nor necessarily generalizable from client to client or situation to situation (Krumboltz, 1966a; Paul, 1967).

In addition to being specific and behavioral, goals need to be determined within the context of realistic criteria (Goldstein, 1962); in fact, Koch (1974) considers the

identification of an achievable, criterial level of successful performance to be as critical as the determination of the specific goal itself. Other writers place equal emphasis on the importance of criteria of success, especially as they relate to reliable measurement (Lichtenstein, 1971; Thompson & Miller, 1973; Zax & Klein, 1966). Krumboltz (1967) reminds counselors that as goals are peculiar to particular clients and situations, so are criteria of success. Goal statements should contain, therefore, at least the specification of the behavior to be performed and the specification of some criterion of successful performance. According to Hosford & de Visser (1974), appropriately stated goals have the following three components: (1) identification of the target behavior by name; (2) description of the conditions under which the behavior is to occur; and (3) specification of the criterion of minimally-acceptable performance. The primacy of the target behavior and the criterion is supported by others who exclude conditions, according to McAshan (1974).

Clearly, the clinical ability to set specific and behavioral goals, as is true of most other skills required for effective counseling or psychotherapy, is a complex one that must be trained. Yet a review of the literature reveals that there have been few, if any, studies refining the training of this skill. Among other factors, certainly, theoretical provincialism has encouraged this void (Berger, 1965; Blocher, 1965; Hackney, 1973; Patterson, 1964). Indeed,

studies in the counselor-training literature, generally, have been rare (Stone, 1975). Reacting to the fact that most studies of skill-training have tended to combine various training components, appeals are beginning to register for studies which analyze the relative effects of these training components or strategies (Frankel, 1971; Horan, 1972; Perry, 1975; Stone, 1975).

Two such strategies, instructions and modeling, have recently attracted some measure of attention in the literature (Heller, 1970; Marlatt, 1972; Stone & Gotlib, 1975). Instructions have been demonstrated to be an effective training medium for a variety of skills (Stone & Stein, 1978). Serving as advanced organizers and providing cognitive structuring (Ausubel, 1963; Bandura, 1969; Paivio, 1971), instructions have effectively trained verbal responses (Green & Marlatt, 1972), client self-exploration (Carkhuff & Alexik, 1967), and therapy-relevant client behaviors (Hoehn-Saric et al., 1964). Modeling has also been demonstrated to be an effective method of skill training (Bandura, 1969, 1977). It has been used to train client role verbal behaviors (Doster & McAllister, 1973; Marlatt et al., 1970; Myrick, 1969) and helper role behaviors Dalton & Sundblad, 1976). In combination, these two methods of training have been effectively used to treat clients (Carkhuff, 1971; Lovaas et al., 1967; Metz, 1965; Pierce & Drasgow, 1969), as well as to train counselors (Ivey et al., 1968; Payne, Winter & Bell, 1972). Some studies have

attempted to determine the comparative effectiveness of instructions and modeling to train counselor role behaviors (Kuna, 1975; Payne & Gralinski, 1968; Payne, Weiss & Kapp, 1972; Perry, 1975; Stone & Vance, 1976; Wallace et al., 1975), verbal behaviors (Doster, 1972; Green & Marlatt, 1972; McFall & Twentyman, 1973; Whalen, 1969), and other behaviors (Masters & Branch, 1969; Rappaport, Gross & Lepper, 1973; Uhlemann, Lea & Stone, 1976). These results have been inconsistent, however.

Often, textbooks and classroom lectures present the need for and the benefits of a given skill without any specific consideration of how this skill is learned. This rather common occurrence, to recommend or urge a desired practice, will be referred to here as exhortation. The purpose of this study, then, was to assess the incremental effects of specific instructions and instructions plus modeling, over the baseline practice of exhortation, on the ability of prospective helpers to set specific, behavioral goals with clients.

Method

Subjects

The subjects (N=66) were students enrolled in courses in the graduate programs of Guidance and Counseling and Social Work at the University of Oklahoma. No course work which they had previously taken had included instruction on developing goals with clients. Their ages ranged from 21 to 55, with a median age of 27 years. There were 25 males and 41 females. These volunteers were randomly assigned to one of three

treatment conditions: (1) Exhortation, (2) Exhortation and Instructions and (3) Exhortation, Instructions and Modeling.

Coached-Clients

The coached-clients (N=6) were female graduate students in Guidance and Counseling who were paid for their participation in the study. They were randomly assigned to the subjects with whom they role-played. The coached-clients were trained, by rehearsal with feedback and/or instructions, for a two-hour period two days prior to the beginning of the study. Each coached-client was given an opportunity to practice the role (see Appendix F) at least three times in dyads.

Raters

Two graduate students in Guidance and Counseling and Geography, respectively, were trained for approximately ten hours in the use of the Counselor Goal-Setting Scale using practice material similar to the simulated interviews to be evaluated. After achieving above 90% consistency with the practice material, they independently rated, in random order, the tape of each subject's performance in setting goals with a coached-client. Inter-judge reliability, expressed as a product-moment correlation, was .81.

Instruments

Color video-tape recording equipment was used to pre-record, and later play back, the treatment conditions. Six audio cassette tape recorders were also used to record the role-play segment (or dependent variable measure).

A Counselor Goal-Setting Scale (see Appendix H), developed for this study, was used by the raters to record the subjects' performance. This scale which has a range of 9 points across 4 dimensions was constructed to reflect the major dimensions of appropriate goal-setting behavior. The first dimension focuses on the necessity to identify the target behavior by name and the appropriate criterion by which it is to be measured (Hosford & de Visser, 1974; Mager, 1962). The exclusion of conditions from this dimension is not without precedent (McAshan, 1974). The second dimension is concerned with the mutuality of the goal and emphasizes the necessity for the client and counselor to share in the goal-setting process (Hackney & Nye, 1973). In the third dimension, the distinction between process goals and outcome goals is emphasized (Hackney & Nye, 1973). Finally, the necessity that a goal be identified before a strategy or solution is developed is given consideration (Delaney & Eisenberg, 1972). The final refinement of these 4 dimensions into the present scale emerged pragmatically from 45 hours of rater-training culminating in an inter-rater reliability above .90.

A Follow-Up Questionnaire (see Appendix G), developed by the author, was used to gauge the subjects' perception of the realism of the study.

Procedure

After assignment to one of the three experimental

groups, all subjects were presented with the Exhortation treatment (see Appendix B), which was a video-taped lecture discussing the desirability of specific, behavioral goal-setting with clients. Discussion of how this is done was carefully avoided. This presentation was made in the classrooms in which the subjects typically met for their classes and lasted for approximately 22 minutes.

The 22 subjects in the "Exhortation" treatment condition were then handed an instructions sheet (see Appendix E) and directed, according to random assignment, to one of six private rooms to perform the dependent variable behavior: a simulated counseling goal-setting task with a coached-client.

The remaining 44 subjects were then presented with the Instructions treatment (see Appendix C), which was also a pretaped lecture, discussing how specific and behavioral goals may be set with clients. This presentation lasted approximately 21 mintues. Following this, the 22 subjects in the "Exhortation and Instructions" treatment condition were handed the instructions sheet (see Appendix E) and directed, according to random assignment, to one of the same six private rooms to perform the counseling simulation.

The remaining 22 subjects were then presented with the Modeling treatment (see Appendix D), which was a videotape of three vignettes demonstrating, respectively, an effective, ineffective, and effective counselor-model setting specific, behavioral goals with a client. This entire sequence lasted for approximately 20 minutes.

Finally, these 22 subjects, who composed the "Exhortation, Instructions and Modeling" treatment condition, performed the goal-setting simulation. A graphic of the procedure is presented in Table 1. Additionally, all 66 subjects completed the Follow-Up Questionnaire (see Appendix G) at the conclusion of their involvement in the study.

Insert Table 1 about here

Results

The means and standard deviation of the three treatment groups': (1) Exhortation; (2) Exhortation and Instructions; and (3) Exhortation, Instructions and Modeling, performance of the criterion measure - specific and behavioral goal-setting - are presented in Table 2.

Insert Table 2 about here

Outcome Analysis

The first question that needs to be considered concerns whether the three treatment conditions are sufficiently promising to warrant further examination. An analysis of variance indicated a significant treatment effect, $F(2,63) = 4.77, p < .012$. Table 3 presents a summary of this analysis of variance.

Insert Table 3 about here

Post hoc comparisons of the treatment means were conducted with Tukey's HSD test which revealed that the difference between any two treatment means had to be greater than 1.05 or 1.32 to reach the .05 or .01 level of significance, respectively. It was hypothesized that: (1) Exhortation and Instructions would have significantly greater effects than Exhortations; (2) Exhortation, Instructions and Modeling would have significantly greater effects than Exhortation; and (3) Exhortation, Instructions and Modeling would have significantly greater effects than Exhortation and Instructions. An examination of Table 4 suggests that the results failed to reject the null hypothesis that there is no significant difference between the effects of Exhortation and Instructions and the effects of Exhortation, although the difference reflects a trend in the predicted direction. The results also failed to reject the null hypothesis that there is no significant difference between the effects of Exhortation, Instructions and Modeling and the effects of Exhortation and Instructions, in spite of the close approximation of the .05 level of significance. However, the null hypothesis that there is no significant difference between the effects of Exhortation, Instructions and Modeling and the effects of Exhortation was rejected.

Insert Table 4 about here

Supplementary Analyses

Two additional analyses of the data were conducted which are ancillary to the substance of the study. The first issue concerns whether the nature of the program in which the subjects were enrolled - Guidance and Counseling or Social Work - exercised a significant influence on their performance of the dependent variable. A two-way analysis of variance revealed no significant effect, $F(4,51) = .33, p < .86$. The other question is related to the effect of counseling experience (more than 6 months) and inexperience (less than 6 months) of the subjects on their performance of the dependent variable. A two-way analysis of variance resulted in no significant effect, $F(1,60) = .03, p < .88$.

A final issue, further removed from the substantive question of this study, concerns the subjects' self-report of their perception of the realism of aspects of it. Table 5 presents the mean ratings, in a possible range of 1 to 5, on each question of the Follow-Up Questionnaire (see Appendix F) developed to record these perceptions. The Exhortation treatment, designed to resemble a classroom lecture in substance and form, was perceived as a reasonable simulation. The coached-clients were perceived as being convincing in their roles. Finally, those subjects who viewed the modeling

vignettes rated them as being reasonable simulations of counselor-client interviews.

Insert Table 5 about here

Discussion

The results of this study are congruent with the general findings of other investigations of the effects of instructions and modeling as skill-training methods. Instructions and modeling in combination were demonstrated to be more effective than exhortation as well as instructions or modeling, singly, for training the skill of setting specific and behavioral goals with clients. Neither the additive effects of instructions nor of modeling significantly affected the performance of the target skill, however. It should be noted here that a conceded limitation of the design of this study is the systematic increase of time across treatments.

The lack of significant incremental effects of instructions alone is not consistent with the findings of other studies in the skill-training literature (Green & Marlatt, 1972; Rappaport, Gross & Lepper, 1973; Stone & Vance, 1976). An interesting finding by Stone & Vance (1976) may account, to some degree, for this result. Instructions were found to be more efficacious in facilitating written responses while modeling was found to facilitate oral responses more appropriately, perhaps because of its resemblance to the

criterion situation. In view of the nature of the task held to be the dependent variable in this study, it is conceivable that instructions lacked the requisite strength of relationship with that behavior in order to have ensured greater effects.

The additive effects of modeling, albeit greater than instructions, were also not significant. This finding, which fails to coincide with the social learning literature (Bandura, 1977), has been discussed in other studies (McFall & Twentyman, 1973; Scheiderer, 1977; Uhlemann, Lea & Stone, 1976). Another possible explanation suggested by the research of McGuire, Thelen and Amolsch (1975) and Stone and Stein (1978) is that the exposure time of the modeling condition may not have been long enough to produce maximum effects. The relatively large effects of modeling, almost reaching statistical significance, would seem to confirm the likelihood of the latter phenomenon operating in this study. Especially when consideration is given to the fact that the entire exposure time of this condition was less 20 minutes and that one-third of this time was used to model a negative performance of the target skill, this likelihood is even more plausible.

The finding of major interest in this study is the demonstrated ability of the combination of instructions and modeling to train specific and behavioral goal-setting with clients. Although this combination has been demonstrated to be effective in the training of other counselor-role

behaviors, this study is among the first efforts to apply these methods of training to this target skill. Recognizing the implicit importance of this finding to the movement for accountability in counseling or psychotherapy, its interpretation must be, nonetheless, cautious. The nature of the skill of clinical goal-setting itself needs to be experimentally refined even as the efficacy of instructions and modeling as training methods of this skill is replicated. It is further recommended that instructions and modeling be combined with feedback and rehearsal as possibly a more efficient model of training specific and behavioral goal-setting. This combination has been established as a system of training counselor-role behaviors (Stone & Vance, 1976). Exposure time should also be manipulated since evidence of its impact of skill-training has appeared (Stone & Stein, 1978).

Parenthetically, the failure of the subjects' program or experience to register significant effects adds to the evidence that the treatment methods are effective in training counselor trainees to set specific, behavioral goals with clients. It is noteworthy that the results of the follow-up questionnaire indicate that the subjects were impressed that this study satisfactorily simulated those training and therapeutic realities it sought to. The subjectivity associated with this assessment must be a part of any consideration of this self-report data. Moreover, in addition to the methodological problems, the mean ratings received, though positive, were not extremely high.

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TABLE 1

Graphic of Procedure

E	E	E
X	I	I
	X	M
		X

E = Exhortation I = Instructions

M = Model X = Role-Play

TABLE 2

MEANS AND STANDARD DEVIATIONS OF GOAL-SETTING RATINGS

Treatment Conditions	Goal-Setting Ratings	
	M	SD
Exhortation	3.77	1.12
Exhortation & Instructions	4.09	1.52
Exhortation, Instructions & Modeling	5.07	1.66

Note: n = 22 for each condition

TABLE 3

ANOVA SUMMARY TABLE FOR TREATMENT EFFECTS

SOURCE	df	SS	MS	F
Treatments	2	20.05	10.03	4.77*
Within-Groups	63	132.33	2.10	
Total	65	152.38		

* $p < .012$

TABLE 4

RESULTS OF TUKEY'S HSD TEST OF THE PERFORMANCE MEANS OF THE THREE TREATMENT GROUPS: EXHORTATION; EXHORTATION AND INSTRUCTIONS; AND EXHORTATION, INSTRUCTIONS AND MODELING.

Means		E 3.77	E&I 4.09	E,I&M 5.07
E	3.77	----	.32	1.30*
E&I	4.09		----	.98
E,I&M	5.07			-----

* significant at the .05 level

TABLE 5

MEANS OF FOLLOW-UP QUESTIONNAIRE RATINGS

Question	Ratings M
I	3.4
II	4.4
III	3.5

Note: n = 66 for questions I & II
n = 22 for question III

APPENDIX A

PROSPECTUS

UNIVERSITY OF OKLAHOMA

College of Education

EFFECTS OF EXHORTATION, INSTRUCTIONS AND MODELING ON HELPER GOAL-SETTING BEHAVIOR

A prospectus for the dissertation in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Counseling Psychology.

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Date

DISSERTATION PROSPECTUS

EFFECTS OF EXHORTATION, INSTRUCTIONS, AND MODELING ON HELPER GOAL-SETTING BEHAVIOR

NAME AND FIELD OF STUDY:

Omowale Amuleru-Marshall; Counseling Psychology

ADVISORY COMMITTEE: Wayne Rowe, Chairman
Dorothy Foster
George Henderson
Charles Butler
Dayle Denton

INTRODUCTION:

Background of the problem. In recent years depleting resources and increasing activism in the interest of consumers have contributed to a general climate of accountability. The helping professions have not avoided the "ripple effect" of this movement and are consequently being forced to defend their use of human and fiscal resources.

This condition is exercising a positive influence on counseling and psychotherapy in at least two very important ways. In the first instance, it provides an occasion for the entire professional area to reaffirm its crucial role in the prevention and remediation of psychosocial dysfunction. In the second, and more important instance, it fosters the demonstration of whether or not and to what extent a given client is helped by a given counselor. Irrespective of treatment of choice orientation, these should be acknowledged to be very important influences. In fact, it is difficult to

understand how the profession of counseling or psychotherapy could hope to survive without them.

The logical extension of this commitment to evaluation is an interest in goal-setting. It is a truism that one cannot know if and when one has arrived if one does not know where one is going. Acknowledging this is not quite enough, however, since the notion of goal-setting is a rather complex one. Even limited involvement with evaluative efforts should reveal that some goals can be so global and general that they are functionally imprecise and vague; these goals lend themselves to a myraid of subjective interpretations. Thus, if goals are to be optimally useful, they need to be more specific and behavioral. They should after all be amenable to general agreement and review; most people should be consensual about their meaning and the relative degree to which they are reached. Consequently, goals, when they are most useful, are observable and measureable with the greatest agreement among the largest number of people.

The process of measuring success, then, would seem to require a considerable skill and, as is the case with any other skill in counseling or psychotherapy, elicits certain training concerns. How are counselors or therapists most effectively trained to set specific and behavioral goals with clients? Traditionally, there are two training media: textbook and classroom lecture. These typically present (a) the need for and the benefits of a given skill and

(b) only occasionally, the useful ways in which this skill is learned. These may be designated, respectively, exhortation and instructions. A less traditional method of training which has come to receive considerable attention in recent years is modeling. This is a method by which a skill is taught by having the trainee imitate the behavior of a model. Increasingly, observational learning, employing live models, video taped models and various combinations of these, is being used to train a wide variety of skills. The question concerning the most effective method among these of training counselors to set specific and behavioral goals with clients has not been resolved by studies reported to date in the experimental literature.

REVIEW OF RELATED LITERATURE:

The impact of consumer advocacy and accountability on the field of counseling or psychotherapy has been acknowledged in the literature ("Nader Report", 1972; Salasin, 1972; Smith, 1975; Stone, 1975). Several writers (Brammer & Whitfield, 1973; Lessinger, 1973; Winborn, 1973) argue that this is an influence for more efficiency as counselors and counselor educators are forced to become more responsible and answerable to the public.

In order to be efficient and accountable, however, tasks must be clearly defined and specific goals must be identified (Hackney, 1973; Horan, 1972). Hackney (1973) views goals as the means by which problem areas are attended to and

action plans are specified. Yet goal-setting is a quite difficult counselor skill (Hill, 1975; Thompson & Miller, 1973).

Considerable discussion (Delaney & Eisenberg, 1972; Hackney & Nye, 1973; Hosford & de Visser, 1974; Krumboltz, 1966a; Krumboltz & Thoresen, 1976; Thompson & Miller, 1973) has been directed toward this topic with particular emphasis being placed on the benefits of setting specific and behavioral goals with clients. When specific and behavioral goals are set, they tend to reduce the disparity which often exists between the counselor's and client's respective perceptions of counseling outcome (Brill, et al., 1964), as well as generally enhance and improve the counseling endeavour (Krumboltz, 1966a; McCarthy, 1973; Thompson & Zimmerman, 1969). It should be recognized that goals are neither static during the course of counseling (Thompson & Zimmerman, 1969), nor necessarily generalizable from client to client or situation to situation (Krumboltz, 1966a; Paul, 1967). Goals need to be determined within the context of realistic criteria (Goldstein, 1962).

Koch (1974) considers the determination of an achievable, criterial level of performance that spells success to be as critical as the determination of the specific goal itself. Krumboltz (1967) cautions that as goals are particular to specific clients and situations, so are criteria of success. The value of criteria of success which make it possible to measure in a quantifiable way has received well deserved

attention (Lichtenstein, 1971; Thompson & Miller, 1973; Zax & Klein, 1966). Goal statements, according to Mager (1962) and Hosford and de Visser (1974), when formulated appropriately, have the following three components: (1) an identification of the target behavior by name; (2) a description of the conditions under which the behavior is to occur; and (3) a specification of the criterion of minimally-acceptable performance. McAshan (1974) reported that some writers in the area of behavioral objectives or goals do not necessarily include a description of the conditions. This suggests the primacy of the other two components of goal statements: the target behavior and the criterion. There are three common methods of, or criteria for, assessing behavior: (1) frequency, (2) duration, and (3) time sampling (Huck, Cormier & Bounds, 1974; Kazdin, 1975). Weigel & Uhlemann (1975) have proposed a procedure for developing individualized behavior change goals with clients.

It would be expected that a skill as valuable to therapeutic success, and the demonstration of that success, as goal setting is, would have inspired a number of training experiments. A review of the literature demonstrates that this is not the state of affairs. Hackney (1973) has suggested that some training settings and theoretical models have encouraged this void. Patterson (1964) considered the client-centered counselor to have the same goal for all clients: maximizing freedom of specific choices of behavior to foster

maximum self-actualization. This is obviously a quite different position from the one exemplified by Krumboltz (1964, 1966a) which posits that each individual client's goals are to be different. That one's approach to goal-setting is associated with one's theoretical orientation has been made clear (Berger, 1965; Blocher, 1965).

Dustin (1968), Munley (1974) and Stone (1975) have, in fact, charged that the field is bedeviled by a paucity of valid studies on counselor training. Those studies that are available have typically combined various components of training (Carkhuff & Truax, 1965; Carkhuff, 1969). Increasingly, appeals are appearing for studies which compare the relative value of these training components or strategies (Frankel, 1971; Horan, 1972; Perry, 1975; Stone, 1975; Toler, 1976).

Two such strategies which are receiving considerable attention in the training literature are instructions and modeling (Heller, 1970; Marlatt, 1972; Stone & Gotlib, 1975). Instructions which serve as advance organizers provide awareness of the target skill as well as necessary cognitive structuring (Ausubel, 1963; Bandura, 1969; Paivio, 1971). Instructions have also been shown to be effective in the modification of verbal responses (Green & Marlatt, 1972; Levy, 1967). Doster (1972) also reported the effectiveness of instructions in the manipulation of client self-exploration (Alexik & Carkhuff, 1967; Carkhuff & Alexik, 1967; Friel Kratochvil & Carkhuff,

1968), and the inducement of therapy-relevant client behaviors (Hoehn-Saric, et al., 1964).

In the social learning literature, observational learning has been demonstrated to be an effective method of skill training (Bandura, 1969, 1977). Client role verbal behaviors have been modified through modeling (Doster & McAllister, 1973; Marlatt et al., 1970; Myrick, 1969). Helper role behaviors have also been trained with models (Dalton, Sundblad & Hylbert, 1973; Dalton & Sundblad, 1976; Flanders, 1968). Modeling has been combined with didactic approaches in a variety of situations. Clients were treated with models and instructions by Metz (1965), Lovaas et al., (1967), Pierce & Drasgow (1969), and Carkhuff (1971). Models and instructions have also been used to train counselor role behaviors (Ivey et al., 1968; Payne, Winter & Bell, 1972).

Other studies have attempted to determine the relative contributions of modeling and instructions in training a variety of skills: counselor role behaviors (Kuna, 1975; Payne & Gralinski, 1968; Payne, Weiss & Kapp, 1972; Perry, 1975; Stone & Vance, 1976; Wallace et al., 1975); verbal behaviors (Doster, 1972; Green & Marlatt, 1972; McFall & Twentyman, 1973; Whalen, 1969); as well as behavior change (Masters & Branch, 1969; Rappaport, Gross & Lepper, 1973; Uhlemann, Lea & Stone, 1976). The results of these studies reveal an inconsistent pattern regarding the relative effectiveness of these two training methods.

Two additional practices in counselor training are pertinent to this proposed study. The use of videotaping reported in the literature reflects a wide and varied applicability of this medium (Poling, 1968a, 1968b). Stern (1975), in a comprehensive review of this literature, observed the following:

> Video playback has been used with individuals and groups, by itself and with other feedback devices, for modeling, observation/analysis facilitation of feedback, self-confrontation, and group processing. In training and practice it has been used with counseling professionals, paraprofessionals, teachers, 'patients', 'clients', families, schizophrenics, and alcoholics.

The employment of coached clients is also not a novel event in the counselor training literature (Heller, Myers & Kline, 1963; Kelz, 1966; Befus & Miller, 1970; McIlvaine, 1972; Whiteley & Jakubowski, 1969).

Statement of the Problem. The problem of this research is: What are the effects of exhortation, instructions and modeling on counselor trainees' ability to set specific, behavioral goals with clients.

Purpose. Its purpose is to determine which one or combination of these methods is most effective in training this skill, thus contributing to the greater gain of efficiency and economy in professional training (Stone, 1975).

STATEMENT OF HYPOTHESIS:

1. Exhortation and Instructions will have a greater effect that Exhortation on the trainees' performance of

specific, behavioral goal-setting.

H_O = There is no significant difference between the effects of Exhortation and Instructions and the effects of Exhortation.

2. Exhortation, Instructions and Modeling will have greater effects of the trainees' performance of specific, behavioral goal-setting than Exhortation.

H_O = There is no significant difference between the effects of Exhortation, Instructions and Modeling and the effects of Exhortation.

3. Exhortation, Instructions and Modeling will have greater effects of the trainees' performance of specific, behavioral goal-setting than Exhortation and Instructions.

H_O = There is no significant difference between the effects of Exhortation, Instructions and Modeling and the effects of Exhortation and Instructions.

METHOD OF STUDY:

Subjects. The subjects will be sixty-six students in the graduate programs of Guidance and Counseling and Social Work at the University of Oklahoma. These volunteers will be randomly assigned to one of three treatment conditions.

Treatment Conditions. There will be three treatment conditions: I. Exhortation; II. Exhortation and Instructions, and III. Exhortation, Instructions and Modeling. The "Exhortation" treatment will be a lecture of approximately twenty

minutes, pretaped and audio-visually, extolling the desirability of setting specific, behavioral goals with clients. It is adapted from Krumboltz (1966b). The "Instructions" treatment will also be a lecture of approximately twenty minutes, pretaped audio-visually, outlining a 4-step method of setting specific and behavioral goals with clients. This is primarily an adaptation of Weigel and Uhlemann's (1975) 10-step goal-setting procedure. It also draws on the work of Delaney and Eisenberg (1972), Hackney and Nye (1973), Hosford and de Visser (1974), and Krumboltz and Thoresen (1976). The "Modeling" treatment will be three vignettes, pretaped audio-visually, in which a "counselor" demonstrates with a "client" how to--in two of them and in the other how not to--use the 4-step method adapted from Weigel and Uhlemann's (1975) work. These vignettes, which will last for a total of approximately twenty minutes, assume that the counselor has already elicited the client's statement of the problem.

Definition of Terms. By EXHORTATION is meant the discussion of the advisability of setting specific and behavioral goals with clients without any meaningful discussion of how this is done. By INSTRUCTIONS is meant the didactic presentation of how specific and behavioral goals are actually set with clients. By MODELING is meant the role-playing or simulation of a counselor demonstrating how specific and behavioral goals are set with a client. The terms SPECIFIC and BEHAVIORAL quality goals in such a manner that they must

identify a discrete target behavior that is observable and/or measurable. Operationally, within the context of this study, such a goal statement must contain two components: it must (a) identify the specific target behavior and (b) identify the criterion by which it is to be measured.

Procedure. The subjects, after random assignment to the three experimental conditions, will all be presented with the "Exhortation" treatment. At the conclusion of this twenty minute segment, the twenty-two subjects in the "Exhortation" treatment condition will each conduct a 10-minute role-play of a counseling interview with a coached client who will present a standardized, personal problem. During this segment, which will be audio-taped, each subject will attempt to set a specific, behavioral goal with the "client".

The remaining forty-four subjects will be in the process of viewing the "Instructions" treatment for a period of twenty minutes. Subsequent to this, those twenty-two subjects in the "Exhortation and Instructions" treatment condition will conduct a 10-minute role-play of a counseling interview with a coached client who will present the same standardized, personal problem. These subjects will also attempt to set a specific and behavioral goal with their respective "client".

The final group of twenty-two subjects who constitute the "Exhortation, Instructions and Modeling" treatment condition will be in the process of viewing the "Modeling" treatment which will also last for approximately twenty minutes.

At the conclusion of this presentation, they will conduct the role-play counseling interview under the same standardized conditions described above. See Table 1 for a graphic representation of this procedure.

TABLE 1

graphic of procedure

E	E	E	E = Exhortation
X	I	I	I = Instructions
	X	M	M = Model
		X	X = Role-Play

Finally, a self-report questionnaire will be administered to all sixty-six subjects to gauge their perception of the realism of the study (Thompson & Miller, 1973).

Experimental Design. The design of this experiment will test the significance of the difference between groups using an analysis of Variance. There will be three treatment groups (see Table 1) with twenty-two subjects randomly assigned to each. The independent Variables will be Exhortation; Exhortation and Instructions; and Exhortation, Instructions and Modeling. The dependent variable will be specific, behavioral, goal-setting behavior. Two graduate students at the University of Oklahoma will rate the tapes as blind judges after a significant inter-rater reliability has been achieved.

This will be done by having the raters practice with written samples of goals until they are achieving above 90% agreement in the use of the rating scale used in this study. The subjects' taped performances in the simulated counseling situation will be rated on a maximum 9-point scale emphasizing two categories: behavior and criterion (frequency, duration and standard).

The basic design will be a multigroup posttest-only design. A one-way analysis of variance, using the F ratio, will be used to compare the groups in terms of posttest means. This analysis will test for significant overall main effects. A post hoc multiple comparison test will be conducted if there are significant main effects (Huck, Cormier & Bounds, 1974).

SIGNIFICANCE OF THE STUDY:

The significance of this study can be defended in terms of two areas of value to counselor training: the comparative effectiveness of training strategies and the application of these to train specific and behavioral goal-setting. In spite of efforts to determine the relative effectiveness of training strategies (Kuna, 1975; Perry, 1975; Stone & Vance, 1976), the results are still inconclusive (Uhlemann, Lea & Stone, 1976). This study can add to the clarification of this question.

There has, additionally, been no study reported which has attempted to investigate the relative effectiveness of

these strategies as they apply to training goal-setting behavior. This study could begin to indicate their relative usefulness in training more complex counselor role behaviors.

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APPENDIX B

EXHORTATION TRANSCRIPT

EXHORTATION

Traditionally, mental health practitioners were given a free hand because of the considerable mystery surrounding the nature of mental health. No one was really quite sure what caused mental illness and, therefore, how to cure it. More importantly, it was considered taboo to discuss it openly; this contributed to the private world of mental health reserved for the unusually brave and/or skilled individuals who dared to work in the field. Fears of inherited and other forms of trait and personality predisposition did not help either. Practitioners typically encouraged this state of affairs which enhanced their importance in the community and, more importantly, protected them from any effective evaluation. Increasingly, in the past few years, this veil of secrecy has begun to be torn and mental health is becoming a topic about which there is less alarm, less shame and, subsequently, less mystery.

Many attribute this change to the mood of the time; to the advent of consumerism and accountability in many facets of service delivery to the public. Undoubtedly, diminishing resources and the resultant competition for funding has contributed also. No less important a factor is the gradual take-over of trait theories and the medical model by learning theories and the environmental model. Whatever the reason, a change is unquestionably occurring. The effects of this change on the mental health field have been positive. Practitioners as well as those who train them realize that the

general public now expects results. The public is demanding from the entire profession that it defends its hitherto unchallenged role in the prevention and treatment of psychosocial dysfunction. And, by extension, each would-be helper is being forced to become more accountable for the quality and quantity of the "help" provided. Consider the following illustration taken from the writing of John Krumboltz:

> From his hiding place Harold spotted Jimmy trudging home from fourth grade. Harold waited until Jimmy drew near and then sauntered out blocking the sidewalk. "Where you think you're going, punk?" Harold taunted. "Home," Jimmy said in a squeaky voice. Harold was in the eighth grade and he towered over Jimmy. "Not this way you're not." "I'll go around." "Not that way you won't." "Leave me alone, you big bully." "I could knock a squirt like you all the way across the street," said Harold advancing with clenched fists. Jimmy was seized with terror and turned to run. "I'm going to get you, shorty," Harold snarled. Jimmy was running as fast as he could, but Harold kept pace with him easily. Harold waited until they approached a large mud puddle, then skillfully he put one foot in front of Jimmy's flying legs. Jimmy went sprawling nose first through the mud puddle. Jimmy picked himself up slowly, surveyed his ruined clothes, and burst into tears as he ran home. Harold laughed, "That'll teach ya, kid." Then he slipped quickly down the back alley. The next day the school principal asked Harold to talk with the counselor. Harold knew the counselor's reputation for helpfulness, so he spoke frankly. "I don't know why I beat up little kids. I'm not really proud about it. In fact, I usually keep it quiet. But whenever I see a little kid, I just feel like giving him a hard time."

Let us assume that the counselor and Harold embark on some mysterious and undefined counseling activities. After

a year, what would you expect to happen if counseling is deemed successful? What would be the counseling outcome? Harold might make any of the three following statements if he were given a follow-up interview. Which one would seem to indicate that the counselor's intervention was successful?

STATEMENT A:
"At last I understand why I am a bully. Considering my background it's only natural that I would beat up little kids. Now whenever I bully someone, I have insight into why I'm doing it."

STATEMENT B:
"I've finally realized that I must accept myself as I am. I am a bully. It used to make me unhappy, but now I am content to be myself and act accordingly."

STATEMENT C:
"I don't beat up little kids anymore. I don't know why. Ever since the P.E. teacher offered to teach me and Charlie how to play tennis, I just lost interest in bullying. I don't accept myself as being the lousy tennis player I am now; Charlie and I have promised each other that someday we are going to be the two best tennis players in the world."

Statement A represents self-understanding without a behavior change, while statement C represents behavior change without either self-understanding or self-acceptance. Given this situation, most counselors would probably choose statement C because most counselors wish to see their clients attain socially appropriate goals. Yet self-understanding and self-acceptance appear as goals of counseling despite their imprecision. The counselors who use these terms, although they wish for their clients the greatest degree of change, have their efforts undermined by the abstract nature of the goals employed. Even if it could be argued that self-understanding and self-acceptance are useful goals in their

own right, it is impossible to determine agreement and goal accomplishment. It is far more desirable to state counseling goals in terms of behavior changes. The assumption that there are intermediate mental states, such as self-understanding and self-acceptance which control behavior, is a clinically cumbersome notion.

It should be possible to state goals differently for each client. No single goal statement should apply to all clients. One of the characteristics of the counseling relationship is the individual expression it facilitates. If we are really committed to the idea that each individual is to be respected as such, we should expect to determine and pursue different goals with each. Society holds certain standards as being generalizable to all its members and formal education is one of the instruments used to inculcate these standards. The extent to which this is accomplished continues to be one of the hotly debated issues of our time. What we counselors do, however, is uniquely designed to help individuals to achieve their individual goals within the framework of these societal standards. Even so, there are a virtually unlimited number of goals which counselors can help their clients to achieve. It is quite conceivable, moreover, that the goals of one client may directly contradict the goals of another. As an example, one may wish to learn how to become more socially active while another client may wish to learn to become less socially active. The same counselor could

effectively help both individuals to accomplish these conflicting goals.

It should be clear that the attainment of goals must be observable to as many people as possible. Certainly all counselors, irrespective of theoretical orientation, should be able to agree when the goal is achieved. This would require that specific behavior be a part of the goal formulation. Behavior is used broadly here to refer to any verbal or written statement, any response that can be seen or heard, and any other response that can be reliably assessed through some type of instrumentation.

The types of goals that a counselor will formulate may generally fall into one of three classes or categories. They are not mutually exclusive nor are they necessarily exhaustive.

The first class of goals is concerned with altering maladaptive behavior. Counselors often see clients who are distraught because they are engaging in a pattern of behavior which does not lead to the satisfactions they desire. Although they often cannot identify the specific maladaptive pattern to the counselor, they do report their subjective feeling which they feel cause and are caused by their behaviors. It becomes the counselor's task to understand the client's behavior and to translate it into useful terms.

The second class of goals revolves around problem-solving or decision-making. As mentioned before, the client will likely not state the specific nature of the problem.

The counselor must assist the client, once the client's subjective experience is understood, to state the needs in a workable format thus setting the stage for a course of action which would teach the client to solve problems.

The final category of goals is preventive in nature and seeks to vaccinate rather than waits to react, so to speak. It is suggested by many people in the field that the highest priority in a counselor's work be placed on educational programs designed to prevent maladaptive behavior and inept decision-making. Many of the problems brought to us by clients for remedy would not have been problems in the first place if we had trained teachers to be more skillful, parents to be more effective and administrators and politicians to be more precise and responsible. It cannot be emphasized enough that imaginative educational programs designed to teach discrete skills could begin to prevent such problems as unhappiness associated with marriage to the wrong person, for the wrong reason, at the wrong time; the discouragement that results from the efforts of a child to learn while always being at the bottom of the class; or the abject loneliness endured silently by someone who never learned to interact effectively with others. The most laudable goal of counselors is to become unnecessary.

As we mentioned earlier, some traditional theoretical formulations inherently inhibit the development of skills in specific and behavioral goal-setting in the counselors who

have brought into these theoretical biases. A closer look at some of these traditional conceptualizations of goals, in terms of inferred mental states such as self-understanding and self-acceptance, may be fruitful.

Actually, self-understanding is a concept that means different things to different people. Among its major weaknesses, relative to counseling goals, is the fact that it can be defined differently by anyone using the term. When challenged, a user can always say, "But that's not my definition of the term." Two of the most common definitions are: (1) self-understanding as interpretation and (2) self-understanding as self-knowledge.

A frequent definition of self-understanding is the interpretation or explanation of behavior in consonance with some given set of concepts or theory. This insight as a goal is vulnerable to a number of problems, but mainly that whether or not the client has arrived at self-understanding depends on the theoretical orientation of the person whose perception defines it. There are many conflicting theories on how self-understanding may be acquired. Let us re-examine the following ways in which Harold - of the earlier illustration - might "understand" himself.

SELF-UNDERSTANDING A:
Aggression is a human need, universally present in children, and I have found a way to satisfy that need.

SELF-UNDERSTANDING B:
My parents have frustrated me, but they are too powerful for me to attack, and so I direct my hatred toward powerless children.

SELF-UNDERSTANDING C:
My parents gave me everything I ever needed, and so I came to believe that everyone must obey my every whim.

SELF-UNDERSTANDING D:
Because my father stole the love of my mother from me, I became jealous. I repressed this jealousy. The repression caused me to project by hostility toward other males.

SELF-UNDERSTANDING E:
Everyone has bad feelings which he must get out of his system. As soon as I have expressed all my bad feelings, I will act differently.

SELF-UNDERSTANDING F:
My early aggressive acts toward young children happen to have been reinforced on a variable ratio schedule, accounting for my present high aggressive response frequency.

Self-acceptance, on the other hand, while sharing some of the weaknesses of self-understanding, is really less satisfactory as a counseling goal. As might be expected, there are a number of definitions advanced. Let us define self-acceptance as that degree to which a person expresses satisfaction with his or her present behavior. When this is used as a goal, the following problems may arise: (1) Self-acceptance as a goal can often negate the value of self-improvement. Dissonance between one's self-perception and one's ideal self can be resolved in only one of two ways: (a) by bringing one's behavior up to meet one's ideal, or (b) by bringing one's ideal down to meet one's behavior. Although self-acceptance can be achieved by either action, counselors who use it as a goal may encourage the client to accept his behavior rather than teach the necessary steps toward achieving the ideal. If it is argued that self-acceptance really means the reverse, that is, that it is not

passive, then why is it necessary to identify an internal mental state called self-acceptance in the first place? The specific, constructive behaviors used to reach the ideal would seem to be much more useful goals. (2) Self-acceptance suggests an inflexibility in human behavior. The notion that each person has a characteristic nature which must be accepted is responsible for such advice as: "Be yourself" or "Act the way you really are." Since we know that a person is what he/she has learned to be, there is no inherent and inflexible nature which must be accepted. Moreover, it is possible and desirable for people to alter their characteristic ways of responding or behaving when it is appropriate to do so. The danger in stating self-acceptance as a goal is in its interpretation: asking a person to maintain a behavior simply because it had been learned in the past. A more effective goal formulation would be one of specifying the behavior, real or ideal, which is appropriate to specific situations.

The issue is really one of behavior identification and measurement. First, one must be able to identify what it is that is to be changed in terms generally agreed upon rather than in esoteric terms. Next, it is necessary to specify how measurements are made. This two-pronged procedure comprises the skill of goal-setting; a skill seldom taught as a part of counselor training programs. Its possible that the major source of resistance and anxiety on the part of counselors is this very lack of skill. More than adherence to a given

theoretical orientation, this inability may be ultimately more obstructive in achieving a significant relationship with the client. We must assume that most counselors are genuinely committed to their clients and would welcome any demonstration of their effectiveness. The question therefore remains: how can success or effectiveness be demonstrated if its criteria are not clearly established? Obviously, we have to specify where we are going if we are to know when we've finally arrived. Accountability, therefore, both for the profession and the individual counselor, is one advantage to be gained from specific, behavioral goal-setting.

Another advantage of specificity in behavioral goal-setting is that the more clearly the goal is set the greater is the perception of success. From educational psychology, we learn that when a task is clearly and specifically defined first, its learning is enhanced. Goals, when stated adequately, serve a similar function. For example, a machinist must know what task is to be performed before he selects a tool. Similarly, a builder does not select materials nor set up a schedule before he has received his blueprints. A client is most likely to perform the requisite learnings when he knows in advance precisely what he is to do and how he is to do it.

Another advantage is the opportunity specific, behavioral goals provide the client to monitor his own progress. As behavior approximates the point of success, identified in

advance, the client is progressively reinforced, thereby securing the counseling outcome. Obviously, this reinforcement can only occur if the goal is adequately identified.

One final advantage of specific, behavioral goal-setting is that it enhances the counseling process, itself. The goals minimize disparities between the role expectations of both counselor and client; at the same time, they make clear the purpose of counseling. That these disparities exist, particularly with lower-class clients, has been demonstrated. When goals are adequately set, the chances of premature termination or frustrated outcomes are significantly reduced.

People come to counselors with problems of varying degrees of severity. The continum ranges from those who want help in simple decision-making to those paralyzed by confusion, turmoil, fear, guilt, and excessive environmental pressures. Many forcast a dramatic increase in the need for professional services as the world becomes more complex. There is obviously increasing need for counselors who can offer the most efficient techniques to the greatest number of persons in the shortest possible time. Specific and behavioral goals are the only defensible type of goals that an effective counselor can set with his clients if he keeps abreast of the experimental developments in his profession.

This presentation adapted from:

Krumboltz, J.D. Stating the goals of counseling. Monograph No. 1, California Counseling and Guidance Association, 1966.

APPENDIX C

INSTRUCTIONS TRANSCRIPT

INSTRUCTIONS

It is not usual for a client to begin a counseling relationship by requesting assistance to change specific behaviors. Seldom do clients say at the inception, "I want to learn to speak up in staff meetings," "I wish to learn to be less anxious in the presence of eligible members of the opposite sex," or "I wish to learn more information related to my career interests." If clients were to express their goals so clearly and specifically, it would be quite easy for the counselor to negotiate with them what they will try to accomplish. Actually, most of the people we see will not specify their problems in behavioral terms. Most of them really cannot identify what behavior they wish to change. Clients are usually confused and uncertain. Presumably, among the most important skills that a counselor possesses is the ability to translate the highly complex problems of clients into terms that are clinically manageable.

The first task of the counselor is that of listening carefully to the client's concerns. As this is being done, the counselor seeks to understand the client's thoughts and the feelings they provoke. He makes every effort to perceive the situation through the point of view of the client. The counselor must communicate this understanding to the client while attempting to check to ensure that this perception of the client's thoughts and feelings is accurate.

There is still more that the competent counselor will

seek to do in the initial stage of the counseling relationship. In addition to listening empathically and clarifying the perception of what the client is experiencing, the counselor also tries to answer the following questions: What precisely is happening to the client in his everyday life? What are the specific ways in which others respond to the client's actions, words, thoughts and feelings? Much attention is focused on the client and on the details of his living environment.

In some cases, listening empathically may be all the counselor needs to do. Understanding without condemnation may relieve the client's quilt feelings. Merely, by providing a sympathetic audience, the counselor may facilitate the client's verbalization of plans, thereby making it possible to proceed without any further intervention by the counselor. All counselor must, of course, be taught to be empathic listeners. But they should be taught more. As we pointed out, a good listener may be all that some clients want, but most require more. Most client's problems, once they are understood within the framework of the clients' experience, will challenge the counselor to employ other skills.

The counselor must be able to assist the client to describe how he/she should ACT instead of the way in which he/she currently ACTS. The counselor must be able to assist the client to translate confusion and fears into a goal for which the client is willing to work and which operationally solve the problem. To do this, the focus must be the specific behaviors in the client's present situation.

The counselor has two primary purposes, then: (1) To facilitate the client's expressions of his/her concerns. This includes helping clients describe the problems as they perceive them and to express their feelings about them. (2) To assist the client to translate this description into behavioral terms. Together they must identify, specifically, the behaviors that should be learned or unlearned.

What then is a good counseling goal? How specific should it be? As examples of counseling goals, the counselor and client might agree to: (a) help develop a client's self-actualizing potential more fully, or (b) increase the frequency of positive self-statement emitted by the client.

Conceivably, both of these may be considered as good outcomes; they may even be the same practical outcome. To a client, developing self-actualizing potential may be a primary goal, holding more meaning or personal appeal. The counselor, on the other hand, may use the term to mean a composite of more specific goals. The problem is that self-actualization is a hypothetical state that cannot be observed. It can merely be inferred from certain visible or audible behaviors of the client. Using self-actualization as a goal, the counselor is unaware of the activities the clients should engage in as he/she approaches attainment of the goal. It is, therefore, difficult for the counselor to know what should be his/her role in the relationship and the client is also deprived of a way to measure progress. As a result, the first goal is

not satisfactory because it fails to provide the counselor with guidelines for conducting the helping relationship.

Only when the outcome goals are expressed in precise terms do the counselor and client understand what is to be accomplished. And this understanding is vital to the effective intervention into the client's problem; thereby reducing the maladaptive behavior. For example, a student counselor was seeing a client whose problem was friction caused by her and her brother's competing desire to use the family car. A vague or inappropriate goal could have been:

> to develop a greater understanding of her feelings, her brother's feelings, and their relationship.

They, in fact, established a much more specific goal:

> to learn how to schedule the use of the family car so that they both used it an equal number of times each week.

Another important facet of the notion of working with specific and behavioral goals are the advantages derived by the counselor. The counselor can obtain the cooperation of the client more easily since the client more clearly understands what is to be done. Additionally, it is easier to select intervention techniques now that specific tasks are identified. Finally, both the counselor and client can recognize progress and this is, in itself, a rewarding experience.

It cannot be over-emphasized that it is crucial to the process of goal-setting that clients participate in it. Many times, goal-setting is taken to mean that the counselor listens

to the client's concerns, makes a mental diagnosis and prescribes a treatment. Such an approach is, in fact, hopelessly doomed. In order for there to be a true and efficient counseling relationship, clients must be involved in the process of goal-setting. When they are not, their involvement is, at best, directionless, and at worst, an interference. An illustration may help: A beginning counselor was seeing a male client who was overweight, self-conscious about his appearance, reluctant to enter into social relationships with others and very lonely. Recognizing the central role played by the problem of his weight, the counselor informed the client that one goal would be for him to lose three to four pounds per week, under a doctor's supervision. The client became really defensive and rejected the counselor's goal, saying: "You sound just like my mother."

A goal to resolve a client's problem is a highly personal task if it is to be useful. It must, therefore, be identified by the client as important enough to make sacrifices for. The counselor, in our example, should have moved more slowly, permitting the client to identify for himself the consequences of his overweight, and then together they could identify the weight goal.

Remember, hardly ever does a client begin a counseling relationship by seeking assistance to change a specified behavior. Clients are more likely to describe a characteristic about themselves rather than the ways in which the characteristic

is experienced. It becomes the counselor's job to orient the client to describe the ways in which he/she would ACT differently. This might seem to be an overly pragmatic point of view. However, it is justified by the fact that the average counselor does not err by being too action-oriented or pragmatic.

Subsequent to this, in order to evaluate whether counseling has been successful or not, criteria of success must be established. If counseling has been successful, then some change in behavior must have occurred. Thus establishing a criterion of success follows the identification of the target behavior and becomes, in a sense, the standard by which this behavior is to occur if behavior change is to be considered successful. So then, useful goals have the following two characteristics: (1) They identify or describe the specific behavior to be or not be performed; and (2) They indicate the acceptable level of performance, that is, how long, how often, or how well, so that client attainment of the goals can be observed, measured and recorded.

Of the two characteristics of specific and behavioral goals in counseling, this latter one--identify the criterion of success or the level of acceptable performance--can be the more difficult skill for the counselor to learn. In determining a level of success, it is necessary to determine how the client is presently performing the target behavior. This process is known as determining the BASE RATE or the point of

beginning. Base rate must be obtained if the goal is to be realistic and also if the client's progress toward it is to be measured.

Measurement of both pretreatment and posttreatment performance of a target behavior can be accomplished in at least three ways, depending on the nature of the behavior and the conditions associated with it. The three common ways by which behavior is measured are: (1) how often (frequency); (2) how long (duration); and, (3) how well (standard). Frequency counts simply require a tally of the number of times the target behavior occurs in a given period of time. This measure is particularly useful when the target behavior is discrete or noncontinuous. A discrete response or behavior has a clear beginning and end so that separate units of the behavior can be easily counted. The second method of measuring behavior is based, as the name implies, on the duration or length of the behavior. Duration is useful in situations where the purpose is to increase or decrease the length of time the behavior is performed as opposed to the number of times it is performed. This is a rather simple measure to use. One merely notes the times when the behavior begins and when it ends. Obviously, the important focus is the clear definition of the behavior including its onset and termination. This measure is used with behaviors that are not discrete but are rather continuous or ongoing. Using duration as a criterion of success would therefore consist

of identifying the length of time for which it is to endure each time it is performed. Finally, the standard of performance refers to the quality of a behavior, e. g. a client may wish to swim daily (frequency) for two hours (duration) or be able to swim at least 100 yards (standard).

Selection of a measure or criterion from among the three--frequency, duration, and standard--depends as mentioned before, on the nature of the target behavior and the conditions associated with its performance. Some behaviors lend themselves well to frequency counts because they are discrete. Some examples are: the number of obscene words used or the number of classes cut or the number of persons greeted. Other behaviors lend themselves to duration because they are ongoing. Examples of these are reading, working, crying, studying, sitting or watching TV. Yet others are suited to the use of standards because the quality of a behavior is essential to its mastery. Examples might be: to play the piano well enough to give a recital; to raise one's grade point average to 2.50.

Now the question could be asked: How does a counselor work with clients so that they develop a statement of the client's goal of counseling which is both specific and behavioral? The counselor and client, by this time, have become quite well-acquainted. Moreover, they have discussed the client's concerns and now share an understanding of these concerns. In order to assist the client to formulate a goal which lends itself to evaluation, the counselor may facilitate the client

through the following steps: (1) the general goal, (2) the behavioral goal, (3) the observable behavioral goal, (4) the measureable behavioral goal.

The general goal is that which the client generates in response to the question: "How would you like your situation to be altered as the result of counseling?" or, "What would you like your situation to be like if counseling were successful?" or, "What would you like to accomplish with my help?" The behavioral goal, then, becomes the client's response to this question: "What would you be able to do then?" or, "What would you be doing differently then?" or, "What would you have done or accomplished then?" or, "How would you act differently then?" These two questions have together caused the client to produce a statement of his/her aspiration for counseling success and to focus on the actions that are prompted by this statement. Now the counselor will seek to help the client to further specify the essential behaviors by formulating the observable behavioral goal. This results from the client's response to the question: "How could I (others) tell you were doing it?" or, "How could I (others) tell you were able to do it?" or, "How could I (others) tell you had accomplished it?" or, "What will I (others) see or hear that will let us know that you are doing it?" Finally, the counselor helps the client to formulate the measurable behavioral goal by posing one of these three questions: "How long would you do it?" or, "How often would you do it?" or, "How well

would you do it?" The question asked by the counselor--how often, how long, how well--is determined by the nature of the behavior in question. Some behaviors lend themselves to a frequency count, how often; while others are amenable to a measure of a duration of time, how long; still others are best suited to a measure by some agreed-upon standard, how well. These three questions, then, employ the three criteria of success. One of these must be a part of each appropriate goal statement which must also contain the target behavior.

Let us now return to the four steps--(1) the general goal; (2) the behavior goal; (3) the observable behavioral goal; and (4) the measureable behavioral goal--and illustrate their uses. Let's say a client's presenting problem is that he is shy in romantic settings, and as a consequence, has no social contact with females. His preoccupation with this dilemma has begun to neutralize his effectiveness in many other facets of his life. In response to the counselor's question: "What would you like your situation to be like if counseling were successful?" He may say, "I want to be confident around women." The counselor then will ask for a behavioral goal: "What will you be doing differently then?" To which the client may respond, "I will be enjoying female companionship." The counselor then presses for an observable behavioral goal, "But how will I, or anyone else, tell that you are doing that?" "Well," the client may say, "I will be dating." Now that the target behavior has been identified,

the counselor can seek to get the client to determine how dating success will be measured. So he asks him, "How often would you want to be dating if counseling is successful?" "About three times a week," the client may respond. So then the goal statement can be formulated in this way: If counseling is successful, the client will be dating at least three times each week.

As a second example of how to formulate a target behavior followed by its criterion, let us examine the following situation: A counselor has been seeing a young woman for two sessions. In summarizing, the counselor might say something like this: "Judy, let's see if I understand all that you've been saying: you can't seem to concentrate on your studies and you are afraid that you may even flunk out. This causes you a great deal of anxiety and you would like to do something about it. Is that about right?" Judy would probably respond, "Yeah, that's it." Applying the four-question method, the counselor would say, "How would you like things to be after counseling?" The reply could be, "Well, I sure wouldn't want to flunk out." This, of course, is the general goal. To guide the client into the behavioral goal, the counselor might say, "What would you have to do differently to prevent flunking, that is?" The client might say, "Well, I guess I'd have to study a lot more." Now we try to establish an observable behavioral goal: "How would I be able to tell if you do study more?" The reply could be, "Well, I figure if I studied more

my grades would improve." And finally, the measurable behavioral goal: "How much improvement would you want or need?" Now that the target behavior is established (study more) we move into the criterial aspect.

"How much more studying time do you feel this requires?" the counselor would say. "Well, probably at least three hours a day on weekdays and six hours a day on weekends." There we have it: the goal statement--if counseling is successful the client will be studying three hours per night on weekdays and six hours during two weekend days.

This presentation adapted from:

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APPENDIX D

MODELING TRANSCRIPT

MODELING

As an orientation, much earlier we discussed with you the advantage of setting specific and behavioral goals with clients. In so doing, some attention was paid to the weaknesses of goals that are not specific and refer to non-behavioral abstractions. Later we attempted to teach you how to set specific and behavioral goals as part of your efforts to help clients. What we would like to do now is present three mini-counseling examples in which three different counselors demonstrate how the skill can be used with clients and how goal-setting should not be done. In the first segment, an example of appropriate goal-setting behaviors with a client is provided. The second counselor will work with a different client only this time a negative example will be provided. Then, to confirm the contrast, a third counselor will, working with the same client, demonstrate once again the skill of setting specific and behavioral goals with clients.

(male client and male counselor)

> "Well Ricky, I feel like we've had a really productive two sessions and I'd like to spend the last few minutes here summarizing some of the things you told me and kind of working on where we're going to go in the future. Ahmm. . . you've told me that your whole life has centered around getting into Medical School and becoming a Medical Doctor and everything was fine the first year and now that you're into your second year, you're finding out that you are having a lot of trouble with your Human Anatomy lab. Ahmm. . . You have a lot of trouble, as I understand it, making the incisions on your cadaver and you're relying a lot on your lab partner who is perfectly

willing to make all the incisions for you while you take notes. But you told me that you don't feel comfortable doing that; that you want to be able to pull your own fair share. I was wondering if underlying what you've told me so far is the feeling that maybe you just weren't cut out to be a doctor afterall."

"That's right. . .you know. . .right now I'm really worried about getting through Medical School. . .you know. . .its come to that point. I'm beginning to think that I, I may not make it."

"And this, I imagine, is pretty scary."

"Yea! I've worked at accomplishing this aim for such a long time now, you know. . .ah. . .the pressure is really starting to get to me. . ."

"I see."

"I may not make it."

"And its awfully hard to perform under that pressure."

"Yea!"

"If the sessions that we're going to have. . . ah if they are going to be successful, what would you like to be able to do when you leave here?"

"Well, you know, eventually, I'd like to make it through Medical School."

"Right, O.K., that sounds like a very general goal; can you be a little more specific about getting through Medical School?"

"Yea. . .er. . .you know, the problem that brought me in was my Human Anatomy course. . . er. . .I haven't been able to cut on the cadavers. You know, I. . .I just haven't been able to do it. I'd get my hand and the scaple up there and all of a sudden I'd just freeze. I just. . .I. . .I've tried several different things and the instructor has been very helpful. My lab partner has been really helpful, you know, she. . .she's done most of the cutting while all I've done is taken notes. . .I've learned that way to a great extent, so far. . ."

"Ihhmn."

"But unless I can start to cut, unless I can pull my fair share of the load, ah. . .I might not pass this course and if I don't pass the course, the exams at the end of second year are going to flunk me out."

"I see, so specifically you want to be able to make incisions into the cadaver and be able to do the disections."

"Yea, and I've got to start doing that right away cause we're at the middle of the semester now and I know its going to take me a while to, you know, to be able to do that over a longer period of time but I need your help right now in making the first cut."

"O.K., say we're off into the future, how long would you like to make the incisions for?"

"Well, initially, I'd like to be able to do it for one three hour segment. . .you know. . .er, our lab meets for three hour periods three times a week and so I think, you know, I can. . .even if I were only to do it one day a week. . .to work that full three hours one day a week. . . ahm. . .I think I could have some success with the course."

"O.K., I agree, so then, specifically, you'd like to be able to perform the disections every other time for three hours?"

"Yea! I think that would ensure my success in the course."

"O.K., I think those are really very specific goals and things that we can work on. You've told me that you want to succeed in Medical School and more specifically that you want to get through the Human Anatomy course and success in Human Anatomy involves making. . .ahm . . .incisions, being able to do your disections and you'd like to be able to share the responsibility by doing it for one three hour period every other time."

"Right, if I can do that, and I can get through this course then I will be O.K."

* *

(female client and male counselor)

"Ann, from what you tell me I think I understand that. . .ah. . .things were really pretty good with Phil, . . .er. . .during the seven years that you were married, up to the time about two years ago when he got that promotion. And since then its really been downhill; he's been taking work home and not spending time with you and. . .ah. . .Things have just been escalating and getting worse and worse. Now you've been bitching at him a little bit and overall it just seems like for the last two years things have not been worth it, maybe."

"That's right."

"Well, do you think perhaps. . .er. . .since he got that promotion that he's changed any?"

"Oh! yes, I have no doubt about it. He was never worried before about how much he accomplished or how much he impressed people or what he looked like when he went to the office. And since then that's the only thing that's on his mind. I don't have any time. . . don't have any part of what he thinks about."

"Hmn. Just like he doesn't care about the things that you value now."

"Oh! no, and he used to."

"Yea. . .seems like it really changed him quite a bit."

"I think it did and too I think I've changed some in the last two years."

"Huh, tell me about that."

"Well. . .one thing is because he is concerned about those things, I feel pressure on myself to perform around his colleagues and. . .and to keep the house nicer and to dress better and all those things and that pressure. . .I don't like and, and it affects me. . .But he can't understand that because he seems to thrive with all that kind of pressure. It's a very difficult

thing for me to deal with and he doesn't see it as a problem at all."

"He really likes the pressure and to you it really makes you uptight and. . .ah. . .maybe in the last couple of years or at least since you origianlly got married. . .ah. . .you've become interested in some things that are a little different from what he is interested in now."

"Oh! I have. Ah. . .for a while before we were married I'd done some art work and. . . when he started doing so much work at the office, I was looking for something to do with my time and energy and I have been working with art and teaching children art at a, at a place for underprivileged children here in town and I've enjoyed that so much and I get a real satisfaction from that, I feel like I'm helping someone else and he doesn't understand that at all, he sees it as a waste of my time."

"Would I be right that the two of you don't talk about your interests very much?"

"Oh! no, we don't at all, sometimes I try. . . or at least at the beginning I tried to. But I've given up now."

"Well it seems to me like you would really like to be happy again in your marriage like you were maybe five years ago."

"Oh! yes, I remember those days so fondly. We'd do things together and we'd go places. . .we'd go shopping together and. . .we just don't do those things anymore and I feel like the time we spend apart takes our interest apart as well."

"Ihhmn."

"And I don't know how to go back to that again and when I try to talk to him about it, he reads the paper or something, he never pays any attention to it."

"Maybe you're going to have to generate some of that happiness on your own."

"Well I try to. . .but that is when I'm outside the house; when I'm with my friends and with the

children and I'm happy then but when I go home I can't take one into the other and I want to be able to do that. And as much as he spends time with his friends as well, there are still hours during the day that are ours together and. . .those aren't very happy."

"As I see it, our task together is to, ah, help you get to the point where you are feeling happy again about your marriage and ahm you'll feel more like you did back in the early days."

"Well, that's what I'd like to do and it's not that I'm not happy with my marriage. I want to stay married to Phil. I just want to enjoy it more and want him to too."

"Maybe not just your marriage but your whole life you'd like to enjoy more."

"That's true, I think. But its hard for me to talk about that."

"Well it might be important that we talk about some of the other things that. . .ah. . .in the other parts of your life that you are not as happy with."

"Well I feel like though I'm satisfied with working with these children, I feel that I have capabilities far beyond that and that these are not being tapped. And no one asks me to do the things that I feel like I do the best and so I feel frustrated in that way. Does that make any sense?"

"Well it sounds to me like. . .ah. . .maybe you feel that you. . .ah. . .that your capabil-itites aren't. . .ah. . .appreciated not only by Phil but maybe by other people in other parts of your life."

"Well, I think that's part of it but it's not that I want to be appreciated so much as I want to be challenged in those areas and I feel that I'm not being challenged."

"It seems to you maybe your life is kind of a blah right now?"

"Aha, and they appreciate it but that's still not a challenge to either my artistic skills

or teaching skills or. . .it just doesn't challenge me. I feel that they love me for just being myself and. . .and that's not challenging."

"Ihhmn."

"So I. . .I do feel that that's what I need."

"Maybe it would be worthwhile if we were to help you to try and feel more fulfilled. . . ah. . .to find interesting and challenging things to. . .ah. . .get involved in with your life."

"There was a time in my life when I had things like that, when I was going to the University I felt that there were things that I did that I enjoyed. I had many friends, a variety of activities, all of which I was at least fairly good at."

"Ihhmn."

"And that life is gone and I miss it and don't know how to recapture that. . .that enjoyment, that love that I had then."

"You know, that happens to quite a few people that. . .we start out and. . .ah . . .we don't have the responsibilities, we're younger, we're caught up in life, it's pretty exciting. But then. . .ah. . .as time goes by we lose some of that enjoyment, some of the sparkle goes out of things and maybe its time for you at your stage in life now to, you know, maybe try to redevelop some of these. . .ah. . .interests and feelings and to. . .ah. . .see if your life can become a more exciting and turning-on experience."

"But I don't know how I can do that without Phil's help; that somehow those, those exciting enjoyable things that we did together and when I think of doing them again or anything else that is exciting and fulfilling I think of doing them with Phil though the exciting things that he is doing right now really exclude me."

* *

(female client and female counselor)

"During the last few sessions that we have had together, Ann, you've told me a good many things about yourself. Ah. . .you've shared many of your experiences with me. I'd like to take just a few minutes now to go back over the things that you've told me and sort of organize them to be sure that. . .ah. . .it's all clear in both of our minds. Is that all right with you?"

"Sure Mary, that's fine, go ahead."

"All right, ahm. . .now you told me that you and Phil have been married for seven years and now you're afraid that something is happening to your marriage. . .ah. . .the earlier times between you were very good. You've always enjoyed being in each other's company. . .ah. . .you've shared many happy experiences together. . .ah. . .sex between you has been very satisfying for both of you. . .ah. . .even your problems when they would come up you were always able to talk through and come to some understanding about. By and large, you just really have enjoyed each others company. Then about two years ago, things began to be different between the two of you. Ahm. . .at that time, Phil got the promotion that he's been working very hard to get and. . .ah. . .since that time he's been spending more and more time at the office. When he does come home he brings work home with him and you feel that he is just literally swamped with work all the time. Ahm. . .because of this you. . . ah. . .have really begun to criticize him quite a bit. Ahm. . .when you speak to him its in a very biting manner; when he speaks to you, you harp back at him and. . .ah. . .you feel that now he's beginning to avoid you because of this. Ahm. . .sex between you has become a rather automatic thing; something that you do because you feel like it's expected of you. Ahm. . .and you find that you are just trying to spend as much time with other people as you can rather than just being with him. Does that pretty well sum up everything that you've said to me so far?"

"It does Mary, it sounds pretty bad, doesn't it? Seems like there must have been something I could have done but. . .it's in a pretty big mess now."

"Well, let's see what you and I can do to make it better. Ahm. . .tell me Ann, how would you like for things to be between you and Phil after the counseling is over?"

"Well, I'd like for us to get along better, I'd like for us to be happy like we were before. I suppose I'd just like to be nicer to him."

"All right, you want to get along better. How do you think things would be different then?"

"Well, I guess if we were happier together, he'd be nicer to me and I'd be nicer to him."

"So you want to be nicer to Phil. I want you to tell me something that would indicate specifically that you were being nicer to Phil. What would you do?"

"Well, I do a number of things now that are mean to him. I guess if I left one of them out or some of them out I could say that I was being nicer to him. But see, I guess the worst one is. . .is that I'm so sarcastic, sometimes for no reason at all. . .I'd just make a sarcastic statement to him. And I know it hurts him but at least I get some reaction from him. I get his attention there for a minute. So I guess those sarcastic statements, if I could cut them out I'd really feel like I was being nicer to him."

"All right, you've been making these sarcastic statements to him for some time."

"Yes."

"Probably, over the last two years you've been making them."

"Yes."

"Ahm. . .realistically, how many of them do you think you will cut out starting right now?"

"Well, I suppose it would be unrealistic to say that I would stop them completely right now since its taken me two years to develop this habit but I guess. . .I guess if I could cut out say. . .two of three sarcastic remarks that

I might otherwise say to him, I think that would be an imporvement and I think he'd notice that."

"All right, I think that's a very wise thing, Ann, ahm. . .let's see if we can put that into a goal statement for you. Ah. . .your goal is to cut out two of the three sarcastic statements that you are making to Phil now. Does that sound like something you can live with?"

"Well it sounds like something I'd like to live with. I don't know if I can do it or not. But it sounds like a good thing to me."

"I think it's a good goal statement, Ann."

APPENDIX E

SUBJECTS' INSTRUCTIONS

Instructions to Subjects

Sitting before you is a graduate student who will play the role of a "client". She has been coached in her role which appears below. Your job is to interview her and gain any information necessary in order to arrive at a mutually agreed upon goal-statement. Imagine that you have been talking with her long enough to get the information listed below. Proceed with the interview collecting any further information you want to have, and try to establish with the "client" a reasonable goal or objective as to what the "client" would like to achieve as a result of your help.

Do NOT try to offer solutions to the "client's" problem or suggestions as to what she might try to do. Remember: Talk with the "client" briefly and then try to negotiate a goal or objective related to what she desires from counseling.

The "interview" will be recorded and limited to fifteen (15) minutes.

The Role

Your client is a young married woman who feels inept in interpersonal dealings. Her recurring problem is that she is particularly dissatisfied with her inability to cope with door-to-door salesmen. They show up on the average of three times per week. This frequency is explained by the fact that she lives in an affluent, newer development of young marrieds, many of whom have small children.

Somehow she can't bring herself to say "no" to these

salesmen. She's been taught that "no" is rude. So, since she can't say "no" to them, she winds up either by wasting about two hours each time listening to their spiel, or else she gets rid of them by buying something from them, usually something she doesn't want or need.

APPENDIX F

COACHED-CLIENT'S ROLE

Client Role

Your person is a young married woman who feels inept at interpersonal dealings. Her recurring problem is that she is particularly dissatisfied with her inability to cope with door-to-door salesmen. They show up on the average of three times per week. The frequency is explained by the fact that she lives in an affluent, newer development of young marrieds, many of whom have small children.

Somehow she can't bring herself to say "no" to these salesmen. She's been taught that "no" is rude. So, since she can't say "no" to them she winds up either by wasting about two hours each time listening to their spiel, or else she gets rid of them by buying something from them, usually something she doesn't want or need. This, naturally, leads to many fights with her husband.

You may begin the interview by saying:

"So you see, I've got to come up with something. I can't allow things to go on as they have been," or, "There are a lot of situations where I can't seem to say what's really on my mind to people. But this business with the door-to-door salesmen is really getting to me. I've got so much of their junk it's getting ridiculous."

APPENDIX G

FOLLOW-UP QUESTIONNAIRE

FOLLOW-UP QUESTIONNAIRE

SUBJECT NUMBER _____

1. How would you rate the first lecture for its resemblance to a typical classroom situation?

   unreal ' ' ' ' ' ' real
   1 2 3 4 5

2. How would you rate the "client" you worked with in terms of how well he/she played the "role"?

   unreal ' ' ' ' ' ' real
   1 2 3 4 5

3. If you saw the role-played model, how would you rate it in terms of its resemblance to a real counseling situation?

   unreal ' ' ' ' ' ' real
   1 2 3 4 5

4. Describe your overall experience referring specifically to its approximation of typical classroom instruction:

_____

_____

_____

_____

_____

_____

_____

APPENDIX H

COUNSELOR GOAL-SETTING SCALE

COUNSELOR GOAL-SETTING SCALE

		Score
A.	Behavior	
	absent	1
	vague or inappropriate	2
	specific	3
	Criterion	
	absent	1
	vague or inappropriate	2
	specific	3
B.	No goal or counselor's goal	0
	Clients goal or mutual goal	1
C.	No goal or short-term goal (process	0
	Long-term goal (target)	1
D.	Action-oriented or implements action	0
	Non-action oriented	1
	Total:	_____

APPENDIX I

RATERS' INSTRUCTIONS

RATERS' INSTRUCTIONS

Throughout this study, and therefore in this scale, the word "goal" is used. For this purpose, "goal" is defined as a target behavior and its criterion.

In Dimension A, on the table, you notice that there are six subdivisions: behavior--absent/vague/specific; and criterion--absent/vague/specific. These are defined below:

Dimension A

BEHAVIOR	CRITERION
1 = No statement of a behavior related to the performance desired by the client in the future. ABSENT	1 = No statement related to the amount of the behavior desired. Direction (more, less) may be included as part of the behavior.
2 = A general, non-specific statement of behavior in terms of: (1) An abstract performance. Examples: "to feel better" "to try harder" or "to handle the situation better." (2) An internal state such as anxiety, embarrassment, guilt, frustration. Examples: "to feel less anxious" "you'd like not to be so frustrated." The behavior stated is not clearly observable or reliably verifiable. VAGUE	2 = A general criterion without discrete quantity. Examples: "pretty soon" or "as early as possible" or "a few more times" or "until you're satisfied" or "a reasonable amount."
3 = Statement of a relatively discrete behavior which is to be performed by the CL and which can be overtly observed and externally verified. Examples: (1) "to be able to say no." (2) "to talk to a salesman for a certain time." (3) "to buy a certain amount." SPECIFIC	3 = A statement related to the behavior and which is reliably quantifiable. Examples: (1) "(to say no) to one (or two) salesmen out of three who approach you.: (2) "(to spend) no more than 15 minutes listening to a sales presentation." (3) "(to spend) $5 or less on products per week."

Dimension B

0 = No goal (automatic if Dimension A totals "1")

0 = Counselor's goal

1. Outright imposition of CO's goal
2. CO leads CL (CL agrees reluctantly or neutrally)
3. CO ignores, distorts or "interprets" CL statements related to desired outcome

1 = Client's goal or mutual goal

1. Outright statement of CL's desires (perhaps organized with help of CO)
2. After being given information CL is involved with decision
3. A negotiated statement

Dimension C

0 = No goal (automatic if Dimension A totals "1")

0 = Short-term goal - a process goal, or an evaluative goal. Example: ". . .why not try that next week and then when you come back we can talk about it," or "let's see if after some assertive training you can try it out for a couple of weeks."

1 = Long-term goal - a target goal, or an outcome, ideal goal (regardless of process). Example: "you want to be able to spend one hour or less talking to salesmen per week." Note: There may no mention of when this goal would be achieved.

Dimension D

0 = When strategy is mentioned in the summation statement (goal statement)

1 = When no strategy for that session or future sessions is mentioned in the summation statement (goal statement).

Prematurely directing the CL into an intervention.

Such remarks as, "let's role-play this situation and we'll see

if you can become more comfortable," may be appropriate as a follow-up to establishing a goal, but cannot be regarded as synonymous with a goal. It is already involving a strategy for inducing change. Examples: "Why don't you hang up a 'No Solicitation' sign?" "Let's say you try to say 'no' in front of a mirror. Would you be willing to try that?" "Why don't you close your eyes and imagine that you're the salesman? How can you handle a 'no'?"

REMINDERS

The important things to bear in mind when doing the rating are:

1. Don't be put off by the fluency or lack of it of the subject. Do they earn their score by performance, rather than by attractiveness or glibness.

2. If the subject mentions the behavior or criterion but later does not do so, he/she cannot be said to have accomplished the task, but, instead, to have accidentally touched on these points without giving them their due significance in the interview. It is what the CL hears last and in a clear, organized way which determines the evaluation of the goal-statement.

3. It isn't what to do, how to do it, or why something is done which defines a goal. It is what the CL wants to be able to do. Not HOW to get there, but WHERE do you want to be?

4. The earlier tapes will probably be heard differently from the later ones. Perhaps the ratings will change over subjects because
   a. you will adjust to the dimensions.
   b. you will become inured or fatigued.
   c. you may become more (or less) vigorous in your judgment.

   After several (say, ten) go back over what you've done to see if indeed you have altered your approach in technique. Thereafter, check it out periodically.

5. It's very important to hear the entire tape (of one subject) before you give a final score. Later statements may alter the rating.

6. It is not what the client says but the counselor's statements that are rated.