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SYSTEMIC CONSULTATION AND GOAL SETTING

ABSTRACT

Over two decades of empirical research conducted within a positivist framework has shown that goal setting is a particularly useful method for influencing task performance in occupational and industrial contexts. The conditions under which goal setting is maximally effective are now clearly established. These include situations where there is a high level of acceptance and commitment, where goals are specific and challenging, where the task is relatively simple rather than complex, and where progress is regularly monitored. Participation in goal setting has also been found to be vital for enhancing performance. Setting both individual and group goals improves performance providing both sets of goals are compatible. In this paper these findings, constructed though the lens of goal theory, are considered from a social-constructionist perspective and their implications for systemic practice are outlined.

INTRODUCTION

The concept of change is at the heart of systemic consultation and therapy. During consultation and therapy changes occur in the way the team, therapist and client co-construct their relationships to one and other, the problem situation and the possibilities for resolving it.

During consultation both the therapist's skilled inquiries and invitations to action, and the clients responses to these lead to the co-construction of a new reality: a reality which empowers clients to entertain new possibilities for thinking, feeling and action; a reality which entails new possibilities for being-in-the-world.

A core tenet of systemic practice is that it is not a useful distinction to view the therapist as responsible for causing beneficial changes in clients since both therapist and client are part of the same system which co-creates a shared reality during the consultation process. Rather, the therapist empowers the client to explore possibilities or perturbs the system and co-creates a reality that affords transformation (Pearce, Concha & McAdam, 1992; Burnham, 1992). It is therefore not surprising that the process of goal setting and reviewing goal attainment does not occupy a central position in current systemic practice, since both are usually associate with the positivist practice of

viewing the therapist as an agent who *does things to* the client to *make the client change.*

However, the process of goal setting and goal attainment monitoring fit with systemic practice within the domains of both explanation and production (Lang, Little and Cronen, 1990). Firstly, within the Explanations Domain, inquiries about desired futures facilitate the co-construction of new realities that may offer clients useful possibilities for change and transformation. Indeed, key figures in the systemic tradition such as Peggy Penn (1985) pioneered feed-forward questions as a routine type of circular inquiry nearly 10 years ago with precisely this argument in mind. Feed forward questions hold much in common with goal setting. They invite clients to detail future scenarios and the implications of these for system members. Secondly, within the Explanations Domain inquiries about goal attainment and beliefs related to different levels of attainment also help create realities which both open possibilities while at the same time taking account of clients constraints and affordances. Third, within the Productions Domain, goal setting and goal attainment review are a useful technology for managing tasks and executing duties which fall outside of therapy and the Explanations Domain but which, nevertheless, many practitioners and clients must complete.

An interesting question is the conditions under which goal setting and review empower people to achieve desired outcomes. Over two decades of empirical research, conducted within a positivist framework, has shown that goal setting is a particularly useful method for facilitating task performance in occupational and industrial contexts (Guzzo et al, 1985, Locke et al, 1981, Locke et al, 1990). Indeed of all the management practices researched, goal setting and review was by far the most effective. This literature contains findings which suggest ways in which therapists, working within a social-constructionist framework, may enrich their approach to goal setting in clinical practice. What follows is an outline of the positivist framework within which this research was conducted, a summary of the key findings and the implications of these for consultation and therapy.

GOALS AND PERFORMANCE

Goal setting is a process where members of a social system define a desired outcome, agree to work towards that outcome and agree to review progress towards that desired outcome. Goal setting may be conducted in an autocratic way, with one member of the system dictating the goals others must strive for, or it may be conducted in a participative way where all members of the team contribute to goal definition. Goals may vary in their clarity and the detail with which the desired outcome is described. System members may vary in their acceptance of, and commitment to goals.

In any system, both group and individual goals may be described.

Goals lead to improved task performance if certain conditions are met. First, a person has to accept the goal and be committed to attaining it (Hollenbeck, 1987). Commitment entails a high level of acceptance and also having a personal stake in the outcome of goal directed action plans. Commitment will be given to an accepted goal if it is consistent with a person's values and world view and if the benefits of goal attainment are, in the individuals estimation, worthwhile.

Second, specific goals lead to better performance than vague goals (Tubbs, 1986). *To improve performance and do your best* is a vague goal. *To complete all current client reports by 5.30 on Fridays* is a specific goal. When people set specific goals, it is possible to specify precisely what an observer would see if they attained the goals. Furthermore, specific goals allow degree of goal attainment to be quantified.

Third, challenging goals lead to maximal performance. If a goal is too easy and does not challenge a person then he or she will not find pursuing the goal rewarding. Goal attainment may be experienced as boring. If the goal is too challenging an individual may find the process of trying to reach the goal frustrating. If a goal is optimally challenging, maximal performance will occur (Shalley et al, 1987).

Fourth, participation in goal setting (in contrast to being assigned goals) is important insofar as it ensures that the defined goal will be specific, moderately difficult and accepted (Shalley et al, 1987). It may also be the case that participation in goal setting gives people a sense of control over the potentially stressful process of goal attainment, and this sense of control is stress reducing (Carr and Wilde, 1988)

Fifth, where more than one person is involved, in the case of work teams or families, group goal setting is as important as individual goal setting. The ideal is to set both individual goals and group goals which are congruent with each other (Matsui et al, 1987; Gowen, 1985).

Sixth, when goal attainment is explicitly assessed, goals are pursued more diligently. People like to be evaluated positively, so they do their best when they know their performance and goal attainment are

being monitored (Locke & Latham, 1990).

Goal setting leads to better performance for relatively simple rather than for complex tasks. For example, goal setting had a stronger effect on performance where goal attainment involved simple brainstorming exercises compared to when it involved conducting complex scientific research (Wood et al, 1987).

Specific psychological processes underpin the relationship between goal setting and performance (Earley & Lituchy, 1991).

Goals improve performance because they highlight the discrepancy between a person's current position and the position they aspire to. This creates dissatisfaction which serves as an incentive. The incentive leads a person to act in a way that reduces the discrepancy (Wood & Bandura, 1989). This process involves obtaining feedback on performance and comparing this with the desired goal.

When individuals achieve goals and obtain feedback about this success, their view of themselves changes. They view themselves as being more competent and effective. In Bandura's terms, they view themselves as having higher self-efficacy (Bandura, 1981).

These increased self-efficacy beliefs then influence the types of goals a person is prepared to aspire to in the future. People with high self-efficacy beliefs set or accept further goals that present them with a high degree of challenge. In this way, a positive feedback loop is set up.

A person's ability level sets a limit on the amplification of this positive feedback loop. At some point a person may set a goal that is too challenging and fail to achieve it because it is beyond their ability level. This will in turn decrease their self-efficacy beliefs in relation to such goals (Earley & Lituchy, 1991).

GOAL SETTING IN CONSULTATION AND THERAPY

Within the positivist framework, goal setting and review is not accepted as merely another lens through which to construct the world. Rather, goals and related constructs are accorded the status of objects to be discovered and the findings described as evidence for the existence of these entities. From a social-constructionist viewpoint, goal theory and its findings are a story: a frame within which certain types of events may usefully be given meaning and significance. Fortunately the goal theory story and the conclusions drawn from it have clear clinical implications for practitioners who wish to use goal theory as one lens through which to view aspects of the consultation process. Here are some of the more useful implications for systemic practice.

Help clients to set specific, moderately challenging goals which take account of their ability levels and current self-efficacy beliefs.
Here are two examples of goal setting that met these criteria.

> **Example 1.** An intelligent middle class couple who had a five year history of marital discord had lost faith in their ability to resolve any conflicts, no matter how simple. They set the following goal as their first in a series of progressively more difficult therapeutic goals: To complete a supermarket shopping trip without becoming involved in an angry stand-off.

> **Example 2.** A 30 year old recovered alcoholic had been dry for three years. He lived alone in Dublin, rarely visited his family of origin and had no network of friends outside of AA. He worked as a clerk in an engineering firm and was bright and socially skilled. However, he felt that he was not doing enough with his life and so sought counselling. He stated explicitly in the first fifteen minutes of the intake interview that he knew he could improve his lifestyle if he only put his mind to it. His therapy goals included: Visiting his mother and brother in the west of Ireland at least once a month; attending a course of night classes in photography and developing a career plan.

Do not help clients consider ways of reaching goals until it is clear that they accept and are committed to them.
A variety of future scenarios, possibilities and goals should be explored. When clients express a preference for one goal or set of goals, three key questions may be asked to check for acceptance and commitment:

- *Do you want to work towards these goals?*
- *What's in it for you if you achieve these goals and what will you lose if you don't?*
- *What's in it for you, if you stay as you are and what will you lose if you pursue these goals?*

If the clients say they want to work towards the goals and can clearly articulate the costs of not doing so and the benefits of achieving the stated goals, then they probably accept the goals and are committed to them. If clients cannot address the acceptance and commitment questions positively, then goal attainment is unlikely. The following example illustrates this point.

> **Example 3.** A single mother with a non-compliant six year old was referred by a concerned social worker for therapy. During

the intake interview the mother said that she and her son had about six big fights a day. The mother agreed to an initial goal of reducing the fights to no more than 4 a day. But when she was asked to explore what she would gain for herself by achieving this goal, she couldn't give a clear congruent answer even after much exploration. She also had no clear view of what the future would look like if she failed to achieve this goal. She feared having her child taken into care, but did not believe that she would ever physically harm the child.

In family work, set both personal goals and overall family goals that are compatible.

One of the major challenges in family therapy is to evolve a construction of the presenting problems that opens up possibilities where each family member's wishes and needs may be respected when these different needs and wishes are apparently conflicting. Helping family members articulate the differences and similarities between their positions in considerable detail and inviting them to explore goals to which they can both agree, first, is a useful method of practice here.

Example 4. Polly, a 15 year old girl referred because of school difficulties said that she wanted to be independent. Her parents wanted her to be obedient. Both wanted to be able to live together without continuous hassle. Detailed questioning about what would be happening if Polly were independent and obedient revealed that both Polly and her parents wanted her to be able, among other things, to speak French fluently. This would help Polly achieve her personal goal of working in France as an *au pair* and would satisfy the parents goal of her obediently doing school work. Getting a passing grade in French in the term exam was set as a therapy goal. It reflected the family goal reducing hassle and the individual goals of Polly and her parents.

Regularly assess progress towards these goals.

Ideally progress towards goals should be assessed in an observable way or in a quantitative manner. Frequency counts of the number of events that occurred are useful. For example: the number of fights, the number of wet beds, the number of compliments, the number of successes. Ratings of internal states are useful ways to quantify progress towards less observable goals. For example: ratings of anger, sadness, fear, confidence etc... on a ten point scale.

If this feedback is positive, discuss it in sufficient detail for

clients' to assimilate it into their world views. This will lead to enhanced beliefs in the family's ability to solve its own problems and increased solution focused behaviour in the future. This practice holds much in common with the problem solving school (Watzlawick et al, 1974), the solution focused approach (deShazer, 1988) the strategic school (Haley, 1976), the AGS commission model (Salamon et al, 1993) and behaviourally based practices (e.g., Martin, 1990) although the rationale for the use of feedback in strategic and behavioural approaches would be framed within a traditional positivist framework.

Distinguish between goal attainment failures due to lack of commitment and those due to lack of ability.
If clients fail to achieve a goal, the therapist must determine whether failure was due to a lack of acceptance and commitment or due to the goal being too difficult for the clients skill and ability level. Commitment may be assessed by asking the three related questions outlined previously concerning the costs and benefits of goal attainment versus the maintaining the status quo. Whether clients have the requisite abilities and skills to achieve a goal may be investigated in three ways. First, ask if similar goals have been achieved in the past. If they have, then the client probably has the required skills. Second, ask the clients to pursue the goal in the session and then observe their skills in action. Finally, ask for a blow-by-blow account of what went wrong when clients tried to achieve the goal that they set. This will throw light on skills deficits or commitment problems.

If failure was due to a lack of acceptance or commitment, then a new goal must be sought to which clients are strongly committed or the pro's and con's of goal acceptance need to be re-explored.
In multiproblem cases a common therapeutic mistake, illustrated by Example 5, is to select a goal to which the therapist is committed but to which the client is not.

> **Example 5.** A therapist selected improving family communication as a primary goal whereas the parents were adamant that getting better housing was their number one goal.

The related error is to set a goal without fully exploring the pro's and con's of goal attainment or relinquishing the status quo. In the following example exploration of the consequences of goal attainment had been too brief.

> **Example 6.** A nine year old boy and his mother experienced extreme reciprocal separation anxiety when the boy tried to

leave his mother at the school gate and attend class. The episode had begun when the boy changed school and after his aunt, to whom the mother was particularly close, had been hospitalised for surgery. The first goal that was set involved the boy travelling to the school gate with his father while the mother remained at home. The goal was not attained. Careful interviewing showed that the boy and his parents were not fully committed to him returning to school because of the anxiety this caused the mother and because of the impracticality of the father being involved in taking the son to school and missing work. Further interviewing focused on the pro's and con's of the mother and son staying close together and the mother and son gradually separating. Eventually, the same goal was set once more, but this time with a higher degree of commitment.

Failure to progress towards a goal due to lack of commitment may also occur because the client is not a customer for any therapeutic change whatsoever . If this is the case, then it is critical to assess the network and identify the customer. A catalogue of such situations and methods for dealing with them is described elsewhere (Carr, 1990). Example 3, above, typifies one such scenario. The customer for change was the worried social worker, not the mother of the non-compliant child. The minimum sufficient network for therapy, in this instance, therefore included the social worker in addition to the mother and the child.

If failure to make progress towards a goal is due to a lack of ability or skill, then a new goal consistent with the clients' ability levels must be set.

A common error, illustrated by Example 6, is to assume that clients have the micro-skills necessary to complete macro-assignments. In these cases smaller goals, ideally goals that will lead to skill development, need to be set.

Example 7. Members of a chaotic distressed family with a handicapped child set the goal of having a weekly family outing. They consistently failed to achieve this goal because they lacked the communication skills or conflict management skills necessary to plan the outing without serious conflict occurring. This goal was put on the back burner and an intermediate goal introduced which was more consistent with their ability level: to complete a family active listening assignment on a weekly basis for a month.

Sometimes failure to achieve a goal that was apparently consistent with a client's ability level when it was set can occur because of an unforeseen change in a client's circumstances as is the case in Example 8. Here the therapist must help clients assimilate the event into their belief systems in a way that allows the failure to be attributed to external factors. If the failure is misattributed to personal shortcomings, this will undermine self-efficacy beliefs. The literature on attributional style and family adjustment has underscored the tendency of members of distressed families to attribute failure to internal, stable and global factors (Munton & Stratton, 1990).

> **Example 8.** Over a series of six sessions, two fosterparents failed to achieve the goal of helping a teenage fosterchild on short term placement complete an evening meal without engaging in verbally-abusive conflict. The failure was in large part associated with the erratic and stormy series of unscheduled and unforeseen visits that occurred between the fosterchild and his natural parents during the period in which the therapy was occurring. The relationship between the lack of goal attainment and the visits were an important therapeutic focus in the sixth session. The way in which the visits activated the teenager's sense of insecurity and ambivalent feelings about both the fosterparents and his natural parents was explored. A contract for further therapy was established. The first goal set was to develop a strategy with the social worker and the teenager's natural parents for arranging a more predictable schedule of visits. The original goal of eating a peaceful evening meal was deferred until this first goal was achieved.

DISCUSSION

The empirical findings from over two decades work on goal theory and task performance and related implications for clinical practice shed light on a number of debates within the fields of systemic consultation and family therapy.

The Unplanned Conversation Debate. Hoffman's recent paper has created a danger within the field of novice therapists advocating and pursuing goaless conversations (Hoffman, 1990). A further problem with the direction taken in Hoffman's paper is that it may discourage therapists from explicitly reviewing progress regularly, a process which enhances goal attainment. While an unplanned approach to the therapeutic process may be useful in promoting a sense of participation and collaboration between therapist and client, the

overall therapy process may usefully be aimed at a specific goal. Perhaps Pearce and Cronen's (1980) Co-ordinated Management of Meaning model offers a useful explanatory framework here. Where *a series of consultations* is the context marker, goal directedness may be important for transformation and movement towards new possibilities. However, where *a particular therapeutic conversation* is the context marker, a less directive way of being may be more appropriate for the therapist.

Goals and Neutrality. One argument against goal setting is that the therapist becomes overly committed to certain therapeutic outcomes and so abandons a position of therapeutic neutrality. This type of argument is a bit like saying that therapists should not evolve hypotheses because they might 'fall in love with them'. Using goal setting and review within systemic practice need not lead the therapist to become overly committed to one set of goals and thereby compromise a position of neutrality. Rather, the reality within which goals are articulated must be carefully and skilfully co-constructed and goals should be treated with the same irreverence as a good working hypothesis.

The Ordeal Debate. Milton Erickson and subsequently Jay Haley argued that in some instances therapy should present the client with an ordeal or challenge (Haley, 1984). Others, notably the MRI school, have emphasised the importance of small therapeutic goals which nevertheless are noticeably different from the status quo and signal movement towards a larger goal (Watzlawick et al, 1974). The findings reviewed above suggest that optimally, goals should be set at the limits of a persons competence. This is in keeping with the Ordeal concept. However, the tasks that lead to goal attainment should be simple, not complex. This fits with the MRI position.

The Power and Deception Debate. Whether therapists should conceal or reveal their expert knowledge has been a central debate within the field. Allied to this has been the debate about whether therapy is a strategic competitive battle or a collaborative and co-operative problem-solving process (Carr, 1991). The work reviewed in this paper underlines the importance of participation in goal setting. This entails a view of therapy as co-operative and open venture rather than a competitive and deceptive enterprise.

The individual's needs and the common good. The subordination of individual needs to the needs of the family has been a central problem within the family therapy field. The goal setting literature points to way out of this dilemma by demonstrating that setting both individual and group goals improves performance provided both sets of goals are compatible. One clinical challenge is to pursue therapeutic inquiries that bring forth compatibility.

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