

A Structured Approach to Goal Formulation in Psychotherapy: Differences between Patients and Controls

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ABSTRACT

Therapeutic goals are considered a vital component in psychological treatments, but to date relatively little attention has been paid to the assessment and evaluation of these goals. In order to validate a self-rating version of the Bern Inventory of Therapeutic goals checklist (BIT-C), the present study investigated if goals, measured this way, can differentiate between patients ($n= 147$) and healthy controls ($n= 106$). Results suggested that BIT-C was successful in discriminating between client and non-clients. Most importantly, clients had a higher tendency to endorse goal categories related to depressive symptoms, substance abuse, coping with somatic problems and current relationships, but a lower tendency to endorse goal categories relating to eating behaviors compared to non-patients. Further, patients perceived attainment of prioritized goals as more distant than non-patients did. The results were discussed in terms of BIT-C being a measure that can be readily applied to identify key targets in psychological treatments.

Key words: BIT-C, treatment goals, assessment, discriminatory ability.

Novelty and Significance

What is already known about the topic?

- Personal goals are an important aspect that influences human behavior.
- In psychological treatments, collaboration and consensus on treatment goals are factors that have been associated with positive outcome.
- The attainment of personal goals in treatment is a dimension that is rarely assessed or evaluated in a structured manner, neither in research nor in clinical practice.

What this paper adds?

- The present paper presents data on a self-report measure to assess personal treatment goals in a structured manner.
- The goals of patients tend to be different from those of healthy controls, but there is also a great deal of overlap between the goals within respective groups.
- Patients tend to perceive goal attainment as more remote compared to healthy controls.

Formulating goals is a feature that seems central and inherent in deliberate influence of human behavior. Within the organizational behavioral management (OBM) literature procedures of goal setting, in combination with feedback procedures, are described as well-established methods for increasing productivity (Alvero, Bucklin, & Austin, 2001; Tammemagi, O’Hora, & Maglieri, 2013). In student settings, goal pursuit has been positively associated with processes that influence educational outcomes (Deci & Ryan, 2000). Furthermore, several studies indicate that endorsing clear and valued goals is generally related to positive psychological functioning (Brunstein, 1993; Emmons,

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1992; Sheldon & Elliot, 1999). In psychological treatments, the importance of goals has more recently been emphasized in the empirical literature. A meta-analysis reported substantial empirical support for a relationship between two goal-related aspects of psychotherapy, goal consensus and goal collaboration, and treatment outcome (Tryon & Winograd, 2011). On the average, a medium size effect was observed, where better outcomes can be expected when there is consensus between client and therapist regarding the therapeutic goals and when they are actively involved in a collaborative effort to formulate treatment-goals. From a behavior analytic perspective, goal-directed behavior can be conceptualized as behavior under the influence of other behavior, that is: verbal behavior or more specifically goal-statements. (Ramnerö & Törneke, 2014). Goal statements provide a focus for therapeutic work, criteria for evaluation of progress and a shared narrative, that may also serve to clarify the respective roles of the client and the therapist. Further, the possibility that the very process of formulating goals may exert a therapeutic effect in itself has been proposed (Grosse Holtforth & Castonguay, 2005). Research on treatment goals has found goal formulations to be related to process issues in psychotherapy, like resistance and drop-out (Michalak, Klappheck, & Kosfelder, 2004). Additionally, different goals and goal categories differ in likelihood of treatment success, even when controlling for variables such as level of problem severity and motivation for change (Berkling, Grosse Holtforth, Jacobi, & Kröner-Herwig, 2005). Grosse Holtforth and Grawe (2002) found that psychotherapy clients endorsed more avoidance oriented goals than normal controls, and that the intensity of avoidance orientation was correlated with the degree of psychological problems in clients as well as in normal controls.

Although the goals that clients formulate in treatment are systematically related to the symptoms presented, they only partially correspond with diagnoses. Clients' goals may be formulated in a much wider area of concern (Dirmaier, Harfst, Koch, & Schulz, 2006). However, while goal formulations may be considered a central feature in psychological treatments, they are not likely to be routinely used in a structured manner for evaluation that would allow for comparison over subjects, treatments or different types of goals, either in clinical practice or in research. Kazdin (1999) pointed to the clients' goals and the attainment of these goals as a central aspect of clinically meaningful change, and that the clients' perspective is often neglected when defining this change. One straightforward reason for this is probably the lack of validated and readily available procedures for assessment of individual treatment goals.

An instrument that specifically addresses the goal-dimension in treatment, from a broad perspective, is Bern Inventory of Treatment goals (BIT; Grosse Holtforth & Grawe, 2002). BIT-C is a checklist format of the inventory that can be used to aid the process of formulating goals. The goals in BIT-C are organized in three levels: 5 goal types, 28 goal categories and 87 specific goals. In each category, the client is given the possibility of formulating other goals than those provided if s/he does not find any that matches his or her personal goals. Furthermore, from this checklist at least one and a maximum five goals are chosen to indicate highest priority. When BIT was tested in outpatient settings for treatment planning and outcome evaluation of psychiatric inpatients (Holtforth *et al.*, 2004), it was found to be reliable and exhaustive, but also that the distributions of goal types were partially associated with diagnoses.

We were interested in validating a convenient and structured approach towards assessment and formulation of therapeutic goals. In a prior study, a Swedish version of BIT-C showed moderate to substantial test-retest reliability over a two-week period (Ramnerö & Jansson, in press), but the discriminatory ability of the checklist format is yet to be demonstrated. As a part of the over-arching purpose of developing an instrument that would have both scientific and practical merits, the purpose of the present study was to investigate if the endorsement of goal categories differs between clients and healthy control subjects, using the BIT-C.

METHOD

Participants

The sample (Table 1) consisted of individuals that were candidates for psychological treatment within primary care settings, and a control group consisting of students at the University of Stockholm and members of a choir from a Stockholm suburb. Nine of the control subjects were excluded due to ongoing psychotherapeutic treatment (implicating possible clinical status). Data was collected between June 2009 and April 2011. The psychotherapy clients were mainly referred from their general practice physicians for treatment. The majority suffered from anxiety, depression, or stress related disorders, as assessed by their treating psychologists. Table 1 shows that the client differed significantly from non-clients with respect depression ($t= 12.14$, $p < .0001$), anxiety ($t= 8.92$, $p < .0001$) and health-related quality of life ($t= 8.31$, $p < .0001$).

Instruments

- *Bern Inventory of Treatment Goal-Checklist* (BIT-C; Grosse, Holforth, & Grawe, 2002), contains 87 goal statements (organized in pre-determined goal categories and goal types) wherein the participant puts a checkmark on those that they endorse. The original format (client form) asked the participant to mark those goals that they considered relevant for the awaiting treatment. In order to make sense of the scale in the non-clinical sample, a slight modification of the written instruction was made. They were asked to mark those goals that they considered important in their present situation. The participants were further asked to select at least one and maximum five goals deemed as being prioritized goals. On a visual analogue scale, the participants indicated to which extent

Table 1. Characteristics of the sample.

		Non-patients	Patients
Gender <i>N</i> (%)	Women	68 (64.2)	106 (72.1)
	Men	38 (35.8)	41 (27.9)
	Less than primary school	0	1 (0.7)
Education (missing data $n= 2$)	Primary school/similar	2 (1.9)	11 (7.5)
	Secondary education/middle school/high school	40 (33.7)	55 (34.0)
	University/similar	62 (58.5)	85 (57.8)
Age <i>M</i> (<i>SD</i>)		26.90 (8.54)	40.81 (10.30)
EQ5 <i>M</i> (<i>SD</i>)		.87 (.12)	.71 (.18)
HAD- Depression <i>M</i> (<i>SD</i>)		3.98 (2.81)	9.93 (4.44)
HAD- Anxiety <i>M</i> (<i>SD</i>)		6.35 (4.09)	11.08 (4.22)

they felt that they had attained a particular goal from “not at all” to “a maximum” by making a mark on a 100 mm long line. In case more than one goal was selected, the participant was asked to rank these according to the importance of goals.

- *Hospital Anxiety and Depression Scale* (HADS; Snaith & Zigmond, 1986) contains 14 items (7 anxiety, 7 depression) in which levels of symptoms experienced the preceding week are rated from 0-3. The instrument has been validated in Swedish samples (Lisspers, Nygren, & Söderman, 1997).
- The *EuroQol Quality of Life Questionnaire* (EQ5-D; The EuroQol Group, 1990) was used to measure health-related quality of life in clients. It consists of five items representing different aspects of health, rated from 1 (no concerns) to 3 (grave concerns). An index is calculated, ranging from 1.00 (full health) to zero (no health). The instrument has been validated in Swedish samples (Burstrom, Johannesson, & Diderichsen, 2001).

Procedure

Clients were offered the possibility of participating by their psychologist they met for the assessment interview. They were informed that the choice of participating would have no impact on the treatment that were to follow. Those clients willing to participate received the questionnaires to complete immediately after the initial session or prior to the second session, but before beginning the actual treatment. The treatments were tailored after the clients' presenting problems. The study did not impose any restrictions on treatments being used, and no content from the treatments was collected. The treatments were primarily short-term therapies that did not deviate from any standard therapeutic procedure based on the problems presented. Nevertheless, although not explicitly encouraged by the authors, the therapist and client could have opted to use the content in BIT-C in formulating therapeutic goals. The control group was recruited by advertising on campus and at choir rehearsals. All subjects were given written information of the study and signed informed consent for participation, explaining the purpose of the study and providing full guarantee for anonymity. The written information contained contact information to the researchers and an invitation to contact them if any question should arise. Study procedures were performed in accordance with the Declaration of Helsinki (World Medical Association General Assembly, 2004). The current project has previously been ethically reviewed and accepted at the Department of Psychology, Stockholm University, as a part of the second author's master thesis.

Data analysis

First, prevalence estimates with corresponding confidence interval (95%) were calculated for each group and χ^2 analyses was used to examine the interrelation between the goal categories and the grouping variable (see Table 2). If a person endorsed at least one goal from a goal category, this was defined as the presence of a particular goal category. In accordance to guidelines (Klein, Proctor, Boudreault, & Turczyn, 2002), estimates with a relative standard error (RSE) greater than .30 were deemed unstable. Thus, estimates for corresponding confidence interval were not reported in order to indicate the presence of statistically unreliable estimates. The χ^2 analyses also served to determine the inclusion of goal categories in subsequent multivariate analyses.

To explore which variables being independently associated with group membership, separate logistic regression models were conducted to identify variables within each goal type. The number of goals (counts) within a goal category was used to index the contribution from a specific goal category. Significant correlates emerging from these analyses were entered into a final multivariate logistic regression analysis. The unique contribution of each predictor was determined by the significance of the odds ratio and the corresponding 95% confidence interval. Nagelkerke R^2 was used to index the amount of variability explained by the predictor variables.

Finally, to investigate if levels of attainment for the five prioritized goals differed between groups and if levels of goal attainment differed depending of the ranking sequence of the prioritized goals, a mixed ANCOVA with Group (2: client vs. non-client group) as between factor and Goals (5: goal priority 1-5) as a within factor was conducted. Only those clients ($n= 84$) and non-clients ($n= 45$) that had selected the maximum number of prioritized goals were analyzed. Due to a significant difference with respect to age between the groups ($t= 11.37, p <.0001$), age was included as a covariate in all multivariate analyses (estimates not presented).

RESULTS

Clients endorsed significantly more goals compared to non-clients (21.0 vs.16.9, $t= 3.03, p= .003$). As seen in Table 2, the prevalence rates were relatively high apart from goal categories for sexuality and suicidality/self-injury, with depressive symptoms being the most prevalent. Within this category, incidence was more prevalent in the client group. When looking specifically at goal categories belonging to different goal types, the prevalence rates between groups tended to differ more in the goal type concerned with problem/symptom orientation goals, followed by goal types concerned with interpersonal goals. Furthermore, whereas the prevalence rates were highly similar for the groups with respect to goal categories belonging to goal types concerned with well-being/functioning, existential and personal growth, and prevalence rates for the relaxation/composure category differed markedly.

Table 3 presents the logistic regression models. Due to only two goal types having more than one goal category being significantly associated with the grouping variable, the final model was only preceded by two models. With respect to the model with goal categories from goal types concerned with problem/symptom orientation goals, higher tendency to endorse goal categories related to depressive symptoms, substance abuse and coping with somatic problems was associated with higher odds of being classified as client, whereas higher endorsement of goal categories relating to eating behaviors was being associated with decreased odds of being classified as client ($\chi^2=163.85, p <.0001, Nagelkerke R^2= .64$). In the model with goal categories from goal types concerned with interpersonal goals, higher tendency to endorse goal categories related to current relationship was associated with higher odds of being classified as client, whereas higher endorsement of goal categories relating to connectedness/intimacy was being associated with decreased odds of being classified as client ($\chi^2=118.45, p <.0001$,

Table 2. Weighted prevalence estimates for each goal category by group.

Goal categories	Goal types	Non-patients (n= 106) % (95% CI)	Patients (n= 147) % (95% CI)	X ²	p
Problem/symptom oriented	Depressive symptoms	82.1 (73.7-88.2)	91.8 (86.3-95.3)	5.46	.019
	Suicidality /self-injury	6.6 (-) ^a	15.6 (10.7-22.4)	4.82	.028
	Fears/anxiety	52.8 (43.4-62.1)	63.9 (55.9-71.3)	3.15	.076
	Obsession/Compulsion	23.6 (16.5-32.5)	22.4 (16.5-29.8)	.045	.83
	Coping with trauma	24.5 (17.3-33.5)	39.5 (31.9-47.5)	6.18	.013
	Substance abuse/addiction	22.6 (15.7-31.5)	49.7 (41.7-57.6)	19.02	<.0001
	Eating behaviours	37.7 (29.1-47.2)	17.7 (12.4-24.7)	12.84	<.0001
	Sleep	18.9 (12.6-27.4)	53.7 (45.7-61.6)	31.45	<.0001
	Sexuality ^a	6.6 (-) ^a	4.1 (-) ^a	.80	.37
	Coping w/ somatic problems	12.3 (7.3-19.8)	59.9 (51.8-67.4)	58.18	<.0001
	Difficulties in life	64.2 (54.7-72.6)	55.8 (44.7-63.6)	1.79	.18
	Life stress	53.8 (44.3-63.0)	72.1 (64.4-79.0)	9.03	.003
	Interpersonal	Current relationship	42.5 (33.5-52.0)	79.6 (72.4-85.3)	36.88
Parenthood		23.6 (16.5-32.5)	37.4 (30.0-45.5)	5.45	.020
Family		30.2 (22.3-40.0)	17.0 (11.8-23.9)	6.13	.013
Other relationships		43.4 (34.4-52.9)	38.1 (30.6-46.2)	.72	.40
Loneliness and grief		33.0 (24.8-42.4)	20.4 (14.7-27.6)	5.13	.024
Assertiveness		64.2 (54.7-72.6)	65.3 (57.3-72.5)	.04	.85
Well being/functioning	Connectedness/intimacy	48.1 (38.8-57.5)	34.7 (27.5-42.7)	4.61	.032
	Exercise and activity	57.6 (48.0-66.5)	47.6 (39.7-55.6)	2.43	.12
	Relaxation/composure	53.8 (44.3-63.0)	74.8 (67.2-81.1)	12.17	<.0001
	Well-being	66.0 (56.6-74.3)	68.7 (60.8-75.6)	.20	.65
Existential	Past, present, future	80.2 (71.6-86.7)	68.7 (60.8-75.6)	4.17	.041
	Meaning of life	38.7 (30.0-48.2)	31.3 (24.3-39.2)	1.49	.22
Personal growth	Attitude towards self	58.5 (49.0-67.4)	70.1 (62.2-76.9)	3.64	.056
	Desires and wishes	62.3 (52.7-70.9)	68.0 (60.1-75.0)	.91	.34
	Responsibility/self-control	69.8 (60.5-77.7)	78.2 (71.9-84.1)	2.31	.13
	Emotional control	53.8 (44.3-63.0)	47.6 (39.7-55.6)	.93	.33

Note: ^a= RSE >.30.

Table 3. Logistic regression analyses predicting group membership.

Model	Predictor	B	SE	Wald	p	OR	CI 95%	
1 Problem/symptom oriented	Depressive symptoms	.65	.19	11.28	.001	1.92	1.31-2.80	
	Suicidality/self-injury	1.05	.67	2.43	.12	2.86	.76-10.72	
	Coping with trauma	-.57	.52	1.18	.28	.57	.20-1.58	
	Substance abuse	.82	.37	4.80	.028	2.26	1.09-4.70	
	Eating behaviours	-1.74	.45	14.76	<.001	.175	.07-.43	
	Sleep	-.03	.56	.002	.96	.98	.33-2.90	
	Coping somatic problems	1.38	.47	8.54	.003	3.97	1.57-10.0	
	Life stress	-.30	.40	.54	.46	.74	.34-1.64	
	2 Interpersonal	Current relationship	.63	.21	9.15	.002	1.87	1.25-2.82
		Parenthood	.01	.31	.001	.97	1.01	.56-1.84
Family		-.20	.43	.21	.65	.82	.35-1.91	
Loneliness and grief		.03	.33	.01	.92	1.03	.54-1.96	
3 Final	Connectedness/intimacy	-.52	.22	5.70	.017	.59	.38-.91	
	Depressive symptom	.59	.22	6.99	.008	1.81	1.17-2.80	
	Substance abuse	1.06	.39	7.22	.007	2.88	1.33-6.23	
	Eating behaviours	-1.60	.45	12.59	<.001	.20	.08-.49	
	Coping w/ somatic problems	1.16	.44	6.82	.009	3.20	1.34-7.65	
	Current relationship	.37	.26	1.94	.20	1.44	.82-2.41	
	Connectedness/intimacy	-.99	.32	9.30	.002	.38	.20-.71	
	Relaxation/composure	.36	.28	1.62	.20	1.44	.80-2.50	
	Past, present, future	-.70	.25	7.87	.005	.50	.30-.81	
	Attitude towards self	.90	.29	9.58	.002	2.47	1.39-4.38	

Note: Age was included as a covariate in all models (estimates not reported).

Nagelkerke $R^2 = .50$).

Significant correlates that emerged from the two models above were entered into a final logistic regression analysis. In addition, the two goal categories significantly associated with the grouping variable from each of the two remaining goal types (well-being/functioning, existential) was included along with a marginally significant ($p = .056$) goal category belonging to the goal types concerned with personal growth (see Table 2). In this model, the estimates for the goal categories from goal types concerned with problem/symptom orientation goals remained largely unaffected by the addition of competing predictors. Of the goal categories from goal types concerned with interpersonal goals, goals concerned with current relationship became non-significant, whereas the significant contribution of goals relating to connectedness/intimacy remained significant. Finally, whereas goals relating to attitude towards self were associated with increased odds of being classified as client, goals relating to past, present, future events were associated with decreased odds of being classified as client. Goals concerned with relaxation/composure became non-significant. The final model was highly significant ($\chi^2 = 189.12$, $p < .0001$, Nagelkerke $R^2 = .71$) and the Hosmer-Lemeshow test indicated good model fit ($\chi^2 = 5.04$, $p = .75$). Overall, prediction success was good, with 85.7 percent of clients and 84 percent of non-clients correctly classified (overall 85%).

The ANCOVA revealed a significant main effect of group ($F_{[1, 126]} = 61.92$, $p < .0001$), due to clients experiencing the prioritized goals as being more remote than the non-client group (estimated marginal means 2.30 vs. 4.81). Furthermore, there was no significant main effect of goals or interaction effect between group and goals, indicating no effects of the ranking sequence of the prioritized goals.

DISCUSSION

In this study, we evaluated whether a structured clinical self-rating format for assessing treatment goals could differentiate between clients and healthy control subjects, in order to establish that the goal dimension is captured as a clinically relevant variable. First, the prevalence rates were relatively high irrespective of group membership, which suggests that BIT-C is able to capture central areas of concern for the well-being of the individual. When looking specifically at the response patterns of the two groups, data revealed that the clients tended to endorse more goals compared to the non-client group and that the prevalence rates between groups tended to differ most in the goal type concerned with problem/symptom orientation goals, followed by goal types concerned with interpersonal goals. More importantly, when logistic regression analyses were conducted in order to predict an individual's group membership, the prediction success was good, with 85.7 percent of clients and 84 percent of non-clients correctly classified in the final model. In this model, the goal categories from goal types concerned with problem/symptom orientation goals was most successful in discriminating between the client and the control group. Specifically, clients had a higher tendency to endorse goal categories related to depressive symptoms, substance abuse and coping with somatic problems, but a lower tendency to endorse goal categories relating to eating behaviors compared to the non-client group. In addition, apart from the goal type concerned with

wellbeing/functioning, one goal category from each of the remaining goal types was successful in discriminating between the client and the control group. That is, whereas goals relating to attitude towards self (personal growth) were associated with increased odds of being classified as client, clients had a lower tendency to endorse goals relating to connectedness/intimacy (interpersonal) and goal categories related to past, present, future (existential) events compared to the non-client group.

These results contribute to previously cited studies (Dirmaier et al., 2006; Grosse Holforth & Grawe, 2002), which indicates that goal orientation is an important part of problem presentation by being predictive of clinical status. Given the good model fit and prediction success with respect to the distribution of treatment goals for the two groups in the final model, it is fair to conclude that the items in the questionnaire demonstrate substantial ability to discriminate between a clinical and non-clinical population.

It is noteworthy that when the participants were asked to select goals deemed as being prioritized goals, the clients rated themselves as being markedly further away from their goals compared to the non-client group. Thus, as desired concerns for the well-being of the individual are seemingly perceived as being remote, this kind of assessment may therefore be an effective tool for identifying key targets in psychological treatments and in helping the client to gain increased proximity to prioritized goals in life.

It is important to recognize that selection of both clients and control subjects may limit the generalizability of the results. As the clients were generally high functioning with mild levels of distress and the control subjects were mainly students, this may restrict the range of goals chosen and present a systematic bias that may limit the generalizability of the results. There was a slight difference in the phrasing in the instructions as a consequence of administering a client-oriented instrument to non-clients., which may have influenced the responses. It may be that asking about one's goals "in the present situation" steers the individual in another direction relative to asking explicitly about goals for "the awaiting treatment". However, this deviation from the original phrasing was made in order to present a credible task to the control subjects.

As no standardized diagnostic procedure was used, it was not possible to determine similarity in terms of diagnoses or other potentially important variables, possibly limiting the generalizability results. Another critical feature of the assessment procedure itself is that we do not know how well BIT self-rating instrument corresponds to the privately held goals that were present before the client was presented with the instrument. If therapeutic goals are a genuinely collaborative effort and part of the process, we may therefore suspect that an instrument, such as BIT, influences this process.

A structured format for goal assessment does not only provide yet another instrument measuring symptoms or distress, as this variable is in fact fundamentally different from symptom- or distress related variables. Treatment efforts run the risk of overly emphasizing symptom reductions as a prioritized goal, and thereby deemphasizing the potential for further individual development as a focus for both assessment and evaluation. It is noteworthy that procedure of formulating goals as such could prime the individual to consider a multitude of goals over a broad range of areas rather than having a narrow symptom or distress focus. Providing a structured approach could also have the potential of ensuring that the therapeutic goals are made explicit and are made

an area of collaborative effort and agreed upon. This also has implications for efforts of quality assurance for psychotherapy, which is a requirement more often met, especially by third-party payers (e.g., Strauss *et al.*, 2013). In our view, assessment of treatment goals would have well deserved place among quality assurance procedures.

Our impression is also that BIT-C is generally very well received, as such an instrument, by clients and therapists alike. We would encourage clinicians to include some kind of assessment of goals and their perceived proximity to goals as complimentary tool to the standard assessment procedures. One pivotal question that remains to be answered concerns the sensitivity to change. It would be critical to show that perceived goal attainment changes as a function of striving towards these goals, and that goal attainment of central areas of concern for the well-being of the individual correlates with changes in other indices of well-being.

In conclusion, despite some limitations, this study revealed relatively clear differences between the groups with respect to the distribution of treatment goals between a clinical and non-clinical population. The present study provides preliminary support for the utility of the self-rating format of BIT-C to be used as a structured approach to goal formulation in psychological treatments.

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Received, June 25, 2014
Final Acceptance, March 30, 2015