Psychotherapy Guidebook

Goal-Directed Psychotherapy

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DEFINITION

Goal-Directed Psychotherapy is a coordinated effort to effect limited changes in specific behavioral responses. This effort utilizes those cognitive, conative (the faculty of striving, making an effort), or affective (dealing with moods or emotions) components of mental functioning that are available in any individual or group of individuals. Goals are highly variable because of the differing potentials brought into the therapeutic relationship by the recipients of our best treatment efforts. Carl Rogers has postulated that the goals for therapy itself may be somewhat more limited than the goals for an effective life, in that therapy is not expected to produce an optimally adjusted person but only to start the development of a new pattern of adjustment. The concept of a limited goal and limited success as the building blocks for enhancing self-esteem is very valuable in moving toward a healthier psychological functioning.

HISTORY

Goal-Directed Therapy had its beginnings in the description of the

psychotherapeutic process by Rogers (1961). He describes the process as a series of small steps (limited goals) by which the patient progresses toward major personality changes; he also describes the sequence in which such steps are taken. The acceptance of limited goals as part of the foundation for stable progression was a major step toward increasing therapeutic options.

The neurotic patient generally brings with him a high degree of cognitive, conative, and affective functioning so that he responds well to Goal-Directed Psychotherapy. Sifneos has developed an anxiety-provoking, goal-oriented brief psychotherapy with neurotic individuals that leads to successful self-actualization in a relatively short period of time. A major preexisting requirement for patient selection is the fact that the patient has had at least one meaningful relationship with another person during his lifetime.

Balint and his colleagues described brief, insightful treatment oriented toward removal of a specific symptom (1972). He called this essentially goal-directed approach by another name — Focal Psychotherapy. Focal Psychotherapy directed therapeutic efforts toward removing a disruptive symptom that both patient and therapist accepted as a root cause of emotional distress. Balint selectively focused on material that related to the disturbing symptom, so that insight helped the patient reach the agreed-upon goal of symptom relief. Ornstein and Ornstein, who were collaborators of

Balint, participated in the pioneering development of Focal Psychotherapy as a goal-directed, dynamic approach.

Detre and Jarecki have pointed out that the multiplicity of criteria used to define a successful outcome adds to the problems inherent in comparing treatment plans (1971). The goals of treatment must, of necessity, vary with the severity of the syndrome presented. Goal-Directed Therapy will have as many goals as there are differing symptom complexes. The goals for the mentally retarded, organically brain-damaged, or chronic schizophrenic are hardly consonant with those for the neurotic patient. Slivkin and Bernstein have pointed out the effectiveness of Goal-Directed group psychotherapy in improving social functioning and work capacity in moderately retarded adolescents (1968).

Goal-Directed Psychotherapy encourages the development of channels for addressing those cognitive, conative, or affective components of personality structure existing in patients that are available to effect behavioral change and emotional growth. Achievement of a limited focal goal can initiate the successful return to a more integrated behavior pattern. Focal success often inspires additional personal growth, and higher levels of responsiveness and improved coping responses in other areas of social functioning.

TECHNIQUE

A first requirement is the assessment of the presenting complaint and its antecedents. The most distressing problem in the patient's view is discussed, so that some mutually acceptable limited goal may be set. It is important to make a realistic and objective assessment of what coping skills are present and how they can be supported most effectively. Once a goal has been set and there is an alliance between patient and therapist, all available coping skills are utilized to effect changes and achieve the designated goal. In the case of the neurotic patient, the goal may be insight, but in the schizophrenic, it may be control of hallucinations by psychopharmacological means. The importance of choosing an attainable goal cannot be overemphasized, since failure to achieve success means reinforcement of preexisting maladaptive functioning.

In my experience with retarded adolescents, permission to choose the special type of doughnut they liked in warmup sessions prior to group therapy was ego building. It was novel to these retarded adolescents that anyone could tolerate freedom of choice for them. It represented moving away from primitive narcissism towards reality, as well as taking part in simple decision-making.

In the case of terminally ill patients, the goal may be the encouragement by the therapist to control some small portion of their environment. This

behavior often makes the dying process more tolerable. With the organically handicapped, a goal may be the utilization of a mechanical aid to reduce helplessness. Goal-Directed Therapy is limited only by lack of enthusiasm and imagination in patient or therapist. There are a limitless number of goals that inspire renewed hope and improved coping mechanisms.

APPLICATIONS

Goal-Directed Therapy has a wide range of applications. It can be used to develop insight in the neurotic patient. At the same time it offers aid, comfort, and renewed coping skills to as diversified a group as the mentally retarded, chronic schizophrenic, organically impaired, and even the terminally ill. Since it requires the setting of a limited, attainable goal by patient and therapist together, it is applicable in all cases where there exists some potential for employing cognitive, conative, or affective patient skills. The results of Goal-Directed Therapy can be wide-ranging, since the pyramiding of limited goals can lead to extensive personality and functioning changes.