PJAHS
Philippine Journal of Allied Health Sciences

Special Collection: Short Report

Elements of Realistic Goal-Setting Model

Michaela Denice Buenaventura[1], Jaclyn Margaret Fajatin[1], Andrea Marie Samaniego[1], Carl Jason Villagracia[1], Rod Charlie Delos Reyes[1]

[1]Graduate School, University of Santo Tomas, Manila, Metro Manila, Philippines

Correspondence should be addressed to: Andrea Marie Samaniego [1]; andreamarie.samaniego.gs@ust.edu.ph

Article Received: August 17, 2021

Article Accepted: December 29, 2021

Article Published: February 15, 2022

Abstract

Goal setting leads to improved clinical outcomes, a more client-centered approach, enhanced motivation and psychological adaptation, and enhanced collaboration between client and clinician. However, goal setting remains problematic for both clients and clinicians. The purpose of this conceptual framework is to provide elements to consider when facilitating a collaborative goal-setting as supported by several theoretical concepts. Using the Goal-Setting Theory, Person-Environment-Occupational-Performance Model, Dekker's tool in setting meaningful goals in rehabilitation, and Canadian Model of Client-Centered Enablement, the authors have identified eleven (11) essential elements, which are the following: external factors, global meaning, collaborate, coordinate, consult, design, clarity, challenge, self-efficacy, commitment, and overall occupation-centered goal. By considering the various elements presented, occupational therapists can avoid having unrealistic expectations from clients during the process of goal setting.

Keywords: *Occupational therapy, Collaborative goal setting, Theoretical concepts*

INTRODUCTION

Goal-setting is the process of collective decision between clients and multidisciplinary team, as well as informed discussion about how to carry out rehabilitation activities within a time frame.[2] Clients' expectations must be understood in order to improve satisfaction and provide client-centered care.[3] Thus, setting goals is important to assist clients and therapists in addressing their condition and achieving their desired attainable outcomes.[4] Moreover, goals influence and impact clients' well-being and affect.[5] Well-being is associated with having meaningful and important goals and purposes.[6] While Emmons and Diener stated that "positive affect is just as strongly related to having important goals as it is to the attainment of these goals".[7] Clients experience positive effects when they have knowledge of their goals and if they perceive it as attainable. Setting appropriate goals aids in becoming more aware of what is essential in their life, reflect on barriers that hinder them from achieving their goals, assess achievable goals, and come up with more synergetic goal relationships.[5]

Collaboration between clinicians and clients is fundamental in rehabilitation goal setting.[8] However, goal setting is not without its challenges. Several studies have identified barriers to the goal-setting of clients and professionals. Client-related barriers to goal-setting include the unsure meaning of "goal-setting," lack of knowledge about the rehabilitation procedure, lack of knowledge of consequences of the condition and outcomes, reluctance to set goals, lack of motivation, psychosocial issues, family dynamics, inability to

accept the condition, and the term 'recovery' holds different meaning to each.[2,8-12] Clinicians' perception of barriers include time constraints, cultural differences, failure to communicate the meaning of goal setting to clients, failure to meet goals that require a different environment, and doubts about the accuracy of assessment tools used for goal setting.[2,11]

The purpose of this conceptual framework is to provide elements to consider when facilitating a collaborative goal setting in occupational therapy, as highlighted by several theoretical concepts. This will serve as a guide in coming up with an overall occupation-centered goal to avoid unrealistic expectations from clients and their families. This will help address more important problems of the client and ensure optimal occupational performance.

Goal setting leads to improved clinical outcomes, a more client-centered approach, enhanced motivation and psychological adaptation, and enhanced collaboration between client and clinician.[1] This will help the occupational therapist explain more and set expected outcomes to the client at the start of the therapy session. Adjusting goals may also be done to fit the client's desired goals if necessary.

DEVELOPMENTAL PROCESS

The initial step involved identifying clinical roadblocks that needed to be addressed. After identifying unrealistic expectations as a roadblock, the group proceeded to a literature review to provide a theoretical foundation for developing a new conceptual model. Existing conceptual models and frameworks were reviewed and used as references for developing a potential solution to address the clinical roadblock. Eleven elements of realistic goal setting were synthesized from the data gathered from different conceptual models and frameworks that bring about the conceptual model. The Elements of Realistic Goal-Setting model underwent peer reviews to establish the thoroughness and comprehensiveness of the model. The model highlighted the elements to consider when creating a realistic goal for the client and how the occupational therapist can assist in improving it. This will provide a clearer picture of how the client's occupational performance will further improve.

THEORETICAL BASES

Goal-Setting Theory. The goal-setting theory focuses on the relationship between a person's goals and their performance. According to research, effective performance results when goals are specific and challenging.[13] Locke and Latham believed that setting a specific and difficult goal will lead to higher performance. Goals must be challenging, achievable, specific, measurable, and meaningful to the client in order to be effective.[13] Moreover, goals inspire people to develop strategies that will enable them to succeed. Therefore, attaining the goal can lead to greater motivation and satisfaction, whereas failing might lead to dissatisfaction and demotivation.

Person-Environment-Occupational-Performance. The PEOP model is a top-down, client-centered approach that includes the client's context while identifying roles, occupations, and goals.[15] This model represents components that come together to assist the client and the clinician in developing a realistic implementation plan. The model involves the use

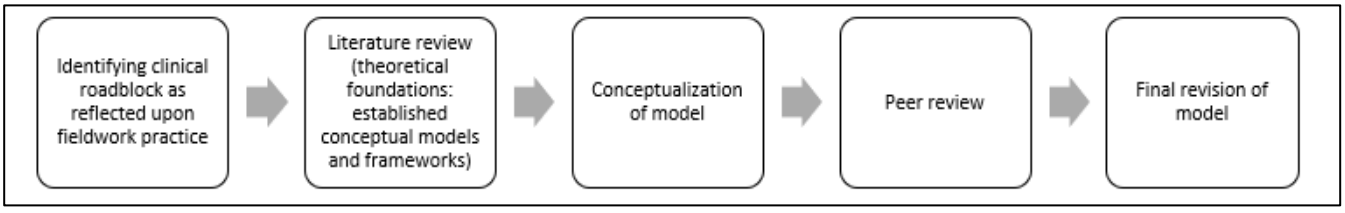

Figure 1. Developmental Process Figure

of its context when addressing performance capabilities/constraints and environmental performance, both of which can act as enablers or barriers to an individual's occupational performance.

Setting meaningful goals in rehabilitation. Setting goals is a crucial part of the rehabilitation process. It is important in making a tailor-fit rehabilitation plan in relation to the client's needs. It is important to consider what the client finds meaningful to them when it comes to goal setting. Clients are perceived to have long-term goals that would reflect their expectations. However, clinicians would consider it unrealistic and would prefer to set realistic short-term goals. Since goal setting is critical in rehabilitation, a tool was developed that will aid in setting meaningful rehabilitation goals. Three important things to consider in goal setting: (1) hierarchy of goals, (2) fundamental beliefs, goals, and attitudes, and (3) global meaning. The client will find goal-setting more meaningful if there is a hierarchy of goals.[1] Goal setting can become meaningful if: first, set one or more overall goals that clients find meaningful; second, set a specific goal that is related to the overall goal. Fundamental beliefs, goals, and attitudes is where important questions are formed on identifying overall rehabilitation goals. Global meaning refers to general orienting systems that direct people's daily lives.

Canadian Model of Client-Centered Enablement. Enablement is the core of occupational therapy, guiding clinical decisions and therapeutic process.[16] The ten (10) enablement skills in this model include adapting, advocating, coaching, collaborating, consulting, coordinating, designing/building, educating, engaging, and specializing. These skills are the manner in which occupational therapists work collaboratively with clients to come up with a shared decision. Clients should be able to make choices, take risks, interact, and react to the therapist to determine the best decision. At the same time, the occupational therapist's role is to support clients, use professional knowledge, help clients see possibilities for change, and ensure the active involvement of clients in decision-making.

ELEMENTS OF REALISTIC GOAL-SETTING MODEL

Person. The person's head contains the concept of *global meaning,* which orients and guides the client in living their lives. This represents the personal factors such as the client's perception of oneself, priorities related to values and relationships, primary involvement in determining what is valuable and worth working towards, as well as how the client deals with things that cannot be changed. It comprises five (5) interlinked yet distinguishable elements borrowed from "Setting Meaningful Goals in Rehabilitation": core values, relationships, worldview, identity, and inner posture.[1] Core values are fundamental beliefs about what is right and worthwhile that guide thoughts and behavior. An example question that can be used for this element is "What are the important values in your life?". Relationships are connections between people, such as children, a spouse, a therapist, or even a pet. An example question that can be used for this element is "Is there somebody in your life who is important to you?". Worldview is the set of fundamental beliefs about life, death, and suffering that structure people's ideas on how life events are related. An example question that can be used for this element is "Do you have a specific outlook or conviction in life?". Identity refers to fundamental beliefs about oneself. An example question that can be used for this element is "Who are you?". Inner posture refers to how people endure what cannot be changed. An example question that can be used for this element is "How do you relate to what is going on in your life?".

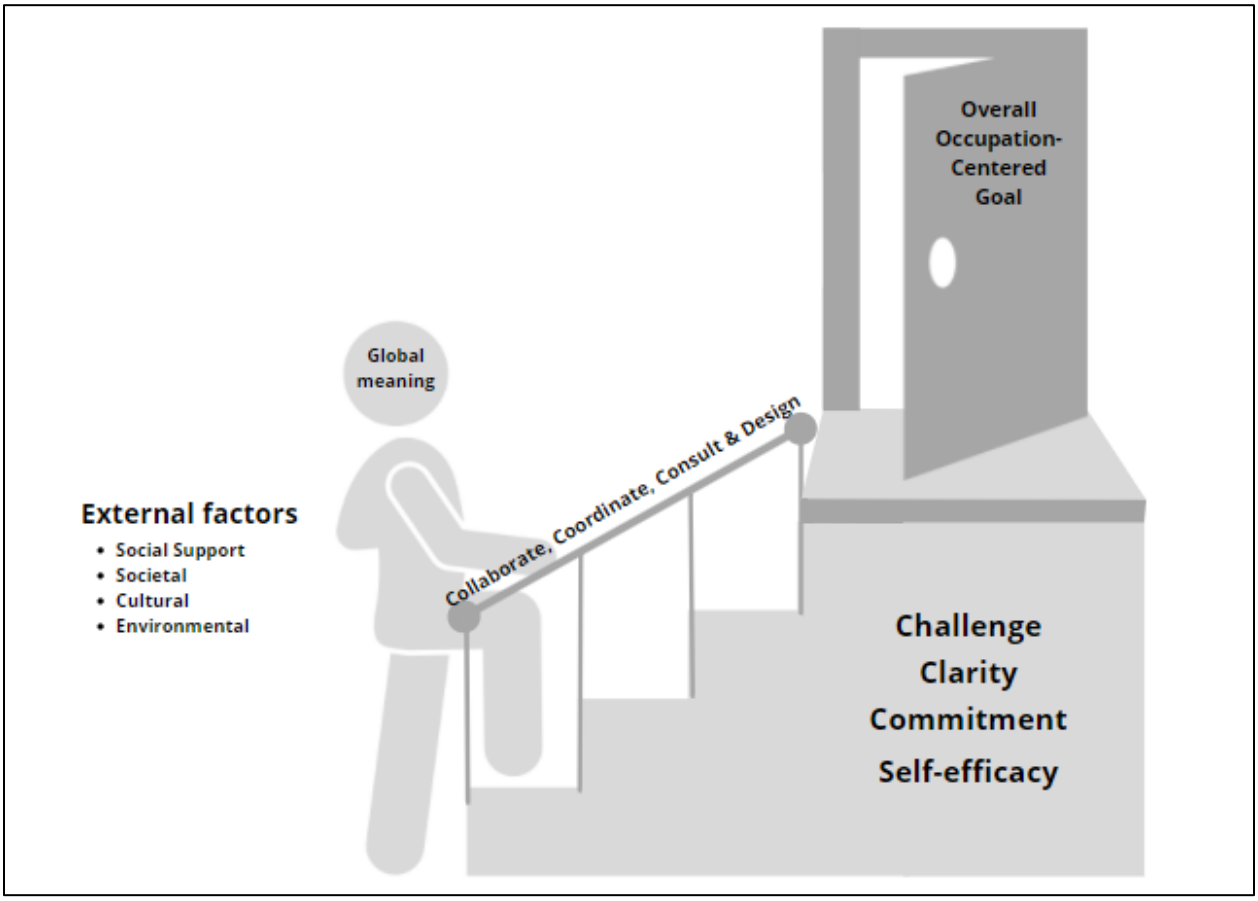

Figure 2. Elements of a Realistic Goal Setting Model

These should be explored to determine what elements can and cannot be changed or addressed by occupational therapy interventions before setting a realistic goal in occupational therapy. Depending on the disease or condition, these may present themselves with varying degrees of impairment, and the therapist should be able to inform the client regarding these elements during the process of goal setting.

Stairs. The stairs represent the prerequisites needed for effective and realistic goal setting, hence the rationale of going up the stairs to achieve an overall occupation-centered goal. The client should be committed to working towards a clear and challenging objective. The client should also believe that they can enact and sustain the necessary actions needed to achieve the overall goal. The concepts included within the stairs (Clarity, Challenge, Self-Efficacy, and Commitment) do not follow a hierarchical order but should all be present in establishing an overall occupation-centered goal. *Clarity* refers to a specific and measurable goal that can be accomplished within a specific time frame and setting. People perform better when they set for specific and precise goals rather than vague and complex ones.[13,17] *Challenge* is the "level of knowledge and skill that is required to achieve a goal".[17] Some evidence shows that people make more progress when they work towards more difficult goals rather than easier ones.[13 18] However, this is likely to depend on whether the goal is realistic. A goal that is extremely difficult to achieve may be unrealistic, resulting in negative affect as a result of the lack of progress. Hence, the most facilitative goals may be those that are difficult but achievable.[5] *Commitment* is one's determination to reach a goal. Self-efficacy and importance/meaning are the two categories that facilitate goal commitment.[13] *Self-efficacy* is the client's perception of their potential to thrive to attain their goals.

Handrails. The handrails represent occupational therapists as the facilitators of realistic goal setting. As seen in the model, there are four enablement skills borrowed from the concept of

the Canadian Model of Client-Centered Enablement- collaborate, consult, coordinate, and design. *Collaborate* highlights the ability of the occupational therapist to work together with the client in planning and implementing interventions to achieve the person's goals, thus developing a client-centered practice. *Consult* is the ability to provide information and advice to the client and other stakeholders involved in the rehabilitation process. This also involves integrating, synthesizing, and summarizing information for proposing recommendations that may reframe problems, challenges, and opportunities to generate a course of action. *Coordinate* involves the management and consolidation of the multiple factors required to achieve the client's goals, with the aim of ensuring that everyone in the rehabilitation team, including the client's relatives, is working together towards the same purpose. *Design* refers to the ability of the occupational therapist to accommodate the client's skills and abilities in the design and implementation of rehabilitation programs and services.

An occupational therapist's role is vital in ensuring that the elements of clarity, challenge, commitment, and self-efficacy are present. It also depicts occupational therapists' collaboration with the client in setting and achieving the overall occupation-centered goal.

External Factors. The external factors are based on the PEOP model. This illustrates how the factors can either enable or hinder a person, influencing the client's overall occupation-centered goal. Extrinsic factors that are important for occupational performance are the following: *Social support* (includes practical, instrumental, and informational support), *Societal* (includes interpersonal relationships, social and economic systems), *Cultural* (includes values, beliefs, customs, and use of time), and *Environmental* (includes the physical properties, tools used, assistive devices or technology, design and natural environment, geography, terrain, climate, and air quality).

Door. The door represents the client's overall occupation-centered goal. The elements of realistic goal setting indicated within the stairs (clarity, challenge, etc.) are necessary to move towards the overall goal. The achievement of occupation-focused/centered/based goals open renewed opportunities for re-engagement in occupations. The *overall occupation-centered goal* is derived from exploring external factors and global meaning, combined with professional skills and knowledge of the occupational therapist and the criteria needed before setting a goal.

Limitations. This conceptual model is primarily intended for the use of occupational therapists when setting realistic and meaningful rehabilitation goals for the clients but can also be used as a guide or framework by other professionals in allied health. However, this model does not address nor explore the potential barriers and factors that contribute to the causes of having unrealistic goals and expectations from the clients' and other stakeholders' perspectives; thus, research is needed to determine these factors and has a more in-depth understanding of it affects the overall rehabilitation. The model has yet to be used in clinical practice by occupational therapists and even more so by other clinicians in the allied medical field. In addition, further studies regarding the use and applicability of this model are encouraged to determine its effectiveness in guiding occupational therapy practice, and other clinicians in facilitating meaning and realistic goal setting for the clients since this model does not include a specific outcomes measurement tool to determine the extent of its effectiveness in generating meaningful rehabilitation goals.

CONCLUSION AND RECOMMENDATIONS

The conceptual model addresses the identified roadblock of unrealistic expectations during goal setting. This serves as a potential solution for how clients and occupational therapists can set realistic goals by considering the various elements presented to attain the overall occupation-centered goal. The person element that consists of global meaning represents clients' primary involvement in determining what is valuable and worth working towards. The external factors will help determine the factors that enable or hinder a client's overall occupation-centered goal. The stairs represent

the prerequisites needed to develop a realistic and effective goal. The handrails serve as a facilitator in ensuring that needed elements are present and depict the occupational therapist's collaboration with the client. And finally, the door represents the client's overall occupation-centered goal. Occupational therapists can utilize this conceptual model as a guide to help them develop realistic goals with their clients. Future researchers can use and improve this model by identifying other possible barriers or solutions that can influence setting goals.

Individual author's contributions

R.C.D.: guided the entire process of making the model, comments for revisions; M.D.B: conceptualization of the model, literature review, analysis of the different key elements, drafting, revising; J.M.F: conceptualization of the model, literature review, analysis of the different key elements, drafting, revising ; A.M.S.: conceptualization of the model, literature review, analysis of the different key elements, drafting, revising ;C.J.V: conceptualization of the model, literature review, analysis of the different key elements, drafting, revising

Disclosure statement

The first author is a Master of Science in occupational therapy professor at the University of Santo Tomas. The remaining authors are MSOT students from the University of Santo Tomas.

Conflicts of interest

The authors report no conflict of interest.

Acknowledgment

This is to acknowledge Ma'am Thea Sheila Ocheda - Alonto for her valuable contribution in formulating our conceptual model, Elements of Realistic Goal-Setting.

References

1. Dekker J, de Groot V, ter Steeg AM, Vloothuis J, Holla J, Collette E, Satink T, Post L, Doodeman S, et al. Setting Meaningful Goals in Rehabilitation: Rationale and Practical tool. Clinical Rehabilitation. 2019 September; 34(1), 3–12. DOI: 10.1177/026921551987629
2. Rosewilliam S, Roskell CA, Pandyan A. A Systematic Review and Synthesis Of The Quantitative And Qualitative Evidence Behind Patient-Centred Goal Setting In Stroke Rehabilitation. Clinical Rehabilitation. 2011 March; 25(6), 501–514. DOI:10.1177/0269215510394467
3. El-Haddad C, Hegazi I, Hu, W. Understanding Patient Expectations of Health Care: A Qualitative Study. Journal of Patient Experience. 2020 April. DOI: 10.1177/2374373520921692
4. Vasta PL. Setting Goals: An Integral Part of Self-Management. Journal of Nephrology Social Work. 2003; 22, 31–35.
5. Cooper, M. (2018). The psychology of goals: A practice-friendly review. 2018 April. DOI: 10.1093/9780198793687.003.0003
6. Little BR, Salmela-Aro K, Phillips, SD (Eds.). Personal project pursuit: Goals, action, and human flourishing. Lawrence Erlbaum Associates Publishers; 2007.
7. Emmons, RA, & Diener, E. A goal-affect analysis of everyday situational choices. Journal of Research in Personality. 1986; 20(3), 309–326. DOI: 10.1016/0092-6566(86)90137-6
8. Brewer K, Pollock N, Wright F, Virginia. Addressing the challenges of collaborative goal setting with children and their families. Physical & Occupational Therapy in Pediatrics. 2014; 34(2), 138–152. DOI:10.3109/01942638.2013.794187
9. Sugavanam T, Mead G, Bulley C, Donaghy M, van Wijck F. The effects and experiences of goal setting in stroke rehabilitation – a systematic review. Disability and Rehabilitation. 2013; 35(3), 177–190. DOI:10.3109/09638288.2012.690501
10. Leach E, Cornwell P, Fleming J, Haines T. Patient Centered Goal-Setting in a Subacute Rehabilitation Setting. Disability & Rehabilitation. 2010; 32(2), 159–172. DOI:10.3109/09638280903036605
11. Légaré F, Ratté S, Gravel K, Graham I. Barriers and facilitators to implementing shared decision-making in clinical practice: Update of a systematic review of health professionals' perceptions. 2018; 73(3), 526–535. DOI:10.1016/j.pec.2008.07.018
12. Wiart L, Ray L, Darrah J, Magill-Evans J. Parents' perspectives on occupational therapy and physical therapy goals for children with cerebral palsy. Disability & Rehabilitation. 2010; 32(3), 248–258. DOI:10.3109/09638280903095890
13. Locke E, Latham G. Building a practically useful theory of goal setting and task motivation: A 35-year odyssey.. American Psychologist. 2022; 57(9), 705–717. DOI:10.1037/0003-066X.57.9.705
14. Cott C, Finch E. Goal-setting in physical therapy

practice. Physiother Can. 1991 Jan-Feb;43(1):19-22. PMID: 10109906

15. Duncan EA. Foundations for practice in occupational therapy. 5th ed. Elsevier Ltd; 2011.
16. Townsend EA, Polatajko HJ. Enabling occupation II: Advancing an occupational therapy vision for health, well-being, & justice through occupation. Ottawa, Ontario: CAOT Publications ACE; 2007.
17. Sheeran P, Webb TL. From goals to action. In H. Aarts & A. J. Elliot (Eds.), Goal-directed behavior. New York: Psychology Press; 2012.
18. Wiese BS. Successful pursuit of personal goals and subjective well-being. In: Little BR, Salmela-Aro K, Phillips SD, editors. Personal project pursuit: Goals, action, and human flourishing. Mahwah, NJ: Lawrence Erlbaum Associates Publishers; 2007.

Note: This article is part of a special collection of articles by some graduate students of the Master of Science in Occupational Therapy degree of the University of Santo Tomas. The peer-review was facilitated by the respective course, from which these articles arose from. PJAHS was not involved in the peer-review process of this article. Nevertheless, this article underwent editorial review of PJAHS prior to online publication.