

Setting Goals: An Integral Part of Self-Management

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Setting goals is an important step in assisting patients to manage their illness and achieve outcomes that are important to them. Too often the only goals set for patients have been clinical goals set by the staff, which may have little meaning for patients. This article briefly explores goal setting theory. An instance of assisting patients to set goals through the use of patient-centered care plans is described. Additional considerations including patients' readiness to change, health beliefs, and self-efficacy are discussed, and the process of setting goals is described. Brief discussions of monitoring, feedback, outcomes, and rewards are included.

In the past few years there has been a great deal written about the importance of patients participating in their care and the necessity for self-management of chronic illnesses, such as End Stage Renal Disease. One important aspect of managing a chronic disease is learning to set goals. Frequently the goals set by the staff for dialysis patients are based on objective biological criteria, such as lab values of hematocrit or phosphorus, or measurements of dialysis adequacy. The staff then has the difficult task of trying to motivate patients to reach these goals, which may have little relevance to patient-perceived needs or objectives.

Goal-Setting Theory

Many studies have shown the positive effect on performance or outcomes of setting goals. For example Strecher et al. (1995) state that there are three motivational mechanisms by which goal setting improves performance. These are effort, persistence, and concentration; an individual with set goals tends to try harder for a longer time and with less distraction. Latham and Locke (1991) refer to these as direction, intensity, and duration: a goal directs activity toward actions relevant to it, a goal regulates effort, and a goal effects persistence and tenacity. For goals to be effective they need to be challenging, achievable, specific, measurable, meaningful to the patient, and have an established time for evaluation (Cott & Finch, 1991).

Setting goals does not automatically result in improved outcomes and may have a negative impact. Imposing objective clinical standards without taking individual patient goals into consideration can decrease patient motivation and involvement in treatment (Wolpert & Anderson, 2001). Goals can also reduce motivation if they conflict with other goals that are important to the individual, if they are so difficult that the individual believes that they are impossible to attain, or if they are not accepted as meaningful to the individual.

Goals which are difficult, yet attainable, generally produce the greatest improvement. If goals are too easy, they may be seen as unimportant and there is little satisfaction in attaining them. They need to be specific and measurable so that there is no question about when the goal has been met. And feedback is essential, whether it is from an external source evaluating the individual's achievements, or whether individuals are comparing their progress with averages of others or their own predetermined criteria.

When goals are complex it is helpful to have intermediate goals, often referred to as proximal goals, leading to the long-term, distal goal. As these proximal goals are met, motivation is enhanced and perceptions of self-efficacy increase. The ultimate task seems more manageable, and as individuals see themselves making progress toward the final goal, their commitment to reaching it is intensified. Proximal goals provide more immediate feedback and have been shown to produce larger improvements in performance compared with distal goals (Bar-Eli, Tenenbaum, Pie, Btsh, Almog, 1997; Stock & Cervone, 1990).

Although there is some disagreement, the majority of studies document the positive effect of individuals being involved in the selection of goals. This insures that the goals will be meaningful to the individual and there will be intrinsic motivation toward attaining them. In some instances, an individualized assigned goal from an authority figure is seen as an expression of confidence and improves performance (Latham & Locke, 1991). Studies such as the ones by Webb and Glueckauf (1994) and Erez and Revital (1986) show that high involvement by participants in the selection of goals increased goal performance.

Patient-Centered Care Plans

Based on the above theory, we decided to incorporate setting individual patient goals into the treatment program at the dialysis unit by the use of patient-centered

care plans. Patients were asked to set specific goals for the subsequent six months. If the task was complex, intermediate goals were set, with a timetable for the accomplishment of each one. Each staff discipline then described the part they would play in assisting patients to meet their goals.

For example, if a patient had the goal of taking some classes at the local community college, there would be a schedule set for obtaining and completing an application; submitting transcripts, health history, and other required documentation; investigating funding possibilities; meeting with a counselor; and so forth. Nursing might assist the patient by rearranging his or her dialysis schedule when necessary and insuring that any physical barriers to accomplishing the goal are addressed. The dietitian might assist by evaluating any lab values that could result in decreased energy, cognitive impairment, or other conditions that would hamper goal achievement attempts. The social worker might assist by referring the patient to programs such as Vocational Rehabilitation, which could assist with funding, or referral for other services which might be necessary, such as career counseling, child care, or transportation. All staff would assist by providing encouragement and reinforcement of the patient's efforts.

The added advantage is that many of the staff's treatment-centered clinical goals can be incorporated into the patient-centered care plan. The need for adequate dialysis, for lab values that maximize patient functioning, and for following other treatment guidelines become important to assisting patients to meet their goals. So rather than patients seeing these clinical goals as an objective standard with little meaning to them personally, the goals become part of the program to help them achieve what they desire, and they have more motivation to cooperate with their treatment regimen.

One of the primary difficulties we had in doing patient-centered care plans was in getting patients to set goals. Many of the patients are elderly and have adjusted to life on dialysis. They had problems trying to think of anything they really wanted to change or seeing possibilities still open to them. Many vague goals had to be made specific. Instead of a goal such as "having more energy" they needed to define what they wanted to do, such as "being able to mop my floor" or "being able to walk around the block." Some patients wanted unrealistic goals, particularly "getting off dialysis." When asked what they would do if they were off dialysis, they fre-

quently had goals that could be accomplished even while on dialysis, but they had formed a dichotomy in their minds between what was seen as acceptable sickness behavior and how they would behave if they were well.

In order to assist patients with thinking about goals, we gave them several categories they might want to consider. These included:

- a) physical. Patients may want to improve their mobility, stamina, or have some specific physical concern with which they want to get assistance.
- b) lifestyle. Patients may want to become involved in educational, vocational, social, or other activity that would improve their quality of life.
- c) treatment related. Some patients may want to reduce fluid gains or improve certain lab values, and actual numerical goals may be determined. They may want to learn more about their illness, and goals could include obtaining information on specific aspects of treatment, or becoming more involved in decisions by attending care plan conferences.
- d) self-efficacy. Patients may want to increase their independence and control. Goals may include such things as learning ways to perform ADLs within their limitations, learning how to take their blood pressure, monitor their medications or other health concerns at home, or learning how to utilize specific resources or services to get their needs met.
- e) other. Patients may have goals to address other needs such as dealing with emotional problems, substance abuse problems, or specific lifestyle or family concerns. Again, the goals need to be defined in measurable ways. For example, if a patient wants to improve depression, goals could include specific steps, such as seeing a psychiatrist for antidepressant medication, attending counseling sessions, or joining an activity group.

In assisting patients with setting goals, it is also important to assess with them what they see as barriers to accomplishing their goals and what types of interventions may be needed. Barriers may include such things as:

- financial limitations
- resource issues such as transportation or childcare
- lack of family support
- lack of information/education
- physical or cognitive limitations
- self-concept or health belief limitations.

Interventions may include such things as:

- referrals for physical or occupational therapy, home health, rehabilitation programs
- educational and skill building activities
- obtaining supplies such as a medication management box, measuring cups for fluid, a walking cane, or other medical equipment
- patient/family education and/or counseling
- referrals to community resources for services such as vocational rehabilitation, adult education, various home services
- obtaining information about community educational, social, recreational, or volunteer programs, or renal support groups.

Patients may be able to accomplish some goals by themselves, and for others, they will need the cooperation of the staff. Since physician referrals are required for such things as physical therapy or home health services, the patient's doctor will need to be consulted and in agreement with the patient's goals in such areas. Various staff members may need to be involved when patient and family education is needed. Social support from family and/or others is also important; exploring with patients who might be able to support their goals and how to enlist their assistance can improve goal performance.

Readiness to Change

Not all patients are ready to make changes when the dialysis staff is ready for them to do so. Generally, trying to force change is counterproductive and leads to resistance. In cases of medical necessity, such as dialysis, patients may not have the luxury of waiting until they feel ready to start treatment. But in the instance of patient-set goals, it is important to evaluate the patient's readiness to change. One tool for this is the Readiness to Change Ruler (Zimmerman, Olsen, Bosworth, 2000). This is simply a scale, drawn like a ruler, with the left end indicating that the patient is not prepared to change and the right end indicating that change is already taking place. Patients evaluate where they are on the continuum. Their reasons for why they placed themselves where they did on the ruler and steps that would assist them to move along the continuum can then be explored with them.

All change involves ambivalence. There is comfort in maintaining the status quo, in the predictability of the familiar. Patients may have become accustomed to the lowered expectations and demands of the sick role, and

the decision to move beyond their current functioning can be frightening as well as exciting. If patients are just considering change, it is most helpful to assist them to examine this ambivalence, and to look at both the barriers and benefits to changing, rather than trying to push them into taking immediate action.

Health Beliefs and Self-Efficacy

In order to increase the likelihood that individuals will change their behavior, they generally need to believe that such changes will be beneficial for them, that there will be adverse consequences of not changing, and that there are not significant barriers or costs to making the change (Rosenstock, Strecher, & Becker, 1988). Costs may be time, money, expenditure of physical or emotional energy, conflicts with other priorities, and so forth. If a patient does not believe change is important, there will be little motivation for working toward a goal, so assessing the patient's beliefs about the personal value of the change is an integral part of setting goals. This can be done using scaling questions, similar to the Readiness to Change Ruler described earlier. Patients can be asked, "How important is it to you to make this change? If 0 was 'not important' and 10 was 'very important,' what number would you give yourself?" (Rollnick, Mason, & Butler, 1999).

An important aspect of goals being accepted by individuals is their perception of their ability to attain the goals and the belief that they are capable of performing whatever behaviors are necessary to accomplishing their goals. There are several ways efficacy can be enhanced. The primary and most effective way is through mastery experiences. The patient can be assisted to develop plans, acquire skills, and make behavior changes that lead to the attainment of proximal goals. As the individual experiences success in meeting these intermediate goals, belief in self-efficacy increases. Another way of increasing self-efficacy beliefs is through vicarious learning or modeling; as the individual sees others succeeding at a particular behavior, belief that he or she too can succeed is increased. An additional way to enhance self-efficacy is through verbal encouragement and support. Bandura (1994) lists a fourth way of increasing self-efficacy, which is the reinterpretation of somatic and emotional states. People may equate anxiety, tension, and fears about performance with failure, and can be assisted to alter negative thought patterns and interpret such feelings as energizing rather than debilitating.

Because self-efficacy is related to a specific behavior, patients may have high levels of perceived efficacy in relation to some aspects of their goals and low efficacy in relation to others. For example, if patients have goals related to adhering to their treatment regimen, they may feel very confident that they can take their medications as prescribed, but have little faith in their ability to follow their diets. Interventions would be aimed at building confidence by assessing what they perceive as barriers and designing appropriate interventions. It is an individual's perception of self-efficacy rather than objective reality that influences behavior.

Another way of maintaining individuals' beliefs in their capacity to succeed is to prepare them for lapses. The path to change is rarely a straight line. Most people slip back into previous behavior patterns at times. Patients can be assisted to see this as an expected part of their efforts to change, and also as an opportunity for learning, rather than as failure. If they can identify issues that resulted in their relapse, they can plan strategies to deal with potential problem areas. Anticipating potential difficulties can help patients prepare ahead of time for situations that could tempt them to relapse. Patients can also be assisted to focus on the successful parts of the plan and identify strategies that worked for them.

Additional Considerations

Self-Monitoring

In promoting the patients' responsibility for self-management and the attainment of goals, it is also important that they be responsible to monitor their progress. In some instances this may be a daily record of performing the desired behavior, or it could take the form of a check-off list as various steps to their goals are accomplished. When goals do require information from the staff, such as lab values, care needs to be taken to insure that it is given to patients regularly. The staff should not take the role of policing patient progress and nagging or criticizing. However, it is very important that the staff does communicate support for the patients and recognize and encourage the efforts and progress that is being made.

Outcomes

Defining goals only in terms of outcomes can produce discouragement and a decrease in self-efficacy beliefs. Some outcomes are not within the patient's control. For example, if a diabetic patient wants to improve glucose control, the goal could be to monitor blood sugar a certain number of times a day, to take medications as prescribed, and so forth. Even if patients adhere to their

regimens perfectly, they might not achieve a specific blood glucose lab number due to factors beyond their control, and this could cause them to feel that their efforts are futile. In such instances, a behavioral goal is preferable to an outcome goal.

Feedback

Strecher et al. (1995) and other authors suggest that goals should focus on a learning and mastery orientation. It is therefore suggested that feedback be related to the individual's performance only. When feedback is based on performance relative to others, the orientation changes to an evaluative orientation. According to Elliot and Dweck (1988) there are two types of achievement goals: performance goals, in which the object is to maintain positive judgments of one's ability and avoid negative judgments, and learning goals in which the object is to increase ability or master new tasks. Their study showed that learning goals lead to efforts to increase competence and respond to failure in a mastery-oriented manner. Performance goals decrease willingness to risk making mistakes and when self-efficacy was low, lead to learned helplessness behavior.

Other authors including White, Kjelgaard, and Harkins (1995) and Harkins, White, and Utman (2000) suggest that people can be motivated by the opportunity to compare themselves with others, and in some situations, concern over the evaluation by an external examiner motivates greater performance than self-evaluation. Some goals are conducive to a comparative feedback situation, and for others this would not be applicable. Even though patients are self-monitoring and may already know their progress, reviewing the results with staff on a pre-determined timetable is important to the goal attainment process.

Rewards

A number of authors have suggested that the use of external rewards tends to externalize motivation, and behavior changes may only be maintained as long as rewards are provided. If goals are focused on learning new skills and behaviors and rewards are internal, such as satisfaction with acquiring new skills, the behavior is more sustained. In some instances new behavior learned as a result of external rewards is maintained when rewards are withdrawn because the new behavior produces positive benefits valued by the patient. Self-rewards, in which individuals determine what the reward for improvement will be and provide it themselves when the goal is reached, also produce more sustained change than external rewards provided by others.

Summary

The steps for setting goals can be summarized as follows:

1. Determine the patient's readiness to change.
2. Assist the patient to set challenging yet realistic goals. If goals are complex, develop intermediate goals. Insure that goals are specific and measurable.
3. Address issues of patient-perceived barriers and supportive interventions needed.
4. Determine the patient's self-efficacy for the behaviors needed to attain the goals; incorporate efficacy-enhancing experiences as needed.
5. Have an established plan for feedback and rewards.

It is important to remember that the goals that are set are the patient's goals and not the staff's. Maintaining flexibility assists patients to sustain their efforts; goals do not need to be set in stone. After a couple of months, patients may find that they were overly ambitious and need to modify their goals, or add additional steps in the process of attaining them. In other cases, patients may find that they achieved their goals in a very short time, and would like to increase the standards they set for themselves or add additional goals. After the six month time period for which the initial goals were set, the patients will have learned about the process and will likely be more skilled at setting their goals for the next six months.

When the focus is on learning, that aim can be met whether the specific goals are met or not. Even if patients have not achieved their goals, they can be assisted to recognize what they have learned that will enable them to make progress toward the next goals they set. It has often been said that those who aim at nothing hit it every time. Helping patients set goals and work toward them empowers them to take control over aspects of their lives and manage the impact of chronic illness more effectively.

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