

**GOAL CONSENSUS AND COLLABORATION**

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*There are differences in the extent to which patient and therapist agree on psychotherapy goals and work together in the helping relationship. This article reviews the empirical research on the relation between psychotherapy outcome and patient-therapist goal consensus and collaboration. Research results suggest that psychotherapy outcome is enhanced when agreement on therapeutic goals and collaborative involvement (often assessed by patient cooperation, role involvement, and homework compliance) are present during the course of therapy. When therapists and patients demonstrate cooperative and affiliative behavior, and when patients are actively involved in the patient role, better outcomes can be expected. We discuss therapeutic practices based on these findings, emphasizing the involvement of therapist and patient in a process of shared decision-making where goals are frequently discussed and agreed upon.*

**Introduction**

This article addresses patient and therapist implementation of the therapeutic contract through goal consensus and collaboration. After providing definitions of our terms, we briefly review the research findings relating therapist-patient goal consensus and collaboration to psychotherapy outcome. For a more in-depth review of these

studies, the reader is referred to our book chapter (Tryon & Winograd, 2002) on which this article is based. We then provide suggestions for applying these research results to clinical practice.

**Definitions**

Goal consensus and collaborative involvement are pantheoretical concepts, that is, they apply to all types of psychotherapies regardless of theoretical orientations and practice settings. *Goal consensus* is therapist-patient agreement on therapy goals and expectations (Orlinsky, Grawe, & Parks, 1994). It is one aspect of the *working alliance*, defined by Bordin (1979) as the patient-therapist bond and agreement on tasks and goals. Meta-analyses (e.g., Horvath, in press; Martin, Garske, & Davis, 2000) found that the working alliance is itself therapeutic. In other words, patients will improve when they have good working alliances with their therapists.

*Collaborative involvement* is the mutual involvement of patient and therapist in a helping relationship. Goal consensus and collaborative involvement are two elements involved in the implementation of the *therapeutic contract*, which is defined in Orlinsky et al.'s (1994) extensive literature review as participants "understanding about their goals and conditions for engaging each other as patient and therapist" (p. 279).

**Research Review**

*Goal Consensus*

There are a number of ways to look at the manner in which goal consensus functions within the psychotherapy relationship. Researchers have examined goal consensus in terms of (a) patient-therapist agreement on goals; (b) the extent to which a therapist explains the nature and expectations of therapy, and the patient's understanding of this information; (c) the extent to which goals are discussed, and the patient's belief that goals are clearly specified; (d) patient commitment to goals; and (e) patient-therapist congruence on the

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origin of the patient's problem, and congruence on who or what is responsible for problem solution.

Relative to goal consensus, psychotherapy outcome has been examined in terms of reduction in patient symptoms and complaints, whether or not sessions are perceived as "good" therapy hours, and whether patients believe that therapy is or was helpful.

When therapists and patients achieve consensus about a treatment plan, and when therapists explain the rationale for the plan and how it works, patients are more satisfied with the initial session (Eisenthal, Koopman, & Lazare, 1983). In addition, when patients and therapists agree on goals requested by patients during intake, patients are less distressed at the end of the interview (MacKay, Cox, Burrows, & Lazzerini, 1978). These factors—greater satisfaction and lower levels of distress—set the stage for patient and therapist involvement in a helping relationship and contribute to patient postintake return for additional therapy (Tryon, 1985). This initial therapeutic engagement is important for therapeutic outcome because most therapies require patient attendance beyond the first session.

The process of goal consensus remains important for the outcome of most postintake sessions as well. Hoyt, Xenakis, Marmar, and Horowitz (1983) found that good therapy hours are associated with more patient-therapist discussion of goals and expectations. These goal-related discussions are also associated with patients viewing therapy as helpful (Goldstein, Cohen, Lewis, & Struening, 1988).

Patient-therapist agreement on treatment goals is also associated with treatment outcome. Research results indicate that goal consensus reached very early in treatment is sometimes positively related to reduction in patient symptoms and complaints much later in treatment or at termination. For example, Dormaar, Dijkman, and de Vries (1989) found that patients' experience of goal consensus and therapists' understanding of patient concerns after the second session predicted reductions in both patient- and therapist-rated target complaints and patient depressive symptoms as late as 6 months after the beginning of treatment. Safran and Wallner (1991) found that patients' and therapists' perceptions of goal consensus obtained after the 3rd session were linked to outcome improvement following 20 sessions of cognitive therapy for depression.

Mussell et al. (2000), in their study of outcome in a 12-session cognitive-behavioral group therapy for bulimia, found that pretreatment ratings by patients of their commitment to therapeutic goals were positively related to remission of bulimic symptoms at termination. Treatment goals may be formulated by taking into account the patients' perceived origin of his or her problem. Tracey (1988) found that intake patient and therapist congruence in terms of whether the patient attributed the problem to internal versus external causes was positively related to patient change at termination. Problem solution congruence on whether the solution to the problem was external or internal, however, did not relate to outcome.

While most studies examining the relationship between patient-therapist agreement on goals have achieved positive results, others have not. Marmar, Gaston, Gallagher, and Thompson (1989) and Gaston, Marmar, Gallagher, and Thompson (1991) found that goal consensus from patients' perspectives did not play a substantial role in the alleviation of patients' depressive symptoms in behavioral, cognitive, or brief dynamic therapy for major depressive disorder.

Patient, therapist, and outside rater perceptions of goal consensus often differ (Tichenor & Hill, 1989). This may account for some of the differing findings in the research literature about the relationship of goal consensus to outcome. Nevertheless, out of 25 studies we reviewed (Tryon & Winograd, 2002), 17 studies (68%) revealed a positive relationship between goal consensus and outcome on at least one measure completed by patient, therapist, or observer.

### *Collaborative Involvement*

Researchers have examined collaborative involvement within the psychotherapy relationship in terms of patient cooperation, role involvement, and homework compliance. When patients indicated a desire for close collaboration with their therapists, therapy sessions were rated more positively by both patient and therapist (Orlinsky & Howard, 1967). This may be because these elements in interaction with one another help support a "relationship between equals" (p. 626). Positive feelings about therapy, on the part of the patient as well as the therapist, may contribute to the patient's further involvement in the therapeutic process.

Patients who are willing to work closely with their therapists not only feel better about their

treatment—they seem to experience better outcomes as well. Patient cooperation has been linked to reductions in somatic complaints and paranoid symptoms (Kolb, Beutler, Davis, Crago, & Shanfield, 1985). Certain patient characteristics may interfere with cooperation. Patients who are more withdrawn and psychotic have been found to have a poorer prognosis than less withdrawn patients (Colson et al., 1985). Patients who are more resistant (Westerman, Frankel, Tanaka, & Kahn, 1987) and patients who are more defensive (Piper, DeCarufel, & Szkrumelak, 1985) have shown less improvement at termination as well. These patients may perform fewer target behaviors or experience higher levels of stress at termination than more cooperative patients (Westerman et al., 1987).

Patients who put more effort into fulfilling their role experienced therapy as more effective than those who expend less effort (Martin, Martin, Meyer, & Slemon, 1986). Patients who rated themselves as more committed to their role, experienced greater symptom reduction at termination than patients who rate themselves as less committed (Gaston et al., 1991).

One way that patients contribute to the collaborative relationship is by completing homework assigned by therapists. A meta-analysis of 27 studies, conducted by Kazantzis, Deane, and Ronan (2000), showed that both homework assignments and homework compliance are positively related to psychotherapy outcome. When therapists ask for or patients volunteer information about homework, patients are more likely to comply with homework assignments than when homework is not discussed (Worthington, 1986). Completion of homework has been positively associated with observer-rated reduction in patient symptoms at outcome. In particular, patient homework compliance has been shown to relate positively to reductions in depressive symptomatology (Persons, Burns, & Perloff, 1988). A study by Schmidt and Woolaway-Bickel (2000) indicated that the *quality* of patients' compliance might make a difference in how much patients improve. They found that patients' ratings of the number of days and hours that they spent doing therapy homework was not related to several therapist- and patient-completed outcome inventories. Therapists' and outside evaluators' ratings of the quantity of homework assignments and the quality of patients' compliance, however, predicted improvement on most of the outcome inventories.

We (Tryon & Winograd, 2002) combined results from 24 studies and found that 89% of the time, collaborative involvement and outcome were significantly and positively related on at least one measure completed by patient, therapist, or observer. There is considerable support for the positive impact of collaborative involvement—in terms of patient role commitment, homework compliance, and patient cooperation—on treatment outcome.

### **Therapeutic Practices**

Results of the studies we (Tryon & Winograd, 2002) reviewed tend to support the positive influences of collaborative involvement and goal consensus on psychotherapy outcome. Readers should bear in mind that the relationships between involvement and consensus and psychotherapy outcome are correlational, and thus, causal inferences cannot be drawn. These studies examined collaborative involvement from different participant (therapist, patient) and nonparticipant (observer) perspectives and defined it in different ways (patient role commitment, homework compliance, and patient cooperation). Results provide considerable support for the positive impact of collaborative involvement on treatment outcome. Thus, if patients and therapists are involved cooperatively and patients are working hard both in and out of sessions, outcome is enhanced.

There is also general support for a positive relationship between goal consensus and psychotherapy outcome, but the overall results of these studies were not as positive as those concerning collaborative involvement. Goal consensus is difficult to assess. Patient and therapist may be working on the same goals but they may talk about them in different ways. In contrast to resistance and homework compliance, it may be more difficult for observers to detect goal consensus.

To maximize the possibility of achieving a positive treatment outcome, therapist and patient should be involved throughout therapy in a process of shared decision-making, where goals are frequently discussed and agreed upon. To engage patients in this process, therapists should try to address topics of importance to patients and resonate to patients' attributions of blame regarding their problems. When therapists communicate in these ways, patients feel understood, and the stage is set for cooperative therapeutic collaboration, a mutual commitment to therapeutic goals, and involvement in the therapeutic process. Pro-

viding patients with understanding, sympathetic listeners who attend to topics that patients value is important to goal consensus. Patients leave sessions satisfied and willing to work on their problems when they are "given clear and complete explanations concerning the recommended treatment plan, its rationale, and its link to the patient's complaints, and with decision-making processes" (Eisenthal, Koopman, & Lazare, 1983, p. 49). Discussions of therapy goals aimed at achieving consensus should take place throughout therapy. Such discussions are associated with therapist-patient beliefs that the therapy session was a good one.

Results of the studies we reviewed suggest that collaborative involvement throughout therapy that includes cooperative, affiliative behavior on the part of both participants is associated with better outcomes. Patients who achieve better outcomes are those that are actively involved in the patient role, discussing concerns, feelings, and goals rather than resisting or passively receiving therapists' suggestions. When patients resist collaborating with therapists, poor outcomes ensue. Therapists who give patients homework assignments and who check on the completion of these assignments achieve better outcomes than therapists who do not ask patients to apply what they learned in therapy in their daily lives. A recent study (Schmidt & Woolaway-Bickel, 2000) indicated that it is not necessarily the quantity of homework assigned, but the quality of completed homework that leads to better therapy outcomes.

## References

BORDIN, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research and Practice*, 16, 252-260.

COLSON, D. B., ALLEN, J. G., COYNE, L., DEERING, D., JEHL, N., KEARNS, W., & SPOHN, H. (1985). *Hospital and Community Psychiatry*, 36, 168-172.

DORMAAR, M., DIJKMAN, C. I. M., & DE VRIES, M. W. (1989). Consensus in patient-therapist interactions: A measure of the therapeutic relationship related to outcome. *Psychotherapy and Psychosomatics*, 51, 69-76.

EISENTHAL, S., KOOPMAN, C., & LAZARE, A. (1983). Process analysis of two dimensions of the negotiated approach in relation to satisfaction in the initial interview. *Journal of Nervous and Mental Disease*, 171, 49-54.

GASTON, L., MARMAR, C. R., GALLAGHER, D., & THOMPSON, L. W. (1991). Alliance prediction of outcome beyond in-treatment symptomatic change as psychotherapy process. *Psychotherapy Research*, 1, 104-113.

GOLDSTEIN, J. M., COHEN, P., LEWIS, S. A., & STRUENING, E. L. (1988). Community treatment environments: Patient

vs. staff evaluations. *Journal of Nervous and Mental Disease*, 176, 227-233.

HORVATH, A. O. (2002). Therapeutic alliance. *Psychotherapy: Theory, Research and Practice*, 38(4), 365-372.

HOYT, M., XENAKIS, S., MARMAR, C., & HOROWITZ, M. J. (1983). Therapists' actions that influence their perceptions of "good" psychotherapy sessions. *Journal of Nervous and Mental Disease*, 171, 400-404.

KAZANTZIS, N., DEANE, F. P., & RONAN, K. R. (2000). Homework assignments in cognitive and behavioral therapy: A meta-analysis. *Clinical Psychology: Science and Practice*, 7, 189-202.

KOLB, D. L., BEUTLER, L. E., DAVIS, C. S., CRAGO, M., & SHANFIELD, S. B. (1985). Patient and therapy process variables relating to dropout and change in psychotherapy. *Psychotherapy*, 22, 702-710.

MACKAY, C., COX, T., BURROWS, G., & LAZZERINI, T. (1978). An inventory for the measurement of self-reported stress and arousal. *British Journal of Social and Clinical Psychology*, 17, 283-284.

MARMAR, C. R., GASTON, L., GALLAGHER, D., & THOMPSON, L. W. (1989). Alliance and outcome in late-life depression. *Journal of Nervous and Mental Disease*, 177, 464-472.

MARTIN, D. J., GARSKE, J. P., & DAVIS, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology*, 68, 438-450.

MARTIN, J., MARTIN, W., MEYER, M., & SLEMON, A. (1986). Empirical investigation of the cognitive mediational paradigm for research on counseling. *Journal of Counseling Psychology*, 33, 115-123.

MUSSELL, M. P., MITCHELL, J. E., CROSBY, R. D., FULKERSON, J. A., HOBERMAN, H. M., & ROMANO, J. L. (2000). Commitment to treatment goals in prediction of group cognitive-behavioral therapy treatment outcome for women with bulimia nervosa. *Journal of Consulting and Clinical Psychology*, 68, 432-437.

ORLINSKY, D. E., GRAWE, K., & PARKS, B. K. (1994). Process and outcome in psychotherapy—Noch einmal. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 270-376). New York: Wiley.

ORLINSKY, D. E., & HOWARD, K. I. (1967). The good therapy hour. *Archives of General Psychiatry*, 16, 621-632.

PERSONS, J. B., BURNS, D. D., & PERLOFF, J. M. (1998). Predictors of dropout and outcome in cognitive therapy for depression in a private practice setting. *Cognitive Therapy and Research*, 12, 557-575.

PIPER, W. E., DECARUFEL, F. L., & SZKRUMELAK, N. (1985). Patient predictors of process and outcome in short-term individual psychotherapy. *Journal of Nervous and Mental Disease*, 173, 726-733.

SAFRAN, J. D., & WALLNER, L. K. (1991). The relative predictive validity of two therapeutic alliance measures in cognitive therapy. *Psychological Assessment*, 3, 188-195.

SCHMIDT, N. B., & WOOLAWAY-BICKEL, K. (2000). The effects of treatment compliance on outcome in cognitive-behavioral therapy for panic disorder: Quality versus quantity. *Journal of Consulting and Clinical Psychology*, 68, 13-18.

TICHENOR, V., & HILL, C. E. (1989). A comparison of six measures of working alliance. *Psychotherapy: Theory, Research and Practice*, 26, 195-199.

- TRACEY, T. J. (1988). Relationship of responsibility attribution congruence to psychotherapy outcome. *Journal of Clinical and Social Psychology, 7*, 131–146.
- TRYON, G. S. (1985). The engagement quotient: One index of a basic counseling task. *Journal of College Student Personnel, 26*, 351–354.
- TRYON, G. S., & WINOGRAD, G. (2002). Goal consensus and collaboration. In J. C. Norcross (Ed.), *Psychotherapy relationships that work* (pp. 106–122). New York: Oxford University Press.
- WESTERMAN, M. A., FRANKEL, A. S., TANAKA, J. S., & KAHN, J. (1987). Client cooperative interview and outcome in paradoxical and behavioral brief treatment approaches. *Journal of Counseling Psychology, 34*, 99–102.
- WORTHINGTON, E. L., JR. (1986). Client compliance with homework directives during counseling. *Journal of Counseling Psychology, 33*, 124–130.