



Chronic Pain Management Mini Series

**Session Two: Help your patients to
stay active despite pain**

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This guide to goalsetting is reproduced for the Physiotherapy Webinar Chronic Pain Management Mini Series.

The work was first published as a chapter in the Physiotherapy Pain Association Yearbook, Topical Issues in Pain 5 which was published in 2005 by CNS Press. This series of five Yearbooks was edited by the late Louis Gifford FCSP. I encourage readers to source the Yearbooks which cover a wide range of issues which remain relevant to supporting patients living with pain.

A Practical Guide to Goalsetting

The aim of this chapter is to introduce the principles and practice of goalsetting within physical rehabilitation. The process of setting a goal with a patient integrates a wide range of theoretical and practical issues. For example, goalsetting has a central role within the Cognitive-Behavioural approach, and this will be discussed. There are also clear links between goalsetting and the development of self-efficacy, and the mastery of fear using a graded exposure approach. Other important aspects of goalsetting within rehabilitation include links with acceptance issues, with pacing and the avoidance of Activity Cycling, and with the role of goals as outcome measures. The chapter is written in such a way as to be readable for a physical therapist with little knowledge of the Cognitive Behavioural approach. It is not intended to be an in-depth analysis of the theoretical issues. The chapter can be thought of as a clinically oriented “guided tour” around goalsetting, to act as an introduction to the key issues. This chapter intersects and overlaps with many other chapters in previous volumes of Topical Issues in Pain.

Goalsetting: The Evidence Base

Much of the material presented is based upon discussions with countless patients and clinicians over the past ten years, and as such, no one “owns” goalsetting or can be specifically credited for its creation. Indeed, goalsetting is part of a complex healthcare intervention, and would therefore not be simply investigated using a Randomised Controlled Trial (Dieppe 2004). An interesting case study presented by Linton et al (1999) hints at its effectiveness. These researchers used six patients, randomly allocated to develop an exercise programme either by negotiating their exercise goal with the therapist, or having the goal set by the therapist. The condition was then reversed, using a different exercise. All six made larger percentage increases in exercise repetitions during the negotiated phase. Further exploration of the role of goalsetting using qualitative methods would be valuable. Goalsetting has been studied more extensively in stroke rehabilitation, and a recent qualitative study in this area by Parry (2004) offers insights into the difficulties which physiotherapists have in adapting their practice to incorporate goalsetting.

A Definition

A useful starting point is a definition from Chambers dictionary: a goal is a noun, meaning “an end or aim to effort or ambition”. It is obvious from this definition that a goal can describe both the destination and the journey. One can set a goal that offers “an aim to ambition”, but the experience of having and pursuing a goal is very different process from the final achievement of the goal. Clinically, many patients who set goals will later find themselves on a different path than the one they anticipated travelling along when the goal was first set. It is our role as physiotherapists to facilitate the process of goalsetting whilst being sensitive to the fact that the people we are working with are involved in a dynamic process. In exploring their potential for the future, the goalsetting process should allow them to be able to continuously review their priorities and to move onto more appropriate goals as rehabilitation unfolds.

Goalsetting within Rehabilitation and within a Self-Management Approach

Rehabilitation is a term usually applied to the process of returning to fitness and function following injury or illness. The term can imply a return to a previous lifestyle and level of activity. In this situation, goalsetting is usually focussed upon the activities that the patient used to do but is not currently managing.

However, many physiotherapists work with patients who are not expecting to return to their previous lifestyle because of their ongoing health problems. In this situation, rehabilitation goals may not be so easily defined. The patient may be considering new activities, having given up old ones because of the health problem. This is where goalsetting needs to be dynamic and flexible. This may involve exploration of a new role for the patient, when their previous role has been altered or abandoned. One patient involved in a goalsetting and rehabilitation programme described herself as “being in the process of recreating herself”. Here then is an illustration of an interaction between goalsetting and a possible redefinition of the individual’s identity that sometimes occurs. Goalsetting can expose and may help reflect the person’s values and priorities.

Functional goalsetting can be a powerful reinforcement for exercise behaviour, if the links between exercise and function are explored with the patient (Figure 1). We can select exercises that might facilitate improvements in physical function, and work with the patient to integrate improvements gained through exercise into improved function. Within this interplay between increased exercise performance and increased function we can also develop setback plans (e.g. how to avoid a setback, and how to cope with one if it happens). Often, a plateau in improvement will occur. How might we help our patients to manage this phase?

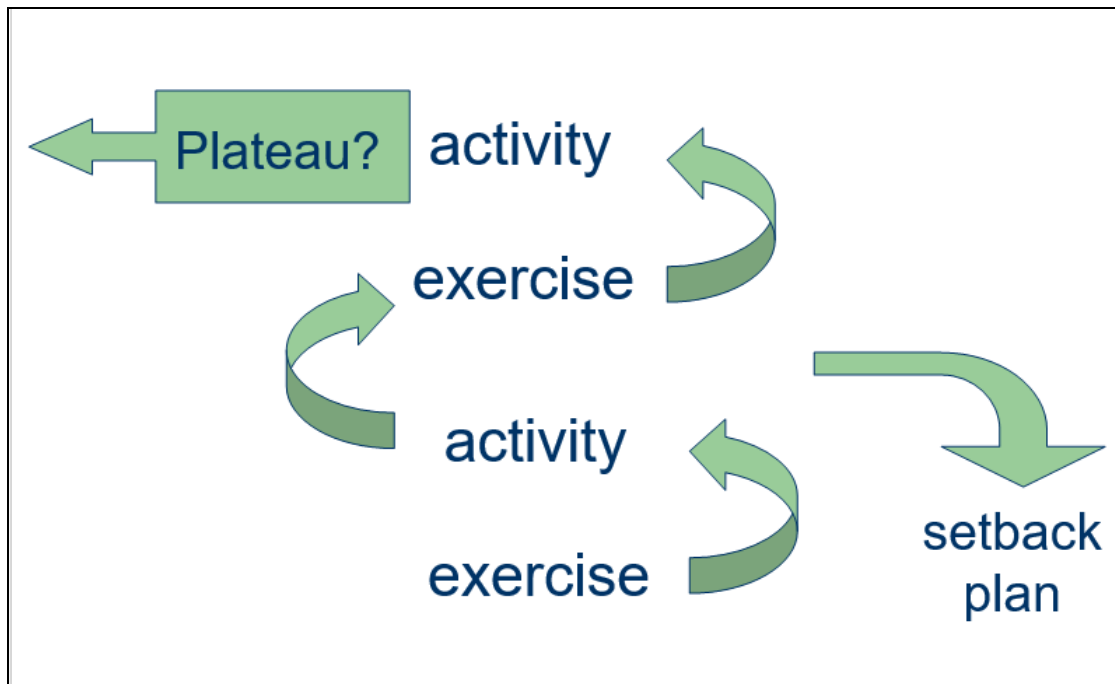


Figure 1. A Rehabilitation Flowchart, indicating the positive interaction between exercise and goalsetting for activity, incorporating a plan for setbacks and a plan for a plateau

Goalsetting: Setting the Scene

Goalsetting can begin once there is an agreement between the patient and the clinician that it is an appropriate area to explore. In some circumstances, this agreement is easily reached. In the example below, the patient has attended for assessment, and as part of the clinical interview the therapist asks the patient what they were hoping to gain from coming to see the therapist.

Therapist: “When you came here today, was there something specific that you were hoping that I might be able to help you with?”

Patient: “I have been thinking about starting to ride my bicycle again, but I wasn’t sure if it would be sensible to try, given the problems I have been having with my knee. I was hoping that you might advise me, and perhaps help me to work out how I could go about starting”.

In this scenario, goalsetting is clearly on the agenda from the start. Note that asking the patient what *they* wanted from the contact was a vital initial step: if we assume what our patients want, we may never meet their needs.

Goalsetting may not be appropriate if the patient only wishes to have the therapist “make them better again”, to take on a healing role, to “wave the magic wand”. We, and our patients, grow up in a culture that understands the curative role of Medicine, operating within a paradigm often referred to as the “Medical Model” or the “Disease Model”. The Medical Model describes a process whereby the patient attends with symptoms, the clinician takes a history and elicits signs, and arranges investigations if appropriate.

This leads to a diagnosis, and based upon that diagnosis a treatment is chosen which leads to recovery. This model has been helpful for treating infectious diseases and fractures, but has serious limitations for long-term conditions for which a cure is not available. Patients often do not realise that a medical, or 'curative', solution is not a realistic hope, or that it might at best offer limited benefit. It is common for many patients to direct a great deal of their energy and resources into a searching for a cure. Unsurprisingly, the clinical experience of many rehabilitation therapists is that a patient with this type of belief is less likely to engage with a self-management approach, including goalsetting.

Careful assessment facilitates decision-making about how best to move forwards. Pertinent enquiries include finding out whether the patient is wholly committed to finding a cure. If the assessment indicates that there is unlikely to be an effective treatment to relieve their symptoms a rehabilitation or self-management approach may be of interest. On the other hand this may not be acceptable if they are stubbornly focussed upon a curative treatment. Self-management could still be explained and outlined, with an offer to return for help with self-management if they are unsuccessful in their aim of finding a cure. A variety of interactions have been proposed that can help these types of patients move on from their passive, 'looking for a cure' approach to a more active, self-managing approach. These include the 'Motivational Interviewing' approach (Miller & Rollnick 2002), an approach that incorporates evidence relating to the 'Readiness for Change' model (Kerns & Rosenberg 2000).

The most frequent situation is where the patient would like a cure, but also is realistic about the odds of finding one. Here the patient may be willing to try a self-management approach alongside a symptom-relieving treatment trial. For example, when a treatment such as TENS is offered, it takes only a moment to suggest that if the TENS is effective in controlling their pain it could be used to help in getting going again with some activities. A potential list could then be generated and discussed. This allows a quick insight into the kind of goals the patient might have. At the next appointment, if the treatment has been helpful, enquiries can be made as to whether or not the goals were achieved. It is important to appreciate that the provision of symptom relief does not automatically lead to an increase in function. For example, the patient might be concerned that any increase in function will cause an unacceptable exacerbation in symptoms, or lead to further/lasting damage? Even if treatment is unhelpful, it can still be fruitful to follow up the brief discussion that established the potential goals. Discussing the obstacles to progress with the goal can be of value (see below).

The assessment process for a self-management programme usually involves reaching an agreement with the patient that they have a chronic health problem that is not amenable to currently available treatments. Once this occurs agreeing to goal setting and self management becomes a good deal easier. Often, patients have tried numerous treatments and already reached the conclusion that spending more time, energy and money in the search for a cure is pointless.

In contrast, some never quite give up hope of a cure, and may rely upon their hope as a way of coping with their ongoing distress. Despite this, these patients may still agree that they want to develop their self-management skills, and even agree to suspend their search for a cure whilst attending the programme.

Some patients are unable to think of a goal. They may be in significant distress, disabled by their symptoms, and unable to consider how they might move forwards in their life whilst their symptoms persist. These 'fragile' patients require a great deal of skill to assess and manage. Their inability to set a goal may reflect their low confidence in their ability to achieve (i.e. low self-efficacy: see below, in the section headed "A Goal Should Be Achievable"). In this situation, it can help to ask, "If someone could wave a magic wand and get rid of your symptoms, what would you do differently?"

Some therapists ask:

"If you woke up tomorrow with no symptoms, what would you do differently?"

Be warned however that the idea of suggesting that they might wake up with no symptoms can unproductively kindle false hopes!

Clearly, if they answer that they would not do anything differently, then the role for help with self-management is immediately restricted since they are very unlikely to productively engage in a goal-orientated programme.

It might be the first time anyone has asked, in a healthcare setting, what they want and they may require time to consider what their goals might be.

Allowing time for reflection and review is therefore important.

Another helpful line of questioning can be to ask them what they have lost since the onset of the condition. This allows a focus on upon any deterioration in their quality of life, which then might lead to a consideration of some of these losses as potential goals. It can be helpful to broaden the patients thinking by exploring a range of possible goal situations, such as work, leisure and recreation, social activity, self-care and domestic activity.

The introduction of goalsetting at the assessment stage helps to establish a clear agenda for the time that the therapist will spend with the patient. In contrast if the assessment only focuses upon the symptoms that the patient has, the patient can be forgiven for thinking that the therapists' sole interest is the resolution of those symptoms.

Using the Problem Oriented Medical Record, with its' emphasis on the patients' "problems", can feel like a negative experience at times. Goalsetting helps shift the assessment towards a more positive focus and can be refreshing for therapists used to the POMR system (see the section below about goals as outcome measures).

Setting a SMART Goal

Once the therapist has reached an agreement with the patient that goalsetting is an appropriate area to explore, the goalsetting process can begin. The acronym “SMART” is widely used and is a useful focus for the goalsetting process.

SMART stands for:

Specific
Measurable
Achievable
Rewarding
Time-limited

I am not aware of the history of the acronym, but there are several variations on this theme. For example, the “R” is sometimes used to stand for “realistic”, but this would seem to duplicate the word “achievable”. I prefer the word “rewarding” because it ties in with the behavioural aspect of the Cognitive Behavioural approach (more on this later).

A Goal Should Be **S**pecific

From the outset, a goal should be described in terms of what the patient might **do**. In other words, what **behaviour** are they aiming to develop? It is not specific to say that they want to “be” happy... the question is, what do they plan to **do** that will bring them happiness? It is not specific to say that they want to be relaxed: their goal could be to “practice a relaxation technique”, which is a behaviour. It is interesting that Fordyce (1976) in his influential text “Behavioural Methods for Chronic Pain and Illness” did not describe the goalsetting process in depth, nor did he use the word “goal” as something that the patient was to focus upon. He saw the treatment goal of the therapist as helping the patient to increase, or decrease, the frequency of a clearly identified “target behaviour”. So, for Fordyce, if our input leads to an increase or decrease in the frequency of the “target behaviour” then we are on the right track. But, if the “target behaviour” (goal) has not been described specifically enough, both patient and therapist run the risk of losing track of progress (or lack of it). Fordyce clearly recognised that human behaviour involves movement, and he therefore recognised the important role of physical therapists in supporting patients to move more, and/or to move (behave) differently.

Later advances in the Behavioural Model included theories such as the Self Regulation Theory, as described by Keefe & Lefebvre (1999). Self-regulation theory highlighted the role of the patient in monitoring, evaluating and reinforcing their own behaviour. This inevitably frames the therapist-patient interaction as a collaborative one, with the patient taking responsibility for setting and taking care of his or her own goals.

Therapists can facilitate this firstly by helping patients seek realistic goals and then by problem solving the practical set-up of the process of achieving them. For example, if a goal is to do more ironing, we might need to be specific about whether the ironing is done standing or sitting, and even which items of clothing are ironed. This might seem pedantic, but details like this can mean the difference between a successful and an unsuccessful attempt (see below, “Goals as Indicators of Obstacles to Change”).

A Goal Should Be Measurable

How many, how far, how long...

This point echoes Fordyce’s concern above. How many shirts are currently being ironed, and how often? How much further does the person want to walk, and does the walk involve rest periods? Does speed of walking matter? Fordyce argued that it is better to measure the behaviour in terms of a “movement cycle” rather than a time period. In other words, what is the best unit of measurement for the activity? For ironing, a “movement cycle” might be a complete shirt for some people, or for others, perhaps just half a shirt. To choose as the “movement cycle” a completely full ironing basket is unlikely to be successful (although I have met patients who have become used to setting this as their goal in the past, and are reluctant to change). In Fordyce’s approach, each successful movement cycle should at first be rewarded, in order to increase the frequency in that behaviour. In the example above, a short rest, and a sense of achievement could reward each half shirt ironed.

Although it can be better to choose some divisible part of the movement in defining a goal, sometimes a time period is more appropriate. For example, visiting a pub with a friend for half an hour, or sitting at a computer for five minutes is likely to be effective. The use of timers can be quite valuable for this kind of goal, and the use of mobile phones with integral timers and alarms can be an advantage.

A Goal Should Be Achievable

This aspect of goalsetting would seem to be straightforward, but in reality it is more complex. Are the horizons of the patient limited by their current beliefs about their abilities? Or are they remembering a previous level of ability (the full basket of ironing in the example above), and setting their sights accordingly?

Earlier, the term self-efficacy was mentioned. Self-efficacy is a measure of a person’s confidence in their ability to perform a given behaviour. For example, how confident are you that you can run a mile? Or two miles? Or three miles? Obviously, your level of confidence (self-efficacy) is likely to reduce as the mileage increases. There is a correlation between self-efficacy and function. Someone who has high self-efficacy about a specific behaviour is more likely to do it, and someone who has low self-efficacy is less likely to do it.

Successful achievement of a goal is likely to increase self-efficacy in that behaviour. In the case of a long-term goal (e.g. running a marathon, or writing a book), self-efficacy may need to be increased by setting smaller targets, or “proximal goals”. Albert Bandura (1997) was highly influential in developing theories and evidence about self-efficacy, and he states that “proximal goals mobilize self-influences and direct what one does in the here and now”. A distal goal is his term for a long-term goal: “distal goals alone are too far removed in time to provide effective incentives...” These concepts can be clinically useful for us: if a patient wants to get back to work, but this might take six months, what are the “proximal goals” that can be worked on which might increase his or her self-efficacy about the “distal” goal of returning to work? If the patient cannot identify these proximal goals but remains fixated upon the distal goal, we might need to spend some time in exploring the options with them.

A Goal Should Be Rewarding

This is a consideration that underpins the Behavioural aspect of the Cognitive-behavioural Model. If a behaviour leads to a consequence that increases the frequency of the behaviour, then that behaviour is likely to increase in its frequency. In this situation, the person behaving is being rewarded by the consequence of the behaviour. Rewards are not always obvious: we do not only increase our behaviour frequency because we are rewarded at every “movement cycle” by a chocolate biscuit! Our rewards might be more complex: a sense of independence, a feeling of getting somewhere, a financial gain, a relief of boredom or guilt (an example of negative reinforcement) are some examples.

Human beings are not straightforward, and are more complex than any psychological model. Our cognitions make the “rewarding” of goals more intricate. How many people will continue with an activity in spite of a significant increase in symptoms because stopping might feel “weak”, like “giving in”? In this case, the “reward” of feeling like we have “beaten” the condition might give a powerful short-term reward. As therapists, however, we know from clinical experience that this kind of motivation can at times lead to a flare up of symptoms followed by a prolonged recovery involving a period of decreased activity that may be of longer duration than the period of activity. This is known as “Activity Cycling”, or the “Boom and Bust” pattern of activity: see Figure 2. We might help our patients to identify this pattern of behaviour, and their “reward” might then be to realise that they have managed an activity successfully and “outwitted” the condition, avoiding the prolonged exacerbation of symptoms.

We may also do well to help our patients to reflect on their achievements. For example, we often pause too briefly to consider our achievements, and quickly move on to consider the next challenge: our patients are no different. They may also minimise their achievements: “it’s nothing compared to what I used to manage” is a frequent response.

This approach can undermine progress, and a strategy to deal with this comparison with the past is required if progress is to be made. The role of the patient in reinforcing his or her own behaviour is emphasised by self-regulation theory (see Keefe & Lefebvre 1999). Rewards do not always have to be complex: there is nothing wrong with the occasional chocolate biscuit as a reward!

Sometimes it can be difficult to identify rewarding goals, or to identify additional rewards if a goal which is less immediately rewarding is achieved. In response to the question, "what might you do to treat yourself?" some people might easily come out with a long list: a hot bath, a glass of something nice, a good book, a favourite video, time out to relax, shopping for something special... the list can be extensive. However, others can find this question very challenging, for a range of reasons. When the patient has limited financial and physical resources, it is all too easy to prioritise more practical concerns and overlook the things that bring more direct pleasure. It is important to help patients understand the importance of planning a "treat" when a goal is achieved.

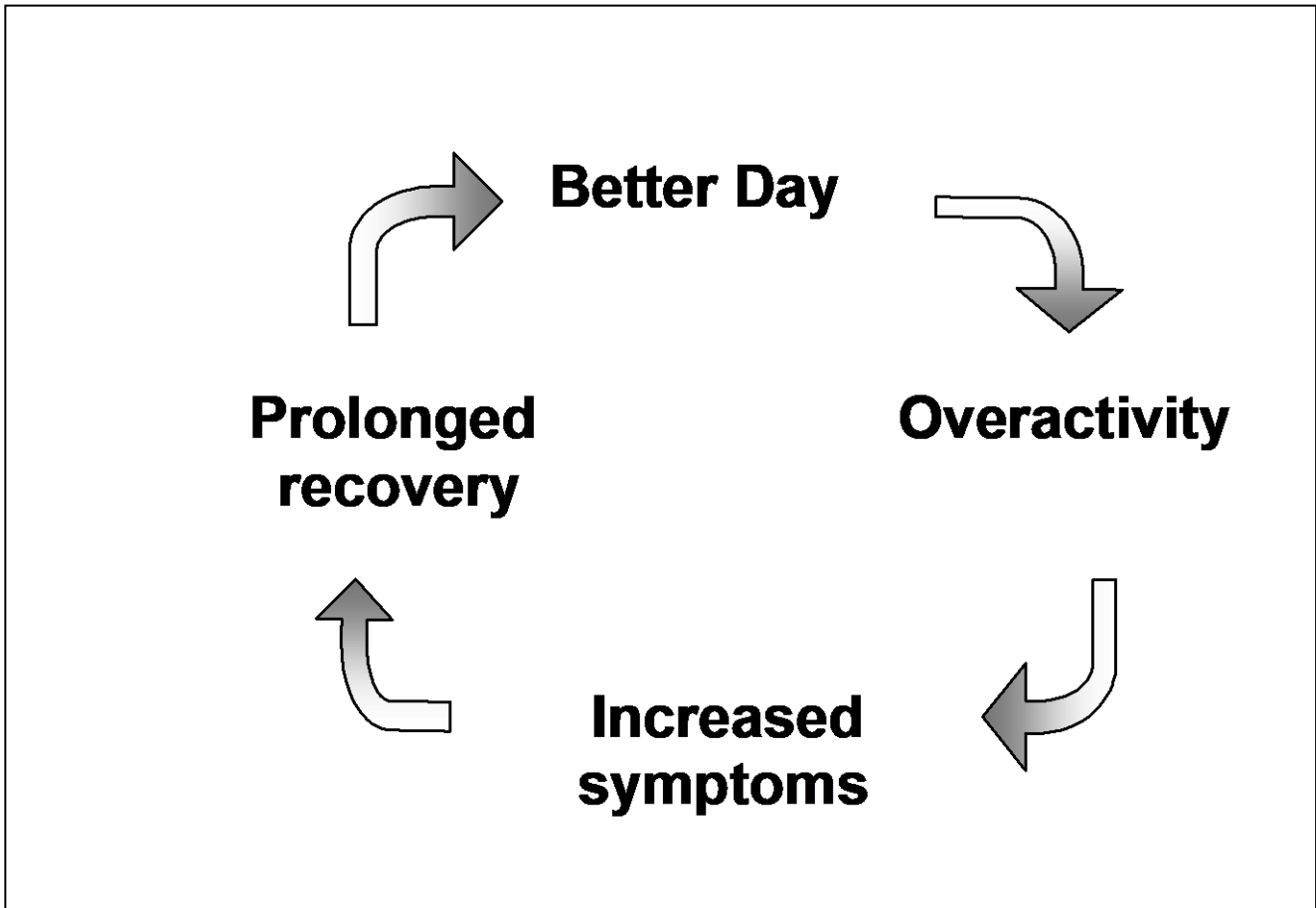


Figure 2. Activity Cycling, or the Boom and Bust cycle. This can lead to deconditioning, and a loss of confidence in activity. The period of recovery is typically more prolonged than the period of overactivity.

A Goal Should Be Time-Limited

When should the goal be achieved by? Is the time limit next week, next month, or Christmas? Without a clear timeframe, a goal can be delayed indefinitely. Often, we are working with people who find the goals that they have set to be challenging. If starting work on the goal is delayed for some reason, then this delay itself can be a reward for inaction. We are all likely to have experienced anxiety about a particular situation, only to have our anxiety relieved when the situation is avoided. For those who occasionally teach, an example might be a presentation that is cancelled: our stress levels drop when we hear we do not need to do it, and the feeling of relative relaxation is like a reward in itself. This type of reward is a form of negative reinforcement: an aversive situation is avoided by non-confrontation of the anxiety-provoking situation, but, there is a risk of avoidance-learning. The sooner we get on and do the presentation, the better, and if we can use relaxation skills to minimise our anxiety about the presentation, then that is better still.

The time-limited aspects of an agreed goal echo the comments earlier about proximal and distal goals. When we trained to be physiotherapists, the distal goal was to be a physiotherapist, but there were many interim goals, including reading, essays and placements that were the “proximal goals” with a shorter time frame. If we overlook “proximal goals” then the distal goal slips from our grasp.

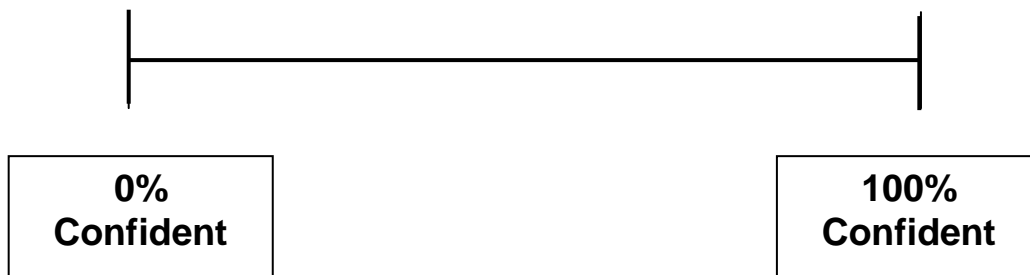
Goals and Targets, and Odds of Success

One way of increasing the likely success of a goal is to break down the goal into smaller targets. Bandura’s “proximal goal” has an overlap with the concept of a “target”.

An example would be a goal to return to work. This requires a range of abilities, for example: to manage the journey, to negotiate successfully with one’s manager and work colleagues regarding one’s abilities and limitations, to tolerate the postures and movements required at work and to manage the work-related stresses. To start to work on this larger goal, smaller targets might be:

- driving half way to work and back, out of rush hour
- practising the walking that will be required at work
- setting aside some time every day to use the home computer, to prepare for longer periods later.

Whilst it is vital that a goal is generated by the patient, not the therapist, we can use our knowledge of posture and fitness to help them to set targets. Following a discussion about this, it can be helpful to ask how confident the patient feels about the agreed next target. A simple visual analogue scale is useful:



What is an acceptable level of confidence? As a guide, I would be concerned about setting targets that have less than a 50% confidence rating, and in the initial stages of rehabilitation, the greater the odds of success, the better. Remember that self-efficacy predicts functional ability, and is a measure of someone's confidence about managing an activity. If a patient's prediction is that they are likely to achieve their target, then they are likely to set more difficult targets in the future if they are successful. If they predict failure, and they do fail, a conclusion that they might draw is that they were right to doubt their ability in the first place. Too hard a target can lead to decreased self-efficacy, especially if it is associated with repeated failure to achieve.

Goals, Targets and Fear-avoidance

The role of fear of harm, and of fear of increased pain, is now well established in the development of chronic incapacity related to pain (Vlaeyen & Linton 2000). Early research suggests that this might be relevant for people with other health conditions, for example Chronic Fatigue Syndrome (CFS) and ME (Silver et al 2000, Nijs 2004). People who have a higher level of concern that an activity or exercise might cause damage, or might cause an exacerbation of their symptoms, are more likely to become more disabled. This fear can reach phobic proportions for some people, but is more often seen at a lower level.

What has this got to do with goalsetting, however? There are several ways in which goalsetting is relevant for someone who has become fearful of movement (kinesiophobic). Firstly, the thorough assessment described above (that allowed the therapist and the patient to consider the role of goalsetting) will have identified whether there might be significant element of kinesiophobia, which might limit the patient's function. During the clinical interview, a comparison should be made between the patients' premorbid level of activity and exercise and their current level. This quickly indicates the degree of disability caused. Also, asking the patient about their experiences of activity and exercise since the onset of their symptoms will let the therapist know how they have approached physical activity. Was the attempt successful or not, and what was the result of the success or failure?

Example:

A person recovering from mild CFS/ME had done well to build up to a walking distance of three miles. Impatience to make progress then led them to turn this walk into an alternating jog/walk, each managed alternately for about 200 metres. Unfortunately, this rate of increase was too rapid, and a relapse occurred, which thankfully was brief. As a result, the patient became fearful to do any jogging at all. Following discussion, they realised that the error was not the jogging, but too much jogging, and set a more realistic target to jog for one hundred metres within the three-mile walk.

A brief review of a person's past physiotherapy experience is also helpful during the assessment. It is important to allow the patient to speak freely by wording the question in such a way that they feel comfortable to let you know how they actually responded.

Example:

Therapist: "Have you ever met up with a physiotherapist before?"

Patient: "Yes, before I had surgery".

Therapist: "I know that not everyone who sees a physiotherapist has a positive experience. How did you get on?"

Patient: "Well, I'm sure that they meant well, but every time I did the exercises I could hardly sleep afterwards. I just thought that it couldn't be doing any good, so I stopped going".

Therapist: "Do you remember what you were doing in the way of exercise?"

Patient: "I had to do side bends as far as I could go, and bend forwards, ten times each. The thing is, it was bending that first started my back problem off".

In this example, we have learnt that the patient has a concern about the safety of bending, and that prescriptive exercise has been unhelpful for them. We also have an indication that their pain can continue to be worse for some time, once aggravated by activity. To gain their trust, we may need to work carefully to establish a level of trust in our approach. To continue the dialogue, the therapist might say:

Therapist: "It sounds as if you have lost confidence in bending".

Patient: "I have, because it causes so much pain afterwards".

Therapist: "Some people I have seen find that the loss of confidence becomes a problem in itself".

Patient: "I know what you mean. It does put me off doing some things."

Therapist: "I wonder what it might be like for you to feel more confident about movement?"

Patient: "I think it might help, but I would still have to contend with the pain".

Therapist: "So it would be helpful to feel more confident, but you would still have to be sensible about how much you did."

Patient: "I suppose so".

Therapist: "If there was a safe way for you to build up your confidence again, what might you do differently as a result?"

Patient: “Well, it would be nice to be able to care for my dog again. My children have taken over that job, and my dog is not getting groomed as well as I would like”.

Here, we have an opportunity to start a contract between the therapist and the patient which addresses the patient’s fear using functional goalsetting. If this patient came to see you, how might you go about negotiating the smaller targets that would allow them to make progress with the larger goal of grooming the dog? How might you help the patient to understand that an increase in symptoms does not equate to harm?

Again, it is important to remember that the patient needs to be setting the goals, and deciding on the targets, and our role is to guide them based on our knowledge of ergonomics, and what might be a successful progression. If a patient’s determination to make progress gets the better of them, they may be tempted to jump over some of the “stepping stones” that would otherwise lead them more gradually towards success, and increased confidence.

Physiotherapists working in this way can often find themselves negotiating with the patient to make slower progress than might have been tried in the past. This can be very challenging for physiotherapists who are used to prescriptive exercise setting and pushing the patient on to do more. Adjustment in this role can take time to achieve successfully.

During the goalsetting process with someone who has become fearful of harm or injury, progress is measured by a gradual increase in confidence (or decrease in fear), and by an increase in function. Symptom levels are not a useful guide to the rate of progress, provided the patient is satisfied that they are not slipping into a pattern of “Activity Cycling”, overdoing it one day and having a prolonged decrease in activity afterwards.

Goals and Baselines

In order to avoid unhelpful Activity Cycling, a useful link can be made with the skills used in setting baselines for exercise and activity (Muncey 2002). The patient needs to know how much of an activity can be managed at a time, without increasing the odds of a persistent increase in symptoms that leads to reduced activity the next day. If they can walk for two minutes on one day, four on the next, and three the day after, an average of three minutes per day has been achieved. Based upon clinical experience with fear-avoidant chronic pain patients, a baseline that is set below this average is likely to be more successful. There are several reasons for this, all of which need to take into account the normal variation of symptoms from day to day. A patient might not feel able to keep up the average on a daily basis, but are more likely, more willing and more confident to manage a lower level, say 50% of average. This is particularly helpful if there is a significant level of fear of increased symptoms after the activity: hence, confidence can be gained at the lower level before an attempt is made to increase a little every day. Patients may learn by Respondent Learning (Keefe & Lefebvre 1999) to associate an activity with an increase in symptoms.

Working at a low baseline should allow them to experience an activity without a significant increase in symptoms, so that the learned association can be broken. Data needs to be gathered before the baseline goal level can be ascertained and started on.

Example:

Patient: "I'd like to walk further, but if I try to do more, I always end up suffering for it. It's difficult to know from day to day how much to do... it's only the next day that I find out if I have overdone it or not."

Therapist: "You are describing a common problem for a lot of the people we see here. Their pain doesn't really help them know when to stop, because of the delay before the pain gets worse".

Patient: "That's right. My doctor said 'stop if it hurts', but that doesn't help me that much."

Therapist: "What if we worked out what you could manage on an average day, and use that as a guide? Perhaps if you started out aiming to keep to something below that average, it would help to control the ups and downs you have been having. They sound a bit like a roller-coaster ride".

There are many reasons why people choose to do more than they perhaps should at times, including the opportunity to feel normal for a while, to keep up with others, to catch up on jobs, guilt about others doing more to help them... the list is long, and addressing these issues is beyond the scope of this chapter. However, I hope that I have indicated that goalsetting inevitably links to pacing, setting baselines, avoiding risks of exacerbations of symptoms, and a whole host of personal motivators that lead to Activity Cycling.

Goals as Indicators of Obstacles to Change

Time spent at each appointment reviewing progress with goals can reap rewards, especially if it helps us to understand why our patients might not be making progress. We cannot expect the process of change to be easy: if it were easy, they probably would have achieved their goals without our help. A clear examination of any obstacles to progress allows us to focus attention upon relevant problem-solving strategies. Problem-solving itself is a large subject, but there are some key points to consider. For example, is the obstacle to progress related to any of the following factors, known informally as the "Four P's":

Planning: was the plan of action insufficient, and does it need to be modified? For example, a goal to go swimming might not be progressing because the patient is unsure about how they will manage to prepare a meal later that day. They may need to refine the plan, perhaps by preparing food the day before, or inviting themselves round to a friend's to eat... whatever the solution is, it has to be the right solution for the patient, and it is helpful if they can generate the solution themselves.

Pacing: was the goal attempt consistent with the principles of good pacing? For example, a goal to go swimming might not be progressing because the patient is concerned about whether the journey to the pool itself will exhaust them. A possible solution might be to allow time to rest before changing to swim. .

Prioritising: is the goal actually high enough on their list of priorities to be tackled? It might be that the goal is otherwise sound, but that at the present time there are other life events that prohibit progress. It might be that these other life events also mean that the contact with the physiotherapist is poorly timed, and might be best delayed until a later date. Having said that, we all know from our personal experience that there is rarely a “best time” to start to change our behaviour, and that a delay in making a difficult change can lead to further procrastination (see earlier discussion about negative reinforcement). A discussion regarding priorities might be relevant: If the patient did not achieve the change, how would that be for them? Would that be acceptable for the time being?

Positioning: does the obstacle relate to positioning issues? For example, does the patient only swim breaststroke, and find the position uncomfortable? If so, problem solving around the use of goggles to allow them to immerse their face might help. Would side-stroke more manageable? Does the positioning problem relate to pacing as well: could they manage a width, with a rest afterwards? Could progress be achieved by incorporating stretches to allow the swimming position to be achieved more easily? Multiple approaches to problem solving may need to be applied to overcome the obstacle.

Record Keeping and Goals

There are several advantages to keeping a written record of progress with goalsetting.

- The process of writing the goal down allows the “SMART” process to be used and checked to see if it is Specific, Measurable, Achievable, Rewarding and Time-limited? If it isn't, does it need revising?
- A written record is also a form of commitment, especially if a goal chart (Figure 3) is to be displayed in a public place in the patient's home.
- Commitment to oneself and to others that a goal will be attempted can be a powerful motivator.
- A goal chart can also help attempts and outcomes to be evaluated. Was the outcome successful, or were there obstacles to change that need to be considered?
- Record keeping emphasises the responsibility of the patient in self-monitoring of behaviour, which is one of the three cornerstones of Self-regulation theory.

Goals As Outcome Measures And Indicators of Treatment Cessation

The goals that are negotiated early on in rehabilitation can act as outcome measures. Simply reviewing the list of goals with the patient and discussing the progress can be enough. Goals might have been fully or partially achieved, and some might still be available for the future. Still others might have been explored during treatment and decisions taken to lessen their priority or even abandon. A goal that has not been achieved is not necessarily a failure, especially if a revised goal that is more achievable or more rewarding has been substituted. Sometimes, this can be a sign that acceptance of the current situation has taken place. For example:

Therapist: "When we first met, one of the goals you set was to return to playing tennis."

Patient: "Looking back, I can see that was unrealistic. I'd love to be able to play again, but to be honest I need to be looking forward to other forms of exercise. I am managing well with my walking goal, and if I continue, I think I can substitute short country walks with friends and still get the social contact I used to get from tennis."

Just because the tennis has not been achieved, this cannot be seen as a treatment failure, because this patient has moved on to more appropriate goals. This 'failure' is one of the shortcomings of a formalised goal-oriented outcome measure like the Goal Attainment Scale (GAS) (Heavlin et al 1982), which has been validated in a Pain Management Programme (Fisher & Hardie 2002). The scale was developed within a mental health setting, and requires an initial decision to be taken as to how much progress might be made with each goal. Final progress is scored according to whether progress is above or below the expected mark. Another linked shortcoming of the GAS for physical rehabilitation is that the process of setting a baseline is often a vital part of goalsetting. How can a patient be expected to predict how much progress they might make if they have not yet collected any data on what they can currently manage?

A more sophisticated measure of goal attainment is the Canadian Occupational Performance Measure (COPM) (Law et al 1998). This is often used by Occupational Therapists, and allows for two aspects of measurement: the patient's rating of their performance, and their satisfaction with that performance. The patient is asked to score their current performance on a 10cm VAS from 1 to 10, and then to score their satisfaction in the same way. Whilst many patients tend to have a correlation between poor performance and poor satisfaction, the measure allows for assessment of any differences between the two. In the example above, the patient might have rated their tennis performance and satisfaction as low at the start of treatment. At the end of treatment, their performance will still be low, but their satisfaction with that performance may have increased. In other words, they are less distressed by their limitations, and more focussed upon other goals.

The scoring element of COPM can be a quick method to assess progress with a goal and the complete assessment form allows for a thorough review of a wide range of areas of goalsetting. It is worthwhile for physiotherapists to become familiar with this type of assessment measure, even if it is not routinely used. It is one of many examples of Occupational Therapy practice that we can learn from to help our patients maximise the benefits gained from their exercise programmes. If we can help someone with a long-term condition make the connection between the exercise programme that they have been developing and their increasing functional ability achieved through goalsetting, then we will have maximised the benefits of the exercise, and improved our physiotherapy outcome.

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