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Client-Articulated Avoidance Goals in the Therapy Context

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This research investigated the relationship between clients' pursuit of avoidance (relative to approach) therapy goals and change in subjective well-being (SWB) from the beginning to the end of therapy. Results indicated that clients with more avoidance therapy goals evidenced a smaller increase in SWB over the course of therapy than those with fewer avoidance goals. Mediational analyses indicated that avoidance therapy goals predicted lower therapist satisfaction, lower therapist satisfaction predicted lower perceptions of therapy effectiveness (perceived problem improvement and perceived goal progress), and these lower perceptions of therapy effectiveness proximally predicted the observed change in SWB. Ancillary analyses linked the adoption of avoidance therapy goals to early parental loss through separation/divorce or death.

Individuals typically seek psychotherapy because they want change in their life. The goals for change that a client brings to therapy have an important and pervasive impact on the therapeutic process (Foster & Mash, 1999). These goals influence how the client orients to the therapy environment, participates in the intervention program, and evaluates the effectiveness of intervention efforts. The client's articulation of his or her goals influences how the therapist perceives the client's life situation, evaluates the problem areas in need of attention, and devises the intervention strategy to be implemented. The client's goals must not only be clearly communicated, but also accurately perceived by the therapist for the prognosis for therapy to be positive (Gresham & Lopez, 1996; Rosen & Proctor, 1981). Given the importance of this issue, it is surprising that relatively little theoretical or empirical work has been conducted on the assessment of clients' goals in therapy. Indeed, this issue remains "among the least researched components of the psychological assessment-treatment process" (Hayes, 1993, p. 251).

Conceptualizations of Client-Articulated Goals

There are two primary approaches to conceptualizing client-articulated goals in the literature. The first is in terms of the client's *ultimate goals*, defined as the primary outcomes that the individual desires to attain by entering therapy (Rosen & Proctor, 1981; see also Gottman & Lieblum's, [1974] conception of "treatment objectives"). These goals represent the client's reason(s) for seeking therapy; they typically are not assessed directly, but are presumed to be expressed as the client explains his or her problems and complaints of distress to the therapist (Nezu & Nezu, 1993). The client's expressions of his or her ultimate goals are sometimes accepted as articulated, although they may be revised somewhat in collaboration with the therapist through clarification, discussion, and reflection (Foster & Mash, 1999). In many empirical investigations, the ultimate goal construct carries the label *treatment goal*, and most studies focus on a single ultimate (treatment) goal for therapy.[1]

A second approach to conceptualizing client-articulated goals is in terms of the personal goal construct. *Personal goals* are defined as the idiographic, personally meaningful end states that individuals envision and intentionally seek to attain in their lives (Karoly, 1993); this construct has also been discussed in the literature using the terms *personal striving* (Emmons, 1999), *current concern* (Klinger, 1977), and *personal project* (Little, 1986). In the therapy context, these goals are assessed by having clients list the important objectives that they are pursuing in their daily lives across domains (family, friends, occupation, education, health, etc.), and each goal is typically rated on various dimensions (e.g., importance, expected progress). The individual's general personal goal system is then analyzed for diagnostic purposes, and this approach is portrayed as an idiographic alternative to the nomothetic, normatively based diagnostic techniques conventionally used (e.g., the California Personality Inventory, the Minnesota Multiphasic Personality Inventory; see Little, 1986).

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[1] "Treatment goal" is also used in the literature to refer to therapist-generated goals (see Foster & Mash, 1999). Rosen and Proctor (1981) referred to therapist-generated goals as "instrumental goals" and defined them as objectives that are viewed by the therapist as the steps necessary for the client to reach his or her ultimate goals (see Kiresuk, Smith, & Cardillo, 1994, for a review of research on instrumental goals in the therapy context, and Maple, 1998, for a discussion of collaborative therapist–client goal-generation procedures used in solution-focused therapies).

The ultimate goal and personal goal constructs have been formulated and researched independently of each other. However, the conceptual space addressed by these constructs seems to contain a significant amount of overlap. That is, for individuals seeking therapy, their ultimate goal for therapy is likely to be one of their personal goals, and their personal goal set is likely to contain other goals that are directly relevant to the therapy context and could also be construed as ultimate goals. Accordingly, it seems reasonable to consider an integrative approach to client-articulated goals that focuses on and assesses clients' therapy-relevant personal goals or ultimate personal goals for therapy. These goals would represent a subset of clients' general personal goals, those signifying how they would like their life to change as a function of therapy (see Karoly, 1993). At the same time, these goals would also represent a precise and documented expression of clients' ultimate goals for therapy. In the following, we will adopt the straightforward label *therapy goals* to refer to these idiographic objectives for therapy. This research focuses on an important dimension of clients' therapy goals: whether they are approach or avoidance in nature.

Avoidance Goals in the Therapy Context

Individuals may seek to approach a positive possibility or avoid a negative possibility, and this approach–avoidance distinction represents a foundational dimension of motivated behavior (Elliot, 1999; Elliot & Covington, 2001). The approach–avoidance distinction is applicable to several different levels of analysis, from neurobiological predispositions (Gray, 1982), to global motives (McClelland, Atkinson, Clark, & Lowell, 1953), to rudimentary reflexes (Sokolov, 1963). With respect to goals, the approach–avoidance distinction is grounded in the regulatory focus of the goal. Approach goals are focused on a positive, desirable outcome or state and regulation entails trying to move toward or maintain the outcome or state (e.g., get good grades in school, eat healthy food, etc.), whereas avoidance goals are focused on a negative, undesirable outcome or state and regulation entails trying to move or stay away from the outcome or state (e.g., not get bad grades in school, avoid eating unhealthy food; see Table 1 for additional examples of approach and avoidance goals). Recent research has linked avoidance goal regulation to a host of negative processes and outcomes. For instance, in the achievement motivation domain, Elliot and colleagues have demonstrated that the pursuit of avoidance goals (e.g., striving to avoid doing poorly on an examination) has negative implications for a host of variables including task absorption, test anxiety, approaches to studying, intrinsic motivation, actual performance, the retention of information, and physical and psychological well-being (Church, Elliot, & Gable, 2001; Elliot & Church, 1997; Elliot & Harackiewicz, 1996; Elliot & McGregor, 1999, 2001; Elliot, McGregor, & Gable, 1999; Elliot & Sheldon, 1997; see, also, Middleton & Midgley, 1997; Skaalvik, 1997; VandeWalle, 1997). More generally, Elliot and colleagues demonstrated that individuals who adopted more avoidance personal goals across domains had more difficulty making progress on their goals and evidenced a longitudinal decrease in both physical and psychological well-being over a 4-month period (Elliot & Sheldon, 1998; Elliot, Sheldon, & Church, 1997).

There is a considerable amount of evidence in the clinical literature indicating that avoidance-based regulatory processes have negative implications for psychological functioning and mental health (e.g., see research on experiential avoidance, Hayes, Wilson, Gifford, Follette, & Strosahl, 1996; avoidance problem solving, Heppner & Baker, 1997; avoidance coping, Windle & Windle, 1996; and behavioral inhibition system reactivity, Fowles, 1994). However, this issue has received almost no research attention with regard to client-articulated goals in the therapy context. In fact, we are aware of only one relevant study, conducted by Klinger and Cox (1986). In that study, male alcoholic inpatients in a chemical dependency treatment program completed a general personal goals assessment upon entry to the program. Participants' goals were then coded on a variety of dimensions, including whether or not they mentioned alcohol, and whether or not their alcohol-relevant goals mentioned the avoidance of alcohol. The proportion of "alcohol-avoidance" goals to total goals was computed, and a negative correlation was observed between participants' proportion of alcohol-avoidance goals and a staff member's judgments regarding whether or not participants successfully completed their treatment program. This finding is difficult to interpret for several reasons, including the fact that the predictor variable represented alcohol-relevant avoidance goals relative to all other goals (including general avoidance goals), and the outcome variable was based on a broad assortment of factors including successful completion of assertiveness training and relaxation training, in addition to alcohol abstinence. Nevertheless, this finding at least suggests that the pursuit of treatment-relevant avoidance goals may have negative implications for clients.

In the present research, we investigated the relationship between clients' pursuit of avoidance therapy goals and their change in subjective well-being (SWB) from the beginning to the end of

Table 1
Sample Approach and Avoidance Therapy Goals

Approach goals	Avoidance goals
"To understand myself and my feelings"	"To stop being confused about my feelings"
"To have closer relationships with my friends"	"To avoid feeling alone and isolated"
"To be more stable and happy"	"To avoid becoming depressed"
"To become more comfortable in test-taking situations"	"To not stress over grades"
"To be more comfortable with sexuality issues"	"To lose my fear of not being able to be intimate"
"To feel more secure in who I am"	"To stop being so destructive to myself"
"To accept feelings and learn from them"	"To not be so moody all the time"
"To be more confident in social situations"	"To be less shy"
"To become a stonger, better coping individual"	"To not be so sensitive to others' remarks and actions"

short-term outpatient psychotherapy in a university setting. SWB is conceptualized as a composite of life satisfaction, positive affective experience, and a lack of negative affective experience (Andrews & Withey, 1976; Diener, 1984); this variable has been a central focus of research in personality and social psychology for the past 2 decades (see Diener, 1994; Emmons, 1999). In recent years, interest in SWB has emerged in the psychotherapy literature, as researchers and theorists have begun to expand their definition of treatment outcome beyond symptom relief to include quality of life considerations (Evans, 1993; Gladis, Gosch, Dishuk, & Crits-Christoph, 1999; Katschnig, 1997; Schalock, 1990). Empirical work on SWB, and quality of life more generally, is at a nascent stage of development in the psychotherapy literature, but a clear call has been sounded for increased research in this area (Gladis et al., 1999). Our study is in accord with this appeal, as we focused on SWB as our central outcome measure. The primary hypothesis investigated here is that the pursuit of avoidance relative to approach therapy goals is related to change in SWB over the course of therapy. More precisely, we posit that the pursuit of avoidance therapy goals bodes ill for the therapeutic process, resulting in a failure to gain SWB benefits from the therapy experience. The rationale for this hypothesis is elaborated in the following.

Mediation and Antecedents

Client or "consumer" satisfaction with the therapy experience has long been of interest to researchers (see Lorr, 1965; Strupp, Fox, & Lessler, 1969), but it is only in the past few years that this issue has begun to receive significant empirical attention (Brestan, Jacobs, Rayfield, & Eyberg, 1999; Lebow, 1983; Silove, Parker, & Manicavasagar, 1990). Two important components of consumer satisfaction are the client's satisfaction with the therapist (i.e., his or her evaluation of the therapist's behavior during therapy) and the client's perceptions of the effectiveness of therapy (i.e., his or her view of whether improvement or progress has been made over the course of therapy; see Brestan et al., 1999; Conte, Ratto, Clutz, & Karasu, 1995; Lambert, Salzer, & Bickman, 1998). A secondary objective of the present research was to investigate the relationship between avoidance therapy goals and these two components of consumer satisfaction (hereafter labeled *therapist satisfaction* and *perceived therapy effectiveness*, respectively) and to test their role as mediators of the relationship between avoidance therapy goals and change in SWB. Specifically, we examined the role of these variables as sequential mediators, with avoidance therapy goals predicting therapist satisfaction, therapist satisfaction predicting perceived therapy effectiveness, and perceived therapy effectiveness serving as the proximal predictor of change in SWB. Each of these predictive relationships is discussed in the following.

There are several ways in which the adoption of avoidance therapy goals could lead clients to evaluate their therapist in a negative fashion. Avoidance goals are ineffective regulatory devices. Avoidance goals focus on a negative outcome/state to move or stay away from, but do not provide an alternative to keep the individual focused in a specific direction, and progress on such goals merely represents the absence of something negative, rather than the presence of something positive (Carver & Scheier, 1998; Elliot et al., 1997; McFarland & Miller, 1994). Accordingly, when presented with client-articulated avoidance goals, therapists may have difficulty generating treatment strategies that align effectively with their clients' goals, given the lack of specific directionality provided by these goals. In addition, therapists who work to design a treatment plan in alignment with their clients' avoidance goals may unintentionally produce an intervention comprising avoidance strategies (which are likely to possess the same limitations as avoidance goals per se). Furthermore, clients who express their goals in terms of avoidance provide their therapist with little information regarding what they actually desire (only what they fear), thus their therapist may have difficultly designing a personalized treatment plan that would address what the client truly needs for optimal functioning. All of these scenarios are similar in that they detail processes likely to undermine the working relationship between the client and therapist, and clients are unlikely to be satisfied with their therapist unless a good working relationship exists (Horvath & Luborsky, 1993). Thus, in this research we anticipated that avoidance therapy goals would exhibit a negative relationship with therapist satisfaction.

Therapist satisfaction, in turn, is expected to be positively related to perceived therapy effectiveness, which we assessed with two variables: perceived problem improvement (i.e., how much the client thinks therapy helped with the problem(s) that led to treatment) and perceived goal progress (i.e., how much the client thinks progress was made on his or her therapy goals). Clients who view their therapist in a negative light will undoubtedly have difficulty fully engaging in, and benefiting from, the therapy process, and at the end of the intervention effort are unlikely to feel that their problems have improved or that they have made progress on their therapy goals. Perceived problem improvement is a rather conventional indicator of perceived therapy effectiveness (and consumer satisfaction more generally; Lambert et al., 1998; Seligman, 1995), and several studies have documented an empirical link between therapist satisfaction and this variable (Bent, Putnam, Kiesler, & Nowicki, 1976; Conte, Buckley, Picard, & Karasu, 1994; Oei & Shuttlewood, 1999). Perceived goal progress is a novel indicator of perceived therapy effectiveness; research has yet to be conducted on the link between therapist satisfaction and this variable. Here we anticipated that therapist satisfaction would be a positive predictor of both perceived problem improvement and perceived goal progress.

Most empirical investigations conceptualize perceived therapy effectiveness as a terminal outcome. However, it is also clearly important to document the link between these perceptions and other treatment outcomes (McMahon & Forehand, 1983), including quality of life indicators such as SWB. We are not aware of any existing research that tests the link between perceived therapy effectiveness and SWB, but it seems reasonable to anticipate that an ineffective intervention will fail to enhance the client's overall well-being. Thus, in this research we anticipated that perceived problem improvement and perceived goal progress would be positive predictors of change in SWB over the course of therapy.

An additional objective was to investigate some possible antecedents of avoidance therapy goals. If, as predicted, avoidance therapy goals have negative implications for the therapeutic process and SWB, it would clearly be important to determine what leads clients to adopt such goals. In this study we examined the relationship between several family stressor variables (parental loss, parental addiction, family suicide, family abuse, and family illness) and avoidance goal adoption. This being the more explor-

atory component of the research, we had few a priori hypotheses. We were particularly interested in the possibility that parental loss may positively predict avoidance goals, given that avoidance motivation more generally has been conceptually linked to relational loss and fear of abandonment (Birney, Burdick, & Teevan, 1969; Elliot, McGregor, & Thrash, 2002).

In sum, the primary hypothesis tested here is that avoidance therapy goals are a negative predictor of change in SWB from the beginning to the end of therapy. We not only predicted that this relationship would be observed, but that it would hold when controlling for several alternative, commonly endorsed indicators of motivation: goal importance, goal-expected progress, and Importance × Expected Progress (see Bandura, 1982; Bergin & Greenfield, 1994; Vroom, 1964). In addition, we investigated the possibility that the relationship between avoidance therapy goals and change in SWB may be accounted for by the following process: avoidance therapy goals predict lower therapist satisfaction, lower therapist satisfaction predicts lower perceptions of therapy effectiveness (in terms of lack of problem improvement and goal progress), and these lower perceptions of therapy effectiveness proximally predict change in SWB. Several demographic variables commonly discussed in the avoidance motivation, consumer satisfaction, and SWB literatures (participants' ethnicity, school status, and gender; Corrigan, 1990; Diener, 1984) were controlled for in testing our hypotheses to ensure that any relationships observed in the university setting were not simply a function of these potential confounding variables (e.g., students beginning their undergraduate experience may encounter myriad difficulties that could influence their SWB independent of goal-based processes). Finally, we investigated family stressor variables as antecedents of the adoption of avoidance therapy goals.

Method

Participants and Procedure

A total of 98 students (26 men, 72 women) at the University of Rochester seeking outpatient psychotherapy services at the university's counseling center participated in the study. The majority of participants were Caucasian ($n = 73$), with the remainder approximately equally distributed among African Americans, Asians, and Latinos. Students at all levels of school status were represented; a relatively small number of participants were freshmen ($n = 7$) or master's level ($n = 5$) students, but the remaining groups were represented approximately equally; 64 participants had previously sought counseling. The therapy consisted of a 12-session, time-limited course of treatment; the therapists were primarily doctoral interns, trained to deliver short-term, psychodynamically oriented psychotherapy. The study was conducted during an approximately 2-year time period; incentive for participation in the study was entry into a lottery drawing for small cash prizes. Of the initial participants, 53 completed the full study.[2]

Participants in the study completed questionnaires before and after therapy. Prior to their first therapy session (and before any contact with their therapist), participants listed five therapy goals and rated the importance of each goal and their expected progress on each goal. Participants also completed a pretherapy (baseline) SWB measure and a family stressors questionnaire, and provided gender, ethnicity, and previous treatment information at this time. After their final therapy session, participants completed measures of therapist satisfaction, perceived problem improvement, perceived goal progress, and posttherapy SWB, and reported their school status. The therapist satisfaction, perceived problem improvement, and perceived goal progress variables were assessed at the end of therapy because a complete assessment of these mediator variables requires that they be measured at this time and, accordingly, this is when they are typically assessed in the literature. For all assessments, participants were assured that their responses would be kept confidential and that their therapist would not have access to the information they provided.

Measures

Therapy goals. In the goals assessment, participants were asked to list five therapy-relevant goals (see the Appendix for the full set of instructions). The procedure used is similar to that used by Elliot et al. (1997) and Elliot and Sheldon (1998) to assess general personal goals, but it was adapted to be applicable to participants' therapy goals.

Two trained coders independently categorized each goal as approach or avoidance (interjudge agreement was 99.6%; disagreements were resolved through discussion). Examples of approach goals written by participants are "To accept feelings and learn from them" and "To be more comfortable with who I am and what I look like;" examples of avoidance goals written by participants are "To not be so moody all the time" and "To stop being so destructive to myself" (see Table 1 for additional examples). An avoidance goals index was created by summing the number of avoidance goals listed in each participants' set of five goals (given that each goal was coded dichotomously as approach or avoidance, this measure represents the number of avoidance goals relative to the number of approach goals). Of the goals listed, 23.3% were avoidance goals, and the observed range was 0 to 5. The validity of this type of avoidance goal measure has been demonstrated in prior research (see Elliot et al., 1997; Elliot & Sheldon, 1997).

Goal importance and goal-expected progress. Two goal-based alternative predictor variables were also assessed: goal importance and goal-expected progress. Participants rated each goal with regard to how important it was in their life on a scale ranging from 1 (*not at all important*) to 9 (*very important*) and with regard to how much progress they expected to make on it over the course of therapy on a scale ranging from 1 (*none at all*) to 9 (*a great deal*). Participants' ratings for each measure were summed to form the goal importance index (Cronbach's $\alpha = .69$) and the goal-expected progress index (Cronbach's $\alpha = .88$). The validity of these measures has been demonstrated in prior research (see Brunstein, 1993; Ruehlman & Wolchik, 1988).

SWB. The SWB measure was composed of items that assessed participants' current positive and negative affectivity, and life satisfaction. Brunstein's (1993) eight-item affect measure was used to assess positive (happy, joyful, pleased, confident) and negative (sad, depressed, frustrated, anxious) affectivity. Participants reported how often they felt each affect during "the past few days" on a scale ranging from 1 (*not at all*) to 7 (*very frequently*). Life satisfaction was assessed with Andrews and Withey's (1976) Delighted–Terrible Scale; "How have you felt about your life as a whole in the past few days?" Participants responded by marking one of the following options: terrible (1), unhappy (2), mostly dissatisfied (3), mixed about equally satisfied and dissatisfied (4), mostly satisfied (5), pleased (6), delighted (7). Pre-therapy SWB and Post-therapy SWB indexes were created by (a) summing the positive affectivity items and summing the negative affectivity items; (b) standardizing the total scores for positive affectivity, negative affectivity, and life satisfaction; and (c) summing the standardized scores for positive affectivity and life satisfaction and subtracting the standardized score for negative affectivity. The item-level

[2] All participants who did not complete the study left therapy before the end of the 12-session treatment; a few participants completed the study but terminated therapy before the end of the 12 available sessions. There were a few missing data points for some measures in the study; these omissions are reflected in the degrees of freedom for the various analyses.

Cronbach's alphas for the pre- and posttherapy SWB indexes were .85 and .86, respectively.[3] The reliability and validity of this SWB index have been demonstrated in prior research (see Brunstein, 1993; Elliot et al., 1997).

Therapist satisfaction. Black's (1996) six-item Satisfaction With Therapist Scale was used to assess participants' evaluation of their therapist. As with other recently developed indicators of therapist satisfaction (see Conte et al., 1995; Oei & Shuttlewood, 1999), this measure asks clients to evaluate their therapist on several behaviors central to the therapy process (sample items include "In general, my therapist had insight into my situation," and "In general, my therapist gave helpful feedback"). Participants responded on a 1 (*disagree*) to 5 (*agree*) scale, and their responses were summed to form the therapist satisfaction index (Cronbach's α = .89). Black has documented the reliability and validity of this measure.

Perceived therapy effectiveness: Perceived problem improvement and perceived goal progress. Perceived problem improvement was assessed with the single item, face valid measure from the *Consumer Reports* survey (Seligman, 1995): "How much did therapy help with the specific problem(s) that led you to counseling?" Participants responded by marking one of the following options: 1 (*made things a lot worse*), 2 (*made things somewhat worse*), 3 (*made no difference*), 4 (*made things somewhat better*), 5 (*made things a lot better*). A *not sure* option was also provided, and was coded *made no difference* for the 1 participant who used it. The validity of this measure has been demonstrated in prior research (see Seligman, 1995). Perceived goal progress was assessed by having participants rate each goal with regard to how much progress they had made on it over the course of therapy. Participants indicated their ratings on a 1 (*none at all*) to 9 (*a great deal*) scale, and their responses were summed to form the perceived goal progress index (Cronbach's α = .83). The validity of this measure has been demonstrated in prior research (see Elliot et al., 1997; Elliot & Sheldon, 1998).

Family stressors. Five areas of familial stress were assessed: parental loss, parental addiction, family suicide, family abuse, and family illness. We selected two straightforward questions to assess each stressor, and participants simply indicated whether the event *did not* (1) or *did* (2) occur in their family. *Unsure* was also provided as a response option, and this response was coded 1.5 for the few participants who used it. Participants' responses were summed for each stressor. The stressors were assessed with the following questions: "parents divorced or permanently separated before you were 18 years old" and "death of a parent before you were 18 years old" (parental loss); "parent(s) with a drug problem" and "parent(s) with a drinking problem" (parental addiction); "family member committed suicide" and "family member attempted suicide" (family suicide); "physical abuse in your family" and "sexual abuse in your family" (family abuse); and "family member with a debilitating illness, injury, or handicap" and "family member diagnosed with a mental disorder" (family illness).

Demographic variables: Gender, ethnicity, and school status. Participants indicated their gender and ethnicity; school status was assessed with a 6-point scale ranging from *first-year undergraduate student* (1) to *doctoral student* (6).

Previous treatment. Participants answered *no* (1) or *yes* (2) to the question "Have you ever been in counseling before (e.g., group therapy, family therapy, individual therapy, couples therapy)?"

Results

Participant Attrition

We conducted t tests to determine whether participants who did and did not complete the study systematically differed on any of the variables assessed at the beginning of the study. No significant differences were observed.[4]

Descriptive Statistics, Intercorrelations, and Avoidance Therapy Goals as a Predictor of Change in SWB

Descriptive statistics and intercorrelations among the study variables are presented in Tables 2 and 3, respectively. A simultaneous multiple regression model (see Aiken & West, 1991) was constructed to test avoidance therapy goals as a predictor of change in SWB from pre- to posttherapy, and to examine potential mediators of this relationship. This basic model was composed of avoidance therapy goals, pretherapy SWB, and the Avoidance Therapy Goals $\times$ Pretherapy SWB interaction product term (computed from centered variables); the demographic variables (ethnicity, school status, and gender) were controlled for in this and all regression analyses.

The regression of posttherapy SWB on the basic model revealed that pretherapy SWB was a significant positive predictor of posttherapy SWB, $F(1, 42) = 9.66$, $p < .005$ ($\beta = .41$), indicating that participants with higher SWB at the beginning of therapy also had higher SWB at the end of therapy. In raw score units (i.e., a sum of the unstandardized scores), the means for pre- and posttherapy SWB were -4.76 ($SD = 9.70$) and 5.78 ($SD = 9.64$), respectively, which means that, overall, participants evidenced higher SWB at the end of therapy relative to the beginning of therapy. School status was a signficant negative predictor of posttherapy SWB, $F(1, 42) = 6.26$, $p < .05$ ($\beta = -.33$), indicating that students in their earlier years of school evidenced a greater increase in SWB from the beginning to the end of therapy. Most importantly, avoidance therapy goals were a significant negative predictor of posttherapy SWB, $F(1, 42) = 4.08$, $p < .05$ ($\beta = -.27$), indicating that participants who adopted more avoidance goals evidenced a smaller increase in SWB from the beginning to the end of therapy. No other relationships were significant. These findings were also obtained when a hierarchical model was used to analyze the data (see Table 4 for results from this analysis).

Next, the simultaneous analysis was repeated with an alternative predictor variable, goal importance, goal expected progress, or the Goal Importance $\times$ Goal Expected Progress interaction term (computed from centered variables), also inserted into the equation. None of these alternative predictors attained significance in these analyses, and the relationship between avoidance therapy goals and change in SWB remained significant ($p \leq .05$).

[3] The item-level Cronbach's alphas for pre- and posttherapy positive/negative affectivity were .91/.77 and .87/.86, respectively. Item-level calculations of alphas may overestimate the reliability of the SWB indices, given the unequal number of items per scale. Scale-level calculations of alphas clearly underestimate the reliability of SWB, given the small number of scales involved. Nevertheless, we also computed the standardardized alpha from the raw scale scores for each SWB index: pretherapy SWB α = .72 and posttherapy SWB α = .69.

[4] Consistent with our significance testing throughout the study, we used an alpha level of .05 for the attrition analyses. Using a less conservative alpha level of .25 (suggested by a reviewer), trends would be present for some variables: completers tended to report more avoidance goals than noncompleters, tended to report lower goal expected progress and importance, and tended to come from families with a greater incidence of illness and suicide.

Table 2
Descriptive Statistics

Variable	*M*	*SD*	Possible range	Observed range
Avoidance therapy goals	1.32	1.09	0–5	0–5
Goal expected progress	28.93	8.83	5–45	10–45
Goal importance	39.30	4.94	5–45	26–45
Pretherapy SWB	−0.103	1.77		−3.12–5.11
Posttherapy SWB	0.00	2.36		−6.61–4.56
Therapist satisfaction	24.90	5.32	5–30	11–30
Perceived problem improvement	4.12	0.62	1–5	3–5
Perceived goal progress	26.60	9.24	5–45	5–42
Parental loss	2.36	0.52	2–4	2–4
Parental addiction	2.39	0.57	2–4	2–4
Family suicide	2.15	0.35	2–4	2–3
Family abuse	2.26	0.48	2–4	2–4
Family illness	2.55	0.65	2–4	2–4
School status	3.77	1.66	1–6	1–6

Note. SWB = subjective well-being

Mediational Analyses

Three requirements must be met to document mediation empirically (see Baron & Kenny, 1986). First, a relationship between the predictor variable and the outcome measure must be established for mediation to be a relevant issue. Second, a relationship between the predictor variable and the potential mediator variable must be established. Third, a relationship between the potential mediator variable and the outcome variable must be established while controlling for the predictor variable, and the direct relationship between the predictor variable and the outcome variable should be reduced. The preceding analyses satisfied the first requirement; the following analyses tested the second and third requirements. The hypothesized model includes sequentially linked mediator variables; thus, testing the second requirement also entails establishing the proposed sequential relationships between these mediators. These sequential relationships simply represent the path through which the predictor variable is hypothesized to be linked to the outcome variable; no additional mediational relationships within the sequence are hypothesized (see Judd & Kenny, 1981, pp. 603–607; readers interested in mediational relationships within the hypothesized sequence may contact Andrew J. Elliot for the pertinent information).

Avoidance therapy goals as a predictor of therapist satisfaction. To examine the first link in the mediational chain, therapist satisfaction was regressed on avoidance therapy goals. This analysis revealed that avoidance therapy goals were a negative predictor of therapist satisfaction, $F(1, 46) = 8.28$, $p < .01$ ($\beta = -.41$), indicating that participants who adopted more avoidance goals were less satisfied with their therapist during the course of therapy. No other variables were significant in this analysis.

Therapist satisfaction as a predictor of perceived therapy effectiveness. To examine the second link in the mediational chain, each perceived therapy effectiveness variable was regressed on avoidance therapy goals with therapist satisfaction also in the equation. Therapist satisfaction was a positive predictor of perceived problem improvement, $F(1, 45) = 12.15$, $p < .005$ ($\beta = .48$), indicating that participants who evaluated their therapist less

Table 3
Intercorrelations Among Variables

Variable	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
1. Av. therapy goals	—																
2. Goal exp. prog.	.10	—															
3. Goal importance	−.00	.21	—														
4. Pretherapy SWB	.08	.24	−.15	—													
5. Posttherapy SWB	−.17	.32*	−.30*	.44**	—												
6. Therapist sat.	−.23	.28*	−.12	.26	.49**	—											
7. Per. prob. impr.	−.38**	.27*	−.05	.22	.46**	.52**	—										
8. Per. goal prog.	.03	.49**	−.17	.18	.52**	.31*	.55**	—									
9. Parental loss	.27*	.09	.19	−.13	−.13	−.25	−.08	.04	—								
10. Parental addict.	.06	.04	.09	−.02	.16	.16	.00	.12	.37**	—							
11. Family suicide	−.21	.18	.20	−.04	.26	.03	.31*	.07	.17	.33**	—						
12. Family abuse	.00	.04	.08	−.13	.05	.11	.13	.09	.39**	.40**	.51**	—					
13. Family illness	−.12	.06	−.10	−.14	.00	.09	−.04	.00	−.04	−.08	.05	.05	—				
14. Gender	.24	−.02	−.03	.18	.05	.20	−.13	.01	.11	−.23	.04	−.08	.04	—			
15. Ethnicity	.05	.15	.07	.04	.04	.07	.07	.07	.09	−.18	.08	−.00	.01	−.02	—		
16. Previous therapy	−.15	.11	−.14	−.00	.05	.23	.06	.09	−.28*	−.03	−.22	−.27	.05	−.05	.04	—	
17. School status	−.07	−.10	.14	−.10	−.29*	.12	.08	−.16	−.08	.06	.06	−.06	.05	−.29*	.02	−.19	—

Note. Av. therapy goals = avoidance therapy goals; Goal exp. prog. = goal expected progress; SWB = subjective well-being; sat. = satisfaction; Per. prob. impr. = perceived problem improvement; Per. goal prog. = personal goal progress; Parental addict. = parental addiction.
* $p \leq .05$. ** $p \leq .01$.

Table 4
Hierarchical Regression Analysis for Predicting Change in SWB

Variable	*B*	*SE B*	β
Step 1			
Pretherapy SWB	1.03	.31	.44*
Step 2			
Ethnicity	.56	.73	.10
School status	−.44	.19	−.31*
Gender	−.89	.78	−.16
Step 3			
Avoidance therapy goals	−.64	.32	−.27*
Avoidance Therapy Goals × Pretherapy SWB	.53	.33	.22

Note. $R^2 = .19$ for Step 1, $p < .05$; $\Delta R^2 = .09$ for Step 2; $\Delta R^2 = .08$ for Step 3. SWB = subjective well-being.
* $p < .05$.

positively felt they made less improvement on their problems during therapy. Avoidance therapy goals were unrelated to perceived problem improvement, and no other variables were significant.

Therapist satisfaction was also a positive predictor of perceived goal progress, $F(1, 45) = 6.52$, $p < .05$ ($\beta = .39$), indicating that participants who evaluated their therapist less positively felt they made less progress on their goals during therapy. Avoidance therapy goals were unrelated to perceived goal progress, and no other variables were significant.

Perceived therapy effectiveness as a predictor of change in SWB. To examine the final link in the mediational chain, analyses were conducted in which posttherapy SWB was regressed on the basic model with therapist satisfaction and one of the perceived therapy effectiveness variables also in the equation. In the perceived problem improvement analysis, school status was a significant negative predictor of posttherapy SWB, $F(1, 38) = 8.28$, $p < .01$ ($\beta = -.35$), indicating that students in their earlier years of school evidenced a greater increase in SWB from the beginning to the end of therapy. Most important, perceived problem improvement was a significant positive predictor of posttherapy SWB, $F(1, 38) = 5.59$, $p < .05$ ($\beta = .33$), indicating that those who felt they made little improvement on their problems during therapy evidenced less of an increase in SWB over the course of therapy. The direct relationship between avoidance therapy goals and posttherapy SWB was nonsignificant ($\beta = -.10$, $p = .45$). Therapist satisfaction was unrelated to posttherapy SWB, and no other relationships were significant. The adjusted R^2 for this overall mediational model was .42 ($p < .001$).

In the perceived goal progress analysis, pretherapy SWB was a significant positive predictor of posttherapy SWB, $F(1, 38) = 4.24$, $p < .05$ ($\beta = .26$), and school status was a significant negative predictor, $F(1, 38) = 5.57$, $p < .05$ ($\beta = -.28$). Most important, perceived goal progress was also a significant positive predictor of posttherapy SWB, $F(1, 38) = 7.27$, $p < .05$ ($\beta = .33$), indicating that those who felt they made little progress on their therapy goals evidenced less of an increase in SWB over the course of therapy. The direct relationship between avoidance therapy goals and posttherapy SWB was nonsignificant ($\beta = -.15$, $p = .28$). Therapist satisfaction was unrelated to posttherapy SWB, and no other relationships were significant. The adjusted R^2 for this overall mediational model was .44 ($p < .001$). Figure 1 presents path models summarizing the mediational analyses for both perceived problem improvement and perceived goal progress.

Family Stressors as Antecedents of Avoidance Therapy Goals

Each of the family stressor variables was examined as a predictor of avoidance goal adoption, using the full sample of participants who started the study (some of the demographic data were not available on participants who did not complete the study, therefore Pearson product–moment correlations were used in these analyses). One family stressor variable was significant: Parental loss was a positive predictor of avoidance therapy goals, $r = .24$, $p < .05$, indicating that participants who suffered the loss of a parent through permanent separation, divorce, or death prior to the age of 18 adopted more avoidance goals in therapy. Examining each parental loss question individually indicated that the separation/divorce and death items contributed about equally to avoidance goal adoption, $r = .20$, $p = .055$ and $r = .17$, $p = .09$, respectively.

Discussion

The results from this study provided strong support for our predictions. Avoidance (relative to approach) therapy goals were a significant predictor of change in SWB from the beginning to the end of therapy. Clients with more avoidance goals evidenced a smaller increase in SWB than those with fewer avoidance goals. This relationship was observed even when controlling for several alternative predictor variables—goal importance, goal expected progress, and Importance × Expected Progress—indicating that this relationship cannot simply be attributed to these other commonly endorsed indicators of motivation. Mediational analyses provided insight into the processes through which avoidance therapy goals influenced SWB. Avoidance therapy goals predicted lower levels of therapist satisfaction, lower therapist satisfaction predicted lower perceptions of therapy effectiveness (perceived problem improvement and perceived goal progress), and these lower perceptions of therapy effectiveness proximally predicted change in SWB. Parental loss was identified as an antecedent of avoidance therapy goals.

In discussing the importance of the client–therapist relationship, Hoyt (1996) stated that "change in psychotherapy is an end result of a process in which development of a positive attitude about therapist helpfulness and satisfaction with the therapeutic relationship is an early step" (p. 441; see, also, Conte et al., 1994; Silove et al., 1990). Our results clearly support this statement, and identify avoidance therapy goals as an important contributor to this process. In essence, the client's adoption of avoidance goals may be seen as a vulnerability, as proximally, these goals appear to jeopardize the client–therapist relationship, and distally, they impede the client's improvement, progress, and overall well-being. Therefore, it seems reasonable to suggest that therapists monitor the goal-setting process in order to enhance the probability of therapy "getting off on the right foot." This monitoring might entail assessing clients' therapy goals at the beginning of the therapy process, and, when applicable, discussing the ineffective

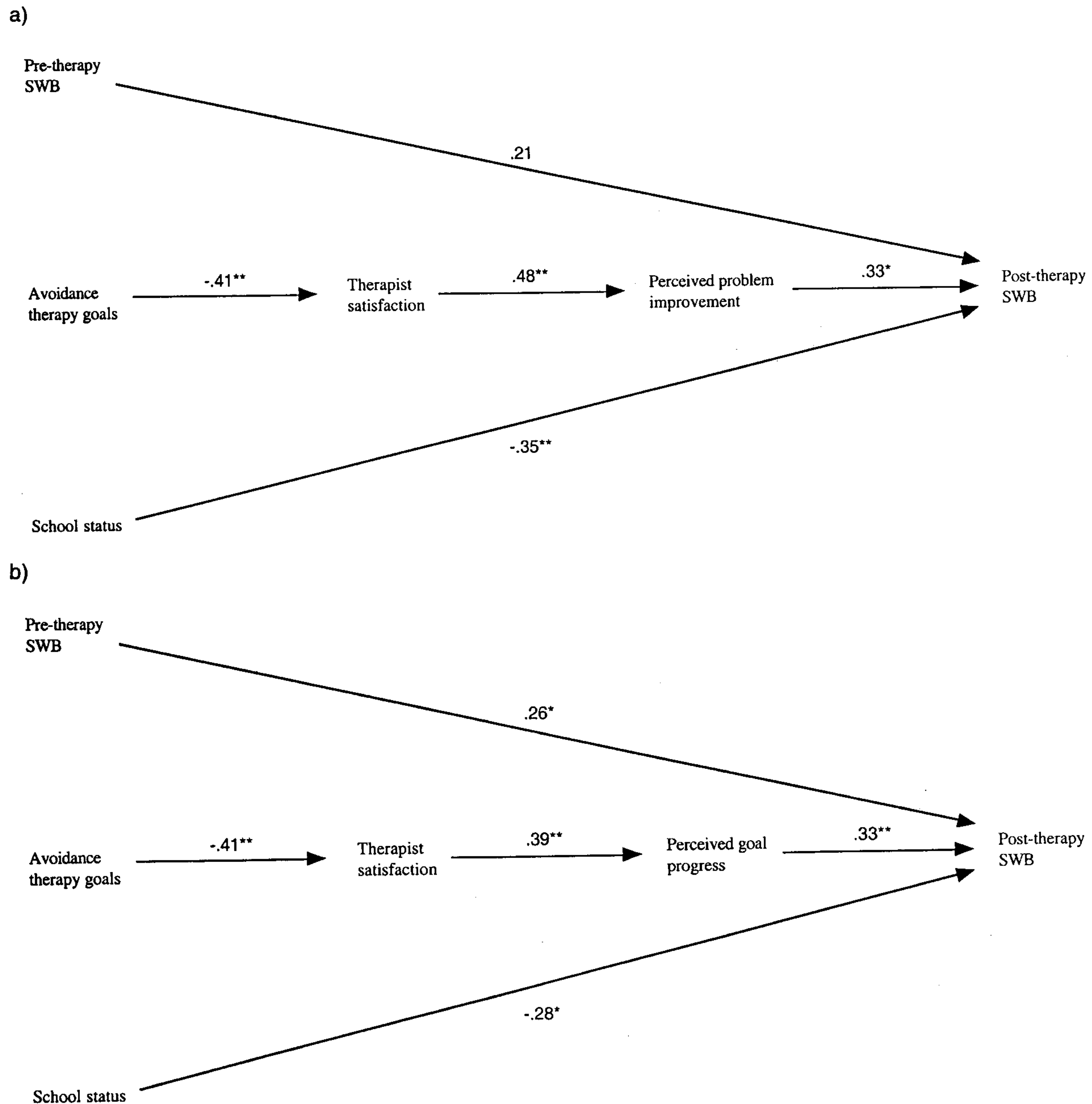

Figure 1. The mediational models for change in subjective well-being (SWB): (a) the percieved problem improvement model, and (b) the perceived goal progress model. Path values are standardized regression coefficients; only theoretically central paths or paths that attained significance in the regression analyses are included in the diagram for presentation clarity. * $p < .05$. ** $p < .01$.

and potentially problematic nature of avoidance goals, and working to reframe these goals in terms of approaching positive possibilities. The time and effort spent on such an intervention procedure early in therapy may pay handsome dividends in the long run.

It is important to note, however, that a straightforward goal-reframing procedure is not likely to be effective (i.e., sufficient) for all clients. For some individuals, avoidance goals are undoubtedly rooted in aversive neurophysiological sensitivities (e.g., avoidance temperament), motivational dispositions (e.g., fear of failure), or relational styles (e.g., insecure attachment; see Elliot & Thrash, in press). In such instances, even if the client is encouraged to generate approach variants of his or her avoidance goals, in actually negotiating daily life, the individual would probably revert back to the avoidance regulation that emerges directly from his or her broader personality system. Thus, in addition to implementing a reframing procedure for avoidance goals, therapists would do well to query clients regarding why they think they are pursuing such goals in the first place. The information gleaned from this querying process may help the therapist determine the direction in which therapy should proceed.

The link between therapist satisfaction and perceived therapy effectiveness is reasonably well documented in the literature (Lebow, 1983; Oei & Shutlewood, 1999), and the research here replicated this established relationship. This relationship was not only demonstrated using a conventional indicator of perceived therapy effectiveness (perceived problem improvement), but also a novel indicator based in idiographic procedures (perceived goal progress). Perceived therapy effectiveness is an important outcome of therapy in its own right, as it carries information regarding the "human significance" of therapy (Seligman, 1995) and is crucial for the economic viability of mental health services (Bilbrey & Bilbrey, 1995; Lambert et al., 1998). Nevertheless, it is also clearly important to link this variable to broader treatment outcomes, and we were able to document such a link in this study by validating perceived problem improvement and perceived goal progress as proximal predictors of change in SWB.

SWB is a general quality of life indicator that provides additional and impressive evidence of the social validity and clinical significance of therapy-related change (Gladis et al., 1999; Jacobson, Roberts, Berns, & McGlinchey, 1999; Kazdin, 1999; Kendall, Marrs-Garcia, Nath, & Sheldrick, 1999). This research represents one of the few studies in the psychotherapy literature that has focused on quality of life, and specifically SWB, as the central outcome variable of interest; it is also one of the few studies to explore predictors of change in clients' quality of life (see Gladis et al., 1999). It should be noted that our focus on quality of life, as opposed to symptom relief, aligns with counseling psychology's long-term commitment to focusing on strengths, and the more recent call in the psychological sciences for movement toward a more "positive psychology" (see Seligman & Csikszentmihalyi, 2000).

Results from our ancillary analyses illustrate the promise of probing the reasons behind avoidance goal pursuit, as these analyses revealed parental loss through permanent separation, divorce, or death to be an antecedent of avoidance goal adoption. Although the long-term consequences of divorce, in particular, remains a much debated issue, several investigators have found early parental loss through divorce or death to be associated with fear of rejection and insecure relational attachments in adulthood (Greenfield & Teevan, 1986; Schuengal, Bakermans-Kranenburg, & Van IJzendoorn, 1999; Summers, Forehand, Armistead, & Tannenbaum, 1998; Van IJzendoorn, 1995; Wallerstein & Blakeslee, 1989). This suggests that for some individuals, avoidance goals are embedded in aversive relational processes such as separation, abandonment, or rejection concerns, or attachment issues more generally. It is doubtful that many clients could consciously articulate the link between their early parental loss and their avoidance goal adoption, but the reasons that such clients are likely to offer for their pursuit of avoidance goals may revolve around current relational concerns, fears, and/or disruptions. Depending on their orientation, therapists may use such information either to focus the therapeutic process directly on these present life struggles or to assist clients in resolving the underlying issues linked to these difficulties.

This research demonstrates the importance of attending to the avoidance goal construct in the therapy context, and establishes the need to acquire additional knowledge about avoidance therapy goals and their associated antecedents, processes, and outcomes. One question that warrants research attention concerns which variables, besides parental loss, serve as antecedents of avoidance therapy goals. It is possible that individuals with certain types of clinical disorders (e.g., those involving anxiety and fearfulness), persons encountering periods of extreme crisis or acute stress in their life, or, as suggested earlier, persons with certain attachment or object relations histories may also demonstrate a greater propensity to adopt avoidance goals in the therapy context. Another interesting question is whether the initial goals that clients report at the beginning of therapy are pursued throughout the course of therapy or whether they change in systematic fashion during the therapy process. A third research question in need of attention concerns whether avoidance therapy goals are linked to other indicators of treatment outcome, besides those investigated here. The quality of the client–therapist relationship has been shown to predict a wide range of treatment outcomes (ranging from client reports of symptom relief to therapist/family member reports of quality of functioning to "hard data" on behavioral change; see Horvath, 1994); thus, our data indicating that the pursuit of avoidance goals undermines this relationship suggest that these goals are likely to be (distally) linked to a broader set of outcomes than those documented here.

There are limitations of this study that should be noted. First, the observed relationships were documented in the context of brief outpatient psychotherapy with university students, and the extent to which they generalize to other types of therapy or other client populations is not clear. Second, the primary component of the study included treatment completers only, thus raising the possibility of sampling bias. It is important to note, however, that attrition analyses revealed no significant differences between completers and noncompleters on any of the variables assessed at the beginning of the study. Third, the process and outcome measures were self-report in nature, thereby raising the possibility that response bias contaminated our findings. This concern is not really applicable to the SWB variable, as the use of multiple assessments and the analysis of change greatly minimizes the impact of response bias (Elliot & Sheldon, 1998). In addition, in a recent review article, Horvath (2000) concluded that research linking the quality of the client–therapist relationship to treatment outcome is probably not influenced by client response bias to any significant degree. Fourth, the mediational results that we obtained are certainly consistent with the sequential model that we predicted, but given that the mediator variables were all assessed at the completion of therapy, the precise directionality of the observed relationships could not be definitively established. Investigating mediation was a secondary objective here; now that the relationship between avoidance therapy goals and change in SWB has been documented, additional research should be designed to address process issues in more intricate fashion.

The main focus of this research has been on a specific aspect of therapy goals, the approach–avoidance dimension, and the primary aim has been to demonstrate the predictive utility of this basic motivational dimension with regard to important clinical processes and outcomes. In closing, we would like to take a conceptual step back to highlight, more generally, the utility of assessing clients' idiographic objectives for therapy.

Therapy goal assessment is inexpensive, relatively quick, and represents an easy and straightforward procedure for clients of most ages who possess at least a moderate degree of intellectual ability and psychological stability. The assessment of therapy

goals is a highly personalized, "ecologically sensitive" (Little, 1999) task that sends a clear message to clients that their individuality and uniqueness are highly valued, and that their distinct perspective is considered an important contribution to the therapy process. Furthermore, the very exercise of concretely articulating their therapy goals may be beneficial for some clients, as it can help them clarify the specific nature of their individual strivings and provide them with insight regarding their overall approach to daily self-regulation.

Therapy goal assessment can be used in the process of diagnosis as an idiographic complement to more standard nomothetic procedures. Knowledge of a client's therapy goals is not only useful for clinical assessment but also affords the therapist rich information regarding the client's specific life situation (content not available through normative assessment). This information is likely to prove useful in the development of a treatment plan for therapy and, therefore, undoubtedly maximizes the probability of a close match between the client's ultimate goals and the therapist's instrumental goals for therapy (Foster & Mash, 1999). It is important to note that therapy goal assessment is agnostic with regard to theoretical orientation and may be used by therapists who deliver a variety of different types and lengths of mental health services.

From a research standpoint, the therapy goal construct promises to yield insights into therapy-relevant self-regulation well beyond the approach–avoidance dimension. Many aspects of clients' therapy goals may be investigated, a sampling of which includes intergoal conflict (Emmons & King, 1988), goal self-concordance (Sheldon & Elliot, 1999), level of goal abstraction (Lecci, Karoly, Briggs, & Kuhn, 1994), developmental appropriateness of goals (Karoly, 1999), and goal meaningfulness (Little, 1989). Research on therapy goals may be carried out in a nonobtrusive manner, in that it can be easily integrated into the therapy process.

In sum, the assessment of clients' therapy goals seem to hold promise as a pragmatic multipurpose tool for mental health professionals, be they practitioners, researchers, or theorists. If, as has recently been posited, much psychological maladjustment and dysfunction can be traced back to ineffective goal setting and self-regulation (Barone, Maddux, & Snyder, 1997; Karoly, 1999), it is imperative that the issue of client-articulated goals in the therapy context receive significantly more attention than it has to date.

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Appendix

The Therapy Goal Assessment Procedure

People seek psychotherapy to facilitate change in their life. On the lines below, please write five ways in which you would like your life to be different after participating in psychotherapy. You may chose to indicate things *specific to therapy* (e.g., "To get more in touch with my feelings" or "To avoid being depressed") or you may indicate ways that you wish your life *in general* to be different (e.g., "To not procrastinate" or "To become physically fit"). This is a very personal activity, so please write down things that are specific to *your* life. Your therapist will *not* see your responses. All of your responses are completely confidential. Please describe each "life goal" in a brief phrase.

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

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