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A Social Exchange Approach to Explaining Satisfaction with Therapy

Brenda B. Counts
Old Dominion University

A SOCIAL EXCHANGE APPROACH TO EXPLAINING SATISFACTION WITH THERAPY

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Brenda B. Counts
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Approved by:

Barbara A. Winstead, Ph.D. (Director)

Valerian J. Derlega, Ph.D.

Louis H. Janda, Ph.D.

ABSTRACT

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Brenda B. Counts
Old Dominion University, 1989
Director: Dr. Barbara A. Winstead

The present study examined the effect of Reward, Cost, Comparison Level, Comparison Level of Alternative, and Investment on Satisfaction and Commitment in therapy from the perspective of social exchange theory and the investment model. Relationship variables were assessed by 114 subjects for the beginning of therapy, the first few sessions; middle of therapy, when therapy was clearly underway and issues were being dealt with; and the end or last few sessions. Results confirmed that Satisfaction and Commitment were significantly predicted by greater Reward, lower Cost, and Comparison Level. Investment was consistently positively related to Commitment and not to Satisfaction. However, Comparison Level of Alternative was correlated with Satisfaction rather than Commitment. As hypothesized, Satisfaction and Commitment at the beginning of therapy were more highly correlated with Reward minus Cost than with Reward plus Cost, but for overall Satisfaction and Commitment, the strength of total Reward plus Cost as a predictor increased. Magnitude of Reward alone was a better predictor of Overall Evaluation than any other combination of variables. Finally, Satisfaction at the beginning of therapy was a significant predictor of Overall Evaluation indicating the influence of early evaluations in the therapy relationship.

Dedication

To my mother, who always had faith in me and who knew I could do it. To my father: Dad, I know you would be very proud of me if you were here, even though you never quite understood why girls needed to go to college. Thank you both for your encouragement and support.

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Researchers have reported that most forms of psychotherapy have produced positive change in the majority of patients treated and that this has been well documented in the literature (Alexander & Luborsky, 1986). However, the forces which produce this change are not well understood. The search for variables promoting positive change in individuals undergoing therapy has prompted interest in the relationship between patient and therapist as a factor influencing differential outcomes in therapy.

Social psychologists have sought predictors of satisfaction and commitment in personal relationships by examining the exchange of resources, rewards and costs, and the comparison level or generalized expectations brought to the current relationship. An expansion of social exchange theory is the investment model which proposes that satisfaction and commitment in relationships are affected not only by rewards, costs, and comparison level, but also by the quality of alternatives and the amount of resources invested.

The current study will use social exchange theory and the investment model to explain satisfaction and commitment in the therapy relationship. The introduction will review clinical research on psychotherapy process and outcome, social exchange theory and the investment model, and empirical work testing these.

Clinical Research on Psychotherapy Process and Outcome

Generally, psychotherapy process variables which have been emphasized in the clinical literature are divided into

three classifications: patient variables, therapist factors, and relationship variables (Henry, Schacht & Strupp, 1986). The magnitude of the effect of each category of these dimensions has been disputed by those with various theoretical orientations. The client-centered or Rogerian school maintained that the consistent communication of warmth and empathic understanding by the therapist was sufficient to produce enduring personality change. In contrast, dynamic therapists believed the best prospects for therapy should have the motivation and capacity to form an intense interpersonal relationship with the therapist (Strupp, 1973). Psychodynamic therapists have asserted that the patient's capacity and willingness to become involved in the therapy process were primary to constructive change (Suh, Strupp & O'Malley, 1986). Others have also argued that patient attitudes were most influential on therapy outcome, and the expectations the individual brings to therapy can help more than the therapist's techniques (Frank, 1973). Thus, there has been debate regarding the effective ingredients in psychotherapy outcome.

Research on the effect of the patient, therapist, and relationship variables on the outcome of treatment has produced equivocal results (Gomes-Schwartz, 1978). While previous efforts had shown patient factors were more predictive of favorable treatment outcome, later findings have reported that positive relationship factors were more predictive (Luborsky & Auerbach, 1985, cited in Alexander & Luborsky, 1986). The diverse results led to the pursuit of general factors common to all effective treatment endeavors (Alexander & Luborsky, 1986).

Many investigators have focused on pretreatment and patient variables. Studies have found that patients who benefited most from therapy were those who were more involved in the therapy process from the beginning, took responsibility for changing their own behavior, and actively examined their feelings and experiences. Individuals who viewed their problems as externally controlled or who distanced themselves from interaction in therapy were less likely to benefit (Kirtner & Cartwright, 1958; Rice & Wagstaff, 1967). Frank (1973) suggested that predictors of favorable treatment outcome were a positive attitude of the client toward therapy and their commitment to work at changing. Gomes-Schwartz (1978) found that patients who benefited most in brief analytic psychotherapy were those who demonstrated adaptive resources and willingness to work with the therapist to resolve their problems. Specifically, the patient's capacity and willingness to actively contribute in the patient-therapist interaction were the most influential determinants of outcome. Also, trusting and nonhostile clients achieved greater change than those who were defensive, withdrawn or hesitant to participate in the therapy process. The client's attitude toward the therapist was of lesser predictive ability (Gomes-Schwartz, 1978). Favorable treatment outcome was found to be especially likely for another group of patients who entered therapy without significant pathology or who were psychologically healthy and adaptable (Moras & Strupp, 1982, cited in Alexander & Luborsky, 1986). In general, patients who experienced a more successful therapy outcome were those who were actively involved in the process, were free of significant pathology

or somatic symptoms, and had a positive attitude toward treatment.

Successful treatment outcome may also be assessed in terms of satisfaction of the patient. Heretofore, treatment outcome had not been given much attention in the satisfaction studies (Kalman, 1983). This may be because patient satisfaction has proven difficult to define since it is a composite of an individual's personality, expectations, attitudes, experiences, perceptions, philosophy, and psychodynamics. The profuse literature on patient satisfaction with treatment is neither cohesive nor conclusive due to the fact that no standard methodology exists to measure satisfaction. However, general patient satisfaction with therapy has been studied extensively because it can contribute to the design and implementation of mental health programs, the success and use of clinical services, and patient compliance with treatment. All of these may be improved by careful attention to the patient's perception of treatment (Kalman, 1983). Many investigators have suggested that the opinions of patients should be systematically evaluated.

Nichols (1975) employed a personal satisfaction form as an outcome index which was found to be a reliable and valid indicator of patient change in psychotherapy. In a two-year study in which the results were replicated, patients were asked to rate the degree of helpfulness of therapy with a self-report questionnaire. A significant number of patients believed they had been helped, and that the more the therapist was interested in them the more they felt they had benefited (Kirchner, 1975). During six-month family therapy

rated by a family satisfaction survey, questionnaire components of global satisfaction demonstrated that the majority of clients were satisfied with their treatment overall, felt better regarding their original problems, and attributed change to their treatment (Woodward, Santa-Barbara, Levin, & Epstein, 1978). Most patients said they would return if they needed further treatment despite the fact that 45 percent of them did not feel that the services rendered were adequate and comprehensive. Since many of the families who were dissatisfied experienced successful treatment outcomes, global satisfaction should not be the sole determinant of effective treatment outcome. Various aspects of satisfaction should be examined in greater detail if ratings are to be interpreted meaningfully (Woodward et al., 1978).

Among the therapist factors studied have been such characteristics as skill, commitment, acceptance, errors in technique, exploration, warmth, friendliness, directiveness, and negative attitudes. The therapist-offered relationship or the attitude of the therapist which is conveyed to the patient has been found to be an effective ingredient in therapy change (Rogers, 1957, cited in Suh et al., 1986).

Gomes-Schwartz (1978) employed the Vanderbilt Psychotherapy Process Scale (VPPS) to assess therapist variables. The therapist-offered relationship had a weak effect on outcome measures based on improvement in the patient's problems, patient distress, and the quality of the patient's functioning. The therapist factors of theoretical orientation, training, professional status, exploratory processes, warmth, and friendliness had little effect on the

outcome in psychotherapy. Other studies utilizing the Vanderbilt Negative Indicators Scale (VNIS) reported significant correlations between therapist errors in technique and global ratings of satisfactory therapy outcome (Kraemer, 1980, cited in Suh et al., 1986).

Rudy, McLemore and Gorsuch (1985) found that when their therapists were perceived as warm, empathic and actively listening, client's self-reports indicated greater satisfaction with therapy. Therapy was also rated as more successful if therapists were accepting, affirming, helping, and protecting. Patients who were seen by therapists of the same sex reported more progress and therapists reported greater change, however, gender of the therapist and client was unrelated to outcome. The number of sessions attended bore little relation to symptom reduction or client-rated progress. However, even a small amount of rejection, blaming, belittling, or suspiciousness by the therapist related negatively to symptom improvement as determined by the Hopkins Symptom Checklist (HSCL) (Rudy et al., 1985). Altogether, the highest correlations with outcome have been the therapist's positive attitude toward the patient and errors in technique.

Some analytically-oriented therapists have emphasized the importance of the patient-therapist relationship. This led to a resurgence of interest in the long-established psychoanalytic concept of the therapeutic alliance, also referred to as the helping or working alliance (Alexander & Luborsky, 1986). The therapeutic or helping alliance has been generally conceived of as the patient's experience of the relationship with the therapist as helpful, or the

ability of the patient and therapist to work purposefully together. The development of a positive therapeutic alliance is considered an essential ingredient for a successful experience in therapy (Alexander & Luborsky, 1986). How to objectify and quantify various aspects of the dynamic interaction between patient and therapist has been the focus of much clinical research within the last decade (Suh et al., 1986). However, development of the methodological techniques to measure this multifaceted interaction is still underway. Because of the dearth of measurement techniques, several scales have been developed since 1975 in an attempt to quantify the therapy relationship (Alexander & Luborsky, 1986). Clearly, the patient and therapist variables as well as their interaction are components of the therapy relationship. Since the patient and therapist variables have been addressed, only those factors which pertain directly to the therapy relationship will be discussed, although most of the alliance scales measure patient and therapist factors individually rather than the relationship interaction.

The Penn Helping Alliance (HA) scales were correlated with factors that aided or impeded development of the therapeutic alliance. Studies found that primary conditions facilitating development of a helping alliance between patient and therapist were psychological health of the patient, basic similarities between patient and therapist, and the therapist's competence. Characteristics which hindered formation of the helping alliance were somatic problems of the patient, amount of life change, and random assignment of patient to therapist (Luborsky, Mintz, Auerbach, Christoph, Bachrach, Todd, Johnson, Cohen, &

O'Brien, 1980, cited in Alexander & Luborsky, 1986). While many investigators found that early development of a positive patient-therapist alliance was predictive of outcome in psychotherapy (Gomes-Schwartz, 1978; Luborsky et al., 1983, cited in Alexander & Luborsky, 1986), the ability of the alliance scales to predict outcome has met with only moderate success (Alexander & Luborsky, 1986).

Another scale, the Working Alliance Inventory (WAI) was designed to primarily assess the strength of the early stages of the therapy relationship (Horvath & Greenberg, 1986). Two areas of agreement between patient and therapist were included, goals and tasks, as well as the development of a personal bond. The task scale was found to be most reliably correlated with therapy outcome when measured by target complaints and a client posttherapy questionnaire (Moseley, 1983, cited in Horvath & Greenberg, 1986).

In studies using the Therapeutic Alliance Rating System (TARS), estimates of the patient's and therapist's positive contributions to the alliance were the most reliable predictors of outcome following brief psychotherapy (Marmar, Horowitz, Weiss, & Marziali, 1986). Outcome measures were the Derogatis Symptom Index, the Beck Mood Scale, the Weissman Social Adjustment Scale, the patient and therapist post-therapy evaluations and an estimate of dynamic outcome. Also, early estimates of a positive therapeutic alliance were strongly associated with outcome in the first and third sessions. The TARS ratings showed high correlations with global change determinants of outcome but had low correlations with outcome measures of symptomology, social functioning, and dynamic outcomes (Marmar et al., 1986).

Findings by Foreman and Marmar (1985) using TARS measures indicated that interventions of the therapist which do not address the patient's negative feelings toward the therapist and the patient's avoidance of communicating this negativism to the therapist hinder the development of a positive therapeutic alliance.

Based on interpersonal process variables of therapy outcome measured by the Structural Analysis of Social Behavior (SASB), greater change in patients was promoted by therapists with significantly higher levels of helping and protecting, affirming and understanding, and lower levels of blaming and belittling (Henry et al., 1986). Patient interpersonal behaviors associated with lower change cases included walling off and avoiding, and trusting and relying, whereas disclosing and expressing were more frequent in patients with greater change. Also, negative patient-therapist interactions, e.g., hostile and controlling, were related to poor treatment outcome (Henry et al., 1986).

Rudy et al. (1985) also used SASB scales to measure therapy progress and the Dymond Outcome Scale to assess amount of client change and success. They showed SASB scores predicted 65% of the progress variance when rated by therapists and clients. Some of the most important determinants of therapy outcome were reflexive social behavior and interpersonal relationship. A significant negative relationship was found between progress in therapy and role reversal, i.e., the client taking care of the therapist (Rudy et al., 1986). During brief family therapy, global measures of patient satisfaction indicated one of the

primary sources of patient dissatisfaction was the patient-therapist interaction (Woodward et al., 1978).

In general, the alliance ratings have been highly predictive of global change outcome measures, but less predictive of symptom improvement, social functioning, and dynamic outcome (Marmar et al., 1986). However, further revision and study utilizing the various alliance scales are underway leading to future possibilities of identifying consistent predictors of successful therapy outcome. Prior research has indicated that patient factors were usually more predictive of therapy outcome than therapist variables.

Social Exchange Theory and the Investment Model

Social exchange theories emphasize the reciprocity in interpersonal relationships. Two such theories that may be applied to personal relationships, including the therapy relationship, are Kelley and Thibaut's (1978) concept of interdependence and an extension of this, Rusbult's (1980a, 1980b, 1983) investment model. Any type of ongoing dyadic association may be viewed as a social exchange in which the development or continuance of the relationship is a function of the rewards and costs that are exchanged (Winstead, Derlega, Lewis, & Margulis, 1988).

A basic premise of social exchange theory is that people have a self-serving motivation to maximize gains and minimize costs thus attempting to obtain their best possible outcomes (Kelley & Thibaut, 1978). A positive outcome is achieved when the rewards gained in a relationship exceed the costs incurred. Rewards or benefits are anything giving pleasure or satisfaction to the individual and costs are anything that is unpleasant (Kelley and Thibaut, 1978). The degree of the reward or cost experienced by the individual will depend on their needs and values, their skills and abilities in performing the behavior and the congruence of the behavior with their needs and values. Outcome is equal to rewards minus costs. If costs are greater than rewards the outcome of the relationship is negative.

In therapy rewards for the client may be improvement in symptoms or behavior, help with problems, and/or having someone who is interested in and cares about them (Winstead et al., 1988). Costs incurred may be feeling anxious or

embarrassed admitting negative things about oneself, labeling oneself as having a problem, the difficulties associated with changing behavior, and discomfort with self-disclosure. Costs also include time spent in therapy and the financial cost of therapy.

However, rewards and costs alone do not determine client satisfaction with therapy (Derlega, Winstead, Hendrick, & Berg, in press). Two standards are used to evaluate outcomes and thereby judge how good the relationship is, the comparison level (CL) and the comparison level of the next best alternative (CLalt) (Kelley & Thibaut, 1978).

The comparison level which an individual adopts depends primarily on past experiences, observations of others and expectations (Thibaut & Kelley, 1959). The CL represents an average or modal value of all past relationship outcomes and reflects the quality of outcome a person believes they deserve. The more attainable the outcome was in the past the more weight it is given in forming the CL. Thus, the CL is a realistic expectation a person has for outcomes in a relationship (Thibaut & Kelley, 1959).

Comparison level for a therapy relationship may be difficult for an individual to establish if they have not been in therapy before. In this case, clients may have distorted expectations of what the therapeutic relationship will be (Derlega et al., in press). They may have unrealistically high expectations of the therapy relationship based on mass media portrayals of therapy in which therapists focus large amounts of time and energy on one or few clients, whereas in reality therapists usually have many clients. Thus, clients with excessively high expectations may be dissatisfied with therapy and leave early, whereas those

with low expectations who are helped quickly may express satisfaction and stay longer (Derlega et al., in press). Clients who have been in therapy before or who have information from friends or relatives who have been in therapy may be able to establish more realistic comparison levels for evaluating the therapy relationship.

Outcomes above CL are deemed satisfactory to an individual while outcomes below CL are considered to be unsatisfactory. Hence, satisfaction is based on the value of the outcomes to a particular individual (Kelley & Thibaut, 1978).

The comparison level of the alternative (CLalt) is defined as the "lowest level of outcomes a member will accept in light of available alternative opportunities in other relationships" (Kelley & Thibaut, 1978, p. 9). If outcomes drop below this standard of CLalt the individual is likely to leave the relationship but if outcomes rise above CLalt dependency on the relationship increases. The location of CLalt is determined primarily by the quality of the most attractive alternative relationship easily available to a person (Kelley & Thibaut, 1978).

CLalt has been shown to be a viable predictor of an individual staying in a current relationship as Rusbult's (1980a) research on commitment has shown. She found that as alternatives decreased or became less attractive the subject had a greater probability of staying in the relationship. The subjects with a more desirable alternative than their current relationship were more likely to leave as measured by a paper and pencil survey questionnaire.

If a participant chooses to go to therapy or to continue

in therapy it implies that their best available alternative (CLalt) is below the level of outcomes found in therapy. Thus, CLalt may predict when an individual will begin or stay in therapy (Winstead et al., 1988). People may be more motivated to begin therapy when a significant relationship deteriorates. If, as a result of therapy, relationships with others improve, clients may terminate or become less committed to therapy.

The work of Rusbult (1980a, 1980b, 1983) has extended social exchange theory through the investment model by clarifying the concepts of satisfaction, attraction, commitment, investments and costs. Commitment may be affected not only by outcome values of the current relationship and the next best available alternative, but also by the size of the individual's investment in the relationship. Investments represent any type of resource put into the relationship which would decline in value or be lost if the relationship terminated. They may be objects, events, persons or activities unique to that relationship such as shared memories, mutual friends, financial investments or even children born of the relationship. There are two primary types of investments. Intrinsic investments are indirect resources which are linked to the relationship and cannot be removed, e.g., shared memories/material goods/activities, emotional involvement, etc., (Rusbult (1980b). Extrinsic investments are put directly into the relationship such as time, money, energy or effort.

Rewards and costs may be items similar to investments or even the same as investments. However, the distinguishing feature of investments is that they are extremely difficult

to remove from the relationship and if the relationship dissolved they would be lost or decrease in value (Rusbult, 1980b).

Commitment may remain high even though satisfaction or attraction to the relationship is low if the person believes their alternative is poor and if they have invested heavily in the relationship. This may result in a feeling of "entrapment" because of the exceedingly high investments (Rusbult, 1980a). Commitment then, is not a simple function of degree of satisfaction in a relationship nor better alternatives (Rusbult, 1980a). Commitment can be best explained by a combination of factors including size of investment, and relationship outcome value (i.e., higher rewards and lower costs).

Rusbult (1980a, 1983) also verified that the more resources are invested in a relationship the more dependency grew. As the magnitude of investment rose, the potential for leaving a dating relationship was lower as determined by paper and pencil questionnaires.

Rusbult's idea of investment can also be applied to the client's commitment in the therapy relationship. The client's investment in therapy which would be lost if the relationship ended may be time, fees paid, effort, and the feeling that this therapist knows the client's personal history and no other therapist does (Winstead et al., 1988). Also, the client may have invested so much in therapy, he/she may feel "trapped" and hesitate to leave and start over with another therapist even if the relationship is not satisfying.

Rusbult (1980a) used paper and pencil measures and role play to test if satisfaction and commitment with the

relationship were reliably predicted by rewards and costs (or outcome value) in ongoing romantic involvements. It was predicted that as satisfaction/attraction, i.e., degree of positive affect became higher that costs would lower. It was found that subject's perceptions of satisfaction were significantly higher with lower costs in one experiment (Rusbult, 1980a). In contrast, other experiments showed satisfaction was predicted by higher rewards but the effect of costs was negligible (Rusbult, 1980a, 1983; Rusbult, Johnson, & Marrow, 1986). In all three studies of romantic involvements and friendships paper and pencil self-report measures were used.

In longitudinal studies of job satisfaction, greater job satisfaction was consistently predicted from increased rewards and decreased costs using a survey questionnaire (Rusbult & Farrell, 1983). In studies of romantic associations (Rusbult, 1980a; Rusbult et al., 1986) and friendships (Rusbult, 1983), greater commitment was positively associated with rising investment in the relationships. Thus, rewards and costs bore a greater relationship to satisfaction and higher investments were more closely associated with commitment.

Social exchange theories predict that a relationship partner will be chosen according to the best outcomes which can be obtained. Kelley and Thibaut's (1978) theory of interdependence hypothesizes that for a current relationship to be satisfying to an individual, the rewards must exceed the costs, the outcomes in terms of rewards minus costs should be equal or exceed their expectations (CL), and the outcomes should also be more than they could receive in a

readily available alternative relationship (CLalt) which is better. Rusbult's (1980a, 1980b) extension of interdependence theory maintains that good outcomes (i.e., higher rewards and lower costs) also result in greater satisfaction and commitment to a relationship which leads to increased possibility of the individual staying in the relationship. However, lower costs did not as consistently predict satisfaction and commitment in empirical studies whereas higher rewards did (Rusbult, 1980a, 1980b, 1983; Rusbult et al., 1986). Not only was increase in relationship satisfaction a good predictor of commitment in a relationship but commitment was also heavily influenced by greater investment of resources and decline in quality of alternative partners.

In determining if the person will seek out therapy or become an active participant in the therapy process, the variables of rewards, costs and comparisons with alternative relationships can be influential and may assist in finding methods of increasing client satisfaction and commitment (Derlega et al., in press). Interactions early in the therapy relationship may provide an indication of experiences in future sessions (Thibaut & Kelley, 1959).

Research on Social Exchange Processes in Personal Relationships

The therapy relationship viewed as a personal relationship has received little systematic study. Findings from research on other types of dyadic interaction, however, may be applicable (Derlega et al., in press). Berg (1984) surveyed liking and satisfaction in a sample of previously unacquainted college roomates at the beginning and end of the school year. Participants completed self-report questionnaires at the beginning of the semester and six months later to determine their impressions. Degree of liking and satisfaction were assessed by Rubin's Liking Scale and a global satisfaction question on how happy they were with their living arrangements. Equity was determined by a response as to who was benefiting more from the relationship and a reward index indicated the subject's ratings of the extent their roomate helped them. At the end of the school year, the amount of benefits received and the comparison level of alternatives (CLalt) were the most significant variables in determining liking and satisfaction than were perceived equity, similarity or self-disclosure (Berg, 1984). As time passed, roomates who planned to stay together increasingly provided each other more help which met their unique needs, whereas benefits for those who did not plan to continue the relationship decreased from the beginning to the end of the school year (Berg, 1984).

In other studies, Hays (1984, 1985) also found that as the relationship progressed, benefits exchanged increased among close friends and decreased among nonclose friends from the beginning to the end of the school term. Thus, the

nature of the social exchange process changed over time. Also, Berg and McQuinn (1986), Hays (1985), and Rusbult (1980a) found similar results regarding benefits as did Berg (1984) in that the magnitude of rewards was the best predictor of the level of relationship satisfaction. Berg and McQuinn (1986) showed that couples still dating four months later demonstrated more relationship-maintaining behavior, evaluated the relationship more positively, had higher satisfaction, and exhibited more self-disclosure on self-report questionnaires. Those who broke up displayed opposite behavior patterns. These differences between those who stayed versus those who left the relationship increased with the passage of time. Hays' (1985) study on friendship development between close and nonclose friends indicated benefits received were positively correlated with friendship intensity over the school term while costs had little effect using self-report measures. Both Berg (1984) and Hays (1985) found that as the relationship progressed, the intimacy level of dyadic interaction and amount of interaction were positively correlated with friendship intensity ratings at all stages of relationship development between pairs of friends. Within two to three weeks of the beginning of a relationship, differences in behavior patterns and attitudes were noticeable between those who developed into close friends and those who did not (Berg, 1984; Berg & Clark, 1986; Hays, 1985) and differences intensified with the passage of time (Berg & McQuinn, 1986; Hays, 1985; Rusbult, 1983). The decision to continue or discontinue the relationship appears to be made very early as well (Berg, 1984; Berg & McQuinn, 1986). The evidence that benefits

received consistently predicted success in friendship and romantic relations verifies social exchange theory (Derlega et al., in press). However, social exchange theory proposes that rewards minus costs should be a better predictor of success in relationships than rewards plus costs (Clark & Reis, 1988). Although some found a negative correlation between costs and satisfaction (Rusbult, 1980a, Study 2; 1980b), others found no relationship between costs and relationship success (Rusbult, 1980a, Study 1; Hays, 1985). Hays (1985) showed in a longitudinal study that rewards plus costs was a better predictor of success than rewards minus costs. Thus, over time rewards as well as costs both seemed to contribute to relationship satisfaction contrary to social exchange theory which says costs are negatively associated with relationship success (Derlega et al., in press). This apparent conflict may be explained if one considers that the partners in a close relationship feel responsible for meeting each other's needs. As closeness increases, each member feels more responsible for the other person and the more benefits they exchange. However, as the benefits exchanged increases, the costs of each person in meeting the needs of their partner also rises (Clark & Reiss, 1988; Hays, 1985).

Berg (1984), also reported that as a relationship developed, emotional aggravation experienced in friendships increased for both close and nonclose friends. Personal dissatisfactions such as emotional aggravation and time spent seemed to be an inevitable part of relationship development. These costs increased as intensity and time in the relationship increased. As time passed the partners were

also more likely to exchange benefits that met their individual needs (Berg, 1984).

Closeness in the therapy relationship may also be positively related to costs (Derlega et al., in press). As time, money, effort, and emotional costs rise, the patient and therapist may feel closer and the patient may either justify the higher costs to himself or others as a reason to remain in therapy or to feel more satisfied with it.

Since little research has been conducted on therapy as a personal relationship, this study will determine the level of benefits and costs which predict a successful therapy relationship over three different time periods, the beginning, the middle, and the end of therapy or counseling. Variables which contribute to satisfaction and commitment to therapy will be identified. The relationship between social exchange variables and overall evaluation of therapy will also be determined.

Hypotheses

The predictive power of social exchange theory and the investment model has been demonstrated across a broad range of dyadic interactions including dating relationships (Berg & McQuinn, 1986; Rusbult, 1980a, 1983; Rusbult et al., 1986), friendships (Berg, 1984; Rusbult, 1980b), and business associations (Rusbult & Farrell, 1983). Based on previous investigations the following hypotheses are presented.

1. The current study is planned as a test of social exchange theory and the investment model applied to the therapy relationship. Social exchange theory asserts that an individual should be satisfied with a relationship to the extent it provides high rewards (R), low costs (C) and exceeds comparison level (CL) or generalized expectations (Kelley & Thibaut, 1978). As in social exchange theory, the investment model distinguishes between two important characteristics of relationships, satisfaction and commitment. Satisfaction is the positivity of affect or attraction to one's relationship and commitment is the tendency to maintain the relationship and to feel psychologically "attached" to it (Rusbult, 1983). However, satisfaction and commitment may exist independently. That is, a person may be dissatisfied but still feel psychological attachment. Greater satisfaction should increase commitment to maintain the relationship as well. In addition, the investment model asserts that commitment should also be influenced by two additional factors, alternative quality and investment of numerous resources. As in social exchange theory, the investment model proposes that persons feel more committed when they perceive that they have only worse

alternatives to their current associations. The quality of alternatives (CLalt) is established by the anticipation of rewards and costs in the alternative, such as spending time with someone else or being alone. Hence, with a highly desirable alternative, commitment to maintaining the relationship would decline. Thus, according to the investment model, the individual's commitment to maintain the relationship should increase to the extent that they are satisfied, have invested heavily in it, and have no acceptable alternative (Rusbult, 1983). Prior research has provided good support for these theories in that greater rewards and generally lower costs lead to higher satisfaction, whereas poorer alternatives (CLalt) and greater investment size resulted in stronger commitment (Rusbult, 1980a, Study 2, 1980b, 1983; Rusbult & Farrell, 1983). In other studies, while rewards were strongly predictive of satisfaction and commitment, costs were either unrelated or weakly related to degree of reported satisfaction (Hays, 1985; Rusbult, 1980a, Study 1, 1983) and commitment (Rusbult, 1980a, Study 2, 1983; Rusbult et al., 1986). Thus, costs bore an ambiguous relationship to satisfaction and commitment.

For the present study, it is predicted that higher rewards and positive expectations (based on CL) will be related to greater satisfaction at each time period in therapy: the beginning, the middle, and the end. It is also predicted that greater investment and lower comparison level of alternatives will be related to greater commitment at each point in therapy. Multiple regression procedures will be utilized to determine the effect of the five variables:

rewards, costs, comparison level, comparison level of alternative, and investment on satisfaction and commitment at each of the three periods of therapy: the beginning, middle, and the end.

2. Social exchange theory also predicts that rewards minus costs (R - C) should be a better predictor of relationship satisfaction than rewards plus costs (R + C) (Clark & Reis, 1988). While some studies have found that costs were negatively related to satisfaction (Rusbult, 1980a, Study 2), others found that rewards plus costs is a better predictor of relationship satisfaction than rewards minus costs (Hays, 1985). One possibility for this positive relationship is that over time, costs may become investments or "sunk costs" for some individuals (Rusbult, 1983). Also, previous costs incurred with little reward may cause the person to become more determined to make the costs pay off in the future. Alternatively, greater costs may increase commitment with time in that the individual may justify to themselves or to others that since they have had such high costs but continue the relationship they must certainly be committed to it (Rusbult, 1983). Hence, the role of rewards and costs may be different at the beginning of the relationship than later in the relationship such that over time costs become investments and have a more positive impact rather than a negative impact on satisfaction and commitment.

It is hypothesized that while rewards minus costs will be more highly correlated with satisfaction and commitment at the beginning of therapy, rewards plus costs will have a stronger relationship to the evaluation of overall satisfaction. To verify these hypotheses the effects of

rewards plus costs (R + C) and rewards minus costs (R - C) will be assessed: 1) for satisfaction and commitment at the beginning of therapy, and 2) for the overall evaluation of therapy and percentage of sessions missed (as a measure of overall commitment). To test the former relationships, the correlations between both R + C and R - C and satisfaction and commitment at the beginning of therapy will be calculated. To test the second set of relationships, rewards and costs for the three time periods will be summed (ΣR and ΣC). The correlations between both ΣR + ΣC and ΣR - ΣC and overall evaluation of therapy and the percentage of sessions missed will be calculated. It is predicted that R - C will have a stronger relationship with satisfaction and commitment than R + C for the beginning of therapy, but ΣR + ΣC will have a stronger relationship than ΣR - ΣC with overall evaluation and percentage of sessions missed.

3. The decision whether to continue or discontinue the relationship seems to made very early in the relationship (Berg & McQuinn, 1986; Hayes, 1985). The literature on psychotherapy has also reported that the early development of a positive patient-therapist relationship (in the first to the third sessions) is predictive of favorable treatment outcome (Gomes-Schwartz, 1978; Marmar et al., 1986).

Satisfaction and investment at the three time periods will be correlated with the overall evaluation of therapy. Although satisfaction at the end of therapy may have the greatest correspondence with overall evaluation, satisfaction and investment at the beginning are expected to make significant additional contributions to overall satisfaction.

Method

Subjects

Subjects consisted of 114 male and female undergraduate students who are requested to complete a questionnaire in partial fulfillment of the requirements for an introductory psychology course. Participants received one research credit and were recruited by a notice placed on the Psychology Department bulletin board.

Procedure

Printed information informed the subjects that the purpose of the project was to investigate people's experiences in individual counseling or psychotherapy. In order to participate, the subjects must have completed individual counseling or therapy for which there was a beginning, middle and end period. They were instructed to read the printed instructions, fill out the entire questionnaire and return it to the Psychology Department Peer Advisor within one week in order to receive credit. Participants were assured that their responses would be confidential and told whom to contact if they had questions. (See Appendix A for complete instructions and questionnaire.)

The general instructions notified the respondents that they would be asked four sets of questions which applied to three distinct time periods in the counseling/therapy relationship, the beginning, the middle and the end, and their overall impression of therapy now. They were requested to answer a set of questions to the best of their ability regarding how they felt at each particular time during therapy regardless of how they felt about the overall experience. The subjects were asked to think of the therapy

relationship divided into three separate phases along a psychotherapy time continuum with a beginning, middle, and end. The beginning therapy period was described as the first few sessions and the middle as that time when therapy was clearly underway but not reaching a conclusion when the focus was on the issues raised at the beginning and were being dealt with. The end of therapy was described as the last few sessions when the subject was preparing to leave and tying up loose ends. The fourth set of questions concerned the subject's overall evaluation therapy after it was completed. The participants were further instructed to answer each of the questions by circling the number which best expressed their feelings about each statement, and that there were no right or wrong answers.

Questionnaire

The first three sections of the questionnaire contained items designed to measure the Rewards and Costs in the therapy relationship, Comparison level, Comparison Level of Alternatives, Investment, Commitment, and Satisfaction. Each of the first three sections of the survey applied to a distinct time period, one applicable to the beginning of therapy, the second set of questions to the middle, and the third set applicable to the end of therapy. At the beginning of each section, specific instructions prompted the respondents to think about that particular time period in their therapy and to remember how they were thinking and feeling at that time and to answer the questions accordingly. Twenty-one identical questions were asked in each of the

three sections. Each item was rated on a nine point Likert-type scale.

The benefits or Rewards derived from the therapy relationship were assessed by four specific questions regarding getting useful feedback about oneself, skill of the therapist, how well the therapist understood the problems, and how helpful the therapy was for personal problems. An overall question on how rewarding the therapy was is also included. Costs were assessed by four specific and one overall question. They included how difficult it was to talk about the problems, discomfort admitting problems, unattractive personal or professional qualities of the therapist, and discomfort in facing a problem or making changes. An overall item asked how much the therapy cost in terms of time, money, energy, effort and/or emotional distress.

Three specific items assessed the level of Commitment: felt committed to attending therapy, felt certain about continuing therapy, and considered changing the therapist. The measures of Satisfaction asked how much the therapist was liked, degree satisfied with therapy, and feelings as a result of being in therapy.

The Comparison Level was determined by how therapy compared to ideas of what should have been gotten out of therapy. The Comparison Level of the best Alternative was measured by asking how therapy compared with other methods of solving problems which could have been chosen, and how therapy compared with other ways problems have been solved before attending therapy. This scale was reverse scored so that high scores reflected the perception that alternatives

are better than therapy. Two investment questions inquired about how much effort or investment was put into therapy and how much would be lost if therapy ended.

The second and third sets of questions for the middle and end of therapy contained the identical 21 questions as the beginning. However, two additional responses for the end of therapy assessed reasons for termination. One item asked if therapy ended for external reasons, such as the therapist moved, financial reasons, insurance expiration, etc. The other item asked if therapy ended for internal reasons, accomplishing as much as wanted or felt that no progress was being made.

The Overall Evaluation of therapy, the fourth set of questions, contained seven items regarding the participant's thoughts and feelings about their experience after therapy ended to determine outcome. Degree of change as a result of therapy was assessed by rating levels of distress, positive changes, improved relationships, acquisition of information/skills, understood and accepted by therapist, and improved feelings about oneself. The degree of overall Satisfaction was also rated. The number of Sessions Missed out of the total number attended to assess Commitment was asked along with how long it has been since completion of therapy. Finally, the survey included a comments section.

Results

To determine the reliability of the index of each of the parameters for the three different time periods, the beginning, middle and end of therapy, reliability coefficients (Cronbach's alphas) were computed. The standardized alphas are reported in Table 1. The reliability coefficients ranged from .52 for Investment at the end to .95 for Reward at the end. Investment and Cost had relatively low reliability coefficients, thus results using these variables must be interpreted cautiously. Reliability analyses for the seven items of the Overall Evaluation indicated that the first question, assessing degree of Current Distress about symptoms, was relatively unrelated to the other six. Thus, the test of hypothesis three was performed on Overall Evaluation (alpha = .93) and Current Distress separately.

The first hypothesis stated that greater Satisfaction with therapy would be predicted by Reward and Comparison Level (CL) for each of the three time periods. Also, higher Commitment to therapy would be predicted by greater Investment and lower Comparison Level of Alternatives (CLalt). Stepwise multiple regression procedures were executed to determine the relation of the five variables, Reward, Cost, Comparison Level, Comparison Level of Alternative, and Investment to Satisfaction and Commitment at the three phases of therapy. The outcome is summarized in Table 2.

CLalt, Reward and Cost were significant predictors of Satisfaction at the beginning of therapy and together accounted for 62% of the variance in Satisfaction. Four

Table 1

Reliability Analysis of the Three Time Periods of Therapy

Scale	Beginning	Middle	End
Reward	.90	.91	.95
Cost	.65	.57	.65
Commitment	.73	.76	.70
Satisfaction	.85	.90	.91
CLalt	.94	.94	.94
Investment	.57	.75	.52

Note. Standardized alpha reported.

Table 2

Multiple Regression: Relation of Reward, Cost, Comparison Level, Comparison Level of Alternative, and Investment to Satisfaction and Commitment

Step	Variable	r	R	R^2	Beta+
		Beginning Satisfaction			
1	CLalt	-.68***	.68***	.47	-.42***
2	Reward	.66***	.76***	.58	.34***
3	Cost	-.46***	.79***	.62	-.22***
		Beginning Commitment			
1	CLalt	-.64***	.64***	.41	-.30***
2	Reward	.63***	.71***	.51	.29***
3	Cost	-.47***	.75***	.56	-.25***
4	Investment	.52***	.76***	.58	.18*
		Middle Satisfaction			
1	CLalt	-.80***	.80***	.64	-.39***
2	CL	.76***	.86***	.73	.27***
3	Cost	-.43***	.88***	.77	-.19***
4	Reward	.80***	.89***	.79	.24**

table continued

Multiple Regression: Relation of Reward, Cost, Comparison Level, Comparison Level of Alternative, and Investment to Satisfaction and Commitment

Step	Variable	r	R	R^2	Beta+
		Middle Commitment			
1	Investment	.74***	.74***	.55	.43***
2	CL	.71***	.80***	.65	.26**
3	Cost	-.36***	.82***	.67	-.16**
4	Reward	.70***	.83***	.69	.18*
		Ending Satisfaction			
1	Reward	.91***	.91***	.83	.50***
2	CL	.89***	.94***	.88	.37***
3	CLalt	-.81***	.94***	.89	-.13*
		Ending Commitment			
1	Reward	.79***	.79***	.62	.46***
2	Investment	.60***	.82***	.68	.29***
3	CL	.71***	.83***	.69	.21*

*** $p < .001$

** $p < .01$

* $p < .05$

+ Betas are from regression equations with all variables entered.

ingredients, CLalt, CL, Cost and Reward, had significant beta weights in relation to Satisfaction in the middle, accounting for 79% of the variance. For Satisfaction at the end of therapy, significant beta weights were obtained for Reward, CL and CLalt which accounted for 89% of the variance. Reward and CL made positive contributions to Satisfaction and Cost made a negative contribution as expected. An unexpected outcome was that CLalt predicted Satisfaction (lower CLalt predicted more Satisfaction) at all three phases of therapy.

Four variables contributed to Commitment in the beginning of therapy, CLalt, Reward, Cost and Investment, explaining 58% of the variance. The variables which predicted Commitment in the middle of therapy were Investment, CL, Cost and Reward. These accounted for 69% of the variance. For Commitment at the end of therapy, Reward, Investment and CL had significant beta weights and explained 69% of the variance. CLalt in the beginning phase was a negative predictor of Commitment and Investment was a positive predictor of Commitment at all phases as expected. Reward and CL (positively) and Cost (negatively) were also significant predictors of Commitment at some phases.

The correlations between Satisfaction and Commitment were high at all three psychotherapy phases: $r=.73$, $p < .001$ at the beginning, $r=.70$, $p < .001$ in the middle, and $r=.78$, $p < .001$ at the end. Thus, it is not surprising that the variables that predict Satisfaction and Commitment at each phase are similar. Investment, however, always predicted Commitment and never predicted Satisfaction which verifies Rusbult's view of the link between investments and commitment (Rusbult, 1980a, 1980b, 1983).

The second hypothesis was that at the beginning of psychotherapy Reward minus Cost (Beg R - C) would have a stronger relationship to Satisfaction and Commitment than Reward plus Cost (Beg R + C); whereas for Overall Evaluation and Commitment Total Reward plus Total Cost (Tot R + C) would be a better predictor than Total Reward minus Total Cost (Tot R - C). To validate this hypothesis, the effect of R + C and R - C was determined for Satisfaction and Commitment at the beginning of therapy as well as for the Overall Evaluation (EVAL) and percentage of Sessions Missed (SESS) (low scores indicated greater Commitment). Pearson correlation coefficients between Reward plus Cost at the beginning (Beg R + C) and Satisfaction at the beginning (BSAT) ($\underline{r}$=.26, $\underline{p} < .01$), and between Beg R - C and Satisfaction at the beginning ($\underline{r}$=.69, $\underline{p} < .001$) were computed. Reward plus Cost at the beginning (Beg R + C) was also correlated with beginning Commitment (BCOMM) ($\underline{r}$=.22, $\underline{p} < .05$), and Beg R - C was associated with BCOMM ($\underline{r}$=.67, $\underline{p} < .001$).

The difference between the correlation of Beg R + C with BSAT and Beg R - C with BSAT was statistically significant ($\underline{z}$=4.44, $\underline{p} < .001$); and the difference between the correlation of Beg R + C with BCOMM and Beg R - C with BCOMM was also significant ($\underline{z}$=4.42, $\underline{p} < .001$). This result confirms the premise that Reward minus Cost would be a better predictor of Satisfaction and Commitment at the beginning of therapy than Reward plus Cost.

To test the relationship of Reward and Cost to Overall Evaluation (EVAL) and Sessions Missed (SESS), Reward plus Cost (ΣR + ΣC = Tot R + C) and Reward minus Cost (ΣR - ΣC = Tot R - C) were summed across the three phases of therapy. It was posited that Tot R + C would be a better predictor

than Tot R - C of Overall Evaluation and Sessions Missed. The Pearson correlation coefficient for Tot R + C and EVAL was r=.51, p <.001, and the correlation coefficient for Tot R - C and EVAL was r=.67, p <.001. The correlation between Tot R + C and SESS was r=.-.15, p <.06, and the correlation between Tot R - C and SESS was r=-.001, n.s. For Overall Evaluation, Tot R - C was found to be a better estimate than Tot R + C, contrary to hypothesis two. But the difference between these correlation coefficients was not statistically significant (z=1.90, p <.06). For percentage of Sessions Missed, Tot R + C was a better predictor than Tot R - C, however, the difference between these correlation coefficients was also not significant (z=1.13, p <.06). Neither the Tot R + C nor the Tot R - C was a strong predictor of percentage of Sessions Missed, but Tot R + C was better than Tot R - C as expected.

Hypothesis three stated that Satisfaction and Investment at the three periods would predict Overall Evaluation. Satisfaction at the end of therapy would have the highest correspondence with Overall Evaluation, however, Satisfaction and Investment at the beginning were also expected to make significant contributions to Overall Evaluation. Stepwise multiple regressions were computed to determine the relation of Satisfaction and Investment at the beginning, middle, and the end of therapy to Current Distress and Overall Evaluation (see Table 3).

Three elements, Satisfaction at the end, Investment at the end, and Satisfaction in the beginning had significant beta weights in relation to Current Distress accounting for 16% of the variance.

Table 3

Multiple Regression: Relation of Beginning Satisfaction (BSAT), Beginning Investment (BINV), Middle Satisfaction (MSAT), Middle Investment (MINV), Ending Satisfaction (ESAT) and Ending Investment to Current Distress and Overall Evaluation (EVAL)

Step	Variable	r	R	R^2	Beta +
		Current Distress			
1	ESAT	-.29**	.29**	.08	-.40***
2	EINV	.05	.36**	.13	.21*
3	BSAT	.17*	.40***	.16	.18*
		Overall Evaluation			
1	ESAT	.80***	.80***	.65	.66***
2	MINV	.64***	.84***	.70	.25***
3	BSAT	.23**	.84***	.71	.11*

*** $p < .001$

** $p < .01$

* $p < .05$

+ Betas are from regression equations with all variables entered.

The findings demonstrated that Satisfaction at the end of therapy was significantly associated with lower levels of distress with current issues. However, Investment at the end and Satisfaction at the beginning of therapy were directly related to feelings of Current Distress so that the more Investment at the end and the more Satisfaction at the beginning, the more Current Distress was reported about the problems which originally led the respondents to therapy.

Overall EVAL after therapy was completed was predicted by Satisfaction at the end, Investment in the middle, and Satisfaction in the beginning with 71% of the variance explained by these three ingredients.

Satisfaction at the end and Investment in the middle and particularly Satisfaction at the beginning substantiates the premise that even when Satisfaction and Investment at the middle and end of therapy are taken into account, Satisfaction at the beginning still makes a significant contribution to Overall EVAL of therapy.

Discussion

The findings of this study provide some support for the application of social exchange theory and the investment model to the therapy relationship. The survey is subject to the limitations of self-report measures in general and has been conducted after-the-fact, i.e., after therapy has ended. Although the age ranges were 18 to 52 years old, younger college-aged students were the predominant respondents. Hence, applying the results to other populations should proceed with caution.

The first hypothesis predicted that more Satisfaction with therapy would be predicted by greater Reward and Comparison Level for each of the three time periods. Higher Commitment would be predicted by greater Investment and lower Comparison Level of Alternatives. As expected, higher Rewards were associated with greater Satisfaction at all three phases of psychotherapy. Costs made a significant negative contribution to Satisfaction at the beginning and middle phases, and CL made a significant positive contribution at the middle and end of therapy.

Cost was a negative predictor of Satisfaction in the beginning and middle stages of psychotherapy supporting social exchange theory and the investment model. Nevertheless, at the end of therapy, Cost did not contribute to variance in Satisfaction. Conceivably, Cost did not play a role at the end of the relationship because near the end of therapy the client usually knows that therapy will be ending or winding down and the necessary issues have usually been dealt with. Hence, Cost may not be an important issue in the end. Cost at the beginning and middle of therapy could have

a greater impact since admitting and dealing with problems could have produced more stress or anxiety than at the end. Also, over the duration or by the end of therapy, a person may have become more accustomed to the extrinsic costs such as time, money, or effort.

The fact that Satisfaction was not associated with higher CL in the beginning but was in the middle and end of therapy partially supported hypothesis one. At the beginning of therapy a Comparison Level may be more difficult for an individual to establish than for other types of relationships if they have not experienced therapy before since CL is based on past experience (Derlega et al., in press; Winstead et al., 1988). As therapy progressed, however, the individual may have been able to establish a more realistic Comparison Level for evaluating the therapy relationship.

An unanticipated outcome was that CLalt contributed to Satisfaction at all three phases. The respondents were asked how therapy compared with other methods of solving problems which could have been chosen from, and how therapy compared with other ways of solving problems used before attending therapy. Those that expressed more Satisfaction with therapy reported that therapy was better than alternative methods of solving their problems. Potentially, in replying to these questions, the participants are indicating how relieved they feel at finding a way of dealing with their problems and that therapy is actually preferable to other means they have tried. This may indicate that in some manner the individuals in this study are referring to the specific value of therapy and that this value is more related to Satisfaction than to Commitment. Individuals who say therapy is much better in

this survey may be experiencing immense relief about having found a way of solving their problems since those who said therapy was preferable to their alternatives were also more Satisfied.

Hypothesis one also predicted that Reward, Cost, Comparison Level, Comparison Level of Alternative, and Investment would make significant contributions to variance in Commitment. Commitment was significantly associated with higher Investment and higher Reward in all stages, lower Cost in the beginning and middle of therapy, and higher Comparison Level in the middle and end. Findings were generally in line with theory. The effect of the three variables, Reward, Cost and CL, had the precise pattern for Commitment as they did for Satisfaction at each phase of therapy. This finding could be due to the fact that Satisfaction and Commitment share a large portion of the variance and are highly correlated with each other at the beginning, middle and end of therapy ($\underline{r}$=.70, .73 and .78, $\underline{p} < .001$, respectively). Examination of other types of relationships has shown weaker although still significant correlations between Satisfaction and Commitment: in romantic associations, $\underline{r}$=.24, $\underline{p} < .001$ (Rusbult, 1980a); $\underline{r}$=.64, $\underline{p} < .01$ (Rusbult, 1986); and in friendships, $\underline{r}$=.43, $\underline{p} < .05$ (Rusbult, 1980b). Consequently, there could have been more overlap between these two components for therapy than for other categories of relationships.

Therapy is a completely voluntary relationship on the part of the client because the relationship ceases to exist unless the client attends. On the other hand, in a friendship or romantic relationship if one partner does not

call or visit for awhile, the other person may take the initiative. Continuing the relationship is not completely dependent on one partner and his or her level of Satisfaction. In psychotherapy, where it is generally the client who is deciding whether or not to continue the relationship, Satisfaction and Commitment are highly related.

Greater Commitment was consistently predicted by higher levels of Investment at all phases in line with the first hypothesis. The fact that Investment always made a significant contribution to Commitment and never to Satisfaction suggested that Investments are indeed components of Commitment and not Satisfaction, supporting the investment model.

Although more Commitment occurred under conditions of elevated Investment, Comparison Level of Alternatives did not predict Commitment in the middle and end of therapy. According to the model, greater Commitment should occur when alternatives are poorer than the current relationship. Perhaps the participants in the survey did not conceptualize a variety of ways of solving their problems. They may have perceived therapy as the only avenue of resolving problems and if that did not work no other options were considered. Consequently, they may perceive the nature of therapy as a relationship for solving problems, whereas they do not view other relationships as having this attribute. However, therapy doesn't compete with other relationships in the same manner that other associations do, for instance making choices among different friendships. Therapy stands apart from other relationships in that the person usually stays until they receive assistance for their problems or feel they

have achieved their goals. If people do see therapy as a special activity, then it follows that it would not involve choosing between therapy versus other relationships as a means of solving problems. Further, other relationships with family, friends, etc., are not perceived as having problem-solving as one of the goals and are not entered into for that purpose.

Other viable interpretations for the unforeseen result that CLalt did not predict Commitment in the middle and end of therapy are that the participants had invested so heavily in the relationship that even though they perceived better alternatives, they felt they would lose these investments if they left therapy and therefore remained committed to it (Rusbult, 1980b).

The second hypothesis predicted that Reward minus Cost at the beginning (Beg R - C) would have a greater relation to Satisfaction and Commitment than Reward plus Cost (Beg R + C). However, for Overall Evaluation and Commitment, Total Reward plus Total Cost (Tot R + C) would be superior to Total Reward minus Total Cost (Tot R - C). Reward minus Cost rather than Reward plus Cost was demonstrated to be significantly linked to Satisfaction in the beginning of therapy validating social exchange theory. Contrary to the hypothesis, Total R - C was still a better predictor than Total R + C for Overall Evaluation. However, the difference between the correlations in the beginning was significant, but was not significant for Overall Evaluation of Satisfaction. As the relationship develops and continues accumulated Costs become Investments thus contributing to Overall Satisfaction (Rusbult, 1983). The value for the

R + C correlation increased from the beginning (r=.26, p <.01, Beg R + C) to the final Overall Evaluation of Satisfaction (r=.51, p <.001, Tot R + C), supporting the notion that Costs become Investments over time.

The second hypothesis also suggested that beginning R - C would bear a greater relationship to Commitment than beginning Reward plus Cost, but that Total R + C would be better than Total R - C in determining Overall Commitment (as measured by percentage of Sessions Missed). Support was found for this premise in that beginning (Beg) R - C was shown to be a better predictor of beginning Commitment than Beg R + C. Total R + C was a better indicator than Total R - C of percentage of Sessions Missed. Neither correlation, however, was statistically significant.

The analyses exhibited that total Reward alone was actually a superior predictor of Overall Satisfaction (EVAL) than any of the combinations of variables. Prior examination by some researchers has demonstrated that the absolute level of Reward predicted relationship success better than any other variable or combination of factors (Clark & Reis, 1988). For example, only magnitude of Rewards determined dating relationship stability rather than equity or equality (Cate, Lloyd, & Henton, cited in Clark & Reis, 1988). Others also found that Reward level was a superior determinant of satisfaction and stability (Berg, 1984; Berg & McQuinn, 1986). Hays (1985) found as well that total benefits received predicted the development of friendship. Although Cost is significantly negatively related to Satisfaction, it is not apparently used by clients in calculating Overall Satisfaction with the therapy relationship. Reward is the variable that predicts Satisfaction.

The third hypothesis predicted that Satisfaction and Investment at the three periods would predict Overall Evaluation. Satisfaction at the end of therapy was anticipated to have the greatest relationship to Overall Evaluation, although Satisfaction and Investment at the beginning were expected to make substantial contributions to Overall Evaluation. As proposed, Satisfaction at the beginning made a significant contribution to Overall Evaluation of Satisfaction even after Satisfaction at the end and middle of therapy and Investment at other phases were taken into account. This outcome supports the work of Berg (1984), Berg & McQuinn (1986), and Hayes (1985) which indicates that the decision to continue or discontinue a relationship is made early in its development. The results suggest that even at the beginning of psychotherapy an individual makes an evaluation of therapy that influences their final overall evaluation of the experience.

Whereas it was presumed that Satisfaction and Investment at all three periods might contribute to Overall Evaluation, other positive contributors were Satisfaction at the end and Investment in the middle. The middle phase was defined as that time when therapy was clearly underway but preparations were not yet being made for it to be over. The focus of therapy was on the issues raised at the beginning and on attempts to deal with them. Apparently, Investment during this phase contributes more to the client's final evaluation of therapy than Investment at other phases of therapy. Moreover, at the end the client could be disinvesting or pulling away from the relationship because they know it will soon be over (Rusbult, 1983).

An interesting finding was that the response to the item asking how much Current Distress was felt now about the problems that originally led (you) to therapy was not highly related to the Overall Evaluation of therapy (r=.20, p <.05). As expected, Current Distress was negatively related to Satisfaction at the end. But, Current Distress had a positive association with Investment at the end and Satisfaction at the beginning. It is likely that Current Distress is related in some degree to distress when the client first entered therapy, a variable which was not assessed in this survey. Some research has demonstrated that people who reported more Satisfaction with therapy were not necessarily those who had fewer problems or symptoms after completion (Rudy et al., 1985).

Furthermore, Satisfaction at the beginning of therapy may represent need for therapy or the hope for improvement. It is reasonable to surmise that the more the person had to gain from therapy, the more Satisfaction was expressed at the beginning of therapy. Another prospect is that even though the client felt satisfied in the beginning, they may not have perceived themselves as getting better. Hence, Satisfaction at the end was lower leading them to quit therapy before improving. The positive beta for Investment at the end in combination with the negative beta for Satisfaction at the end also implies that the individual might not have been getting enough out of therapy even though their Investment was high which prompted them to leave.

The degree of anguish clients feel about their problems is to some extent related to their motivation for therapy particularly at the beginning, and may be related to how

satisfied they feel with therapy at that time. Distress could also be associated with Investment such that even at the end of therapy they feel more invested than other people. It would have been interesting to inquire about levels of distress before entering therapy and at the other phases.

In summary, findings for the first hypothesis established that Satisfaction and Commitment were significantly predicted by greater Reward, lower Cost, and higher Comparison Level. Investment was invariably positively related to Commitment and never to Satisfaction, whereas Comparison Level of Alternatives was associated with Satisfaction and not with Commitment.

Results from the second hypothesis confirmed that Reward minus Cost was superior to Reward plus Cost as a significant determinant of Satisfaction and Commitment at the beginning of therapy. Total R - C was also a better indicator of Overall Evaluation of therapy than Total R + C, although the correlation for Total R + C and Evaluation was much greater than the Beginning R + C correlation with Beginning Satisfaction. However, magnitude of Reward alone was a better predictor of Overall Evaluation of Satisfaction than any combination of elements. Commitment to therapy was more highly correlated with Total R + C rather than Total R - C, though neither correlation was significant.

Assessment of the third hypothesis verified that Satisfaction at the beginning of therapy was significantly associated with Overall Evaluation of therapy. Significant contributors to Overall Evaluation of therapy were Investment in the middle and Satisfaction in the beginning, with Satisfaction at the end having the most substantial effect.

Satisfaction at the end was related to lower reports of Current Distress with problems which originally led to therapy. However, Current Distress was positively related to Investment at the end and Satisfaction in the beginning.

The general purpose of the study was the application of the investment model and social exchange theory to the therapy relationship. Future research might address similar questions using a longitudinal design. In a longitudinal study, responses would not be retrospective or influenced by the way people reconstruct memories of events. The results of the investigation showed that symptom change and relationship satisfaction are not necessary related. Subsequent endeavors could explore what factors predict symptom change rather than relationship satisfaction. It was clear from the comments of this sample that there were some who did not perceive themselves as going to therapy voluntarily or who were not interested in doing the kind of work in therapy necessary for promoting positive change. Such client variables as type of initial problem, severity of problem, attitudes regarding therapy, participation, motivation, etc., could be evaluated. These ingredients would merit assessment as contributors to Satisfaction and Commitment as well as to perceptions of Reward, Cost, Investment, and other relationship parameters.

The study showed that using theories or models designed to explain personal relationships is useful in understanding the therapy relationship. This investigation also revealed ways in which the therapy relationship is similar to personal relationships (e.g., relation between Reward, Cost, Comparison Level and Satisfaction; the high correlation

between Commitment and Investment; the relation between Reward, Cost, CL and Commitment); and ways in which the therapy relationship is different (e.g., the high correlation between Commitment and Satisfaction; the relation between CLalt and Satisfaction). Consequently, it was demonstrated that social exchange and investment model concepts which had been previously applied to personal associations are valuable in examining the patient-therapist experience.

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Counseling/Psychotherapy Student Survey

We are investigating people's experiences with individual counseling or psychotherapy. In order to answer the questionnaire you must have been in individual counseling or therapy that is now over. If you have never been in individual counseling or psychotherapy or if you are currently in counseling or therapy and have not yet completed it, please do not fill out this questionnaire. Return it to the Peer Advisor, Room #130C. If you have been in counseling or therapy for which there was a beginning, middle and end, please read the instructions on the following pages, fill out the entire questionnaire and return it (including this cover page) to the Peer Advisor in the Psychology Department, Room #130C. If you have been in therapy or counseling more than once, give answers that apply only to your most recent therapy experience.

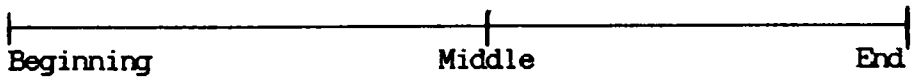
It takes about 30 minutes to fill out the enclosed questionnaire. If you have any questions about the survey, please contact Dr. Barbara Winstead, Psychology Department (Mills Godwin Bldg., x3-4212) or Brenda Counts at 1-898-4733.

Your responses are completely confidential. We do not want your name on the questionnaire, though we are asking you to provide information about your gender and age. Your responses will be combined with the data of many other persons. After your responses have been tabulated on the computer, the original questionnaire that you filled out will be destroyed.

IN ORDER TO RECEIVE CREDIT FOR PARTICIPATING, PLEASE RETURN THE COMPLETED QUESTIONNAIRE WITHIN ONE WEEK. We appreciate your cooperation in helping us to conduct this study.

General Instructions:

You will be asked four sets of questions. The first three sets of questions apply to three distinct time periods in the counseling/therapy relationship: the beginning, the middle and the end. Answer these three sets of questions to the best of your ability regarding how you felt at each particular time during counseling/therapy regardless of how you felt about the overall experience. Think of the therapeutic relationship divided into three separate phases, that is, along a time continuum with a beginning, middle and end. The psychotherapy time continuum would look like this:



For instance, you may have felt very differently at the middle of counseling/therapy than you did at the beginning or at the end. Your positive or negative feelings could have changed in each of these three distinct time periods.

The fourth and last set of questions applies to your perceptions and feelings about the overall counseling/therapy experience. Answer this set of questions considering how you felt after your therapy was completed. Again, your feelings may be very different from what you experienced at the beginning, middle or end.

The term "therapy" will be used but it applies to "counseling" and "psychotherapy" throughout the questionnaire. The term "therapist" will also apply to "counselor." Please answer each of the following questions by circling the number which best expresses your feelings about the statements. There are no right or wrong answers.

Before you started going to the therapist, how much did you expect therapy would help you?

1	2	3	4	5	6	7	8	9
not at all								extremely

Questions for Beginning of Therapy

The following questions apply to your thoughts and feelings at the beginning of therapy. Think about the first few sessions of your therapy, then answer these questions remembering how you were feeling and thinking about therapy during those first few sessions.

Please do not skip any items or questions.

1. To what extent were you able to get useful feedback about yourself in going to therapy in the beginning?

   1 2 3 4 5 6 7 8 9

   not at all extremely

2. How skilled did you feel the therapist was in the beginning?

   1 2 3 4 5 6 7 8 9

   not at all extremely

3. How well did you feel the therapist understood your problems in the beginning?

   1 2 3 4 5 6 7 8 9

   not at all extremely

4. How helpful was the therapy for your personal problems in the beginning?

   1 2 3 4 5 6 7 8 9

   not at all extremely

5. How rewarding was your therapy in the beginning?

   1 2 3 4 5 6 7 8 9

   not at all extremely

6. How difficult was it to talk about your problems in therapy in the beginning?

   1 2 3 4 5 6 7 8 9

   not at all extremely

7. How uncomfortable did it feel to admit to yourself that you had problems that you could not deal with alone and needed help with in the beginning?

   1 2 3 4 5 6 7 8 9

   extremely comfortable extremely uncomfortable

8. To what extent did the therapist have unattractive personal or professional qualities in the beginning?

   1 2 3 4 5 6 7 8 9

   not at all extremely

9. To what extent were you forced to face a problem or make changes that made you uncomfortable in the beginning?

1	2	3	4	5	6	7	8	9
not at all								extremely

10. Give an estimate of how much the therapy cost you (for example, in terms of time, money, energy, effort, and/or emotional distress, etc.) in the beginning.

1	2	3	4	5	6	7	8	9
extremely high								extremely low

11. To what extent did you feel committed to attending the therapy in the beginning?

1	2	3	4	5	6	7	8	9
not at all								extremely

12. To what extent did you feel that you wanted to continue the relationship with the therapist in the beginning?

1	2	3	4	5	6	7	8	9
not at all								extremely

13. Did you consider changing your therapist in the beginning?

1	2	3	4	5	6	7	8	9
not at all							extremely often	

14. How much did you like the therapist in the beginning?

1	2	3	4	5	6	7	8	9
not at all								extremely

15. To what degree were you satisfied with the therapy in the beginning?

1	2	3	4	5	6	7	8	9
not at all								extremely

16. How did you feel as a result of being in therapy in the beginning?

1	2	3	4	5	6	7	8	9
much worse off							much better off	

17. How did therapy compare to your idea of what you think you should have gotten out of therapy in the beginning?

1	2	3	4	5	6	7	8	9
much worse								much better

18. How did therapy compare with other methods or ways of solving your problems which you could have chosen from, such as talking to a friend, relative, or working it out for yourself in the beginning?

1	2	3	4	5	6	7	8	9
much worse								much better

19. How did therapy compare with other ways you have solved your problems before you ever attended therapy in the beginning?

1	2	3	4	5	6	7	8	9
much worse								much better

20. How much effort or investment did you put into therapy in the beginning?

1	2	3	4	5	6	7	8	9
not much at all								extremely high amount

21. How much would you have lost if the therapy relationship ended in the beginning?

1	2	3	4	5	6	7	8	9
lost nothing								lost a great deal

Questions for Middle of Therapy

The following questions apply to your thoughts and feelings at the middle of therapy. Think about that time when therapy was clearly underway but you were not yet preparing for it to be over. This was the period when the focus of therapy was on the issues raised at the beginning and you were trying to deal with them.

Please do not skip any items or questions.

1. To what extent were you able to get useful feedback about yourself in going to therapy in the middle?

   1 2 3 4 5 6 7 8 9

   not at all extremely

2. How skilled did you feel the therapist was in the middle?

   1 2 3 4 5 6 7 8 9

   not at all extremely

3. How well did you feel the therapist understood your problems in the middle?

   1 2 3 4 5 6 7 8 9

   not at all extremely

4. How helpful was the therapy for your personal problems in the middle?

   1 2 3 4 5 6 7 8 9

   not at all extremely

5. How rewarding was your therapy in the middle?

   1 2 3 4 5 6 7 8 9

   not at all extremely

6. How difficult was it to talk about your problems in therapy in the middle?

   1 2 3 4 5 6 7 8 9

   not at all extremely

7. How uncomfortable did it feel to admit to yourself that you had problems that you could not deal with alone and needed help with in the middle?

   1 2 3 4 5 6 7 8 9

   extremely comfortable extremely uncomfortable

8. To what extent did the therapist have unattractive personal or professional qualities in the middle?

   1 2 3 4 5 6 7 8 9

   not at all extremely

9. To what extent were you forced to face a problem or make changes that made you uncomfortable in the middle?

1 2 3 4 5 6 7 8 9

not at all extremely

10. Give an estimate of how much the therapy cost you (for example, in terms of time, money, energy, effort, and/or emotional distress, etc.) in the middle.

1 2 3 4 5 6 7 8 9

extremely high extremely low

11. To what extent did you feel committed to attending the therapy in the middle?

1 2 3 4 5 6 7 8 9

not at all extremely

12. To what extent did you feel that you wanted to continue the relationship with the therapist in the middle?

1 2 3 4 5 6 7 8 9

not at all extremely

13. Did you consider changing your therapist in the middle?

1 2 3 4 5 6 7 8 9

not at all extremely often

14. How much did you like the therapist in the middle?

1 2 3 4 5 6 7 8 9

not at all extremely

15. To what degree were you satisfied with the therapy in the middle?

1 2 3 4 5 6 7 8 9

not at all extremely

16. How did you feel as a result of being in therapy in the middle?

1 2 3 4 5 6 7 8 9

much worse off much better off

17. How did the therapy compare to your idea of what you think you should have gotten out of therapy in the middle?

1 2 3 4 5 6 7 8 9

much worse much better

18. How did therapy compare with other methods or ways of solving your problems which you could have chosen from, such as talking to a friend, relative, or working it out for yourself in the middle?

1	2	3	4	5	6	7	8	9
much worse								much better

19. How did therapy compare with other ways you have solved your problems before you ever attended therapy in the middle?

1	2	3	4	5	6	7	8	9
much worse								much better

20. How much effort or investment did you put into therapy in the middle?

1	2	3	4	5	6	7	8	9
not much at all							extremely high amount	

21. How much would you have lost if the therapy relationship ended in the middle?

1	2	3	4	5	6	7	8	9
lost nothing							lost a great deal	

Questions for End of Therapy

The following questions apply to your thoughts and feelings at the end of therapy. Think about that time in therapy when you were preparing to leave. This would have been the last few sessions when you and your therapist were tying up loose ends. If therapy ended abruptly, these questions may apply only to the last session and the days before it.

Please do not skip any items or questions.

1. To what extent were you able to get useful feedback about yourself in going to therapy in the end?

   1 2 3 4 5 6 7 8 9

   not at all extremely

2. How skilled did you feel the therapist was in the end?

   1 2 3 4 5 6 7 8 9

   not at all extremely

3. How well did you feel the therapist understood your problems in the end?

   1 2 3 4 5 6 7 8 9

   not at all extremely

4. How helpful was the therapy for your personal problems in the end?

   1 2 3 4 5 6 7 8 9

   not at all extremely

5. How rewarding was your therapy in the end?

   1 2 3 4 5 6 7 8 9

   not at all extremely

6. How difficult was it to talk about your problems in therapy in the end?

   1 2 3 4 5 6 7 8 9

   not at all extremely

7. How uncomfortable did it feel to admit to yourself that you had problems that you could not deal with alone and needed help with in the end?

   1 2 3 4 5 6 7 8 9

   extremely comfortable extremely uncomfortable

8. To what extent did the therapist have unattractive personal or professional qualities in the end?

1 2 3 4 5 6 7 8 9

not at all extremely

9. To what extent were you forced to face a problem or make changes that made you uncomfortable in the end?

1 2 3 4 5 6 7 8 9

not at all extremely

10. Give an estimate of how much the therapy cost you (for example, in terms of time, money, energy, effort, and/or emotional distress, etc.) in the end.

1 2 3 4 5 6 7 8 9

extremely high extremely low

11. To what extent did you feel committed to attending the therapy in the end?

1 2 3 4 5 6 7 8 9

not at all extremely

12. To what extent did you feel that you wanted to continue the relationship with the therapist in the end?

1 2 3 4 5 6 7 8 9

not at all extremely

13. Did you consider changing your therapist in the end?

1 2 3 4 5 6 7 8 9

not at all extremely often

14. How much did you like the therapist in the end?

1 2 3 4 5 6 7 8 9

not at all extremely

15. To what degree were you satisfied with the therapy in the end?

1 2 3 4 5 6 7 8 9

not at all extremely

16. How did you feel as a result of being in therapy in the end?

1 2 3 4 5 6 7 8 9

much worse off much better off

17. How did the therapy compare to your idea of what you think you should have gotten out of therapy in the end?

1 2 3 4 5 6 7 8 9

much worse much better

18. How did therapy compare with other methods or ways of solving your problems which you could have chosen from, such as talking to a friend, relative, or working it out for yourself in the end?

1 2 3 4 5 6 7 8 9

much worse much better

19. How did therapy compare with other ways you have solved your problems before you ever attended therapy in the end?

1 2 3 4 5 6 7 8 9

much worse much better

20. How much effort or investment did you put into therapy in the end?

1 2 3 4 5 6 7 8 9

not much at all extremely high amount

21. How much did you lose when the therapy relationship ended?

1 2 3 4 5 6 7 8 9

lost nothing lost a great deal

22. Did therapy end for external reasons (such as the therapist moved, financial reasons, insurance expiration, etc.)?

1 2 3 4 5 6 7 8 9

not at all external purely external reasons (I would definitely have continued in therapy but could not because of external reasons.)

23. Did therapy end for internal reasons (you had accomplished as much as you wanted to or felt that you were not making progress and were not going to make progress).

1 2 3 4 5 6 7 8 9

not at all internal purely internal reasons (I felt it was time to end therapy.)

Overall Evaluation of Therapy

The following questions apply to your thoughts and feelings about your overall therapy experience. Think about the entire time period that you were in therapy and how you felt after it was all over.

Please do not skip any items or questions.

1. How distressed do you feel now about your problems or the issues that originally led you to go to therapy?

   1 2 3 4 5 6 7 8 9

   not at all extremely

2. To what degree do you think you have made positive changes in your life as a result of therapy?

   1 2 3 4 5 6 7 8 9

   not at all extremely

3. To what extent do you feel that going to therapy has improved your relationship with other people?

   1 2 3 4 5 6 7 8 9

   not at all extremely

4. To what extent did you get information or acquire skills that helped you solve the problems you sought therapy for?

   1 2 3 4 5 6 7 8 9

   not at all extremely

5. Do you feel that you were understood and accepted by your therapist?

   1 2 3 4 5 6 7 8 9

   not at all extremely

6. To what extent do you feel that going to therapy has improved how you feel about yourself?

   1 2 3 4 5 6 7 8 9

   not at all extremely

7. To what degree were you satisfied with therapy overall?

   1 2 3 4 5 6 7 8 9

   not at all extremely

8. Please estimate how many sessions you missed or cancelled:

   I missed approximately _____ sessions out of a total of _____ sessions.

9. How long has it been since you completed therapy? _____

10. Your Sex: _____ Your Age: _____

Comments

I feel improved in the following ways as a result of counseling/therapy:

I feel worse in the following ways as a result of counseling/therapy:

Please write here any comments about the survey or your counseling/therapy experience that might be helpful for us to know about.