

# Comment

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## The Consumer Reports Mental Health Survey

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### What We Set Out to Do

Microwave ovens, mutual funds, and mental health care providers? At first blush, the latter subject might not be considered the bailiwick of *Consumer Reports* (CR). When we first discussed the possibility of conducting an ambitious survey about mental health care among CR readers, we took a moment's pause, but we found the subject a good fit. The service sector has long been an important area for CR. Using naturalistic survey studies with appropriate statistical controls, we have covered auto and homeowners' insurance, airlines, hotels, rental cars, restaurants, department stores, mail-order catalogs, HMOs, doctors, lawyers, and other services.

For mental health care, as for these other consumer services, our goal was to use CR's objectivity and independence to measure real-life consumer experiences. We challenged the social scientists on staff to ask CR readers about their emotional problems, what they did to find help, and how satisfied they were with the help they found. Our professional researchers were aware of opportunities and difficulties of naturalistic self-report methodology, as discussed below. In the end, we met our primary objective. We believe the aggregate experience of several thousand people seek-

ing help will in turn empower many thousands of prospective mental health care consumers and family members. We hope we have advanced the science of research in this important field as well.

### The Method

Each spring CR asks its subscribers about a number of different consumer topics. To this end, many different versions of the 1994 Annual Questionnaire were sent to our four million plus subscribers. One version contained our customary inquiry about auto repairs as well as a four-page survey entitled "Health Care: Stress and Other Emotional Problems." Of the 184,000 randomly selected CR subscribers to whom the survey was mailed, 22,000 responded, a 13% response rate. To detect nonresponse bias, and as part of our validation process, we mailed a special survey to another smaller randomly selected sample. This validation survey has historically generated a response rate of more than 50%. Because of the sensitivity of the subject, only one wave for the mental health version was mailed, achieving a response rate of 38%. From this and past research, we believe the survey findings are reasonably representative of CR subscribers.

Respondents were asked to complete the mental health section of the survey if they had sought help for emotional problems since 1991. Of the 6,900 who completed that section, 2,800 went exclusively to friends, family, or clergy. The remaining 4,100 respondents could, and often did, seek more than one source of help: mental health professionals (2,900), family doctors (1,100), and self-help or support groups (1,300).

### What We Found

#### Mental Health Professionals

Forty-three percent of the respondents reported feeling either "very poorly" or "poorly" when they began treatment, and 44% said they were feeling "so-so" (CR, 1995). There was a checklist of 13 differ-

ent conditions, and respondents could check all that applied ( $Mdn = 2$ ). The most frequently cited problem was depression, followed by marital or sexual problems, general anxiety, frequent low moods, problems with children or other family members, and job problems.

We created an overall outcome scale from three different measures: specific improvement for the problems that led the respondents to seek help, satisfaction with treatment, and global improvement (how their state of mind at the time of the survey compared with their state of mind when they first sought help). Because initial severity was related to outcome, appropriate statistical controls for this variable as well as for type of condition were made when different modalities of treatment and type of practitioner were compared (Seligman, December 1995).

Respondents were asked to report on their experiences with the mental health professional (psychiatrist, psychologist, family counselor, social worker, or other counselor or therapist) who treated them most during this time. Most (62%) were highly ("very" or "completely") satisfied with their treatment, 27% were "fairly well satisfied," and 11% reported some level of dissatisfaction. When respondents were asked about the effect of therapy on the problems that led them to treatment, the vast majority reported that it helped "a lot" (42%) or "somewhat" (44%). Almost all of the other respondents checked "no change" or "unsure," with 1% reporting that therapy made things worse.

Treatment usually helped. Most respondents reported improvement, and positive evaluations cut across all modalities of treatment and types of mental health professional. Whereas short-term (less than six months) treatment demonstrated positive effects, long-term (more than six months) psychotherapy was associated with greater improvement, even after statistical controls were applied for type of emotional problem and initial level of severity. Although these results are intriguing and suggestive, we believe our research is not the definitive study.

Among the 1,600 respondents who took medications for emotional problems, 44% experienced side effects. Nevertheless, these medications usually proved effective: 59% of the respondents said the medication helped a lot, and 27% said the medication helped a little. Among those who went to therapists, there was no significant difference in outcome between talk therapy alone and talk therapy plus medication. Although this finding held true across type of problem, initial level of severity, and duration of treatment, we do not infer from our data that medication for emotional problems is either unwarranted or superfluous.

Among mental health professionals, there were no significant differences by type of therapist, with the exception of marriage counselors, whose ratings were somewhat lower than were those for the other practitioners. This finding held true even after applying statistical controls for initial severity and type of emotional problem. We stated in the *CR* (1995) article that this finding may be due to the lack of regulation over credentials for family counselors in some states.

Outcomes were lower when the respondents reported that health insurance limited their choice of therapist, the number of sessions, or both, but we found no difference between those enrolled in managed care or fee-for-service plans.

#### **Family Doctors and Self-Help Groups**

The comparison between therapists and family physicians excluded respondents who had been to both. The vast majority (85%) of doctors' patients were taking medication for their emotional problems, as compared with only 20% of therapists' patients. For short-term care, no difference was found between family physicians and mental health professionals, although most respondents who went only to family physicians had less severe symptoms than did those who went to therapists. In fact, the more troubled patients of family doctors usually self-referred to therapists (and were thereby excluded from the aforementioned comparison). Those who had long-term psychotherapy fared considerably better than those who went only to physicians. Treatment length had no significant impact on improvement for the patients of family doctors.

Most respondents in self-help groups had also seen a mental health professional, which confounded comparisons between the two modalities. Although the sampling framework positively skewed the sample in Alcoholics Anonymous toward long-

term membership (successful members don't "graduate"), it was associated with high ratings and widespread loyalty.

#### **Methodological Strengths and Weaknesses**

Most psychological outcome studies use an experimental design. Our survey, being more naturalistic, lacked the controls of this methodology. As a result, we were careful about direct causal statements and emphasized throughout our article (*CR*, 1995) that the survey respondents believed that it "helped."

First, we present the limitations. There was no control group. The findings are based on self-assessment rather than clinical observation. The data are historical, and assessments were usually made after conclusion of treatment. The findings reflect the experiences of *CR* subscribers, who are more educated and have a higher household income than the general U.S. population. These limitations were explicitly stated in the *CR* (1995) article. We do not challenge the experimental approach; in fact, it is a cornerstone of much of *CR*'s product testing. However, we believe an axiom of social science that no one methodology can tell the entire story: Both experimental and survey methodologies have advantages as well as limitations.

Our take on the methodological issues is as follows:

##### **External Validity**

Our method captured what therapy patients report about their real-life experiences, where clients have multiple problems, where duration and type of treatment are tailored to the needs of the clients, and where clients can actively participate in treatment decisions.

##### **Sampling**

Although our sample was based on a well-educated population, so are many other outpatient therapy clients. There may be a psychographic difference between *CR* subscribers and other well-educated people, however. *CR* subscribers may be good problem solvers, which may carry over into their success in getting treatment. Then again, most outcome samples are far smaller than the *CR* sample and have their own sampling issues. Further work is needed to measure whether participants in controlled experimental studies exhibit consistent biases. In contrast, were unsuccessful patients too dysfunctional to comply with the *CR* survey? *CR* probably has few extremely dysfunctional subscribers, and

we specifically stated that our findings do not apply to that population.

#### **Controls**

Although a formal control group is an obvious advantage of the experimental approach, the survey provided a valuable comparison—people who went to family doctors. Most severely afflicted respondents who initially went to their family doctors self-referred to mental health professionals. Clearly, they saw the advantage of going to a specialist, and among those who had been to both family doctors and therapists, the latter were rated considerably higher than the former.

#### **Self-Report**

The critique that self-report is a "softer" measure than research based on clinical assessment may be overstated: Clinical assessment and self-report data tend to correlate highly. Furthermore, the *CR* respondents specifically attributed much of their improvement to their therapy. Although there can be biases in self-report, over the years we have learned to respect our survey data and not to dismiss the reports of thousands of our educated, conscientious subscribers as "opinion" or "cognitive dissonance."

#### **Time Frame**

The survey methodology was retrospective. Therefore, there was an amorphous time frame including both current and former patients, patients who started many years ago as well as those who started within the past three years. As a result, there may have been an overrepresentation of long-term patients. Our methodology limited the ability to assess progressive changes in functionality over time. This is a serious limitation, although it exists by definition in most surveys.

#### **Summary**

At the start of our research, *CR* had no vested interest in whether psychotherapy helped or, if it did, whether one type of therapist, long-term versus short-term therapy, or drug therapy versus talk therapy proved more effective. The only goal was to follow the inductive process—what do the data suggest? The data show that, free of the artificial constraints of controlled studies in the real world, a population of consumers can often benefit from psychological intervention services: Real relief can be found at the hands of professional mental health care providers.

How much can be generalized beyond

that? The population under study and the naturalistic limitations of the study design direct researchers not to stray too far from the specific results. But, importantly, the uniqueness of the study—its large sample size and independent sponsorship—may, in our view, help to expand the scope of subsequent research and push the envelope in creative design. Indeed, as we close this chapter of our own scientific inquiry on the subject for the present, we are hopeful that our next research initiative in a few years or so will rest on significant interim advances. Until then, we are appreciative of ideas and suggestions for improvement.

In this issue of the *American Psychologist*, we do not want to participate in a debate that values either experimental or naturalistic design more than the other. Both have value depending on the question to be addressed. We chose the survey method to answer the general question of therapy's effectiveness in a real-world setting. Right alongside the survey results in the November 1995 *CR* article, we published an entire page about the specific types of therapy that are best suited for specific problems and acknowledged that these recommendations were based on controlled studies.

We want to acknowledge Martin Seligman's role as a consultant in our current research; his insight and expertise were invaluable in helping us design our questionnaire and conduct the analysis. At the same time, we reaffirm our independent position on the interpretation of these data. The *CR* (1995) article and this comment (and nothing else) outline our position on the results of our study and its ramifications. In summary, we think prospective consumers of mental health care services have benefited from this research. We hope the scientific method in this field has advanced in a meaningful way as well.

## REFERENCES

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Seligman, M. E. P. (1995). The effectiveness of psychotherapy: The *Consumer Reports* study. *American Psychologist*, 50, 965-974.

## Errors in Seligman's "The Effectiveness of Psychotherapy: The Consumer Reports Study"

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Seligman's (December 1995) article presents an interesting view of how a consumer sur-

vey can be used to evaluate psychotherapy as a healing technique. The article undoubtedly will and should be influential. Unfortunately, though, the article is marred by three methodological errors and a puzzling inconsistency.

The first error—the typographical slip—is the bane of all of us. Figures 2, 3, and 4 (Seligman, 1995), which present some of the major data, incorrectly report either the total size of the sample or the size of the various subgroups receiving therapy from different sources. This error is easy to see: The total *N* is given as 2,738, but the subgroup *ns* add up to 2,938. If the error is in the total *N*, no material conclusions are affected. This is probably the case, as mistyping a single digit could have produced the error. However, if the error is in one of the subgroup *ns*, the seriousness depends on which subgroup is affected.

Figures 2-4 (Seligman, 1995) purport to show three things: (a) that therapy extending for more than six months produces a higher rate of symptom improvement than therapy extending for less than six months; (b) that the improvement rates are about equal for psychiatrists, psychologists, and social workers; and (c) that the rates for these three types of therapists exceed the rates obtained by physicians and marriage counselors. Visually, the graphs dramatically make these points. However, neither the figures nor the text presents the numbers or percentages of clients who received brief (less than six months) or extended (more than six months) therapy, separately for type of therapist. For instance, in the figures, psychiatrists have a slight advantage over psychologists both for clients who received brief therapy and for clients who received extended therapy (in Figure 1, 32% and 52% major improvement for psychiatrists vs. 31% and 46% major improvement for psychologists). But suppose that psychologists see a higher percentage of clients in extended therapy than psychiatrists do—a fact not addressed in Seligman's article. Then the overall rates of improvement could be markedly higher for psychologists than psychiatrists. Or the reverse could be true. What these figures do show is that, conditional on length of therapy, the statements about the equivalencies of therapists with different training are true. This is not a trivial alteration of the original statement.

Seligman (1995) stated, "The dropout rates due to the resolution of the problem were uniform across duration of treatment (less than one month = 60%; 1-2 months = 66%; 3-6 months = 67%; 7-11 months = 67%; 1-2 years = 67%; over two years = 68%)" (p. 971). The dropout rates were anything but uniform. Each interval reported covers a different, progressively increas-

ing number of calendar months. Of the people who were still in therapy at the start of Month 1, 67% resolved their problem in the following month. Of the people who were still in therapy after 1 year, 67% resolved their problem in the next 12 months. The dropout rate was 67% per month in the first case and an average of 6% per month in the second case.

As a further puzzle, if the "successful resolution" figures just cited are correct, all but 5% of the sample should have left therapy with successful resolution after six months (60% would leave in less than one month; of the remaining 40%, 67% would leave in the next month, etc.). This is difficult to reconcile with Figures 2-4 (Seligman, 1995), which uniformly report major improvement rates of less than 33% for clients with six months or less of therapy. Either successful resolution of a problem by psychotherapy does not entail major improvement or, as is more likely, survey respondents are very sensitive to exactly the way in which a question is worded.

These errors are not at all innocuous. They are directly relevant to the cost-effectiveness of psychotherapy, a topic dear to the managers of HMOs. If Figures 2-4 (Seligman, 1995) are to be believed literally, general psychotherapy clients should be channeled to social workers unless some specific requirement (e.g., need for drugs) indicates that medical intervention is required. This leaves little place for the clinical psychologist. When dropout rates are correctly interpreted, the HMO managers' dilemma becomes apparent. The managers' costs for psychotherapy will generally increase linearly with the length of treatment. The dropout rates indicate that the longer a person has been in psychotherapy, the lower is the probability of successful termination in the next month. Weighed against this, of course, is the very real possibility that people in long-term therapy may have more serious problems than clients who can rapidly complete treatment. This will have to be quantified so that cost-benefit calculations can be made. Seligman made an impressive argument for using surveys to assist in such calculations. What researchers now need to do is to refine the ways in which they treat the resulting data.

## REFERENCE

- Seligman, M. E. P. (1995). The effectiveness of psychotherapy: The *Consumer Reports* study. *American Psychologist*, 50, 965-974.

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