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Going Beneath the Surface: What People Want from Therapy

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ABSTRACT
Therapies of depth, insight, and relationship have been missing from, if not pushed out of, the public conversation on mental health treatment. After decades of attack from multiple fronts, these therapies are misunderstood, undervalued, and overlooked by the general public. In order to address this challenge and change this trajectory, we must start by listening to the public and understand their needs, values, and preferences about therapy. We conducted an extensive research project, leveraging qualitative and quantitative tools and techniques widely used in the corporate world, focused on "listening" to the public and understanding what people want and need from therapy. It's indisputable that therapies of depth, insight, and relationship are highly effective. What we know now is not only that these therapies work, but that they resonate with a large segment of the public. We learned that many people intuitively know that there is more beneath the surface, believe that therapy is a process that takes time, and are willing to make that investment. Our research also provides a blueprint for communicating the value of depth therapies to the public, grounded in what we heard from the people themselves, based on four key messages. Considerations for ongoing engagement with the public and future research are provided.

KEYWORDS
Psychotherapy; evidence-based; market research; public engagement; communication

Background

Mental healthcare and ways to deal with emotional suffering are top of mind for many in our country. The traumas of the COVID-19 pandemic have heightened suffering for many, and racial and social inequities – longstanding and harrowing – have contributed to outrage and anguish. Stigma seems to be declining, especially among the younger generations, as celebrities and professional athletes are increasingly speaking out about their own mental health journeys. All of this is driving increased interest in and demand for mental healthcare, and, understandably, people have questions about what the best care is for them and how to find it. At the same time, general knowledge about therapy seems to be low, and misconceptions about depth therapy, in particular, as seen in ongoing stereotypes, seem prevalent. Thus, many do not have ready answers for their questions, and they are unsure about how to identify the type of care they need, how to find it, and how to assess whether it's of high quality. This void has, for the most part, been filled by the advertising and marketing messages from for-profit tech companies, insurance companies, and Silicon Valley investors looking to disrupt and dominate another industry. These entities have products to sell and profits to make, and see an opportunity among vulnerable people faced with a fragmented collection of independent clinicians. Even as our media channels are inundated with advertising from these tech companies, we wonder if these messages align with what people want and need. Do people resonate with their quick-fix appeals? Are people equipped with the information and education to assess their needs and identify what might help them best? What do people really want from therapy?

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In the context of these questions, we believe that the public should know more about mental health care in general, and more about therapies of depth, insight and relationship in particular. They might even find these therapies highly appealing, as they offer desirable benefits – they are highly effective and long-lasting. There is a robust, high quality evidence base (Gerber et al., 2011) showing that depth therapies are highly effective treatments (Steinert et al., 2017; Abbass et al., 2004; De Maat et al., 2009; Rosso et al., 2019; Bateman & Fonagy, 2008; Leichsenring et al., 2013; Leichsenring & Rabung, 2008; Driessen et al., 2013; Leichsenring & Rabung, 2011). The treatments have been tested in many ways, including randomized control trials with thousands of patients, and found to be highly effective for a variety of conditions and populations, and especially for complex cases such as personality disorders, chronic depression and anxiety, and comorbidities (Lazar, 2018). Studies also show that many people need to receive a certain amount of therapy in order to show improvement; for example, one study showed that the average client needs 50–75 sessions, and the large Consumer Reports study suggested 2 years of weekly sessions (Lambert et al., 2001; Morrison et al., 2003; Seligman, 1995). Importantly, the effect sizes, or improvements due to these treatments – high at the end of many studies – continue to increase over time (Abbass et al., 2004; Lazar, 2018). This is in stark contrast to the finding that relapse rates of short-term therapy are unacceptably high, with the majority of patients receiving "evidence-based" treatment seeking additional treatment within 6–12 months for the same condition (Westen et al., 2004). Although the benefits of depth therapies – effective, tested therapies that last for the long-term – are likely what many people want, we do not see them reflected in the public narrative about therapy and we are concerned that these therapies have been missing, if not pushed out, from the public conversation by a variety of forces.

Along with limited awareness and understanding about therapy among the general public, we can identify multiple, powerful, vested, and monied interests promoting specific therapy brands, cultivating customers, and communicating to the public for years. It is not uncommon to see articles in the popular press touting "evidence-based treatments" or, more specifically, "cognitive behavioral therapy." For example, NBC News published "What is cognitive behavioral therapy and how does it work" (DiGiulio, 2019), which presented CBT as the "gold standard" treatment for an enormous range of emotional and physical symptoms. While it is understandable that the popular press is not fully apprised of the entire evidence base of research in the field, we were surprised and dismayed to see that same article re-posted uncritically by the American Psychological Association on its LinkedIn account. Unfortunately, articles such as these are misleading for the public, which has little access to the evidence for the effectiveness of various treatments, and even less access to the skills to evaluate it. A layperson is probably not the typical reader of the Journal of the American Medical Association and thus would not have read JAMA's article asking "Is Cognitive Behavioral Therapy the Gold Standard for Psychotherapy?" (Leichsenring & Steinert, 2017), and learned that the answer was clearly "No."

In addition to the popular press, many individuals look to their insurance companies for mental health information and treatment options. For-profit insurance companies, beholden to quarterly financial results, are heavily incented to prefer those services that minimize cost – namely, medications or short-term, time-limited psychotherapy – and have seemingly worked diligently to restrict coverage for and access to quality mental healthcare. One strategy is to limit the number of therapists in their provider networks, which they may do by restricting therapists' reimbursement to below-market rates, or by having "ghost networks," meaning many of the therapists listed as in-network either have full practices, have retired, or are dead (Holstein & Paul, 2017). Another strategy is more hidden, yet more troubling. The 2019 class-action victory in a lengthy lawsuit filed against United Behavioral Health (Wit v UBH) reveals how deeply financial incentives infected, and indeed directed, UBH's coverage decisions. UBH was found to have systematically applied treatment coverage criteria developed by United's finance team, over the objections of United's own clinicians. UBH relied on these internal criteria to deny mental health treatment coverage, which, according to the lawsuit, resulted in individuals' suffering, relapsing and dying. The Judge also found that UBH's criteria fell short of meeting generally accepted standards of care. Importantly, the Standards of Care

outlined in the Judge's ruling have become the backbone of new legislation for parity and medical necessity guidelines for mental health care in multiple states.

In addition, individuals who are suffering will likely have seen some of the many direct-to-consumer ads for psychiatric medications. These ads, for which the industry spends $4.5–5.5 billion per year, make medications seem more appealing, more effective, and less risky (Ventola, 2011). From these ads, the public is unlikely to learn that the efficacy of medication has been over-stated by approximately one-third (Carroll, 2018). Most recently, the next wave of direct-to-consumer advertising arrives from a different industry entering the mental health field – technology. Silicon Valley investors and technopreneurs are aggressively developing products – mobile apps, websites, artificial intelligence – and aggressively advertising them online, on the radio, on the side of many a city bus. Despite scarce evidence that such products work, they are attracting staggering levels of investment. In 2020, digital behavioral health funding increased substantially over 2019, with $2.4 billion in funding across 67 deals (Wang & Zweig, 2021) and, in the first quarter of 2021, investments in new digital health deals were at a high of $6.7 billion, with mental health investments once again topping the list (Oss, 2021). These investments respond to the size of the opportunity: Talkspace estimates the "total global addressable market" for its services at $480 billion (Talkspace, 2021a). Employers and insurance companies are attracted to these services, often based on programmable algorithms, and see a quick way to cut costs. As of March of 2021, for example, Talkspace, which recently went public for $1.4B, reported contracts with 10 health plan clients and 91 enterprise clients, claiming that the number of people eligible to receive services through these partnerships exceeds 55 million (Talkspace, 2021a).

Some of these technology companies are positioning themselves as offering therapy or comprehensive mental healthcare, yet in fact, they do not. For example, some companies market asynchronous texting services as "therapy," even though there is no synchronous therapist-client communication let alone opportunities to share real-time conversation or exploration of issues, or emotional reactions that can be some of the most powerful aspects of one's experience in therapy. Others promote the ease of "seamlessly switching therapists, at no extra cost," (Talkspace, 2021b) which provides a way to avoid engaging with difficult emotions or conflict with one's therapist, and thus eliminates the opportunity to leverage some of the most important functions of the therapist-patient relationship. Other companies sell online self-help services, such as mindfulness or breathing exercises, or coaching services. The public likely does not know that anyone can call themselves a coach, and there is no graduate degree or state license for coaching. These deprofessionalized services offer an even further incentive for profit-maximizing corporations. It seems as though reach and efficiency and profitability have superseded questions of quality, let alone depth, insight and relationship.

Many of our professional organizations and academics seem unlikely to stand up for therapies of depth, insight and relationship; on the contrary, they seem to be limiting their focus to short-term, manualized treatments. Academics can complete research studies more quickly when they are studying a 10-session treatment protocol, vs a multi-year therapy process, and thus publish more prolifically. The American Psychological Association Division 12 maintains a list of empirically supported treatments and 90% of the treatments on its list are CBT, despite criticisms, from psychologists themselves, of this list and the problematic usage and definition of "evidence" and the corruption of the evidence-based practice model, (Tolin et al., 2015; Wachtel, 2010). In fact, despite the strong and robust evidence base for depth therapy highlighted earlier, evidence-based treatments have come to be synonymous with "short-term, technique-oriented, diagnosis-specific, symptom-reducing, protocol-following interventions … based on one type of evidence – the 'gold standard' of scientific investigations – randomized controlled trials" (Gnaulati, 2018, p. 2). These trends make it less likely that the therapists of tomorrow will be exposed to therapies of depth, insight, and relationship.

Thus, whether from insurers, pharmaceutical manufacturers, technology firms, and even our own mental health professions, almost every resource and message available to the public is steering them

toward short-term, algorithm-based, depersonalized, quick-fix solutions, whether in the form of a medication or a time-limited, manualized treatment. Risks and costs are under-stated, while efficacies are overstated. These dynamics are reinforced by a cultural zeitgeist that values "quick-fixes" over reflection and long-term solutions. Thus, therapies of depth, insight, and relationship find themselves squeezed out of the public conversation around how to help those who are suffering. Specifically, many don't see psychoanalytic therapy as a credible source, and it is often perceived as antiquated, ineffective, never-ending, too expensive, and mainly for the privileged. There have been intentional efforts to discredit psychoanalytic and other depth treatment in multiple realms, for example, by suggesting there is no "evidence" supporting it and further research is not indicated (Marcus et al., 2014; Mayo-Wilson et al., 2014; Steinert et al., 2017). To be sure, some of the problems have been generated by the psychoanalytic community itself, as fragmented as it is and disconnected from the mainstream population as it can be.

One way to conceptualize the challenges faced by therapies of depth, insight and relationship is to think of them as a branding problem. This means centering the associations, emotions, mental models, and expectations about depth therapies – the way these therapies have come to "live" in people's minds and hearts – as a core part of the issue. Using this perspective highlights the need to first listen to the public, the users and potential users of therapy, in order to find ways to engage with them that are meaningful, relevant, impactful, and on their terms. Our ultimate goal is not to help therapists or professional organizations profit from this understanding, but to support people's informed decisions and right to choose from a wider range of therapeutic alternatives, and to bring therapies of depth, insight, and relationship back to their consideration set. With this in mind, our original research focuses on understanding people's values and preferences for therapy and therapists – a component of evidenced-based practice often ignored but critical for the success of mental health treatment. The corporate world has a long history of using and refining methodologies to do similar research, asking people questions directly in order to understand their needs, attitudes, preferences and associations. While our objectives are very different from those traditionally pursued by for-profit corporations, these tools and methodologies are nonetheless useful for our goals. In general, nonprofits can benefit from leveraging frameworks and techniques from the for-profit world (e.g., Delboy et al., 2010; Kylander & Stone, 2012).

This effort is significantly different from other types of research in the mental health field, focusing on either clinical outcomes or on clinicians' perceptions. Our project was led by the authors, both of whom had significant education and experience in the marketing and marketing research fields prior to becoming clinicians. Except for access to the sample for our survey, the entire project, including contributions from project leaders and the rest of the research team, was conducted on a pro-bono basis. Working with limited financial resources limited the breadth of what we were able to cover in our research, but did not compromise its quality or adherence to market research best practices. Moreover, while the authors identify as advocates of therapies of depth, insight, and relationship, multiple measures were taken to minimize any bias in the research design, the questions we asked, and the people we talked to.

Methodology

A basic market research design when studying a new issue, topic, or population, typically considers two sequential stages. First, a qualitative phase using an unstructured discussion or observation guide, in order to explore the topic in more depth, develop an initial understanding and set of hypotheses, and provide input on key topics to investigate and language to use in the second stage. The second stage consists of quantitative research, typically conducted using a structured questionnaire presented to a representative sample of the population of interest. Our overall objective was to understand the general public's needs, attitudes, and associations regarding mental health and psychotherapy, and develop a way in which we could meaningfully communicate the value of therapies of depth, insight, and relationship.

Qualitative research

For our qualitative phase, we conducted a total of 46 in-depth interviews in three iterative waves, between September of 2018 and May of 2019. Our specific objectives were to explore themes associated with mental health issues, treatment modalities, psychotherapy effectiveness, associations to types of therapy, and assessment of a concept describing therapies of depth, insight, and relationship.

We developed an interview guide with specific themes and questions, while allowing flexibility to deepen exploration as needed. The interview guide was written based on the key issues we wanted to address and refined in each wave based on preliminary findings. The interviews, lasting between 30 and 90 minutes, were conducted in person or over the phone by members of the research team. During the third wave, we received additional support from graduate Marketing Communications students from a university in the Chicago area.

The interviewees were recruited from the personal networks of members of the research team and of the Psychotherapy Action Network, excluding clinicians and clinical students, or their close relatives, as their views and opinions might not represent those of the general public. The majority of interviewees are residents of the Chicago area and have different levels of experience with therapy. While we attempted to have a balanced representation of different demographics, the sample for qualitative research does not aim to be statistically representative of the general population.

Quantitative research

The quantitative phase of our project included an online survey, completed by a final U.S. representative sample of 1,535 respondents (margin of error is ± 2.53% for the total results, with a 95% confidence level) during early March of 2020. The sample is representative of the population in terms of age, gender, ethnicity, geographic region, and household income. It is important to note that fieldwork for our survey took place before lockdowns due to the COVID-19 pandemic were commonplace, and before remote mental health services became prevalent. The specific objectives of this phase were to quantify attitudes and behaviors associated with mental health, treatment options, and psychotherapy in particular. We also measured people's associations to two specific treatment modalities, Psychoanalysis and Cognitive Behavioral Therapy. During the quantitative phase, the research team consisted of the research leads and two graduate students from a dual program in Business Administration and Market Research.

Online survey research is the most widely used quantitative method in market research. By one account, 89% of market research professionals globally use it regularly (Statista Research Department, 2021). In the United States, where 93% of adults say they use the internet (Pew Research Center, 2021), this method has the potential to reach the majority of the total population, making it the standard approach for commercial survey research. Other data collection methods used in quantitative research (e.g., phone or in-person surveys) might help in reaching highly specific low incidence groups, which is not a requirement for our project, and are also prohibitively expensive for our endeavor.

The instrument utilized in this phase was a structured questionnaire, created by the research team, based on the main themes captured in the qualitative phase. The questions took different forms (e.g., Likert scales, multiple choice) depending on what they were capturing (e.g., attitudes, associations, awareness, behaviors). The questionnaire was programmed for online distribution using a survey software that allows for complex questionnaire flow and skip logic, and implementation of best research practices (e.g., response and statement randomization). The online survey took respondents about 15–20 minutes to complete.

A critical step in conducting survey research is to clearly define the population under study. While our goal was to understand and "listen to" the general population, we wanted to gather responses from people with at least some awareness of the issues we would be asking about in the

survey. Thus, the research population was defined as those who reported being aware of therapy or counseling. This became our main screening criteria, as it defined who qualified to take the survey and who did not, and was captured using a multiple-choice question in the first section of the survey, also known as "screener." Everyone contacted to participate in the survey answered the screener and was then either allowed to proceed to the main questionnaire, if they met the screening criteria, or terminated, ending the survey for them at that point. A number of respondents were eliminated if they failed standard market research quality control checks (e.g., "speeding" through the survey, selecting "decoy" response alternatives, and reporting employment in the sector of interest). In total, we contacted approximately 3,000 people and 61% of them met our screening criteria. After applying the other filters and quality control checks, our final sample consisted of 1,535 complete and valid surveys. The screener also included key demographic questions (age, gender, race/ethnicity, state of residence, and household income range), asked to everyone we contacted, regardless of whether or not they qualified to complete the survey. This information was required from everyone for data weighting purposes (see below).

Following common practice in online survey research, the sample was recruited from an online panel. An "online panel" is, at its core, an extensive list of people who have agreed to provide some personal information and be contacted periodically to participate in market research. Panels are actively maintained and managed by dedicated Online Panel Providers (OPP). OPPs ensure diversity in the composition of their panel, actively ensure data quality, offer incentives to their panelists, and keep their panelists' information updated. The OPP does *not* provide its panelists' personal information to organizations doing market research. Instead, our research team shared with the OPP a link to the online survey we programmed, so that the OPP could e-mail its panelists directly, inviting them to participate in the survey. The OPP followed market research best practices to minimize sampling bias when distributing the link.

In addition to working with a professionally managed OPP, we took steps to make sure that the final sample adequately represented our research population on five key demographics: age, gender, race/ethnicity, household income, and geographic region.[1] One of the most widely used techniques to ensure that survey data is statistically representative is data weighting (Mercer et al., 2018). This method allows different groups to be fairly and adequately represented in the data analysis, leading to more representative and accurate results. In addition, weighting survey data can also address issues of coverage created by systematic differences between groups with different levels of internet access (Dever et al., 2008). In order to conduct this process, we collaborated (pro-bono) with a Marketing Analytics Expert.

The process involves identifying "weighting targets" and creating "weighting factors" for each respondent, based on their demographics, so that their responses will be subject to a statistical correction once aggregated. The data weighting method we used is called Iterative Proportional Fitting (IPF). IPF takes the marginal population distributions and, through an iterative statistical process, calculates individual weighting factors for each survey respondent. When those weighting factors are applied (i.e., when the sample is "weighted"), the aggregate results will be distributed to reflect the desired weighting targets. Thanks to the sampling precautions taken during the data collection process, all weighting factors in our sample fell under a reasonable range, thus avoiding any significant distortion in the data.

Because the demographic distribution of our research population (as defined by our screening criteria) was unknown, we followed a two-step IPF process, starting with U.S. Census demographic data as a weighting target for the *total number of screeners* we collected. On the weighted data for all screeners, the team calculated the distribution of each of the five demographic variables of interest, among those respondents who *qualified* for the survey (i.e., those who met the screening criteria).

[1]Gender and race/ethnicity were direct questions. Respondents reported their exact age, which was grouped in predefined ranges by the survey program. Household income (before taxes) was asked by presenting income ranges. Respondents provided their state of residence, grouped into regions following a predefined algorithm.

These distributions became the *weighting targets* for the final sample of 1,535 respondents. As a result, the aggregate data the team analyzed and presented is representative of the research population across the five target demographics.

One important item to note is the difference between the demographic distribution of the overall U.S. population and that of our research population. As observed in Exhibit A, the distribution in both populations is very similar in terms of gender, income, and geographic region. However, there are differences when it comes to age and race/ethnicity. Those who qualified for our survey (e.g., people aware of therapy) are more likely to be white (vs the overall U.S. population) and skew older (vs the overall U.S. population). Because of the two-step weighting approach we followed, we can determine that these differences are *not* due to sample bias, but a result of relatively higher therapy awareness among people identifying as white and those who are older.

Exhibit A: Demographic distribution comparison between U.S. Census and our final sample.

	Demographic distribution	
	U.S. Census	People who qualified to the survey
Gender		
Male	49%	46%
Female	51%	54%
Ethnicity		
White (non-Hispanic)	62%	74%
Black or African-American	13%	7%
Hispanic or Latino (any race)	19%	13%
Asian or Asian American	6%	5%
Other	1%	1%
Age		
18-24	14%	7%
25-34	21%	13%
35-44	19%	16%
45-55	19%	22%
55-70	28%	41%
Annual HH Income		
Under $25,000	19%	18%
$25,000 - 49,999	21%	23%
$50,000 - 74,999	17%	19%
$75,000 - 99,999	13%	11%
$100,000 - 149,999	15%	15%
$150,000 or more	16%	13%
Region		
Northeast	17%	16%
Midwest	21%	24%
South	38%	37%
West	24%	23%

Note. Left column is publicly available U.S. Census data, used as weighting targets during the first step of the data weighting process. Right column is the estimated distribution of those who qualified to the survey (i.e., people aware of therapy), used as weighting targets during the second step of the data weighting process.

Research findings

In this section we provide an overview of the findings and insights from our research. We focus on the results from our quantitative survey, while providing direct quotes from the qualitative interviews in order to provide the reader with additional perspectives in people's own words.

Attitudes and perceptions about therapy

A high-level finding from our survey is that people, despite their reported awareness of therapy, do not appear to have strong opinions about mental health or mental health treatment. In the 56 statements evaluated, most people selected one of the two middle points of the six-point agreement scale we used. Only eight statements had a Top-2 Box higher than 50% and only nine of them had a Bottom-2 Box[2] higher than 50%.

When asking people what they want from psychotherapy (multiple choices could be selected), the top two answers received the same level of support (about 70%): "learning skills and coping strategies," a focus of most manualized treatment modalities, and "better understanding yourself and the root of your issues," a focus of therapies of depth, insight and relationship. These are closely followed by "sharing your feelings and thoughts without being judged or shamed" (66%), and "feeling heard and understood by someone who cares about you" (60%), both of which suggest the value placed on aspects of the therapeutic relationship. A similar percentage stresses the role therapy can play in becoming empowered to make their own choices in life. Interestingly, only 37% of people believe that the main goal of therapy is to help people change their behavior. These last two findings might suggest a distinction made between therapy as *helping people feel empowered to change* in contrast to therapy *aimed at behavioral change*, which would suggest the value people place on change coming from within. Indeed, one of our qualitative participants stated that "[therapy] *is empowering because you hopefully get to discover the root of the issue*." Another participant stated, "*people think something is wrong with them and an outside force will fix it, but real changes come with an inward focus*."

We were pleasantly surprised to discover that about two-thirds of the population recognize that therapy takes time, acknowledging that "emotional and psychological problems inherently take time to understand and resolve." A similar proportion believe that going to therapy is an investment that is worth making. Only a relatively small proportion of respondents, one in ten, does *not* appear to see value in focusing on understanding problems (as opposed to finding practical solutions) or on examining past issues and childhood experiences (as opposed to present-day problems). Our qualitative interviewees added more depth to these responses, stating that "[therapy] *is a liberating way for you to expose yourself to yourself*" and that it presents "*an opportunity to examine your thought process with guidance*." In addition, only a few respondents in our survey (10%) expressed stigmatized views, such as the belief that going to therapy implies the presence of significant psychological issues, or that seeing a therapist is like "paying to have a friend." However, a higher percentage (36%) perceive therapy as a way to "fix" something that is not working.

People's views on the therapeutic experience seem to be weaker than opinions about other topics, as suggested by the lower Top-2 Box scores. For example, the statement with the highest percentage of agreement only reached 32%, representing people's views on the usefulness of talking about the relationship between therapist and patient. The majority of people do not seem to see the value of exploring those dynamics. Moreover, in our qualitative interviews we tested several different descriptions of transference (without the technical terminology) and most people had a negative reaction to this concept, occasionally leading to drops in mood during the interview itself. One qualitative participant said it clearly: "*I don't have a problem with the therapist, I have problems in other relationships!*" At the same time, the majority of people seem to recognize and value, even if implicitly, the interpersonal aspects of the therapeutic relationship. This is suggested by the very low percentages of people who believe that the therapist's personality does not matter much (8%), or that are skeptical about the therapist's genuine feelings of care (7%).

The remaining attitudinal statements we evaluated in our survey provide insights into a number of categories, summarized below:

[2]Top-2 Box is the percentage of people who selected "Strongly agree" or "Agree" with a specific attitudinal statement. Bottom-2 Box is the percentage of people who selected "Strongly disagree" or "Disagree."

- **Origin of mental health issues**. About half of people consider patterns and relationships as an important source of mental health issues and a reason to seek therapy. Less than 20% of people think that "mental health problems" mainly stem from other sources (e.g., chemical imbalances, irrational thoughts).
- **Comfort with feelings and vulnerability**. About a third of people feel able to handle their feelings on their own, and about the same percentage feels comfortable opening up to others.
- **Structure of therapy sessions**. We found that most people are not necessarily looking for structured or concrete sessions. Around 20% of people would prefer a therapist who sets the agenda for each session, who gives homework, or who gives advice. This is a significant proportion of the population, but does not seem to represent the opinion of the majority.
- **Racial and cultural identity**. Only 15% of people stated that they would strongly prefer a therapist of their same racial or cultural background. These proportions are somewhat higher among those who identify as Black/African American (25%) and Hispanic/Latino (22%), but do not reach the high percentages that we would have anticipated.
- **Appeal of "evidence-based."** "Evidence-based" claims make about 40% of people more trusting of a therapy modality. Interviews in our qualitative interviews reflected these mixed views. While some valued the understanding that "*evidence-based means that research supports it*" and keeps therapy from being "*touchy-feely or poking around in the dark*," others highlighted the importance of the "*therapist's intuition and skill*" and "*the therapist having used practices with others and having real-world experience*."
- **Remote vs in-person therapy**. A little over 10% of people believe it makes no difference if therapy happens in person or not, which would suggest that people place value on in-person sessions. After the expansion of teletherapy due to the Covid-19 pandemic, attitudes in this area have most likely shifted since the time the survey was conducted.
- **Medications**. Medications are generally accepted, viewed positively, and seen as providing helpful and important benefits. Participants in our qualitative interviews stressed the importance of medications as an adjunct to therapy, as they can "*provide some relief*," but they "*don't fix the root cause; meds enable you to do talk therap*y."

As an alternative way to measure people's preferences for different types of therapy, we asked respondents in our survey to choose one of two options presented to them: "therapy that takes longer but addresses the root cause of your symptoms, so that it can offer lasting results," or "therapy that takes fewer session and helps you manage your symptoms, but doesn't necessarily address the root cause of the problem." In hindsight, we recognize the wording of the two options in this forced choice was not equitable. However, we were surprised by the magnitude of relative support for the type of therapy that addresses "the root causes" of symptoms: 91% of respondents selected that option, while only 9% selected the shorter therapy that focused on symptom management.

Behavioral intentions and experience with mental health treatment

When people were asked to select which actions they might take if they were feeling "frustrated, sad, anxious, or not in control of their thoughts and emotions," the top two responses reflect contrasting preferences: about 58% stated that they would talk to friends and family, and a similar percentage said that they would keep themselves active and busy as a coping mechanism. About half of the respondents also indicated that they would try to remain optimistic and think positively. These top three responses were the leading responses across all demographics investigated in our survey. A bit under half of the respondents (48%) said that they would consider speaking with a therapist. It is worth noting that this percentage is higher among older respondents (e.g., 54% for those between 55–70 years old, versus 36% for those 18–24) and for white respondents (51%, versus 42% for nonwhite respondents). Motivation for considering therapy was described by one of our qualitative

interviewees, who stated "*it's such a shame that there's a stigma, that needing help is a sign of weakness and personal failure*."

All other possible coping behaviors in our hypothetical scenario received lower percentages. For example, 39% of people would consider praying or seeking spiritual guidance and 32% stated that they would practice yoga, meditation, or mindfulness. A third of our respondents (32%) stated that they would keep it to themselves and get through their problems on their own. While this is a significant percentage of the population, it would suggest that other "independent" coping strategies (e.g., staying active, remaining optimistic) do *not* necessarily imply that people would choose to go through difficulties in isolation. Additionally, only 23% would consider taking medication to regulate their thoughts and emotions, and a similar percentage would search for ideas on social media. Only one in ten respondents stated that they would consider using a mental health app to feel better; this percentage has likely increased after mental health apps gained more prominence during the COVID-19 pandemic. Importantly, only 15% of people would explicitly take an avoidant approach to mental and emotional difficulties, stating that they would avoid thinking about it until the problem went away.

As mentioned above, a little under half of our respondents stated that they would consider speaking with a therapist in the scenario we described. When asking those who did *not* select that option why they would not consider talking to a therapist, the most common answer (41%) was the belief that therapy is too expensive. This suggests an important access barrier to seeking therapy, one that might be both realistic and also significantly based on perceptions. The next group of reasons why people would not consider seeking therapy include the belief that they can handle problems on their own, the presence of family and friends they can rely on, and the discomfort of talking to a stranger about their problems. These responses were selected by, on average, 25% of the respondents. Only a minority of people expressed concerns associated with their perception of therapy, including the belief that therapy is too time-consuming (14%), that it is for people suffering from "major" mental health disorders (11%), or that therapy doesn't really work (6%). Finally, only 9% acknowledged that they believe that talking to a professional is a sign of weakness.

We asked people what steps they would take and what criteria they would follow if they were hypothetically considering starting therapy. As a result, their responses reflect behavioral *intentions* rather than people's actual behavior or unconscious decision-making factors. Most people (59%) said they would ask their physician for recommendations, highlighting the gate-keeping role that physicians play in recommending treatment, and perhaps specific types of therapy. A little over half of people (53%) would also look for the mental health providers covered by their insurance, which is consistent with the concerns about the cost of therapy reported above. These two steps were the top two responses across all demographics. In contrast, only a third of respondents would ask their family or friends for referrals, and a quarter of respondents would use an online search engine like Google. Notably, younger people are significantly more likely to engage in these two behaviors.

When asked for the criteria people would follow when choosing a therapist, the factor mentioned by most (65%) is whether the therapist is in-network with the patient's insurance. This, again, is consistent with the concerns about the potential cost of therapy, and possibly a lack of awareness of other variables in selecting a therapist or type of therapy. The second most mentioned factor (52%) is the location of the therapist's office; we believe that, with the increased prevalence of teletherapy due to the COVID-19 pandemic, the importance assigned to this factor may have shifted. Interestingly, the third decision factor, selected by half of the population, is "the therapist's personality." We consider this as an acknowledgment of the importance of interpersonal factors in the therapeutic relationship. As one qualitative interviewee stated, therapy's effectiveness "*depends on if the therapist fits your personality even if he's a good therapist*." The fourth decision driver (47%) is the recommendation by the person's physician, which is consistent with the gatekeeper role previously mentioned. Importantly, the physician's recommendation seems to be more important for older people, while younger people would likely assess a wider range of consideration factors.

In a second cluster of decision criteria, selected by 35–39% of people, we find aspects related to the experience levels of the therapist, specifically "experience working with people like me" (we found no significant differences across demographics) and the therapist's expertise in the specific issues the person would want to work on. A third cluster of factors, selected by 25–28% of people, include "word of mouth" aspects (recommendations from friends and family and online reviews), as well as the number of years the therapist has been in practice. It is worth noting that, besides the therapist's personality, the perceived relevance of their clinical experience, and their years of practice, all other characteristics of the therapist appear to be much less important when selecting a therapist. For example, the therapist's theoretical orientation is a decision factor for only 15%. Even lower percentages are associated with the therapist's degree type (12%), the school they attended (6%), or their publications (5%).

We wanted to know what people had actually done to deal with mental health, emotional, or psychological difficulties. We found that about half of our sample (47%) had direct experience with therapy or counseling, almost 90% of them as an adult; 25% of those with direct experience were current patients (we did not ask for the type of therapy people received). Two-thirds of our total sample had "indirect" experience, as defined by having close friends or family members who had ever received therapy or counseling. One-third of our sample had direct experience with psychiatric medications, and about 28% reported having used mindfulness/meditation or self-help books, the former being more significant among younger respondents. Other modalities (e.g., in-patient treatment, self-help groups) were selected by around one in ten participants. Only 5% stated having direct experience with therapy apps, although we believe this percentage may have increased as a result of the COVID-19 pandemic. Finally, almost a third of the population (31%) reported not having direct experience with any of the presented alternatives.

We also investigated people's willingness to consider mental health apps. 36% of people said they would consider apps for meditation and mindfulness practice (e.g., Calm, Headspace), 31% were open to apps that connect them to an actual therapist (e.g., BetterHelp, Talkspace), and only 18% said they would be open to journaling or AI-based apps (e.g., Moodnote, Woebot). A total of 43% said they would *not* consider using any of these types of apps, implying that almost three fifths of people (57%) would consider them. These percentages may have shifted since our fieldwork, as teletherapy and mental health apps gained prominence due to the COVID-19 pandemic and advertising campaigns. The data showed clear variation based on the age of the respondents. Whereas 82% of people aged 18–24 and 75% of those 25–34 said they would consider using apps, 54% of people 45–54 and only 44% of those 55–70 years old said the same.

Most valuable aspects of therapy

We wanted to understand what people considered as the most valuable aspects of therapy. For current or former therapy patients, we asked this question in the context of their personal experience. For those with no direct experience, we asked it in the context of a hypothetical scenario. As expected, people who had been to therapy selected more choices, probably as a result of a broader appreciation and experience of the therapeutic process. For example, "talking to someone who is not judgmental" and "feeling understood and heard by another person" were two of the most valuable aspects of therapy as reported by those with direct experience (62% and 57% respectively), but they were not as dominant among those without such experience (48% and 39% respectively). "Becoming more self-aware" and "talking to someone with an objective perspective" are two other elements more valued by those with direct experience with therapy than by those without (54% vs 42% and 52% vs 40% respectively). As we can observe, the interpersonal experience of an empathic therapist is, understandably, considered in higher regard by those who have actually gone through therapy. Our qualitative interviews also suggest that a safe environment with an empathic, nonjudgmental therapist is seen as a key ingredient of therapy. As one of our qualitative interviewees stated, therapy is "*a place of constancy, safety*, [where] *I can be whoever I am and say whatever I want to say, without*

judgment or shame, with one person who will take what I say and guide me further in a more wholesome way."

It is important to note that, among those with direct therapy experience, learning new coping skills to manage thoughts and emotions is considered one of the most valuable aspects of therapy by a significant number of people (59%). About half of those with no direct experience (51%) also consider this would be valuable. In the group with no direct experience, that aspect of therapy is considered as valuable as getting to the root of their problems (51%). This speaks to the importance of "getting to the root" in the value people perceive in therapy. Near half of those with direct experience (46%) also consider getting to the root as one of the most valuable aspects of therapy.

Concept testing

In order to understand what people thought and felt about therapies of depth, insight, and relationship, we developed a description (a "concept") that we presented to our participants to gauge their reactions. We did not name the therapy we were describing, since there is no public-facing "name" that would encompass our description. This technique, called Concept Testing, is widely used in market research in order to get feedback from the public about a product idea, as part of the product development process. During our survey we used a description first tested and refined successively during our qualitative interviews. The concept we used in the survey is presented in Exhibit B.

Exhibit B: Therapy description used in Concept Testing during online survey.

This therapy can be useful for symptoms like depression, anxiety, or unhappiness, or for more serious mental health conditions. Its main focus is on understanding and dealing with the underlying causes of those issues. People gain self-awareness and self-understanding, which can lead to new ways of seeing and handling problems in life.

During therapy sessions, people are encouraged to talk openly about whatever is on their mind, at their own pace and on their own terms. The therapist listens in a curious and nonjudgmental way, asking questions and providing their perspective, but does not follow a pre-defined agenda or focus on teaching "skills". There is no predetermined duration for this kind of therapy; it may take as long as the person continues to see benefits.

People will likely talk about their past, including their childhood, and how it may still influence their present-day life. There may also be an emphasis on understanding past and present relationships, experiences and patterns. This therapy believes that our thoughts and feelings might have important meaning. Thoughts and feelings are considered neither "negative" nor "irrational," and making sense of them is a big part of what helps people feel better.

With this therapy, many people experience not only a reduction of their symptoms, but can live a richer and freer life. They may continue to improve even after they stop going to therapy, because this therapy addresses underlying patterns that affect many areas of their life. People can recognize and stop old patterns, look at their past in different ways, change how they feel about themselves and others, and open up new possibilities for living going forward.

Note. This description was included as a part of the online survey in our quantitative research. Prior iterations of the description were used during the qualitative interviews.

The overall feedback to this description of a therapy of depth, insight and relationship during our qualitative interviews was positive. Some of the positive comments centered on its individualized nature, the appreciation to go deeper to identify underlying issues, its long-lasting impact, and the non-judgmental stance toward the patient and their feelings. Some of the concerns we heard involved the unknown and potentially lengthy duration of treatment and lack of clear direction. Some people reacted against what they perceived as a minimization of the impact of their symptoms and their wish for symptom relief. As one interviewee put it: "*My symptoms are my worries, troubles, and problems. If you're telling me there are underlying issues, it makes my problems seem not legitimate*." Significantly, almost all our interviewees seemed confused or turned off by the notion that understanding and exploring the therapeutic relationship could be a part of this type of therapy (an aspect included during our qualitative phase). Following this homogeneous consensus, we decided to remove that part of the description in the final version we tested quantitatively.

In our online survey, after people had an opportunity to read the concept, we asked for their reactions along three dimensions, with consistent results across multiple demographics:

(1) *Differentiation*: We found that most people (51%) found that this form of therapy was slightly different or not at all different from their current perception of therapy. This suggests that the way people think about therapy is consistent with a description of therapy that values depth, insight, and relationship.
(2) *Interest*: 37% said they would be extremely or very interested in learning more about this type of therapy (a similar percent said they would be just interested). While the expressed interest does not reach a majority, it makes sense that not many people would want to learn about a form of therapy in the abstract.
(3) *Willingness to consider*: An overwhelming 58% stated that they would definitely or probably consider this form of therapy (30% said they may or may not, and only 12% said they would probably or definitely not seek it).

When asking people for the most important benefits perceived in the concept, most of the items were selected by around half of our sample as one of the "most important" benefits; not a single or a few of them stood out. This might be a result of the complexity of the description we presented and an expression of how this form of therapy can be appreciated from different angles. The benefits selected the most (by around 53% of people) include recognizing and stopping old patterns, focusing on the underlying causes of psychological and emotional problems, and increasing self-awareness and self-understanding. Toward the bottom of the list, with around 40%, we found benefits that may not have been phrased in lay-person language, or that might have sounded too abstract, including how this therapy can "open up new possibilities for living" or "help people live a richer and freer life." Interestingly, the benefit *least* selected (33%), which would suggest it may not be considered a benefit altogether, is the possibility to continue in therapy for as long as the person wants. Finally, only 4% stated that they don't see any benefits in this kind of therapy.

When asking for the most important concerns people had about our therapy description, the results were also widespread, although people seemed to identity fewer concerns than benefits. The clear top two concerns involved worries about cost (39%), given that there is no predetermined duration, and the possibility that it might take a very long time to see any effects (34%). Again, stating the long-term nature of this kind of therapy might be a source of concern rather than being perceived as a benefit. The third most mentioned concern (24%) involved the possibility that, without a predetermined structure, people could "talk about things that don't matter." All other possible concerns were selected by less than 20% of our sample. Moreover, 24% of people stated that they did not have any concerns with this type of therapy. Interestingly, very few people (less than 10%) expressed concerns that, by focusing on underlying causes or "talking about the past," this therapy would not focus enough on or help solve current problems. This would reinforce the notion that, while "current problems" are important, people recognize the value of understanding their underlying and historical causes.

Awareness of types of therapy

During the qualitative phase we asked about people's awareness of specific types of therapy. It became clear that the two modalities with greater overall awareness were Psychoanalysis and Cognitive-Behavioral Therapy (CBT). This finding was confirmed during our quantitative survey. Two-thirds of the population stated being aware of "Psychoanalysis/Psychoanalytic Therapy" (66%) and a similar proportion (64%) of CBT. Self-reported awareness does not, understandably, imply that people have a complete or accurate understanding of what these therapies are about. Awareness levels only indicate how much exposure these "brands" of therapy have had among the general public. In third place, "Mindfulness-based Therapy" was selected by 42% of people, and 30% stated

being aware of "Humanistic Therapy (e.g., client-centered, existential)." All other types of therapy included in the survey received 16% awareness or less. Notably, "Psychodynamic Therapy" was among the brands we included and awareness was only 16%. While the term psychodynamic is common among professionals, it does not appear to have much recognition among the general public. Awareness of other types of branded therapies, ranging between 10% and 16%, included EMDR, ACT, DBT, and IFS (acronyms and full names were provided in the survey).

Comparing Psychoanalysis and CBT

Since Psychoanalysis and CBT were the only two modalities with significant levels of awareness, we measured the associations, in people's perception, between each modality and a number of attributes. Overall, Psychoanalysis is mostly associated with self-understanding, getting to the "root cause" of problems, being able to help people from all demographics, and being an individualized yet expensive treatment option. CBT, on the other hand, is mostly associated with changing behaviors, being able to help people from all demographics, helping people gain control over their lives, and being a relevant, effective and updated form of therapy for current psychological problems.

However, when compared side by side, Psychoanalysis appears to be perceived less favorably than CBT by the general public along most dimensions. We observed this in both phases of our research, with both our qualitative interviewees and our quantitative survey respondents. The following sections summarize the findings in four areas. All the percentages shown are Top-2 Box scores, i.e., the percentage of people who indicated they "Agree" or "Strongly Agree" that a specific attribute represents each of the two modalities. The percentages measure the strength of the association of each attribute with each therapy modality.

1) How Psychoanalysis and CBT help

Psychoanalysis is more strongly associated than CBT (56% vs 45%) with the idea that it helps people "get to the root cause of their problems." Albeit by a smaller margin (58% vs 54%), Psychoanalysis also trumps CBT in the perception that it "helps people know and understand themselves better." These two aspects, as noted previously, are important aspects that people value in therapy. As we heard in our qualitative interviews, Psychoanalysis is "*for exploring yourself in more depth*." On the other hand, CBT is more strongly associated than psychoanalysis with helping people "think and feel in different ways" (56% vs 49%) and helping people "get more control over their lives" (60% vs 48%). Finally, people overwhelmingly associate CBT (64% vs 42% for Psychoanalysis) with the help it provides to "change behaviors." As one qualitative interviewee told us, CBT "*is about changing how you think or behave, about breaking the cycle of negative mental and recurring patterns*."

2) What the therapy process is like

The attributes more strongly associated with Psychoanalysis are not necessarily favorable ones. More people believe that Psychoanalysis, compared to CBT (40% vs 30%), "requires a long time to see any changes or results." One of our qualitative interviewees stated that psychoanalysis took "*years and years*," while another stated that CBT "*doesn't take as long as other therapies*." In addition, Psychoanalysis is more strongly perceived (35% vs 26%) as being "more emotionally demanding and stressful than other forms of therapy." Both modalities were tied in two attributes where we would have expected that Psychoanalysis, given the way it thinks of itself, would have had an advantage. First, about 41% believe, equally for Psychoanalysis and for CBT, that whether either modality works or not, "depends on the relationship between patient and therapist." Second, about 55% see both modalities as "individualized and tailored to each patient and situation." Finally, CBT is more strongly associated by a significant margin (57% vs 40%) with being focused on "offering tangible solutions or guidance."

Importantly, during the qualitative interviews several people shared perceptions about Psychoanalysis being conducted by therapists who are "*cold*" and "*unempathic*" and particularly

passive. One interviewee stated that a psychoanalytic therapist is "*not a good listener* [and] *wouldn't validate what I'm saying*," and another one stated that "*the doctor lets you talk and takes notes, but therapy is more helpful if doctor and patient are talking together*." These perceptions are relevant to consider since, as discussed above, the experience of an empathic therapist is one of the most valued aspects in therapy. Thus, for some people, Psychoanalysis may not even be included in their consideration set of therapies, as they view psychoanalysts as cold, unempathic and not meeting their general conceptions of a trusted therapist. Some of our respondents acknowledged that these perceptions are associated with longstanding stereotypes or "*cliches*" seen in popular media. Some interviewees also shared negative perceptions of CBT (e.g., as being "*mechanical*," "*one-size-fits-all*" or "*what insurance companies like* [because it is] *short term*"), but these comments were less prevalent than the negative associations to Psychoanalysis.

3) Who Psychoanalysis and CBT are for

Psychoanalysis is significantly more strongly associated (44% vs 33% for CBT) with helping "people with serious mental health issues or personality disorders." In contrast, CBT has a stronger association and a similar advantage (55% vs 44%) with being "for people with everyday problems like anxiety, depression, unhappiness, and relationship issues." This apparent split in people's associations was also observed in our qualitative interviews, and might represent a challenge for Psychoanalysis to be considered a viable mainstream therapeutic option. In addition, more than half of people consider that both Psychoanalysis and CBT can be "helpful for everyone, regardless of age, gender, race, orientation, etc," although CBT holds an advantage in this perception as well (62% vs 56%). Finally, when asked if they would consider each modality if they were looking for a therapist for themselves, more people stated that they would consider CBT than Psychoanalysis (48% vs 39%). While this is an important metric that conveys which modality people feel would be a better "match," based on their own perceptions, it is also important to remember that, based on a separate question in our survey, the therapist's theoretical orientation is not a significant decision factor when choosing a therapist.

4) General perceptions of Psychoanalysis and CBT

The only attribute with which Psychoanalysis has a strong association is the perception of being expensive (55% vs 46% for CBT). Three attributes were related to the modalities' effectiveness, and CBT has an advantage in all of them based on people's perceptions. CBT is more strongly perceived as "one of the most effective forms of therapy" (51% vs 37% for Psychoanalysis), as providing "long-lasting results" (50% vs 41%), and as having "extensive research showing that it works" (53% vs 48%). These attributes were echoed in some of our qualitative interviews, with one person stating that it is "*proven that* [CBT] *works with very challenging problems, not just easy ones*," while another expressing that "*even though it's a fundamental theory in psychology, I don't know if* [Psychoanalysis] *produces good results in a therapeutic sense*." CBT is also more strongly associated with being a "very popular form of therapy," (53% vs 44%) and "relevant and updated to treat psychological problems in today's day and age" (60% vs 47%). These results are consistent with comments during our qualitative interviews about Psychoanalysis being "*outdated*" and, as one interviewee told us, the perception that "*CBT is talk therapy*."

Discussion and recommendations

The breadth of our research provides the most extensive dataset on people's opinions, needs, and attitudes about psychotherapy that we are aware of. Here we will synthesize and discuss the most salient themes, which apply to multiple demographic segments. We did not find systematic differences for any particular demographic group throughout the sample, suggesting that the overall findings apply to the whole research population. This was surprising, given the differences, such as varying utilization rates, among different racial and economic groups. It may be a reflection in the lay public of a lack of clear information or detailed familiarity with the therapy process or different

therapies. Perhaps defining "awareness of therapy" as a screening criterion served as an "equalizing" function that smoothed demographic differences. It may also point toward aspects of our shared humanity.

First, people told us that they want to work with an empathic, nonjudgmental therapist, and they want to learn how to make important changes in their lives and open up new choices for themselves. While many types of therapy claim to offer these elements and benefits, people seem to want specific benefits that only depth therapies offer. Specifically, we learned that, when it comes to figuring out how to alleviate their suffering, what many people want is to get to the root of their problems, to understand themselves deeply, and to address the issues underlying their symptoms. An important segment of the public knows and understands that it will require time and effort, and they do not want to settle for symptom relief or quick fixes. We learned that many people intuitively know that there is more beneath the surface, believe that therapy is a process that takes time, and are willing to make and take that time.

These hopes for therapy are clearly distinct from the packaged solutions and messaging that currently predominate in the marketplace, and counter to the common narrative that's dominant in many of the public conversations about therapy – that it should be quick, easy, in the palm of your hand, at any moment of the day, and perhaps even with an interchangeable therapist. For example, despite the promises of "therapy anywhere/anytime" that large corporations, most of them relatively new in the mental health space, are selling, and even despite a cultural zeitgeist defined by quick fixes, there are people who want to make an investment in themselves, and are willing to spend their time and resources on this most valued investment – their self, their mind, their future. When it comes to specific types of therapy, namely CBT and Psychoanalysis, our research confirmed the perception gaps we anticipated between these two most recognized forms of therapy, and also identified new ones. While analyzing the origins and development of these gaps in people's minds is beyond the scope of our project, we believe that it may result from a two-pronged process. On one hand, the ways in which CBT, with the support of multiple stakeholders, has become closely aligned to the entire category of "psychotherapy," has resulted in people associating CBT with a number of benefits which technically stem from other therapies. On the other hand, psychoanalysis may have contributed in various ways to its own disconnection from the public discourse.

In addition to understanding the general public, our project aimed at addressing a practical issue. Our central goal is to identify how to engage with the general public in order to communicate the value of therapies of depth, insight, and relationship in ways that are meaningful and impactful. In order to do so, we need to define a clear value proposition and design our communications based on the attitudes, needs, and preferences of the general public, rather than those of clinicians and professional organizations. We have developed a framework, grounded in our research, that includes four key elements that should be present in any efforts to communicate with the general public about depth therapy. They represent the most important dimensions, based on people's perceptions and attitudes, that communicate the value of therapies of depth, insight, and relationship.

Basic must-have: "Feel heard"

At a basic level, "feeling heard" is an expectation people have from *any* form of therapy. As such, it must be considered in any attempt to engage with the general public. The core message of this dimension is that therapy is a place where people will be heard and understood without judgment. Based on our research, two-thirds of people believe that the most valuable aspect of therapy is sharing thoughts and feelings without feeling judged. About 60% think that "feeling heard and understood" is one of the most important benefits of therapists in general. In addition, the majority of people consider that talking to someone who is not judgmental and feeling understood are the main benefits of therapy. In qualitative interviews, these themes also came up consistently as a core part of therapy.

Key rational benefit: "Change and choice"

"Rational" benefits, also known as "functional" benefits, refer to what someone would "get" out of participating in therapy. Based on our research, we believe that the core message to convey is that therapy can help people change old patterns of behavior, thoughts, feelings, and relationships, so that they can then make different choices in their life. In fact, about 60% of people believe that the most important part of therapy is becoming empowered to make your own choices in life. Similarly, the majority of respondents believe that a key reason to seek out therapy is to change repeating patterns. Consistently, the majority also considered "stopping old patterns" as one of the main benefits in the therapy concept we tested. In qualitative interviews, people emphasized the value of therapy as a way to identify changes they would like to make, change repeating patterns, find new ways to feel and behave, pursue personal growth, and feel empowered to make choices.

Key emotional benefit: "Worth it"

It has been long recognized in the marketing and branding literature (e.g., Gobe, 2001) that rational benefits are not enough; people's choices are to a large extent motivated by an emotional connection leading to the experience of emotional benefits. The core emotional benefit we recommend focusing on is encompassed in the concept of worth: therapy is worth the effort, the time, and the investment, because *you* are worth getting to know and grow. The emotional benefit embedded in this message is two-fold: it speaks to the value of doing something valuable and worthwhile for oneself, and to the experience of being seen as a worthwhile human being. These benefits are supported by the finding that two-thirds of people believe that emotional and psychological problems inherently take time to understand and resolve, and that going to therapy is an investment in oneself that is worth making. People also value and understand the importance of self-awareness and self-understanding. Moreover, in qualitative interviews, people with experience in therapy considered it a powerful process that takes time and offers the possibility to understand oneself better and feel liberated.

Most differentiating factor: "Get to the root"

In order to stand out relative to other forms of therapy, therapies of depth, insight, and relationship need to highlight how they are different and unique. Based on our research, a key way to convey this difference is through the message that therapy is a way to increase self-awareness and to "get to the root of the problem." Over two thirds of our sample believe that the main goal of therapy is to better understand yourself and the root of your issues. The majority considered this aspect of the concept we tested (its focus on underlying causes) as one of the most important perceived benefits, and about half of people considered "getting to the root of the problem" the most valuable aspect of therapy. In addition, 91% said they would prefer therapy that addresses root causes of symptoms, rather than only providing ways to manage symptoms (even if the latter would require fewer sessions). Finally, in our qualitative interviews, people see increasing self-awareness and "getting to the root" as empowering and helpful to make sense of inner experiences and to find new ways of dealing with relationships and life.

It is important to note that, while our research provides strong support for communication strategies that incorporate these four elements, they will not necessarily be equally appealing for every member of the general public. A fundamental marketing principle is that no product, service, brand, or experience will be equally appealing to all people. Similarly, no type of therapy can be everything to everyone, and we should not attempt to be so. Therapies of depth, insight, and relationship – just like any of their alternatives – will be appealing only to a subset of the general public. The four elements we recommend are the pillars of a research-based strategy to communicate and engage with that segment of the population. Importantly, our research suggests that this segment

is not defined by specific demographics, but rather by their attitudes toward mental health and therapy itself.

Along these lines, our research also suggests a number of public-facing messages *not* to convey to the general public, as they elicited negative reactions in our research and might be confusing, irrelevant, or off-putting to the public. When communicating directly to the public, one should not:

- Downplay the value of "learning" skills and strategies to "manage" thoughts and feelings (i.e., symptoms).
- Disparage claims to "evidence" (e.g., EBT) as merely a marketing ploy.
- Dismiss people's questions or desires for structure, guidance, or assistance.
- Discourage or downplay a focus on symptoms and symptom relief.
- Denigrate medications and their use.
- Dismiss concerns about the expense or duration of treatment.
- Focus on the dynamics of the therapeutic relationship (e.g., transference, enactments), even if we use them as part of our clinical approach.
- Focus on the duration of treatment one way or the other – whether on long duration of depth therapy or in suggesting that short-term treatments might not be as effective.

Even if not well-publicized, it's clear that the evidence base for depth therapies is strong, valid and substantive. It's indisputable that these therapies are highly effective, and they receive the support of many clinicians. What we know now, thanks to our research, is not only that these therapies work, but that they resonate with a large number of people who value them and want the benefits that only they can offer. We need to start talking about therapy and mental health care in new and different ways. If we don't, we run the risk of either alienating a big part of the public, who would not find their needs and preferences represented in contemporary narratives about therapy, or of keeping them from understanding the full range of benefits that therapy can offer. If we do – and our research points the way – we would be returning to the full definition and true spirit of "evidence-based practice," which encompasses research, therapist wisdom and clinical experience, *and* patient preferences and values (American Psychological Association, 2021). While our research does not assume the preferences of any individual, specific patient, it provides data and insights to inform that third component of EBP. There is a significant portion of the general public whose "preferences and values" resonate with those of therapies of depth, insight, and relationship. Engaging with the public using the insights from our project would help ensure that those who suffer can have the opportunity to think of therapy as providing the care and experience that resonates with their attitudes, needs, preferences and values.

In order to bring therapies of depth, insight, and relationship back to the table, however, listening to the general public is only the first step. In order to effectively *engage* with the general public, organizations and clinicians advocating for these types of therapy need to work together. Engagement and communication need to be consistent, ongoing, and systematically managed efforts. One-off activities (e.g., a press release, a viral internet video, an isolated advertising campaign) will not work. Educating and engaging the public is a process that needs to be sustained. Like all relationships, it needs to be built, tended to, and nurtured over time. It is critical that supporting organizations are aligned around the messaging recommended by our research, so that public communications and messages are consistent with one another, and take action to engage their members and other constituents in this endeavor.

Because the expertise and capabilities required for communicating with the public effectively fall outside of the scope of most clinically-oriented professional organizations, it is critical that external experts, providers and agencies (e.g., social media, digital marketing, advertising) are enlisted to become part of our efforts. Finally, but equally important, is the need for financial resources to support ongoing initiatives and capabilities. While we can use tools and frameworks that are commonplace in the corporate world, nonprofits do not have access to the financial resources that large businesses can use. While appropriate funding will be a challenge for any initiative that

attempts to engage the general public, basing our communication on what we learned from our research, where we listened directly to the general public, will make any investments more efficient.

Future directions

While it is our hope that our research will offer the foundation to build a meaningful and productive relationship with the public through an effective and relevant communications strategy, we also know that there are other audiences involved in the mental health landscape. Future research efforts with therapists, academics, graduate students, referral sources or gatekeepers, and policymakers will be critical. The challenges experienced by therapies of depth, insight, and relationship are multi-faceted, and so must be their solution. Additionally, the impacts of COVID-19 and telehealth have not been sufficiently addressed in our research, due to timing. There could also be an opportunity to research specific sub-segments of the general population, to understand their needs, values, and associations in more depth. Our research, being the first of its kind, focused on understanding the public broadly. We did not find many systematic significant differences in our results, whether by different demographic groups or experience with therapy. Nevertheless, additional research aimed at understanding specific segments of the population would be a welcome addition to this body of work. Large corporations are already doing this kind of research (e.g., Facebook, 2019/2021). While we don't have their financial resources, we cannot afford to leave the understanding of the general public to them alone.

Our research findings and recommendations contain the ingredients for building a relationship with the public in which there is renewed trust, respect, and consideration of therapies of depth, insight and relationship, leading to the revitalization of these therapies in the mind of the public. If therapists and professional organizations can carry out our recommendations, we are confident we can achieve our goals of providing the public with important information and education, enhancing access to mental health treatments that work, and elevating depth therapies as an effective, relevant and valued treatment option.

Disclosure statement

No potential conflict of interest was reported by the authors.

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