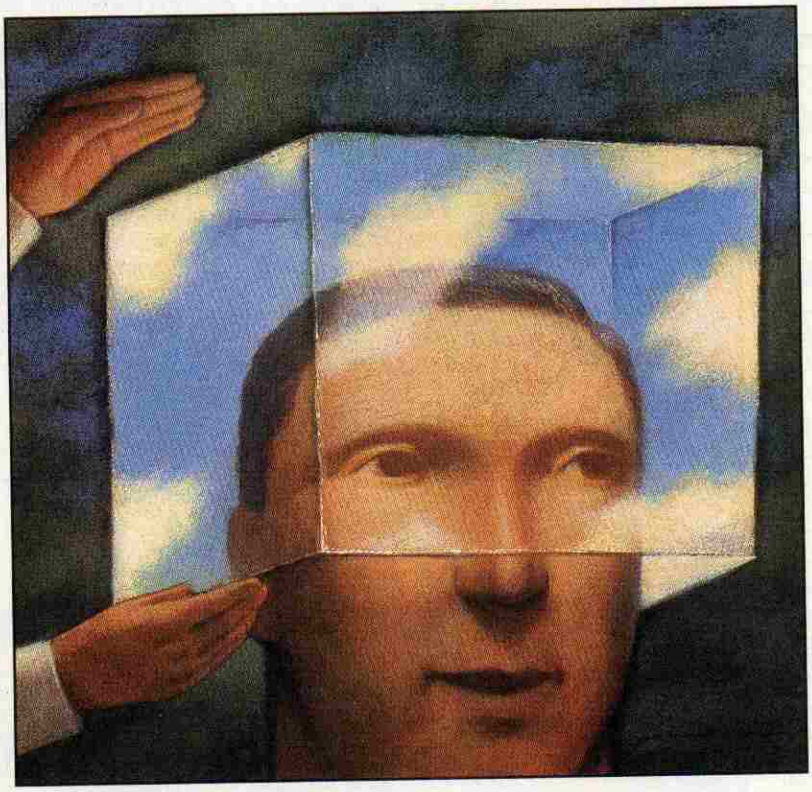
MENTAL HEALTH
DOES THERAPY HELP?

Our groundbreaking survey shows psychotherapy usually works. This report can help you find the best care.



Coping with a serious physical illness is hard enough. But if you're suffering from emotional or mental distress, it's particularly difficult to know where to get help. You may have some basic doubts about whether therapy will help at all. And even if you do decide to enter therapy, your health insurance may not cover it—or cover it well.

As a result, millions of Americans who might benefit from psychotherapy never even give it a try. More than 50 million American adults suffer from a mental or addictive disorder at any given time. But a recent Government survey showed that fewer than one-third of them get professional help.

That's a shame. The results of a candid, in-depth survey of CONSUMER REPORTS subscribers—the largest survey ever to query people on mental-health care—provide convincing evidence that therapy can make an important difference. Four thousand of our readers who responded had sought help from a mental-health provider or a family doctor for psychological problems, or had joined a self-help group. The majority were highly satisfied with the care they received. Most had made strides toward resolving the problems that led to treatment, and almost all said life had become more manageable. This was true for all the conditions we asked about, even among the people who had felt the worst at the beginning.

Among our findings

- People were just as satisfied and reported similar progress whether they saw a social worker, psychologist, or psychiatrist. Those who consulted a marriage counselor, however, were somewhat less likely to feel they'd been helped.
- Readers who sought help from their family doctor tended to do well. But people who saw a mental-health specialist for more than six months did much better.
- Psychotherapy alone worked as well as psychotherapy combined with medication, like *Prozac* or *Xanax*. Most people who took drugs like those did feel they were helpful, but many people reported side effects.
- The longer people stayed in therapy, the more they improved. This suggests that limited mental-health insurance coverage, and the new trend in health plans—emphasizing short-term therapy—may be misguided.
- Most people who went to a self-help group were very satisfied with the experience and said they got better. People were especially grateful to Alcoholics Anonymous, and very loyal to that organization.

Our survey adds an important dimension to existing research in mental health. Most studies have started with people who have very specific, well-defined problems, who have been randomly assigned to a treatment or control group, and who have received carefully scripted therapy. Such studies have shown which techniques can help which problems (see "What Works Best?," page 737), but they aren't a realistic reflection of most patients' experiences.

Our survey, in contrast, is a unique look at what happens in real life, where problems are diverse and less well-defined, and where some therapists try one technique after another until something works. The success of therapy under these real-life conditions has never before been well studied, says Martin Seligman, former director of clinical training in psychology at the University of Pennsylvania and past president of the American Psychological Association's division of clinical psychology.

Seligman, a consultant to our project, believes our readers' experiences send "a message of hope" for other people dealing with emotional problems.

Like other surveys, ours has several built-in limitations. Few of the people responding had a chronic, disabling condition such as schizophrenia or manic depression. We asked readers about their past experiences, which can be less reliable than asking about the present. We may have sampled an unusually large number of people in long-term treatment. Finally, our data comes from the readers' own perceptions, rather than from a clinician's assessment. However, other studies have shown that such self-reports fre-

quently agree with professionals' clinical judgments.

Who went for help

In our 1994 Annual Questionnaire, we asked readers about their experiences with emotional problems and their encounters with health-care providers and groups during the years 1991 to 1994. Like the average American outpatient client, the 4000 readers who said they had sought professional help were mostly well educated. Their median age was 46, and about half were women. However, they may be more amenable to therapy than most.

Many who went to a mental-health specialist were in considerable pain at the time they entered treatment. Forty-three percent said their emotional state was either very poor ("I barely managed to deal with things") or fairly poor ("Life was usually pretty tough").

Their reasons for seeking therapy included several classic emotional illnesses: depression, anxiety, panic, and phobias. Among the other reasons our readers sought therapy: marital or sexual problems, frequent low moods, problems with children, problems with jobs, grief, stress-related ailments, and alcohol or drug problems.

The results: Therapy works

Our survey showed that therapy for mental-health problems can have a substantial effect. Forty-four percent of people whose emotional state was "very poor" at the start of treatment said they now feel good. Another 43 percent who started out "fairly poor" also improved significantly, though somewhat less. Of course, some people probably would have gotten better without treatment, but the vast majority specifically said that therapy helped.

Most people reported they were helped with the specific problems that brought them to therapy, even when those problems were quite severe. Of those who started out "very poor," 54 percent said treatment "made things a lot better," while another one-third said it helped their problems to some extent. The same pattern of improvement held for just about every condition.

Overall, almost everyone who sought help experienced some relief —improvements that made them less troubled and their lives more pleasant. People who started out feeling the worst reported the most progress. Among people no longer in

Mental-Health Insurance

WHO PAYS—AND HOW MUCH?

Private insurers have always covered mental disorders and substance abuse more grudgingly than medical illness, either by building in limits or by interposing a case manager between you and your benefit. And very few plans deal well with the lifelong needs of people with chronic, severe mental illness. On the whole, says Kathleen Kelso, executive director of the Mental Health Association of Minnesota, "insurers would just as soon cover us from the neck down."

Almost all traditional fee-for-service plans pay 80 percent or more of the fee when you visit the doctor with a medical problem. But for outpatient therapy, the majority pay just 50 percent, and frequently that's after "capping" bills at well below the therapists' actual fees —which range on average from $80 to $120 according to Psychotherapy Finances, an industry newsletter. Most insurance plans also impose one or more other limits on mental-health coverage, such as the number of outpatient visits and hospital days they will pay for. In addition, many plans have annual or lifetime dollar maximums; for outpatient care, it can be as low as $1000 and $10,000, respectively. In recent years consumer advocates have lobbied for state laws that would equalize coverage for psychiatric and other illnesses. So far, just six states—Maine, Maryland, Minnesota, New Hampshire, Rhode Island, and Texas—have passed so-called "parity" laws. Consumers Union supports such laws, and has actively worked for their passage.

Health maintenance organizations (HMOs) also limit access to psychiatric services, typically providing a maximum of 20 outpatient visits and 30 hospital days a year. Patients usually have to go through their family physician or another gatekeeper to gain access to those benefits, and may get less than the maximum.

In our survey of mental-health care, respondents whose coverage limited the length and frequency of therapy, and the type of therapist, reported poorer outcomes. (However, we found no clear difference in outcome between people with fee-for-service coverage and those in HMOs and preferred provider plans.) Paying for therapy on their own was clearly a hardship for many: Twenty-one percent cited the cost of therapy as a reason for quitting.

To hold down spending, increasing numbers of employers, HMOs, and fee-for-service plans are turning to specialized managed-care companies to run their mental-health benefit. These specialty firms refer patients to a network of clinicians who must adhere to strict treatment guidelines. And they *have* reined in spending, saving some employers as much as 30 percent in the cost of mental-health care.

But many patients—and their therapists—feel they're being shortchanged. Psychiatrists complain about the difficulty of extending a hospital stay for patients considered too sick to leave and the challenge of getting approval for more than brief outpatient care.

Although many plans run by managed-care firms nominally have generous benefits, reality may fall somewhat short. All services must be authorized by a case manager. To get approval for additional sessions, therapists must provide details about a patient's problems and the course of treatment.

With scores of managed-care companies nationwide, there's great variability in how they tend to the needs of their subscribers. Even critics acknowledge that some plans are quite accommodating, and that some overly stringent practices have been curbed. But concern about heavy-handed practices has prompted several states to enact laws regulating managed-care services.

How to choose a plan

If you're picking a health-care plan and are concerned about mental-health coverage, you should ask some pointed questions:

■ **What are the stated benefits?** Pay close attention to the benefit limits, including co-payments, limits on the number of hospital days and outpatient sessions, and annual or lifetime dollar maximums. A typical plan with limits covers 30 days of inpatient care and 50 or fewer outpatient visits. But the cap it sets on covered charges may be low, and the copayments high.

■ **If the benefits cover only "medically necessary" treatment, who makes that determination?** It's best if that decision is left to you and your therapist. But in many managed-care plans it's a case manager who decides whether you need therapy or hospitalization, and how long it should last.

■ **What are your rights of appeal if coverage is denied or cut short?** In many plans the grievance process consists of a single appeal.

■ **In a managed-care plan, how large is the provider panel?** The more therapists in your area, the more likely you'll find one whose personality and expertise are a good match for you.

■ **Will the plan add new providers to its panel?** This can be important if you're already seeing a therapist who's not part of the plan but is willing to join.

■ **Which facilities are approved by the plan?** Be sure there's a hospital that's convenient and that offers a broad spectrum of mental-health and substance-abuse services. Also look for transitional and intermediate-care programs, such as mental-health day centers.

treatment, two-thirds said they'd left because their problems had been resolved or were easier to deal with.

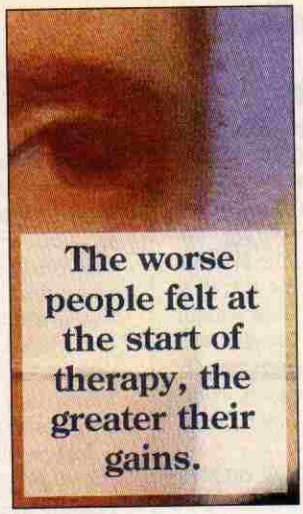
Whom should you see?

In the vast field of mental health, psychiatrists, psychologists, and clinical social workers have long fought for turf. Only psychiatrists, who are medical doctors, can prescribe drugs and have the training to detect medical problems that can affect a person's mental state. Otherwise, each of these professionals is trained to understand human behavior, to recognize problems, and to provide therapy.

Historically, social workers have been the underdogs and have had to fight for state laws requiring insurance companies to cover their services. But many of today's budget-minded insurers *favor* social workers —and psychiatric nurses—because they offer relatively low-cost services.

In our survey, almost three-quarters of those seeking professional help went to a mental-health specialist. Their experiences suggest that any of these therapists can be very helpful. Psychiatrists, psychologists, and social workers received equally high marks and were praised for being supportive, insightful, and easy to confide in. That remained true even when we statistically controlled for the seriousness and type of the problem and the length of treatment.

Those who went to marriage counselors didn't do quite as well, and gave their counselors lower grades for competence. One reason may be that working with a fractured couple is difficult. Also, almost anyone can hang out a shingle as a marriage counselor. In some states the title "marriage and family therapist" is restricted to those with appropriate training. But anyone can use other words to say they *do* marriage therapy, and in most places the title "marriage counselor" is up for grabs.



The worse people felt at the start of therapy, the greater their gains.

What about doctors?

Many people are more comfortable taking their problems to their family doctor than to a psychologist or psychiatrist. That may work well for some people, but our data suggest that many would be better off with a psychotherapist.

Readers who exclusively saw their family doctor for emotional problems—about 14 percent of those in our survey —had a very different experience from those who consulted a mental-health specialist. Treatment tended to be shorter; more than half of those whose care was complete had been treated for less than two months. People who went to family doctors were much more likely to get psychiatric drugs—83 percent of them did, compared with 20 percent of those who went to mental-health specialists. And almost half the people whose doctors gave them drugs received medication without the benefit of much counseling.

The people who relied on their family doctors for help were less distraught at the outset than those who saw mental-health providers; people with severe emotional problems apparently get themselves to a specialist. Even so, only half were highly satisfied with their family doctor's treatment (compared with 62 percent who were highly satisfied with their mental-health provider). A significant minority felt their doctor had neither the time nor temperament to address emotional issues. In general, family doctors did help people get back on their feet—but longer treatment with a specialist was more effective.

However, if you begin treatment with your family doctor, that's where you're likely to stay. Family doctors referred their patients to a mental-health specialist in only one out of four cases, even when psychotherapy might have made a big difference. Only half of those who were severely distressed were sent on, and 60 percent of patients with panic disorder or phobias were never referred, even though specific therapies are known to work for those problems.

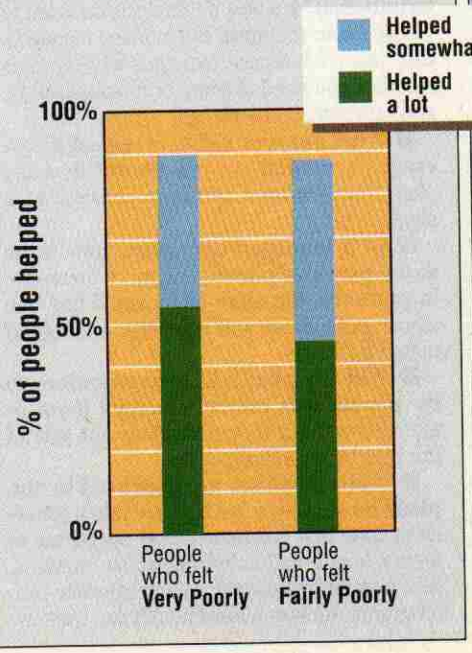
Other research has shown that many family doctors have a poor track record when it comes to mental health. They fail to diagnose some 50 to 80 percent of psychological problems, and sometimes prescribe psychiatric drugs for too short a time or at doses too low to work.

The power of groups

It was 60 years ago that a businessman and a physician, both

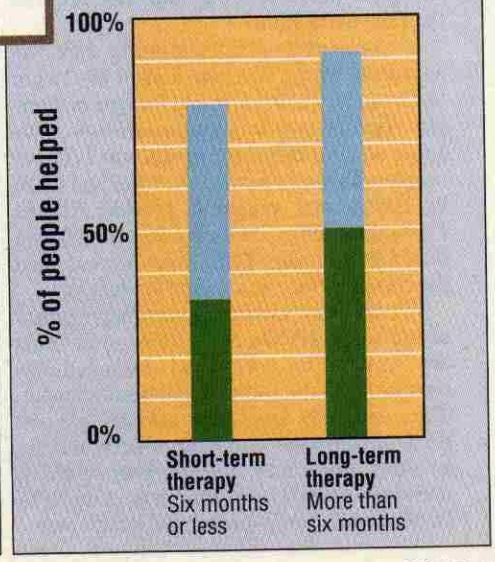
How much can therapy help?

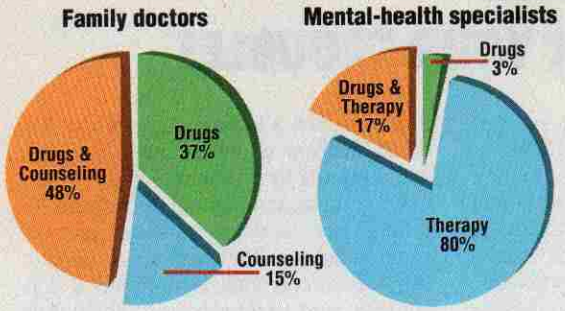
Almost everyone got some relief from the problems that brought them to a therapist, no matter how poorly they felt at the start.



Short-term or long-term?

Staying in therapy for more than six months brought greater improvement to more people.





Talk or drugs? Family doctors were much more likely to dispense mostly medication or a mix of drugs and talk. Very few mental-health therapists relied mainly on drugs; the vast majority provided psychotherapy.

struggling with alcoholism, realized they could stay sober by talking to one another. They talked to other alcoholics, too, and eventually worked out the system of long-term recovery known as Alcoholics Anonymous, or AA. Today there are over a million active AA members in the U.S., and attending an AA group is often recommended as part of professional treatment. The AA format has also been adopted by dozens of other self-help groups representing a wide spectrum of dysfunctional behavior, from Gamblers Anonymous to Sex and Love Addicts Anon. Support groups also bring together people who are dealing with medical illness or other trials.

One-third of our survey respondents went to a group, often in addition to individual psychotherapy. Overall, they told us, the groups seemed to help.

Readers who went to AA voiced overwhelming approval. Virtually all endorsed AA's approach to treatment, and most said their struggle with addiction had been largely successful. In keeping with AA's principle that recovery is a lifelong process, three-quarters of our readers had been in the group for more than two years, and most were still attending. Most of those who had dropped out said they'd moved on because their problems had improved.

Certainly, not everyone who goes to AA does as well; our sampling method probably over-represented long-term, and thus successful, AA members. AA's own surveys suggest that about half of those who come to the program are gone within three months. Studies that follow people who have undergone treatment for alcoholism find that AA is no more or less effective than other programs: A year after entering treatment, about half the participants are still in trouble.

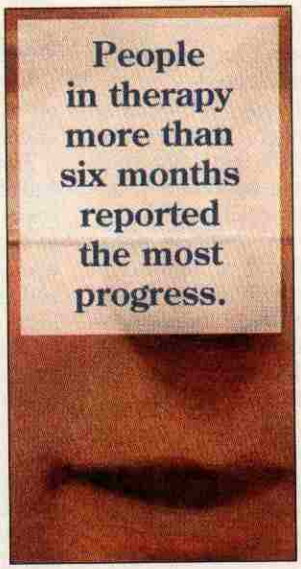
Nevertheless, AA has several components that may maximize the chance of success. In general, most alcoholics do well while they are being actively treated. In AA, members are supposed to attend 90 meetings in the first 90 days, followed by three meetings a week for life.

Drugs, pro and con

For decades, drug therapy to treat problems such as depression carried a raft of unpleasant, sometimes dangerous side effects. Then came *Prozac* (fluoxetine), launched in 1988. Safer and easier to take than previous antidepressants, *Prozac* and other drugs in its class—including sertraline (*Zoloft*) and paroxetine (*Paxil*)—have radically changed the treatment of depression. Along the way, people have claimed that *Prozac* seems to relieve a growing list of other complaints—from eating disorders to shyness to, most recently, premenstrual syndrome.

In our survey, 40 percent of readers who sought professional help received psychiatric drugs. And overall, about 60 percent of readers who took drugs said the medication helped a lot.

However, many of our readers did well with psychotherapy alone; in fact, people who received only psychotherapy improved as much as those who got therapy plus drugs.



For many people, having the option of talk therapy is important because every psychiatric drug has potential side effects that some individuals find hard to tolerate. Almost half of all our respondents on medication reported problems with the drug. Drowsiness and a feeling of disorientation were the most common complaints, especially among people taking the older antidepressants such as amitriptyline (*Elavil*).

Although the problems associated with psychiatric drugs are well-known, 20 percent of readers said their provider never discussed them—a disturbing lapse in communication. Equally disturbing was the finding that 40 percent of the people taking antianxiety drugs had done so for more than a year—25 percent for more than two years—even though long-term use results in habituation, requiring larger and larger doses.

Antianxiety medications such as *Xanax* and *Valium* can provide relief if used for a short time during a particularly stressful period, such as the death of a parent. But they haven't been well tested for generalized anxiety—a kind of chronic, excessive worrying combined with physical and emotional symptoms—and therapists have found them only erratically effective.

Xanax is approved by the U.S. Food and Drug Administration for panic disorder, which causes repeated bouts of unbearable anxiety; studies show that it acts quickly to reduce panic attacks. But after two months, *Xanax* apparently performs little better than a placebo. (See CONSUMER REPORTS, January 1993.) The reason many people take antianxiety drugs for so long is that they're extremely hard to kick; if the drug is stopped, symptoms return in full force.

How long will it take?

When a person needs psychotherapy, how much do they need? That has become a critical question—both for clinicians and for the insurers that pay for therapy. And it's a hard one to answer.

Nationally, most people who get therapy go for a relatively short time—an average of four to eight sessions. It's not clear, however, whether people stop going because they have been helped enough, because they don't think the therapy is working, or because they've run out of money. Controlled studies of specific kinds of therapy usually cover only 12 to 20 visits. While brief therapy often helps, there's no way to tell from such studies whether 30 or 40 sessions, or even more, would be even more effective.

For the people in our survey, longer psychotherapy was associated with better outcomes. Among people who entered therapy with

similar levels of emotional distress, those who stayed in treatment for more than six months reported greater gains than those who left earlier. Our data suggest that for many people, even a year's worth of therapy with a mental-health specialist may be very worthwhile. People who stayed in treatment for more than two years reported the best outcomes of all. However, these people tended to have started out with more serious problems.

We also found that people got better in three distinct ways, and that all three kinds of improvement increased with additional treatment. First, therapy eased the problems that brought people to treatment. Second, it helped them to function better, improving their ability to relate well to others, to be productive at work, and to cope with everyday stress. And it enhanced what can be called "personal growth." People in therapy had more confidence and self-esteem, understood themselves better, and enjoyed life more.

Despite the potential benefit of long-term therapy, many insurance plans limit mental-health coverage to "medically necessary" services—which typically means short-term treatment aimed at symptom relief. If you want to stay in therapy longer, you may have to pay for it yourself.

Our findings complement recent work by psychologist Kenneth Howard of Northwestern University. By following the progress of 854 psychotherapy patients, Howard and his associates found that recovery followed a "dose-response" curve, with the greatest response occurring early on. On average, 50 percent of people recovered after 11 weekly therapy sessions, and 75 percent got better after about a year.

Recommendations

Emotional distress may not always require professional help. But when problems threaten to become overwhelming or interfere with everyday life, there's no need to feel defeated.

Our survey shows there's real help available from every quarter—family doctors, psychotherapists, and self-help groups. Both talk therapy and medication, when warranted, can bring relief to people with a wide range of problems and deep despair.

With such clear benefits to be had, the strict limits on insurance coverage for mental-health care are cause for concern. As the debate over health care continues, we believe that improving mental-health coverage is important.

If you want to see a therapist, you should approach therapy as an active consumer. In our survey, the more diligently a person "shopped" for a therapist—consulting with several candidates, checking their experience and qualifications, and speaking to previous clients—the more they ultimately improved. Once in treatment, those who formed a real partnership with their therapist—by being open, even with painful subjects, and by working on issues between sessions—were more likely to progress.

When you look for a therapist, competence and personal chemistry should be your priorities. You'll be sharing your most intimate thoughts and feelings, so it's important to choose someone who puts you at ease.

Many people first consult their family doctor, who has already won their confidence and trust. If you decide to stay with your physician for treatment, bear in mind that the approach will probably be medically based and relatively short.

If you would prefer to work with a therapist, ask your doctor for a referral. Other good referral sources are national professional associations or their local or state chapters. For information or referrals you can call the American Psychiatric Association, at 202 682-6220; the American Psychological Association, 202 336-5800; the National Association of Social Workers, 800 638-8799, ext. 291; the American Association for Marriage and Family Therapy, 800 374-2638; and the American Psychiatric Nurses Association, 202 857-1133. Also contact local universities, hospitals, and psychotherapy and psychoanalytic training institutes. For general information on mental illness, call the National Alliance for the Mentally Ill, 800 950-6264.

Family and friends may also know of reputable therapists; try to get several names to consider. Our readers who located therapists through personal or professional references felt better served than those who relied on ads, their managed care company's roster, or local clinics. ■

THE TYPES OF THERAPIES AND THERAPISTS

If you're considering mental-health treatment, you're facing a wide choice of therapies and practitioners. Many therapists favor a particular theoretical approach, though often they use a combination.

In **psychoanalysis**, Freud's classical technique employing a couch and free association, patients explore and confront troubling childhood experiences. In **psychodynamic therapy**, the emphasis is on discovering unconscious conflicts and defense mechanisms that hinder adult behavior. The goal of **interpersonal therapy** is to enhance relationships and communication skills. **Cognitive therapy** is aimed at helping people recognize and change distorted ways of thinking. **Behavioral therapy** seeks to replace harmful behaviors with useful ones.

As for choosing a therapist, be careful. Anyone can legally be called a psychotherapist, whether or not he or she has received the training and supervision needed to competently practice. Look for someone licensed or certified in one of the following fields:

- **Psychiatrists** are physicians who have completed three years of residency training in psychiatry following four years of medical school and a one-year internship. All are trained in psychiatric diagnosis and pharmacotherapy, but only some residency programs provide extensive experience in outpatient psychotherapy.
- **Psychoanalysts** have a professional degree in psychiatry, psychology, or social work, plus at least two years of extensive supervised training at a psychoanalytic institute.
- **Psychologists** with the credential Ph.D., Psy.D., or Ed.D. are licensed professionals with doctoral-level training, typically including a year of clinical internship in a mental-health facility and a year of supervised post-doctoral experience.
- **Social workers** typically train in a two-year master's degree program that involves fieldwork in a wide range of human services, including mental health settings. Those who seek state certification or licensing as a clinical social worker need two years of supervised post-grad experience and must pass a statewide exam.
- **Marriage and family therapists** may have a master's or doctoral degree from an accredited graduate training program in the field, or may have another professional degree with supervised experience in the specialty.
- **Psychiatric nurses** are registered nurses who work in mental-health settings, often as part of a therapeutic team. Advanced practice nurses have a master's degree and can provide psychotherapy.

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