BetterHelp members experience significant reduction in depression symptoms: Viable alternative to traditional face-to-face counseling.

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Abstract

E-counseling, or the delivery of mental health services over the internet, has been suggested to be a viable approach to increasing access to mental healthcare, and broadly improving mental health and well-being. The present investigation reports findings from a survey that assessed changes in presenting depression symptoms from before to after using BetterHelp – the largest e-counseling platform worldwide. Results show that BetterHelp members experienced a significant reduction in depression symptoms (7-point improvement on the PHQ-9). Improvements in depression after using BetterHelp were found to be comparable to improvements from face-to-face counseling (5.7-point improvement; MachPherson et al., 2013, 10.6-point improvement; Mohr et al., 2012). Most impressive, 78% of BetterHelp members classified as having Severe Depression before using BetterHelp were no longer classified as having Severe Depression after use. A secondary study highlights that members also find BetterHelp to be more convenient, affordable, and accessible than face-to-face counseling. These results suggest that BetterHelp e-counseling is a viable alternative to face-to-face counseling.

Introduction

Psychotherapy (also often referred to as talk-therapy or counseling) is commonly used by mental health professionals to improve people's mental health and well-being (Seligman et al., 2005). Research studies show that counseling is even more effective at improving mental health than other treatments, such as medication (DeRubeis et al., 2008). While research has demonstrated the many benefits of counseling, access to counseling is still one of the largest barriers to getting this type of help, and the majority of research has only assessed the benefits of counseling delivered face-to-face (Arch et al., 2012; Seligman et al., 2006; Washburn et al., 2012). Telemental health, or the use of technology to provide long-distance counseling, is a field that is rapidly growing in response to this demonstrated and very urgent need.

In 2012, the American Psychological Association adopted a resolution formally recognizing the effectiveness of counseling, and also recognizing the need to work to increase access to these services, especially among traditionally underserved populations. Approximately 1 in every 4 adults in the United States is in need of counseling at any given time, yet only 13.4% of adults in the U.S. report actually being enrolled (Backhaus et al., 2012). Though many explanations exist as to why this is the case (such as stigma surrounding seeking mental well-being support, and lack of affordable care; Mohr et al., 2010), limited geographical access to trained professionals remains one of the most significant issues nationally and globally.

A study published in 2009 found that in the US, 77% of counties across the country experience a severe shortage of mental health professionals, with the grand majority of affected counties being located in more rural areas (Thomas et al., 2009). Studies examining the efficacy of technology-based counseling have found that online counseling not only offers clinical outcomes comparable to traditional face-to-face settings, but that members of online counseling platforms in some instances feel more comfortable, calm and relaxed during sessions, and experience enhanced user satisfaction when using online counseling platforms as compared to experiencing therapy in

more traditional settings (Yuen et al., 2012;D'Arcy et al., 2016). Furthermore, research shows that people in need of counseling are in fact more likely to seek out help when online counseling is provided as an option (Glasheen et al., 2016). Finally, when compared to face-to-face counseling, online-counseling provides both increased patient empowerment (i.e. maximizes flexibility of location of therapy as well as flexibility in scheduling therapy), and increased clinical efficacy (i.e. allows therapists to see clients in less time) (Gratzer et al., 2016).

To our knowledge, no research has been done investigating the benefits of e-counseling that combines text-therapy with other e-therapy modalities such as telephone, live chat, and live video, even though existing research has shown that text-therapy can provide equivalent or superior benefits to face-to-face therapy (D'Arcy et al., 2016). To examine the benefits of e-counseling, changes in depression symptom severity amongst BetterHelp - the largest e-counseling platform worldwide - members from pre-treatment to 3-months post-treatment were examined in Study 1 and user satisfaction was examined in Study 2.

Counselors at BetterHelp are licensed, trained, experienced, and accredited psychologists (PhD / PsyD), marriage and family therapists (MFT), clinical social workers (LCSW), or licensed professional counselors (LPC). All BetterHelp counselors have a Masters Degree or a Doctorate Degree in their field, have been qualified and certified by their state professional board after successfully completing the necessary education, exams, training, and practice, and all possess at least three years and 1,500 hours of hands-on experience. Thus, BetterHelp represents high-quality e-counseling – comparable to the quality of counseling which is often received face-to-face. BetterHelp members are able to choose from text, video, live chat, and phone counseling. For these reasons, the present research enables us to begin clarifying the unique benefits of a high-quality and modality-integrated e-counseling platform.

Study 1

Method

Participants. 318 (78% female) BetterHelp members met inclusion/exclusion criteria (explained below). Ages of participants meeting eligibility criteria ranged from 19 to 72 (M = 33.27, SD = 11.29). Participants were included only if pre-treatment levels of depression fell in mild, moderate, moderately severe, or severe ranges based on the PHQ-9 Scoring and Interpretation Guide (UMHS Depression Guideline). Participants reporting only minimal levels of depression were not included. Finally, participants were only included after they had used BetterHelp for between 90 and 104 days (3 months, plus two weeks) to ensure adequate time for treatment to take effect.

Before beginning e-counseling with BetterHelp (Time 1, or baseline), members were asked to complete the PHQ-9, probing current levels of depression. Between 90 and 104 days later (Time 2, or 3-month follow-up), participants were asked to again complete the same questionnaire. At Time 1, 37% of the final sample presented with mild symptoms, 29% presented with moderate symptoms, 24% presented with moderately severe symptoms, and 10% presented with severe symptoms. Figure 1 displays depression symptom category at baseline based on the PHQ-9 Scoring and Interpretation Guide.

Figure 1

Depression symptom category at baseline (n=318)
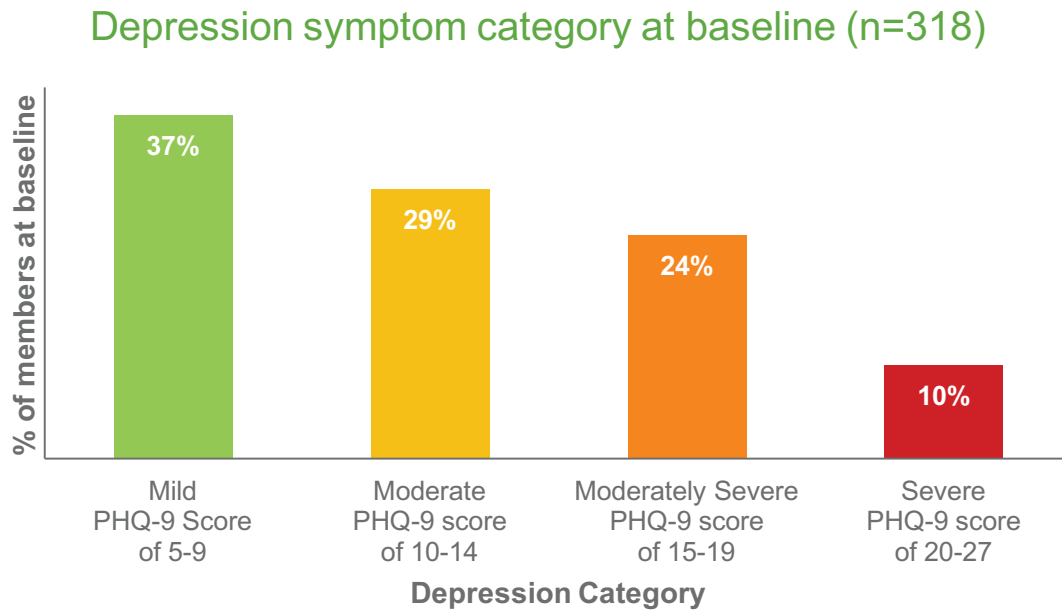
Measures. The Patient Health Questionnaire (PHQ-9; Kroenke et al., 2002) is a validated brief self-report measure frequently used in clinical practice to monitor depression symptoms and severity. Presently, the PHQ-9 was used to assess severity of depression symptoms among participants at baseline and follow-up. The PHQ-9 is a 10-item measure which asks a series of questions regarding how often, in the past 2 weeks, patients have been bothered by specific problems. The measure takes minutes to complete and is scored on a 4-Point Likert scale ranging from 0 – Not At All to 3 – Nearly Every Day.

Results

Analysis approach. To compare depression symptom severity levels before and after BetterHelp counseling and to assess change pre/post treatment, we used within-group t-tests. Within-group t-tests – also known as paired samples t-tests – control for correlations between data sets and as such are the best choice when seeking to detect change between pre- and post-tests. Participants were split into four groups before analysis, based on severity of symptoms

before treatment (these groups being mild, moderate, moderately severe, or severe).

Depression symptoms. Depression symptom severity was found to be significantly lower at Time 2 than at Time 1 across all four groups. Results showed that the largest improvement post-treatment was seen in participants who had the highest scores pre-treatment. In other words, **using BetterHelp for 3 months (or more) significantly lowered members' depression symptoms, and members with the most severe levels of depression before using BetterHelp experienced the most improvement in their depression after use.**

Point change. Diagnostic categories on the PHQ-9 span 4 points. On average, members diagnosed with Mild Depression before use saw an improvement of one point on the PHQ-9 after use, members with Moderate depression saw an improvement of 3 points, members with Moderately Severe depression saw an improvement of 6 points and members with Severe depression saw an improvement of 8 points.

Diagnostic category change. In addition to testing statistical significance, we ran descriptive analyses to assess how many people changed diagnostic categories. An individual's PHQ score enables us to classify them into one of five categories that represents the severity of their depression symptoms: Severe, Moderately Severe, Moderate, Mild, or Minimal depression. 36% of members classified as having Mild Depression before using BetterHelp changed to the Minimal Depression classification level after use. 65% of members classified as having Moderate Depression were classified as having only Mild or Minimal Depression after using BetterHelp, and 67% of members classified as having Moderately Severe Depression were classified as having moderate, mild, or minimal levels after use. **Most impressive, 78% of members** classified as having **Severe Depression before using BetterHelp were no longer classified as having Severe Depression after use, with 15% of these individuals now being classified as having only Mild Depression, all within three months of use.**

Table 1 displays these results for individuals in each category, and Figure 2 displays a breakdown of symptom category improvement based on the pre-treatment diagnosis category.

Table 1

Descriptive Statistics and t-test Results for Mild, Moderate, Moderately Severe, and Severe pretreatment categories

Outcome	Pre-treatment		Posttest		n	95% CI for Mean Difference	p	t	df
	M	SD	M	SD					
Mild	7.29	1.37	6.50	3.92	119	0.11, 1.47	0.02	2.299	118
Moderate	12.03	1.41	9.35	5.24	91	1.56, 3.77	0.00	4.875	90
Moderately Severe	17.04	1.33	11.33	5.12	75	4.55, 6.86	0.00	9.8272	74
Severe	22.94	2.16	15.18	5.62	33	0.55, 0.83	0.00	7.73	32

Figure 2

Depression symptom improvement based on pre-treatment diagnosis category
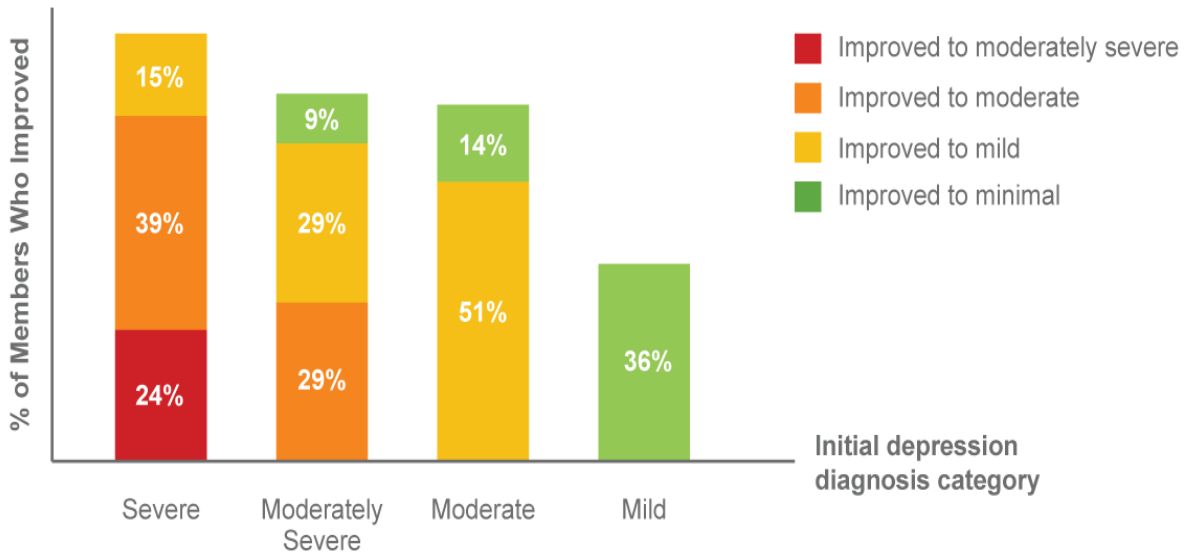
Improvement in depression symptom is based on PHQ score change from baseline to 3 month follow-up.

Discussion

Results of this study demonstrate that BetterHelp members see significant reduction in levels of depression symptom severity after three months of use, with individuals who were most severely impaired at baseline seeing the largest improvement post-treatment. These results demonstrate that after three months of using BetterHelp, many members can expect improvements in depression symptoms. This means that regardless of the starting point, BetterHelp improved the depression diagnostic category of members by *at least* if not more than one category.

Although we did not use a randomized controlled design, which randomly assigns people to treatment conditions, our results show that BetterHelp members experienced a significant reduction in depression symptoms (7-point average improvement). Improvements in depression after using BetterHelp were found to be comparable to improvements seen in face-to face counseling (5.7-point improvement; MachPherson et al., 2013, 10.6-point improvement; Mohr et al., 2012). Most impressive, 78% of BetterHelp members classified as having Severe Depression before using BetterHelp were no longer classified as having Severe Depression after use. This data suggests that significant improvements in depression can be expected among people who choose to use BetterHelp's e-counseling.

Study 2

Given the potential accessibility, affordability, and effectiveness of e-counseling, we conducted a second study to gain insight on user experience with BetterHelp e-counseling. The present investigation reports findings from a survey that asked current members of BetterHelp – the largest e-counseling platform worldwide – to report their experiences with both e-counseling and face-to-face counseling. More specifically, it assessed whether BetterHelp e-counseling differs from face-to-face counseling with regard to:
1.) Affordability, 2.) Convenience, 3.) Effectiveness, 4.) Fit, 5.) Accessibility, 6.) Progress, 7.) Satisfaction, 8.) Quality, 9.) Meeting needs, and 10.) Therapeutic alliance.

Method

Participants. Forty-eight participants (88% female) between the ages of 22 and 65 (*M* = 40.96, *SD* = 12.89) responded to an account notification from BetterHelp inviting them to complete a survey post participation. Potential participants were invited to participate in the study only if they had been using BetterHelp for 3 months or more, to ensure time to fully experience and understand BetterHelp e-counseling. All participants were asked to answer a series of questions with regard to their experiences with BetterHelp. Participants were then asked "Have you ever been in face-to-face counseling?" A subset of thirty-eight participants (79%) had also been in face-to-face counseling. This subset of participants was then asked the same series of questions regarding their experiences with face-to-face counseling.

Measures. *Therapeutic alliance.* The quality of the therapeutic relationship was assessed using the Working Alliance Inventory (WAI) – short form (Munder, 2010). Questions were phrased to assess alliance with BetterHelp counselors or alliance with face-to-face counselors. The WAI has been shown to have good reliability and validity ($\alpha_{\text{BetterHelp}}$ = .94; $\alpha_{\text{face-to-face}}$ = .97 in the present sample).

Satisfaction with counseling. To measure satisfaction with counseling, items were developed assessing a range of factors that tend to affect satisfaction with counseling (see Table 2 for questions).

Table 2

Questions assessing satisfaction with counseling.

Label	Question	Scale
Affordable	BetterHelp is affordable.	Agree/Disagree
Convenient	BetterHelp is convenient.	Agree/Disagree
Effective	BetterHelp is effective.	Agree/Disagree
Fit	BetterHelp is the right kind of help for me.	Agree/Disagree
Accessibility	BetterHelp is help right when I need it.	Agree/Disagree
Progress	BetterHelp has allows me to make progress on my own problem.	Agree/Disagree
Quality	How would you rate the overall quality of your BetterHelp experience?	1 (Fair) - 4 (Excellent)
Needs	What proportion of your treatment needs are being met through BetterHelp?	1 (Very few) - 4 (All or nearly all)
Return	How likely are your to return to BetterHelp again in the event that you need help with a new problem?	1 (Very unlikely) - 5 (Very likely)
Recommend	How likely is it that you would recommend BetterHelp to a friend or colleague?	0 (Not at all likely) - 10 (Extremely likely)

Note. Participants were asked these exact same questions about their experience with face-to-face counseling (i.e., "BetterHelp" was replaced with "face-to-face counseling".) 'Recommend' was only asked about BetterHelp experience.

Comparing BetterHelp *to face-to-face counseling.* To directly assess whether participants preferred BetterHelp when they compared BetterHelp to their experiences with face-to-face counseling, we once more rephrased our satisfaction questions so that participants compared their experiences (e.g., "How would you rate the overall quality of BetterHelp compared to face-to-face therapy?")
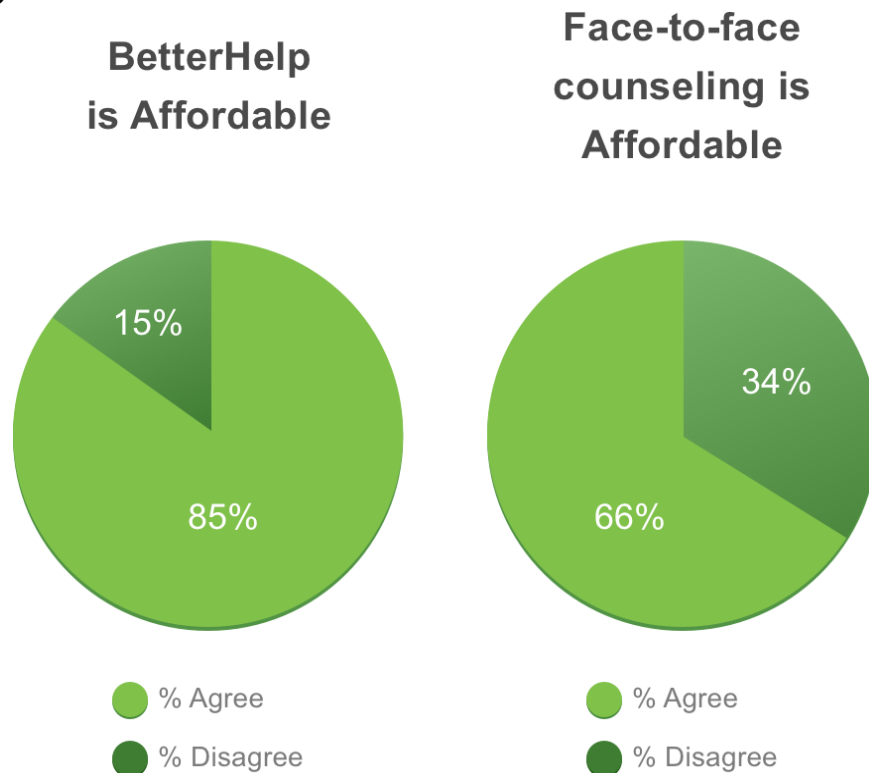
Results

Therapeutic alliance. To compare therapeutic alliance for BetterHelp to therapeutic alliance for face-to-face counseling, we used within-group t-tests. Ratings of therapeutic alliance were significantly greater for BetterHelp (M = 4.4, SD = 0.7) than face-to-face counseling (M = 3.2, SD = 1.2), $t(31)$ = 5.35, $p < .01$ (CI = 0.73 - 1.62). This result provides support for the idea **that BetterHelp e-counseling creates**
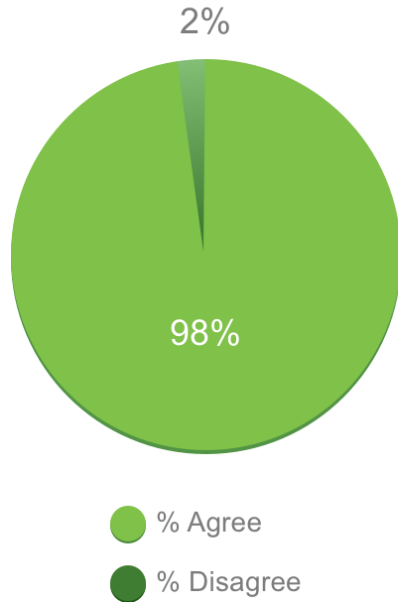
a satisfying therapeutic alliance between counselor and client. These data further suggest that therapeutic alliance for e-counseling is even stronger than for face-to-face counseling.

Satisfaction. To assess satisfaction with BetterHelp and satisfaction with face-to-face counseling, we first used descriptive statistics to clarify the percentage of people who were satisfied with each dimension of counseling for both BetterHelp and face-to-face counseling (see Figure 3). Our sample size and the distribution of responses prevented us from being able to conduct McNemar's Chi-squared tests on these dichotomous variables. Descriptive results, however, suggest greater satisfaction with BetterHelp e-counseling than face-to-face counseling. **All analyses supported BetterHelp as being more satisfying than face-to-face therapy.** In particular, BetterHelp was found to be significantly more convenient, affordable, and accessible than face-to-face therapy.

Figure 3

BetterHelp is Affordable
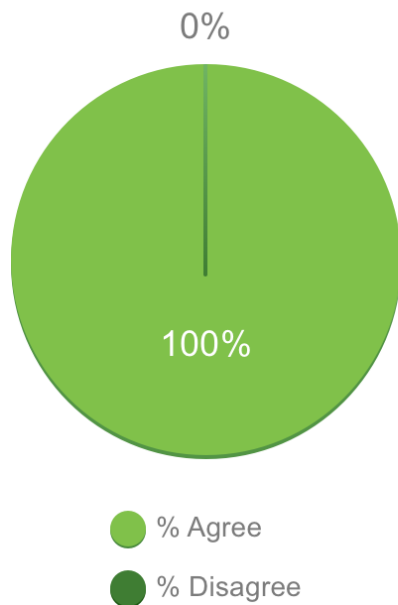
15%

85%

- % Agree
- % Disagree

Face-to-face counseling is Affordable

34%

66%

- % Agree
- % Disagree

BetterHelp is Effective

2%

98%

- 🟢 % Agree
- 🟢 % Disagree

Face-to-face counseling is Effective

29%

71%

- 🟢 % Agree
- 🟢 % Disagree

BetterHelp is Convenient

0%

100%
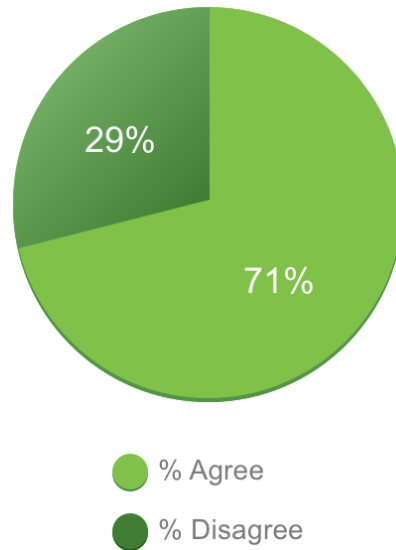
- 🟢 % Agree
- 🟢 % Disagree

Face-to-face counseling is Convenient
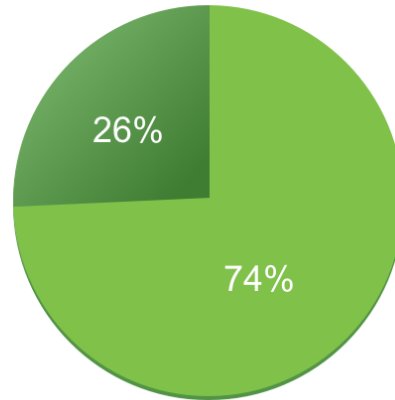
20%

80%
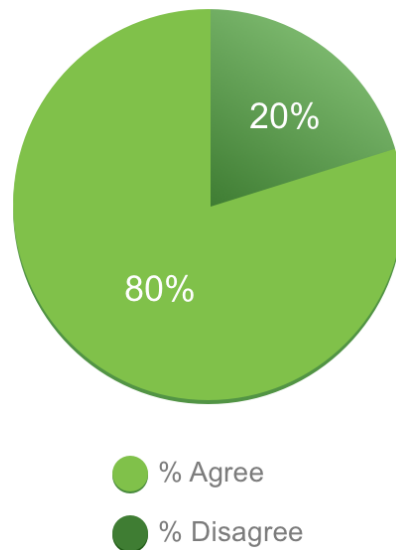
- 🟢 % Agree
- 🟢 % Disagree

BetterHelp has allowed me to make progress on my problem

2%

98%
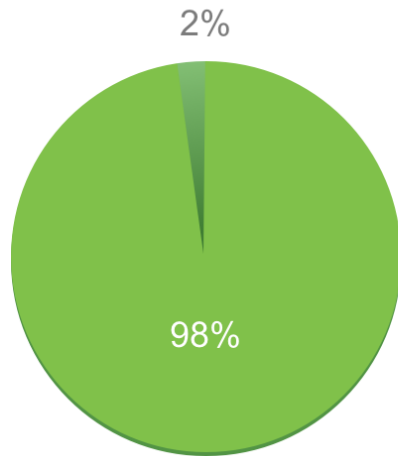
- % Agree
- % Disagree

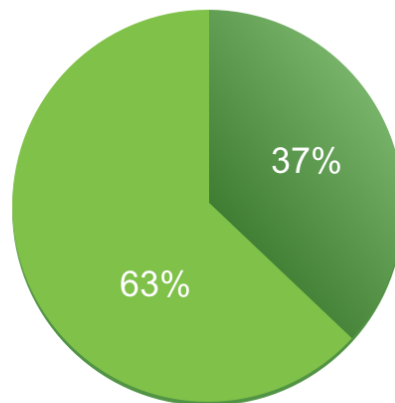## Face-to-face counseling has allowed me to make progress on my problem

26%

74%

- % Agree
- % Disagree

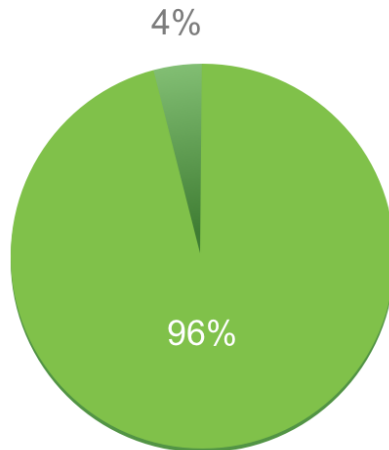## BetterHelp is help right when I need it

9%

91%
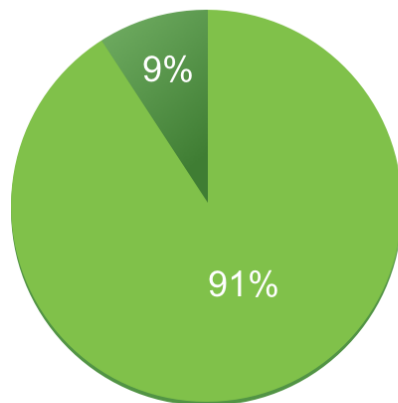
- % Agree
- % Disagree

Face-to-face counseling is help right when I need it

37%

63%
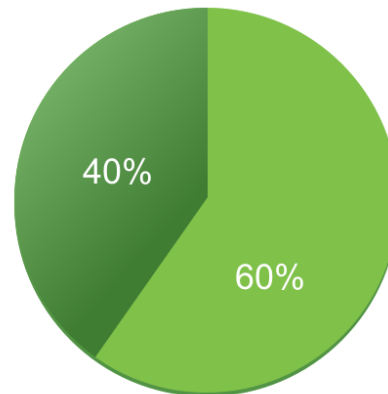
- % Agree
- % Disagree

BetterHelp is the right kind of help for me

Face-to-face counseling is the right kind of help for me

4%

96%

40%

60%

% Agree
% Disagree

% Agree
% Disagree

To continue assessing satisfaction with BetterHelp and satisfaction with face-to-face counseling, we used within-group *t*-tests for our continuous variables. Ratings of quality were significantly greater for BetterHelp (*M* = 3.7, *SD* = 0.5) than face-to-face counseling (*M* = 2.7, *SD* = 1.0), *t*(34) = 5.45, *p* < .01 (*CI* = 0.63 - 1.37). Ratings of how well treatment needs were met were significantly greater for BetterHelp (*M* = 3.3, *SD* = 0.7) than face-to-face counseling (*M* = 2.5, *SD* = 1.0), *t*(34) = 4.20, *p* < .01 (*CI* = 0.40 - 1.14). Ratings of how likely one would be to return were significantly greater for BetterHelp (*M* = 4.8, *SD* = 0.6) than face-to-face counseling (*M* = 2.9, *SD* = 1.2), *t*(34) = 7.48, *p* < .01 (*CI* = 1.37 – 2.40). These results provide further support that clients of BetterHelp are more satisfied with e-counseling than face-to-face counseling (see Figure 4).
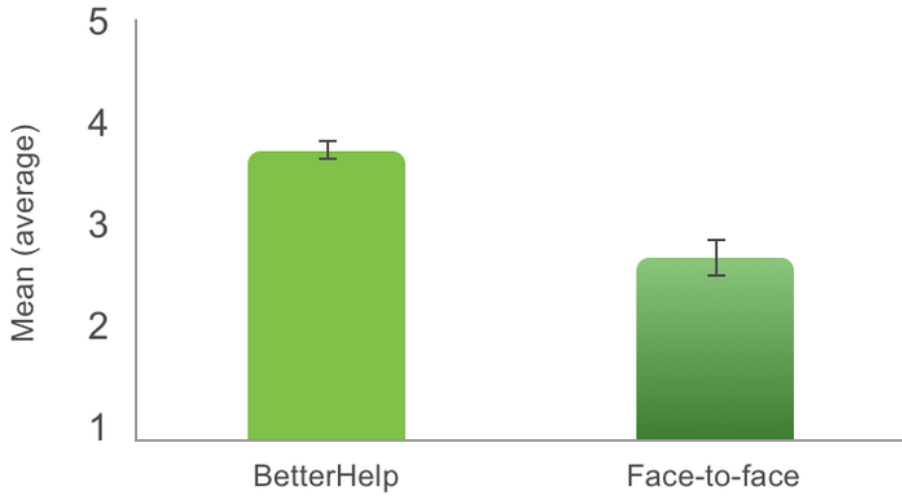
Figure 4

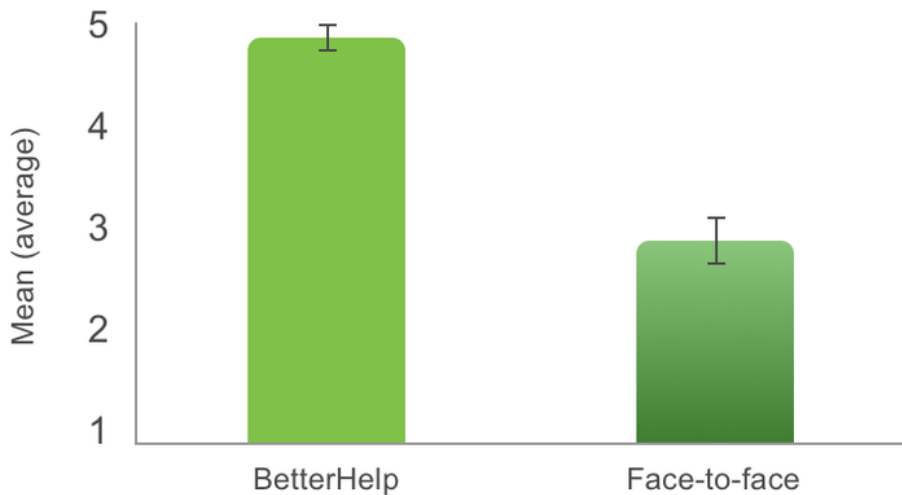## Theraputic Alliance (using the Working Alliance Inventory)
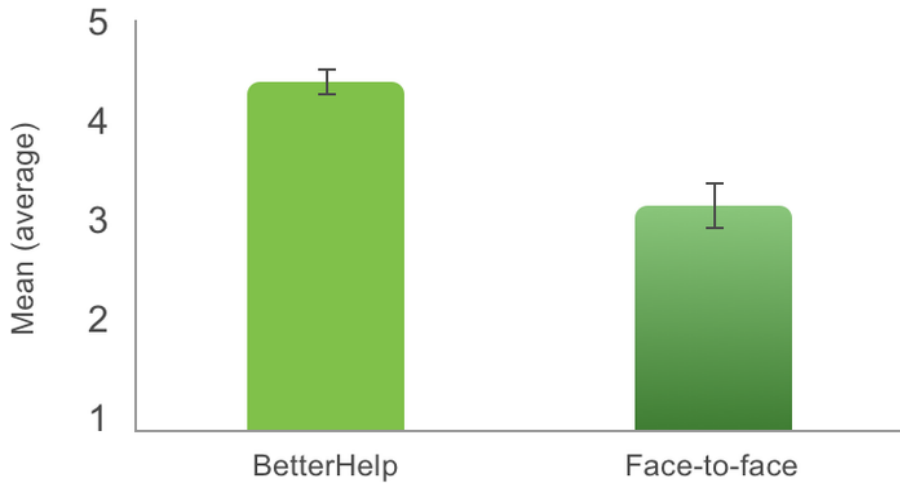
What proportion of your treatment needs are being met through (counseling)?
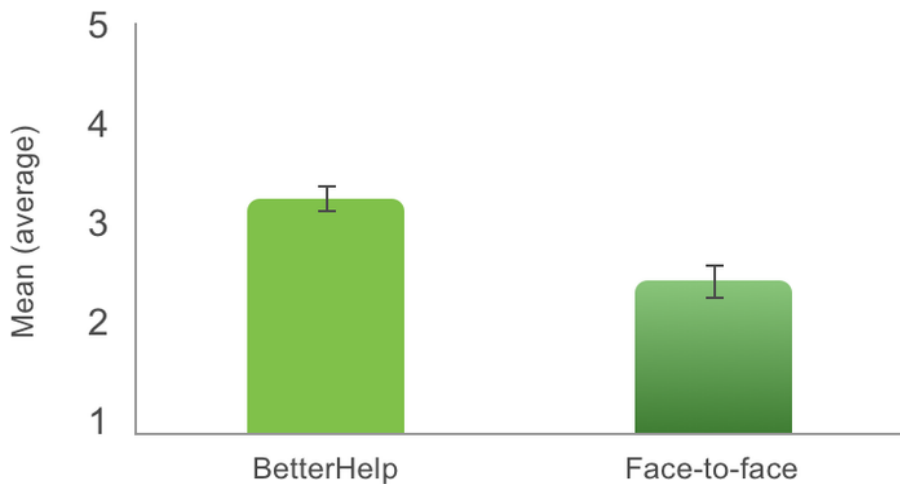
How would you rate the overall quality of your (counseling) experience?

How likely are you to return to (counseling) again in the event that you need help with a new problem?

Finally, when asked how likely one would be to recommend BetterHelp to a friend or colleague on a scale from 0 (Not at all likely) to 10 (Extremely likely), participants reported scores ranging from 5-10 (*M* = 9.2, *SD* = 1.3).

Comparing BetterHelp to face-to-face counseling. Descriptive statistics were used to directly assess whether people found experiences with BetterHelp to be better or worse than experiences with face-to-face counseling.

First, we assessed whether people would choose BetterHelp or face-to-face counseling in the future (see Figure 5). Next, we assessed how participants compared BetterHelp to face-to-face counseling on each of the dimensions of satisfaction. The strongest effects suggest that **BetterHelp members find BetterHelp to be more convenient and accessible than face-to-face therapy**, and all analyses supported BetterHelp as being more satisfying than face-to-face counseling (see Figure 6).

Figure 5

How likely are you to return to BetterHelp instead of face-to-face therapy in the event that you need help with a new problem?

- Very unlikely that I would choose BetterHelp over Face-to-face therapy
- Somewhat unlikely that I would choose BetterHelp over face-to-face therapy
- Not sure that I would choose BetterHelp over face-to-face therapy
- Somewhat likely that i would choose BetterHelp over face-to-face therapy
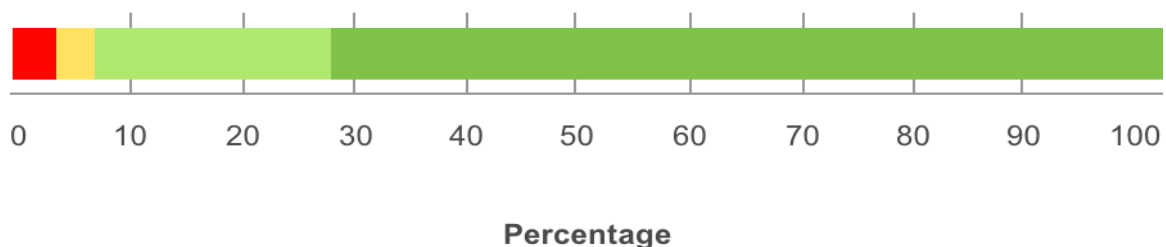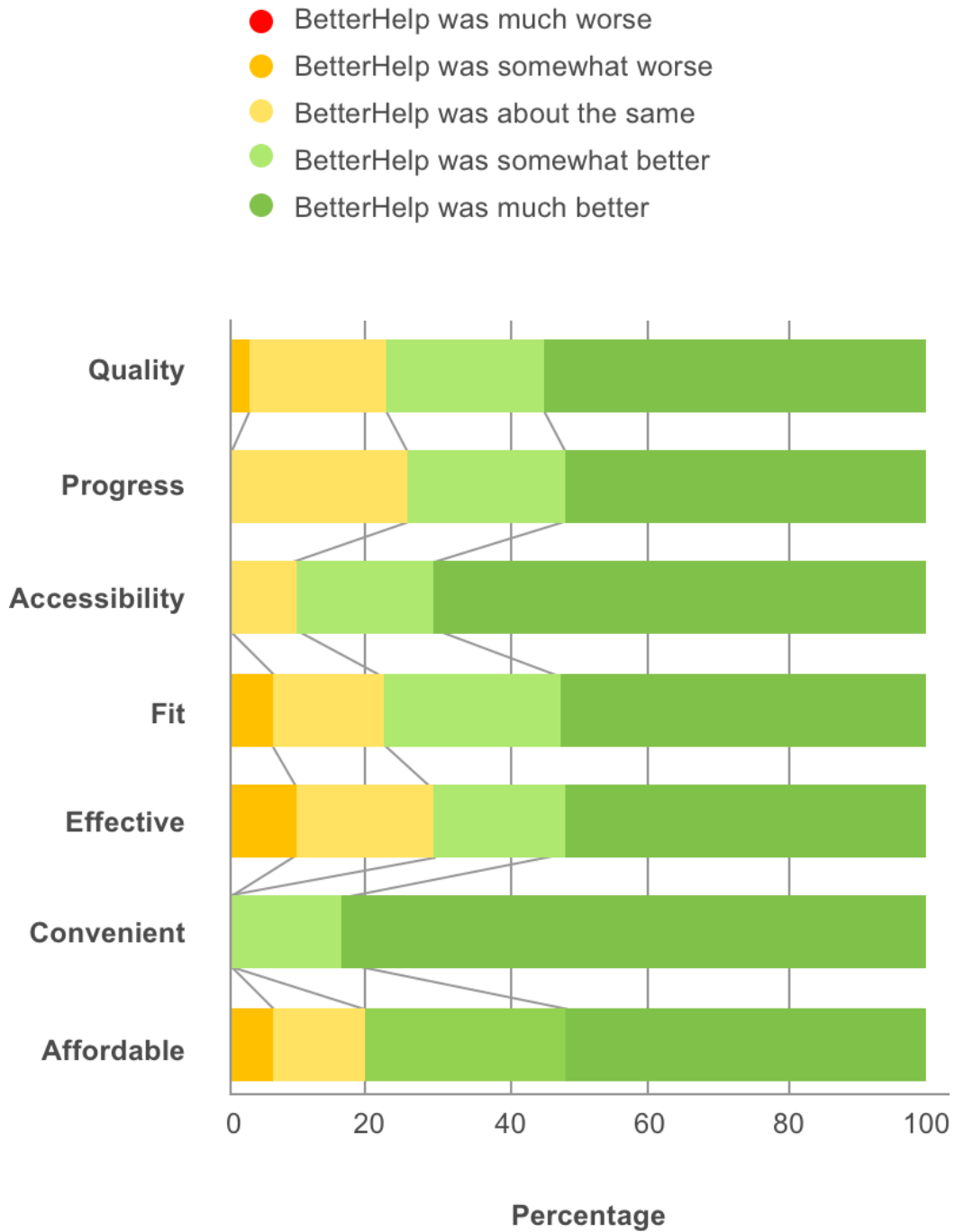- Very likely I would choose BetterHelp over face-to-face therapy

Percentage

Figure 6

How would you compare your experience on BetterHelp to face-to-face therapy?

Discussion

As expected, e-counseling appears to address a number of significant barriers (i.e., convenience, affordability, and accessibility) that sometimes prevent face-to-face counseling from being effective. Notably, the present data further suggest that therapeutic alliance for BetterHelp e-counseling may be even stronger than face-to-face counseling. While there are many reasons as to why this may be the case, we postulate that these strong alliances are formed when using BetterHelp as a result of BetterHelp counselors' flexible availability. Face-to-face counseling is often limited to a pre-determined number of sessions (as defined by insurance companies or by financial capabilities). Research has shown that the national average number of counseling sessions available to an individual is less than 5, despite knowledge that between 8-13 sessions are needed to see improvement (Hansen et al., 2002). BetterHelp counselors are able to quickly respond to members' needs, with an average response time of 10.6 hours, and have more frequent interaction with members as compared to a face-to-face therapist, with BetterHelp members receiving an average of 3.7 sessions over the course of a week.

Furthermore, it is possible that counselors are able to minimize stigma and prejudice (e.g., racial, gender, socio-economic) that may be more likely to emerge and impact counselor/client relationships when counselors see clients. Alternatively, when interacting with a therapist online versus face-to-face, anxieties related to therapy held by the client regarding the counselor/client relationship may be mitigated with the help of the existing e-separation (Sucala el al., 2012). Though additional research is needed to clarify the mechanisms underlying this finding, these results have important implications for counseling practice and suggest that BetterHelp's high-quality e-counseling is a viable alternative to face-to-face counseling.

It is important to note that participants were asked to retrospectively recall experiences with face-to-face therapy, which may have occurred longer ago than their experiences with BetterHelp, and as such may have been more difficult to accurately recall. Although retrospective reports have known draw-backs, they are widely used

and accepted in the psychology literature, particularly for exploratory studies such as this one.

General Discussion

Research has demonstrated that e-counseling, and more specifically text-based counseling, is a viable method of both improving mental health and well-being and overcoming existing barriers to mental health treatment (Aguilera, 2012). Despite this, few studies to date have investigated benefits or user experience with e-counseling. Given the potential scalability of e-counseling, this study sought to clarify the benefits of e-counseling with BetterHelp.

The results of this study strongly suggest numerous benefits of BetterHelp e-counseling. Results show that BetterHelp members experienced a significant reduction in depression symptoms (7-point improvement). Improvements in depression after using BetterHelp were found to be comparable to improvements from face-to face counseling (5.7-point improvement; MachPherson et al., 2013, 10.6-point improvement; Mohr et al., 2012). Most impressive, 78% of BetterHelp members classified as having Severe Depression before using BetterHelp were no longer classified as having Severe Depression after use. A second study additionally suggests that members are highly satisfied with the price and convenience of BetterHelp.

Although the present investigation addressed multiple limitations of existing research, it is not without its own limitations. This study, like most survey studies, may have been affected by sampling bias. Only participants who were already using BetterHelp for 3 months were included in analyses. Because individuals who terminated treatment before 3 months were not included in pre/post analyses, results exclude those who may not have found BetterHelp beneficial and sought other forms of therapy in that time. It was essential for us to focus on this group to ensure that all participants were familiar with, and had the time to benefit from, the service; however, this approach may have led to a bias towards including people in the study who favored BetterHelp e-counseling.

That being said, we should not discount the positive impacts that BetterHelp had on the members who chose to opt in. No intervention approach will work for everyone. Given the affordability and accessibility of Betterhelp e-counseling, our findings suggest that Betterhelp e-counseling represents an opportunity to have a bigger impact, across a larger number of people, for a reduced cost.

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