Effects of Branding on Willingness to Attend Therapy

by

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Abstract

Mental Health is an increasingly common topic of conversation in America throughout the past decade. This research paper explores the effect that branding has on an individual's willingness to attend therapy. Our results could not prove that branding played a significant role in an individual's willingness to attend therapy. However, we were able to prove that three key moderators: Brand Trust, Psychological Safety, and Brand Authenticity were statistically significant in determining an individual's willingness to attend therapy. Practical insights for therapists center around promoting the individualistic care a patient could expect to receive while attending their practice.

Contents

Introduction

Mental Health in America is a topic of increasing prevalence. Nearly 1 in 5 adults suffer some form of Mental Health episode in a given year. Furthermore, 1 in 4 children face trauma during their adolescents ((Mental Health America, 2019).

Cognitive Behavioral Therapy is perhaps the most well-known option for addressing mental health issues in America (Gilbert, 2019). A quick Google search of "CBT therapist near me" is likely to show at least some results. Furthermore, there has been a recent increase in interest in online-only platforms, such as BetterHelp and Talkspace. Even so, the statistics show that therapy could be better.

This research paper specifically looked into the effects branding has on individuals' willingness to attend therapy. We hypothesized that 1. Branding would increase an individual's willingness to attend therapy 2. Corporate control would increase an individual's willingness to attend therapy 3. Brand trust will explain an individual's willingness to attend therapy above and beyond other identified factors.

To test these results, we utilized an online survey with 23 Likert Scale questions relating willingness to attend therapy with psychological safety, brand trust, brand affect, brand authenticity, and corporate efficiency. The control group was independent practitioners and the test groups were independent branded and network branded therapists.

Our research findings did not show that branding would increase an individual's willingness to attend therapy nor that corporate control increases an individual's willingness to attend therapy. To test these hypotheses, we used ANOVA testing to compare sample means and were unable to reject the null hypothesis that there was no significant relationship at alpha .05.

Our research was able to show a statistically significant relationship between brand trust and an individual's willingness to attend therapy. Hierarchical regression analysis shows the resulting contributed R-Square was .031, which results in a significant F-Stat. This finding extends the primary theoretical model that Chaudhuri and Holbrook defined in 2001.

The practical insights of these findings are geared towards entrepreneurial therapists. Essentially, these therapists should focus the bulk of the marketing efforts on individualism and not a corporate brand image.

Problem Statement

Mental Health in America

Mental health in America has become an increasingly salient topic of conversation over the past decade. Mental Health America's "2019 State of Mental Health in America Report" sheds light on the numbers behind the outward effects of mental health issues. For adults, 18.07% experienced a mental health issue in the past year, with 4.13% experiencing a serious mental health issue. 56.4% of adults with mental illness do not receive treatment, with 20.6% of adults with mental health issues claiming they cannot receive the treatment they need, a statistic that has not declined since 2011. For youth, Mental Health America reports that 12.63% suffered one major depressive episode last year, which is an increase of approximately 175 thousand individuals from the prior year. Moreover, 61.5% of youth that experienced a depressive episode did not receive the treatment they needed. Finally, the report claims that 1 in 4 children experience maltreatment in their lives and there has been a 3.8% increase in childhood abuse cases from 2011-2015, causing lower grades in school and emotions of hopelessness and worry (Mental Health America, 2019). Clearly, Mental Health America's report suggests America still needs improvement in caring for mental health. However, improving America's mental health care may also improve other startling statistics.

Youth suicide has increased by 56% and is the second-leading cause of 10-24-year-old deaths, trailing only accidents (Wan, 2019). Perhaps even more devasting is the increase in mass shootings in America. In 2018, there were a record 8 mass shootings and 2019 has already seen 6, most recently being El Paso, TX, and Dayton, OH. Although Northwestern sociologist and epidemiologist Lori Post disagrees that mental health issues cause mass shootings (Thometz, 2019), mass shootings seem to spark interest in mental health (Szabo, 2012). It is unclear if and

to what extent improving mental health care will decrease youth suicide and mass shootings, however, there may be improvement along these dimensions.

Mental health should not be constrained to the most devastating topics such as suicide and mass shootings. Currently, America is facing a loneliness problem in which 40% of Americans report that “they sometimes or always feel their social relationships are not meaningful” and 20% report feeling “lonely or socially isolated” (HRSA, 2019). Moreover, HBR’s Levinson reports that executive burnout causes despair, helplessness, rage, and an “inescapable sense of inadequacy” (Levinson, 1996). Thus, improving mental health care may turn around America’s loneliness problem and create a more connected, positive society.

Literature Review

This section dives into the various literature surrounding therapy and branding.

Therapy

The two primary therapy modalities that this paper reviews are Cognitive Behavioral Therapy and Psychoanalysis. These modalities are widely researched, accepted, and practiced, making them excellent candidates for this paper as there is a large enough sample size to obtain statistically significant results. Moreover, novel insights in these categories will have wide-range effects on improving mental health care in America.

Cognitive Behavioral Therapy (CBT) is one of, if not the most, used and recognized psychotherapy (Gilbert, 2019). As the name implies, CBT is a mesh of Cognitive Therapy and Behavioral Therapy (Gilbert, 2019). CBT is short-term psychotherapy for a variety of problems such as depression, anxiety, relationships, anger, loneliness, phobias, eating disorders, and more. Additionally, the patient and therapist work to understand how the patient's thought processes today differ from their childhood (American Institute for Cognitive Therapy, 2009). Simply put, cognitive therapy deals with thought processes whereas behavioral therapy deals with the behavior patterns that stem from such thought processes. The basic premise for why CBT exists is that people can become trapped and inundated with "attention, reasoning, and safety-seeking strategies", which negatively affects the person's ability to comprehend and solve complex life issues (Gilbert, 2019). Thus, CBT uses various tools such as Socratic dialogue, guided discovery, behavior experiments, exposure therapy, self-monitoring, self-reflection, and self-change (Gilbert, 2019).

Psychoanalysis is the other prominent form of psychotherapy. This modality focuses on changing undesired behaviors and thoughts by revealing the underlying motivations causing

them. Additionally, the therapist-patient relationship is close. Finally, psychoanalysis stems from research conducted by Sigmund Freud (APA, 2019). Psychoanalysis and CBT are similar, both attempting to modify undesired behaviors. However, CBT more heavily focuses on childhood development in consideration of behaviors while psychoanalysis focuses on underlying motivations that cause certain behaviors. Many therapists combine elements of both, thus, this paper will analyze the CBT market in Ann Arbor as it is typically combined with psychoanalysis (APA, 2019).

Cognitive Behavioral Therapists in and near Ann Arbor tend to be clinical social workers or psychologists. There may be variance between other cities, however, this paper assumes that the certification levels are fairly homogenous between cities. Moreover, after observing Google Search results, there seem to be two dominant organizational branding strategies. First, name the practice after the lead counselor and list their certification level. Second, name the entity after the disorder or issue it solves. Interestingly, there does not appear to exist specific corporate branded therapy practices in the area (corporate refers to entity independence, and not the actual legal structure of the firm).

Online Counseling Platforms

Online counseling platforms help solve the mental health crisis by providing greater access to care for individuals who otherwise would not be able to obtain it, typically due to travel time and cost (Rios, Kazemi, and Peterson, 2018). Two prominent online counseling platforms are Better Help and Talkspace.

Better Help's mission is to "make professional counseling accessible, affordable, and convenient" (Better Help, 2019). Additionally, a study by Enitain Martell et al shows that Better Help is particularly effective for individuals "without a history of past psychotherapy". The Apple app store reports that there are over 3000 counselors on Better Help, all with at least three years of experience. The basic service is similar to Uber, in which counselors are matched to clients and can interact via messaging or scheduling live chats.

Talkspace's mission is "provide more people with convenient access to licensed therapists who can help those in need live a happier and healthier life" (Talkspace, 2019) Interestingly, the website mentions that Talkspace is not attempting to replace in-office therapy, but to provide day to day assistance with mental health needs. Their service is very similar to Better Help, albeit at slightly higher prices[1]

These two platforms are not the only entrants in the online therapy world. The American Psychiatric Association (APA) reports the expanding use of mobile health (mHealth) technology as "unprecedented". The volume of these apps inspired the APA to crowdsource help from psychiatrists to review the apps for their worthiness (APA, 2019).

Mental health is garnering national attention, but less than stellar mental health statistics, America is left wondering what else can be done to improve mental health care.

[1] $65/week for Talkspace's cheapest plan, while Better Help's average plan is $55/week

Principals of Branding

This section reviews two perspectives on branding: the type of branding and the effect of branding. For the type of branding, this paper analyzes general corporate branding and brand extensions. Additionally, this paper will analyze brand loyalty and brand authenticity for the effects of branding.

Branding, at its most elementary level, "serve as markers for the offerings of the firm" (Brands and branding 740). There are three key branding subtopics to consider. First, brand positioning, which relates to creating and maintaining the key associations between customer and firm. This is essentially, at a high level, what the company wants its customers to perceive when thinking of their brand. Applying this to the therapy industry, what are the key perceptions required for therapists to elicit positive responses between their practices and patients? Second, brand intangibles, which are brand image elements that are not tangible. For example, user imagery, purchase and consumption imagery, and history, heritage, and experiences (Brands and branding 740). Applying this to the therapy industry, what are the key factors for therapists to consider regarding how customers imagine their brand and reputation. Third, brand relationships, which is the intimate aspect of a brand's relationship with its customers. Six different dimensions build brand relationships: self-concept connections, commitment, behavioral interdependence, love/passion, intimacy, and brand-partner quality (Brands and branding 740). A key factor for the therapy industry relates to self-concept connections, such as "Do I believe this brand values what I value?". In summary, branding, in general, is a popular method for signaling quality expectations and connecting with target customers.

Brand extensions use an existing brand to move into a completely new market. This differs from line extensions, which use an existing brand to move into a new product line within

the current market. Brand extensions are generally cheaper to conduct compared to creating an entirely new brand, with an additional benefit that customers will already be familiar with the existing brand. There are two key insights regarding brand extensions to focus on. First, attribute beliefs surrounding the original brand are carried over during the new brand extension, which can be positive or negative depending on customers' prior perceptions of the attribute. For example, a Crest brand extension into mouthwash is fine, however, it was detrimental for a brand extension into the gum category. Second, there must be a basis of fit between an existing brand and its brand extension for the brand extension to reap the benefits of positive customer sentiment for the original brand (Aaker and Keller, 1990). This affects the therapy industry because a successful brand extension is predicated on attribute beliefs and fit between the original brand and brand extension.

Brand loyalty is extensively researched, and one particular segmented definition is that brand loyalty is composed of purchase and attitudinal loyalty (Chaudhuri & Holbrook, 2001). Brand trust and brand affect determine purchase and attitudinal loyalty (Chaudhuri & Holbrook, 2001). Brand affect is defined as "[to] elicit positive emotional response in average consumer because of use" and Brand trust is "[the] willingness of an average consumer to rely on brand to perform its function (Chaudhuri & Holbrook, 2001). Brand trust will likely play a particularly important role in this study, as trust "reduces uncertainty in which consumers are feeling especially vulnerable" which is the case for seeking therapy due to mental health stigma (Chaudhuri & Holbrook, 2001), (Yanos, Lucksted, Drapalski, & Roe, 2015).

Another, more constructivist viewpoint, is that brand loyalty stems from "consumer identification that helps satisfy one or more key self-definitional needs" (Bhattacharya & Sen, 2003). This framework relates consumer brand preferences to self-identification of similarity,

distinctiveness, and prestige (Bhattacharya & Sen, 2003). Although both frameworks are excellent generalizable tools, they have not been applied to franchising in CBT.

Another similar concept is brand authenticity, which is seen as having overtaken quality as the premier purchasing criterion (Mohart, Malar, Guevremont, Giradrdin, & Grohmann, 2014). Authenticity stems from four dimensions: continuity, integrity, credibility, and symbolism (Mohart, Malar, Guevremont, Giradrdin, & Grohmann, 2014). Thus, a combination of these different attributes and dimensions should provide a clear picture of the potential success of a franchise CBT practice.

Methodology

Hypotheses

There are three key hypotheses that this research paper focuses on.

H1: Branding will increase an individual's willingness to attend therapy

H2: Increasing the perceived degree of corporate influence will increase an individual's willingness to attend therapy

H3: Brand trust will explain an individual's willingness to attend therapy above and beyond other identified factors

Clearly, hypothesis one is of greatest concern for this paper. The essence of this research is rooted in practicality over theory, attempting to understand the nature of therapy and branding. As the literature suggests, branding has positive impacts on purchase behavior through brand trust, brand affect, and brand authenticity mechanisms. Brands inevitably are commonplace to in part help consumers make efficient purchasing decisions in terms of ease and quality. However, what is the nature of branding in the context of therapy, which is a more vulnerable, emotionally charged setting?

Hypothesis two is further practicality, seeking to understand the effects of corporate control on branding in therapy. Although branding is the first step in separating an independent practitioner from a more corporate sentiment venture, there are different degrees of corporate influence on the brand. Thus, individuals are likely to distinguish the degree of corporate control during their evaluation of a brand and use that as a purchasing criterion. For example, imagine the Michigan beer market. Due to three-tiered distribution laws and a vast amount of craft breweries, Michigan convenience stores tend to have a vast selection of beer brands to choose from. One may choose a craft IPA, Bud Light, or something in between such as Founder's

Brewery. Using a similar setup, would individuals prefer independent practitioners, corporate controlled brands, or some setup in the middle?

Hypothesis three is more traditional in nature and is meant to extend the work of Chaudhuri & Holbrook into the context of CBT therapy. They showed that brand trust and brand affect play important roles in determining purchase and attitudinal loyalty. However, there context was not as niche as CBT therapy, which has elements distinct from the random product that were used in their study (Chaudhuri & Holbrook, 2001). Specifically, CBT therapy is not a product but a service and it's a service that is emotionally impactful by its very nature. Thus, there may be differences in these contexts that cause brand trust or brand affect to not affect purchasing loyalty in the same manner or degree that Chaudhuri and Holbrook predicted.

Research Design

This study is straightforward, using an online survey and basic statistical analysis to gather and analyze data.

The online survey was conducted using Qualtrics and Turk Prime. Qualtrics is a widely recognized and user-friendly survey platform, making it the ideal survey software to use. Turk Prime is beneficial for customization and target audience specifications. For this study, Turk Prime was chosen to 1. Prohibit the collection of Amazon Worker IDs, which are considered PII by the IRB and 2. To limit the study to North American IP address to avoid GDPR regulations.

Developing the survey was a combination of literature review and brainstorming alone and with peers. The survey begins with a traditional IRB approved consent form (Appendix 1) and then assigns a participant into one of three conditions: Independent Practitioner (control group), Independent Branded, and Network Branded. All participants are shown an image of a

female counselor, however, differences between the groups are given via the presence or absence of a "TherapyX" logo in the upper right corner and the narrative statement above said image (Appendix 2). The control group does not see the TherapyX logo, while the other two test groups do. In place of TherapyX, control group subjects are told the name of the practice is Shelly's Therapy, which is meant to be the name of the female counselor that is shown and represents independent practitioners naming strategy, which appears to be their personal name.[2] Moreover, narrative statements relate to the degree of corporate control that is assumed for the brand. Specifically, the control group is told that "Shelly owns her own practice, Shelly's Therapy", while the Independent Branded group is told that "Shelly owns her own practice, TherapyX". The network branded group is told that "Shelly owns her own practice, TherapyX, which is a part of a larger national brand with multiple locations throughout the United States". In all conditions, we control for experience levels by telling participants the therapist has been practicing for 15 years and for control by telling participants the therapist controls all aspects of the practice. This allows the study to test the perception of corporate control has on willingness to attend therapy and not actual differences in corporate control.

All participants are asked the name of the therapy practice to ensure they actually read the narrative statement. Moreover, if a participant places into either test conditions, they are asked how many TherapyX offices there are. Independent Branded condition participants should answer "1", while Network Branded participants should answer "More than 1". This ensures that participants actually understand the nature of corporate control on the brand. If any of the above answers are incorrect, the participant is not allowed to continue to the survey.

[2] A Google Search of "CBT Therapist" in Ann Arbor, MI shows a majority of practicing therapists naming their practice after themselves

There are 23 questions divided into 6 categories: willingness to attend therapy, Psychological Safety, Brand Trust, Brand Affect, Brand Authenticity, and Corporate Efficiency. willingness to attend therapy is the dependent variable while the other five are meant to be potential moderators for testing willingness to attend therapy. To help differentiate the five moderators, the research team took an approach similar to Kahneman in his book, "Thinking, Fast and Slow". Below is how each of the moderators would speak, if they could.

1. Psychological Safety "Attending branded therapy is more socially acceptable than independent therapy"
2. Brand Trust "I can rely on branded therapy to perform therapy better than an independent therapist"
3. Brand Affect "A branded therapist elicits a more positive response from me, so I am more willing to attend"
4. Brand Authenticity "A branded therapist has my best interests in mind, beyond that of an independent practitioner"
5. Corporate Efficiency "A branded therapist has more resources than an independent practitioner"

All questions are asked using a 5-point Likert Scale ranging from 1 – Strongly Disagree to 5 – Strongly Agree (Appendix 3). willingness to attend therapy has three questions. The first two are framed such that a 5 is positive and 1 is negative, whereas the third question is framed such that the opposite is true. This helps prevent straight-line answering and is another approach to ensure participants are fully comprehending the questions. Each moderator category has four questions associated with it. Similar to the willingness to attend category, the first three questions are framed such that a 5 is positive and 1 is negative while the fourth question is framed oppositely.

The rationale behind questions is a mix of literature review and brainstorming. For example, all questions regarding brand trust and brand affect are taken from Chaudhuri & Holbrook, 2001. Psychological safety questions were adapted from Business Community, using similar questions but applying them for this survey. Lastly, brand authenticity and corporate efficiency questions were organically brainstormed and vetted by Ross Marketing Professor Christie Brown.

After answering questions, participants were asked to answer basic demographic questions (Appendix 3).

Results

Below are the results of the Qualtrics survey. Overall, we had a total of 247 survey respondents. However, we omitted 9 participants because of straight-line responses. For example, participant ID 55 answered all 4's and 5's, which is illogical given the survey setup. Thus, we obtained 238 qualified responses split into three conditions: Independent Practitioner (n=80), Independent Branded Therapist (n=79), and Network-Owned Therapist (n=79).

Descriptive Statistics

Below is an overview of categorical means for the three conditions. Categorical mean is the simple average of question responses, excluding the negative frame question. We exclude the negative frame question because those serve to primarily check for straight-line answering and it is unfair to assume a 1 in a negative frame question would be a 5 in a positive frame. More in-depth descriptive statistics for each condition can be found in Appendix 4.

Independent Practitioners:

WTA	4.04375
Psych Safety	3.829167
Brand Trust	4.016667
Brand Affect	3.791667
Brand Authenticity	4.0625
Corporate Intelligence	4.15

Independent Branded:

WTA	4.0253165
Psych Safety	3.742616
Brand Trust	3.907173
Brand Affect	3.6751055
Brand Authenticity	4.1097046
Corporate Intelligence	4.2236287

Network Branded:

WTA	3.8481013
Psych Safety	3.6371308
Brand Trust	3.742616
Brand Affect	3.4472574
Brand Authenticity	4.0590717
Corporate Intelligence	4.2995781

Below are the results tailored to each of the three hypotheses

H1: Branding will increase a patient's willingness to attend therapy

We were unable to prove that a significant relationship exists between branding and willingness to attend therapy. The primary method of analysis to test this hypothesis was ANOVA testing. We used ANOVA testing because we had three conditions and wanted to observe any statistically significant differences in their means. Seen below, the F-Stat is below the F-Critcial point, suggesting that we fail to reject the null hypothesis that there are significant differences in the means between any of these three groups.

Anova: Single Factor						
SUMMARY						
Groups	*Count*	*Sum*	*Average*	*Variance*		
Independent Practitioner	80	323.5	4.04375	0.722745253		
Independent Branded	79	318	4.025316456	0.65960727		
Network Branded	79	304	3.848101266	0.938169426		
ANOVA						
Source of Variation	*SS*	*df*	*MS*	*F*	*P-value*	*F crit*
Between Groups	1.849021713	2	0.924510857	1.195553147	0.304369832	3.03424789
Within Groups	181.7234573	235	0.773291308			
Total	183.572479	237				

H2: Increasing the perceived degree of corporate influence will increase an individual's willingness to attend therapy

We were unable to prove that a significant relationship exists between corporate influence and willingness to attend therapy. Please see the above ANOVA table. Additionally, please see Appendix 5 for all ANOVA tables. Special note to ANOVA on Brand Affect. This was the only case where the null hypothesis was rejected at the alpha .05 level.

Anova: Single Factor						
SUMMARY						
Groups	*Count*	*Sum*	*Average*	*Variance*		
Independent Practitioner	80	303.3333333	3.791666667	0.608649789		
Independent Branded	79	290.3333333	3.675105485	0.800497674		
Network Branded	79	272.3333333	3.447257384	0.91990335		
ANOVA						
Source of Variation	*SS*	*df*	*MS*	*F*	*P-value*	*F crit*
Between Groups	4.871978749	2	2.435989375	3.14063211	0.045076569	3.03424789
Within Groups	182.2746132	235	0.775636652			
Total	187.146592	237				

Further analysis via a T-Test shows that there is a significant difference between Independent Practitioners and Network Branded when it comes to Brand Affect. However, the difference is that Network Branded has a lower mean score on Brand Affect in a statistically significant manner. Thus, although we cannot prove a significant relationship between corporate control and willingness to attend therapy, the directionally correct answer is likely that corporate control construes a negative influence on willingness to attend therapy.

t-Test: Two-Sample Assuming Unequal Variances		
	Independent Practitioner	*Network Branded*
Mean	3.791666667	3.447257384
Variance	0.608649789	0.91990335
Observations	80	79
Hypothesized Mean Difference	0	
df	150	
t Stat	2.482170654	
P(T<=t) one-tail	0.007080448	
t Critical one-tail	1.6550755	
P(T<=t) two-tail	0.014160896	
t Critical two-tail	1.975905331	

H3: Brand trust will explain an individual's willingness to attend therapy above and beyond other identified factors

We were able to verify that brand trust explains willingness to attend therapy in a significant manner. To accomplish this, we used hierarchical regression analysis to compare the additional R-Square value added to the model once we included the brand trust variable. By adding brand trust, the R-Sqaure change is .031, which results in an F-Stat change 0f 16.550. This result is less than .000 Sig F change, indicating that it is statistically significant. For the entire hierarchical regression analysis, please see Appendix 6.

Model Summary[c]

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.728[a]	.530	.521	.60880878	.530	65.569	4	233	.000
2	.749[b]	.561	.551	.58945691	.031	16.550	1	232	.000

a. Predictors: (Constant), Corporate_Intel, Psych_Safety, Brand_Affect, Brand_Auth

b. Predictors: (Constant), Corporate_Intel, Psych_Safety, Brand_Affect, Brand_Auth, Brand_Trust

c. Dependent Variable: WTA

Discussion

Overall, it appears that branding therapy would not increase an individual's willingness to attend therapy. Moreover, although not statistically verified, the trend suggests that branding actually decreases an individual's willingness to attend therapy. This suggests that therapy is a unique setting where individualism is key to a successful practice. The remainder of the discussion section will be broken down into literature analysis and practical insights from the perspective of an entrepreneurial therapist.

Literature Analysis

The primary theoretical model that this paper used was based on the work done by Chaudhuri & Holbrook, 2001. Essentially, we sought out to determine if brand trust and brand affect, the primary two mechanisms Chaudhuri & Holbrook observed to determine brand loyalty, would extend in the therapeutic space. The results are mixed. Brand trust was shown to play a significant role in determining willingness to attend therapy. This seems to make intuitive sense, as brand trust is the consumer's belief that the service will satisfactorily perform its task. It is rather straightforward to see that the higher brand trust was rated, the more likely an individual would attend therapy. What was not as obvious is that brand trust, at least in the model, was the most significant factor in determining willingness to attend therapy. The R-Square contribution for brand trust was .031, whereas the next leading moderator, Psychological Safety, additional contribution was .026. This suggests that potential patient's decision criteria for attending therapy slightly favor a belief that the therapy practice will help them compared to a belief that they will not be socially stigmatized for attending therapy.

Interestingly, brand affect did not play a significant role in determining an individual's willingness to attend therapy. The contributed R-Square for Brand Affect was only .002, the second lowest in the model. This suggests that the instantaneous positive affect that hypothetical brands had was not relevant for willingness to attend decisions. Albeit that this analysis is an applied form of Chaudhuri & Holbrook, it is nonetheless interesting that there were not the same loyalty effects. Perhaps there was a limitation in the study's more or less neutral hypothetical branding, which may cause brand affect to not have as strong of an effect on willingness to attend. Or, perhaps the emotional nature of therapy mitigates the effect of positive emotions and thus causes brand affect to not play an important role.

Practical Insights

Mental Health in America is a growing concern, as highlighted at the beginning of this paper. Statistics showing that 1 in 5 individuals suffer a mental health episode in a given year or that 1 in 4 children suffer childhood trauma suggest that therapy is desperately in demand.

There are many keys to successful therapy practice and these results suggest that the overall key to marketing for therapists is individualism. This is likely not groundbreaking news; however, it is nonetheless important. The primary competitor for therapists beyond non-usage is the online-only platforms such as BetterHelp and Talkspace. A salient point of distinction then is suggesting that those corporately branded therapists are not catered towards individual needs in the degree that an independent practitioner is.

As with any business, therapy patients have customer value propositions that need to be fulfilled to adequately satisfy their jobs to be done and provide them the gains / mitigate the pains they have. This research suggests, at the very core, individualism is of utmost importance.

Thus, value propositions that aspire to provide therapy but in a manner that highlights the individual should be top of mind for any therapist hoping to increase their clientele list. For example, constant email reminder advertisements may degrade the patient's perception of the therapist individual focus, instead of associating the therapist as a brand more akin to traditional non-individualistic brands. Instead, it is likely more beneficial to promote an individual-level referral program that encourages current patients to spread hopefully positive sentiments to others regarding the practice they visit. Note, this is strictly analyzing marketing programs on the merit of their individual feel. There may be other complications, such as current patients being unwilling to talk about their experiences that need to be considered.

Furthermore, for the aspiring therapist hoping to own and manage multiple offices, it seems important to make each office discrete from each other. Branding multiple office locations under a fictitious brand name will likely not be favorable if increasing demand is the primary objective. Likely, it is better to continue using a self-naming strategy, which may provide benefits of corporate efficiency while maintaining the individualistic nature of therapy.

At the very least, therapists should implement their own surveys that gauge their clients' perception of the individual nature of their practice. This will provide the therapist with an interesting launching board for further decision making. If there is a negative statement, understanding why is essential to discovering root-cause issues with the practice and hopefully leads to the therapist being able to change the negative perception. If there is a positive sentiment, then the therapist has a good best practices guide that they can continuously update and improve or focus on other areas, such as quality of care, atmosphere, or technology.

Limitations and Future Research

Two primary limitations should be considered for this research. First, the survey is a survey conducted entirely online. This measure was taken for cost-effectiveness, ease, and time constraints. However, the major tradeoff is how well the survey simulates a real-life purchasing decision for attending therapy. Thus, another future study that has more time and resources could utilize a natural or lab experiment that simulates actual purchasing decision situations in a more organic manner.

The second limitation is the moderator variable selection. Namely, was there an important variable that was omitted? Our recommendation would be to conduct another survey similar to ours but include a trained therapist and psychologist on the research team. They may have more nuanced and complete understandings of the full set of moderators that affect willingness to attend therapy.

Although not a limitation per se, the final future research recommendation is to understand why this study does not have brand affect playing an important role in determining willingness to attend therapy.

Conclusion

Mental Health is a prevailing problem in America and the proposed study seeks to understand the effects of branding on patient's willingness to attend therapy. By understanding this effect, if any, therapists can better organize their practices to persuade and inspire the millions of Americans not receiving proper care for their mental health diagnoses.

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Appendix 1

Principal Investigator: Nico Romero, Student, University of Michigan
Faculty Advisor: Justin Frake, Professor, University of Michigan

You are invited to participate in a research study about individual's willingness to attend therapy

If you agree to be part of the research study, you will be asked to complete a brief survey asking your level of agreement with various hypothetical statements

Benefits of the research: Research will be used to further improve society's understanding of therapy

Risks and discomforts: No significant risks or discomforts expected. If you have prior negative experience with therapy and therapists, you may recall negative experiences and emotional distress.

Compensation: The HIT describes payment details.

Participating in this study is completely voluntary. Even if you decide to participate now, you may change your mind and stop at any time. You may choose not to answer any survey question or continue with the survey for any reason.

Participants who successfully complete the study will receive payment. Successful completion is determined at the sole discretion of the study author(s) using common methods to identify non-genuine responses. Examples of non-genuine responses include nonsense answers, responses completed in an extremely short or long amount of time, failure to respond to instructions provided in the survey, and/or otherwise clearly failing to offer genuine responses. Participants should complete the study in one sitting without interruptions to help ensure their response is not considered as non-genuine due to time length. Only submissions considered genuine will receive payment. We have included some attention check questions in the survey and your inability to correctly answer these questions could result in your participation termination without compensation. Duplicate attempts are not allowed and will not receive payment.

We will protect the confidentiality of your research records by not collecting personally identifiable information and destroying data records three years after publishing our study.

Information collected in this project may be shared with other researchers, but we will not share any information that could identify you.

If you have questions about this research study, please contact Nico Romero (ncoromer@umich.edu 313-817-4886) and Dr. Justin Frake (jfrake@umich.edu 734-764-1230).

The University of Michigan Institutional Review Board Health Sciences and Behavioral Sciences has determined that this study is exempt from IRB oversight.

If you consent to participate, please click the forward button to continue. If you do not consent, please return the HIT.

Above is the IRB approved consent form that all participants agreed to before participating in the survey

Appendix 2

This is Shelly and she has been practicing cognitive-behavioral therapy for the past 15 years.

Shelly owns her own therapy practice, Shelly's Therapy. She controls all aspects of her practice, from client sessions to marketing efforts.

Following are questions to judge your opinions on attending therapy with Shelly.

Independent Practitioner Group Example

This is Shelly and she has been practicing cognitive-behavioral therapy for the past 15 years.

Shelly owns her own therapy practice, which she named TherapyX. She controls all aspects of her practice, from client sessions to marketing efforts.

Following are questions to judge your opinions on attending therapy with Shelly.

Individual-Owned Group Example

This is Shelly and she has been practicing cognitive-behavioral therapy for the past 15 years.

She owns her own therapy practice, TherapyX, which is a part of a larger national TherapyX Brand with multiple locations throughout the United States. She controls all aspects of her practice, from client sessions to marketing efforts.

Following are questions to judge your opinions on attending therapy with Shelly.

Network-Owned Group Example

Appendix 3

Questions

Demographic

1. What is your age?
    a. 18-24 years old
    b. 25-34 years old
    c. 35-44 years old
    d. 45-54 years old
    e. Over 55 years old
2. What is your gender?
    a. Male
    b. Female
    c. Other (please specify)
    d. Prefer not to answer
3. What is your ethnicity?
    a. White
    b. Hispanic or Latino
    c. Black or African American
    d. Native American or American Indian
    e. Asian / Pacific Islander
    f. Other
4. What is the highest degree or level of school you have completed?
    a. Less than a high school diploma
    b. High school degree or equivalent
    c. Bachelor's degree (e.g. BA, BS)
    d. Master's degree (e.g. MA, MS, MBA)
    e. Doctorate (e.g. PhD, MD, EdD)
    f. Other (please specify)
5. What is your current employment status?
    a. Employed full-time

b. Employed part-time
c. Unemployed
d. Student
e. Retired
f. Self-Employed

6. What is your marital status?
    a. Single (never married)
    b. Married
    c. In a domestic partnership
    d. Divorced
    e. Widowed
7. What is your household income?
    a. Below $10K
    b. $10K – $50K
    c. $50K-$100K
    d. $100K-$150K
    e. Over $150K

*All of the following questions will utilize a standard 5 point Likert Scale ranging from Strongly Disagree, Disagree, Neutral, Agree, Strongly Agree

willingness to attend therapy

1. Would you be willing to attend a session with this therapist if you deemed it appropriate to seek care and faced no barriers to receiving care?
2. Would you be willing to consistently see this therapist if you deemed it appropriate to seek care and faced no barriers to receiving care?
3. Would you be uncomfortable attending a session with this therapist if you deemed it appropriate to seek care and faced no barriers to receiving care?

Psychological Safety

1. I would feel safe to tell my friends about this therapist
2. I would feel comfortable being vulnerable because of this therapist
3. I would feel socially accepted while seeing this therapist
4. I would be judged negatively by my peers if I see this therapist

Brand Trust

1. I would trust this therapist
2. I feel that this therapist would deliver on what they promise
3. I feel that this therapist would not disappoint me
4. I would not rely on this therapist

Brand Affect

1. This therapist would make me feel happy
2. This therapist would please me
3. This therapist would calm my nerves
4. This therapist would make me feel sad

Brand Authenticity

1. This therapist would live by their values
2. This therapist would be a positive influence
3. This therapist would be honest
4. This therapist would not be committed to helping others

Brand Effectiveness

1. This therapist would have sufficient knowledge to help patients
2. This therapist would have resources to effectively help patients
3. Therapy sessions with this therapist would be organized well
4. This therapist would not provide the help I need

Appendix 4

Central Tendency																							
N	80																						
Categorical Mean																							
WTA	4.04375																						
Psych Safety	3.829167																						
Brand Trust	4.016667																						
Brand Affect	3.791667																						
Brand Authenticity	4.0625																						
Corporate Intelligence	4.15																						
	WTA1	WTA2	WTA3	PsychSafety1	PsychSafety2	PsychSafety3	PsychSafety4	BrandTrust1	BrandTrust2	BrandTrust3	BrandTrust4	BrandAffect1	BrandAffect2	BrandAffect3	BrandAffect4	Authenticity1	Authenticity2	Authenticity3	Authenticity4	CorporateIntel1	CorporateIntel2	CorporateIntel3	CorporateIntel4
Mean	4.1	3.9875	2.4125	3.875	3.75	3.8625	2.225	4.05	4.0625	3.9375	2.4375	3.8	3.7125	3.8625	2.1375	4.0625	4.05	4.075	2.1125	4.15	4.15	4.15	2.075
Median	4	4	2	4	4	4	2	4	4	4	2	4	4	4	2	4	4	4	2	4	4	4	1
Mode	4	4	2	4	4	4	2	4	4	4	2	4	4	4	1	4	4	4	1	4	4	4	1
Spread	WTA1	WTA2	WTA3	PsychSafety1	PsychSafety2	PsychSafety3	PsychSafety4	BrandTrust1	BrandTrust2	BrandTrust3	BrandTrust4	BrandAffect1	BrandAffect2	BrandAffect3	BrandAffect4	Authenticity1	Authenticity2	Authenticity3	Authenticity4	CorporateIntel1	CorporateIntel2	CorporateIntel3	CorporateIntel4
Quartiles - 25th	4	4	1.75	4	3	3	1	4	4	3.75	2	3	3	4	1	4	4	4	1	4	4	4	1
Quartiles - 50th	4	4	2	4	4	4	2	4	4	4	2	4	4	4	2	4	4	4	2	4	4	4	2
Quartiles - 75th	5	5	3	5	5	5	3	5	5	5	3	4	4	4	3	5	5	5	3	5	5	5	3
Variance	0.749367	0.898576	1.6125	1.174050633	1.202531646	0.955537975	1.163924051	0.73164557	0.945411392	0.996044304	1.464398734	0.769620253	0.865664557	0.854272152	1.309968354	0.666893038	0.73164557	0.855063291	1.721360759	0.711392405	0.686075949	0.711392405	1.260126582
Stdev	0.86566	0.947932	1.269843	1.083536171	1.096600039	0.977516227	1.078853118	0.855362829	0.972322679	0.998020192	1.210123438	0.877280031	0.930410961	0.924268441	1.14453849	0.816658056	0.855362829	0.924696324	1.312006387	0.843440813	0.828297018	0.843440813	1.122553599

Independent Practitioner Descriptive Statistics

Central Tendency	
N	79
Categorical Mean	
WTA	4.0253165
Psych Safety	3.742616
Brand Trust	3.907173
Brand Affect	3.6751055
Brand Authenticity	4.1097046
Corporate Intelligence	4.2236287

	WTA1	WTA2	WTA3	PsychSafety1	PsychSafety2	PsychSafety3	PsychSafety4	BrandTrust1	BrandTrust2	BrandTrust3	BrandTrust4	BrandAffect1	BrandAffect2	BrandAffect3	BrandAffect4	Authenticity1	Authenticity2	Authenticity3	Authenticity4	CorporateIntel1	CorporateIntel2	CorporateIntel3	CorporateIntel4
Mean	4.1139241	3.9367089	2.1012658	3.734177215	3.556962025	3.936708861	2	3.987341772	4.012658228	3.721518987	2.278481013	3.607594937	3.518987342	3.898734177	2.113924051	4.113924051	4.012658228	4.202531646	1.949367089	4.278481013	4.253164557	4.139240506	2.215189873
Median	4	4	2	4	4	4	2	4	4	4	2	4	4	4	2	4	4	4	2	4	4	4	2
Mode	4	4	2	4	4	4	2	4	4	4	2	3	4	4	2	4	4	5	1	5	5	5	2

Spread	WTA1	WTA2	WTA3	PsychSafety1	PsychSafety2	PsychSafety3	PsychSafety4	BrandTrust1	BrandTrust2	BrandTrust3	BrandTrust4	BrandAffect1	BrandAffect2	BrandAffect3	BrandAffect4	Authenticity1	Authenticity2	Authenticity3	Authenticity4	CorporateIntel1	CorporateIntel2	CorporateIntel3	CorporateIntel4
Quartiles - 25th	4	3	1	3	3	3	1	3.5	4	3	1	3	3	3.5	1	4	4	4	1	4	4	4	1
Quartiles - 50th	4	4	2	4	4	4	2	4	4	4	2	4	4	4	2	4	4	4	2	4	4	4	2
Quartiles - 75th	5	5	2.5	5	4	5	2	5	5	5	3	4	4	5	3	5	5	5	3	5	5	5	3
Variance	0.7945472	0.9831224	1.1178189	1.172022071	1.121713729	0.931840312	0.948717949	0.83317048	0.679324895	1.254787407	1.254787407	1.010710808	1.073352808	0.93833171	1.17916261	0.691983122	0.781888997	0.676403765	1.407659851	0.716325868	0.70431678	0.864978903	1.35053554
Stdev	0.8913738	0.9915253	1.0572695	1.082599682	1.059109876	0.965318762	0.974021534	0.912782038	0.824211681	1.120172936	1.120172936	1.00534114	1.036027416	0.968675235	1.085892541	0.831855229	0.884244874	0.822437697	1.186448419	0.846360365	0.839235831	0.93004242	1.162125441

Individual-Owned Descriptive Statistics

Central Tendency	
N	79
Categorical Mean	
WTA	3.8481013
Psych Safety	3.6371308
Brand Trust	3.742616
Brand Affect	3.4472574
Brand Authenticity	4.0590717
Corporate Intelligence	4.2995781

	WTA1	WTA2	WTA3	PsychSafety1	PsychSafety2	PsychSafety3	PsychSafety4	BrandTrust1	BrandTrust2	BrandTrust3	BrandTrust4
Mean	3.8860759	3.8101266	2.3544304	3.82278481	3.53164557	3.556962025	2.417721519	3.860759494	3.873417722	3.493670886	2.265822785
Median	4	4	2	4	4	4	2	4	4	4	2
Mode	4	4	2	4	4	3	1	4	4	4	2

	BrandAffect1	BrandAffect2	BrandAffect3	BrandAffect4	Authenticity1	Authenticity2	Authenticity3	Authenticity4	CorporateIntel1	CorporateIntel2	CorporateIntel3	CorporateIntel4
Mean	3.329113924	3.405063291	3.607594937	2.265822785	4	4.063291139	4.113924051	2	4.379746835	4.278481013	4.240506329	2.17721519
Median	3	3	4	2	4	4	4	1	4	4	4	2
Mode	3	3	4	2	4	4	4	1	5	5	4	2

Spread	WTA1	WTA2	WTA3	PsychSafety1	PsychSafety2	PsychSafety3	PsychSafety4	BrandTrust1	BrandTrust2	BrandTrust3	BrandTrust4
Quartiles - 25th	4	3	1	3	3	3	1	3.5	3	3	1
Quartiles - 50th	4	4	2	4	4	4	2	4	4	4	2
Quartiles - 75th	5	5	3	4.5	4	4	4	4	4	4	3
Variance	0.9483934	1.1301525	1.4881532	0.891269068	1.200908796	0.916585524	1.52839987	0.7624148	0.753002272	1.201882506	1.27458617 3
Stdev	0.9738549	1.0630863	1.2198988	0.944070479	1.095859843	0.957384732	1.236284704	0.87316367 3	0.867757035	1.096304021	1.128975719

Spread	BrandAffect1	BrandAffect2	BrandAffect3	BrandAffect4	Authenticity1	Authenticity2	Authenticity3	Authenticity4	CorporateIntel1	CorporateIntel2	CorporateIntel3	CorporateIntel4
Quartiles - 25th	3	3	3	1	4	4	4	1	4	4	4	1
Quartiles - 50th	3	3	4	2	4	4	4	1	4	4	4	2
Quartiles - 75th	4	4	4	3	4.5	5	5	3	5	5	5	3
Variance	0.992859461	1.192794547	1.215839013	1.069457968	0.666666667	0.726712106	0.768906199	1.538461538	0.46932814	0.639402791	0.569620253	1.250243427
Stdev	0.996423334	1.092151339	1.102650903	1.034146009	0.816496581	0.852474109	0.876872966	1.240347346	0.685075281	0.799626657	0.754731908	1.118142848

Network Owned Descriptive Statistics

Appendix 5

Anova: Single Factor						
SUMMARY						
Groups	*Count*	*Sum*	*Average*	*Variance*		
Independent Practitioner	80	323.5	4.04375	0.722745253		
Independent Branded	79	318	4.025316456	0.65960727		
Network Branded	79	304	3.848101266	0.938169426		
ANOVA						
Source of Variation	*SS*	*df*	*MS*	*F*	*P-value*	*F crit*
Between Groups	1.849021713	2	0.924510857	1.195553147	0.304369832	3.03424789
Within Groups	181.7234573	235	0.773291308			
Total	183.572479	237				

Willingness to Attend ANOVA

Anova: Single Factor						
SUMMARY						
Groups	*Count*	*Sum*	*Average*	*Variance*		
Independent Practitioner	80	306.3333333	3.829166667	0.880432489		
Independent Branded	79	295.6666667	3.742616034	0.80327455		
Network Branded	79	287.3333333	3.637130802	0.721338671		
ANOVA						
Source of Variation	*SS*	*df*	*MS*	*F*	*P-value*	*F crit*
Between Groups	1.469979701	2	0.73498985	0.916426758	0.401370052	3.03424789
Within Groups	188.4739979	235	0.802017012			
Total	189.9439776	237				

Psychological Safety ANOVA

Anova: Single Factor						
SUMMARY						
Groups	*Count*	*Sum*	*Average*	*Variance*		
Independent Practitioner	80	321.3333333	4.016666667	0.705766526		
Independent Branded	79	308.6666667	3.907172996	0.689278373		
Network Branded	79	295.6666667	3.742616034	0.632334379		
ANOVA						
Source of Variation	*SS*	*df*	*MS*	*F*	*P-value*	*F crit*
Between Groups	3.022795447	2	1.511397724	2.236057957	0.109148309	3.03424789
Within Groups	158.8413502	235	0.675920639			
Total	161.8641457	237				

Brand Trust ANOVA

Anova: Single Factor						
SUMMARY						
Groups	*Count*	*Sum*	*Average*	*Variance*		
Independent Practitioner	80	303.3333333	3.791666667	0.608649789		
Independent Branded	79	290.3333333	3.675105485	0.800497674		
Network Branded	79	272.3333333	3.447257384	0.91990335		
ANOVA						
Source of Variation	*SS*	*df*	*MS*	*F*	*P-value*	*F crit*
Between Groups	4.871978749	2	2.435989375	3.14063211	0.045076569	3.03424789
Within Groups	182.2746132	235	0.775636652			
Total	187.146592	237				

*Brand Affect ANOVA – This is the only ANOVA test that was significant. This suggests that Network Branded has a statistically significant lower mean than Independent Practitioner given the T-Test shown in paper.

Anova: Single Factor						
SUMMARY						
Groups	*Count*	*Sum*	*Average*	*Variance*		
Independent Practitioner	80	325	4.0625	0.534722222		
Independent Branded	79	324.6666667	4.109704641	0.523423131		
Network Branded	79	320.6666667	4.05907173	0.495041293		
ANOVA						
Source of Variation	*SS*	*df*	*MS*	*F*	*P-value*	*F crit*
Between Groups	0.126710072	2	0.063355036	0.122353978	0.884891431	3.03424789
Within Groups	121.6832806	235	0.517801194			
Total	121.8099907	237				

Brand Authenticity ANOVA

Anova: Single Factor						
SUMMARY						
Groups	*Count*	*Sum*	*Average*	*Variance*		
Independent Practitioner	80	332	4.15	0.489170183		
Independent Branded	79	333.6666667	4.223628692	0.588950197		
Network Branded	79	339.6666667	4.299578059	0.406253381		
ANOVA						
Source of Variation	*SS*	*df*	*MS*	*F*	*P-value*	*F crit*
Between Groups	0.889340378	2	0.444670189	0.898746053	0.408474304	3.03424789
Within Groups	116.2703235	235	0.494767334			
Total	117.1596639	237				

Corporate Efficiency ANOVA

Hierarchical Regression Analysis Results

Model Summary[c]

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.731[a]	.534	.526	.60560843	.534	66.881	4	233	.000
2	.749[b]	.561	.551	.58945691	.026	13.944	1	232	.000

a. Predictors: (Constant), Corporate_Intel, Brand_Affect, Brand_Auth, Brand_Trust

b. Predictors: (Constant), Corporate_Intel, Brand_Affect, Brand_Auth, Brand_Trust, Psych_Safety

c. Dependent Variable: WTA

Psychological Safety

Model Summary[c]

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.728[a]	.530	.521	.60880878	.530	65.569	4	233	.000
2	.749[b]	.561	.551	.58945691	.031	16.550	1	232	.000

a. Predictors: (Constant), Corporate_Intel, Psych_Safety, Brand_Affect, Brand_Auth

b. Predictors: (Constant), Corporate Intel, Psych Safety, Brand Affect, Brand Auth, Brand Trust

c. Dependent Variable: WTA

Brand Trust

Model Summary[c]

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.747[a]	.559	.551	.58969949	.559	73.723	4	233	.000
2	.749[b]	.561	.551	.58945691	.002	1.192	1	232	.276

a. Predictors: (Constant), Brand_Trust, Corporate_Intel, Psych_Safety, Brand_Auth

b. Predictors: (Constant), Brand_Trust, Corporate_Intel, Psych_Safety, Brand_Auth, Brand_Affect

c. Dependent Variable: WTA

Brand Affect

Model Summary[c]

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.743[a]	.552	.544	.59437839	.552	71.654	4	233	.000
2	.749[b]	.561	.551	.58945691	.009	4.907	1	232	.028

a. Predictors: (Constant), Brand_Affect, Corporate_Intel, Psych_Safety, Brand_Trust

b. Predictors: (Constant), Brand_Affect, Corporate_Intel, Psych_Safety, Brand_Trust, Brand_Auth

c. Dependent Variable: WTA

Brand Authenticity

Model Summary[c]

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.749[a]	.561	.553	.58822982	.561	74.384	4	233	.000
2	.749[b]	.561	.551	.58945691	.000	.031	1	232	.861

a. Predictors: (Constant), Brand_Auth, Psych_Safety, Brand_Affect, Brand_Trust

b. Predictors: (Constant), Brand_Auth, Psych_Safety, Brand_Affect, Brand_Trust, Corporate_Intel

c. Dependent Variable: WTA

Corporate Efficiency