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PSYCHIATRIC AND PSYCHOTHERAPEUTIC LITERACY: ATTITUDES TO, AND KNOWLEDGE OF, PSYCHOTHERAPY

ADRIAN FURNHAM

ABSTRACT

Background: Whereas there is now a rapidly emerging literature on psychiatric literacy (Jorm, 2000), there is much less work on the public's knowledge of, and beliefs about the purpose of, and processes involved in, psychotherapy. This study looked at what lay people think happens during psychotherapy; what the processes and aims are; and the aetiology, treatment and prognosis for a mood and psychotic (bipolar, schizophrenia) and two neurotic (depression, obsessive-compulsive) disorders.

Methods: In total 185 British adults, recruited by a market research company, completed a four-part questionnaire, lasting about 20 minutes.

Results: Participants were generally very positive about psychotherapy believing the experience to be highly beneficial. Schizophrenia was seen to have a biological basis; depression and bipolar disorder were perceived to have family, work and other stress-related causal issues; obsessive-compulsive disorder was seen to be caused by stress and family-related issues. Participants thought psychotherapy a very effective treatment but drug treatments more effective for schizophrenia and bipolar disorder. 'Talking it over' was judged highly relevant, specifically to depression. Participants believed that depression had a good chance of cure, and remission, but that neither schizophrenia nor bipolar disorder had much chance of an effective cure.

Conclusion: Lay people show a curious pattern on insight, ignorance and naivety with regard to the cause and cure of mental disorders. They appear to have a modestly realistic but somewhat naive view of the process and efficacy of psychotherapy. This may influence how they react to their own and others' mental illness. It has clear implications for education in psychiatric literacy.

INTRODUCTION

Debates about mental health frequently find their way into the media. Examples include celebrities 'taking a break' due to exhaustion and depression, as well as to prisoners being held in hospitals until they are 'mentally fit' to stand trial. However, the journalistic stories rarely give the general public any insight into what these illnesses are: What causes them? How symptoms are manifest? What is the most appropriate and efficacious 'cure'? (Angermeyer & Dietrich, 2006; Angermeyer & Matschinger, 1996ab; Angermeyer & Schulze, 2001; Bhugra, 1989; Furnham, 1988; 1997; Furnham & Wong, 2007).

International Journal of Social Psychiatry. Copyright © 2009 SAGE Publications (Los Angeles, London, New Delhi and Singapore) www.sagepublications.com Vol 55(6): 525–537 DOI: 10.1177/0020764008094428

Over the last two decades, many Western governments have attempted to make the public more aware of general *physical health issues*. Although the benefits of public knowledge of physical diseases are widely accepted, knowledge about *mental disorders* (mental health literacy) has been comparatively neglected. Charities such as MIND and the Samaritans have been trying to make the public more aware of these issues and to rethink how people experiencing illnesses are treated. The lifetime risk of developing a mental disorder is high (Kessler *et al*., 1994). It is clearly desirable that the public are aware of the nature of mental illness and are able to recognize and understand the signs in themselves, their families and others. If people are well informed they will, it is hoped, be able to obtain appropriate help for themselves as well as their friends and family when these issues arise (Angermeyer & Dietrich, 2006).

The term *mental health literacy* refers to knowledge of, and beliefs about, mental disorders that assist in the recognition, prevention or management of these disorders (Jorm, 2000). Mental health literacy was defined as 'knowledge and beliefs about mental disorders which aid their recognition, management or prevention' (Jorm *et al*., 1997abc). Jorm and colleagues have done a great deal of research in the area (Chen *et al*., 2000; Jorm *et al*., 2000) and the concept seems to be spreading (Goldrey *et al*., 2001; James *et al*., 2002; Mubbashar & Farooq, 2001).

The majority of the general public seems unable to correctly identify mental disorders when shown written vignettes of a person suffering from severe depression or schizophrenia (Jorm *et al*., 1997a). Surveys have shown that a lack of understanding of the terms mania and schizophrenia is common (Hillert *et al*., 1999) and that schizophrenia is commonly associated with a 'split personality' (Angermeyer & Matschinger, 1999; Furnham & Wong, 2007).

The decision as to whether or not to seek help is associated with a wide range of factors, including the availability of appropriate services, as well as particular individual socio-demographic and psychological variables (Sheikh & Furnham, 2000). The groups least likely to make use of mental health services are, for example, men, older people and people from ethnic minorities (Leong & Zachar, 1999). This may be because of their understanding of the nature of mental illness, as well as the taboo associated with them.

There is a growing body of research into lay beliefs about mental illness and theories of their causes and consequences (Angermeyer & Matschinger, 1996ab; Angermeyer *et al*., 1998; Cohen & Sturenig, 1962; Dammann, 1997; Dinos, *et al*., 2004; Duggan *et al*., 2003; Furnham, 1988; Furnham & Bower, 1992; Furnham & Murao, 1999; Ojanen, 1992; Oyefeso, 1994; Pistrang & Barker, 1992; Shapiro, 1995). Various studies have focused on lay beliefs about the best cure for, and ways of overcoming, particular psychological problems (Knapp & Karabenick, 1985). These studies replicated both the factor structure and the cure-specific nature of the perception of the efficacy of different cures (Furnham & Henley, 1988; Henley & Furnham, 1988) and addictions (Furnham & McDermott, 1994). These studies emphasized the importance of self-control but also the receipt of professional help depending on the precise nature of the problem or illness considered.

Studies looking at treatment rather than cure found that generally most members of the public believe that mental disorders are treatable (Reiger *et al*., 1988; McKeen & Corrick, 1991), but that some psychiatric treatments are considered generally rather unhelpful (Reiger *et al*., 1988; Sims, 1993), whereas counselling is usually considered most helpful (McKeen & Corrick, 1991).

This study is partly concerned with lay people's (as potential clients) beliefs about psychotherapy (Furnham & Wardley; 1990; Heaven & Furnham, 1994; Wong, 1994). Furnham and Wardley (1991) investigated lay theories of efficacy of therapies and prognosis for different problems to see whether lay people differentiated between illness and cures and had an idea about optimal matching. They

found that the more knowledgeable people were about psychology, the more sceptical they tended to be about the efficacy of cures. Knowledge about psychological cures also led to a greater awareness of the limited benefits of therapy (Furnham *et al*., 1992).

This study was part replication (beliefs about therapy) and part extension by looking together at the cause, cure and prognosis for four different conditions. Comparatively few lay belief/psychiatric literacy studies have looked at either bipolar or obsessive-compulsive disorder, although schizophrenia and depression have been extensively researched. This study should give insight into areas of knowledge and ignorance that may assist those interested in progressing the public understanding of psychiatry.

One aim of this study addressed this topic in that participants were asked to rate the causes and the effectiveness of different therapies for four different specific disorders: depression, schizophrenia, obsessive-compulsive disorder and bipolar disorder. The disorders used in this study were chosen because of the extensive popular interest in them and the academic research into lay theories of them (Furnham & Wong, 2007; Furnham *et al*., 2008). It was predicted that understanding of cause and cure would differ across disorders, with 'physical' therapies being rated more effective for schizophrenia than for depression (Furnham *et al*., 2001) (Hypothesis 1 (H_1)). Previous studies have indicated that talking cures were thought to be more efficacious for neurotic disorders and drugs more effective for psychotic and mood disorders.

It was also predicted that there would be a significant effect of 'knowledge or experience of psychotherapy', with those who were more knowledgeable (in terms of education and experience) having more realistic attitudes about psychotherapy and more sceptical about the effectiveness of therapies for the different disorders than those who were less knowledgeable (H_2). Participants were asked if they had suffered from the disorders in question, to determine whether this was a useful predictor, as indicated by Jorm *et al*. (1997ab). It was predicted that contact would lead to greater knowledge (H_3).

METHOD

Participants

There were 185 participants: 92 male and 93 female. They ranged in age from 18 to 81 years. (*mean* = 37.87, *SD* = 17.26). Approximately a quarter (28.3%) left school at 16, while 58% left at 18. Just over a third (38.9%) were graduates. In total 46.7% were single, 42.4% married. Almost exactly half (50.8%) were childless, whereas the remainder had between one and six children. In total 32.4% said they had been seriously ill, while 64.7% had health insurance. They claimed on average to have made 2.46 visits to their general practitioner in the previous year (*SD* = 2.64).

One third (33%) said they had consulted professional help for a psychological problem.

Questionnaire

The questionnaire was divided into four sections.

1. *Patient reaction to psychotherapy*. The 20 attitude statements were taken from Furnham and Wardley (1990), which was also used by Wong (1994). It has face and construct validity.
2. *Attitudes to, and beliefs about, psychotherapy*. The 40 attitude statements were also taken from Furnham and Wardley (1990), which have been replicated by Furnham *et al*. (2001).

3. *Mental illness and psychotherapy*. This consisted of four pages each with 25 questions pertaining to four specific mental illnesses. Of the 25 questions, 13 pertained to cause, seven to cure and five to outcome. The questionnaire was based on various studies on lay theories of the cause, manifestation and cure for mental illness (Furnham, 1997; Furnham & Akande, 1997). It was designed specifically for this study.
4. *Personal details*. Including demographic variables but also personal experience of mental illness and psychotherapy.

Procedure

A market research company was asked to collect data from 200 British adults from a wide variety of backgrounds. They were instructed to obtain a representative sample, half male, half female from a wide spread of ages (over 18 years old). Researchers from four major British cities selected individuals, gave them the questionnaire and envelope with instructions and a small incentive to complete the task. They collected the questionnaire the following day. Of the 200 questionnaires distributed 192 were collected (91.4%) of which 185 (88%) were completely correctly for analysis.

RESULTS

Preliminary inspection of the demographic details showed, predictably, that older people had less education, more children, greater income, less good physical health and less likelihood of visiting a therapist. Those who had consulted a professional for a psychological problem tended to be younger, less well educated and more likely to have been seriously physically ill at one time or another. They also believed they led a riskier lifestyle. Preliminary analysis showed little evidence of systematic age or sex differences in response to individual questions.

Part 1: Reactions to psychotherapy

Table 1 shows the most frequent reactions (items 5, 13, 14, 15) and those with lowest (items 4, 6, 20). These clearly showed that participants were positive about the process of psychotherapy, believing all patients to feel supported, relieved and hopeful in psychotherapy and not rejected or misunderstood. They tended, however, not to believe that transference frequently happened (item 20).

An exploratory factor analysis (with VARIMAX rotation) of the 20 items revealed four factors that accounted for over 50% of the variance. These were similar to those found by Furnham and Wardley (1990). The first factor, which accounted for a quarter of the variance and had nine items loading on it, was labelled *positive: support and help*. The mean score for this factor indicated that participants believed patients felt frequently helped and supported in therapy. The second factor contained four items, all of which indicated drawbacks of psychotherapy. The mean score on this factor suggested participants thought these experiences were relatively infrequent. This was labelled *negative: confused and misunderstood*. The third factor had three items loading on it whose theme seemed to be *involvement.* The fourth factor was labelled *ambiguous* because of the items loading on it indicating both positive and negative features.

A series of regressions was then computed to examine individual difference predictors of the various factor scores asking the question of which individual difference factors best predicted

Table 1
Means and factor loading for the 20 questions on the reactions to psychotherapy

During therapy	X	SD				
1. Clients say to friends they see something new about themselves	4.83	1.22	0.64			
2. Clients feel bored, impatient and doubtful of the value of therapy	4.38	1.35		0.68		
3. Clients say they are more in touch with their feelings	4.83	1.18	0.81			
4. Clients now feel confused or side-tracked from important things	3.67	1.30		0.75		
5. Clients are clearer about what needs to change or be worked on in therapy	5.10	1.01	0.66			
6. Clients feel rejected, judged or put down by therapists	3.15	1.33		0.66		
7. Clients feel they learn and rehearse better ways of coping	4.97	1.04	0.63			
8. Clients report being misunderstood by a therapist	3.87	1.40		0.74		
9. Clients feel involved in the tasks of therapy	4.71	1.16			0.60	
10. Clients feel pressured to act for themselves as opposed to being passive	4.35	1.21				
11. Clients feel that they are understood	4.88	1.20	0.69			
12. Clients feel alone between sessions with the therapist	4.52	1.40				0.72
13. Clients feel supported and relieved	5.09	1.29	0.57			
14. Clients are made to think about uncomfortable/painful ideas	5.02	1.28				
15. Clients feel more hopeful and confident	5.03	0.92	0.58			0.77
16. Clients experience contact with the therapist as a person	4.57	1.47	0.64			
17. Clients say their family/friends notice improvements	4.61	1.19	0.72			
18. Clients feel 'addicted' to their therapy; unable to give it up	4.38	1.42				0.61
19. Clients believe it is good value for money	4.15	1.31			0.36	0.35
20. Clients report being attracted to their therapist	3.96	1.54			0.75	
Eigenvalue			5.21	2.54	1.65	1.17
Variance (%)			26.70	12.70	8.25	5.80

7 = Extremely frequently; 1 = Extremely rarely

the four themes (factors) concerning clients' experience of psychotherapy. Thus, demographic variables (sex, age, income), 'ideological' variables (participants' political and religious beliefs) and subjectively rated and reported health variables, including consulting with a psychologist, were the predictor variables and each of the four factor scores the criterion variable. Four regressions were computed but none was significant. Thus, it seemed that none of the individual difference variables were systematically related to these four belief factors. There was therefore no support for H_2 in that there was no relationship between experience of participants consulting professional help for psychological problems and their beliefs about the process of psychotherapy.

Part 2: Attitudes to, and beliefs about, psychotherapy

The descriptive results showed five items with scores > 5.00 indicating that participants thought these to be frequently occurring in therapy (items 11, 14, 22, 23, 26) (Table 2). This indicated that participants believe therapists taught coping strategies and encouraged emotional expression. They also believed therapy was a long-term business. Equally there were five items with scores < 3.25 indicating that participants thought them to be fairly rarely occurring (items 5, 20, 29, 30, 37). This showed participants did not believe clients were prescribed drugs or required to lie on a couch. They also did not believe most patients were women and that younger people were more likely to

Table 2
Means for the attitudes to and beliefs about psychotherapy

	X	SD
1. Most psychologists use personality questionnaires	4.33	1.43
2. Psychotherapy often involves resolving sexual conflicts	4.18	1.28
3. Most psychotherapists ask about dreams	4.34	1.52
4. Most patients in psychotherapy have to be taught to confront and cope with fearful objects/situations	4.95	1.42
5. Psychotherapists often prescribe drugs	3.43	1.68
6. A major aim is to force clients to take responsibility for the consequences of their actions	4.42	1.58
7. Psychotherapists aim to teach their clients to achieve better self-understanding of their motives	5.44	1.11
8. A major component is teaching about relaxation to cope with anxieties	4.83	1.44
9. Clients are taught to alter their life-goals to be more realistic	4.28	1.34
10. Psychotherapists believe most psychological problems are unconscious	4.19	1.47
11. Psychotherapists teach clients strategies to reduce conflict or frustration	5.01	1.19
12. Most clients 'get better' in therapy	4.38	1.29
13. Women make better psychotherapists than men	3.58	1.60
14. Psychotherapists encourage the expression of emotion and feelings previously suppressed/repressed	5.15	1.00
15. Some psychotherapists expose people to their worst fears e.g. spiders	4.19	1.65
16. All psychotherapists reassure and give clients emotional support	4.95	1.52
17. Psychotherapists aim to let clients find their own solutions to problems	4.38	1.34
18. Most psychotherapists believe many psychological problems originate in childhood	4.75	1.35
19. Only patients who want to change benefit from psychotherapy	4,76	1.32
20. Only younger, more flexible clients benefit from psychotherapy	2.90	1.33
21. The skill and personality as opposed to the technique of the psychotherapist determines the outcome	4.31	1.46
22. Psychotherapy requires relaxing surroundings	5.02	1.47
23. The establishment of rapport is of major importance	5.49	1.31
24. Psychotherapists mainly just listen to their clients	4.45	1.29
25. Most psychotherapy clients become attached to their therapist	4.16	1.56
26. Most therapies last many months	5.04	1.50
27. Most clients consult psychotherapists as a last resort	4.82	1.36
28. Psychotherapy is only useful with a limited number of personal problems	3.95	1.54
29. Most psychotherapy clients lie on a couch	3.23	1.58
30. Most psychotherapy clients are women	3.28	1.36
31. Most clients are resistant to change	3.76	1.37
32. The client/therapist relationship is the most crucial aspect of treatment	4.45	1.55
33. Many therapists point out errors in their client's logic	3.76	1.40
34. Most therapies last many years	3.61	1.55
35. Nearly all therapists give clients 'homework exercises'	4.26	1.40
36. Therapists attempt to change the irrational beliefs of their clients	4.17	1.40
37. On average, clients have between two and four sessions a week	3.42	1.44
38. Clients are encouraged to practise new coping skills in the session	4.64	1.35
39. The major problem of therapy clients is that they see the world in a distorted way	3.76	1.58
40. Therapy sessions are often extremely emotional for clients	5.04	1.40

7 = Extremely frequently; 1 = Extremely rarely

'get better'. A clear limitation of this section was that no distinction was made between different types of therapy.

Part 3: Knowledge about specific illnesses

The descriptive results show mean response for the possible causes, treatments and outcomes of the four illnesses (Table 3). In total 12 principal components analysis were computed; four for each of the 13 items in perceived cause in each condition, four for treatment and four for prognosis. The results across the four conditions (psychological problems) were very consistent. Perceptions of cause showed three clear factors. First, explanations for hereditary factors and brain disorders were loaded on the same factor, no doubt indicating a *biological factor*. The second factor had items of *stress/emotional factors*, such as family and work problems. The third factor contained items such as will of God, lack of willpower and loss of traditional values – a *moralistic perspective*. Similarly, the factor analysis of the seven cures was similar across all four conditions. *Drug treatments* and *psychotherapy* loaded on one factor (usually rated efficacious) and the other five treatments were on the other factor. Principal components analysis for the prognosis items always yielded two factors but they differed considerably from condition to condition. Thus, people did not appear to differentiate very clearly between the efficacy of the seven 'cures'.

There was both consistency and variety across the four different conditions. Participants thought 'stressful life events' tended to be a major cause in all four conditions. Equally, very few believed 'loss of traditional values' or the 'will of God' carried any explanatory power for the cause of these four conditions. Overall, both psychotherapy and drug treatments, particularly the former, were rated as highly efficacious.

With regard to schizophrenia, the participants believed it was caused primarily by a brain disease, possibly inherited and possibly related to stressful life events. Psychotherapy and drug treatments were rated as by far the most effective treatments. This confirmed H_1. Overall, they were not very optimistic about the outcome, with remission being relatively unlikely.

Results were very different for depression. Social factors at work and home were seen as primary determinants and professional or drug therapy the most effective treatment. Participants appeared to think that the prognosis for recovery was good.

The ratings of bipolar disorder were similar to that of schizophrenia but life events and family difficulties were rated as important causes. Psychotherapy and drug treatments were rated as best treatments, and 'pulling oneself together' as particularly ineffective. The pattern for obsessive-compulsive illness was similar.

A series of MANOVAS and ANOVAS were then calculated to examine specific differences in the demographic and experimental correlates of participants. There were fewer than chance sex differences for beliefs in all four disorders as revealed by the MANOVAS.

A comparison was run of the beliefs of those 61 participants who had sought help for psychological problems and those 123 who had not. Because of the possibility of type II errors, only those significant at $p < 0.01$ will be discussed, yet they were few in number. Regarding schizophrenia, participants who had undergone psychotherapy believed *less* that family relations were a cause, but more that overprotective parents were. However, they had similar views on treatments and prognosis as the non-therapy group. Those who had received therapy believed more in the loss of traditional values and the will of God in explaining depression. They also rated natural cures and meditation more highly as efficacious treatments. Those who had had therapy rated growing up in a broken home/and overprotective parents more highly than those who had not had therapy as

Table 3
Mean scores for the ratings of cause, treatment and outcome for the four specified disorders

	Schizophrenia		Depression		Bipolar disorder		Obsessive-compulsive	
How likely do you believe the following to be in causing the disorder?*								
1. Difficulties in family relationships	3.84	(1.71)	5.72	(1.22)	4.84	(1.70)	4.40	(1.65)
2. Work difficulties	3.39	(1.53)	5.53	(1.23)	4.60	(1.71)	3.96	(1.59)
3. Stressful life event	4.43	(1.05)	5.90	(1.18)	5.10	(1.64)	4.95	(1.52)
4. Brain disease	5.45	(1.56)	4.20	(1.66)	4.86	(1.70)	4.37	(1.82)
5. Heredity	4.76	(1.87)	4.30	(1.74)	4.47	(1.83)	4.10	(1.66)
6. Allergies	2.35	(1.49)	2.63	(1.60)	2.50	(1.50)	2.70	(1.59)
7. Lack of will power	2.00	(1.24)	2.92	(1.70)	2.55	(1.59)	2.92	(1.81)
8. Expecting too much of oneself	3.00	(1.75)	4.58	(1.71)	3.96	(1.80)	3.93	(1.91)
9. Growing up in a broken home	3.19	(1.87)	4.37	(1.71)	3.88	(1.86)	3.48	(1.69)
10. Lack of parental affection	3.32	(1.87)	4.65	(1.66)	3.94	(1.77)	3.82	(1.67)
11. Overprotective parents	2.77	(1.73)	3.64	(1.67)	3.28	(1.68)	3.48	(1.69)
12. Loss of traditional values	2.28	(1.56)	2.87	(1.89)	2.55	(1.65)	2.53	(1.60)
13. Will of god	1.92	(1.64)	1.73	(1.42)	1.57	(1.25)	1.61	(1.27)
How useful do you consider the following to be in the treatment of the disorder?+								
14. Relaxation	3.87	(1.60)	4.69	(1.66)	4.03	(1.50)	4.35	(1.64)
15. Pulling oneself together	2.53	(1.63)	3.64	(1.91)	2.88	(1.67)	3.42	(1.91)
16. Talking it over	3.87	(1.72)	5.22	(1.50)	4.36	(1.69)	4.58	(1.65)
17. Natural cures	3.18	(159)	3.73	(1.78)	3.34	(1.65)	3.36	(1.73)
18. Meditation	3.39	(1.70)	4.13	(1.72)	3.57	(1.56)	3.81	(1.65)
19. Psychotherapy	5.03	(1.54)	5.43	(1.31)	5.43	(1.55)	5.48	(1.20)
20. Drug treatments	5.66	(1.47)	4.92	(1.71)	5.60	(1.63)	4.50	(1.80)
How likely are the following to be the long-term outcome of the disorder?*								
21. Cure	3.17	(1.57)	5.24	(1.46)	3.78	(1.62)	4.84	(1.48)
22. Remission with possibility of relapse	4.92	(1.37)	5.39	(1.13)	4.98	(1.27)	4.83	(1.30)
23. Partial remission	4.81	(1.26)	4.85	(1.30)	4.85	(1.20)	4.65	(1.31)
24. Chronic stable state	4.46	(1.30)	4.16	(1.52)	4.59	(1.35)	4.24	(1.43)
25. Chronic progressive course	4.11	(1.24)	3.89	(1.45)	4.20	(1.32)	3.94	(1.39)

* 7 Extremely likely; 1 Extremely unlikely
+ 7 Extremely useful; 1 Not at all useful

a potential causal factor in bipolar disorder. There were no other differences. Overall, there were fewer than chance differences between the two groups. Thus, H_2 was rejected.

Next, alpha coefficients were calculated for the combined treatment factors for each condition. This was done essentially to check the internal reliability of measures if different items were combined. This indicated the extent to which participants believed (some/all) treatments were effective. All were satisfactory: schizophrenia (0.73), depression (0.72), bipolar disorder (0.81) and obsessive-compulsive disorder (0.77). Similarly, the alpha coefficients of the totalled cure ratings were calculated. This gives an overall rating of the prognosis for each condition. Again, all alpha coefficients reached marginally satisfactory levels: schizophenia (0.61), depression (0.62), bipolar disorder (0.69), obsessive-compulsive disorder (0.63). These scores were therefore combined to make eight scores: four for treatment and four for cure.

Following this point, bi-serial correlations were computed between these beliefs and whether the participants had ever consulted professional help for a psychological problem; whether they had ever been seriously ill or not; and the extent to which they were religious. Those who had had treatment for psychological problems tended to be *less* optimistic about the treatment of all four problems (schizophrenia $\rho = 0.16$; depression $\rho = 0.17$; bipolar disorder $\rho = 0.21$, obsessive-compulsive disorder $\rho = 0.18$). However, not all the correlations with outcome were significant. The eight correlations with illness showed four significant correlations. Those who had been seriously ill were less optimistic for the treatment of schizophrenia ($\rho = 0.16$), depression ($\rho = 0.18$), bipolar disorder ($\rho = 0.18$) and obsessive-compulsive disorder ($\rho = 0.19$). None of the correlations for religion were significant.

DISCUSSION

The results of this study, where they replicated and extended previous studies, are broadly in agreement with them. Furnham and Wardley (1990) rank ordered the individual statements of belief that participants most and least agreed with. These results, now nearly 20 year old, can be directly compared with those in Table 1. They found items 3, 15, 13, 11 and 5 to be the top five for agreement, while in this study they were 5, 13, 14, 15. Those that attracted least agreement in Furnham and Wardley (1990) were 2, 4, 6 and 14, whereas in this study they were 4, 6, 8 and 20. Overall, the results were broadly similar and indicated that both samples saw psychotherapy as supportive, creating insight and improving coping skills. However, in contrast with the early study they do recognize that clients are occasionally required to confront uncomfortable and painful ideas and feelings.

It is difficult to determine the accuracy of these beliefs. Are lay people naively optimistic, poorly informed or completely realistic? There is little way in judging this except perhaps to compare their views with those of practising therapists (clinical psychologists). This indeed is what Furnham, Wardley and Lillie (1992) did with the same questionnaire as used in this (and other) studies. They found a significant difference on half the items (4, 6, 8, 9, 11, 13, 14, 16, 18, 20) (Table 1). Comparing mean scores in that study and this one, it seems that, compared to lay people, therapists would say it is rarer for patients to feel confused and side-tracked (4), rejected and judged (6) or misunderstood (8). Equally, therapists believed patients were more likely to experience involvement (9), understanding (11) and support (13). Therapists compared to adults both in Furnham *et al*. (1992) and this study believe less that patients are made to confront negative ideas (14), become addicted to therapy (18) or report attraction to a therapist (20), but more that clients experience contact with the therapist as a person.

Thus, although it seems the case that the results from Table 1 appear to show that lay people are highly positive about psychotherapy, the views of trained and practising clinicians are rather more sceptical. It is of course impossible to determine whether clinicians' and therapists' views are simply self-serving and overly optimistic.

Next, concerning the results shown in Table 2, Furnham *et al*. (2001) found that participants agreed most strongly with five items and disagreed most strongly with three items. Indeed, these results were themselves almost identical to the results of Furnham and Wardley (1990) and Wong (1994), which was the first published (Canadian) replication using these measures. In this study the results were again very similar, particularly with respect to items that participants disagreed

with. Overall, it seems that participants seemed relatively well informed about the process of, as well as the purpose and procedures in, psychotherapy. They know that drugs are rarely prescribed and they reject old stereotypes that, for instance, psychotherapy clients lie on a couch. Yet they do appear to hold ideas that are wrong: for instance, the majority still believe patients are asked about their dreams.

Again it is possible to compare the results of this study with the responses of over 50 practising psychologists who completed the same study. Furnham *et al*. (1992) found many (19 out of 40) differences were the most significant on items 1, 3, 4, 5, 8, 11, 13, 14, 15, 23, 27, 29 and 34) (Table 2). Given that the results of this study are very similar in terms of means and standard deviation to the 120 British adults tested by Furnham *et al*. (1992), it is possible to suggest that these differences would be replicable today. The results strongly suggest the following: compared to the lay people in this study clinicians and therapists in Furnham *et al*. (1992) believed that the behaviours described in items 1, 3, 5, 8, 9, 11, 13 and 22 occur much less frequently. The results showed that therapists thought the behaviours in items 1, 3, and 29 very infrequent, but those in items 14, 15 and 16 to be very frequent.

Are clinicians and therapists more accurate and realistic because of their experience or are they simply making many more self-serving attributions? Certainly, it is relatively simple to verify some of these statements. For instance, the use of questionnaires and drugs and the average length of therapy suggests that many of the ideas of lay people are far from accurate.

However, a clear limitation of this study and those upon which it was based was that it did not differentiate sufficiently between different types of psychotherapy. Clearly the nature of psychoanalytic psychotherapy is very different from that of cognitive behaviour therapy. Indeed, it may even be argued that they have different intermediary aims.

Perhaps the most interesting and certainly the most unique part of this study concerns the data shown in Table 3. Four points need to be made from these findings. The *first* is that overall there are surprising similarities rather than differences in the perceptions of lay people across these very different conditions. Thus, for instance, they believe the role of genetics (heredity) much the same across all four problems. Equally, they appear to believe psychotherapy is good for (that is useful in treating) all problems.

Second, they do have some insight into the differences between the conditions. Thus, they appear to be aware of the fact that the prognosis for neurotic disorders is better than that for psychotic disorders (see item 21, Table 3).

Third, there are some surprises given the stereotypes and myths surrounding various mental illnesses. Thus 'lack of parental affection' and 'difficulties in family relationships' and 'over-protective parents' are thought of as least important in leading to schizophrenia. Thus, older ideas about schizophrenogenic parents appear to hold comparatively less sway today. Equally it is perhaps surprising the extent to which lay people believe depression is relatively simple to cure. It is true that the study did not differentiate between various types of depression, which merits further research.

Fourth, in Furnham *et al*. (1992) where they compared lay people with therapists/clinicians on cure there were many dramatic differences. With few exceptions (anxiety/panic attacks, enuresis and sleep disorders), therapists/clinicians were much less optimistic about cure and pessimistic about prognosis. Thus, for bipolar disorder lay people scored 4.05 and clinicians 3.33 (on a seven-point scale where 7 is good and 1 is bad prognosis). For obsessive-compulsive disorder lay people scored 4.62 and clinicians 3.83; while for schizophrenia it was 3.05 for lay people but 2.64 for clinicians.

CONCLUSION

Overall, the results appear to indicate that lay people place rather too much hope in the usefulness of psychotherapy (of one sort or another) and tend to be a little over-optimistic of the possibility of (total) cure as opposed to effective management of these and other mental illnesses. Naivety and false optimism about the course of a mental illness could lead to problems for people with, or related to those who have, that illness. As researchers like Angermeyer and Matschinger (1996ab) and Jorm *et al*. (1997abcd; 1999; 2000) have pointed out, being better informed about mental illness is very important socially. This study, like others in this series, indicates that various myths persist in this area. It has also demonstrated that patients do not very strongly differentiate between various types of mental illness. This has implications for those interested in the public understanding of psychiatry and directing attempts to inform those with specific disorders as well as their families.

LIMITATIONS

All studies have limitations. This study included mainly educated people from the southeast of England where psychotherapy and counselling provisions are higher than in the rest of the country. Ideally, a larger more representative sample would have been obtained. The study did not enquire about participants' experiences of counselling as opposed to psychotherapy, which may have been important. Nor did it enquire about participants' direct experience of the four problems outlined. It would also have been desirable to have a current group of professional psychotherapists and clinicians complete the questionnaire for comparative purposes. Perhaps most importantly, studies on beliefs about psychotherapy should differentiate between major types or schools of psychotherapy and counselling. Combining them under one heading, could paradoxically, increase participant ignorance of the practice.

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Professor Adrian Furnham, Department of Psychology, University College London, UK.

Email: a.furnham@ucl.ac.uk