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Psychiatric literacy and personality disorders

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ABSTRACT

Past literature suggests that mental health literacy among the general public is lamentably poor. The study aimed to examine the effect of demographics, knowledge of psychology and psychiatry, and experience of mental illness as predictors for understanding and recognising personality disorders from vignette descriptions. An opportunistic sample of 187 participants with a mean age of 28 years completed an on-line questionnaire in which they were asked to describe and evaluate vignettes of 10 personality disorders. The results revealed major differences between the personality disorders in terms of recognition, and identification and perceived adjustment. The results showed that those who were female, older and had experienced a mental health problem were more accurate and mental health literate.

1. Introduction

This article is concerned with psychiatric literacy or the 'public understanding of psychiatry'. Many studies have been conducted in this area (Angermeyer et al., 2004; Angermeyer and Dietrich, 2006), but none have been specifically concerned with personality disorders.

The term 'mental health literacy' was first coined by Jorm et al. (1997) meaning 'knowledge and beliefs about mental disorders which aid their recognition, management or prevention' (p. 182). This comprises several components, including the ability to recognise specific mental disorders; knowledge and beliefs about risk factors and causes; self-help interventions and professional help available; attitudes which promote appropriate help-seeking; and the recognition and knowledge of ways to obtain mental health information. Jorm et al. have done a great deal of research in the area (Chen et al., 2000; Jorm, 2000), and the concept of mental health literacy seems to be gaining acceptance (Mubbashar and Farooq, 2001; James et al., 2002; Goldney, et al., 2005). The exploration of many aspects of mental health literacy has mostly been through the use of vignette methodology (Farrer et al., 2008) which is also employed in this study.

In Jorm's (2000) review, he noted that many lay people cannot correctly identify mental disorders and they have difficulties understanding psychiatric terms. For example, Jorm et al. (1997) found that 39% of participants correctly identified Depression but only 27% correctly identified Schizophrenia. More recent studies have reported considerably higher recognition of Schizophrenia and Depression (Link et al., 1999; Lauber et al., 2003). However, this increase may not entirely reflect greater awareness; but may possibly be the result of methodological disparities in the way mental health literacy is measured.

In Jorm et al.'s (1997) early study, participants were asked "What would you say, if anything, is wrong with John/Mary?" In contrast, Lauber et al. (2003) presented a close-ended question. They required participants to indicate whether the person described in the vignettes were suffering from an 'illness' or a 'crisis'. Link et al. (1999) asked the participants to rate the likelihood of X experiencing a 'mental illness'. It can be noted that both Link et al. (1999) and Lauber et al. (2003) implied that there was something wrong with the person. This implied 'problem' may contribute to the discrepancy between Jorm et al.'s (1997) findings and more recent studies.

Wang et al. (2007) found that in Canada, 75.6% of their participants were able to recognise depressive symptoms and use the correct label. The authors claimed that the higher recognition rate in their second study compared to the Australian survey may be due to it being conducted more recently and the results reflecting more current knowledge. However, they also pointed out their use of an unrepresentative sample, consisting of more female and higher educated participants than the Australian study. The unavailability of demographic and socio-economic details from the Australian study renders any comparison impossible.

In a recent article concerned with whether lay people could label a person as being a psychopath (i.e. having Anti-Social Personality Disorder), Furnham et al. (2009) used three vignettes and found that 97% of participants could recognise Depression; 61% could recognise Schizophrenia; but only 39% could correctly identify a Psychopath (Anti-Social Personality Disorder).

The current study is concerned specifically with lay understanding of personality disorders: that is, their ability to recognise a disorder, (in some sense identify it or correctly label it) and the person with it as having a problem. There are a number of websites such as that provided

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by The Royal College of Psychiatrists which describes the disorders, their treatment, prevalence, change over time and access to self help (The Royal College of Psychiatrists, 2010). It points out that 10–30% of people who visit a General Practitioner will have a personality disorder.

It does seem that some disorders are studied much more frequently than others (i.e., Borderline, Narcissistic and Antisocial vs. Schizoid and Dependent). Academic studies are concerned with issues like prevalence (Oldham and Skodol, 1991; Coid et al., 2006; Huang et al., 2009), the reliability of diagnosis (Tyrer et al., 2007), as well as the efficacy of treatment (Bateman and Fonagy, 2008).

There is also a literature on successful people with personality disorders; particularly in the workplace (Board and Fritzon, 2005; Furnham, 2010). However, with greater relevance to this study is the existence of a number of books aimed at the lay person that attempt to describe the various personality disorders in detail (e.g., Dotlich and Cairo, 2003; Miller, 2008). Another example is the work of Oldham and Morris (1995) whose book attempts to explain all the disorders in lay language including how to live and work with them.

This exploratory study is concerned with the ability of lay participants to recognise the presence of a psychological problem, label a personality disorder correctly, and to rate the person with the disorder; with respect to happiness, success at work and quality of personal relationships. The first hypothesis is that some disorders will be much more easily recognised than others by lay people, and that in particular, Obsessive-Compulsive Personality Disorder will be readily identified. This is because some of these concepts have "seeped" into the media, where they are often discussed, while other types of disorder such as Schizotypal or Borderline Personality Disorder are infrequently mentioned. The second (related) hypothesis is that lay people will be reasonably proficient at identifying the presence of a personality disorder but will be poor at providing the correct diagnostic label for that disorder. The third hypothesis is that there will be a negative relationship between the probability of a disorder being identified and the ratings of adjustment (i.e. happy, successful at work and enjoying good personal relationships). The fourth hypothesis is that females will demonstrate better psychiatric literacy than males — a phenomenon evident in previous research (Cotton et al., 2006; Wang et al., 2007). We also aimed to investigate the influence of experience of psychological problems (either personally or knowing someone with a psychological problem) and age on the ability to identify personality disorders.

2. Method

2.1. Participants

A total of 187 participants took part in the study, recruited through opportunity sampling and student mailing lists. All participants took part on a voluntary basis and were not remunerated for their participation. Of the recorded demographics (49 participants chose not to disclose personal details) there was an age range of 18 to 66 years ($M=28.01$ years, S.D. = 13.37 years). There were 87 recorded females and 51 males; the majority of participants reported being of British ethnicity (56.7%, $N=106$), although other ethnic backgrounds, like European Caucasian (11.8%, $N=22$), Asian (3.2%, $N=6$) and Mixed British (2.1%, $N=4$) were represented. Many of the respondents were students (40.6%, $N=76$), but there were also some in full-time work (19.3%, $N=36$), part-time work (6.4%, $N=12$), retired (2.7%, $N=5$), unemployed (2.1%, $N=4$) and some with another occupational status (2.7%, $N=5$). As regards highest educational qualifications, 32.1% ($N=60$) had A-levels (12th grade) and 31% ($N=58$) had a degree. Finally, 9.1% ($N=17$) reported having been personally treated for a psychological illness, and 57.2% ($N=107$) reported having known someone who had been treated for a psychological illness.

2.2. Questionnaire — personality disorders questionnaire

The questionnaire consisted of 10 vignettes describing three cluster A (Schizotypal, Paranoid and Schizoid) four cluster B (Antisocial, Borderline, Histrionic and Narcissistic) and three cluster C (Avoidant, Dependent and Obsessive-Compulsive) disorders as defined in DSM-IV-R (American Psychiatric Association, 2000). The vignettes were adapted and modified from those found in three textbooks: Spitzer et al. (1994); Nevid et al. (1997); Seligman et al. (2001) and. The vignettes were around 150 to 200 words long and written to be easily understandable. An example is given below:

Laura is a married 45 year old lawyer. She was the youngest full partner in the firm's history and is known as the hardest driving member of the firm. She is too proud to turn down a new case and too much of a perfectionist to be satisfied with the work done by her assistants. Displeased by their writing style and sentence structure she finds herself constantly correcting their briefs and therefore is unable to keep up with her schedule. When assignments gets backed up, she cannot decide which to address first, starts making schedules for herself and her staff, but then is unable to meet them and starts working 15 hours a day. Laura never seemed to be able to relax. Even on vacations, she develops elaborate activities schedules for every family member and gets angry and impatient if they refuse to follow her plans. Her husband is fed up with their marriage and can no longer tolerate her emotional coldness, rigid demands and long working hours.

How would you describe this person? .....
How happy overall do you think they are? Very 8 7 6 5 4 3 2 1 Not at all.
How successful at work do you think they are? Very 8 7 6 5 4 3 2 1 Not at all
How good are their personal relationships? Very 8 7 6 5 4 3 2 1 Not at all
Do you think that, in any sense they have a psychological problem Yes…. No…..
If so what is it?.....

We kept the sex of the Personality Disorder person the same as in the textbook vignettes. All were male except those for Borderline, Histrionic and Obsessive-Compulsive disorder cases. This could have had an effect on recognition and ratings as it is known that there are sex differences in the personality disorders (Lynam and Widiger, 2007). It is known that males are more likely to be diagnosed Narcissistic, Anti-Social and Paranoid as compared to females. We felt it was appropriate to leave the sex differences as they were, though it is possible that had all vignettes concerned people of the same sex, (all male and all female) the ratings may have been different.

There were three rounds of piloting. On the advice of a test publisher who developed a measure of the personality disorders (Hogan and Hogan, 1997) the vignettes were changed slightly to make them less "clinical" and more "normal". These changes were relatively minor and also attempted to make the descriptions of similar length. We recognise the importance of the vignettes (subtlety, veridicality and representativeness) for all studies in this area. Readers are welcome to contact the first author to obtain copies of the questionnaire.

Second, the 10 vignettes without labels and randomised with respect to the three clusters were sent to six clinical psychologists in three countries. They were told that the vignettes represented 10 personality disorders. They were given a list of the disorders and asked to match them up. Five of the six got them fully "correct", while one confused two disorders. Three more clinicians were asked to label the disorders without the list. Two "correctly" identified all ten, while a third got one "wrong". Third, the draught questionnaire was given to 10 people who were asked to be critical with respect to the clarity of the instructions as well as vignettes — and changes were made accordingly.

2.3. Procedure

A web-based approach was adopted for the data collection. The participants were told that there was no time limit, but on average the questionnaire should take approximately 20 min to complete. Participants were also informed that all information collected would be kept strictly confidential, only accessible to members of the research team and held in accordance with the UK Data Protection Act (Office of Public Sector Information, 1998). They were informed that they were free to withdraw from the study at any time. Participants were also told that all input was completely anonymous and results could not be personally identifiable from any report or publication.

3. Results

In order to assess how successful participants were at recognising a psychological disorder as being present for each of the personality disorder vignettes, a Cochran's Q test was conducted. This revealed that there was a highly significant difference in the proportions of successful identifications of a psychological problem as a function of the personality disorder, $Q\ (9)=191.815$, $p<0.001$. Table 1 shows the personality disorders in descending order of how successfully participants identified a problem for each vignette. Inspection of this table reveals that participants were most successful at identifying Borderline Personality Disorder as a psychological problem, followed by the Schizoid, Schizotypal and Antisocial Disorders. Less than half of the participants identified Paranoid, Histrionic, Avoidant, and Obsessive-Compulsive disorders as being psychological problems. Dependent and Narcissistic personality disorders were least likely to be seen as psychological problems.

The Cochran's Q test was then used to assess how successful participants were at actually *naming* the psychological problem being described. Again, there was a highly significant difference in