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original papers

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The public's knowledge of psychiatrists: questionnaire survey

AIMS AND METHOD

One objective of the Royal College of Psychiatrists' stigma campaign is to improve the public's knowledge about psychiatric illness. There has been little work in the UK on the public's knowledge of the training of psychiatrists and the treatments they use. Using a questionnaire, we compared a sample representing the general population (*n*=223) with a sample attending psychiatric out-patients (*n*=67) to assess their level of knowledge.

RESULTS

Half of the general population sample did not know that psychiatrists were medically qualified, and 80% underestimated the length of psychiatric training. There was variable knowledge of the conditions treated by psychiatrists and treatment methods used, with the out-patient group having better knowledge of drug treatments.

CLINICAL IMPLICATION

If the general public do not know about the training and expertise of psychiatrists, this is likely to limit their willingness to seek treatment for mental illness.

One of the primary aims of the Royal College of Psychiatrists' stigma campaign is "to close the gap between the different beliefs of health care professionals and the public about useful treatments and interventions" (Cowan & Hart, 1998).

A number of studies in the USA and Europe have attempted to look at beliefs about psychiatric illness, psychiatrists and the treatments they employ, with some consistent findings over time and across countries. These studies found that psychiatric illnesses were not well recognised, for example, Brockington *et al* (1993) found that less than a quarter of the population surveyed were able to recognise schizophrenia or depression as mental illnesses from descriptive vignettes.

There have also been studies that looked at public perceptions of the treatments available for psychiatric illness. In a paper by Priest *et al* (1996) looking at attitudes prior to the Defeat Depression Campaign, the majority of those surveyed thought that people with depression should not be given antidepressants, and expressed the opinion that drug treatments only dulled the symptoms and that such treatments were addictive. Jorm *et al* (1997) compared the beliefs of health professionals and the public, revealing major discrepancies between the two groups about the helpfulness and harmfulness of standard psychiatric treatments. The public see antidepressants, antipsychotics and admission to hospital as harmful, whereas the professionals (represented by psychiatrists, psychologists and general practitioners (GPs)) see them as helpful.

Opinions are based on factual knowledge as well as other factors such as stereotypes in the media and social influences. The most accessible starting point in changing opinions is to identify gaps in knowledge and to use this information to target any education campaigns.

The study

We designed a self-rated questionnaire that asked about the training of psychiatrists, the conditions they treat and the treatments they use, which was piloted and refined. This consisted of 10 questions with lists of possible responses and tick boxes, including several questions where more than one response could be given. We also asked for the age, gender and postcode of each respondent.

In order to survey a population broadly representative of the general population, questionnaires were placed at the reception desks in two health centres, one urban (Glasgow) and one rural (Castle Douglas), during both day and evening surgeries (general population sample). The questionnaires were offered to all those attending, however, there is no information available about those who refused to take part. A sample attending general adult psychiatric out-patients was also surveyed using the same method, to compare their level of knowledge with that of the general population, in the expectation that their level of general knowledge about psychiatrists would be greater than the general population. The same questionnaire was sent to post-membership psychiatrists in the West of Scotland to provide a standard for comparison.

Findings

The general population sample completed 223 questionnaires; 118 (53%) attending the urban practice and 105 (47%) the rural practice. Their mean age was 43 (range 17–83). Table 1 shows their age and gender compared with those of the total population of these areas. Of the patients attending the psychiatric out-patient clinic, 67 completed questionnaires; their mean age was 40 (range 18–65) and 34 (51%) were male.

Forty-seven psychiatrists returned completed questionnaires, representing a response rate of 78%. Demographic details were available for 33 (70%) of the psychiatrists; 18 (55%) of these were female and the mean age was 40 (range 30–56). No information was collected about the specialities of the psychiatrists surveyed.

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Table 2 shows the responses to the questionnaire; 50% of the general population sample and 36% of the out-patient sample did not know that psychiatrists were medically qualified. Of the total sample 80% underestimated the length of training required from leaving school to becoming a fully qualified psychiatrist. Psychiatrists themselves estimated this would take more than 10 years (94% of psychiatrists).

Knowledge of the conditions treated by psychiatrists was variable. Most of the general population sample responded that psychiatrists treat depression, schizophrenia and sexual abuse, although more than a fifth did not know psychiatrists treated patients with schizophrenia. Only 36% of the general population identified dementia as a condition that psychiatrists were involved in treating, although those attending as psychiatric out-patients had significantly greater levels of knowledge regarding psychiatrists' involvement in treating dementia and drug problems.

Counselling was the most frequently recognised treatment method, with a much smaller proportion of the general population sample recognising tablets, injections or electroconvulsive therapy. The psychiatric out-patient group had significantly better knowledge of pharmacological treatments.

The psychiatrists surveyed had differing views about some conditions treated, for example whether psychiatrists have a role in treating marital problems (51%), multiple sclerosis (23%) and epilepsy (40%). There was also a lack of consensus about the use of counselling (85%), hypnosis (57%) and brain surgery (60%).

The general population and out-patient samples responded that referrals to psychiatrists came mainly from GPs, hospital doctors and the courts. There was disagreement between psychiatrists about whether self-referrals were a legitimate way of accessing a psychiatrist (34% agreed, 66% disagreed).

Discussion

Limitations

The sample chosen to survey was not a truly random sample of the general population, although sites and times of surveying were selected in both rural and urban sites to represent a range of socio-economic groups. Our samples were broadly similar in age distribution to the total populations of these areas, apart from an underrepresentation by those over pension age. There was also an underrepresentation of male respondents in the rural site. The sample responding to the questionnaire was self-selected, and it was not possible to calculate a response rate or comment on the characteristics of those who chose not to take part.

Level of public knowledge

The study highlights a clear lack of knowledge about psychiatrists in several areas. Psychiatrists are believed to have less training than is actually the case and half of the sample did not know that psychiatrists are medically qualified. This result is similar to that found by Thumin and Zebelman in 1966 (Thumin & Zebelman 1967) in the USA, suggesting that knowledge in this respect has not improved over time. Although our study did not compare knowledge levels about other professional groups, it is clear that our sample was not able to recognise these essential characteristics of the profession.

This study demonstrated a variable level of knowledge about the illnesses most commonly treated by psychiatrists, although no attempt was made to discover what understanding people had of the terms given. The lack of knowledge about psychiatrists' role in treating dementia may reflect the fact that much of the management and treatment occurs in primary care.

In terms of treatment methods used, counselling was by far the most commonly selected, perhaps reflecting the increase in its availability and popularity as a treatment. Those attending psychiatric out-patients had more knowledge about medication, both oral and injected, as might be expected.

It would seem therefore that the public remains confused about whether psychiatry is involved with treating emotional problems or mental illness, as found previously by Clarke and Martire (1978). Lawrie (1999) has suggested that a more medical/biological view of psychiatry has had the effect of reducing stigma; however, if the general public are not aware of this model it is unlikely to be of benefit in reducing stigma.

Table 1. Age and gender of respondents compared with total population

	Glasgow total population[1] (%)	Urban practice sample (%)	Castle Douglas total population[1] (%)	Rural practice sample (%)
Male	46.7	43.2	45.9	27.0
Female	53.3	56.8	54.1	73.0
16–17	2.8	0.8	3.2	4.8
18–29	24.7	22.7	17.8	16.4
30–44	24.7	31.9	23.6	34.6
45–pension	23.2	34.5	25.3	24.0
Males with pension	7.7	3.4	10.0	7.7
Females with pension	16.9	6.7	20.1	12.5

1. From 1991 Census.

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Table 2. Patients' and psychiatrists' response to questionnaire

	General population *n*=223 (%)	Out-patient attenders *n*=67 (%)	Psychiatrists *n*=47 (%)
How many years of training would it take to become a fully-trained psychiatrist?			
< 10 years	180 (81)	52 (78)	3 (6)
> 10 years	29 (13)	11 (16)	44 (94)
Don't know	14 (6)	4 (6)	0 (0)
Is a psychiatrist a medical doctor?			
Yes	112 (50)	43 (64)	47 (100)
No	82 (37)	17 (25)	0 (0)
Don't know	29 (13)	7 (11)	0 (0)
Which kinds of problems do psychiatrists treat? (number replying yes)			
Depression	209 (94)	61 (91)	47 (100)
Schizophrenia	174 (78)	57 (85)	47 (100)
Sexual abuse	162 (73)	42 (63)	42 (89)
Alcohol problems	142 (64)	50 (75)	47 (100)
Drug problems	128 (57)	50 (75)*	47 (100)
Dementia	81 (36)	38 (57)**	47 (100)
Marital problems	62 (28)	18 (27)	24 (51)
Epilepsy	15 (7)	11 (16)*	19 (40)
Multiple sclerosis	20 (9)	4 (6)	11 (23)
Meningitis	5 (2)	1 (1)	1 (2)
What types of treatments do psychiatrists use? (number replying yes)			
Counselling	202 (91)	56 (84)	40 (85)
Tablets	119 (53)	50 (75)**	47 (100)
Psychotherapy	116 (52)	38 (57)	47 (100)
Hypnosis	111 (50)	29 (43)	27 (57)
Electroconvulsive therapy	95 (43)	32 (48)	47 (100)
Injections	46 (21)	34 (51)***	45 (96)
Brain surgery	6 (3)	4 (6)	28 (60)
Who can send you to see a psychiatrist? (number replying yes)			
Hospital doctor	177 (79)	54 (81)	46 (98)
Refer yourself	61 (27)	16 (24)	16 (34)
General practitioner	210 (94)	64 (96)	46 (98)
Police	54 (24)	23 (34)	31 (66)
Relative	42 (19)	14 (21)	7 (15)
Courts	160 (72)	43 (64)	46 (98)

General practice attenders *v.* out-patient attenders; χ^2 tests: $*P<0.05$, $**P<0.005$, $***P<0.0005$.

The high number of respondents stating that the courts or the police can refer one to see a psychiatrist may indicate a link in people's minds between psychiatric illness and criminality.

Psychiatrists' views

The fact that consultants and specialist registrars did not consistently agree about some of the conditions treated, the treatments used and routes of referral to psychiatry is perhaps not surprising given the range of different psychiatric services and styles of practice. Whether marital problems or childhood sexual abuse come within a psychiatrist's remit, and whether counselling and hypnosis are recognised treatments that psychiatrists use seems to be open to question among this group.

Implications for the stigma campaign

The stated aim of the stigma campaign, "to close the gap between the different beliefs of health care professionals and the public about useful treatments and interventions", is likely to prove difficult if the findings of this study can be generalised to the whole population. The diverse nature of the field of psychiatry is likely to complicate the task of presenting a comprehensive and comprehensible account of treatments for psychiatric illnesses. The task is made more difficult by the negative stereotypes that continue in the media, and have remained stable over time despite a consistent move away from restrictive institutions and harsh treatment practices.

It has been shown that even small increases in knowledge can have a significant effect on overall attitudes and behaviour (Wolff *et al*, 1996), and so it would seem essential to make every effort to educate the public. If this is accepted, this study would suggest that targeting of very specific factual information about the availability of effective and humane treatments for specific conditions provided by medically qualified practitioners is required. This may then lead to an increase in the likelihood of patients seeking help when

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appropriate for psychiatric conditions and a reduction in the associated stigma.

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The forgotten children: children admitted to a county asylum between 1854 and 1900

AIMS AND METHOD

To assess the part that the 19th century asylums played in the development of the discipline of child psychiatry. Admissions to the Worcester County Asylum between the years 1854 and 1900 were screened to identify children aged 16 and under. An item sheet was used to record details of the admission.

RESULTS

One-hundred and ninety-five children were admitted. Risk of suicide and dangerousness were routinely recorded, family history rarely. It was not possible to make retrospective diagnoses. The death rate was high and contact with the family was minimal post admission.

CLINICAL IMPLICATIONS

Children were treated exactly like the adult patients, and therefore asylums did not contribute significantly to the development of the discipline of child psychiatry.

The first attempt at a coordinated strategy for the provision of child and adolescent mental health services has been formulated only in the last decade of the 20th century (NHS & Health Advisory Service, 1995). Until then the mental health of children had been the province of public and private agencies, whose policies were developed in the late 19th century and whose perspectives on children often still reflect this. Such a diversity of service origin is one of the strengths of mental health provision for children (Howells & Osborn, 1980), but also a weakness in that it can lead to misunderstandings and confusion (Pearce, 1999).

The Lunatic Asylums Act 1845 made it mandatory for each borough and county to provide adequate asylum accommodation at public expense for its pauper lunatic population. Admissions to the asylum were a financial burden on the parish of origin, and therefore admission was a last resort (Tuke, 1898). There is a paucity of original source material, so little is known about the group of children who did get admitted. An examination of case notes of children admitted to Bethlem hospital is one of the few studies on this subject, but is not a representative view, as only people who had not been insane for over 12 months, or had never been discharged as insane from another hospital, were admitted there (Wilkins, 1987). I describe the children admitted to a typical county asylum between 1854 and 1900, using contemporaneous case notes.

Method

The Worcester County Asylum (Powick Asylum) in the village of Powick opened in 1854. Patient admissions were sequentially recorded in large leather-bound ledgers. Initially both males and females were recorded in the same book, but subsequently males and females were recorded separately. All ledgers available were examined and those children aged 16 and under on

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