

## REPRESENTATIONS OF PSYCHIATRIC TREATMENTS

*D. Goerg<sup>1</sup>, E. Zbinden<sup>1</sup>, W. Fischer<sup>1</sup>, J. Guimón<sup>2</sup>*

Department of Psychiatry

University Hospital of Geneva  
Geneva, Switzerland

<sup>1</sup> Sociologists, Department of psychiatry, University Hospital of Geneva

<sup>2</sup> Honorary Professor, University of Geneva, Geneva  
Professor of psychiatry, University of the Basque Country

Address for correspondence :

D. Goerg, Département de psychiatrie

2, Chemin du Petit-Bel-Air

CH-1225 Chêne-Bourg

Geneva, Switzerland

tel. +4122/305.57.50 / fax +4122/305.57.99

E-mail : [Danielle.Goerg@hcuge.ch](mailto:Danielle.Goerg@hcuge.ch)

## SUMMARY

*Objectives* : The goal of this study is to determine whether the public differentiates between the various mental disorders and their treatments, since social representations of mental illness and its treatment play an important role in its detection and in orienting patients towards certain therapies.

*Methods* : The public's representations are examined in a survey carried out among a stratified sample of the Swiss population, through the use of clinical vignettes, for three mental illnesses in terms of definition as an illness, etiology, treatments foreseen and prognosis.

*Results* : A clear differentiation exists between schizophrenia, on the one hand, and depression and panic disorder on the other. Schizophrenia is more frequently considered as a real illness, with a multifactorial etiology, a more pessimistic prognosis and for which psychotherapy and family therapy are the prescribed treatments. There is, however, a lack of differentiation in regards several etiological factors of psychiatric disorders, in particular psychosocial factors which are given very considerable weight, and certain treatments, especially those involving medication, which is only recommended for all three psychiatric disorders by a quarter of subjects interviewed.

*Conclusions* : The public's representations appear to be nuanced. Even if a majority of the population has some experience of psychiatry or psychology (acquaintance with people working in the field, psychological difficulties experienced either personally or within the subject's entourage), its representations often show a lack of awareness of the current scientific debate.

## KEY WORDS

Representations, psychosocial factors.

## RESUMEN

Las conclusiones del estudio que presento determinan que las representaciones sociales aparecen matizadas. No obstante, una mayoría de la población tiene alguna experiencia en psiquiatría o psicología. Las representaciones sociales muchas veces muestran invitan a pensar en que la población posee una falta de conciencia sobre el debate científico común.

## PALABRAS CLAVE

Representaciones, factores psicosociales.

## PUBLIC REPRESENTATIONS OF MENTAL DISORDERS AND PSYCHIATRIC TREATMENTS : DIFFERENTIATION OR LACK OF DIFFERENTIATION ?

### INTRODUCTION

The public representations of, and attitudes towards, mental disorders and their treatment play an important role both in the detection and in the treatment of the mentally ill. These social representations condition the way in which therapists, patients and their families perceive each other. They are also determining factors of how compliant patients will be with the treatments proposed.

Certain studies on the attitudes of the general population towards psychiatric treatment and particularly towards psychotropic medication have shown that the public very seldom differentiates between the various mental disorders and the different categories of psychotropic drugs and their indications. Thus the studies of Angermeyer et al. in Germany [1-4] showed that the public makes practically no distinction between schizophrenia, major depression and panic disorder insofar as treatment is concerned. The public gives much greater preference to psychotherapy than to medication. The proportion of those opposed to psychotropic drugs is twice as high as those favoring them for the treatment of schizophrenia or panic disorder, and this opposition to psychotropic medication is stronger still for depression. In Australia, Jorm et al. [5] also observed that the same system of beliefs concerning the appropriate treatments was applied to diverse mental disorders. For Benkert et al. [6], in another study on public attitudes towards psychotropic medication in Germany, the majority of the population disregards recourse to psychotropic medication in cases of mental disorder. The spectrum of mental illness seems reduced, for the public, to two extremes : madness and malaise in which the public also classifies severe disorders such as depression. For madness there is a tendency for medication to be accepted; for malaise, medication is in general refused as it is not perceived as an illness.

Other works aimed mainly on the recognition of psychiatric disorders, their causes and prognosis, as well as attitudes towards those who suffer from such disorders, have sometimes shown more differentiated results in the general public [7-11] and in specific population samples [12-14]. If little difference seems to be made between diverse psychiatric disorders,

part of these works tend to show that schizophrenia is more readily perceived as an illness, is considered to have darker outcome and provokes a greater social distance than other disorders.

The hypothesis examined in our study is that the population in Switzerland does not differentiate between various psychiatric disorders nor between the different treatments which might be chosen for these disorders. More specifically, the question of lack of differentiation between three serious psychiatric disorders (schizophrenia, depression, panic disorder) will be dealt with under the following different aspects: their definition as an illness, their etiology, treatments deemed to be adequate, and finally their prognosis. If differences nevertheless appear, their determining social factors and the elements which may be linked to them will be investigated.

## METHODS

The results presented are part of a study carried out with a representative sample of the population resident in Switzerland, aged between 20 and 75. The stratified sample was based on gender, age and professional activity. The 1016 subjects thus selected answered a standardized questionnaire principally covering the representations of psychiatric disorders and their treatment, attitudes towards psychotropic medication, attitudes towards medication in general and attitudes towards psychiatric patients. The socio-demographic, professional, cultural and familial characteristics of the subjects were also examined.

In order to depict the public's representations of psychiatric disorders and psychiatric treatments, three clinical vignettes were elaborated. The vignettes presented the following three cases: major depression, schizophrenia and panic disorder. They were created on the basis of DSM-III criteria with the assistance of a psychiatrist. Each of them was presented to a third of the sample. Interviewers selected vignettes in a set order (schizophrenia, major depression, panic disorder). The vignette portraying a case of schizophrenia was thus given to 353 subjects, that for major depression to 333 subjects and that for panic disorder to 330 subjects. The three sub-samples had no differences in the principal socio-demographic, professional, cultural and family background characteristics of those interviewed. Neither were they differentiated according to their proximity to psychiatry, contacts with persons having undergone psychological difficulties or their own experience with such problems.

Following the presentation of each vignette, we asked those interviewed what would, in their opinion, be the most useful treatments for the person described (with a choice of a maximum of three treatments) out of a list of six possibilities, with other forms of therapy left open to suggestion. For those subjects who did not select medication, an open-ended question with 18 pre-coded answers was asked pertaining to the reasons they did not mention it. These items were regrouped into six variables, of the presence/absence kind. The social representations of the etiology of illness were first addressed through a list of 18 items, borrowed from Angermeyer [15]. Six weighted indices were created, regrouping three items each referring to the same dimension; the answer "yes" was worth 2 points, "maybe", 1 point. An index totaling positive replies to the 18 items was also drawn up. The two items on definition of illness and prognosis were closed questions.

Other indices on societal factors were also established. These principally concerned cultural differentiation (foreigners, persons having moved here from other regions, a mother tongue which is not that of the region in which the person lives, spouse with a different mother tongue), a weighted index of proximity to psychiatry (a psychiatric institution located nearby, knowledge of the workings of a psychiatric institution, types of links to an institution) and a weighted index of contacts with persons suffering from mental disorders.

Answers on the vignettes were compared with diverse usual tests -  $\chi^2$  and variance analysis (+ Scheffe test) - according to the type of variable concerned. Logistic regression analyses have been used to distinguish societal factors associated with the definition of the different disorders in terms of illness.

## RESULTS

### Definition of mental illness

**Assessment of the public's perception of the persons described in the different clinical vignettes as suffering from psychiatric disorder was indicated in their opinion as: certainly ill, probably ill, probably not ill or certainly not ill.**

- Insert Figure 1 about here -

Taking into account positive answers and those with a positive tendency, we noted that more than 7 subjects out of 10 considered the persons presented in the vignette to be mentally ill. The vignette presenting a case of schizophrenia provoked more positive answers

(more than 8 subjects out of 10) than those concerning either depression or panic disorder (approximately two-thirds of the cases), with statistically significant differences (Figure 1).

The distinction between schizophrenia on the one hand, and depression and panic disorder on the other, was more marked for the unequivocally positive response (38.5% for schizophrenia and, respectively, 21.3% for depression,  $p < .001$ , 18.8% for panic disorder,  $p < .001$ ).

## ETIOLOGY OF PSYCHIATRIC DISORDERS

Questioned about the factors which could be at the origin of the situation presented in the clinical vignettes, the public, overall, favored psychosocial stress factors (important life-disturbing events, work problems, family or couple difficulties) and psychological factors (personal psychological problems, lack of willpower, too demanding of oneself) in interpreting the causes of psychiatric illness (Table 1). These were followed by biological factors (diseases of the brain, weak or fragile constitution, heredity), those linked to early socialization (lack of parental affection, separation of parents during childhood, overprotective parents), societal factors (a perceived estrangement of today's world from nature, loss of tradition, social inequalities and exploitation). Supernatural factors (divine intervention, astrology, witchcraft) were very rarely mentioned.

- Insert Table 1 about here -

The public did not differentiate between the clinical vignettes for two types of etiological factors: psychosocial stress and societal factors. Clinical cases inspired, however, contrasted representations of their etiology for the three other factor types - psychological, biological and those linked to early socialization. Thus the social representations of the etiology of schizophrenia were particularly differentiated, as much from those of depression as from those of panic disorder, by the greater weight granted to factors linked to socialization. Biological factors were evoked more frequently for schizophrenia and panic disorder; psychological factors for schizophrenia and depression. Among psychological factors, the public much more often considered a lack of willpower to be the cause of schizophrenia than of depression (30.9% as against 19.6%,  $p < .001$ ) and even more so for panic disorder (10.2%,  $p < .001$ ). In contrast, schizophrenia was less closely linked than the other two diagnoses to self-exacting behavior (15.2% in the case of schizophrenia, as against

26.7% for depression,  $p < .001$ , and 22.7% for panic disorder,  $p < .05$ ). A greater number of causes were mentioned for schizophrenia than for the other two illnesses: subjects gave an average of 3.9 affirmative answers for items concerning the etiology of schizophrenia, 3.2 for depression and 3.0 for panic disorder ( $p < .001$ ). This indicated a still more pronounced endorsement of a multifaceted explanation for schizophrenia than for the other two diagnoses.

Very few differences appeared in the representations of the etiology of depression and panic disorder. However, the weight of psychological factors, and most specifically a lack of willpower, was greater in the first case, and that of biological factors in the second.

#### Considered treatments

Subjects had to choose three treatments thought most beneficial for the person described in each of the clinical vignettes from a list comprising six types of therapy. In addition to psychiatric-type solutions, this list mentioned possible recourse to natural or alternative means. We also gave the possibility of evoking other forms of treatment. The selection of treatments gave indications on the social representations subjects made of the different treatments and on their representations of the various psychiatric disorders.

- Insert Table 2 about here -

Psychiatric approaches were most clearly preferred and individual psychotherapy appeared as the most appropriate treatment for mental disorders since it was selected by almost six out of ten subjects (Table 2). More than one-third of the subjects considered relaxation therapy useful, one-fourth chose psychotropic medication and approximately one-fifth, family therapy. Natural products or means as well as meditation and yoga were also mentioned by one-fifth of the subjects interviewed. Other possibilities were only rarely suggested, and subjects who said that the person described was not in need of any form of treatment were exceptional.

Very significant variations were found between treatments chosen for schizophrenia on the one hand, and depression or panic disorder on the other. The exception was medication which was mentioned with the same frequency for the three types of psychiatric disorders. Two-thirds of the subjects considered that psychotherapy was the most important treatment for schizophrenia, while half suggested it for the other disorders. For schizophrenia, the subjects considered family therapy in second place, then to a lesser degree, medication. The other treatments proposed - relaxation, natural means, meditation and yoga - were very

seldom chosen, whereas they were mentioned more often in the two other clinical cases; this was particularly true for relaxation. The public thus mentioned a significantly lower number of treatments for schizophrenia, whereas the range was more diversified for depression and panic disorder (1.8 on an average for schizophrenia, 2 for the two other diagnoses,  $p < .01$ ).

There were several differences between the treatments selected for depression (natural means, meditation, yoga, and family therapy) and for panic disorder, where other possibilities, principally recourse to somatic medicine, were called into play.

## REASONS FOR NOT CHOOSING MEDICATION

Choosing medication as a form of treatment for psychiatric disorders was relatively infrequent, as already noted, since it was only mentioned in a quarter of cases, whatever the psychiatric disorder described. What reasons could explain this fact? Doubts about the effectiveness of medication (45.6% of those who did not choose medication) and fear of side-effects (43.4%) were frequently evoked. Other reasons linked either to the characteristics of the persons presented in the vignettes, who supposedly did not need medication (30.5%) or were not ill (24.0%), or to negative attitudes towards medication in general (18.9%), were less cited. Very few subjects stated that they were unfamiliar with psychiatric medication (4.6%). Grounds alluded to were the same for the three clinical cases under consideration, with the sole exception of fear of side-effects, slighter for schizophrenia than for depression and panic disorder combined. These results reinforced the observation previously noted that the public lacks specific awareness of psychotropic medication and its connection to distinct psychiatric disorders.

## PROGNOSIS OF PSYCHIATRIC DISORDERS

**The answer to a question on the outcome the vignette subject would have, should he or she follow the treatment suggested by the person interviewed, gave further information on the representations that the public had of psychiatric disorders.**

- Insert Figure 2 about here -

A relatively favorable prognosis on outcome was given (Figure 2). More than nine subjects out of ten (94.4%) thought that the person could be cured or improve, even if only

partially, whatever the diagnosis in question. However, if we confined ourselves to the "possibility of a cure", schizophrenia again appeared more serious than the other two disorders, since only one-quarter of the subjects interviewed (24.7%) considered it likely; 34.4% for depression ( $p < .05$ ) and 44.9% for panic disorder ( $p < .001$ ). The prognosis for depression was less favorable than that of panic disorder ( $p < .05$ ).

There was a relationship between the definition of the psychiatric disorder and prognosis: subjects who defined the disorder as an illness more rarely considered that it could be cured. Nevertheless, this relationship was statistically significant only with regard to depression. For schizophrenia and panic disorder, relationships were much more vague indicating undoubtedly a certain ambiguity in the public's representations of these disorders. What could explain the lack of recognition of mental disorders?

A majority of those interviewed considered the cases presented in the vignettes as showing some kind of mental disorder, especially for schizophrenia. We felt it was important to investigate which factors were linked to an absence of recognition of the disorder as a psychiatric illness and into what other set of social representations did this lack of recognition fall.

*We made a logistic regression, for each of the clinical vignettes, to relate the non-recognition of illness with socio-demographic characteristics (gender, age), socio-cultural (professional level, cultural distance) and variables of proximity to psychiatry and contacts with people suffering from psychiatric disorders. The probability of not defining schizophrenia as an illness was different for men and women. For men there was no relation to any other variables, but for women, non recognition was linked to a younger age and lower socio-professional level (Table 3).*

- Insert Table 3 about here -

*Furthermore, an absence of definition for schizophrenia as an illness corresponded to differing representations of its etiology and treatment. Female subjects who did not identify a psychiatric disorder in the vignette less frequently suggested an etiology of a biological or psychological nature. Insofar as treatment was concerned, the use of psychotherapy (51.9% for 77.6%,  $p < .01$ ) and medication (11.1% for 36.0%,  $p < .05$ ) were considered much less pertinent.*

None of the factors retained in logistic regression appeared to intervene in the assessment of depression and panic disorder. We found however several differences with

regard to representations on their etiology and treatment. When depression was not perceived as an illness, societal factors were less frequently mentioned in its etiology, and psychotherapy as well as medication more rarely suggested as a treatment. For panic disorder, factors linked to early socialization were less frequently cited and, if psychotherapy was less often suggested, other treatments (mostly of a somatic nature) were, on the contrary, chosen more often.

## DISCUSSION

There are several similarities as well as differences in the social representations the public has of the definition, etiology, treatment and outcome of psychiatric disorders.

1. Investigating the aspects of differentiation, it would appear that the principal difference is found in the contrasting representations that the public has of schizophrenia as compared to depression and panic disorder.

Schizophrenia is more often perceived as an illness than depression and panic disorder (84% versus 62% and 69% respectively). Link et al. [9], comparing five vignettes in the USA, and Jorm et al. [7], examining the recognition of schizophrenia and depression in the Australian population, also found that the former was more often defined as an illness than the latter (respectively 88% versus 69% for depression in the first case and 84% versus 72% in the second). Its prognosis also appears more pessimistic, thus corroborating the results of other studies [7,14]: only one-fourth predicts a cure against one-third for depression and 45% for panic disorder. In regards to etiology, schizophrenia is more often perceived than the other two diagnoses as being linked to early socialization, and biological factors weigh more heavily than for depression. This coincides with other studies, such as the Australian survey showing that the public gives more importance to childhood events and to genetic factors in the case of schizophrenia than in that of depression [8]. In Germany, biological factors are considered more important for schizophrenia than for both depression and panic disorder [16]. Finally, in our study, psychological factors are cited more often for schizophrenia than for panic disorder. Among the psychological factors, lack of willpower and low self-exacting behaviour seem to indicate the existence of a kind moral judgment, which also appeared in the Australian study, but in the same proportion for both diagnoses studied. With regard to treatment, the population massively favors two psychiatric-type treatments : individual

psychotherapy and family therapy. This could be linked to the type of etiological representation made of this disorder. Other forms of treatment - relaxation techniques or alternative methods, often selected for depression or panic disorder - are only exceptionally mentioned. Jorm et al. [5] also observed that lifestyle interventions (naturopath, vitamins, physical activity, family, friends, etc.) received more positive rankings for the depression vignette than for schizophrenia. For all the treatments proposed, with the exception of medication which we shall discuss later, important differences exist in public representations between schizophrenia and depression or panic disorder.

In contrast, social representations of depression and panic disorder are very little differentiated. These disorders are less clearly perceived as illnesses than schizophrenia. Only one subject out of five considers them to obviously be illnesses, even if for an important portion of those interviewed (41%, respectively 50%) the possibility is not excluded. For a non-differentiated portion of the population, depression does not seem to appear as an illness, but rather as a fairly ordinary condition. Representation of panic disorder is undoubtedly more vague and at times could be linked to somatic problems. In fact, the public is more favorable to the somatic causality of panic disorder and the psychological causality of depression which is more often thought to be a result of a lack of willpower. The treatments proposed are quite often the same, even though the public gives a slightly higher preference to relaxation techniques and recourse to natural means, meditation or yoga for depression. Other methods, frequently of a somatic nature, are mentioned for panic disorder. Finally, the prognosis for this disorder is slightly more favorable than for that of depression.

The chasm between schizophrenia on the one hand, and depression and panic disorder on the other, thus appears evident. This divergence undoubtedly arises from the elements of bizarre behavior and social nonconformity which schizophrenic disorder presents more obviously than do other clinical tableaux. Different studies dealing with social distance towards the mentally ill tend to confirm this hypothesis. It appears that the desired social distance varies according to the type of psychiatric disorder. Angermeyer and Matschinger [10] observed that the greatest social distance is found towards alcohol dependents, then towards schizophrenic patients. Individuals suffering from narcissistic personality disorders are better accepted, whereas individuals suffering from panic disorder with agoraphobia or from major depression meet with the greatest social acceptance. Link et al. [9] found very similar results. Respondents desired the most social distance from cocaine and alcohol

dependents, then from the person depicted as having schizophrenia. The major depression and the troubled person vignettes were much better accepted. But these authors go one step further and show that social distance is directly related to the perception of dangerousness.

2. It is true that beyond the differences examined to this point, other aspects of social representations tend more towards a lack of differentiation. This principally concerns the etiology of psychiatric disorders and treatments.

In social representations of the etiology of disorders, very considerable weight is given to psychosocial factors whatever the diagnosis under consideration. Societal factors, though much weaker, do not vary either. The very great importance given to psychosocial factors appears in different countries. In the United States, stressful circumstances are considered as the first cause of various psychiatric disorders [9]. In Australia, the factors most often cited as causes both for schizophrenia and depression are to be found in the immediate social environment [8]. Angermeyer and Matschinger [11] also underlined the emphasis placed by the public on psychosocial factors, for schizophrenia in particular, an accent which bears witness to the extent to which notions of stress have been disseminated in the general public. With regards to the treatments recommended for the different psychiatric disorders, we must first of all point out the very great importance conferred on psychotherapy. Despite the differences according to the diagnoses evidence of which was previously given, it appears as the preferred treatment of mental disorders, which corresponds to the results of the different studies realized in Germany [1,4,6], with slightly different methods. The predominance of psychotherapy among treatments, as well as the weight of psychological factors in the etiology of disorders, seem to show the wide spread dissemination of psychological notions in the public.

In contrast, the public gives minor importance to medication, and this whatever the disorder, even if it ranks third among treatments proposed. Only a quarter of subjects suggest recourse to medication for schizophrenia as well as for depression and panic disorder. Jorm et al. [5] show that the Australian public has a negative vision of medical treatments (which mainly include different types of medication, but also electroshock therapy and psychiatric hospitalization), while it is favorable to psychological intervention or intervention linked to lifestyle. Benkert et al. [6,17] obtained more favorable results with pharmacotherapy for schizophrenia than for the six other disorders examined, while Angermeyer et al. [2], as with our study, reported the same absence of discrimination. However, the place attributed to

pharmacotherapy is still weaker than in our results, since only 14% of the population is favorable. We cannot, however, know if this difference is linked to the method used (three recommended treatments in our study, appreciation of each form of treatment for Angermeyer), to differences between the German and Swiss populations, or finally to an evolution in judgements over time, as Angermeyer's surveys were carried out in 1990 and ours in 1997.

Among the reasons listed for not choosing medication, the public especially expresses doubts about their effectiveness and a fear of side effects. These reasons appeared in the studies of Angermeyer et al. [1-3]. They do not vary according to the clinical case foreseen, with the exception of slightly improved tolerance to their side effects for schizophrenia. Studying arguments for and against pharmacotherapy, Angermeyer et al. underline the degree to which sedative qualities are generally attributed to medication. For these authors, the public does not discriminate between the different categories of psychotropics, and extrapolates the properties of tranquilizers to psychotropics in general.

## CONCLUSION

In summary, the contrasted public views of mental disorder emerge, showing a clear differentiation between schizophrenia, on the one hand, and depression and panic disorder on the other; a lack of differentiation for several etiological factors, and the utilization of medication. Some results suggest a certain ambiguity in representations, particularly in the perception of disorders as illnesses, and their prognoses. Results also demonstrate what Jorm [18] called a poor "mental health literacy". The public shows an obvious unawareness of the current state of knowledge, or more specifically, of the opinion of experts currently dominant in this domain. It seems however that certain arguments springing from current scientific debate (or sometimes from some earlier debates) have been incorporated into a "common-sense viewpoint". We can thus explain the importance accorded to psychosocial factors in the etiology of the different mental disorders under examination or the weight of individual psychotherapy in the treatment of these same illnesses. Pop psychology has permeated a large proportion of the public and certain elements are used to describe disorders which sometimes do not appear to be serious. This is particularly true for depression and, to a certain degree, panic disorder.

Faced with the clinical vignette presenting a case of schizophrenia, other features may play a leading role: those which refer to bizarre behavior, the signs of madness. However, for a segment of the population this disorder is not perceived as an illness. For them, the “otherness” of deviancy is not burdened by psychiatric connotations. For men, this absence of recognition is not tied to social characteristics nor to their psychiatric experience. It is as if the disorder can only be understood as a function of some unknown logic which our data does not reveal. On the other hand, older women and those with higher professional qualifications seem to better identify the illness. By analogy with that shown by Boltanski [19] – perception of morbid sensations varies between social classes, and women pay greater attention to their bodies than do men – we can suppose that the same logic could apply to the perception of mental illness in others. Women, who are generally responsible for the health care of others (children, family), could acquire through life experience a greater capacity to perceive pathological signs.

One last point must be underlined. These representations are those of a population which, in its majority, may have had a certain experience in the domain of psychiatry or psychology. More than half (53%) know people who work in psychiatry or psychology; more than two-thirds (69%) indicate that members of their family, their friends or acquaintances have suffered from psychological difficulties; 60% that members of their entourage have been treated by a psychologist or psychiatrist; 45% that persons in their entourage have been admitted to a psychiatric hospital; finally 28% of the subjects interviewed say that they have had psychological difficulties themselves, even if those who sought counseling for this reason are fewer. It would therefore seem that if personal experience with mental illness may modify attitudes towards psychiatric patients [20 and in the results of our study to be published], such experiences have little effect on the representations and knowledge of the public.

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Table 1 Etiological factors of psychiatric disorders (mean of the indices)

Factors	Total	Schizo- phrenia	Depressio n	Panic Disorder	Varianc e analysis	$S/D^2$ S/PS D/P D  (Scheffe differ.)	(sign.)
Psychosocial stress	3.4	3.3	3.3	3.5			
Psychological	3.1	3.2	3.1	2.8	*** <sup>1</sup>	*	*
Biological	2.2	2.3	2.0	2.3	**	*	*
Linked to socialization	2.1	2.4	2.0	1.7	***	*	*
Societal	2.1	2.2	2.0	2.0			

Probability is indicated as follows: \*  $p < .05$ , \*\*  $p < .01$ , \*\*\*  $p < .001$ .

Answers cover the comparison of one psychiatric illness to another (in this case schizophrenia vs. depression).

Table 2 Treatments proposed for psychiatric disorders: % of favorable mentions

Treatments	Total	Schizophrenia	Depression	Panic Disorder	S/D <sup>1</sup> $\chi^2$	S/PD $\chi^2$	D/P $\chi^2$
Psychotherapy	56.6	67.7	50.5	50.9	*** <sup>2</sup>	***	
Relaxation therapy	36.4	15.6	45.6	49.4	***	***	
Medication	25.7	26.9	22.8	27.3			
Family therapy	22.1	38.5	16.5	10.3	***	***	*
Natural means	20.8	11.0	29.7	22.1	***	***	*
Meditation, yoga	20.3	14.4	27.6	19.1	***		*
Other treatments	12.5	7.6	10.5	19.7		***	**

Answers cover the comparison of one psychiatric illness to another.

Probability is indicated as follows: \*  $p < .05$ , \*\*  $p < .01$ , \*\*\*  $p < .001$  (in this case schizophrenia vs. depression).

Table 3 Logistic regression on the absence of definition of schizophrenia as an illness (women)

Variables	Odds	Sig
Age	-.0600	.0074
Professional level	-.6317	.0168
Cultural differentiation	-.0734	.7368
Proximity to psychiatry	-.0962	.2985
Contacts with persons suffering from psychiatric disorders	-.0792	.5727

Figure 1 Representation of psychiatric disorder in terms of illness (in %)

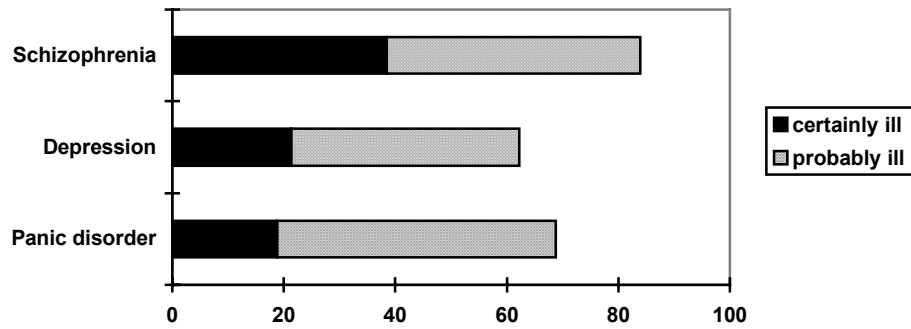


Figure 2 Presumed evolution of psychiatric disorders: estimation of the possibility of improvement /cure (in %)

