Non-expert’s theories of three major personality disorders

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ABSTRACT
Background The aims of this study were to assess lay people's ability to recognize personality disorders as psychological ‘illnesses’ and to establish their beliefs concerning causes and treatment of each disorder.

Methods Two hundred fourteen participants answered a questionnaire, consisting of three case vignettes describing paranoid, narcissistic and obsessive–compulsive personality disorders, according to DSM-IV-TR, each followed by 20 attitudinal statements concerning aetiology and treatment.

Results Narcissistic personality disorder was the disorder least recognized as a psychological ‘illness’. Overall, psychological causes and treatments were given more prominence than biological ones. Results suggest that personal experience of mental health problems (whether theoretical or practical) seems to improve ‘illness’ recognition.

Conclusion To the extent that personality disorders were recognized as psychological ‘illnesses’, recognition was increased if the personality disorder was related to a similar Axis I disorder. Experience of mental health problems and knowledge of psychology or psychiatry improves ‘illness’ recognition, although not for every personality disorder. Psychological causes were endorsed more strongly than biological causes for all disorders—but again, the extent to which a disorder was thought to have a psychological rather than biological cause varied as a function of the disorder. A similar pattern was observed for treatment preferences. Copyright © 2010 John Wiley & Sons, Ltd.

Introduction

Jorm, Korten, Jacomb, Christensen, et al. (1997) coined the term ‘mental health literacy’, describing it as ‘knowledge and beliefs about mental disorders which aid their recognition, management or prevention’ (p. 182). Jorm and his colleagues have examined various aspects of mental health literacy including the effect of age (Farrer, Leach, Griffiths, Christensen, & Jorm, 2008) and cultural differences (Nakane et al., 2005) as well as methods of improving literacy (Parslow & Jorm, 2002). Research has shown a discrepancy between the beliefs of mental health professionals and the public concerning the aetiology of mental disorders and the effectiveness of various treatments (Jorm, 2000; Jorm, Korten, Jacomb, Rodgers, et al., 1997). Hopefully, if the public’s mental health
literacy is improved, greater awareness will result in early detection, diagnosis and treatment of psychological disorders (Wright, Jorm, Harris, & McGorry, 2007).

‘Lay theories’ are beliefs about the causes, manifestations and cures of various mental disorders conditions such as autism (Furnham & Buck, 2003) and schizophrenia (Furnham & Bower, 1992). Negative opinions concerning the mentally ill are common among the general public, particularly in young people aged between 16–19 years old as well as in mental health workers (Crisp, Gelder, Goddard, & Meltzer, 2005; Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000). Numerous studies have also shown that the less educated are more likely to hold negative attitudes of those with mental illness (Brockington, Hall, Levings, & Murphy, 1993; Crisp et al., 2005; Furnham, Daoud, & Swami, 2009; Jorm, Korten, Jacomb, Christensen, et al., 1997; MacLean, 1969; Rabkin, 1974; Trute & Loewen, 1978). There is also evidence that health-care professionals too have negative views about many mental illnesses (Furnham, 1988). Previous campaigns have already been shown to be effective, such as the ‘Changing Minds’ campaign, which resulted in a reduction in the percentage of stigmatizing opinions reported (Crisp et al., 2005).

Furnham and Thompson (1996) showed that lay theories about the aetiology of psychological disorders are rationally related to theories about the necessary treatment for them. In the case of schizophrenia, research has shown that experience of those with mental disorders is related to more positive attitudes towards those affected, and contributes to the formation of beliefs about aetiology of disorders and treatment preferences (Angermeyer & Matschinger, 1996a,b). The public often consider environmental causes, such as life stressors, to be the cause of psychological disorders such as depression and schizophrenia, and regard biological reasons as being less important than environmental factors (Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999; Wolff, Pathare, Craig, & Leff, 1996a). Psychopharmacology is viewed negatively for a range of psychological disorders, whereas psychological therapies, such as counseling, are perceived positively (Furnham et al, 2009; Jorm, Korten, Jacomb, Christensen, et al., 1997; Priest, Vize, Roberts, Roberts, & Tylee, 1996). However, there is evidence from Australia, America and Germany over the last 15–20 years suggesting that biogenetic causal attributions and pharmacological explanations are becoming more popular (Angermeyer & Matchinger, 2004; Jorm, Christensen, & Griffiths, 2006; Schnittker, 2008).

Jorm, Korten, Jacomb, Christensen, et al.’s (1997) Australian study showed that lay people have difficulty in recognizing even the most common and well-known mental disorders, with depression being correctly identified by only 39% and schizophrenia by a mere 27% of the sample. However, Furnham et al. (2009) found that 97% of participants correctly identified depression from a case vignette, 61% recognized schizophrenia, but only 39% could correctly identify a person with psychopathy, which is related to antisocial personality disorder. To an extent, however, it is unsurprising that the public find the recognition of mental disorders, particularly personality disorders, challenging, given that often, even mental health professionals fail to provide reliable diagnoses of any of the personality disorders (Gunderson & Ronningstam, 2001).

Personality disorders are academic constructs used to identify maladaptive patterns of personality, with no clear separation from normal behavioural traits (Widiger, Simonsen, Krueger, Livesley & Verheul, 2009). It is estimated that between 9–13% of adults may have a personality disorder (Phillips, Yen, & Gunderson, 2004), yet relatively little research has been carried out on understanding them and how the public perceives them. In a recent British study, the weighted prevalence of personality disorders were, however, 4.4% and highest in men, separated and unemployed participants in urban locations (Coid, Yang, Tyrer, Roberts, & Ullrich, 2006). It is estimated that more than 50% of people diagnosed with a person-
ality disorder meet the diagnostic criteria for another (McGlashan et al., 2001). Co-morbidity is also associated with personality disorders and DSM-IV-TR (American Psychiatric Association, 1994) Axis I clinical disorders, such as depression (Brieger, Ehrt, & Marneros, 2002; Brieger, Ehrt, Bloeink, & Marneros, 2003). Furthermore, there are several conflicting theories concerning the aetiology and necessary treatment of personality disorders. There are many controversies about classification of the personality disorders in DSM-IV-TR and considerable speculation into how they will be described in the new DSM-V.

Currently, the DSM-IV-TR (American Psychiatric Association, 2000) classifies personality disorders as Axis II disorders and identifies 10 different types separated into three clusters. Cluster A is characterized by ‘odd’ personality disorders, cluster B by ‘dramatic’ personality disorders and cluster C by ‘anxious’ personality disorders. There is an additional category of ‘personality disorder not otherwise specified’, for personality disorders which do not fit into the aforementioned clusters.

One recent Delphi study found that service users and providers believe that efforts to improve public understanding and reduce discrimination experienced by people with personality disorder was rated as the top priority for service departments in this field (Crawford et al., 2008).

This study is an exploratory study concerned with lay people’s ability to recognize (from vignettes) an individual with a personality disorder as having an ‘illness’ or experiencing a ‘life crisis’, and to investigate their labelling ability and their beliefs concerning the aetiology and treatment of such disorders. It used a combination of attitudinal statements, and both closed and open-ended questions related to case vignettes in order to determine public opinion, as an analysis of topical papers by Brockman, D’Arcy and Edmonds (1979) showed that closed questions resulted in more positive views of mental illness, while vignettes and open questions elicited more negative beliefs. The main hypotheses are as follows:

Hypothesis 1: Paranoid personality disorder will be more likely than the other personality disorders considered to be recognized by participants as an ‘illness’, as it tends to be manifested in behaviours that are ‘odd’ and ‘different’ and share some similarities with forms of serious, more familiar mental illnesses, such as schizophrenia.

Hypothesis 2: Paranoid personality disorder is more likely to be given a biological cause and a biological treatment (i.e. medication), following a medical model.

Hypothesis 3: Narcissistic personality disorder will be least well recognized as an ‘illness’ as it tends to be manifested in behaviour that is more obviously on a continuum from normal behaviour.

Hypothesis 4: Narcissistic personality disorder will be mainly attributed to psychological causes and given either no treatment or a psychological therapy, following a psychosocial model.

Hypothesis 5: Obsessive–compulsive disorder will be accredited to psychological causes and given a psychological therapy, also following a psychosocial model. People will recognize this personality disorder as requiring a psychological therapy, because of its resemblance to the more familiar Axis I anxiety disorder, obsessive–compulsive anxiety disorder (OCD), for which psychological treatment is often offered.

Hypothesis 6: People with a personal experience of mental illness, in a professional capacity or otherwise, are more likely to recognize personality disorders as ‘illnesses’.

Hypothesis 7: People who have studied psychology or psychiatry are more likely to recognize personality disorders as ‘illnesses’.

Method

Participants

A total of 214 participants took part in this study, of whom 52% were female and 48% were male with an age range of between 16 and 83 years of age (M = 28.6, standard deviation (SD) = 14.3). The majority of participants were of European
Caucasian descent (80.2%), with the remainder being Asian (10.3%), Chinese (4.0%) and of some other ethnic descent (5.5%). Of the 184 participants who completed the relevant part of the questionnaire dealing with demographic information, 44.6% claimed to have studied psychology or psychiatry, 20.7% disclosed having had treatment for a psychological illness and 74.5% of participants claimed to know someone else who had had treatment for a psychological illness. This was more a sample of convenience than a representative sample.

**Materials**

**Vignette identification.** Participants were given three case vignettes (see Appendix) each between 150 and 200 words long, describing individuals with symptoms typical of three personality disorders (one from each DSM-IV cluster). Two vignettes were adapted from a textbook by Spitzer, Gibbon, Skodol, Williams and First (1994) and one adapted from a textbook by Seligman, Walker and Rosenhan. (2001). These are clinical psychology textbooks which provided these ‘typical case vignettes’ to illustrate the diagnostic criteria. There was only one per disorder. Inevitably, the research results depend on the quality of these vignettes. For instance, the gender of the person in each case could affect participant recognition of labelling of the disorder.

Participants were asked to indicate if the person in the case vignette had a problem (yes/no); what was the nature of that problem (‘How would you describe their problem?’); whether the person described had a ‘psychological illness’ (yes/no); or was experiencing a ‘life crisis’ (yes/no). Other concepts like ‘mental health problem’, ‘psychological problem’ or ‘mental disorder’ were considered in preference to ‘psychological illness’. Pilot work suggested that participants thought the personality disorders that they recognized (i.e. obsessive-compulsive disorder) were thought of as mental illness.

A content analysis was done on the only open-ended question, using Q-sort methodology. This is based on two or more people categorizing items into different groups according to criteria devised by themselves after first inspecting the items. To qualify as a ‘correct’ answer, participants were given ‘lenient’ criteria: for instance, obsessive-compulsive could be classed as obsessive/obsessional, compulsive or perfectionistic. In all, 10% of the classification was done by two people to check reliability, which was satisfactory. The analysis aimed to examine whether the three personality disorders were seen as a psychological illness, and whether causal attributions and treatment preferences were perceived to be psychological or biological.

**Attitudinal statements.** Participants were asked to rate on a Likert-type scale the extent to which they agreed with 20 attitudinal statements, with 1 indicating strong agreement through to 7 (indicating strong disagreement). These attitudinal statements related to the aetiology (10 items) and treatment (10 items) of each personality disorder case, which were derived from a review of previous studies (Furnham et al., 2009). These statements were designed to establish whether participants believed the causes of personality disorders were mainly biological or psychological, and whether treatment is necessary, and if so, whether it should be psychological (i.e. using psychological therapy) or non-psychological (i.e. using medication).

**Demographics.** Eighty-six percent of respondents answered the demographic questions. Additionally, participants were asked to indicate on a binary scale (1, Yes; 0, No) whether they had formally studied psychiatry or psychology. They were also asked to state on a binary scale (1, Yes; 0, No) whether they themselves had ever had treatment for a psychological illness and whether they knew anyone else who had treatment with a psychological illness (see Participants above).
**Procedure**

Participants were members of the general public recruited opportunistically in public places (e.g. a university campus, work places and through personal contacts), and over the internet. Approximately half came from each setting. The internet sample was recruited from various websites known to the authors. The recruitment of participants online helped to try to obtain a more representative sample of the population, and not just people living and/or working in and around London. However, it must be recognized that this was a convenience sample with young, educated people interested in mental illness being considerably over-represented. This was mainly a function of the fact that the sample came from personal contact sources known to the authors. The questionnaire took approximately 10–15 min to complete; all participants took part on a voluntary basis and were assured of their anonymity.

**Results**

**Illness recognition**

Table 1 presents the relative frequencies with which respondents indicated that the case vignettes could be described as reflecting psychological ‘illnesses’. Statistical analysis (Cochran’s Q test) showed there was a significant difference between participants labelling of the different disorders as ‘illnesses’, $Q(2, N = 214) = 39.48, p < 0.01$. Further analysis, using McNemar tests, revealed that paranoid personality disorder was considered to be more of a psychological illness than narcissistic personality disorder, $\chi^2(1, N = 214) = 26.01, p < 0.001$, as was the case with obsessive–compulsive personality disorder compared to narcissistic personality disorder, $\chi^2(1, N = 214) = 25.96, p < 0.001$, but there was no significant difference between participants’ labelling of paranoid personality disorder or obsessive–compulsive personality disorder, $\chi^2(1, N = 214) = 0.37, p > 0.05$, as psychological ‘illnesses’. These results only partially confirm the first hypothesis that paranoid personality disorder would be the most likely to be considered as an ‘illness’. However, these results support the third hypothesis, that narcissistic personality disorder would be the least likely personality disorder to be recognized as a psychological ‘illness’.

Content analysis of the answers for the paranoid personality disorder case vignette revealed that 50.0% of participants who answered, used the word ‘paranoid’ or ‘paranoia’ in their description of the person described in the case vignette. However, only 1.7% of participants correctly identified the case vignette as describing ‘paranoid personality disorder’. Content analysis of the narcissistic personality disorder case vignette revealed that 16.3% of participants who answered, used the words ‘narcissistic’ or ‘narcissism’ in describing the person in the case vignette and 5.0% directly described the person as having ‘narcissistic personality disorder’.

Content analysis of the obsessive–compulsive personality disorder case vignette revealed that 18.4% of participants who answered, used the words ‘obsessive’ and/or ‘compulsive’ in describing the person in the case vignette. Additionally, 13.5% described the case vignette person as having ‘obsessive–compulsive disorder’, the Axis I anxiety disorder, but only 4.3% directly described the person as having ‘obsessive–compulsive personality disorder’.

**Causal attribution**

In the aetiology section of the questionnaire, questions 1–5 tapped potential psychological causes for
the disorders, and questions 6–10 tapped potential biological causes. The mean scores on each of the 10 questions for the three personality disorders are presented in Table 2. In order to obtain reliable estimates of psychological vs. biological attributions, summated scales were formed by averaging the ratings for questions 1–5 (psychological) and for questions 6–10 (biological) for each of the three personality disorders. There was good reliability on all six scales (Cronbach's alpha: median (Mdn) = 0.88; Range, 0.85–0.91) and the means for the summed scales are presented in Table 3.

A 2 (attribution type) × 3 (personality disorder) repeated measures analysis of variance (ANOVA) was then conducted. There was a highly significant effect of attribution, F(1, 213) = 308.28, p < 0.001 (η²p = 59.1%), a significant effect of disorder, F(2, 426) = 24.29, p < 0.001 (η²p = 10.2%) and a weak but significant interaction between these two variables, F(2, 426) = 3.47, p = 0.035 (η²p = 1.6%). Overall, a psychological attribution (M = 3.09) was more favoured than a biological attribution (M = 4.31), and an inspection of Table 3 shows that this was true for all three disorders. Paired-sample t-tests were all highly significant: paranoid, t(213) = 10.74, p < 0.001, d = 0.73; narcissistic, t(213) = 14.33, p < 0.001, d = 0.98; obsessive–compulsive, t(213) = 14.73, p < 0.001, d = 1.01. These results support the fourth and fifth hypotheses, that both narcissistic and obsessive–compulsive personality disorders would be attributed to psychological rather than biological causes. However, they do not support the second hypothesis that paranoid personality disorder would be
attributed to a biological cause rather than a psychological one.

For psychological attributions, paired-sample $t$-tests revealed that paranoid personality disorder was considered to have a more psychological causation than either narcissistic personality disorder, $t(213) = 3.31, p < 0.001, d = 0.23$ or obsessive–compulsive personality disorder, $t(213) = 2.67, p = 0.008, d = 0.18$, but no difference was found between narcissistic and obsessive–compulsive disorders, $t(213) = 0.66, p = 0.513, d = 0.05$. With respect to biological causation, it was the case that paranoid personality disorder was seen as having a more biological basis than either narcissistic personality disorder, $t(213) = 6.82, p < 0.001, d = 0.47$ or obsessive–compulsive disorder, $t(213) = 4.78, p < 0.001, d = 0.43$. However, unlike psychological causation, obsessive–compulsive disorder was seen as having a more biological basis than narcissistic disorder, $t(213) = 2.80, p = 0.006, d = 0.19$. Therefore, paranoid personality disorder had higher attributions for both biological and psychological causes than the other two personality disorders.

**Treatment preferences**

The mean scores for each of the 10 treatment-related, attitudinal statements are presented in Table 4. Inspection of this table reveals that two questions (Question 1 and Question 10) are ‘generic’ whereas the remaining eight questions are either ‘psychologically related’ (Questions 4, 5, 8 and 9) or ‘biologically related’ (Questions 2, 3, 7 and 8). The generic questions were analysed separately, whereas the psychologically related and biologically related questions were summated in a similar manner to the casual questions. There was good reliability on all six scales (Cronbach's alpha: $Mdn = 0.84$; Range, $0.78–0.89$) and the means for the summed scales are presented in Table 5.

Table 4: Mean scores and standard deviations for treatment-related attitudinal statements as a function of personality disorder

<table>
<thead>
<tr>
<th>Attitudinal statement</th>
<th>Personality disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Paranoid M (SD)</td>
</tr>
<tr>
<td>No treatment is needed for people with this problem.</td>
<td>4.60 (1.60)</td>
</tr>
<tr>
<td>Psychopharmacology is a beneficial treatment for people with this problem.</td>
<td>3.91 (1.51)</td>
</tr>
<tr>
<td>Psychopharmacology is a necessary treatment for people with this problem.</td>
<td>4.75 (1.42)</td>
</tr>
<tr>
<td>Psychological therapy is a beneficial treatment for people with this problem.</td>
<td>2.64 (1.25)</td>
</tr>
<tr>
<td>Psychological therapy is a necessary treatment for people with this problem.</td>
<td>3.82 (1.49)</td>
</tr>
<tr>
<td>Help from a GP is beneficial for people with this problem.</td>
<td>3.37 (1.43)</td>
</tr>
<tr>
<td>Help from a GP is necessary for people with this problem.</td>
<td>4.27 (1.49)</td>
</tr>
<tr>
<td>Help from a psychologist is beneficial for people with this problem.</td>
<td>2.63 (1.27)</td>
</tr>
<tr>
<td>Help from a psychologist is necessary for people with this problem.</td>
<td>3.79 (1.49)</td>
</tr>
<tr>
<td>This sort of problem is curable.</td>
<td>3.36 (1.48)</td>
</tr>
</tbody>
</table>

*Note: Likert-type scale was used: 1 (Strongly agree) to 7 (Strongly disagree).*

GP, general practitioner; SD, standard deviation.
Table 5: Mean scores for treatment preferences as a function of personality disorder

<table>
<thead>
<tr>
<th>Personality disorder</th>
<th>Treatment preferences</th>
<th>Psychological M (SD)</th>
<th>Biological M (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paranoid</td>
<td></td>
<td>3.22 (1.12)</td>
<td>4.07 (1.14)</td>
</tr>
<tr>
<td>Narcissistic</td>
<td></td>
<td>3.66 (1.26)</td>
<td>4.73 (1.20)</td>
</tr>
<tr>
<td>Obsessive-compulsive</td>
<td></td>
<td>3.20 (1.18)</td>
<td>4.10 (1.07)</td>
</tr>
</tbody>
</table>

Note: Likert-type scale was used: 1 (Strongly agree) to 7 (Strongly disagree).
SD, standard deviation.

One-way repeated measures ANOVAs were conducted on the scores from Questions 1 to 10—and both were significant, F(2, 426) = 12.22, p < 0.001 (η²_p = 5.4%) and F(2, 426) = 13.38, p < 0.001 (η²_p = 5.9%) respectively—indicating that the personality disorders differed in the degree to which the participants felt treatment was unnecessary and the degree to which they felt the disorder was curable. Pairwise comparisons revealed that treatment was felt to be less necessary for narcissistic personality disorder than either paranoid personality disorder, t(213) = 3.41, p < 0.001, d = 0.23 and obsessive-compulsive personality disorder, t(213) = 5.08, p < 0.001, d = 0.35. There was no difference between paranoid and obsessive-compulsive personality disorders, t(213) = 0.89, p = 0.373, d = 0.06. With respect to curability, participants felt that obsessive-compulsive personality disorder was more likely to be curable than either paranoid personality disorder, t(213) = 2.65, p = 0.009, d = 0.18 and narcissistic personality disorder, t(213) = 5.28, p < 0.001, d = 0.36. They also felt that paranoid was more curable than narcissistic, t(213) = 2.49, p = 0.013, d = 0.17.

A 2 (treatment preference) × 3 (personality disorder) repeated measures ANOVA was then conducted. There was a highly significant effect of treatment preference, F(1, 213) = 170.84, p < 0.001 (η²_p = 44.5%), a significant effect of disorder, F(2, 426) = 38.04, p < 0.001 (η²_p = 15.2%) and a weak but significant interaction between these two variables, F(2, 426) = 4.62, p = 0.001 (η²_p = 2.1%). Overall, a psychological treatment (M = 3.36) was favoured over a biological treatment (M = 4.30), and an inspection of Table 5 shows that this was true for all three disorders. Paired-sample t-tests were all highly significant: paranoid, t(213) = 10.77, p < 0.001, d = 0.74; narcissistic, t(213) = 12.38, p < 0.001, d = 0.85; obsessive-compulsive, t(213) = 10.44, p < 0.001, d = 0.71. As with the causal findings, these results support the fourth and fifth hypotheses, as a psychological treatment is preferred for both narcissistic and obsessive-compulsive personality disorders. However, they do not support the second hypothesis, as a psychological treatment is also preferred for paranoid personality disorder.

For psychological treatments, paired-sample t-tests revealed that the narcissistic personality disorder was considered to be less treatable than either paranoid personality disorder, t(213) = 4.91, p < 0.001, d = 0.34 or the obsessive-compulsive personality disorder, t(213) = 5.87, p < 0.001, d = 0.40, but no difference was found between paranoid and obsessive-compulsive disorders, t(213) = 0.23, p = 0.815, d = 0.02. With respect to biological treatments, the pattern of results was the same; narcissistic disorder was thought to be less treatable than either paranoid disorder, t(213) = 7.29, p < 0.001, d = 0.50 or obsessive-compulsive disorder, t(213) = 7.90, p < 0.001, d = 0.54. Again, no difference was found between paranoid and obsessive-compulsive disorder, t(213) = 0.36, p = 0.719, d = 0.03. Therefore, narcissistic personality disorder was seen as being less treatable than the other two personality disorders—irrespective of the type of treatment employed.

Demographic variables

The relationship between personality disorder, personal experience of mental illness, domain knowledge (formal study of psychology or psychiatry) and a decision to identify a personality disorder as an illness (response frequency) is shown in
Table 6: The relationship between personality disorder, personal experience of mental illness, domain knowledge and decision to identify a personality disorder as an illness (response frequency and percentage)

<table>
<thead>
<tr>
<th>Personality disorder</th>
<th>Personal experience of mental illness?</th>
<th>Studied psychology or psychiatry?</th>
<th>Personality disorder identified as a mental illness? (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paranoid</td>
<td>No</td>
<td>No</td>
<td>15 (8.2) 17 (9.2)</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>Yes</td>
<td>2 (1.1) 10 (5.4)</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
<td>30 (16.3) 40 (21.7)</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>Yes</td>
<td>28 (15.2) 42 (22.8)</td>
</tr>
<tr>
<td>Narcissistic</td>
<td>No</td>
<td>No</td>
<td>26 (14.1) 6 (3.3)</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>Yes</td>
<td>8 (4.4) 4 (2.2)</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
<td>43 (23.4) 27 (14.7)</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>Yes</td>
<td>37 (20.1) 33 (17.9)</td>
</tr>
<tr>
<td>Obsessive–compulsive</td>
<td>No</td>
<td>No</td>
<td>24 (13.0) 8 (4.4)</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>Yes</td>
<td>4 (2.2) 8 (4.4)</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
<td>35 (19.0) 35 (19.0)</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>Yes</td>
<td>17 (9.2) 53 (28.8)</td>
</tr>
</tbody>
</table>

Table 6. Because of the unrepresentativeness of the sample and the fact that so many had education in, and experience of, mental illness, these variables were investigated. A saturated log linear model with personal experience, domain knowledge and mental illness decision as dichotomous variables was fitted to the data for each personality disorder. For the paranoid personality disorder, there was a significant relationship between experience with mental illness and domain knowledge, \( \chi^2(1, N = 184) = 7.44, p = 0.006 \); individuals who had personal experience of mental illness were nearly twice as likely to have formally studied psychology or psychiatry than those without personal experience (50.0% vs. 27.3%). Neither personal experience \( \chi^2(1, N = 184) = 0.29, p = 0.588 \), nor domain knowledge, \( \chi^2(1, N = 184) = 1.26, p = 0.262 \) differentially influenced the identification of paranoid personality disorder as a mental illness. For narcissistic personality disorder, there was a significant relationship between personal experience and domain knowledge, \( \chi^2(1, N = 184) = 5.92, p = 0.015 \); and individuals who had personal experience of mental illness were more likely to endorse narcissistic personality disorder as a mental illness (42.9%) than those without personal experience (22.7%), \( \chi^2(1, N = 184) = 4.74, p = 0.030 \). The study of psychology or psychiatry was not a significant factor, \( \chi^2(1, N = 184) = 1.80, p = 0.180 \). Finally, for obsessive–compulsive personality disorder, the relationship between personal experience and domain knowledge just failed to reach significance, \( \chi^2(1, N = 184) = 3.34, p = 0.068 \). However, both personal experience and domain knowledge were significant factors in predicting decision choice. With respect to the former, 62.9% of those with personal experience of mental illness identified obsessive–compulsive disorder as an illness compared with only 36.4% of those without personal experience, \( \chi^2(1, N = 184) = 5.62, p = 0.018 \); and individuals with knowledge of psychology/psychiatry were more likely to identify obsessive–compulsive personality disorder as an illness (74.4%) than those without such knowledge (42.2%), \( \chi^2(1, N = 184) = 15.84, p < 0.001 \).
Discussion

Summary of the findings

Paranoid personality disorder was recognized by 58.4% of participants as a psychological ‘illness’, with a similar proportion of participants (55.6%) also identifying obsessive–compulsive personality disorder as an ‘illness’. Narcissistic personality disorder was identified as an ‘illness’ by only 34.1% of the participants.

The content analysis of the one open-ended question revealed that paranoid personality disorder was correctly identified by less than 2% of participants who answered the question, but incorrectly described, in several instances, as OCD, and occasionally as ‘borderline personality disorder’ or ‘antisocial personality disorder’ (both from DSM-IV cluster B). Furthermore, obsessive–compulsive personality disorder was frequently confused (13.5%) with obsessive–compulsive disorder, the Axis I anxiety disorder, and was only correctly identified by 4.3% of participants. This is to be expected, given that even mental health professionals have difficulty in diagnosis as a result of symptom overlap between personality disorders and co-morbidity associated with DSM-IV Axis I clinical disorders (Brieger et al., 2002, 2003; Gunderson & Ronningstam, 2001). Links were also made between paranoid personality disorder and both paranoid schizophrenia and paranoid psychosis, Axis I disorders, which have certain symptoms in common with the personality disorder. This suggests that respondents may have been drawing on their knowledge of similar Axis I disorders in their ‘illness’ recognition of the described personality disorders. One participant showed a lack of awareness about disorders of personality in general, claiming for the narcissistic personality disorder that the person represented in the case vignette was ‘very selfish and arrogant, not necessarily a psychological condition though, more a personality trait’. However, there remains considerable debate in the personality disorder literature about classification partly because many patients fulfil criteria for the diagnosis of more than one disorder and also because of the tension between state and trait factors in the personality disorders.

One possible explanation for the poor identification of personality disorders as psychological ‘illnesses’, is perhaps, as Johannsen (1969) claims, ‘The lay public seems to adhere to a single operational definition of the mental patient. To the average man, a person becomes a mental patient only when he enters a psychiatric hospital’ (p. 218). Therefore, it may be that without such seemingly revealing medical information being given about the case vignettes in the questionnaire, the cases do not warrant the label of ‘psychologically ill’ in the public’s eyes. Hall, Brockington, Levings and Murphy (1993) showed a public reluctance to apply the label of ‘mental illness’, to all but extreme abnormal behaviour, making personality disorders particularly difficult to recognize, as the line between ‘normal’ and ‘abnormal’ personality-related behaviour is unclear and arbitrary at best (Skodol & Bender, 2009). It may well be the results would have been different had we used the term ‘mental health problem’ rather than ‘psychological illness’ to prime the participants.

In the present study, one participant claimed that the abnormal behavioural traits described in the narcissistic case vignette were ‘not strong enough to be classed as Narcissistic’, supporting the possibility that the cases may not have been regarded as extreme enough in terms of behaviour to warrant an illness description. Another possible reason for poor recognition is that perhaps non-labelling of the mentally ill is a sign of greater tolerance, as opposed to less. However, a reluctance to identify personality disorders as psychological ‘illnesses’, for whatever reason, is of concern, as research suggests that denial of a psychological disorder diagnosis can lead to a poor prognosis (Warner, Taylor, Powers, & Hyman, 1989).

While the study showed that many lay people (even those with some training in mental health disciplines) have difficulty identifying these personality disorders, it is worth remembering the poor inter-rater reliability of these diagnoses in
clinical practice. This implies disagreement and ambiguity in the minds of mental health practitioners as regards the personality disorders (Widiger et al, 2009).

All three of the personality disorders in this study are believed to have higher prevalence in men than in women. DSM-IV-TR states that obsessive–compulsive personality disorder occurs twice as often in men as in women. Garb (1997) showed that there is a gender bias among clinicians, with a differential diagnosis being made depending on whether a male or female presents with the same personality disorder symptoms. Perhaps then, it is unsurprising that the public too, may associate certain disorders with different genders and so may not recognize obsessive–compulsive personality disorder, for example, as the case vignette used in this study describes a female presenting with the related symptoms, and not a male, as might be expected.

Frequently, participants claimed that the abnormal behaviour described by the case vignettes was a result of ‘modern life’ (mentioned for both paranoid and obsessive–compulsive personality disorders), with traits displayed by the narcissistic case vignette ‘becoming increasingly common these days’. Furthermore, one might contend that in certain environments, such as a working office, personality disorders may thrive, such as narcissistic personality disorder, which may be more accepted and those affected may even seem well adapted to, and successful in business, for the main part (Furnham, 2007).

The results show a public belief in a multifactorial explanation of causes of personality disorders, which is comparable with the beliefs held by mental health professionals. Yet, on the whole, psychological causes were given greater prominence for the three personality disorders than biological causes, which is in keeping with previous research on lay theories of mental illness in general (Link et al., 1999; Wolff et al., 1996b).

Perhaps the greater attribution of both psychological and biological causes to paranoid personality disorder in comparison to the other two personality disorders, suggests that participants believed paranoid personality disorder to require more of a causal explanation. This in itself implies that the behaviour described in the paranoid personality disorder case vignette is considered more of a deviation from what is considered ‘normal’, than the other two personality disorders.

Interestingly, participants showed a diverse range of beliefs concerning causal attribution of personality disorders. One participant, with some knowledge of theoretical psychology, employed a Jungian theory of cause in the case of the obsessive–compulsive personality disorder case vignette, describing an ‘overactive animus or lack of integration/assimilation of masculine qualities’.

As with causal attribution for the three personality disorders, on the whole, psychological treatment is preferred to biological treatment, findings which agree with previous research (Jorm et al., 1997; Priest et al., 1996). The study is perhaps limited in that the questions concerning psychological treatment were not specific to types of psychological therapy as a means of care; however, it was presumed that the lay public, and even some professionals, might have been unfamiliar with specific therapy suggestions, given the scarcity of research into the causes and appropriate treatment for personality disorders.

The open-ended question following the case vignettes revealed some concerning public beliefs regarding treatment, with one participant simply claiming that the obsessive–compulsive personality disorder case vignette is advised to relax and sleep well, and let others take control. Beliefs such as these exacerbate the failure to diagnose personality disorders, with abnormal behaviour going unrecognized and untreated.

Interestingly, narcissistic personality disorder was regarded as the least likely to be cured—but also least in need of treatment. Obsessive–compulsive personality disorder was thought to require treatment—and be the most curable. Paranoid personality disorder was also thought to require treatment—but not to be as curable as obsessive–compulsive personality disorder.
The results suggest that broadly, personal experience of mental health problems or knowledge gained through formal study of psychology or psychiatry has an effect on the identification of personality disorders as psychological illnesses. Both factors were influential with respect to obsessive–compulsive personality disorder—and personal experience was relevant with respect to narcissistic personality disorder. No effect of either experience or knowledge was noted for paranoid personality disorder.

Limitations
This study focused on a typical personality disorder from each cluster: paranoid personality disorder from A, narcissistic personality disorder from B and obsessive–compulsive personality disorder from cluster C. On reflection, it may well have been advisable to choose other disorders which have been most frequently researched like antisocial, borderline and schizotypal disorder.

As noted above, it may also have been wiser to use terms like ‘psychological problem’, even ‘personality problem’ rather than ‘psychological illness’ when priming the participants at the beginning of the vignette identification.

Finally, it needs to be repeated that this study did not have a representative sample and therefore, the results cannot be said to properly investigate public attitudes. In this sense, it can only speak to differences in attitudes and beliefs of those with and without formal education in mental health.

References


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Appendix: Case-vignettes

Paranoid personality disorder

Philip is a 70-year-old retired businessman and appears to be in good health and mentally alert. He and his wife have been married for 50 years, and she is the only person he had ever trusted. Philip has always been suspicious of others. He never confides in anyone but his wife. He is careful about revealing personal information to others assuming that they are out to take advantage of him. He had refused sincere offers of help from his acquaintances because he suspected their motives. Philip has always involved himself in work and claims to have no time for play, even after his retirement. He spends most of his time monitoring his stock market investments and has changed brokers several times because he suspected that minor errors on his statements were evidence of attempts made by them to cover up fraud.

Adapted from Spitzer et al. (1994)

Narcissistic personality disorder

Bill is a handsome, well-dressed 24-year-old man working in an advertising firm. Bill made a favourable impression when applying for the job. During the interview, Bill was very enthusiastic about his personal accomplishments and stated that he had been instrumental in the dramatic success of a small company where he worked part time as a student. However, Bill began to have trouble with some of his co-workers. They found Bill annoying because he had bragged endlessly about his success and criticized his former co-workers for their incompetence. He also speculated openly to the other male employees that several of the female employees in his department had crushes on him. He dated in succession four women in his department but these relationships ended with Bill claiming that the women ‘weren’t interesting’. In fact, the women just could not tolerate his self-centred attitude. Bill had demanded for the furniture in his office to be replaced although it was only 3 years old. He complained to his manager, stating that his performance exceeded all his co-workers, and he should be rewarded. At the end of the first year in the company, Bill was estranged by both his co-workers and his supervisors. Bill perceived the situation as him being victimized by them because he was so much more successful.

Adapted from Seligman et al. (2001)

Obsessive–compulsive personality disorder

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 get 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.

Adapted from Spitzer et al. (1994)