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## **Who do they think we are? Public perceptions of Psychiatrists and Psychologists.**

**Objective:** Psychiatrists and psychologists assess and treat individuals with a wide-range of mental health needs, and the differences between them are not always well understood by other professionals or the public. Most work on perceptions in mental health has evaluated issues such as diagnosis, risk, prognosis, and blame. Little has evaluated and contrasted broader perceptions of psychiatrists and psychologists. We qualitatively explored views of members of the public, in order to identify such wider understanding.

**Method:** Nine individuals with no experience of mental ill-health were interviewed using a semi-structured interview guide. Transcripts were thematically analysed.

**Results:** Three core themes were identified: perception of roles, stigma, and increasing future awareness. There was frequent misunderstanding of these professions. In general, however, psychiatrists were seen as more authoritarian and with a medication focus, though their interventions were believed to be effective. Psychologists were perceived as friendlier and having a better rapport, though participants thought they only typically looked at 'minor' difficulties.

**Discussion:** Public perceptions matter. There is a lack of clarity in the public mind about our roles. These data should aid professionals' self-reflection of potential transference issues, and to consider local applicability and variation of our findings. The two professions should consider public psychoeducative programmes to inform and encourage engagement.

**Keywords:** Mental Health, Psychology, Psychiatry, Stigma, Engagement

**Declaration of Conflicting Interest:** None Declared

## Introduction

*“Well, I’d say take her to the nearest psychiatrist or psychologist or neurologist, or psychoanaly...or maybe just the plain family doctor. I’d have him check on you too.”*  
– James Stewart, *Vertigo*.

Psychiatrists and clinical psychologists assess and treat individuals with a wide-range of mental health needs. Definitions typically reflect differences in three domains; type of training, theoretical background, and function. The main difference being that psychiatry is a medical speciality, using pharmacological intervention whereas clinical psychology requires completion of postgraduate clinical training and utilises psychological intervention (CBT, systemic etc.) to manage mental health issues. Research suggests there is little variation in the assessment instructions across the three most widely utilised clinical psychology training models (e.g. clinical-science, scientist-practitioner, and practitioner-scholar; Ready & Veague, 2014), with the scientist-practitioner model being internationally dominant (Pachana, Sofronoff, Scott, Helmes, 2011), and medical training has generally agreed core competencies and specialist training structures (WPA, 2017).

Several national and international studies have explored predictors and moderators of mental health help-seeking (O’Connor, Martin, Weeks, Ong, 2014), attitudes towards mental health services (Mackenzie, Erickson, Deane, Wright, 2014) and perceptions of health professionals (Medina, Kullgren, Dahlblom, 2014) and the general public (Choudhry, Mani, Ming, Khan, 2016; Kishore, Gupta, Jiloha, Bantman, 2011) on mental health help-seeking and care provision. However, little work has directly explored and contrasted public belief about the mental health care professionals who deliver treatment.

The changing face of healthcare means roles and responsibilities of the two professions are not static and therefore discrete definitions for each role can be challenged. There is a push for psychiatrists to practice in primary care settings and for a wider range of practitioners to deliver psychological therapies. Furthermore, cultural and some more detailed aspects of both training and clinical practice can vary between jurisdictions and indeed within countries. This, combined with an uncertain impact of an ever more global media, may lead to confusion at both professional and public level.

There are anecdotal debates about supposed 'rivalries' and tensions between the roles, though there is very little hard data on this (Koeske, Koeske, Mallinger, 1993; Schindler, Berren, Beigel, 1981). The limited existing literature has tended to be editorials or debate pieces: work by psychiatrists tending to focus upon *stigma towards* their profession, whereas that by psychologists often focusing upon the *awareness of* theirs (Dempsey, 2007).

It has been argued (Hopson, 2014) that psychiatrists have been 'demonised' in works of fiction and stigmatised by other medical specialties (Stuart et al., 2015), leading the World Psychiatric Association to propose an action plan (Sartorius et al., 2010) to combat this. In the UK the Royal College of Psychiatrists instigated a "ban the bash" campaign, as professional prejudice was argued to be hindering recruitment (Ajaz, David, Brown, Smuk, Korszun, 2016). Clinical psychology does not have recruitment difficulties, but faces concerns about a lack of sociodemographic diversity (BPS, 2015), a pattern recognised internationally (Pillay, Ahmed, Bawa, 2013). Ferguson (2015) expressed apprehension that psychology is seen as over-reliant on 'simplistic' mechanistic models by the public and scientific community. In the 1990s the American Psychological Association surveyed the public (Farberman, 1997) and college students (Turner & Quinn, 1999), finding that they often had very little understanding of the

roles of clinical psychologists. Noteworthy, the journal *Clinical Psychology Forum* published a special edition (BPS, 2014) on “bridging the gap” between the two professions, but this was editorially based, and largely written by professionals.

### *Aim*

Perceptions matter in mental health, but little work has evaluated and contrasted public beliefs about psychologists and psychiatrists. In this work, which we believe to be the first of its kind, we qualitatively explored the opinions of members of the public, with no direct experience of mental ill-health, on the similarities and differences between these professionals. Understanding this may help tackle stigma, encourage psychoeducation, and aid professionals’ self-reflection on the local relevance, differences, and application of such findings.

### **Methods**

#### *Participants*

Participants were recruited via a UK-based internet advertisement website, gumtree.com. For participant demographics see Table 1. The sample size was defined by the criterion of data saturation (Guest, Bunce, Johnson, 2006), such that the final sample was achieved when new information was no longer being added – authors endeavoured to ensure that all perceptions that might be important were uncovered before the sample became repetitive. There was an approximately 50:50 female:male split, and a range of employment status, though the sample had a relatively young median age (27), a high rate of participants with university level qualifications (8 of 9) compared with the general population, and only individuals from Caucasian and Asian backgrounds volunteered to participate. Written informed consent was

collected from all participants. The study was approved by Oxleas NHS Foundation Trust Research and Development office, London, where participants were interviewed.

[insert Table 1 here]

### *Procedure*

A semi-structured topic guide with open-ended questions was developed and participants were interviewed by two researchers (CC & DT). A focussed interview structure was adopted in that the interviewer had minimum hold on the interviewee's responses allowing them to diverge in order to pursue an idea or response in more detail and focussing them towards the key subject only when required. The interview schedule was devised following an initial literature review of the topic of perceptions of these two professions. Although to date there has been no study of direct comparison of public perceptions between them, perceptual work on either psychology or psychiatry typically evoked similar themes: training, clinical roles, effectiveness, and stigma. From this, and with particular reference to the fact that our work would explicitly draw profession comparisons at each point, we drew up eight core questions regarding training, effectiveness, stigma of seeing such a professional, treatments or interventions provided, wider public/media portrayals, historical representations, involuntary/coercive treatments and future public engagement. Although the interview schedule comprised of these core questions, this was modified throughout the study in a reflexive-iterative manner, particularly with follow-on sub-questions that prompted comparisons if participants were focussing that answer on one professional group. Through this process new sub-questions emerged which were asked to the subsequent participants; an example of this iterative process is that question 4 ("What treatments or interventions do psychiatrists and psychologists provide") was expanded to

further ask “Where does this occur in different types of mental health settings?”, “Do different people/people with different problems go to different professionals or treatment centres?” and “How might you find us or access care?”. Other examples from the interview schedule include: 1) Sometimes people with mental ill-health are treated against their wishes – what is your understanding of this? Why does it happen, how does it happen, who is responsible? 2) What might psychologists and/or psychiatrists do to better engage with the public? What aspects do you think they might wish to focus on?

Each interview lasted approximately one hour. All interviews were recorded and transcribed verbatim for analysis. Field notes were taken, which were discussed during the analysis process.

#### *Data Analysis*

Thematic analysis was utilised as it allowed for flexibility, theoretical freedom, and had a descriptive rather than interpretative function (Braun & Clarke, 2006). Primary analysis was undertaken by two researchers (KP & CC). A hybrid process of inductive and deductive thematic analysis of raw data was utilised in that some themes were identified from the data whilst others were hypothesised a priori. Responses were collapsed under the questions they were broadly addressing no matter where they occurred during the interview. An iterative method of constant comparison was adopted in order to reduce and condense the themes into the most salient categories.

Validity and reliability were established via two analysts (KP & CC) jointly coding all transcripts to ensure that codes and themes were adequately grounded in the raw data. The master table of themes was continuously updated throughout analysis; identification and inclusion of contradictory or negative cases and accounts were sought.

## Results

Interviews were conducted with nine participants - there was a high level of congruence across the interviews with the identification of three core themes: perception of roles, stigma, increasing awareness.

### Perception of roles

The theme of perceptions of professional roles had four subordinate categories: training requirements, treatment provisions, accessing care, and portrayal.

There was confusion about the roles of psychiatrists and clinical psychologists, with some confusing/exchanging the professional that provided particular interventions, for example that psychologists provided pharmacological interventions and psychiatrists provided talking therapies.

*I feel that psychologists would probably just issue medication, whereas psychiatrists would use a talking... but then the psychiatrist would try their hardest to solve the problem by talking and then if that doesn't help they send them to a psychologist perhaps to issue medicine.*

However, psychiatry was more commonly associated with pharmacological treatment, and this was further linked with 'complexity' of need and of refractory illnesses. Psychiatrists were perceived to be more likely to treat patients posing a danger to others or themselves, and to enforce involuntary treatment against individuals' wishes. Despite links to illness severity, pharmacological treatment was commonly described as having a 'faster' and 'better' therapeutic effect than psychological intervention, but this was also considered to be at the risk of addiction, relapse and side effects. Clinical psychologists were generally associated



with treating less severe mental ill-health, with such patients considered to inherently have a better prognosis.

Several methods of accessing mental health care were suggested, including referral via a general practitioner (GP/primary care physician), online search tools, schools/universities, and via hospitals; with relevant professionals acting as gatekeepers to the more specialised care psychiatrists and psychologist provided. Some participants felt that access to a psychologist was 'easier' and did not always require a referral, linked to perceptions that psychiatrists treated "very severe" mental ill-health.

Participants all reported that both professions required some form of post-graduate education, though the psychiatrist role was considered 'protected', contrasted with several types of psychologists (forensic, sports) and similar professions (e.g. counsellors) leading to confusion as to their specific training requirements and job role.

*Psychologists I think, the thing is it seems to be broad, I don't know it could be anything. Because for example you've got like criminologists, I don't know if that's obviously related to psychology, so I think psychologists could be for loads of things, like for example a sports psychologist. So I think they tend to be a bit more broad.*

Psychologists were generally considered to be more trustworthy, understanding and reassuring, and therefore less likely to induce patient apprehension and more likely to form a therapeutic alliance.

*Maybe a psychologist [...] it's more like the power, on the same level as the patient and building a rapport, it's more of a rapport going on as opposed to a psychiatrist, I think.*

Some participants described psychiatrists as 'authoritative' and 'frightening' with the power to medicate unnecessarily, and only deal with symptoms and not any 'underlying cause', which was associated with less therapeutic alliance.

*Probably a person that quite easily prescribes medication, [...] quite easy to go to the medication solution which is not always what they need to do. And so their image would be a bit more to do with a person who gives you your medicine, a bit more a person who decides where you need to be; if you need to be hospitalised, if you need to be following some kind of programme. A bit more controlling maybe. And having a bit more control over the patient.*

*I think people would be more trustworthy towards a psychologist ... I think psychiatrists are frightening people a little because they have this power of giving medicine that might not be relevant.*

'Power' was seen as a key aspect of psychiatrists' ability to instigate involuntary treatment, though participants were able to report reasons why involuntary care might be appropriate, including risk and where individuals lacked insight. In such contexts, psychological interventions were described as being sought 'after sectioning' and pharmacological treatment.

*I know there are different clauses and so you would be sectioned for different reasons. I can't remember what they are but there are different things that you have that if a health professional thinks you fit into different certain criteria you would be sectioned in a different way, and that means you can be forced to be treated in different ways.*

Participants considered that the *factual* media typically portrayed mental health professionals in a positive manner and did not clearly differentiate between roles. However, psychologists were perceived to have greater media exposure, which was linked to their being more “accessible”. Negative media portrayals included their ‘over-analysing’ news events. In terms of *fictional* portrayals, psychiatrists were seen as having much more exposure, commonly quite negatively, as a form of ‘arch manipulator’ due to their skills in assessing the human psyche. Hannibal Lecter was noteworthy as a paradigmatic example.

*Well I guess psychologists tend to be portrayed as more friendly, and kind of open and accessible. Whereas psychiatrists tend to be a bit more, like have a bit more power and a bit more severe in general.*

Historical portrayals were largely negative, primarily involved psychiatrists, and typically referenced involuntary treatment, restraint, over-prescribing of medication, and isolated, unregulated, and unethical treatment. All participants noted historical stories of abuse in psychiatric care, including by experimental scientists and also governments trying to detain political dissidents.

*But obviously there’s the other extreme of mental institutions, I don’t know whether that’s the right term, with the whole lab coat, people running in and injecting people and that kind of thing. I guess just playing on those fears of how mental institutions used to operate quite a lot of years ago.*

*Kind of people locked up, people thrown in there who are not supposed to be in there. People being restrained, injected and electric shock therapy, and things like that.*

*I know that... I think that in communist countries they were using psychiatry as a way to get rid of people. You just had to put the label of mad on them, and they are not going to question the government anymore.*

### Stigma

Perhaps unsurprisingly given the context of the discussion, discourse often related to stigma in reference to the severity of the mental health issue and the perceived aetiology of the disorder and how these factors in turn facilitated or hindered help-seeking behaviour

Most participants reported they anticipated that they would be *less* likely to disclose details of mental health concerns to a GP/primary care physician, and would prefer to seek support directly from a mental health professional. They differentiated that although there was less stigma associated with seeking help from a GP in general, that such professionals were less expert and might thus be prone to higher levels of pejorative judgement of patients.

*Well obviously the GP isn't specialised. I would think there would be less stigma because everybody goes to their GP but I think lots of people don't want to say anything to their GP because of the general stigma around mental health.*

Participants typically described attributing a higher level of stigma to those disorders which they perceived to be more severe in nature, particularly citing schizophrenia and bipolar affective disorders: these were thought to be 'untreatable' and to pose a higher risk to the public, and therefore more likely to be seen by a psychiatrist.

*I think a psychiatrist when you get told something like that there is a negative connotation to it, so maybe if you were told you need to see a psychologist that might be...might sound better.*

*Possibly because psychiatrists conjure up a more severe image 'there really must be something wrong with you if you're seeing a psychiatrist'. Whereas a psychologist feels a bit more voluntary, a bit more 'popping down to see your counsellor' or whatever.*

Gender, age, and culture were also discussed in the context of stigma and help-seeking. Participants of both genders anticipated that men would be less likely to seek support for fear of being perceived as 'weak', but that young people would be more likely to access care than older generations, due to campaigning and a wider positive cultural shift in attitude towards mental health. Other cultural differences in behaviour and stigma were identified as potential barriers to seeking support, including a "sort yourself out" attitude.

*... back home in Singapore it's a little bit more 'oh there's something wrong with you, I don't want to associate with you'. So I would feel a little scared I think.*

### Increasing future awareness

Increasing awareness was discussed in the context of three subordinate themes: mental health issues, treatment, and clarification of professional roles. Increasing awareness of psychologists and psychiatrists' roles was discussed, with reference to the provision of psychoeducation on mental health disorders, the different roles of psychiatrists and psychologist, the types of treatment they are offer, and how support from them can be sought. Further information on the aetiology of mental health disorders was reported as being a particularly pressing educative need for the general public, necessary to dispel stigma and misconceptions. Methods suggested including media campaigns, higher visibility of help-seeking options in primary care, online, and in schools and universities.

*I mean you are going to publish in the research that is for medicine, but not in the main stream media, so maybe that can be a way to start communicating with people about research. Because really for me it's a bit blurred – psychiatry - people may have misconceptions or fears because they are not knowledgeable enough about what it is.*

## **Discussion**

Much work has examined perceptions of mental health, but little has explored public opinions of those delivering care: these are important as they may impact service-engagement, and provide valuable information for our professions to better engage and educate. There were mixed results on the understanding of professional roles. The confusion around talking therapy may arise from the fact that both are 'talking' professions, and some psychiatrists do deliver psychological therapies – notably, the frequency of such practice varies between countries. The cultural legacy of Sigmund Freud may also be significant: he was named by some participants, and the evoked image was of the therapist's couch. It is not clear why there was some confusion over which profession dispensed medication, though this was linked with more 'severe' ill-health.

Psychiatrists were generally associated with more serious mental illness and risk, including self-harm, suicide, and involuntary treatment; psychologists' work with 'less serious' ill-health made their roles more nebulous for most participants. There were some broad accuracies in terms of the increase in provision of psychology in primary care settings, and psychiatrists having greater roles in involuntary detention and risk assessment. The findings are in line with the APA's surveys in the 1990s (Farberman, 1997, Turner & Quinn, 1999) that found most participants were poorly aware of psychologists' roles.

Whilst both professions were correctly identified as requiring significant post-graduate training, psychiatry was assigned a 'uniqueness' as it necessitated attending medical-school, with psychology perceived as having broader training and clinical practice possibilities, however there is national and international variance in this. Farberman (1997) also found participants uncertain about psychologists' qualifications, with many thinking a Master's level degree was sufficient: however respondents in that work noted that they regarded their relationship with their psychologist as more important than their credentials.

There were varying findings on clinical effectiveness. Some thought that psychologists had good outcomes as they commonly saw 'less unwell' individuals. However, medications were seen as 'powerful' and 'effective', albeit at the cost of side-effects and fear of addiction, capturing a misperception that has been reported elsewhere (Benkert et al., 1997; Kessing, Hansen, Demyttenaere, Bech, 2005). The wider literature on *perceptions* of psychiatric effectiveness has been quite mixed, with data showing individuals viewing it as variously helpful, harmful, and of uncertain efficacy (Britten, 1998; Kobau, Diiorio, Chapman, Delvecchico, 2010; Thornicroft, Rose, Mehta, 2010). A 'softer' perception of psychology might facilitate engagement but may come at the price of it being perceived as what Ferguson (2015) called "not a real science", and participants linked psychologists with 'minor' issues such as mild distress. Whilst psychiatry may have an image problem about its rigor amongst other medical specialities (Stuart et al., 2015), psychology may have a similar issue amongst the 'harder' sciences (Yong, 2012). Pseudo-science lifestyle connotations may be hard to shake (Wai, 2012): there is a popular UK general lifestyle magazine available in newsagents called "Psychologies" – it's hard to imagine an analogous "Psychiatries".

Psychologists were generally seen as having a better rapport than psychiatrists. Echoing the construct of 'powerful' medication, psychiatrists were perceived as authoritative, and their ability to instigate involuntary treatment (although this is no longer a unique role in the UK, and indeed in the NHS Organisation that hosted this work, a Clinical Psychologist has such 'detaining powers') instilled them with less of a sense of a therapeutic alliance, and made them more fearful characters. This generally mapped onto descriptions of factual media portrayals, although most thought that news coverage about the professionals, such as in stories about the NHS, was positive. Psychologists were seen as more common 'commentators' on television, which was ascribed to their warmer personalities, though some had negative connotations of 'news-pundits' providing a false degree of certainty in 'analysing' the motives or actions of others. This may fit with Lilienfeld's argument that psychology retains an unhelpful 'pop science' (Lilienfeld, 2012).

There was a clear difference in terms of historical and fictional accounts of the two professions. Some of this was linked with the era of institutionalisation, which was largely before the development of the contemporary profession of clinical psychologist, and strongly linked psychiatry with coercion, governmental control, and unethical methods. Sartorius and colleagues (Sartorius et al., 2010) noted some improvement in the image of psychiatry with time, with public attitudes even worse in the past. There was a notable fictional trope of the psychiatrist as a cerebral and evil societal manipulator: one participant said of a movie that had a psychiatrist as a serial killer that it "wouldn't have worked" if the character had been a psychologist.

An interesting finding was that most participants thought that it would be easier to speak to either a psychologist or a psychiatrist than to their GP: although they knew their GP better,



such professionals were seen as less skilled in mental health, and thus more prone to stigmatising views. It was typically considered to be more stigmatising to see a psychiatrist than a psychologist, but this was because of the inference of greater illness burden and risk - “there really must be something wrong with you”. Positively, all participants were keen to learn more about the two roles, the majority said that it would be helpful to have more such information in the public domain, including GP surgeries.

### *Limitations*

Our sample size was relatively small, although not unduly so for qualitative work and we were minded that we had reached data saturation. However, this could be challenged, notably with reference to the demographics of our sample. Our participants were a mix of men and women, of varying ages, educational levels, and occupational statuses. Nevertheless, they were a self-selecting relatively young cohort who responded to an online advertisement, almost all had university level education, and all lived in a very large and cosmopolitan environment, London; views from less urbanised, older and less well-educated groups may have varied. Further, only those of Caucasian and Asian ethnicities or backgrounds volunteered for this work, and experiences of those from different backgrounds might vary. This is particularly pertinent when considering how both professions have faced challenges in terms of wider recruitment and issues about variable provision of care to those from ethnic minorities, such as evidence for reduced provision of talking therapies and higher rates of involuntary detention to those from ethnic minorities. The generalisability of our findings may therefore be challenged, particularly outside the UK where models of health-care, stigma, and media portrayals may vary. However, as noted, psychiatry training and psychology training are each relatively consistent globally, albeit local models and cultures of practice can vary

(including *within* countries); furthermore media portrayals, for better or worse, are increasingly international. This initial work contrasting these professions might thus best be utilised as a starting point for more local evaluations or conversations: identifying what may be common, and considering relevant differences. It is our opinion that there is likely to be much from this current work that is applicable quite widely.

### *Conclusions*

There is a lack of clarity in the public mind about our roles. We believe that this matters, and that a better understanding can help demystify a system that may feel confusing, and which has historically often had quite negative connotations. Our findings fit with an editorial divide: participants expressed greater uncertainty of *what* psychology does, and greater concern about *how* psychiatry does it.

At the individual level, it affords the opportunity for self-reflection on how some of our patients may view us. At a profession level, both psychiatry and psychology have identified image issues. For psychiatry this is impacted by the past, the media, and – though not explored in this work - a perceived ‘second class’ status amongst medical professions. A study of trainee psychiatrists (Catthoor et al., 2014) found that 75% had heard negative or humiliating comments stigmatising their profession, leading to coping mechanisms of keeping quiet about their job or offering preventive explanations, both of which risk perpetuating stigma. For psychology, a lack of diversity has been noted. As well as identifying such issues, it falls on the professions to correct errors, but to engage in broader education, mindful of why the public might feel as they do, including engaging with the media in relevant campaigns. Evaluation of such reflexivity at training selection, and during the course of professional training would seem especially appropriate and helpful.

Our findings may be viewed to align with, and add to, these issues. Psychiatry is perceived as a harsher though effective profession, with involuntary detainment, powerful but harmful medications, and historical aspects of a coercive and patriarchal system of care; psychology is perceived as softer, but vaguer and for 'minor' psychological ailments. Following a comment from the first participant, all were told at the interview's end that one of the interviewers was a psychiatrist, and one a psychologist, and they were asked which was which. All 'guessed' that the older male interviewer (DT) was a psychiatrist and the younger female interviewer (CC) was a psychologist, which was indeed correct.

Psychiatry and psychology work together in contemporary mental health care: we have far more in common as professions and clinicians than the aspects of training and practice that differentiate us. However, perceptions are powerful, and matter, and should not be underestimated. The challenge is to reflect on, and respond to these.

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**Table 1. Participant demographics**

|  |         |
|--|---------|
| <b>Age (years)</b>                     |         |
| Median                                 | 27      |
| Range                                  | (18-57) |
| <b>Gender</b>                          |         |
| Female                                 | 5       |
| Male                                   | 4       |
| <b>Race</b>                            |         |
| White                                  | 6       |
| Asian                                  | 3       |
| <b>Employment status</b>               |         |
| Employed                               | 3       |
| Unemployed                             | 2       |
| Student                                | 3       |
| Retired                                | 1       |
| <b>Highest educational achievement</b> |         |
| A-Levels                               | 1       |
| Bachelors Degree                       | 8       |