Comparing Mental Health Literacy and Physical Health Literacy: An Exploratory Study.

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Abstract

Background: This study compared mental health and physical health literacy using five health problems from each area.

Aims: The aim was to determine whether the same group had better physical than mental health literacy

Method: A sample of 263 participants completed an online questionnaire requiring them to name a problem/illness described in 10 vignettes and suggest treatment options. Five vignettes described mental health problems (anxiety, bipolar-disorder, depression, OCPD and schizophrenia) and five physical problems (angina, COPD, diabetes, a heart attack, and sinusitis). Participants were also asked to rate their sympathy and estimates of prevalence for each disorder.

Results: Recognition of the mental health disorders was superior compared recognition of the physical disorders. Analysis of treatment beliefs, sympathy and prevalence ratings also showed significant differences between disorders.

Conclusions: Results highlight the importance of education and the lack of public knowledge regarding major physical health conditions.

Introduction

Mental health literacy (MHL) was defined by Jorm et al. (1997) as knowledge and beliefs about mental disorders which aid their recognition, management or prevention. Jorm proposed that greater MHL allows individuals to take action to improve both their own mental health and that of others in the community (Jorm, 2012). Since the mid-1990s there has been an abundance of research examining MHL. This study compares a person's Mental vs Physical health literacy (PHL)

Research consistently reveals that under-recognition of mental health disorders is widespread (Jorm, 2012). Typically, these studies also highlight substantial differences between recognition of discrete disorders, particularly focusing on schizophrenia and depression. Ability to correctly identify or label the mental health disorders varies significantly across different demographic groups, including gender (Cotton et al., 2006); nationality (see Furnham & Hamid, 2014); age (Farrer et al., 2008); ethnicity (Gonzalez, Alegria, & Prihoda, 2005); level of education (Fisher & Goldney, 2003) and training (Kitchener, & Jorm, 2002). Research has also explored how MHL varies across specific groups such as internet users (Lawlor et al., 2008), university students (Furnham, Cook, Martin, & Batey, 2011) and nurses (Yeo et al., 2001).

One emergent finding is a clear distinction between the lay understanding and recognition of depression and schizophrenia with around two to three times the number of people recognising the former compared to the latter (Lauber, Nordt, Falcato, & Rössler, 2001). Studies have also begun to examine MHL in a range of other DSM disorders such as anxiety disorders (Furnham & Lousley, 2013), bipolar disorder (Furnham & Anthony, 2010), and the personality disorders (Furnham & Winceslaus, 2011). Relatively high levels of mental health

disorder recognition amongst the public is also correlated with a greater likelihood of seeking help (Wright, Jorm, Harris & McGorry, 2007).

Physical Health Literacy (PHL)

The term 'health literacy' has been used in health literature since the mid-1970s (Ad Hoc Committee on Health Literacy, 1999). In this study however we will refer to PHL in a similar way to MHL namely the "knowledge and beliefs about physical disorders which aid their recognition, management or prevention. There is an extensive research literature in this area (Ferandez, Larson & Zikmund-Fisher, 2016). PHL however generally describes and explains the relationships between patient literacy levels (their ability to read and write) and their ability to comply with or adhere to prescribed treatments (Nutbeam, 2000). It has been shown that low PHL results in poor health outcomes (Berkman et al., 2011). Many studies have found links between deficient health literacy and limited understandings of individuals' specific chronic health disorders. There is an extensive literature in this area not dissimilar from the MHL research (Fernandez et al., 2016).

Current Study

This study will investigate the PHL with respect to five disorders: angina, bronchitis (Chronic Obstructive Pulmonary Disease: COPD), diabetes, heart attack and sinusitis. These were chosen because they are common and relatively well known. Both the physical and mental conditions were taken from a study describing the ten most costly physical and mental health. Various hypotheses were tested, mainly based on the extant literature.

H_1: Lay people will have higher MHL in conditions with higher prevalence such as (a) depression and (b) anxiety; as well as lower literacy in disorders that are less common such as (c) OCPD; (d) schizophrenia and (e) bipolar disorder.

H_2: (a) Females; (b) those with an interest in mental illness; and (c) those who have received some mental health education will have high. This will be consistent with past research (Swami, 2012; Lauber et al., 2005).

H_3: (a) Lay people will be less likely to correctly label mental illnesses than physical ones. (b) The physical illnesses associated with the greatest morbidity, such as Acute Myocardial Infarct, will be most easily identified due to public education campaigns.

H_4: (a) Treatment beliefs will vary across all disorders, disorders associated with the highest levels of morbidity will receive the highest ratings for seeking professional help (b) participants will be more likely to suggest medical care for vignettes describing physical illnesses and (c) specific psychological care for those with mental illness.

H_5: Lay people will perceive that there are lower rates of mental illness than physical illness. This is a result of the stigma attached to mental illness.

H_6: Lay people will rate higher levels of sympathy for those describing individuals suffering from physical illness as opposed to those suffering from mental illnesses due to the stigma attached to mental illness.

H_7: There will be a) a positive correlation between age and ability to label physical illness and b) a negative correlation between age and ability to label mental illness. This is thought due to the age at which mental illnesses become prevalent and perhaps to an increased level of education regarding mental illnesses.

Methods

Participants

In total 261 participants completed the questionnaire but those with relevant advanced training and currently practicing psychology and medicine were removed from the sample. There were 65.2% female, 34.3% male, and 0.5% identified as 'other'. The mean age of the participants was 26.2. years (range 16 to 62 yrs). The ethnic profile of the sample consisted of 88.4% white, 1% Afro-Caribbean, 3.4% Asian, 4.8% mixed/multiple ethnicities, 1.9% other, and 0.5% missing. In all 28.5% had a degree (e.g. a BSc or BA); 16.9% had a postgraduate qualification (e.g. a PhD, MSc, MA) and 2.9% had vocational qualifications (e.g. NVQ, HNC, or HND). 1.9% held no qualifications. A total of 88.4% of participants spoke English as their first language, and 86.2% of the sample knew someone who suffered from at least one of the conditions.

Questionnaire

The questionnaire comprised of ten vignettes: five chronic conditions that can broadly be categorised as physical health conditions and five that can be described as mental health conditions. The conditions themselves were taken from Goetzel, Hawkins, Ozminkowski, & Wang (2003) a study describing the ten most costly physical and mental health conditions for US employers.

The Bipolar disorder vignette was taken from Ellison, Mason and Scior (2015), which had been adapted from a vignette used by Wolkenstein and Meyer (2008). The Depression and Schizophrenia vignettes were taken from Jorm et al. (1997) and Lawlor et al (2008) respectively. The Generalized Anxiety vignette was taken from Fricchione (2004). Finally the OCPD vignette was adapted from Furnham and Winceslaus (2012).

The vignettes for physical health conditions had to be written by the medically trained researcher who used lists of archetypal symptoms from the NHS choices website to compose the vignettes (Department of Health, 2014). Every effort was made to recreate the style of the mental health literacy type vignettes. They were written in laymen's terms and between 50 and 200 words in length and available from the first author.

Participants were asked to read each vignette carefully and answer a series of four questions about each one. These included two open questions and two Likert-based scale questions with a scale of one to eight. The questions used were: What if anything is X's main problem? How do you think he/she could best be helped? How likely is it for a person to experience this problem over their lifetime? How much sympathy do you have for people with this problem?

Procedure

The study received appropriate departmental ethical approval. The questionnaire was piloted on students and doctors. Potential participants were contact by the authors via the social media. Participants generally took between 10 and 20 minutes to complete the full questionnaire. Those participants who did not complete the task were removed.

Results

Reliability analysis involved a second-rater who coded 10% of questionnaires (n=21) using the same coding system as the author (Condition identified/ condition not identified). Results were shown to be very reliable (Kappa = 0.95). In cases where more than one response was given, and the correct condition was mentioned, the response was coded as correct.

1. *Vignette Recognition of Mental Health Disorders (H_1)*

It was evident that vignette recognition varied greatly over the 10 disorders (see Table 1)

Insert Table 1 and Figure 1 here

Particularly good recognition was shown for depression, anxiety, and bipolar disorder, with 89.9%, 79.7% and 75.4% of people correctly identifying the vignettes describing depression, generalised anxiety disorder and bipolar disorder respectively. 72.4% recognised schizophrenia while just 3.4% of the sample were able to correctly identify OCPD, although a further 3.8% were able to recognise it as a personality disorder. From these results we can infer that hypothesis a), b), c) and d) were confirmed although we must reject hypothesis e) as recognition of bi-polar disorder was higher than expected.

Throughout all the vignettes describing mental health conditions, the proportion of correct answers was higher than the proportion of incorrect answers, with the exception of OCPD. To test H_1 and to establish whether recognition of the disorders did indeed vary significantly, a Cochran's Q test was carried out.

Figure 1 shows the differences in rates of recognition across all 5 mental health disorders. A

2. Factors affecting vignette labelling of mental health problems (H_2)

a) The findings revealed that the mean female score (4.23 ± 1.203) was significantly higher than the mean male score (3.90± 1.395) t(204) = -2.847 p=.005. This confirms part a) of H_2. A paired t-test was also conducted to examine whether gender had an impact on recognition of physical health vignettes. This found similar results in that recognition scores were significantly higher in females (3.16 ±1.376) than in males (2.72 ±1.354) t(204)= -2.179, p=.030. The individual break down of gender differences between each disorder can be found in Table 2.

Insert Table 2

b) Whilst people, who claimed to be 'very interested' or 'extremely interested' in psychology, were found to have higher levels of recognition for mental health (4.23 ± 1.203); this difference was not significant when compared to those who described themselves as just moderately interested in psychology and below (4.19 ± 1.074) t(204)= 0.262 p=.794.

c) Those who had basic experiences of healthcare, or psychology were examined using a one-way MANOVA to explore whether these skills made a significant difference to their ability to recognise disorders. Basic training in health care had no significant effect*: (*F= 0.229, $p > .05$; partial $\eta 2 = .00$.) and basic training in psychology only had a marginally significant effect (F=0.174, p<.045; partial $\eta 2 = .03$.). Advanced health care training and advanced psychology training both had significant effects on recognition of physical health vignettes (F=12.558 p<.001) and mental health vignettes (F=8.883 p<.001) respectively.

3. Comparison of vignette labelling between mental and physical health conditions (H3)

Recognition of physical health conditions was remarkably low. Diabetes was the only condition correctly labelled by more than half the sample, with 50.7% of respondents labelling it correctly. The heart attack vignette was only labelled correctly by around 47.8% of the population which is surprising given recent public awareness campaigns (Public Health England, 2015). However, it must be noted that whilst recognition of heart attacks was poor, it was still the second most correctly labelled vignette amongst those describing physical disorders. This is in line with what was suggested by hypothesis $H_{3\,B}$.

In order to create a rudimentary comparison between mental health and physical health literacy, participants were given scores out of five for how many of the conditions each individual correctly labelled. Overall scores (out of a total possible score of 5) for correct labelling of mental health vignettes (3.2 ± 1.122) were revealed to be higher than scores for correct labelling of physical health vignettes (2.01±1.379). Thus the third hypothesis was

rejected. A paired t-test revealed that the sample scores for correctly labelling mental illnesses were significantly higher ($p < .001$). As with mental illnesses, a full Q sort technique was performed, breaking down suggestion labels for each vignette. Whilst participants did not always know the technical terms for conditions, they often had some degree of understanding of what the condition was. This was particularly true for lesser-known conditions such as OCPD and angina. Diabetes had a particularly low level of understanding (the lowest of all the physical conditions) with just 52.7% of the population suggesting correct or partially correct labels for it.

Insert Table 3 here

4. Treatment beliefs across all disorders (H_4)

To examine treatment beliefs another Q-sort content analysis was performed. This involved categorising the answers given to the question "how can X best be helped?" into distinct categories e.g. medication, professional psychological help or self-care (See Table 3). The majority of participants recommended a form of professional help across all disorders. Schizophrenia received the highest rating for seeking professional help overall, whilst the heart attack received the highest rating for seeking help amongst the physical conditions; with seeking help being suggested by 95.0% and 92.8% of the population in each condition. A total of 54.1% of participants specified in the heart attack vignette that the character could best be helped by some form of emergency care. Participants were generally good at describing different treatment types with 14.5% suggesting lifestyle changes such as exercise for the vignette describing depression. However, help with mental health disorders through chatting with members of the community such as family and friends was a relatively underutilised treatment type with it being suggested by just 7.2% of the sample across all the mental health vignettes. Sinusitis and OCPD had the lowest ratings for seeking professional help (71.2% and

74.9% respectively). To examine to what extent treatment varied between disorders, a Cochran's Q test was used. This uncovered a significant difference in the rates of seeking professional help across all ten disorders $p<.001$. The difference between categories of treatment suggested for mental health and physical health underwent bivariate analysis which found no significant difference between them.

Insert Table 4 here

5. Estimates of prevalence between mental and physical health disorders (H_5)

Sinusitis received by far the highest rating of prevalence (8.62±1.78), with depression (7.71±1.63) and anxiety (7.50±1.68) also receiving fairly high ratings. Psychosis (3.33± 1.82) and OCPD (3.00±1.83) received the lowest ratings of prevalence. The data indicates that in general the sample assumed that the prevalence of mental health disorders is either very high (>7.0) or very low (<4.5) whereas the prevalence ratings of physical health disorders were predominantly (with the exception of sinusitis) rated as just moderately prevalent (5.5-7.0). Overall the total prevalence rating was (33.4±6.54) across all physical disorders and (29.2±6.69) across mental health disorders ($t(206)=8.873$ $p<.001$).

Insert Table 5 here

6. Levels of sympathy towards sufferers of mental and physical health disorders (H_6)

Participants' sympathy was fairly consistent across all vignettes, with an average rating of 7.86/10. Depression received the highest rating of sympathy (8.74±1.72), with schizophrenia, anxiety, bipolar disorder and heart attacks also receiving high ratings (8.64, 8.25, 8.23 and 8.12 respectively). COPD attained the lowest sympathy rating (6.54±2.25) – this could be a result of the vignette character being a 'smoker'. Overall, the total scores for sympathy across the two categories were 36.6 for physical disorders and 40.0 for mental health disorders. A t-test showed this significant ($t(206) =7.399$ $p<.001$). Age also correlated with sympathy levels for

physical illnesses: older participants were more receptive to those with physical health problems (r=.221, n=195, p=.006).

7. Relationship between age and health literacy (H_7)

There was a negative correlation between age and recognition of mental health, as predicted by H_7, (r = -.124, n = 207, p <.05) while a positive correlation (r=.228, n=207, p<.001) was observed between age and physical health vignettes. This provides evidence in support of H_7.

Discussion

Many of the results confirmed findings from other studies. Levels of 'correct' labelling varied significantly across disorders, where 'correct' refers to participants who used currently accepted psychiatric terms for each disorder. Recognition for levels of depression and schizophrenia were broadly similar to other recent studies, if slightly higher. Wright and Furnham (2015) for example found that 89% and 48% of participants could correctly label depression and schizophrenia compared to the 90% and 72% found in this study. Recognition of OCPD was broadly similar to levels found by Koutoufa and Furnham (2014) who found 2% levels of recognition as opposed to the 3.4% found here. They also showed that many of the participants identified the OCPD vignette as being a 'perfectionist' (12.6%) or having 'OCD' (30.4%), terms that are intrinsically related to OCPD (Baer, 1994). This demonstrates that participants may have an inherent understanding of what OCPD actually is, but not know the official psychological term for it (Link et al., 1999).

Disorders with high levels of prevalence, such as anxiety and depression (Kessler et al., 2005) were more easily recognised by participants. However, recognition was (with the exception of depression) consistently higher than expected across all the mental health vignettes. Bipolar disorder in particular was surprisingly high (79.7% compared to 28.4% in Furnham, Annis, &

Cleridou, 2014). This could result from the use of a predominantly female, relatively young and well-educated sample. This factor has been used to explain higher levels of MHL in the past (Furnham & Dadabhoy, 2012). However, higher levels found here could in fact be due to real progression in public awareness of mental health conditions, similar to those found by Reavley and Jorm (2014).

The results regarding factors affecting MHL are fairly consistent with past research; for example, the fact that females are more literate than males (Cotton et al., 2006; Swami, 2012). A higher level of self-proclaimed interest in psychology did not significantly result in more accurate recognition. This also provides support for studies that have used high levels of psychology students in the past (Furnham & Lousley 2013), as interest in the subject does not always result in higher levels of MHL. It also substantiates research by Lauber, Nordt, Falcato and Rössler (2003) who found that a self-reported interest in psychiatric topics in the media did not increase recognition.

The results show that having had *advanced healthcare training* (i.e. having studied medicine or pharmacy at degree level) engendered significantly higher levels of recognition of physical illnesses. Similarly, having had *advanced psychology training* (having studied psychology at degree level) had an effect on levels of recognition of mental health - as demonstrated previously (Lauber et al. 2005; Reavley, McCann, & Jorm, 2012). For this reason, the exclusion of participants with this relevant experience from analysis was warranted. Whilst having *basic healthcare training* (e.g. a first aid course) did not increase the ability of participants to recognise the mental illness, having *basic psychology training* (e.g. an introductory university course) did. This concurs with other studies that a small amount of education (see Kitchener, & Jorm 2006 for review) can make a real difference to MHL and thus facilitate early help seeking. The fact that training makes a significant difference, whereas pure interest does not,

highlights the importance of using targeted campaigns to improve MHL such as *beyondblue* (Jorm, Christensen, & Griffiths, 2005).

Comparing Physical and Mental Health Literacy

The findings were the opposite of what was expected, and contradict that which is implied by Jorm (2012). The findings highlight suboptimal levels of recognition across all physical disorders. Particularly of note is the finding that merely 47.8% of the population sampled could label a heart attack (although 59.3% believed it to be heart related). Moreover, a heart attack is a life-threatening condition that requires urgent medical attention – uncertainty in recognition is associated with a dramatic rise in morbidity (Cummins, Ornato, Thies, & Pepe, 1991). Recognition of diabetes and COPD was also suboptimal and, as they are both conditions that hugely benefit from early diagnosis (Wee, Ho, & Li, 2002). The diabetes results also revealed a poor level of understanding of the disease, only approximately half participants were even partially correct.

There are several possible explanations for these findings. The nature (i.e demography) of the sample was less likely to have come across the physical illness. The physical illnesses tend to manifest in older people (Goldberg et al., 2000; Mehta et al 2001; Chang, & Mosenifar 2007), whereas mental health problems often affect younger generations (Patel, Flisher, Hetrick, & McGorry, 2007). Research has demonstrated the link between contact with mental illness and MHL (Wolff, Pathare, Craig & Leff, 1996) and this may apply to physical illness. This is evidenced by the fact that there was a correlation between age and recognition of physical illnesses (older people also seemed to have more sympathy for those with physical illnesses). It is also plausible that physical illnesses were not easily recognised because they are less frequently dealt with through film and television, whereas many of the mental health issues are. This reasoning was used to explain the higher levels of recognition for certain

illnesses like bipolar disorder in Furnham and Winceslaus (2012). Perhaps fundamentally people consider bipolar disorder more interesting than angina. This reiterates the need for general health education in schools (Kemm, 2003). There was however a small positive correlation between youth and mental illness recognition. This could indicate genuine improvement in MHL as a result of public education campaigns, which often target younger generations (World Health Organization, 2005).

The study did show that, compared to recognition scores, a significant number of participants suggested that the patient seek professional help. It is possible that participants would have felt obliged to suggest that the individual seek treatment, regardless of whether they would do so in reality. However, the knowledge of specific treatments was generally good i.e. recommending psychological or physical treatments for the appropriate category of disorder. Moreover, the study represents an improvement on other research, as participants were more likely to suggest that the individual seek help from friends and family than professionals (Cotton et al., 2006; Jorm & Wright, 2007; Burns & Rapee, 2006).

The results for levels of sympathy suggest that people are more likely to feel sympathy for things to which they can relate (Loewenstein & Small, 2007).

As always, the study does have several limitations. The sample used was very highly educated, with the vast majority having started or completed further education. This has been shown in the past to result in increased MHL (Kaneko & Motohashi, 2007). In further studies it would be highly desirable to have a much larger and representative population using both on-line and interview methods. It would be particularly interesting to test the extent to which general as well a medical/psychological education and interests related to PHL and PHL.

Also the study only used one vignette to describe each condition. Sai and Furnham (2013) demonstrated that recognition for schizophrenia and depression can vary between different

vignettes describing the same disorders. This is a problem that could be easily addressed by further research. Further, in this study we examined five mental and five physical health problems. It leads us to conclude that over PHL was weaker than MHL. However this interesting finding needs to be confirmed on a different and perhaps bigger set of various illnesses and disorders

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Figure 1. Graph showing average scores between physical and mental health vignettes out of a possible total of 5 (error bars show standard error)

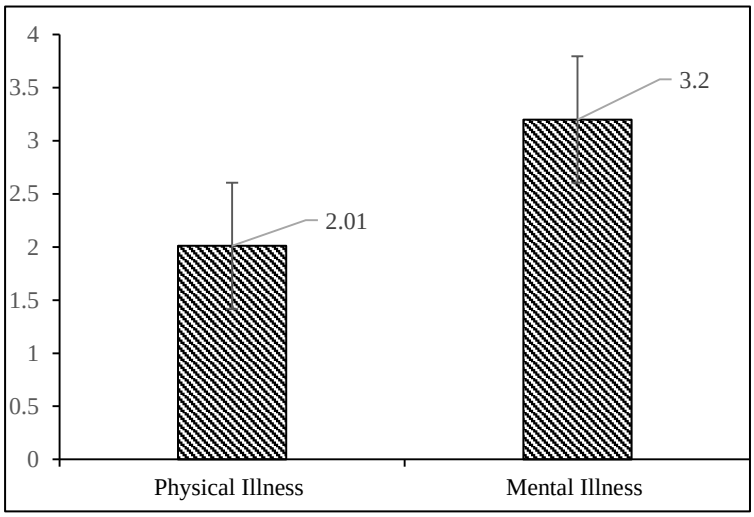

Table 1

Percentage of corrected and partly corrected labelling those recommending professional help across all vignettes

	Corrected	**Partly Corrected**	**Help**
1. Anxiety	75.4%	77.8%	85.5%
2. Bipolar Disorder	79.7%	86.5%	94.2%
3. Depression	89.9%	89.4%	91.8%
4. OCPD	3.4%	56.0%	69.6%
5. Schizophrenia	72.4%	87.0%	94.7%
6. Angina	30.0%	70.5%	76.3%
7. COPD	38.2%	69.6%	82.6%
8. Diabetes	50.7%	52.7%	85.5%
9. Heart Attack	47.8%	60.9%	91.3%
10. Sinusitis	47.3%	56.0%	76.8%

Table 2

Gender difference in correct recognition of vignettes N = 207

	Vignette	Males		Females				
		Percentage Correct/%	N correct	Percentage Correct/%	N	F	P	Total Percentage Correct
Physical Health	Anxiety	66.2	47	80.8	143	4.82	0.02*	73.5
	Bipolar	74.6	53	88.1	156	7.19	0.01**	81.4
	Depression	85.9	61	92.7	164	1.78	0.18	89.3
	OCPD	5.6	4	0.7	1	4.76	0.03*	3.2
	Schizophrenia	57.7	41	78	138	6.46	0.01**	67.9
	Mean	**58.0**	**41**	**68.06**	**120**	**8.10**	**0.01****	**63.0**
Mental Health	Angina	15.5	11	27.7	49	1.31	0.25	21.6
	COPD	36.6	26	42.4	75	5.73	0.01**	39.5
	Diabetes	40.8	29	59.3	105	4.06	0.04*	50.1
	Heart Attack	45.1	32	49.2	87	0.00	0.93	47.2
	Sinusitis	33.8	24	54.8	97	5.71	0.01**	44.3
	Mean	**34.4**	**24**	**46.68**	**83**	**7.67**	**0.00****	**40.5**
	Overall total	**46.2**	**33**	**57.37**	**102**	**9.87**	**0.00****	

Table 3

Categories of individual suggestions for how characters in each vignette could "best be helped".

Mental health disorder / Physical illness	Suggestion of help	Percentages
Angina	Medication	46.3
	Medical Help	33.8
	Lifestyle Change	42.0
	Didn't know/ blank	9.2
COPD	Medication	20.8
	Medical Help	66.7
	Emergency Help	1.9
	Lifestyle Change	12.1
	Self help	3.4
	Quit Smoking	4.8
	Didn't know/ blank	13.0
Diabetes	Medication	32.4
	Medical Help	64.7
	Emergency Help	1.4
	Lifestyle Change	16.4
	Lifestyle change alone	1.9
	Do nothing	2.4
	Didn't know/ blank	9.2
Sinusitis	Medication	38.6
	Medical Help	46.4
	Rest	15
	Lifestyle Change	3.9
	Self-help	10.6
	Didn't know/ blank	5.8
Heart attack	Medication	1.4
	Medical Help	46.4
	Emergency Help	54.1
	Lifestyle Change	11.1
	Self-help	3.9
	Psychological Help	18.4
	Didn't know/ blank	4.8
Anxiety	Medication	43
	Medical Help	13.5

	Psychological Help	71.0
	Lifestyle Change	14
	Self-help	5.8
	Community support	0.5
	Didn't know/ Blank	4.3
Bipolar Disorder	Medication	66.7
	Medical Help	18.8
	Psychological Help	57
	Lifestyle Change	3.9
	Community support	4.8
	Didn't know/ Blank	2.9
Depression	Medication	48.8
	Medical Help	19.3
	Psychological Help	74.9
	Lifestyle Change	14.5
	Community support	10.6
	Didn't know/ Blank	2.9
OCPD	Medication	16.4
	Medical Help	4.3
	Psychological Help	63.8
	Lifestyle Change	17.4
	Self-help	11.6
	Community support	5.3
	Didn't know/ Blank	9.2
Schizophrenia	Medication	48.3
	Medical Help	21.3
	Psychological Help	70.5
	Emergency psychological help	5.3
	Lifestyle Change	2.9
	Community support	8.7
	Self-help	1.0
	Didn't know/ Blank	2.9

Note. Figures shown are percentages and do not total 100 as many participants gave more than one suggestion.

Table 4

Differences between suggested treatments for physical and mental health

	Physical Health	Mental Health	F Value	P Value	Total Average
Medication	27.9	44.64	2.20	0.176	36.27
Professional help	66.76	77.39	0.46	0.514	72.075
Self-help	24.64	20.2	0.42	0.534	22.42

Table 5

Mean ratings of prevalence and sympathy across each disorder amongst those who recognised each disorder

Condition	Mean Prevalence Rating/10	SD	Mean Sympathy Rating/10	SD
Angina	6.80	2.02	7.56	1.79
Diabetes	5.98	1.83	7.82	1.85
COPD	5.52	1.82	6.54	2.25
Sinusitis	8.26	1.78	7.40	2.27
Heart attack	6.40	1.84	8.12	1.81
Bipolar	4.28	1.81	8.23	1.77
Depression	7.71	1.63	8.74	1.56
OCPD	3.00	1.83	7.25	2.22
Anxiety	7.50	1.68	8.25	1.78
Schizophrenia	3.33	1.82	8.64	1.72