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Lay Theories of Psychotherapy III: Comparing the Ratings of Lay Persons and Clinical Psychologists

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This study set out to compare the beliefs of lay, nonspecialist adults and trained practicing clinical psychologists on the topic of psychotherapy. Approximately 200 lay people (working adults and students) and over 50 practicing psychologists completed a four-part questionnaire that examined attitudes to psychotherapy, beliefs concerning what patients report during psychotherapy, the efficacy of quite different types of psychological treatment, and finally the prognosis for a wide range of psychological problems. The ratings of the two groups, lay vs. professional, were compared on an item-by-item basis, as well as by interpretable factors that were found in previous studies (Furnham & Wardley, 1990, 1991). The results showed a predicted pattern of similarities and differences with most differences occurring on the questionnaires concerned with beliefs about what happens in psychotherapy and the efficacy of therapy, and least differences in the part concerned with the anticipated attitudes of psychotherapy clients. Overall, psychotherapists seemed less optimistic and more skeptical concerning the efficacy of therapies and the prognosis of personal problems. These results are discussed in terms of available literature on lay expectations of psychotherapy.

KEY WORDS: lay theories; psychotherapy; health.

INTRODUCTION

Over the last decade, there has been a growing interest in lay health beliefs, particularly as they relate to health-related knowledge and behavior (Bishop, 1987; Calnan, 1987; Millstein & Irwin, 1987; Jemmott, Croyle, & Ditto, 1988). Most of this interest has concentrated on physical aspects of health, but there is a growing interest in lay beliefs about mental health (Furnham, 1988; Furnham & Bower, in press; Furnham & Smith, 1988; Hall & Tucker, 1985; Llewelyn, 1988).

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Studies on lay theories of mental health issues have included studies on lay beliefs concerning alcohol (Furnham & Lowick, 1984), depression (Brewin & Furnham, 1986; Rippere, 1981), neuroticism (Furnham, 1984), and schizophrenia (Furnham & Rees, 1988). There are also a number of studies on lay theories for the cure of various mental illnesses (Furnham & Henley, 1988; Henley & Furnham, 1988; Furnham, 1988). Far fewer studies have examined lay attribution beliefs, expectations, or theories concerning psychotherapy. This study is concerned with lay theories of psychotherapy — that is the organized, multifaceted, and interconnected beliefs that people have about the nature, and efficacy of psychotherapy. It is particularly concerned with comparing the views of lay person and practitioner (consultant and client) on various issues to do with the nature of psychotherapy.

Furnham and Wardley (1990, 1991) in a series of studies have examined lay theories of psychotherapy. Furnham and Wardley (1990) requested that subjects complete a 40-item questionnaire concerning their beliefs about various aspects of psychotherapy and therapists themselves. Various interpretable factors emerged from a factor analysis of the two questionnaires used in this study.

Overall, the subjects in this study appeared to be very positive toward psychotherapy. All the statements about how psychotherapy clients felt better (more in touch with their feelings, hopeful, confident, supported, relieved, understood) were rated as more true than all the negative statements that referred to the fact that clients feel rejected, confused, bored, and misunderstood. The most highly rated of the negative items was that clients felt pressured to do something for themselves and tend to be left alone between sessions, while the most lowly rated of the positive items was that therapy is good value for money! However, the subjects did believe that therapy was addictive, and about half believed that subjects felt very attracted to their therapist.

They also appeared to have a fairly realistic idea of what occurs in psychotherapy. For instance, the tended not to believe that psychotherapists prescribe drugs or that most psychotherapy patients lie on a couch. On the other hand, subjects tended to agree that psychotherapists aim to help clients achieve self-insight and express emotions. However, it is probably true that many psychotherapists of all persuasions would not agree with some items that most of the subjects endorsed, e.g., "A major component of all psychotherapy is teaching about relaxation, which helps people cope with anxieties," "Most psychotherapists believe that many psychological problems originate in childhood."

Furnham and Wardley (1991) concentrated on lay beliefs concerning the efficacy of different types of psychotherapy and the prognosis for dif-

ferent psychological problems. Lay people discriminated quite clearly between the efficacy of the 22 different therapies which were factor-analyzed into six clear factors. In this study subjects perceived cognitive and group therapies as most effective and the physical and surgical therapies as least effective to "cure" a wide range of problems. They were most impressed by traditional psychotherapy but least impressed by primary scream or rebirth therapy. It is of course possible that they are responding not so much to the perceived efficacy of the therapy as to their popularity or exposure among lay people, or about the generality of the techniques.

It was particularly interesting to note how the psychological experience factor related to these variables. The *more* experience subjects had the *less* they believed in the efficacy of most therapies, especially regressional techniques, but also cognitive and psychodynamic therapies to "cure" a wide range of psychological problems. It seems as if with increasing experience of psychology comes increasing skepticism (and possible cynicism or indeed realism) regarding the efficacy or at least general usefulness of psychological therapies. In both studies, the actual amount of experience of psychology in terms of reading, contact with psychologists, and knowledge about the discipline and its professional practices was the best determinant of the various attitudes and beliefs.

Many studies have asked what clients, as members of the lay public, expect upon entering psychological treatment and how these expectancies effect the course and outcome of that treatment. This research reveals that lay people have set beliefs about and conceptions of counseling before taking up therapy. Apfelbaum (1958) has suggested possible client sex differences in expectancies, with males expecting a directive, critical, analytical, and non-indulgent counselor and females anticipating counselors who are nonjudgmental, permissive listeners. Later research indicates that expectations of counseling may be important determinants of where the person turns to for help, many potential clients never seek counseling because of their low expectancy that they will be helped (Snyder *et al.*, 1972), whether the person discontinues counseling after the initial interview (Heilbrun, 1970), and the effectiveness of counseling (Goldstein, 1962). Some investigators report results which suggest the expectancy of gain is a powerful determinant of counseling effectiveness (Kraus *et al.*, 1969). Other research on client expectancies has been concerned with clients' perceptions of the types of problems appropriate for counseling (Frankel & Perlman, 1969).

Tinsley and Harris (1976) used a questionnaire to investigate student expectancies of counseling. The strongest expectancies found were of seeing an experienced, genuine expert, an accepting counselor they could trust. Tinsley *et al.* (1988) reviewed and assessed investigations in which clients'

expectations for counseling or psychotherapy were manipulated. Numerous writers have argued clients approach therapy with expectations regarding the nature of therapeutic interview and the roles they and their counselors/therapists will assume (Bordin, 1955; Patterson, 1958). Moreover, it has been argued that clients' expectancies may either facilitate or hinder the communication process and the effectiveness of therapy (Apfelbaum, 1958; Goldstein, 1962). For instance, expectancies influence choice of help giver, and attracted research in the relation between the expectancies and help-seeking behavior (Parham & Tinsley, 1980). Expectancies may be related to persistency in therapy (Sandler, 1975), and client's decision to discontinue therapy after the initial interview may result largely from a discrepancy between client expectations of therapy and what actually happens. Further, assuming a client stays in therapy, expectancies may be important determinants of the effectiveness of therapy. The ultimate goal in this line of research is to enable therapists to influence client's expectancies in order to produce a more beneficial result from treatment. These client expectancies may be seen to result from the more general theories that lay people have of psychotherapy.

Lay people also have ideas about recovery from psychological problems and the relevant cures. Knapp and Karabenick (1985) investigated the perceived importance of the contributors will-power, inner control, and positive outlook toward overcoming the six problems of: smoking, stuttering, nightmares, dog phobia, hearing voices, and overeating. Factor analysis showed lay people to consider some contributors as more important than others for the different problems. Furnham and Henley (1988) in their study of lay beliefs about the overcoming of psychological problems of agoraphobia, anorexia nervosa, compulsive gambling, and schizophrenia, found five clusters of factors perceived by lay people as important. These they labeled as inner control, understanding, avoidance, physical base, and fate. Furnham and Henley's (1988) work supported that of Knapp and Karbenick's earlier findings, and replicated the factor structured despite the fact that few very different problems, namely alcoholism, depression, sex problems, and shyness were used. More recently, Furnham (1988) replicated the factor structure of lay beliefs about overcoming psychosomatic problems. It is of interest that both inner control — implying self-help — *and* receiving help from others were thought by subjects to be important for overcoming problems. Knapp and Karabenick (1985) have suggested that these two strategies may be mutually exclusive, an emphasis on self-reliance reducing or even precluding help seeking from others and *vice versa.* An alternative view, which seems to be supported by results reported here, is that the two approaches may be complementary: family, friends, and professional helpers may be invaluable, even necessary, sources

of support and advice concerning appropriate curative strategies, but the successful implementation of these strategies may depend to a large extent on the will-power and personal effort of the individual concerned.

Lay theories and expectations can be compared to orthodox, explicit, academic theories of professional practitioners. This paper is particularly concerned with comparing the views of lay people and professionals: in this instance, clients (patients) and psychotherapists who might be expected to have quite different views about psychotherapy for a variety of reasons. Despite the relevance of this work, few studies have been done. Hence, there are few or no studies comparing lay individuals who have experienced vs. have not experienced psychotherapy, or those who have experienced positive vs. negative outcomes in psychotherapy. Researching how the layman "thinks" is both interesting and of practical importance in therapy. Cognitive, clinical, and social psychologists suggest some lay "theories" contribute to and maintain various behavioral states such as depression. The understanding of lay theories may lead to the next step of solving a psychological problem such as depression through the breakdown of the structure of beliefs maintaining it. Along with these theories about psychological problems, research has shown people to have established beliefs about what a visit to a psychologist would involve.

There is a problem with much research into subjective lay theories or expectations of psychological states or processes concerns obtaining clear "objective" or expert opinion against which to compare them. While it may be possible to infer that lay people, scientific experts, and professional practitioners differ on certain points, relatively few studies have been able to obtain sufficient evidence of the latter to compare with the former. This study set out to compare the views of two groups — lay vs. professional people — with regard to lay beliefs of psychotherapy. Two lay groups were obtained — mature adults and students — who were compared to trained and more practicing clinical psychologists. All completed the same questionnaire and hence their results were directly comparable.

It was predicted from the extant literature (Furnham, 1988) that mature adults and students would differ less between each other than they would between themselves and the clinical psychologists. Second, it was predicted that there would be greater consensus between the clinical psychologists than between the lay people as evidenced by the spread of their ratings. Third, it was predicted that lay people would be more positive and optimistic about psychotherapy, the efficacy of treatment, and the prognosis for particular complaints than the practicing clinical psychologists. Fourth, it was predicted that the area that would yield most of the difference was prognosis and the area that would yield least difference was clients' reports during therapy.

METHOD

Subjects

Two groups of subjects took part in the study: lay people and psychotherapists.

Lay People. In all, 200 lay people (122 adults, 78 students) took part in this study, 84 males and 116 females. They ranged in age from 17 to 76: the mean being 27.7 years (*SD* = 13.3 yr). Most of these subjects had completed secondary school (80%) but obtained no further qualifications, while 11% had completed university education and some of them had postgraduate qualifications. They came from a variety of occupations though none were in psychological or psychotherapeutic-related occupations. Most (29%) were nominal Christians but many claimed to be agnostic. In all, 149 were single, 48 married, and 5 divorced. They came from all social classes and were obtained by the second author in London, Hertfordshire, Hampshire, and Sussex by door-step requests. Though not a true random or stratified sample, it was though large and heterogeneous enough to examine the hypotheses in this study. Fifteen percent had actually seen a psychotherapist, while 27.5% had thought of doing so and 62.5% knew someone who had received psychological help. In this sense, a significant number of the sample had ground to be "consumers" of psychotherapy.

Psychologists. In all, 54 psychologists took part in this study, 28 males and 26 females. They ranged in age from 25 to 51: the mean being 31.2 years (*SD* = 10.8 yr). All of these subjects had completed secondary school and undergraduate degrees, 46 subjects had completed postgraduate qualifications. Of the psychologists, 50 had completed the BPS requirements. Because of their eclectic training, they had some experience of traditional psychotherapy and a wide variety of other techniques.

It was of course impossible to match the groups given that a matching would reduce the representatives of the therapist group who tended to be older, better educated, and quite naturally more experienced in psychology.

Questionnaires

The questionnaire comprised 118 questions that was divided into four sections. The questionnaire was devised by the authors piloted with a number of subjects and shown to various researchers and psychologists including a Professor of Psychoanalysis. Numerous changes were made primarily to eliminate ambiguities. Details of the items making up the questionnaires can be found in Furnham and Wardley (1990, 1991). All were factor analyzed using VARIMAX rotation, and the Kaiser criterion and scree test

(both liberal criteria) were used to derive the factor structure. Factor analyses were computed on all the subjects' data, but the results were almost identical to the factor analysis results from just the lay sample. The ratio of items to respondents was minimally 5:1. Items were then summed to yield subscale scores and each had an acceptable Cronbach alpha of >.60. In fact, with two exceptions, the alphas were above 0.70 which is more acceptable, but this is debated, and others are less convinced of the importance of high alphas at all (Boyle, 1991).

Reactions to Psychotherapy

This consists of 20 statements about the "clients" of psychotherapy. The instructions read: "After a course of psychotherapy some clients feel better and others do not. Some clients feel the treatment has been enormously helpful and therapeutic while others feel it has been a waste of time. In this part of the questionnaire we want you to indicate how frequently you think clients of psychotherapy report having certain reactions." Subjects responded on a 7-point (7 = extremely frequency, 1 = very rarely) scale.

Six factors emerged with an eigenvalue of >1.00 which accounted for about 60% of the variance. The first factor, which accounted for a fifth of the variance, had all six negative items loading on it, and which implied psychotherapy was unhelpful and hence was called *negative reactions.* The second factor, which accounted for 15% of the variance had three items loading on it about how constructive psychotherapy appeared to be and was labeled *understanding.* The third factor had four items loading on it and was labeled *confident improvements.* The fourth factor had only two items loading on it both concerned with active change. The fifth factor had three items loading on it concerned with the *therapist relationship,* while the final and sixth factor was labeled *insight,* because both items were concerned with the insight that patients have and the personal improvement they experience.

Attitudes to, and Beliefs About, Psychotherapy

This consisted of 40 items and concerned such things as the aims of therapists, the nature of the client-therapist relationships, and the experience of therapy for both parties. Subjects responded on a 7-point scale (7 = strongly agree; 1 = strongly disagree).

The statements for both sections were obtained from three sources: popular and academic psychology textbooks on psychotherapy, interviews

with ten lay-people who were nonspecialists and had no experience of psychotherapy, and interviews with five psychotherapists from a wide variety of backgrounds. Both questionnaires were piloted and in the process, some questions were changed and others omitted.

In all, eight factors emerged from the factor analysis with an eigenvalue of >1.00. The first factor, which accounted for nearly 20% of the variance, seemed to concern items specifically concerned with what psychotherapists *teach* clients about coping strategies. The second factor had items loading on it which referred mainly to the background of *therapy sessions* themselves. The third factor was labeled *conflicts and emotions* because high loading items referred to the beliefs and insights of psychotherapists on these two issues. The fourth factor, which only had two items loading on it as >0.40 was called *limited benefits* because it concerned who were actually helped by psychotherapy. The fifth factor had three items loading on it, two of which referred to the *duration* of therapy. The sixth factor, not unlike the first was labeled *instruction* because both high loading items concerned the skills and strategies that therapists hope to instruct their clients in. The penultimate factor referred to *progress in therapy,* and the final factor contained items that most subjects believed *untrue.*

The Efficacy of "Psychological Cures"

Subjects were presented with a list of 22 different psychological techniques plus a one to two sentence description of each. The list and the descriptions were taken from a number of introductory textbooks on abnormal psychology. They were told to indicate how effective they believe each "cure" is for psychological problems in general. If the cure was considered effective for nearly all or very many psychological problems, they circled 5 or 4, but if rarely or never effective, they circled 2 or 1.

Six factors emerged from a VARIMAX rotated factor analysis with eigenvalues of >1.00 or above. The first factor had six items loading .40 and above and accounted for nearly a fifth of the variance. It was labeled *cognitive therapies* because most therapies loading on it were essentially cognitive. The second factor had four items loading on it and was labeled *behavioral therapies*. The third factor had four items loading highly on it and was labeled *physical therapies* as all four involved medical/physical methods (chemotherapy, megavitamin, psychosurgery, and electro-convulsion therapy). The fourth factor was labeled *psychodynamic therapies* and had just two items loading on it — psychotherapy and psychodynamic therapy. The fifth factor had three items loading on it — gestalt, rebirth,

and hypnosis — and was labeled *hypnosis* because of the high loading of that item. Finally, the final factor was labeled *group feedback* because of the item loading on it. Items that loaded 0.40 or above on any factor were arithmetically computed so that each subject had a total of six scores.

Prognosis for Psychological Problems

Subjects were given a list of 36 "psychological problems" presented in alphabetical order from agoraphobia to tics, with brief descriptions of the nature of the problem (i.e., fetishism — sexual excitement over non-living objects). The list was derived from DSM III and included most of the "relatively well-known psychological problems." They were told to read the following list of psychological and behavioral difficulties and rate each according to how often and easily people recover (good prognosis) to how little people recover (bad prognosis). The higher the number ringed, the better chance people have of being cured. If people never heard of the problem, or are not sure of what it was, they coded 0.

The VARIMAX rotated factor analysis showed four factors emerged with an eigenvalue of >1.00, which accounted for about 60% of the variance. At first glance, the first and third factors appeared to be associated with neurotic disorders and the second and fourth, psychotic disorders. Also the problems that loaded on the first factor were perceived as having a good prognosis, while those that loaded on the second factor were perceived as generally having a poor prognosis. The first factor which accounted for over 40% of the variance was labeled *general anxiety* because of the high loading of certain items. The second factor which clearly referred to numerous serious psychotic illnesses was labeled *serious cognitive disturbances.* The third factor which accounted for just under 5% of the variance was labeled *obsessionality* and the final factor which had eight items loading on it (>.40) was labeled *personality disorders.* Although this factor structure does not follow the established nomenclature, it is quite interpretable.

Procedure

Subjects who were all volunteers, were tested in a variety of settings. Some were conducted in door-to-door surveys (about 40%), while others were tested at their place of work (about 20%) and some in educational settings (40%). They were large commercial organizations who employed people from various backgrounds. The clinical psychologists were contacted in their work settings and students at London University. Very few refused

Table I. The Means for the Three Groups Showing the Analysis of Variance and Post-Hoc Comparison

	Means				Scheffé tests		
	Adults (N = 122)	Students (N = 78)	Therapists (N = 54)	ANOVA (F level)	A S	A T	S T
A. Attitudes of therapy clients (7 = extremely frequently; 1 = very rarely)							
1. Negative reactions	3.59	3.67	3.14	5.05[b]		*c*	*c*
2. Understanding	5.05	4.85	5.40	5.62[b]	*c*		
3. Confident improvements	4.88	4.54	4.89	3.26[a]			*c*
4. Active changes	4.78	4.83	4.87	0.12			
5. Therapist relationships	4.17	4.20	3.89	1.40			
6. Insight	5.05	5.00	4.83	1.05			
B. Beliefs about psychotherapy (7 = strongly agree; 1 = strongly disagree)							
1. Teach	4.88	4.50	3.89	20.92[a]	*c*	*c*	*c*
2. Therapy sessions	5.03	4.71	4.68	4.24[b]		*c*	
3. Conflict and emotions	4.94	4.48	4.08	15.81[a]	*c*	*c*	*c*
4. Limited benefits	3.00	3.00	2.61	1.84			
5. Duration	3.99	4.20	3.16	11.55[a]		*c*	*c*
6. Instruction	5.26	5.05	4.68	8.05[a]		*c*	*c*
7. Progress in therapy	4.58	4.07	3.92	8.73[a]	*c*	*c*	
8. Untrue	3.99	3.56	2.89	34.09[a]	*c*	*c*	*c*
C. Efficacy of therapies (5 = almost all; 1 = almost none)							
1. Cognitive therapies	3.69	3.23	2.95	11.77[a]		*c*	*c*
2. Behavioral therapies	2.85	2.79	2.71	0.33			
3. Physical therapies	2.83	2.35	1.82	14.48[a]	*c*	*c*	*c*
4. Psychodynamic therapies	3.46	3.25	2.78	8.49[a]	*c*	*c*	
5. Hypnosis	3.07	2.72	2.27	9.69[a]		*c*	
6. Group feedback	3.43	3.27	2.90	5.46[b]		*c*	
D. Prognosis (7 = good prognosis; 1 = bad prognosis)							
1. General anxiety	4.63	4.78	4.87	1.45			
2. Serious cognitive disturbance	3.44	3.05	2.52	14.69[a]	*c*	*c*	*c*
3. Obsessionality	4.35	4.45	4.29	0.63			
4. Personality disorders	4.24	4.20	3.58	7.47	*c*	*c*	

[a] $p < .001$.
[b] $p < .01$.
[c] $p < .05$.

(there was a 92% response rate with lay people and 86% with clinical psychologists); there was a minimal number of incompleted or spoiled questionnaires and many subjects expressed considerable interest in the study.

RESULTS

The results for this study are shown quite clearly in Table I. The factors were first analyzed followed by individual items (with *post hoc* Scheffé

Table II. The Means for the Three Groups Showing the Analysis of Variance Results[d]

Statements	Groups			ANOVA (F levels)
	Adults (122)	Students (78)	Therapists (54)	
4. Clients feel confused or side-tracked from important things.	3.19[a]	3.46[a]	2.46[b]	6.86[a]
6. Clients say they feel rejected, attacked, judged, or put-down by therapists.	3.00[b]	3.43[a]	2.68[c]	6.48[a]
8. Clients report being misunderstood by the therapist.	3.54[a]	3.93[a]	3.24[b]	4.67[b]
9. Clients feel involved in the tasks of therapy.	4.57[a]	4.68[a]	5.16[b]	4.53[b]
11. Clients feel understood.	4.88[a]	4.87[a]	5.50[b]	5.96[b]
13. Clients feel supported and relieved.	5.03[a]	4.84[a]	5.43[b]	5.39[b]
14. Clients are made to think about uncomfortable/painful ideas in an unhelpful way.	2.99[a]	3.11[a]	2.33[b]	7.02[a]
16. Clients experience contact with the therapist as a person.	4.46[a]	3.89[b]	4.81[c]	7.63[a]
18. Clients feel "addicted" to their therapy—unable to give it up.	4.09[a]	4.34[b]	3.77[a]	3.18[c]
20. Clients report being very attracted to the therapist.	3.82[a]	4.20[b]	3.20[c]	6.92[a]

[a] $p < .001$.
[b] $p < .01$.
[c] $p < .05$.
[d] 7 = extremely frequent; 1 = very rarely. Items with different superscripts (a, b, or c) are significantly different at the $p < .05$ level according to *post-hoc* Scheffé analysis.

tests to determine differences between groups). Although the latter analysis is likely to increase Type 1 errors, it shows more clearly the pattern of different beliefs. This study concentrated on group differences. Other factors such as sex, age, and educational status were examined but not reported in this paper as that issue was not central.

Attitudes to Therapy Clients

Three of the attitudinal factors showed significant differences. Compared to the students, therapists believed psychotherapy patients are less likely to express negative reactions to the treatment. Although the adults also believed negative reactions more frequently than therapists did, this difference was not significant. The second factor, understanding, also yielded significant differences: therapists significantly more than students believed that psychotherapy clients felt supported and understood. The

third factor showed that therapists and adults were more confident about improvements as a function of psychotherapy than students. The other factors failed to show any significant differences. However, these results seem to indicate that therapists, compared to lay people, feel fewer therapy clients have negative reactions, and more report being understood.

Table II shows the results of the 10 (out of 20) individual items which yielded significant differences. As has been shown on many of the negative items (4, 6, 8, 14, 18) lay people (both adults and students) have higher agreement scores, while on the positive items (9, 10, 13, 16) therapists believe clients are more likely to endorse these than lay people. This may be a good example of self-serving attributions.

Beliefs About Psychotherapy

The results from the second section of the questionnaire are highly significant and very consistent. All except one (factor 3) showed significant differences always between the working adults and the therapists, but in three cases between all three subject groups. Furthermore, the results are quite consistent in that the therapists agreed *less* than the working adult on all eight factors. That is, clinical psychologists compared to working adults believed less: that psychotherapists help to teach people to develop better coping skills, that therapy sessions are full of passion, that therapy involves a great deal of conflicts and emotions, that psychotherapy lasts a long time, that psychotherapists communicated particular skills and strategies to their clients, that people made much progress in therapy, and that many untrue statements about psychotherapy were true. Interestingly, the only factor that showed no significant difference, referred to the limited benefits of therapy. There were more significant differences between therapists and lay adults, than students and therapists or indeed, adults and students.

Table III shows the results of 22 items (out of 40) which yielded significant differences. The results show very clear patterns. On items 1, 2, 3, 5, 8, 9, 11, 13, 22, 24, 25, and 29, adults have the highest agree and therapists the lowest agree scores, while on items 4, 10, 26, 27, 34, 35, 37, and 38, students have the highest score and therapists the lowest. Interestingly, relatively few items showed therapists having the highest mean agree scores (14, 15, 23). Item 8 shows the biggest difference. The *post hoc* Scheffé scores shows that while the adults were always significantly different in their responses from students on some items (2, 9, 14, etc.), students did not differ significantly from the therapists.

Table III. The Means for the Three Groups Showing the Analysis of Variance Results[d]

	Groups			ANOVA
	Adults	Students	Therapists	(*F* level)
1. Most psychotherapists use personality questionnaires.	4.40[a]	3.84[b]	1.85[c]	63.61[a]
2. Psychotherapy often involves resolving sexual conflicts.	4.79[a]	4.26[b]	4.05[b]	7.06[a]
3. Most psychotherapists ask you about your dreams.	4.68[a]	3.74[b]	3.18[c]	22.65[a]
4. Most patients in psychotherapy have to be taught to confront and cope with fearful objects/situations.	5.38[a]	5.48[a]	4.55[b]	10.77[a]
5. Very often psychotherapists prescribe drugs.	2.52[a]	2.14[a]	1.25[b]	21.06[a]
8. A major component of all psychotherapy is teaching about relaxation which helps people cope with anxieties.	5.45[a]	4.88[a]	2.75[b]	81.70[a]
9. Most psychotherapists attempt to teach clients to alter their life-goals to be more realistic.	4.50[a]	3.94[b]	4.00[b]	3.99[b]
10. Psychotherapists believe that the cause of nearly all psychological problems are unconscious.	3.87[a]	4.00[a]	3.18[b]	4.86[b]
11. Psychotherapists teach clients various strategies to reduce conflict or frustrations.	5.38[a]	4.97[a]	4.03[b]	21.98[a]
13. Women tend to make better psychotherapists than men.	3.87[a]	3.33[a]	2.61[b]	11.49[a]
14. Psychotherapists encourage the expression of emotion and feelings that have long been suppressed/repressed.	4.27[a]	5.26[b]	5.46[b]	12.85[a]
15. Some psychotherapists actually expose people to those things (heights, snakes) that they most fear.	4.27[a]	5.26[b]	5.46[b]	12.85[a]
22. Psychotherapy, by its very nature, requires surroundings of a relaxing nature.	5.26[a]	4.93[a]	4.62[b]	4.16[c]
23. The establishment of rapport is of major importance during the early phase of therapy.	5.73[a]	5.52[a]	6.14[b]	5.17[b]
24. The work of a psychotherapist consists mainly of listening to clients verbalizing their problems.	4.86[a]	4.56[a]	3.72[b]	13.13[a]
26. Most therapies last many months.	4.61[a]	5.15[a]	4.05[b]	8.57[a]
27. Most clients only consult psychotherapists as a last resort.	4.81[a]	4.84[a]	3.62[a]	12.64[a]
29. Most psychotherapy clients lie on a couch.	2.42[a]	2.01[a]	1.48[b]	10.37[a]
34. Most therapies last many years.	2.93[a]	3.47[a]	2.24[b]	11.71[a]

Table III. Continued

	Groups			ANOVA
	Adults	Students	Therapists	(*F* level)
35. Nearly all therapists give clients "homework exercises" for them to do between therapy sessions.	4.53[a]	4.57[a]	3.25[b]	17.51[a]
37. On an average, clients have between two and four "sessions" a week.	3.17[a]	3.41[a]	2.07[b]	15.23[a]
38. Clients are encouraged to practice new coping skills in the "session."	4.17[a]	4.83[b]	3.94[a]	9.18[a]

[a] $p < .001$.
[b] $p < .01$.
[c] $p < .05$.
[d] 7 = strongly agree; 1 = strongly disagree. Items with different superscripts (a, b, or c) are significantly different at the $p < .05$ level according to the *post-hoc* Scheffé tests.

Efficacy of Therapy

Five of the six ANOVAs on the factor scores showed significant differences. Again the pattern was most clear — on all five, the therapists rated the efficacy of all therapies as lower than the lay adults. However, the rank ordering between the groups was similar with cognitive and psychodynamic therapies being seen as most effective for a wide range of psychological problems, while behavioral and physical were seen as less effective. Once again there were far fewer differences between students and therapists compared to lay adults and therapists.

Table IV shows the results of the 16 items (out of 22) which showed significant differences. With only two exceptions the lay people (more the adults than the students) thought each "therapy" more generally efficacious. The exceptions were behavioral contracting and role-playing, which therapists thought more often useful than the adults. On four of the 16 significant items, students did not differ significantly from therapists.

Prognosis

Two of the factors yielded significant differences. Therapists thought the prognosis for serious cognitive disturbances less good than students, who in turn thought it poorer than the lay adults. Similarly, the therapists thought the prognosis for personality disorders poorer than the lay adults. Table V shows the results for the 22 items (out of 36) which showed significant differences. Generally, the pattern was quite consistent with lay

Table IV. The Means for the Three Groups Showing the Analysis of Variance Results[d]

	Groups			ANOVA
	Adults	Students	Therapists	(*F* level)
3. Psychotherapy	2.32[a]	1.94[a]	1.16[b]	28.20[a]
4. Megavitamin therapy	2.45[a]	2.41[a]	1.61[b]	19.04[a]
7. Systematic densentization	3.65[a]	3.79[a]	3.35[b]	5.59[b]
8. Implosion therapy	2.90[a]	3.11[a]	2.68[b]	4.98[b]
9. Aversion therapy	2.88[a]	3.01[a]	1.88[b]	33.74[a]
11. Behavior contracting	2.35[a]	2.28[a]	3.03[b]	15.35[a]
12. Modeling/role playing	2.63[a]	2.68[a]	3.14[b]	6.72[b]
13. Assertiveness training	3.72[a]	3.45[b]	3.33[b]	6.55[b]
14. Rational-emotive therapy	3.41[a]	3.00[b]	3.07[b]	6.75[b]
15. Thought-stopping therapy	3.26[a]	2.97[a]	2.27[b]	28.01[a]
16. Non-directive therapy	3.43[a]	3.12[b]	3.09[b]	4.52[c]
17. Existential therapy	3.52[a]	3.24[a]	3.00[b]	7.72[a]
18. Gestalt therapy	3.28[a]	3.20[a]	2.77[b]	7.23[a]
19. Hypnosis	3.13[a]	2.92[a]	2.50[b]	10.26[a]
21. Group therapy	3.67[a]	3.63[a]	3.33[b]	3.79[c]
22. Primary scream (rebirth/therapy)	2.03[a]	1.79[b]	1.55[b]	5.00[b]

[a] $p < .001$.
[b] $p < .01$.
[c] $p < .05$.
[d] 5 = almost all; 1 = almost none. Items with different superscripts (a, b, or c) are significantly different at the $p < .05$ level according to *post hoc* Scheffé analysis.

people (particularly the adults) believing prognosis to be much better than the therapists. The exceptions to this however were five anxiety/panic attacks, 13 enuresis, 25 impotence, 27 neurosis, 30 phobias, and 31 sleep disorders. The range of beliefs about prognosis in all groups is also apparent in Table V. Once again, while the lay adults showed significant differences between themselves and the therapists on between a quarter and a fifth of these items, students were not significant from therapists.

DISCUSSION

This study set out to compare lay people (i.e., potential clients) and psychotherapists' perceptions of four things: the attitudes of clients actually undergoing psychotherapy, beliefs about the practice of psychotherapy, beliefs about the general efficacy of various therapies, and the perceived prognosis of numerous psychological illnesses. The results revealed numerous and consistent differences which showed that, compared to lay people, psychotherapists seemed more skeptical and pessimistic about the efficacy of therapy and the prognosis for various psychological illnesses.

Table V. The Means for the Three Groups Showing the Analysis of Variance Results[d]

		Groups			ANOVA
		Adults	Students	Therapists	(*F* level)
2.	Alcoholism	4.48[a]	4.32[a]	3.22[b]	13.68[a]
3.	Anorexia	4.35[a]	4.31[a]	3.52[b]	5.05[b]
4.	Amnesia	4.01[a]	3.75[a]	2.95[b]	6.58[b]
5.	Anxiety/panic attacks	4.81[a]	4.87[a]	5.40[b]	4.08[b]
6.	Childhood autism	3.71[a]	2.76[b]	1.84[c]	23.02[a]
7.	Compulsive behaviors	4.62[a]	4.46[a]	3.83[b]	5.35[b]
9.	Delusions	4.39[a]	4.20[a]	2.86[b]	17.61[a]
10.	Dementia	2.46[a]	2.10[a]	1.21[b]	14.65[b]
11.	Drug dependence	4.04[a]	3.70[a]	2.96[b]	9.08[a]
13.	Enuresis	5.40[a]	5.72[b]	6.05[b]	4.71[b]
14.	Exhibitionism	4.54[a]	4.74[a]	4.00[b]	3.72[c]
18.	Compulsive gambling	4.36[a]	4.47[a]	3.64[b]	5.89[b]
19.	Hyperactivity in children	4.76[a]	5.03[a]	4.24[b]	5.14[b]
22.	Hypochondriasis	4.56[a]	4.57[a]	3.86[b]	4.65[b]
25.	Impotence	4.93[a]	4.75[a]	5.46[b]	4.20[b]
26.	Manic depressive illness	4.05[a]	3.60[b]	3.33[b]	3.94[a]
27.	Neurosis	4.57[a]	4.66[a]	5.62[b]	11.58[a]
29.	Paranoia	4.02[a]	4.02[a]	2.86[b]	13.16[a]
30.	Phobias	4.76[a]	5.08[a]	6.01[b]	13.94[a]
31.	Sleep disorders	4.74[a]	5.15[b]	5.47[c]	5.91[a]
34.	Senile dementia	2.08[a]	1.25[b]	1.15[b]	14.62[a]
35.	Schizophrenia	3.05[a]	2.47[b]	2.64[b]	3.61[b]

[a] $p < .001$.
[b] $p < .01$.
[c] $p < .05$.
[d] 7 = good prognosis; 1 = bad prognosis. Items with different superscripts (a, b, or c) are significantly different at the $p < .05$ level according to *post-hoc* Scheffé tests.

On the whole, the psychotherapists believed that clients in psychotherapy tended to report more positive, favorable reactions than lay adults and students. This may be due to a number of factors: the fact, for instance, that therapists probably had more contact with clients/patients than the lay people and hence were in a better position to judge, or defensive, self-esteem enhancing attributions designed to boost their ego. But whereas the psychotherapists believed more than lay people that clients report satisfaction, they tended not to believe that therapists teach specific skills but rather that they provide some sort of social support and help vent fears and other negative emotions. Certainly where it is possible to obtain "objective" statistics on psychotherapeutic practices (i.e., the use of questionnaires and drugs, the average length of therapy, etc.), it seems quite apparent, as may be expected, that therapists are more correct/realistic than lay people.

However, where some of the most consistent and dramatic changes do appear is in the beliefs about the efficacy of different therapies and the prognosis of different problems. In both, therapists seem more skeptical. By-and-large, therapists see the different therapies as much less generally useful than lay people, who seem to think that particularly cognitive and psychodynamic therapies have pretty wide application to many different problem areas. The only area where these differences are not apparent is in the area of behavioral techniques, where therapists believe some more generally efficacious than lay people. It seems as if therapists believe that different therapies are suitable for particular problems (and that some therapies are by-and-large fairly useless), while lay people believe therapies are suitable for a wide range of psychological problems.

The issue of lay person naivete vs. therapist skepticism is best observed on the issue of prognosis. On the whole, and with relatively few exceptions, lay people believe the prognosis for a wide range of psychological problems to be better than the therapists. Again, it is very difficult to obtain reliable and valid figures on prognosis such that one might be able to say who is right or wrong, but it does seem the case that lay people are overoptimistic regarding the prognosis of physically-based deteriorating illnesses like dementia.

The issue of patient/client expectations is an important one because such well-known processes as self-fulfilling prophecies, placebo effects, and attribution errors, expectations about the nature of treatment and the efficacy of cure can contribute in a very real way to the client's progress in therapy. Equally unrealistic and hence unfulfilled expectations can do the precise opposite (Furnham, 1988). Hence, it may be extremely important to elicit lay beliefs early on in the therapy process (through interview and questionnaire) to determine the clients' beliefs about their problem — etiology, prognosis, the type of therapy that they are expecting to receive, and its perceived efficacy. Where necessary, misguided beliefs can be corrected at the beginning of the treatment if thought to be appropriate.

Research such as this has, however, a number of important methodological problems. The first concerns the issue of *confounding variables* — for instance, the therapists were significantly better educated than the lay people and it could be education, rather than occupational difference that accounts for these results. One way to deal with this problem would be through an analysis of co-variance, but as these variables and others are likely to be confounded in reality it would be extremely difficult to co-vary all confounding variables. This research may demonstrate important and striking differences but not necessarily be able to account for their origins. Second, there may be important systematic individual dif-

ferences between lay people as a function of education or more likely differences between therapists from different schools of thought and practice. However, it is indeed a testament to the robustness of these findings that so many group differences arose despite the possible importance of individual difference variables.

Finally, when comparing the beliefs of different groups such as in this study, it is most desirable to have some base-rate, reliable data in order to establish which of these groups is more likely to be correct or realistic in their judgment. Whereas in the judgments of some so-called experts vs. naive persons, this data may be available, but in the area of mental health treatment such data that do exist are incomplete and frequently unreliable. Whereas for some of the items there is no doubt sufficient evidence to be able to adjudicate between therapists and lay people, in general, this does not exist. It is all too tempting to believe the therapists are more often realistic than lay people because of their experience in this area. However, there is such a wealth of evidence in clinical, cognitive, and social psychology of the nature and type of perceptual and cognitive errors and biases that it would seem unwise simply to believe an expert group, however honest their perceptions may be.

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