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Research Article

Social representations of mental illness among professionals and non-professionals illustrated with the example of schizophrenia

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Abstract

Objective: People with psychotic spectrum disorders may experience social exclusion and its negative effects, so it is important to find out the reason for this exclusion. The paper presents social representations of schizophrenia in the context of traits attributed to persons suffering from schizophrenia as compared to healthy persons by groups of non-professionals and professionals (psychiatrists and psychologists).

Method: The participants were 230 individuals aged 23-74, all with higher education. They were asked to assess to what extent 30 personality traits can be attributed to people with schizophrenia and to healthy people.

Results: The results show significant interactions between the respondents' professions and their perceptions of mental health. While all the professional groups have more negative views of people suffering from schizophrenia than of healthy people, the most negative assessments of people with schizophrenia are made by non-professionals. There is a significant interaction between one's profession and perception of mental health as regards positive traits. Only the group of non-professionals considered the level of positive traits displayed by people with schizophrenia as lower than the level displayed by mentally healthy people. Furthermore, non-professionals assessed mentally healthy people more positively than did both groups of professionals.

Conclusion: People with schizophrenia may experience negative effects of exclusion. The research results presented in this paper provide the starting point for explaining the reasons for this. The study indicates a tendency to stigmatize schizophrenics, which is most visible in the attribution of less positive features to them compared to healthy people. This mainly applies to non-professionals. The results indicate the need to conduct educational programs and campaigns about mental illnesses, available to the entire society. Educational efforts aimed at the entire society should provide detailed information about mental illnesses like schizophrenia. Education is the basis for shaping and modifying society's beliefs about people with mental illnesses.

Introduction

Mental illnesses are among the most important threats and challenges present in the contemporary world. They affect 110 million people in Europe [1]. 12% of the world's population experienced mental disorders in 2019. Mental disorders jumped in the ranking of top causes of health loss worldwide to 7th place [2].

Data from research carried out in 2010 in EU countries [3] show that each year, more than 38.2% of the entire EU population (164.8 million people) suffer from one of the 27 investigated mental disorders. Psychotic disorders, including schizophrenia, affect approx. 5 million people.

In the EZOP research [4], focusing on the epidemiology of psychiatric disorders in Poland and the mental condition of Poles, it was found that 23.4% of the studied population were diagnosed with at least one disorder out of 18 defined in ICD-10 and DSM-IV classifications in their lifetime. When extrapolated to the general population, this produces over 6 million people of working age living in Poland. In that same study, only approx.

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30.6% of participants (corresponding to approx. 7.91 million people in the studied population) declared they had ever met a person with a mental illness. This means that in the case of the greater part of the population, perceptions of mentally ill people do not have a solid foundation and apparently are based on popular stereotypes.

The results of previous studies show that people with psychotic spectrum disorders experience negative effects of exclusion and rejection [5]. In Poland people with mental illnesses are treated with great reserve: when it comes to all roles and situations connected with responsibility and trust, objection is much more common than acceptance. The roles that people with mental illnesses are allowed to perform (acceptance more common than objection) are only relatively distant, parallel ones, not involving trust or a considerable measure of responsibility. The system of distance described in the EZOP research is very restrictive and exclusive, regardless of the respondents' sex or age [4].

Hence, those with mental illnesses do not only suffer from the disorder but also from stigmatization and exclusion. The stigma of mental illness is strong and prevalent in the Polish society. It hampers the process of getting well because it is a huge burden for psychiatric patients [6].

The present study concerns lay knowledge, i.e., intuitive, abstract representations of mental illnesses on which people tend to rely so as to understand, interpret, and predict the social world they live in. Lay knowledge may differ a lot from scientific knowledge but ensures a person a cognitive framework to perceive particular social groups; it may also be connected with the mechanisms of prejudice and discriminative practices [7].

The theory of social representations is one of the concepts within the area of lay knowledge. Lay knowledge refers to individual knowledge, whereas social representations are characteristic of entire social groups [8].

The social representations theory is useful in explaining and describing i.e., mental illnesses (the representation of madness). Social representations do not only refer to reality but actually also create it and give it some meaning. The representations are formed and modified in the process of communication and integrate social groups that understand and evaluate behaviors or events in the surrounding world similarly [8]. They may serve some functions in identity protection and maintaining social inequalities or social exclusion [9].

Since social representations are produced by social groups, different groups may have different representations of the same phenomenon or object. For example, the representations of madness or mental illness shared by experts may differ from ones shared by people who are not professionals in that area. The author adopted the theory of social representations because assumes that education, knowledge about mental illness, and greater contact with sick people will cause differences in the perception of people with schizophrenia among various professional groups. The aim of the work is to analyze the perception of traits of mentally ill people and healthy people and to compare the differences between groups of experts and group of non-professionals.

Methods

Research tool

The questionnaire was prepared in Polish and consisted of demographics and the list of personality traits used in an earlier study [10]. Four traits, however, were added to the list (apprehensive, open, withdrawn, sociable). The four features (2 positive and 2 negative) were added to the questionnaire because its original version (intended to study rehabilitated people) did not include features that often accompany an episode of schizophrenia, such as anxiety and difficulties in interpersonal contacts. On the other hand, the added features (in their negative aspects) may be a consequence of the social stigmatization of people with schizophrenia.

The set of features was used because the author assumed that people differ in personality, regardless of the group they belong to (healthy *vs.* mentally ill). Attributing particular characteristics (especially negative ones) to specific social groups is associated with the process of stigmatization and all its consequences.

The final questionnaire consisted of 30 traits. In the first part of the questionnaire, the participants assessed a person suffering from schizophrenia to what extent she/he possesses each of the mentioned features separately on a 5-point scale (1 this trait definitely does not apply to a person suffering from schizophrenia; 5- this trait definitely applies to a person suffering from schizophrenia). In the second part of the questionnaire, the participants assessed a healthy person to what extent she/he possesses the same 30 features on a 5-point scale (1-this trait definitely does not apply to a healthy person; 5- this trait definitely applies to a healthy person). Additionally, positive/negative traits were calculated as the arithmetic mean of all positive or negative traits, respectively.

Sample

A total of 230 participants completed the questionnaire, of whom 59 were psychiatrists (six physicians in the course of specialization in psychiatry were included in the group of psychiatrists), 77 were psychologists, and 94 were representatives of other professions with higher education. All respondents were Polish. The inclusion criterion for the study was higher education.

In the psychiatrist's group, 41 were female, and 18 were male. Their ages ranged from 25 to 74 (M = 39.10; SD = 12.15). Seven (11.9%) of the psychiatrists had a medical history of mental illness, 27 (45.8%) had relatives, and 41 (69.5%) had friends who suffered from mental illnesses.

There were 62 female and 15 male psychologists. Their age ranged from 25 to 62 (M = 38.47; SD = 8.49). Three (3.9%) of the psychologists had a medical history of mental illness, 21 (28.4%) had relatives and 38 (49.4%) friends who suffered from mental illnesses.

In the group of other professions, 68 were female and 26 were male. Their ages ranged from 23 to 74 (M = 39.19; SD =

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11.86). Three (3.2%) of the third group had a medical history of mental illness, 14 (14.9%) had relatives and 25 (26.6%) friends who suffered from mental illnesses.

Data collection

Participants were informed about the purpose of the study and the anonymity and voluntary nature of participation in the study. Completing the survey, the respondents agreed to participate in the study.

The survey was posted on MySurveyLab; information about the survey was sent to e-mail addresses of psychiatric treatment centers throughout Poland with a request to have it completed by the psychiatrists and psychologists working there. Furthermore, the link to the questionnaire was posted on a social networking group for psychiatrists and psychologists on Facebook with a request to complete it. As a result, the questionnaire was completed by 36 psychiatrists, 38 psychologists, and 9 people with other higher education. Additionally, in order to reach a wider group (including those who do not use e.g., Facebook), a paper form of the questionnaire was distributed by students of pedagogy. The paper-and-pencil version was completed by 39 psychologists, 23 psychiatrists, and 85 people with other higher education.

The online survey was conducted in various regions of Poland. However, the study using a paper questionnaire was limited to the Silesian Voivodeship (southern Poland). The research was conducted from 2019 to March 2020 (it was completed due to the COVID-19 pandemic). All participants in the research completed the questionnaire voluntarily and anonymously, which was their consent to participate in the study.

Statistical analyses

All statistical analyses were performed using IBM SPSS 8.0. Descriptive statistics were calculated for each trait separately for each profession (psychiatrists, psychologists, other professions) and the assessed person (mentally ill/healthy). Two-Way Mixed-Design ANOVA (MANOVA) was conducted. Wilks's Lambda, F-ratios p-value, and Eta Squared (effect strength) were calculated. Since MANOVA turned out to be statistically significant, a contrast analysis was performed.

Results – Characteristics of people with schizophrenia and healthy people

To check whether there is a significant difference in traits attributed to people with schizophrenia and healthy people between different professional groups, Two-Way Mixed-Design ANOVA (MANOVA) was conducted. The results showed there was a difference between the three professional groups with regard to different characteristics, $\Lambda = 0.558$, $F(60.396) = 2.23$, $p < 0.001$, $\eta 2 = 0.25$. Tests of contrasts showed 18 interaction effects between professional groups and the perception of mental health (Table 1).

In the case of the 'ambitious' trait, the interaction effect is that non-professionals assess people suffering from schizophrenia as being less ambitious than healthy people. In the group of psychiatrists and psychologists, such a difference does not exist.

A similar effect exists in the case of being 'firm'. In addition, non-professionals assess healthy people as more decisive than do psychiatrists and psychologists.

With regard to being 'calm', psychiatrists evaluate healthy and sick people similarly. However, both psychologists and other professions assess people with schizophrenia as less calm than healthy people. In addition, non-professionals have a greater tendency to attribute this trait to healthy people than do psychiatrists.

'Honesty' is attributed to people suffering from schizophrenia at a similar level by the three professional groups. Non-professionals attribute it to people with schizophrenia less than to healthy people. Furthermore, psychiatrists consider healthy people as honest less than non-professionals.

Being 'prone to anger' is a trait that does not differentiate between psychiatrists and psychologists in terms of the level of attribution either to people with schizophrenia or to healthy individuals. The non-professional group tends to judge patients with schizophrenia as more prone to anger than healthy people. In addition, members of that professional group perceive people with schizophrenia as more prone to anger than do psychiatrists and psychologists.

In the case of traits such as 'trustworthy', 'forgiving', and 'willing to cooperate', the interactions between mental health perception and the professional group are similar. Both psychologists and non-professionals (but not psychiatrists) assess people suffering from schizophrenia as less trustworthy, less forgiving, and less willing to cooperate than healthy people. In addition, psychiatrists tend to attribute traits such as trustworthiness, forgiveness, and willingness to cooperate to healthy people to a lesser degree than psychologists and non-professionals.

Psychiatrists and the non-professional group (but not psychologists) perceive people with schizophrenia as less 'devoted to the family' than healthy people. At the same time, the non-professional group has a greater tendency to attribute this feature to healthy people than do psychiatrists and psychologists.

All three surveyed professional groups rate people with schizophrenia as less 'open' than healthy people. In addition, psychiatrists and psychologists have a lower tendency to attribute this trait to healthy people than do non-professionals.

'Loyalty' is less attributed to people with schizophrenia than to healthy people by the non-professional group (not psychiatrists and psychologists.) Moreover, psychiatrists and psychologists have a lower tendency to attribute this trait to healthy people.

'Aggressiveness' is attributed to people with schizophrenia more than to healthy people by all three professional groups. However, psychiatrists and psychologists have a lower

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Table 1: Traits of people with schizophrenia and of healthy people.

	Traits of people with schizophrenia (sch)			Traits of healthy people (h)			Differences between sch and h	Differences between professions	Differences between professions	Interaction effect profession*health
	Profession			Profession				sch	h	
	A Mean (S.D.)	B Mean (S.D.)	C Mean (S.D.)	A Mean (S.D.)	B Mean (S.D.)	C Mean (S.D.)				F level
Ambitious	2.88 (0.70)	3.05 (0.61)	3.13 (1.08)	2.92 (0.82)	3.12 (0.78)	3.60 (0.95)	**Csch<Ch**	-	-	**4.07***
Firm	2.63 (0.74)	2.90 (0.82)	2.93 (1.09)	2.83 (0.75)	2.95 (0.74)	3.44 (0.82)	**Csch<Ch**	-	**C > A C > B**	**3.67***
Shiftless	3.24 (0.92)	3.23 (0.90)	3.18 (0.97)	2.64 (0.87)	2.57 (0.88)	2.66 (0.98)	Asch>Ah Bsch>Bh Csch>Ch	-	-	0.24
Greedy	2.14 (0.97)	2.36 (0.93)	2.23 (1.07)	2.51 (0.82)	2.71 (0.83)	2.91 (0.96)	Asch<Ah Bsch<Bh Csch<Ch	-	A<C	1.81
Calm	2.83 (0.89)	2.71 (0.79)	2.57 (1.07)	2.83 (0.81)	3.08 (0.76)	3.24 (0.85)	**Bsch<Bh Csch<Ch**	-	**A<C**	**5.67****
Honest	3.07 (1.00)	3.13 (0.77)	3.09 (0.95)	2.86 (0.86)	3.17 (0.66)	3.44 (0.92)	**Csch<Ch**		**A < C**	**4.59***
Busy	3.00 (0.72)	3.05 (0.76)	3.40 (0.95)	2.81 (0.80)	3.25 (0.75)	3.55 (0.91)	-	A < C B < C	A<C A<B	2.78
Prone to anger	3.00 (0.72)	3.03 (0.84)	3.69 (1.02)	2.71 (0.77)	2.90 (0.82)	2.87 (0.99)	**Csch>Sh**	**A<C B<C**	-	**8.29****
Lazy	2.51 (0.82)	2.81 (0.78)	2.49 (0.95)	2.64 (0.80)	2.74 (0.72)	2.72 (0.97)	Csch<Ch	-	-	1.69
Trustworthy	2.92 (0.60)	2.71 (0.69)	2.69 (0.89)	2.90 (0.90)	3.27 (0.77)	3.50 (0.89)	**Bsch<Bh Csch<Ch**	-	**A<B A<C**	**9.88****
Forgiving	3.03 (0.69)	2.95 (0.63)	3.10 (0.80)	2.85 (0.81)	3.18 (0.74)	3.38 (0.82)	**Bsch<Bh Csch<Bh**	-	**A<B A<C**	**4.95****
Willing to cooperate	2.80 (0.74)	2.84 (0.65)	2.89 (0.90)	2.78 (0.91)	3.22 (0.75)	3.53 (0.91)	**Bsch<Bh Csch<Ch**	-	**A<B A<C**	**6.21****
Coarse	2.56 (0.79)	2.74 (0.80)	2.78 (0.99)	2.51 (0.84)	2.56 (0.93)	2.53 (0.99)	Csch>Ch	-	-	0.50
Dedicated to the family	2.59 (0.81)	2.75 (0.73)	2.86 (0.92)	2.95 (0.86)	3.01 (0.70)	3.69 (1.02)	**Asch<Ah Csch<Ch**	-	**A<C B<C**	**5.38****
Apprehensive	3.66 (0.96)	3.65 (0.91)	3.84 (0.98)	2.69 (0.88)	2.79 (0.89)	2.72 (0.98)	Asch>Ah Bsch>Bh Csch>Ch	-	-	0.80
Open	2.46 (0.92)	2.39 (0.78)	2.46 (1.05)	2.90 (0.96)	3.19 (0.89)	3.54 (0.95)	**Asch<Ah Bsch<Bh Csch<Ch**	-	**A<C B<C**	**4.93****
Loyal	2.97 (0.74)	2.97 (0.73)	2.95 (0.88)	2.93 (0.83)	3.13 (0.78)	3.59 (0.93)	**Csch<Ch**	-	**A<C B<C**	**7.27****
Unyielding	2.85 (0.83)	2.90 (0.77)	3.02 (1.19)	2.78 (0.65)	2.90 (0.70)	3.09 (0.85)	-	-	A<C	0.26
Aggressive	2.98 (0.63)	2.92 (0.66)	3.47 (0.99)	2.58 (0.79)	2.61 (0.83)	2.40 (0.99)	**Asch>Ah Bsch>Bh Csch>Ch**	**A<C B<C**	-	**10.80****
Persistent	2.51 (0.75)	2.81 (0.69)	2.84 (0.95)	2.85 (0.78)	3.21 (0.77)	3.45 (0.92)	Asch<Ah Bsch<Bh Csch<Ch	A<C	A<B A<C	1.32
Reasonable	2.64 (0.71)	2.69 (0.65)	2.48 (0.90)	2.90 (0.82)	3.21 (0.77)	3.55 (1.00)	**Bsch<Bh Csch<Ch**	-	**A<C B<C**	**10.10****
Insidious	3.32 (0.88)	2.48 (0.81)	2.62 (1.15)	2.51 (0.88)	2.62 (0.78)	2.62 (0.99)	-	-	-	0.51
Communicative	3.41 (0.95)	3.35 (0.86)	3.34 (1.05)	3.17 (0.97)	3.39 (0.89)	3.86 (0.98)	**Csch<Ch**	-	**A<C B<C**	**8.73****
Do not let others push them around	2.93 (0.89)	2.95 (0.71)	3.07 (0.96)	2.83 (0.77)	3.17 (0.77)	3.30 (0.91)	Csch<Ch	-	A<C	1.96
Able to refuse	2.92 (0.95)	2.86 (0.68)	3.18 (0.99)	2.97 (0.83)	3.23 (0.86)	3.59 (0.93)	Bsch<Bh Csch<Bh	-	A<C B<C	2.37
Keeping his/her word	2.90 (0.74)	2.91 (0.59)	2.76 (0.86)	2.97 (0.83)	3.19 (0.78)	3.64 (0.95)	**Bsch<Bh Csch<Ch**	-	**A<C B<C**	**10.77****
Impetuous	2.86 (0.68)	3.01 (0.73)	3.67 (1.07)	2.58 (0.89)	2.70 (0.73)	2.66 (1.00)	**Bsch>Bh Csch>Ch**	**A<C B<C**	-	**10.67****
Independent	2.44 (0.77)	2.56 (0.66)	2.54 (0.94)	2.98 (0.92)	3.16 (0.86)	3.60 (0.88)	**Asch<Ah Bsch<Bh Csch<Ch**	-	**A<C B<C**	**4.75****
Withdrawn	3.29 (0.92)	3.66 (0.99)	3.34 (0.97)	2.61 (0.77)	2.68 (0.79)	2.43 (1.08)	Asch>Ah Bsch>Bh Csch>Ch	-	-	2.07
Sociable	2.36 (0.94)	2.49 (0.74)	2.54 (1.01)	2.90 (0.82)	3.10 (0.75)	3.78 (0.96)	**Asch<Ah Bsch<Bh Csch<Ch**	-	**A<C B<C**	**8.37****

A: Psychiatrists; B: Psychologists; C: Other professions; **$p < 0.01$ *$p < 0.05$; Higher scores indicate higher agreement. ABC – post hoc.

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tendency to attribute it to people with schizophrenia than do non-professionals.

'Reasonableness' is less attributed to people with schizophrenia than to healthy people by psychologists and the non-professional group (but not psychiatrists). In addition, the non-professional group has a greater tendency to attribute this trait to healthy people than do psychiatrists and psychologists.

'Communicativeness' is less attributed to people suffering from schizophrenia than to healthy people by the non-professional group. In addition, they overestimate its level among healthy people (in comparison with the opinion of psychiatrists and psychologists).

Psychologists and the non-professional group (but not psychiatrists) believe people with schizophrenia keep their word less than healthy people. 'Keeping one's word' is overestimated among healthy people by the non-professional group as compared to psychiatrists and psychologists.

Psychologists and the non-professional group (but not psychiatrists) consider people suffering from schizophrenia as more 'impetuous' than healthy people. In addition, in comparison with psychiatrists and psychologists, the non-professional group attributes a greater intensity of this trait to schizophrenics.

The characteristics of 'independence' and 'sociability' are attributed to people with schizophrenia to a lesser extent than to healthy people by all three professional groups. Moreover, the non-professional group attributes these traits to healthy people to a greater extent than do psychiatrists and psychologists.

Apart from the interaction effects discussed above, all three professional groups assessed people with schizophrenia as more shiftless, apprehensive, and withdrawn, and less greedy and persistent than healthy people.

To check whether there is a significant difference between different professional groups in positive and negative characteristics attributed to people suffering from schizophrenia and healthy people, Two-Way Mixed-Design ANOVA (MANOVA) was conducted. The results showed there was a difference between the three professional groups, $\Lambda = 0.909$, $F(4.452) = 5.495$, $p < 0.001$, $\eta 2 = 0.046$. Tests of contrasts showed 1 interaction effect between professional groups and the perception of mental health (Table 2).

In the case of positive traits, the interaction effect between the variables 'perception of mental health' and 'profession' is that non-professionals (not psychiatrists or psychologists) attribute more positive traits to healthy people than to people with schizophrenia. They also attribute positive characteristics to healthy people to a greater extent than do psychiatrists and psychologists.

In the case of negative traits, the interaction effect is negligible. However, there are differences in the attribution of negative traits. All three professional groups attribute more negative characteristics to people with schizophrenia than to healthy people. What is more, in comparison with psychiatrists, non-professionals attribute more negative traits to schizophrenics.

Discussion

This study was designed to examine the differences between professionals and non-professionals as regards their view on the characteristics of healthy people and people suffering from schizophrenia.

All the professional groups assessed people with schizophrenia as more shiftless, apprehensive, and withdrawn, as well as less greedy and less persistent than healthy people. There was no interaction between the participants' profession and the perception of those traits. All the professional groups assessed people suffering from schizophrenia also as less open, less sociable, less independent, and more aggressive. There were interactions between the participants' profession and the perception of those traits.

Non-professionals compared to both groups of experts tend to overestimate positive traits of healthy people, particularly firmness, devotion to the family, openness, loyalty, reasonableness, communicativeness, keeping one's word, independence, and sociability.

The research showed that in comparison to professionals (psychiatrists, psychologists), non-professionals assess people with schizophrenia more negatively than healthy people, attributing them a greater degree of traits such as being prone to anger, impetuous, and aggressive. It was confirmed that non-professionals, compared to psychiatrists and psychologists, assess people with schizophrenia more negatively. They attribute more negative traits to people suffering from schizophrenia and perceive them as more dangerous than

Table 2: People's suffering from schizophrenia and healthy people's positive and negative traits.

	Features of people with schizophrenia (sch)			Features of a healthy person (h)			Differences between sch *vs.* h	Differences between profession	Differences between profession	Interaction effect profession*health
	Profession			Profession				sch	h	
	A Mean (S.D.)	B Mean (S.D.)	C Mean (S.D.)	A Mean (S.D.)	B Mean (S.D.)	C Mean (S.D.)				F level
Positive features	2,98 (0,54)	3,02 (0,45)	3,06 (0,51)	2,90 (0,74)	3,17 (0,66)	3,54 (0,74)	**Csch < Ch**	-	**A < C** **B < C**	**10,42****
Negative features	2,89 (0,53)	2,95 (0,53)	3,13 (0,57)	2,61 (0,66)	2,71 (0,60)	2,69 (0,74)	Asch > Ah Bsch > Bh Csch > Ch	A < C an and b < c	-	1,53

A: Psychiatrists; B: Psychologists; C: Different Professions; **$p < 0,01$; *$p < 0,05$; Higher scores indicate higher agreement. ABC- post hoc; abc- a priori.

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psychiatrists and psychologists. This situation may result from society's lack of knowledge about mental illnesses and the media's publicity of negative social phenomena (e.g. aggressive crimes) as a consequence of mental illness. Experts with knowledge and greater experience in contact with various mentally ill people have more opportunities to revise media messages.

The perception of a person suffering from schizophrenia revealed by non-professionals is similar to the results of the study by M. Kowalczyk and colleagues [11], in which Poles showed a tendency to negatively interpret the portrait of a person suffering from schizophrenia, and based on prejudices, they emphasized pejorative traits such as psychomotor agitation, aggression, and threat. Moreover, most Poles believe that a person suffering from schizophrenia is disabled and this makes it difficult for them to meet their own needs – they need financial support. 56% of Poles would not employ a person with schizophrenia, and 57,7% of them would not enter into a romantic relationship with a person suffering from schizophrenia. In the same research, half of Poles claim that a person with schizophrenia does not have the right to start a family and act as a parent. This showed the perception of a person with schizophrenia as unable to take responsibility for their partner and offspring and unable to provide an adequate standard of living for their family.

Also in the research of Targońska, et al. [12], a negative image of a mentally ill person emerges. Mentally ill people were perceived as avoiding the eyes of passers-by (30%), depressed and sad (40,91%), avoiding strangers (32,73%), and unable to cooperate (29,09%). Moreover, 76,36% of Poles believed that mentally ill people should not work in socially responsible professions, and 44,55% of respondents said that they should not take care of children.

The advantage of the conducted study, compared to previous studies is the comparison of specific personality traits attributed to a person with schizophrenia and a healthy person (taking into account profession), which allows for the explanation of the mechanisms of stigmatization and social exclusion of people with mental illness.

The perception of a mentally ill and mentally healthy person (especially among non-professionals) indicates the tendency known in social psychology, i.e., group categorization and attributing more positive characteristics to "one's own" group, combined with underestimating the positive traits of "the strange" group and overestimating their negative characteristics, providing the basis for prejudice. This phenomenon can be explained by the considerable social distance between people with mental illnesses, revealed in previous research [4].

This social representation of a mentally ill person is also visible and maintained through media messages promoting the perception of psychiatric patients as brutal people with the tendency to commit crimes, especially when the media coverage of a crime includes the information that the criminal was undergoing psychiatric treatment. Such connotation between a mental illness and crime has no justification in science. In fact, research results even show a mental illness does not determine committing a crime [13]. In their assessments, media (and consequently, people) ignore other important motivational factors, e.g., personality (which can differentiate between people - including people with schizophrenia). Such images lead to greater social isolation of people suffering from mental illnesses and their family members, especially in the case of schizophrenia [14].

Stigmatizing labels of a mental illness leads to external negative consequences, such as limited opportunities for having a romantic relationship, getting a job [11] or an apartment [15], and may affect the general quality of life of psychiatric patients, lowering their self-esteem, and through the mechanism of self-fulfilling prophecy, cause their social withdrawal as a way to cope with rejection [15].

The difference between the perceptions of mental illness among professionals and non-professionals is probably due to their education, knowledge, and possibilities of correcting social messages based on experiences of contact with mentally ill people. Education is therefore the foundation for overcoming the stigmatization of mentally ill people. The educational role of professionals in shaping the sense of responsibility for overcoming stigmatization should be emphasized here. The vast majority (92,73%) of the participants in the study by Targońska, et al. [12] believed that the level of education about mental disorders in Poland is insufficient, and 51,82% of Poles claim that the topic of mental illnesses is rarely discussed in social campaigns. It should be noted that in the same study, 51,82% of respondents stated that schizophrenia is the most stigmatizing disease, and 60,91% stated that mental illness is a shameful disease because one is perceived as worse than others.

The research results showed also interesting differences between professionals: psychologists and psychiatrists. Both psychologists and non-professionals (but not psychiatrists) assess people with schizophrenia as less trustworthy, less forgiving, and less cooperative than healthy people. On the one hand, this relationship may result from the fact that psychiatrists attribute these features to healthy people to a lesser extent (they generally do not overestimate them) than psychologists and non-professionals. On the other hand, psychiatrists are the first people in contact in the event of a disease flare to experience cooperation from patients, e.g. regarding taking medications, and they are also people who listen to intimate confessions about, for example, positive symptoms – which can build the image of the patient as trustworthy, as well as forgiving, for example when recovering from a paranoid episode. Psychologists most often have contact with the patient/client after leaving the hospital, during the period of remission, and this contact may be less intimate.

Another difference in the attribution of traits between psychologists and psychiatrists concerns "dedicated to the family". Psychiatrists and laypeople (but not psychologists) perceive people with schizophrenia as less dedicated to the family than healthy people. This difference may result from

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the different experiences of psychologists and psychiatrists in contact with people with schizophrenia. In the hospital, psychiatrists rather observe the family's dedication to the patient, e.g. in the form of visits or providing necessary supplies. However. Psychologists, often psychotherapists, in the therapeutic process (after completing hospital treatment) will often notice the patient's/client's involvement in family life and the emotional connection with the family.

Limitations

The first limitation of the presented study is that the results can only be applied to the Polish population with higher education. Due to the way the research was conducted, it should also be noted that respondents from the Silesian Voivodeship (southern Poland) were overrepresented.

The second limitation of the study is that it was conducted using the self-report method, which only indicates a cognitive aspect of attitudes toward people with schizophrenia (social representations). In the future, an important step will be to study the actual behavioral components of attitudes towards people suffering from schizophrenia.

Conclusion

The research results presented in this paper provide the starting point for explaining the reasons for the exclusion and rejection of people with schizophrenia. Stigmatization is a process caused mainly by the lack of knowledge of the population, characterized by a negative assessment of the mentally ill person, affecting the lower quality of life. The study results show that stigma is present mainly among non-professionals. It would be necessary to conduct educational programs and campaigns about mental illnesses, available to the entire society. Educational efforts aimed at the entire society should provide detailed information about mental illnesses like schizophrenia. Education is the basis for shaping and modifying society's beliefs about people with mental illnesses.

(Appendix)

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